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THE BUCK STOPS WHERE? A CRITIQUE OF VICARIOUS LIABILITY IN THE MEDICAL MALPRACTICE CONTEXT

C. J. COLWELL[†]

*In Canadian tort law, liability is almost always linked to some notion of fault, save for a few well-established exceptions. By far the most common exception is vicarious liability, i.e. the liability of employers for the torts of their employees. In its 1999 ruling in *Bazley v. Curry*, the Supreme Court of Canada articulated exactly why this kind of faultless liability exists in Canada, and how it is justified.*

In medical malpractice cases involving teaching hospitals, there are usually three possible defendants to a negligence action: the attending physician, the treating resident, and the hospital. Due to the legal nature of their employment relationship, if the resident is found liable, so too is her employer, the hospital. This liability is regardless of fault. The attending physician, on the other hand, can only be held liable with fault.

*This paper proposes that imposing vicarious liability on the hospital or any other party in this type of action is inconsistent with the justifications outlined in *Bazley v. Curry*. Liability in this particular context, it is argued, should be limited to liability with fault.*

This paper also briefly explores possible reasons why the courts have demonstrated a general preference to have hospitals, rather than attending physicians, pay judgments to injured plaintiffs. It takes notice of a newly emerging non-delegable duty of care owed by hospitals to patients, and further points out the unique public source of funding for malpractice judgments regardless of who is liable.

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INTRODUCTION: INTUITIVE QUESTIONS AND LEGAL INCONSISTENCIES

On May 30th, 1997, the Newfoundland Court of Appeal (NLCA) delivered its ruling in *Kielley v. General Hospital Corp.*¹ The appeal involved a hospital found vicariously liable for the negligent harm caused by a resident in its employ. Relying upon the 1982 Nova Scotia case *Considine v. Camp Hill Hospital*, the hospital pled that the attending physician, supervising the resident and ultimately responsible for the welfare of the patient, should also have been held vicariously liable.²

The hospital's position, intuitively, makes a lot of sense. A hospital is a fictional entity, and while fictional entities (like corporations, for example) are quite often found liable at law, in this case, it was the attending physician who actually admitted the patient, supervised the resident, and was the instrument by which the hospital enforced the quality of care. He was an independent contractor with "hospital privileges," and was directing the resident towards the ends of his own private enterprise. He was billing the provincial health authority for the patient's care. He was the fully qualified individual medically responsible for the patient for the entire length of his admittance; he could quite reasonably be expected to bear some of the responsibility for the patient's loss. The expert medical witnesses who testified at trial voiced similar concerns.³

The Court found that this was not the case at law. It found that the attending physician, by no means the employer of the resident, could not be found vicariously liable for the negligent harm caused by the resident under his supervision. The hospital, on the other hand, employing the resident, was easily found to be vicariously liable, and thus jointly and severally liable with the resident for the damages awarded to the plaintiff.

¹ *Kielley v. General Hospital Corp.* [1997] N.J. No. 123 (N.L.C.A.) (QL) [*Kielley*].

² *Considine et al. v. Camp Hill Hospital et al.* (1982), 133 D.L.R. (3d) 11 (N.S.S.C.) (QL) [*Considine*].

³ *Supra* note 1 ¶ 30.

The focus of this project is whether this decision accurately reflects the law in Canada. Vicarious liability has a long history in the common law, and since the 1999 Supreme Court of Canada case *Bazley v. Curry*, Canadian common law has had an explicit articulation of why it exists at all.⁴ The operation of and the justifications for vicarious liability are intriguing, but in cases like *Kielley* and *Considine*, they are ultimately problematic. Insofar as vicarious liability operates in the medical malpractice context, I argue that finding the hospital vicariously liable - that is, liable without fault - is inconsistent with the goals of and justifications for that very liability. In particular, substantial problems arise over both the possibility of future deterrence, as well as providing just and fair compensation when vicarious liability is applied in the medical malpractice context. In addition, there has occasionally been insufficient separation between the two very separate legal issues of *faultless* vicarious liability, and breaches of direct duties of care leading to liability *with fault*.

In order to demonstrate this legal phenomenon, we shall begin with an exploration of vicarious liability in general as it exists in Canada. Then, we shall examine the relationships, legal and otherwise, between residents, physicians, and hospitals.⁵ In doing so, we shall demonstrate that, while *Kielley* may have been rightly decided based upon previous case law, vicarious liability in the medical malpractice context is inconsistent with its own justifications in Canadian law. Finally, I will propose possible solutions to this legal inconsistency, and then briefly consider the relatively new emergence of a possible non-delegable duty of care owed by hospitals to individual patients.

⁴ *Bazley v. Curry*, [1999] 2 S.C.R. 534 [*Curry*].

⁵ It must be stated at the outset that we are confining ourselves to dealing only with the vicarious liability that currently operates between hospitals, physicians, and residents, and are not venturing to say what our conclusions might entail for other healthcare workers such as nurses, alternative practitioners, or hospital custodial staff.

I: VICARIOUS LIABILITY: GENERAL PRINCIPLES

Operation

Before continuing, it is important to articulate exactly the kind of liability we are talking about. By vicarious liability, we are referring to legal liability for the acts of another *without fault*. The employer (or other liable party) does not need to be at fault for vicarious liability to operate. If an employer fails to supervise adequately, does not take proper steps to ensure the quality of the employee during hiring, does not provide proper instruction or equipment, or in any other way falls below the requisite standard of care, then liability is direct and lies in negligence. Liability with fault is also in effect when an employer, while meeting the standard of care in its own actions, owes a non-delegable duty of care to the plaintiff that was subsequently breached by an employee (and so, was breached by the employer). Vicarious liability kicks in when the tortfeasor-employee was at fault, and the employer has met its own standard of care, *but is nevertheless* found liable. It is much easier to internally justify vicarious liability if it is somehow linked to fault, but this must be avoided. The only “fault” that exists linking the employer to the harm caused by the employee is that the harm must have been caused via a tort. What we are talking about in this project is liability without fault, for the acts of another, in a negligence action.

Despite our intuitive sense that liability should somehow be linked to fault, vicarious liability is firmly entrenched in the common law, and has been for over three hundred years. The 1698 case of *Jones v. Hart* articulates the law of *respondeat superior* (“let the superior answer”), the legal ancestor of vicarious liability:

The action well lies in this case: If the servants of A, with his cart run against another cart, wherein is a pipe of wine, and overturn the cart and spoil the wine, an action lieth

against A. So where a carter's servant runs his cart over a boy, action lies against the master for the damage done by this negligence: and so it is if a smith's man pricks a horse in shoeing the master is liable. For whoever employs another, is answerable for him, and undertakes for his care to all that make use of him.

The act of a servant is the act of his master, where he acts by authority of the master.⁶

Strict liability in general is a relative anomaly in the common law. According to P.S. Atiyah:

[I]n the modern law of torts liability is still generally based on some notion of 'fault.' A person is not, subject to well known exceptions, generally liable in tort except where he has intentionally or negligently caused some loss or damage to the plaintiff.⁷

As mentioned above, vicarious liability is not strict *per se*, as the servant (henceforth used interchangeably with "employee") must have committed an initial tort. Non-tortious harms caused by the employee will not suffice. However, once this has been established, then the master (employer) will also be liable, regardless of personal intent or negligence. It cannot be stressed enough that, contrary to general tort principles, vicarious liability is imposed without fault.

