Liability of A Federal Hospital for A Doctor's Private Wing Practice in Ethiopia: A Comparative Perspective

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Abstract

This paper examines whether the doctors practicing in the private wing of a federal hospital should be considered civil servants of the hospital or independent contractors. It identifies the test that distinguishes a civil servant from an independent contractor in the Ethiopian law of liability for others. It argues that the contextual interpretation of Art. 2134 of the Civil Code is a preferred approach over the flexible interpretation of control test to determine the status of the doctor's practice in the private wing. Accordingly, the examination of the totality of the relationship between the doctor practicing in the private wing and the federal hospital unfolds that a doctor should not be considered to be an independent contractor but a civil servant. The use of this approach is in line with the provision's flexibility that ensures responsiveness to new developments in civil servant-independent contractor dichotomy. Its result of making the federal hospital liable for the professional fault of the doctor in the private wing practice is also justified by the underlying policy reasons for the law of liability for others.

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Introduction

In 2009, the Ministry of Health of Ethiopia established private wing in federal hospitals as a way to motivate and retain doctors. Accordingly, federal hospitals designate some of their rooms and equipment for use in the private wing. In this wing, doctors practice beyond the regular working hours of the hospital and charge fees for their services. The net income from this practice is paid to the practicing doctors in accordance with the directives set by the Ministry. The introduction of the private wing has opened a new frontier in Ethiopian hospital law of liability for doctors. The central legal question is whether the doctors practicing in the private wing should be considered civil servants of the federal hospital or independent contractors.

If a doctor in the private wing is considered a civil servant of the federal hospital, according to the cumulative reading of Art. 2126 (2) and Art. 2128 of the Civil Code (CC), the federal hospital is liable for the doctor's professional fault in the private wing. However, if the doctor practicing in the private wing is considered an independent contractor, the federal hospital will not be held liable for the doctor's professional fault; the doctor will bear sole responsibility. This arises from different interpretations of Art. 2134 of the CC which exonerates the federal hospital from liability for the faults of independent contractors.

The foundations of the doctrine of vicarious liability[1] and its application to identify an employee from an independent contractor have been challenging

[1] In this paper, I have used two phrases, liability for others and vicarious liability, to explain the same doctrine. The latter is used in common law countries. Liability for the acts of others is used widely by civil law countries, which Ethiopian law shortens to 'liability for others'. Thus, the phrase 'liability for others' or its derivative (the federal hospital's liability for doctors) is used in Sections 1 and 3 of this article. However, in Section 2 and, to a

to both the common law and civil law systems.[2] In both legal systems, "there is something fundamental about this doctrine"[3] which should be examined to understand its application and underlying rationale. The use of comparative law would provide insights to understand the reasons and application of Ethiopian law of liability for others in the private wing context. Accordingly, the writer has selected Canadian and French legal systems.

In order to identify employee from independent contractor, the Canadian jurisprudence have developed the contextual approach, which is currently the accepted test in the common law courts.[4] Since this approach is developed by the Supreme Court of Canada, it reflects the development of the principle in both Canadian common law provinces and the Quebec civil law system. This shows the applicability of the contextual approach beyond the common law tradition.

Ethiopia's law of hospitals' liability for doctors have structural similarity with the French legal system as well as differences from it in application. Particularly, the evolution from control test to a more flexible interpretation of control test in France to identify an employee from an independent contractor, which practically results in similar conclusions with common law courts,[5] is a relevant experience to explore for Ethiopia.

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limited extent, in Section 3 of this article, the term 'vicarious liability' is used to present the Canadian law in its own context. *See* Paul Giliker, *Vicarious Liability in Tort: A Comparative Perspective* (Cambridge, Cambridge University Press: 2010) at xlii.

[2] *Ibid* at xli -xlii.

[3] *Ibid* at xlii.

[4] *Ibid* at 73.

[5] *Ibid* at 78.

This article argues that the contextual approach should be preferred over the flexible interpretation of control test to determine the status of the doctors' practice in the private wing. The writer argues that the doctor in the private wing should be considered a civil servant by virtue of a contextual approach to the interpretation of Art. 2134. The use of this approach is in line with the provision's flexibility that ensures responsiveness to new developments in civil servant-independent contractor dichotomy. Consequently, the federal hospital will be liable for the professional fault of the doctor in the private wing practice. This result is also justified by the underlying policy reasons for the law of liability for others in Ethiopia.