After the commission of an initial tort, there are two more requirements necessary for vicarious liability to operate. First, there must be a relationship between the tortfeasor and the defendant that gives rise to the liability. Second, that relationship must somehow be connected to the commission of the tort.⁸ By far, the relationship most likely to give rise to vicarious liability is that of employer and employee. Independent contractor and principal-agent

⁶ *Jones v. Hart* (1698), 90 E.R. 1255 (K.B.) at 1255.

⁷ P. S. Atiyah, *Vicarious Liability in the Law of Torts* (London: Butterworths, 1967) at 3.

⁸ *Ibid.*

relationships can sometimes create this kind of liability as well, though for our purposes only independent contractors and employment relationships are relevant.⁹

The key factor for determining whether or not an employment or pseudo-employment relationship exists was traditionally the degree of control exercised by one party over the other.¹⁰ This criterion is quite effective when dealing with simple employment relationships. For example, if one were to open up a transport-trucking business, and hire a driver to deliver various goods, then it would logically follow that the employer would be liable for the negligent harms caused by the driver. The employer can dictate when the driver travels, how she shall drive, the timings she has to meet, and can establish that any failure to observe these instructions could result in dismissal. There is a clear element of control exercised by the company over the employee sufficient to invoke vicarious liability (we will visit why this is so below, when justifications for vicarious liability are discussed).

However, as Weinrib notes:

[t]his test of employment has been found to be difficult to apply to skilled workers and professionals, such as physicians working for hospitals, where the employer coordinates the work but cannot plausibly be said to direct the manner in which it is executed.¹¹

Consider our trucking scenario. If the owner is not a trucker herself, and coordinates the shipping of the goods but has no real say in the manner in which the driver delivers them, this kind of problem may exist. The driver being a totally independent enterprise may further complicate it; if she owns her own truck and merely ships goods for the owner, what is the degree of control then? Addressing concerns such as these, “courts have more recently moved to the ‘organization’ test, which asks in effect whether the

⁹ *Ibid.*

¹⁰ Ernest J. Weinrib, *Tort Law* (Toronto: Emond Montgomery, 2003) at 662.

¹¹ *Ibid* at 661.

supposed employee is a cog in the defendant's organizational machinery."¹² Lord Denning commented in *Stevenson, Jordan and Harrison v. Macdonald and Evans* that an employee is employed as part of the business, and his work is done as an integral part of the business, whereas the work of an independent contractor "although done for the business, is not integrated into it but is only accessory to it."¹³

However, this liability for employers is limited. The tort must have been committed within the "scope" of employment. The employer is not unconditionally vicariously liable for the acts of the employee. In *Jones v. Hart*,¹⁴ above, Holt C.J. articulates that the act must be "by authority of the master." The master is not liable if the employee was "on a frolic of his own."¹⁵

This aspect of vicarious liability has been litigated recently in Canada in the cases of *Bazley v. Curry*¹⁶ and *Jacobi v. Griffiths*,¹⁷ and in the U.K. in *Lister v. Hesley Hall*.¹⁸ All of these cases dealt with institutional sexual abuse of children. The Courts' decisions on what conduct was legally within the employee's "scope of employment" were eclectic, but rotated around the basic elements of the "Salmond Test," i.e. "that a wrongful act is deemed to be done by a 'servant' in the course of his employment if 'it is either (a) a wrongful act authorized by the master, or (b) a wrongful and unauthorized mode of doing some act authorized by the master.'"¹⁹

The exact definition of the acts under type (b) was extremely important in all three of those cases, but is of little concern in the vast majority of cases with

¹² *Ibid.*

¹³ *Stevenson, Jordan and Harrison v. Macdonald and Evans*, [1952] 1 T.L.R. 101 at 111 [Evans].

¹⁴ *Supra* note 6.

¹⁵ *Joel v. Morison* (1834), 172 E.R. 1338 (Ex.) as per Parke B., reproduced in Weinrib, *supra* note 10.

¹⁶ *Supra* note 4.

¹⁷ [1999] 2 S.C.R. 570 [Jacobi].

¹⁸ [2001] 2 All E.R. 769 (HL) [Lister].

¹⁹ *Supra* note 18, as per Lord Steyn quoting J.W. Salmond in *Salmond on Torts* (London: Stevens and Haynes, 1907) at 83.

which this current project is concerned. We are here dealing with vicarious liability in the medical malpractice, i.e. negligence, context. Whether or not a hospital would be found vicariously liable for a resident/employee who sexually battered a patient would seem to be unsettled, judging by the Supreme Court of Canada's relatively inconsistent judgments in *Curry* and *Jacobi*.²⁰ It would be difficult to imagine sexual battery as being an unauthorized mode of delivering medical care, though *Curry* might indicate otherwise.²¹

In any case, the tort committed and whether or not the act would pass this part of the test for vicarious liability is relatively moot, considering we are concerned here with the operation of vicarious liability in the medical malpractice context as a whole and whether it is justified at all. The core issue of this paper is not the nature of the act, but, rather, the fundamental justifications for vicarious liability and the courts' arguably unjustified application of it. Henceforth, it will be taken as a given that any tort committed by either a physician or a resident while treating a patient would be considered to satisfy the Salmond test, though we will be focusing primarily upon negligence. Negligent medical treatment, in any case, would seem to qualify quite easily under the principles set out in *Curry and Jacobi*, as medical treatment clearly falls within the scope of employment of healthcare professionals.

We have thus far shown the basic legal elements of vicarious liability as it operates in Canadian law: (1) there must be a relationship which gives rise to a master-servant dynamic (almost always employment, sometimes independent contractors); (2) there must be a tort committed by the servant/ employee; and (3) that tort must have been committed within the scope of employment.

²⁰ In *Curry*, *supra* note 4, the Supreme Court unanimously found that sexual battery within a school's grounds gave rise to vicarious liability. In *Jacobi*, *supra* note 17, it found by a 4-3 split decision that, despite the fact that the relationships between all the parties were remarkably similar to those in *Curry*, the same tort committed in a private home did not give rise to vicarious liability. The decisions were delivered on the same day.

²¹ See also *Weingerl v. Seo*, [2005] O.J. No. 2467, 256 D.L.R. (4th) 1 (Ont. C.A.), where a clinic employee, an ultrasound technologist, sexually battered a patient who came in for an ultrasound. The clinic was found vicariously liable.

Justification

Explaining the operation of vicarious liability in Canada solicits the question: why does it exist at all? As stated above, liability of any kind, be it civil or criminal, is almost always connected to some socially acceptable element of fault. Once the criteria are satisfied, vicarious liability will indemnify a master against a plaintiff regardless of any fault element, intentional or negligent (though recovery through these avenues is not closed to the plaintiff, so long as she can prove that the hospital breached the standard of care or committed the intentional tort).

In *Bazley v. Curry*, McLachlin J. (as she then was) gave a lengthy and extremely useful exegesis of the justifications for vicarious liability in Canadian law.²² Though, as stated above, that case turned upon the issue of scope of employment (as well as the faultless liability of charitable organizations), her survey of the justifications for vicarious liability is generally taken to be authoritative.²³

There are arguably two legal justifications for the existence of vicarious liability. Both are based purely upon policy concerns. The justifications are: (1) deterrence; and (2) fair compensation.²⁴ I would further divide the second point into three categories: (a) satisfaction, i.e. that it is fair and just that the plaintiff have access to a solvent defendant (“deep pockets” compensation); (b) risk creation, i.e. that it is fair and just that those that create the risk should bear the loss; and (c) loss-spreading.

These ideals were espoused by LaForest J. in *London Drugs*, where he was determined to prevent employers from exporting liability to employees despite contract law that seemed to provide otherwise.²⁵ He found justification

²² *Supra* note 4.

²³ Dalhousie Law School teaches vicarious liability in its Business Associations classes using *Bazley v. Curry*, for example. See also *3464920 Canada Inc. v. Strother*. 2005 BCCA 385.

²⁴ *Curry*, *supra* note 4 ¶ 29.

²⁵ *London Drugs Ltd. v. Kuehne & Nagel International Ltd.*, [1992] 3 S.C.R. 299 [*London Drugs*].

for vicarious liability in the policy considerations above, and McLachlin J. approved of them in *Curry*:

Faced with the absence in the existing law of a coherent principle to explain vicarious liability, La Forest J. found its basis in policy (at p. 336): “the vicarious liability regime is best seen as a response to a number of policy concerns. In its traditional domain, these are primarily linked to compensation, deterrence and loss internalization.”

Fleming has identified similar policies lying at the heart of vicarious liability. In his view, two fundamental concerns underlie the imposition of vicarious liability: (1) provision of a just and practical remedy for the harm; and (2) deterrence of future harm. While different formulations of the policy interests at stake may be made (for example, loss internalization is a hybrid of the two), I believe that these two ideas usefully embrace the [page553] main policy considerations that have been advanced.²⁶

Fair Compensation

McLachlin J. goes on to explain each of the two justifications in detail, beginning with fair compensation’s sub-category (a) satisfaction:

First and foremost is the concern to provide a just and practical remedy to people who suffer as a consequence of wrongs perpetrated by an employee... This policy interest embraces a number of subsidiary goals. The first is the goal of effective compensation. “One of the most important social goals served by vicarious liability is victim compensation.

²⁶ *Supra* note 4, ¶ 28-29, McLachlin J. citing LaForest J. in *London Drugs, ibid.*, and John G. Fleming, *The Law of Torts*, 9th ed. (Sydney: LBC Information Services, 1998).

Vicarious liability improves the chances that the victim can recover the judgment from a solvent defendant. (B. Feldthusen, “Vicarious Liability for Sexual Torts”, in *Torts Tomorrow* (1998), 221, at p. 224.) Or to quote Fleming, the master is “a more promising source of recompense than his servant who is apt to be a man of straw” (p. 410).²⁷

Returning to our trucking scenario, let us assume our employee-driver negligently falls asleep at the wheel of a truck while transporting cans of cola and crashes into a family of four that is non-negligently travelling by car on a family vacation. The two children are rendered quadriplegic. The parents sue the driver and company. The driver is found negligent and liable, the company is found not negligent (i.e. it met its requisite standard of care and is not at fault).

It would seem likely that the lone truck driver, on her meager salary, would not be able to pay the total damages awarded in compensation for two children rendered quadriplegic. The company, on the other hand, has significantly greater assets. It would be rather unjust for the family to go uncompensated simply because the driver cannot afford to pay (and is indeed physically unable to pay). Vicarious liability, justified under satisfaction, could solve this dilemma.

Atiyah is critical of this doctrine of “satisfaction” applied on its own:

After all there will always be plenty of people in the world better able to pay damages than any particular defendant who may be unfortunate enough to be sued for a tort, but mere wealth... could never by itself be treated as a ground for imposing liability in tort.²⁸

²⁷ *Supra* note 4 ¶ 30, McLachlin J. citing B. Feldthusen, “Vicarious Liability for Sexual Torts”, in Nicholas J. Mullany and Allen M. Linden, eds., *Torts Tomorrow: A Tribute to John Fleming* (Sydney: LBC Information Services, 1998) at 224, and John G. Fleming, *The Law of Torts*, 9th ed. (Sydney: LBC Information Services, 1998).

²⁸ *Supra* note 7, at 22.

However, he considers also that the law must not be an abstract academic creation that never cashes out in reality (literally and figuratively). Combined with other justifications, such as loss spreading or deterrence, “satisfaction” may have a place.²⁹

The second component of fair compensation, *viz.* (b) risk creation, is closely related to this idea. Engaging in an enterprise, whether for profit or not, invariably creates risks that would not exist otherwise. Creating these risks is not in itself enough to attract liability; however, it still seems intuitively just and fair that the entity that creates the risk should bear the loss once a tort has been committed. LaForest J. in *London Drugs* tapped into this particular concern: “a person, typically a corporation, who employs others to advance its own economic interest should in fairness be placed under a corresponding liability for losses incurred in the course of the enterprise.”³⁰ McLachlin J. continues this common law justification in *Curry*:

Effective compensation must also be fair, in the sense that it must seem just to place liability for the wrong on the employer. Vicarious liability is arguably fair in this sense. The employer puts in the community an enterprise which carries with it certain risks. When those risks materialize and cause injury to a member of the public despite the employer’s reasonable efforts, it is fair that the person or organization that creates the enterprise and hence the risk should bear the loss. This accords with the notion that it is right and just that the person who creates a risk bear the loss when the risk ripens into harm. While the fairness of this proposition is capable of standing alone, it is buttressed by the fact that the employer is often in the best position to spread the losses through mechanisms like insurance and higher prices, thus minimizing the dislocative effect of the tort within society.³¹

²⁹ *Ibid.*

³⁰ *Supra* note 25 ¶ 50.

³¹ *Supra* note 4 ¶ 31.

The truck driver employee has not created the risks associated with her transporting pop cans. She is merely working for her salary and participating in the risk of this one act. The company, on the other hand, is sending this truck on numerous trips, all of which are to serve the ends of the company (whether for profit or not is irrelevant: *Curry* makes this quite clear). As Atiyah says:

The master [then] is to be treated as a sort of holder of an equity in the servant though an equity with unlimited liability; after paying the servant his wages and ‘fringe benefits,’ the master takes what is left, whether it is profit or loss, arising from the servant’s work.³²

It would be unjust if a company could escape liability for the harms resulting from the risks it has created by exporting it to the individual employees actually carrying out the tasks to achieve the company’s ends: “[T]he feeling that one who derives a benefit from an act should also bear the risk of loss from the same act is probably a deep-rooted one which has played its part in the formulation of the modern law.”³³

In her comments above, McLachlin J. touches on the third component of fair compensation *viz.* (c) loss spreading. She is far from alone in considering this a valid justification for imposing liability. Atiyah writes:

The most widely held view among modern American writers is that vicarious liability is justified by the principle of loss-distribution. In the great majority of cases an employer who has to pay damages for the torts of his servants does not in fact have to meet these liabilities out of his own pocket. The cost of the liabilities is distributed over a large section of the community, and spread over some period of time. This occurs partly because of the practice of insurance, and partly

³² *Supra* note 7, at 18.