The article is organized into three major parts. The first two sections provide the background information upon which the analysis to answer the research question is based. In the first section, a brief overview of the Ethiopian law of civil liability of a hospital and a doctor is presented with special emphasis on the liability of a federal hospital for a doctor's official fault. This part shows how the private wing opens a new frontier in Ethiopian law regarding a federal hospital's liability for its doctor. Section two primarily provides insights from Canadian and French legal systems on the vicarious liability of a hospital for doctors relevant to the research question of this article, and section three answers the research question by arguing that the federal hospital should be liable for the official faults of doctors practising in the private wing.

I. An Overview of Ethiopian Law of Hospitals and Doctors Liability: Special Emphasis on Liability of Federal Hospitals for Doctors

A. Federal Hospital and Private Wing

A federal hospital is defined in the Federal Hospitals Administration Council of Ministers Regulation No. 167/2009 as "a hospital accountable to the Ministry of Health or a health service delivery and teaching hospital under a university."[6] The Ministry of Health currently administers four specialized hospitals under this regulation. The teaching hospitals are governed by their respective universities, which in turn, are accountable to the Ministry of Education. These hospitals are financed by the federal government.[7] Their activities are overseen and supervised by the Governing Board (hereinafter referred to as the Board).[8] Their day to day clinical and administrative services are undertaken by their respective Chief Executive Officer (CEO).[9]

A federal hospital is mandated to "provide regular and emergency medical diagnostic services,"[10] "referral services,"[11] and to "undertake applied research activities to improve the quality of health services."[12] The Board members are designated by the head of the institution to whom they are accountable, *i.e.*, the Minister for Health or the University President.[13] The Board's powers and duties include examination and submission of the

[6] *The Federal Hospitals Administration Council of Ministers Regulation*, Regulation 167/2009, art.2 (1).
[7] *Ibid* art. 13.
[8] *Ibid* art. 7(1).
[9] *Ibid* art. 11(1).
[10] *Ibid* art. 4(1).
[11] *Ibid* art.4(2).
[12] *Ibid* art. 4 (3).
[13] *Ibid* art.6 (1).

hospital's annual work plan, budget, performance and financial reports. It shall also "approve the internal rules of procedures of the hospital and follow-up the implementation of same," and "decide on studies and proposals of the hospital regarding the establishment of private wing health services."[14] The CEO's powers and duties include to "employ and administer the employees of the hospital in accordance with directives to be approved by the Government following the basic principles of the civil service laws."[15] In addition, the CEO shall "effect payments in accordance with the approved budget and work program of the hospital;" [16] "ensure the adequate availability of human and other resources to enable the hospital discharge its activities;"[17] "undertake studies, and submit to the Board, on outsourcing clinical and non-clinical services to improve overall quality of health care, and implement the same upon approval;"[18] "undertake studies, and submit to the Board, on the establishment and operation of private wings, and implement the same upon approval".[19]

The 'private wing' is "a system established within a federal hospital whereby health professionals provide medical and diagnostic services and obtain benefits from fees collected."[20] The primary objective of the private wing is to promote the retention and motivation of health professionals in federal hospitals, thereby reducing the high attrition rate of qualified professionals from the federal hospital to private sector practice.[21] Though this objective

[14] *Ibid* arts. 7 (2), (8), (4) & (6).
[15] *Ibid* arts. 11 (2b).
[16] *Ibid* art. 11 (2d).
[17] *Ibid* art. 11 (2e).
[18] *Ibid* art. 11 (2g).
[19] *Ibid* art. 11 (2h).
[20] *Ibid* art.2 (2).
[21] *Federal Hospitals Private Wing Organization and Function Directive*, Ministry of Health, Ethiopia 2010, no.1, art.2. [Translated by author, original in Amharic]

relates to all health professionals, specialists and general practitioners are its primary targets due to their high attrition to and concentration in the private sector.[22] The other objectives of the private wing include building the capacity of the federal hospitals and improving the quality of health care services by using the income generated by the private wing to satisfy the needs of clients who pay for care provided to them by a doctor of their choice.[23]