³³ *Ibid.*

because most employers are anyhow not individuals but corporations.³⁴

The trucking company is likely to be in a much better position to purchase insurance (though, in our scenario, it may be presumed that the driver herself is required to be insured, up to a point. This interesting variable will be revisited below in sections 2-4). The company can “spread the loss” in this manner, such that it is not borne totally by the plaintiff family, nor the defendant driver, but rather in small amounts by all the insurance company’s premium payers. Even if the company is not insured, the cost will be borne by many shareholders, and will be accommodated by a combination of raised prices on products and services and a lower profit margin. The fair compensation justification presumes it is more just to spread a loss widely through the community rather than have it borne entirely by any one member, especially the harmed plaintiff, but also the lone defendant employee, (at least in our case of a negligent accident: intentional torts might call this into question based upon some notion of retribution).

So, linked together in fair compensation, are three principles that, when operating together, compose half of the Supreme Court of Canada’s justification for imposing this liability without fault: (a) satisfaction; (b) risk creation; and (c) loss-spreading.

It is important to mention that fair compensation in its entirety depends upon some moral notion of what is fair and just. It is very much rooted in a moral argument. The idea that the innocent plaintiff deserves compensation for her harm, that the entity that creates the risk should bear the loss, and that it is more fair to spread the loss rather than have it concentrated are all directly linked to some notion of social justice. Fair compensation, severed from deterrence, is not linked at all to any economic reality (save, perhaps, an argument that loss-spreading is somehow economically efficient). It is pure “deep-pockets” reasoning, based upon the logical fallacy of appeal to pity (do we not all pity our unfortunate family of four who have had to suffer so much at the hands of the large, faceless trucking company?). It is not an

³⁴ *Ibid.* at 22-23.

objective justification for faultless liability while it exists totally independent of some other means of imposing legal (vice moral or ethical) liability. As Coleman succinctly writes, “no one seriously believes that all victims deserve to be compensated for their losses... even victims who do not deserve to suffer may have no right to repair. Compensation simpliciter is not a goal of tort law.”³⁵

Deterrence

The other half of vicarious liability’s justification provides the real-world grounding for fair compensation:

The policy grounds supporting the imposition of vicarious liability - fair compensation and deterrence - are related. The policy consideration of deterrence is linked to the policy consideration of fair compensation based on the employer’s introduction or enhancement of a risk. The introduction of the enterprise into the community with its attendant risk, in turn, implies the possibility of managing the risk to minimize the costs of the harm that may flow from it.³⁶

The idea behind this doctrine is that by imposing liability, the courts can compel the employer to manage the risk and ensure that future torts are avoided, or at the very least occur less. McLachlin J. continues her legal justification for vicarious liability in *Curry*:

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, may have a

³⁵ Jules L. Coleman, *Risks and Wrongs* (Cambridge: University Press, 1992) at 209.

³⁶ *Supra* note 4 ¶ 34.

deterrent effect. Employers are often in a position to reduce accidents and intentional wrongs by efficient organization and supervision. Failure to take such measures may not suffice to establish a case of tortious negligence directly against the employer. Perhaps the harm cannot be shown to have been foreseeable under negligence law. Perhaps the employer can avail itself of the defence of compliance with the industry standard. Or perhaps the employer, while complying with the standard of reasonable care, was not as scrupulously diligent as it might feasibly have been.³⁷

For Richard Posner, the concept of deterrence is the only justification for vicarious liability, though the connection to fair compensation still lingers:

The reason for the employer's liability is that most employees lack the resources to pay a judgment if they injure someone seriously. They therefore are not very responsive to the threat of tort liability. The employer, however, can induce them to be careful, as by firing or otherwise penalizing them for their carelessness... Making the employer liable for his employees' torts will give him an incentive to use such inducements.³⁸

The effectiveness of vicarious liability in promoting deterrence is open to considerable criticism, most notably from a law and economics perspective. According to that theory, the only measures the employer will take in order to prevent accidents are those that are cost effective. Companies will always act within the "Learned Hand" model for reasonable care, and indeed must if they are rational self-maximizers. They will spend no more and take no more care (burden "B") than is justified, taking into account the costs of the tortious harms (liability "L"), multiplied by the likelihood they will occur (probability "P"). A company, in maximizing returns, will only logically spend up to B

³⁷ *Ibid.* at ¶ 32

³⁸ Richard A. Posner, *Economic Analysis of Law*, 7th Ed. (New York: Wolters Kluwer, 2007) at 188.

so long as $B < PL$. This is, in fact, a possible definition of reasonable care.³⁹ It makes good business sense, and is totally rational when one removes the logical fallacy of appeal to pity. If the costs of reducing accidents were to rise beyond the amount expected to be paid out in judgments, no company in reality would ever pay it.

Imposing vicarious liability increases L , thus allowing for an economically justifiable increase in B . That notwithstanding, the most efficient balance between increases in spending and the lowering of committed torts will remain the most reasonable choice.

McLachlin J. mentions in the passage above that in order to effect deterrence, the employer must be found vicariously liable. Otherwise, the employer might escape direct liability (and therefore not be motivated to deter) by claiming the harm was not foreseeable, or that it took all reasonable care (the industry standard).⁴⁰ In other words, it might escape liability by being found faultless. It is questionable, however, whether the imposition of vicarious liability will change overall behavior, as reasonable care, i.e. spending the maximum amount of B such that B is still $< PL$, will always be the prevailing practice. Further, how can an employer be expected to deter harms that were not reasonably foreseeable in the first place? Whether through direct or vicarious liability, B is the maximum, and constant, amount employers will spend in order to deter their employees from committing torts. It is unlikely that the threat of liability without fault will ever increase the employer's deterrent steps beyond the reasonable care formula. Some authors have argued that vicarious liability actually *discourages* employers from taking deterrent measures.⁴¹

³⁹ *United States v. Carrol Towing Co.*, 159 F.2d. 169 (2d Cir. 1947), Judge Learned Hand, as cited in Weinrib, *supra* note 10 at 68.

⁴⁰ *Supra* note 37.

⁴¹ See Jennifer H. Arlen and W. Bentley MacLeod, "Beyond Master-Servant: A Critique of Vicarious Liability," in M. Stuart Madden, ed., *Exploring Tort Law*. (Cambridge: University Press, 2005). The authors argue that vicarious liability does not, overall, compel employers to be extra diligent in preventing accidents, but rather encourages them to "outsource" liability by using independent contractors.

What may serve to justify vicarious liability, however, is that by increasing the scope of employers' liability, i.e. by making them liable for their employees' torts, the courts increase both P and L, and therefore increase the total justifiable amount of B. In addition, the employer need not owe the plaintiff any direct duty of care: the trucking company will still be liable, even though it was the driver who owed the family of four a direct duty of care. So, there should conceivably be some decrease in the occurrence of harms.

It would not seem necessary to provide a lengthy justification for why negligent harms are undesirable and must be deterred. Whether from a justice perspective, invoking rights-based arguments of non-interference, or from an economic efficiency point of view arguing for the most efficient use of resources in order to maximize wealth, there exists at the core of tort law the notion that harms, i.e. losses, should be avoided.

Deterrence and fair compensation are thus the two prevailing Canadian justifications for imposing liability without fault upon employers (or other pseudo-employers) for the acts of their employees. It is worth noting that, as mentioned above, the two principles work together in order to ground vicarious liability in reality. Indeed, vicarious liability really only seems justifiable in situations where they are both applicable. McLachlin J. in *Curry* agrees:

A wrong that is only coincidentally linked to the activity of the employer and duties of the employee cannot justify the imposition of vicarious liability on the employer. To impose vicarious liability on the employer for such a wrong does not respond to common sense notions of fairness. Nor does it serve to deter future harms. Because the wrong is essentially independent of the employment situation, there is little the employer could have done to prevent it. Where vicarious liability is not closely and materially related to a risk introduced or enhanced by the employer, it serves no deterrent purpose, and relegates the employer to the status

of an involuntary insurer.⁴²

It may be logical, then, to conclude that vicarious liability, in its legal application and operation as discussed above, should only kick in when both of its goals and justifications are applicable. As McLachlin J. concluded:

[A] meaningful articulation of when vicarious liability should follow in new situations ought to be animated by the twin policy goals of fair compensation and deterrence that underlie the doctrine, rather than by artificial or semantic distinctions.⁴³

II: THE MEDICAL ORGANIZATION: PHYSICIANS, RESIDENTS, MASTERS AND SERVANTS

Our particular project is focused upon the justiciability of vicarious liability in the medical malpractice context. We are concerned, therefore, with the kinds of relationships that exist in that circumstance.

Lahey concisely notes:

The vast majority of health care services in Canada are received from care providers who work either as independent professionals in private practice or as the employees of health care institutions or firms that are controlled and operated by independent corporate bodies.⁴⁴

⁴² *Supra* note 4 ¶ 36.

⁴³ *Supra* note 4 ¶ 36.

⁴⁴ William Lahey, "Medicare and the Law: Contours of an Evolving Relationship," in Jocelyn Downie & Timothy Caulfield & Colleen Flood, eds., *Canadian Health Law and*

Hospitals in Canada are creatures of statute. They are established by provincial acts under constitutional authority,⁴⁵ and regulated by provincial bylaws, or other subordinate legislation, passed pursuant to those acts.⁴⁶ As stated above, the statutes generally establish the hospital as an independent corporate body, which is not legally considered a government entity, although it is paid for by the government and is effecting a government policy.⁴⁷ Provincial governments regulate through statute, provide funding for “medically necessary” procedures, and articulate general guiding principles for all statute created not-for-profit hospitals and occasionally even for-profit private clinics.⁴⁸

Hospitals, as kinds of corporate bodies, are the employers of many different types of professionals and staff. Most notably, medical doctors who have not yet fully qualified to practice medicine independently in accordance with their established curriculum, habitually called “residents,” are usually employed by certain “teaching” hospitals in order to augment patient care as well as to further the public purpose of training future physicians. They remain affiliated with a local university medical school program, though they are not students, but graduates.

These “physicians in training” are placed by the hospital under the supervision of a fully qualified attending physician (though, it must be remembered that residents are not medical students: they have graduated from medical school and have achieved their M.D. designation. They are, generally speaking, far from ineffectual). The duties and responsibilities of residents can be laid out somewhat informally, or articulated generally by legislation. The bylaws of the IWK children’s hospital in Halifax, NS, for example, dictate the general conduct of residents:

Policy, 3d ed. (Markham: LexisNexis, 2007) at 13.

⁴⁵ *Constitution Act, 1867* (U.K.), 30 & 31 Vict., c.3, reprinted in R.S.C. 1985, App. II, No. 5., s. 92(7)

⁴⁶ e.g. *Queen Elizabeth II Health Sciences Centre Act*, S.N.S. 1995-96, c. 15, s. 12; *Hospitals Act*, R.S.N.S. 1989, c. 208, s. 6; *Medical, Dental and Scientific Staff (General) Bylaws*, N.S. Reg. 305/2007 (June 12, 2007)

⁴⁷ *Eldridge v. British Columbia* [1997] 3 S.C.R. 624 [*Eldridge*].

⁴⁸ *Supra* note 44 at 14.

5.13.1 Residents shall not be Members of the Medical, Dental and Scientific Staff Organization.

5.13.2 Residents shall be assigned to an appropriate Department defined in the Rules and Regulations.

5.13.3 Residents shall have an Undergraduate/ Postgraduate appointment at the University Faculty of Medicine or Faculty of Dentistry. Elective students and residents who are not appointed to training programs at the University must be registered with the Dean's office of the Dalhousie Faculty of Medicine or Dentistry as applicable.

5.13.4 Each ... Resident shall be under the supervision of the appropriate Department Chief, Division Head or Post-graduate Residency Training Program Director (where such a position exists).

5.13.5 The nature, extent and number of responsibilities, including patient care responsibilities, assigned to a... Resident by the above at any given time shall be commensurate with the... Resident's demonstrated level of skill, the educational objectives established for the rotation or unit in the relevant clinical area from time to time, and the limits and privileges of the... license held by the... Resident at the relevant time.⁴⁹

Residents are placed under the supervision of a senior, fully qualified physician. The duties and responsibilities of attending physicians, as they pertain to teaching, are also articulated in the IWK bylaws:

5.12.1 Attending physician... responsibilities shall be as outlined in the Rules and Regulations pursuant to these Bylaws.

5.12.2 Each Member of the Medical... Staff shall undertake

⁴⁹ *Medical, Dental and Scientific Staff (General) Bylaws*, N.S. Reg. 305/2007 (June 12, 2007) s. 5.13

duties as specified by the Chief of the Department or Head of the Division to which such Member is assigned.

5.12.3 Each attending physician who has teaching responsibilities shall provide instruction to other Members of the Medical... Staff, Medical... Students and other learners as required by the Chief of the Department or Head of the Division to which such attending physician... is assigned.⁵⁰

Attending physicians are generally held in extremely high regard by those assigned to learn from them. This is not surprising, considering their superior experience and standing. The expert testimony given in *Keilley*⁵¹ reflects the fact that attending physicians are the duly qualified and ultimately responsible individuals in this relationship, in addition to being the teachers and mentors of the junior doctors. Residents quite naturally aspire to achieve the status of the attending physician:

Medical education is a journey to the top of one totem pole, only to fall off and land at the bottom of the next. All physicians have this experience through medical training... The premedical college student gazes on the first year medical student thinking “I’ll be there some day.” The new intern watches a third-year family medicine resident running a code blue hoping someday to have the same level of confidence. But above all, every move of the attending physician will be observed for clues on how to master the art of family medicine.⁵²

This is not meant to characterize residents as “googley-eyed” admirers who bungle around while the attending physician practises medicine. As mentioned above, residents are medical school graduates, and as they

⁵⁰ *Medical, Dental and Scientific Staff (General) Bylaws*, *supra* note 49, s. 5.12

⁵¹ *Supra* note 1 ¶ 30.

⁵² R. John Presutti, “The Art of Teaching,” in Robert L. Bratton, ed., *Mayo Clinic’s Complete Guide for Family Physicians and Residents in Training* (Toronto: McGraw-Hill, 2000) at 127.

progress in their training the skills they acquire and knowledge they display quite naturally, as in all professions, result in a greater assignment of responsibility:

As family practice residents move into their second and third years, the emphasis shifts to micromanagement and long-term outcome. Differential diagnosis skills should be well developed. It is during this time that residents can refine their skills in all areas from patient communication to procedures. This is also a transition time for residents who soon will be facing their new positions as family medicine attending physicians.⁵³

While residents are still residents, they are usually employees of hospitals and not entitled to act independent of the general supervision of the attending physicians within whose charge they have been placed. It stands to reason, however, that residents will be given more and more metaphorical rope the more senior they are and the more skill and knowledge they demonstrate. Their position, then, is a rather fluid one.