The patient in the private wing is charged for the medical and diagnostic services she receives, and this payment is kept in an account that is separate from the federal hospital's account. Fifteen (15) per cent of the net income in this account goes to the federal hospital, while the remaining eighty-five percent is distributed among the health professionals practicing in the private wing [24] in accordance with the recommendation of Private Wing Coordinating Committee (the Committee) and the decision of the CEO. The law, however, cautions that private wing health care services may not prejudice the regular medical and diagnostic services provided by the federal hospital.[25] As a result, the private wing provides outpatient services beyond the regular working hours of the federal hospital (after 5:30 PM – 8:00 AM, Saturdays, Sundays and Public Holidays). In addition, the private wing is not

[22] In Ethiopia, the government health facilities are the major medical service providers in comparison with private sector and charitable organization. However, for instance, during 2006/7, of the total number of 1,806 doctors (for a country of 75 million people at that time) in Ethiopia, about 56 % of specialists and 38 % of general practitioners were practicing not in government health facilities. The primary reason is the attractive income they get in the private and charitable organizations. Federal Ministry of Health, *Human Resource for Health Strategic Plan: Ethiopia 2009-2020* (Draft Document for Consultation, 2010) at 21.
[23] *Supra* note 21 art. 2.
[24] *Ibid* art. 10 (2).
[25] *Supra* note 6 art.12 (2).

allowed to provide emergency services, as the emergency service units of federal hospitals work twenty-four hours every day.[26]

The private wing is accountable to the CEO of the federal hospital through its Head.[27] The Head directs the overall activities of the private wing. In fact, the Committee, which is chaired by the Head of the private wing, follows up the day to day activities of the private wing and supports the Head in the discharge of her responsibility.[28]

B. Ethiopian Law of Hospitals and Doctors Liability

The law of obligations stipulated in Book IV (Obligations) and Book V (Special Contracts) Title XVI (Contracts for the Performance of Services) of the CC provides for civil liability of hospitals and doctors. There is no distinct body of law that governs civil liability of hospitals and doctors constituting what in other jurisdictions is commonly referred to as law of "medical negligence" or "medical malpractice".[29] Neither has case law developed in this regard. The law of obligations deals with contractual and extra-contractual duties (tort); hence, a patient's relationship with a hospital or a doctor is established in contract or, in absence of contract, a hospital or a doctor shall be liable for patients extra-contractually. Art. 2037 (1) of the CC provides that a case having contractual cause of action is not allowed to claim for damages based on extra-contractual cause of action. Therefore, a patient-hospital relationship or a patient–doctor relationship is established

[26] *Supra* note 21 art. 8.
[27] *Ibid* art.3 (1).
[28] *Ibid* art.3 (5).
[29] For example in Canada, the two phrases are commonly used interchangeably. See Bernard Dickens, "Medical Negligence" in Jocelyn Downie, Timothy Caulfield & Colleen M. Flood, *Canadian Health Law and Policy* 4th ed (Markham, LexisNexis Canada Inc.:2011) at 116.

either in contract or tort law. A brief overview and reflection on the liability each of these relationships entails is presented below.

1. Hospital Liability

A hospital's liability to a patient may be either direct or indirect (liability for doctors). Direct liability of a hospital does not arise frequently. It refers to the administrative and equipment deficiencies, power interruption and other related problems which may cause injury to the patient. Direct liability of a hospital may arise in contractual and extra-contractual patient-hospital relationship. On the other hand, liability for doctors refers to the hospital's liability for the professional fault of its employee doctors. In Ethiopian law, the hospital's liability for doctors is determined on the basis of the extra-contractual provisions (Arts. 2126-2128 and.2130-2134) of the CC regardless of whether the patient-hospital relationship is contractual or extra-contractual.

a. Direct Liability of a Hospital

Direct liability of a hospital may arise from a hospital contract or the patient-hospital's extra-contractual relationship. Art. 2641 of the CC defines a hospital contract as "a contract whereby a medical institution undertakes to provide a person with medical care from one or several physicians, in connection with a given illness." Art. 1675 of the CC provides that the general law of contract in Book IV (Obligations) Title XII (Contracts in General) shall be applicable to all contracts without prejudice to Book V (Special Contracts) of the CC, where a hospital contract belongs. Thus, all the requirements which are basically referred to as capacity, consent and object stipulated in general law of contract shall be satisfied to have a valid hospital contract.