In contrast, attending physicians are not usually employees of hospitals, but are instead granted admitting privileges to the hospital's facilities in order to effect its purpose. They follow the hospital's regulations, but are usually at the same time part of a self-governing medical staff organization within the hospital.⁵⁴ They are not paid by the hospital: attending physicians bill directly to the appropriate provincial health authority.

Both the physician and the resident, though not technically "insured," are extremely likely to be protected from having to pay negligence judgments from the Canadian Medical Protective Association (CMPA).⁵⁵ If the CMPA is unable to combat the suit or avoid settlement, it will most likely cover the

⁵³ *Ibid.* at 127.

⁵⁴ Lahey, *supra* note 44 at 13. See also *Medical, Dental and Scientific Staff (General) Bylaws*, *supra* note 49, s. 5.13.

⁵⁵ Donalee Moulton, "Canada said not immune to malpractice insurance 'crisis'" (2003) 22:39 *Lawyers Wkly.* 9(2) (95% of physicians in Canada are members of the CMPA).

cost of the judgment or settlement so long as the physician or resident is a member. Many hospitals require physicians and residents to be members of CMPA before they will allow them privileges or employ them.⁵⁶ The hospital is also extremely likely to be insured, though through a separate entity. Even if uninsured, the hospital usually has access to the deep pockets of the provincial health authority, as its mandate would not normally allow for it to become insolvent or bankrupt.⁵⁷

Hospitals, physicians, and residents exist in an extremely unique environment when it comes to Canadian employment situations. Hospitals are corporate bodies, created by statute, usually operating not-for-profit. While not technically government entities, they are effecting a government purpose. Attending physicians are not employees of hospitals, though they work in them and are governed by their bylaws. They are not paid by the hospital, but rather bill the government directly for the patients treated. Residents are not fully qualified to practice medicine on their own, and must always operate officially under the supervision of an attending physician. However, as residents gain seniority, they come to resemble attending physicians more and more in practice. They are usually employees of the hospital, and paid by it.

III: VICARIOUS LIABILITY IN CANADIAN MEDICAL MALPRACTICE LAW: FROM *HILLYER* TO *KIELLEY*

If an attending physician opens her own practice, she will be vicariously

⁵⁶ Bernard Dickens, "Chapter 3: Medical Negligence." in Jocelyn Downie & Timothy Caulfield & Colleen Flood, eds. *Canadian Health Law and Policy*, 3d ed. (Markham: LexisNexis, 2007) at 129.

⁵⁷ *Ibid.* at 129. See also *Yepremian v. Scarborough General Hospital* (No.2), 120 D.L.R. (3d) 341 (Ont. H.C.J.), where the Ontario Ministry of Health and the CMPA both contributed to a substantial settlement.

liable for all the torts committed by her office staff, so long as she meets the legal requirements to be found vicariously liable as set out above in section I.⁵⁸ However, a physician who operates out of a hospital through “privileges” will not be found vicariously liable for the hospital staff e.g. orderlies or nurses. They are not the employees of the physician, but of the hospital. This includes residents.⁵⁹ Were a physician with hospital privileges to give negligent direction to a nurse, or negligently supervise a resident, she might be found liable for the harms that resulted, but this would be liability with fault, not vicarious liability.⁶⁰

The hospital, as the employer of its staff, easily meets the requirements set out in section I to be found vicariously liable. Dickens agrees:

If a hospital employee, such as a nurse or radiology technician is negligent and causes injury to the hospital's patient, the hospital will be held legally liable. The patient is not required to prove that the hospital itself was at fault in any way.⁶¹

The hospital, under the current state of the law in Canada, is not vicariously liable for the torts of attending physicians. They are not employees, but independent contractors.⁶² Strangely enough, despite being quite deeply “integrated” into the function of the hospital (how would a hospital fulfill its mandate without doctors?), vicarious liability has never really operated between the two at common law.

It would seem that their relationship easily passes Lord Denning's integration

⁵⁸ Ellen I. Picard and Gerald B. Robertson, “Chapter 10 – The Doctor's Liability for the Acts of Others” in *Legal Liability of Doctors and Hospitals in Canada*, 3d ed. (Toronto: Carswell, 1996) at 356-357.

⁵⁹ *Ibid.* at 358.

⁶⁰ *Bugden v. Harbour View Hospital et al.* [1947] 2 D.L.R. 338 (N.S.S.C.). Further, a physician is not negligent in presuming that the hospital staff will carry out their duties in a non-negligent manner.

⁶¹ *Supra* note 56 at 129-130; *Vancouver General Hospital v. Fraser Estate* [1952] 2 S.C.R. 36.

⁶² There is, however, a recent trend in Canada for hospitals to employ physicians directly, for various reasons. See Dickens, *supra* note 56 at 130.

test, above, from *Evans*.⁶³ The hospital, through its bylaws, also exercises considerable control over the physician, including the power to revoke, or refuse to renew, privileges. These factors notwithstanding, hospitals have traditionally not been found vicariously liable for the torts of attending physicians.⁶⁴

The reasoning behind this may well be due to the fact that hospitals, in earlier times especially, could not reasonably be expected to directly control the acts of the physicians in their employ. As Atiyah comments, “how, it was thought, could a surgeon performing an operation, be treated as the servant of a hospital when it was evident that no one could tell him how to do it?”⁶⁵ After showing that the hospital did not negligently hire (or give privileges to) the surgeon, and provided appropriate equipment, the discussion invariably leads to questions like: “What more could the hospital reasonably be expected to have done to prevent the harm?” But this concern is directed towards liability with fault, not vicarious liability. According to *Curry*, the factors that should be considered in determining vicarious liability must relate to fair compensation and deterrence. We shall return to this common⁶⁶ point of confusion shortly.

The classic, and often referred to, case is *Hillyer v. St. Bartholomew’s Hospital*.⁶⁷ In that case, a hospital was found not vicariously liable for the negligent acts of both a physician conducting an operation and the nursing staff under his supervision. The physician, at common law, could not reasonably be considered a servant of the hospital due to the impossibility of control. The nursing staff was also found to be outside of the control of the hospital, and therefore not legally its servants, for the duration of the operation. During

⁶³ *Supra* note 13.

⁶⁴ See *Evans v. Liverpool* [1906] 1 K.B. 160. This case is worthy of note not only because it establishes the historical lack of vicarious liability found against hospitals for the actions of physicians, but also because the plaintiff, suspecting his initial suit against the hospital would fail, attempted to sue in strict liability as per *Rylands v. Fletcher* (1868), L.R. 3. H.L. 330.

⁶⁵ *Supra* note 7 at 88.

⁶⁶ See Atiyah, *supra* note 7 at 88: it is not uncommon for courts to blur the line between reasons for finding direct and vicarious liability.

⁶⁷ [1909] 2 K.B. 820 (C.A.).

that time, they were under the direct control of the surgeon and were “borrowed servants.”⁶⁸ The hospital could exercise no direct control, and therefore the doctrine of *respondeat superior* could not operate.

It is doubtless that in 1909 the English Court of Appeal was not taking into account precisely the same policy considerations that the Supreme Court of Canada was in 1999. However, the underlying themes of fair compensation and deterrence seem to be present in both. In *Hillyer*, the concept of control seems to be directly related to the principle of deterrence. During the surgery, it was the surgeon who could exercise control, and finding the hospital vicariously liable for the negligent acts of the nursing staff could have no deterrent effect upon future harms. Farwell L.J. seems to imply that this is exactly what occurs in reality:

[A]s soon as the door of the theatre or operating room has closed on them for the purposes of an operation... they cease to be under the orders of the defendants, and are at the disposal and under the orders of the operating surgeon until the whole operation has been completely finished; the surgeon is for the time being supreme, and the defendant [hospital] cannot interfere with or gainsay his orders. This is well understood, and is indeed essential to the success of operations; no surgeon would undertake the responsibility of operations if his orders... were subject to... interference by the governing body.⁶⁹

This would also seem to imply that, were the plaintiff to sue the surgeon, he could be found vicariously liable for the negligence of the nurses and hospital staff in general. Applying this reasoning to the modern law of vicarious liability may seem rather ludicrous, considering that modern attending physicians do not in any way employ hospital staff. When one considers the justifications for vicarious liability in the first instance, however, this may not be so clear. This phenomenon can be observed in the cases of *Kielley* and *Considine*, mentioned above.

⁶⁸ *Ibid.* at 826.

⁶⁹ *Ibid.*

In the 1982 Nova Scotia case *Considine*, a supervised resident performed a prostate surgery that resulted in harm to the patient.⁷⁰ The patient sued the resident and the hospital, and later joined the attending physician as defendant. The court found that none of the defendants' conduct fell below the standard of care, and so the action failed. However, the trial judge made some extremely interesting comments in *obiter* regarding where he would have found liability:

It is my opinion that Dr. Ajayi [the resident] was under the control and direction of Dr. Mack to such an extent and degree that for the procedures to which this decision is addressed, Dr. Mack is responsible for Dr. Ajayi... Dr. Mack accepted Dr. Ajayi as his assistant in this case... Dr. Mack clearly chose to delegate some or all of the procedures to Dr. Ajayi... In this way he adopted that which Dr. Ajayi did for and on his behalf as though Dr. Mack was doing it himself. I do not know whether Dr. Mack billed full tariff for this [procedure] to medical services insurance. If he did, then I would find all the more reason to conclude as I do with respect to the matter of his responsibility for the acts of Dr. Ajayi. I am convinced that on the facts of this particular case Dr. Mack either accepted or must be deemed to have accepted, or both, the risks inherent in his permitting Dr. Ajayi to perform all or a part of the surgical procedure on the male plaintiff. If I had found Dr. Ajayi responsible in law for loss suffered by the male plaintiff arising out of the surgical procedures, then I would have had no hesitation in finding the defendant Mack equally responsible.⁷¹

The trial judge was unclear as to whether he would have found vicarious liability or a breach of a non-delegable duty of care. Taking into account the rulings in both *Hillyer*, three quarters of a century before *Considine*, and *Curry* seventeen years after, vicarious liability seems to make a lot of sense.

⁷⁰ *Supra* note 2.

⁷¹ *Ibid.* ¶ 16.

In accordance with *Hillyer*, the trial judge noted that the attending physician exercised total control over the resident, despite his being an employee of the hospital, and was the only legal person in any position to deter negligent conduct. Taking into account the other justification for vicarious liability from *Curry*, viz. fair compensation, the attending physician was likely billing for the procedure (risk creation = loss bearing). He was also likely (at least, in contemporary reality) protected from personally having to pay a judgment by the CMPA (satisfaction/ solvent defendant, and loss spreading). It would seem that the justifications for vicarious liability as found in *Curry* support the trial judge's *obiter* comments.

In *Keilley*,⁷² however, the Newfoundland Court of Appeal found otherwise:

There is no general principle that doctors are vicariously liable for the negligence of residents under their supervision.... The Considine case is among four referred to by the authors of *Legal Liability of Doctors and Hospital in Canada* as being inconsistent or potentially inconsistent with the established case law. In respect of Considine it was said that if the decision was based on vicarious liability (in contrast to the surgeon unreasonably delegating a duty owed to the patient), it would be inconsistent with established case law [*sic*].⁷³

As the courts are often wont to do,⁷⁴ the NLCA immediately proceeded to discuss the possibility of finding liability with fault:

Though there is no employer-employee relationship or general principle of law upon which to find Dr. Sussex vicariously liable for Dr. Barrett's negligence it does not necessarily follow that a specialist is never held liable for the actions of a resident under his supervision. Indeed

⁷² *Supra* note 1.

⁷³ *Ibid.* ¶ 35.

⁷⁴ *Keilley, ibid.* See also: *Karderas et al. v. Clow et al.* (1972), 32 D.L.R. (3d) 303; *McFadyen et al. v. Harvie et al.*, [1941] O.R. 90 (Ont. C.A.); Atiyah, *supra* note 7 at 88.

counsel for Dr. Sussex concedes that if Dr. Sussex had directed Dr. Barrett to do some thing which failed to meet the required standard of care, Dr. Sussex would be liable. But, he submits, Dr. Sussex cannot be held liable for Dr. Barrett's exercise of his own judgment.⁷⁵

The NLCA was quite correct: there is no established Canadian case law for finding an attending physician liable for the negligent acts of a resident, or any hospital employee. However, it is interesting to note that the justifications for vicarious liability as found in *Curry*, coupled with the nature of the relationship between the attending physician and resident, would seem to imply otherwise. In practice, the courts have rigidly applied the test for vicarious liability from section I, above, without taking into account the actual justifications for the test's existence at all. Residents are employees of the hospital; attending physicians are not. So ends the discussion of liability.

IV: NON-SEQUITUR

The hospital-resident-attending physician triangle causes some significant problems for the traditional application of vicarious liability. The hospital, though it ostensibly has considerable control over the general duties of the attending physician through its bylaws, has no direct control over how she carries out those duties. The physician is not an employee of the hospital, but an independent contractor billing the provincial health authority, and is governed only by the rules of the independent medical staff organization and their professional self-regulating body (e.g. The College of Physicians and Surgeons of Nova Scotia).⁷⁶ The physician directs the conduct of hospital staff, including residents, in accordance with the hospital bylaws. The resident

⁷⁵ *Supra* note 1 ¶ 36.

⁷⁶ Created by the *Medical Act*, S.N.S. 1995-96, c. 10.

is an employee of the hospital, and is paid by it, but is controlled only by the orders of the attending physician. As the resident becomes more senior, she acts more and more of her own accord, and begins to more closely resemble an independent contractor.

In summary, there exists the bizarre situation where the hospital employs the resident, but exercises no control, and the attending physician controls the resident, but does not employ her. The current operation of vicarious liability in the medical malpractice context, then, does not achieve its own stated objectives.

So far as deterrence is concerned, the resident is deterred from being negligent by personal liability,⁷⁷ but the attending physician, not the hospital, holds further powers of control. The attending physician is deterred from providing negligent supervision by the possibility of facing personal liability,⁷⁸ but faces no further motivation, as she is not vicariously liable for the acts of the resident. The hospital, though it faces vicarious liability for the negligence of the resident, is in no position to control her except through the attending physician, over whom it has only general control through the bylaws (*viz.* the assignment of duties). It would seem that vicarious liability could not possibly motivate deterrence in this context.