An important feature of hospital contracts is their proprietary nature. The obligation of a person receiving medical care is the payment of a service fee. This is a very important criterion defining the nature of the patient-hospital relationship. Private hospitals are established for profits and they provide medical services for service fees. Thus, the relationship a private hospital establishes with a patient is contractual. However, this is not always the case with government hospitals.[30] A segment of the population receives medical services from government hospitals for free as a public good upon presentation of proof for being pauper from her/his local administration. The relationship the government hospital establishes with these patients is extra-contractual. In other cases, government hospitals relationship with patients is contractual.

The direct liability of a hospital in contractual relationship with the patient is mainly established by reference to the terms of the contract. In addition, Art. 2652 of the CC provides for the direct contractual liability of a hospital for its in-patient services of boarding and lodging by assimilating this to the responsibilities of an innkeeper.[31] The main liabilities in this regard are for any damages the patient may suffer on account of the deficiencies in the hospital's accommodation and dietary services.

[30] Prof. Krzeczunwicz implied that patient-public hospitals relationship is generally extra-contractual. However, this has to be examined with the health care system where these hospitals provide medical service for fee or for free. George Krzeczunwicz, *The Ethiopian Law of Extra-Contractual Liability* (Addis Ababa, Faculty of Law, Haile Sellassie I University:1970) at 77.

[31] The provision reads, "[w]here the sick person, for purposes of his treatment, is lodged and fed by the medical institution, such institution shall, as regards its obligations and responsibility arising from that lodging and feeding, be subject to the provisions regarding innkeepers' contracts (Art. 2653-2671)."

The direct liability of a government hospital in extra-contractual relationship with the patient arises from the violation of any law stipulating the standards of hospital administration, health care services and products which cause damage to the patient. Art. 2035 of the CC provides that infringement of any law, ordinance or administrative regulations is a fault. For example, a government is legally bound to provide health care services by fulfilling hygienic standards.[32] An adverse event causing injury to the patient caused as the result of sub-standard hygienic conditions in a hospital may be regarded as a direct fault of the hospital.

b. Liability of a Hospital for Doctors

Liability of a hospital for doctors is determined on extra-contractual principles whether the patient-hospital relationship is contractual or extra-contractual. If the patient-hospital relationship is extra-contractual, it is clear that the indirect liability of the government hospital is established on the tort provisions of the CC (Arts.2126-2128 and Art. 2134).

Where the patient-hospital relationship is contractual, Art. 2651 of the CC provides for the civil liability of a hospital for the fault of their employee physician or auxiliary staff. The civil liability of a person for the fault of other person is stipulated in the extra-contractual provisions of the CC. That is why the doctor's liability for her/his auxiliary or employees is determined on the basis of the tort provisions of Arts.2130-2133. This does not mean the contractual doctor-patient relationship is transformed into extra-contractual relationship. The nature of the doctor-patient relationship remains contractual but liability is established on tort principles. The broader term

[32] *Food, Medicine and Health Care Administration and Control Proclamation,* Ethiopia 2009, no.661, art.43.

"civil liability" in Art. 2651 refers to the use of tort in determining liability in contractual relationship. Contract law uses the same approach with respect to damages assessment by reference to the damages provisions of tort law where the former is found to be inadequate (Art. 1790 of the CC). In the only medical malpractice suit before the Federal Supreme Court Cassation Division, the tort principle of damages assessment on the basis of equity as stipulated in Art.2102 was utilized in a contractual patient-hospital relationship. [33] Therefore, even if the patient-hospital relationship is contractual, it can safely be concluded that the liability of a hospital for its doctors' professional fault will be established in accordance with tort principles.

The liability of a hospital for doctors in accordance with extra-contractual principles is established after showing the professional fault of the doctor. Art. 2031 of the CC on professional fault provides as follows:

> 1. A person practicing a given profession or activity shall, in the practice of such profession or activity, observe the rules governing that practice.
> 2. He is liable where, after due consideration of scientific data or rules recognized by the practitioners of his craft, he appears to be guilty of imprudence or negligence constituting definite disregard of duty.