The second justification for vicarious liability, fair compensation, would also seem to be problematic. As mentioned above, all three possible defendants in our triangle are solvent. The attending physician and resident are likely protected by the CMPA, and the hospital is either insured, covered by the provincial government, or both. No matter who commits the initial tort, the plaintiff will be able to recover, and the loss will be spread.

So far as risk creation is concerned, there may be considerable problems with saying that any party in this scenario has really “created” the risk. The risk inherent in the existence of a healthcare facility (within a public healthcare

⁷⁷ In accordance with the principles set out in *ter Neuzen v. Korn*. (1995), 127 D.L.R. (4th) 577 (S.C.C.) [*Korn*].

⁷⁸ *Ibid.*

system) is not so much created by the hospital or the physicians, but the reality that people get injured and ill, and desire a remedy for this pre-existing condition: it is the illness, not the hospital, that creates the initial risk.

Now, one could turn to our trucking company scenario and take this claim to mean that the company could just as easily claim that their enterprise did not create the risk of the crash, but rather the demand for soda pop cans in convenience stores across the province did. The company, having not really created the risk, should not be found vicariously liable.

I would argue that these two situations are in fact quite different. Healthcare, at least in Canada, is serving a public purpose of critical concern. It is almost always a heated election issue at any level of government, and as the Canadian population ages, it will in all probability continue to be so. It would be difficult to imagine the public being nearly as concerned if suddenly there were no pop cans available in the province, as if suddenly there were no doctors or hospitals. I would argue, therefore, that the reality of human experience is what actually creates the risk in the healthcare context, and even if not, physicians and hospitals do not fall into the same category of enterprise that was of concern in *London Drugs*.⁷⁹ While entities serving a public purpose are still generally subject to vicarious liability,⁸⁰ it is doubtful that any have control and supervision relationships as unique as those that exist in this particular healthcare context.

According to the Supreme Court of Canada in *Curry*, if the two essential principles that justify vicarious liability are not both present, then vicarious liability should not be imposed in new situations.⁸¹ I would propose that the requirements necessary to impose vicarious liability in new situations should logically apply just as equally to those that existed in the past. According to the factors laid out above, the medical malpractice context does not seem to satisfy the requirements, either separately or simultaneously, to justify the imposition of vicarious liability.

⁷⁹ *Supra* note 25.

⁸⁰ *Supra* note 4. This principle goes at least as far back as *Mersey Docks and Harbour Board Trustees v. Gibb* (1866), L.R. 1 H.L. 93.

⁸¹ *Supra* note 4 ¶ 36.

Along the same lines of reasoning in *Hillyer* and *Considine*, the closest legal person that comes to satisfying the principles set out in *Curry* is actually the attending physician. After all, she is the only one in a position to deter the resident from committing negligent acts and, in billing for the procedure, could be construed as creating the risk and exporting liability for resultant harms to the resident and hospital. However, imposing vicarious liability upon the attending physician would not efficiently meet the goal of loss spreading (as mentioned above, all three parties are either protected or insured), and, as mentioned above, the argument for risk creation in this context is extremely weak at best.⁸²

It does not therefore seem appropriate to impose vicarious liability upon any party within this problem. If one considers the justifications given for vicarious liability at Canadian law, and applies them to the reality of the medical malpractice context, it does not follow.

CONCLUSION: WHERE THE BUCK STOPS

There is little doubt that the existing case law supported the Newfoundland Court of Appeal's judgment in *Keilley*. It is worthy of note that had vicarious liability not been imposed on the hospital in the first instance, the appeal would never have occurred.⁸³ The resident, having been found negligent, would have paid the judgment. He would likely have been protected by the CMPA, and thus would have been solvent. The plaintiff would have recovered for his loss, the loss would have been spread, and residents everywhere would continue to be deterred by a combination of concern for professional

⁸² There may also be overwhelming policy reasons not to impose vicarious liability upon teaching physicians. For one, the imposition of such liability may not motivate physicians to more diligently supervise residents, but rather to simply avoid teaching altogether (thereby making their PL=0).

⁸³ Presuming, for the purposes of our project, that the hospital would not have tried to claim that the attending physician should have been vicariously liable for the negligence of the nursing staff.

reputation, direct liability, and CMPA membership fees. Direct liability, in the medical malpractice context, could work on its own. The only side effect would seem to be decreased litigation between the CMPA and the hospital's insurer over who would actually pay the judgment.

The law continues to evolve. The relatively recent 2002 case of *Jaman Estate v. Hussain* considered the question: could hospitals be found liable with fault for the acts of physicians, despite meeting the standard of care?⁸⁴ In that case, the Manitoba Court of Appeal considered the impact of *Yeapremian v. Scarborough Hospital*.⁸⁵

In *Yeapremian*, the Ontario Court of Appeal found by a 3/2 split decision that the hospital owed no common law non-delegable duty of care to its patients. It was the legislature's, and not the Court's, place to expand the hospital's liability so drastically. Leave to appeal to the Supreme Court of Canada was granted on this issue, but the case was resolved by a substantial settlement before being heard.⁸⁶

In *Jaman*, the Manitoba Court of Appeal ruled that it may be possible to find at trial the existence of a non-delegable duty of care owed by a rural medical clinic to its patients, and so an action based upon this should not be summarily dismissed. It relied heavily upon the fact that *Yeapremian*, while not reaching the Supreme Court, was a split decision and, in addition, resulted in settlement.

If a hospital did owe such a duty, any negligence on the part of its attending physicians would cause the hospital to be liable with fault. It is difficult to imagine exactly how a hospital would discharge such a duty, given the reality of health professionals' relationships laid out above. There may exist some overarching policy considerations⁸⁷ inducing the courts to find hospitals

⁸⁴ [2002] M.J. No. 283 (C.A.) [*Jaman*].

⁸⁵ (1980), 20 O.R. (2d) 494 (C.A.) [*Yeapremian*].

⁸⁶ *Yeapremian v. Scarborough General Hospital* (No.2) (1981), 31 O.R. (2d) 384, 120 D.L.R. (3d) 341 (Ont. H.C.J.).

⁸⁷ Provincial limitation periods, for example, might potentially bar a plaintiff from suing a physician, or from joining a physician to an action, but not a hospital if it were named

(rather than negligent physicians) liable for harms, through either vicarious liability or non-delegable duties, and thus have them bear the loss.

Indeed, the medical malpractice context carries with it a peculiar feature when it comes to paying judgments: the loss, with or without vicarious liability, is already spread. Any medical services required due to the tort are covered by the plaintiff's provincial health plan, and any damages awarded in court will be paid by either the CMPA (whose funds come from physicians' salaries), the hospital's insurer, or by the government directly to support the hospital: all of these entities are funded, directly or indirectly, by the public purse. No matter where the loss initially falls, the buck eventually gets passed, however inefficiently, to the Canadian taxpayer. Perhaps, then, it does not matter who exactly bears the loss, so long as it is not the innocent plaintiff. Notwithstanding this potential truth, it still stands to reason that if a law is to exist, it should at the very least operate in accordance with its own justifications. For now, vicarious liability, as it exists in Canada and is applied in the medical malpractice context, does not.

as a defendant in time. See *e.g. Limitations of Actions Act*, R.S.N.S. 1989, c.258, s. 2(1) (d). Alternatively, it might be that the imposition of liability may encourage physicians to emigrate, whereas hospitals do not have this option.

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