Art. 2031 is only useful in establishing the fault; i.e., the breach of the standard of care the doctor owes to the plaintiff. The plaintiff has to prove the imprudent or negligent disregard of a duty as elaborated in Art. 2031.

[33] *Marie Stopes International Ethiopia v W/t Senaiet Alemaheyhu*, 2011, Federal Supreme Court Cassation Division, No 64590 (available on www.fsc.gov.et).

Moreover, the plaintiff has to establish the damage she sustained is caused by the professional fault of the doctor as per Art. 2028 of the CC.[34]

Prof. Krzeczunwicz noted that according to Art. 2031, professional fault materializes when a doctor disregards the "rules" or "scientific data" used by the practitioners of her craft.[35] "Rules" may be understood to mean professional obligations stipulated, in a strict sense, by law, or in a loose sense, by standards, ethical codes, clinical guidelines or expert evidence of "the usual conduct" in the profession.[36] In the former case, the plaintiff can also have a claim in accordance with Art. 2035 of the CC, which stipulates that any infringement of a law is fault. But in the latter, by the production of the said documents or expert testimony, the plaintiff can establish the standard of care expected from the professional, the violation of which entailed the professional fault.[37] Moreover, consideration of "scientific data" involves the evaluation of the practice of the practitioner against updated scientific facts and knowledge in her profession.[38] The plaintiff has to prove that the "rules" or "scientific data" are disregarded by imprudence or negligence. The court's decision is based on the "conduct of a reasonable man."[39] For the purpose of Art. 2031, 'reasonable man' refers to a reasonable practitioner belonging to the defendant's profession.

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[34] The article provides that "[w]hosoever, by his fault, causes damage to another, shall make it good."
[35] *Supra* note 30 at 78.
[36] *Ibid* at 78-9.
[37] *Ibid* at 79.
[38] *Ibid.*
[39] *Civil Code of Ethiopia* (1960) art. 2030 (2).

We have seen that a government hospital's liability for doctors is determined by the extra-contractual principles. Now, I will briefly explain these extra-contractual principles.

i. Government Hospital Liability for Doctors

A government hospital is a public health facility administered and funded by the Ministry of Health, the Ministry of Education or the Health Bureau of States where they are located. Its governance is structured to ensure the involvement of the community it serves, while formally remaining accountable to the Federal or State government. Most government hospitals are administered by the States. The health professionals providing health care services, including specialists and general practitioners in government hospitals, are civil servants.

In principle, a doctor in a government hospital is liable for her professional fault that causes damage to a patient.[40] However, if the fault is an official fault, the patient may sue the hospital through the State.[41] 'Official fault' is defined as a fault committed by a civil servant believing "in good faith that he acted within the scope of his powers and in the public interest."[42] In other cases, a fault is regarded as a personal fault.[43] In this case, the State will not be answerable for the civil servant's fault. For example, a doctor committing sexual assault against a patient commits a personal fault. Intentional acts constituting faults are likely to be regarded as personal faults though most medical cases arise due to the negligence of a doctor. Therefore, by and large, a civil servant doctor's fault is regarded as an official fault.

[40] Art. 2126(1) CC.
[41] Arts. 2126 (2) *cum* 2128 CC.
[42] Art. 2127 (1) CC.
[43] Arts. 2126 (3) *cum* 2127 (2) CC.

Art. 2134 of the CC provides an exception to the principle that a government hospital is liable for the fault of a civil servant doctor who may, otherwise, be regarded as an independent contractor. It states that "[a] person is not answerable for the faults committed by another person while carrying out work which he has required him to do, where the latter is not subject to the former's authority and is to be considered as having retained his independence." Therefore, a government hospital cannot be held liable for a doctor who is considered as an independent contractor in law. In this case, the patient-doctor relationship is governed by the medical contract provisions of the CC, which will be briefly discussed next.

2. Doctor's Liability

a. Direct Liability

The direct liability of a doctor emanates from a doctor-patient relationship in a medical contract. Art. 2639 of the CC defines a medical contract as "a contract whereby a physician undertakes to provide a person with medical care and to do his best to maintain him in good health or cure him, in consideration of payment of a fee." The application of a medical contract, as can be understood from its definition, is limited to governing the doctor-patient relationship under three scenarios. First, the medical contract governs the doctor-patient relationship in some health care facilities that are owned and fully managed by the doctor treating the patient. In such a circumstance, the doctor enjoys full independence of practice, which is the required element in the definition of a medical contract. Second, a medical contract governs the practice of specialists in private hospitals and clinics when they work part-time as independent contractors, not as employees. The income from this practice is shared between the specialist and the health facility in accordance with the agreement between them. Their clients in this practice

are mostly informed patients looking for contractual relations with them. Third, a new proposal to allow solo practice by doctors will be governed by medical contract.[44] Other than in these three scenarios, where the doctors are employees of the private health facility, the patient concludes a hospital contract with the facility, not a medical contract with the doctor. In this sense, it could be said that the scope of application of medical contract in Ethiopia is limited.

The medical contract law emphasises the personal nature of the obligation the contract imposes on a doctor in Art. 2649 (1) of the CC. The provision reads: "[a] physician who undertakes to treat a person shall carry out his obligations personally." Art. 2647(1) of the CC provides that the doctor shall be liable to the patient or third party for the fault she commits. The fault is determined by reference to the rules of her profession.

B. Liability of a Doctor for Assistants

The law allows the doctor to hire assistants but "under his control on his own responsibility".[45] This does not establish a contractual relationship between the doctor's assistant and the patient. Rather, the doctor-patient relationship remains contractual. However, the liability of the doctor is established based on extra-contractual principles. The law clearly provides that the doctor is

[44] Solo practice is defined as "an independent medical practice where within the limits of his/her respective qualification and in compliance with the standards… a health provider diagnoses and treats acute and/or chronic illnesses, but also provides preventive care through health education and counseling." Ethiopian Food, Medicine and Healthcare Authority, *Minimum Standards for Solo Practice* (Draft Document for Consultation, Addis Ababa: 2010) at sec.1.2 .7. While this paper is submitted for publication, the draft standard for solo practice is approved. Soon, this practice will start upon the implementation of the standards.
[45] Art.2649 (2) CC.

liable for her assistant's fault in tort[46] according to the principle of an employer's liability for employee fault.[47]

C. Contractual or Extra-Contractual Cause of Action: Does it Matter?

Prof. Krzeczunwicz explained the major implications of establishing a cause of action in contract or tort. In establishing the civil liability of a hospital or a doctor, the most compelling reasons to consider the distinction between contractual and tort-based actions are: period of limitation[48] and damages assessment.[49] A contractual legal action against a hospital or a doctor can be brought within ten years from when the patient sustained the damage as a result of the professional fault.[50] In contrast, medical malpractice claims in tort shall be barred after two years from the time the patient sustained the damage.[51] With respect to compensation, the contractual award of damages is an amount that equals the normal damage that the injury caused the patient as assessed in the eyes of a reasonable person.[52] The plaintiff is not expected to produce documentary or other evidence to corroborate a claim for an actual damage. Rather the burden of refuting the reasonable estimate of damages in contract lies with the defendant. If successful, the defendant will pay a lesser damage than the normal damage assessed in the eyes of a reasonable person.[53] However, in tort, the damage awarded to the plaintiff is

[46] Art. 2649 (3) CC.
[47] Arts. 2130-33 CC.
[48] *Supra* note 30 at 122.
[49] *Ibid* at 121-2.
[50] Arts. 1845 *cum* 1846 CC.
[51] Art.2143 CC.
[52] Art.1779 CC.
[53] Art. 1780 CC.

an actual damage.[54] The plaintiff has to prove the actual damages, in contrast to the reasonable man assessment of damage in contract law. In general, the amount of damages is higher in tort, and the burden of proof to establish the amount of damage is lower for claims in contract than in tort. Nonetheless, it is advisable for the plaintiff to sue the defendant hospital or/and doctor in both contract and tort as alternative claims to improve the chance of success in the suit.

For the purpose of establishing the liability of the federal hospital for doctors' professional fault, the nature of the federal hospital-patient relationship is not the defining factor. Both contractual and extra-contractual federal hospital-patient relationship involves the application of tort principles in establishing the liability of the federal hospital for its doctors' professional fault. However, identifying the nature of the relationship is important to determine the period of limitation and the amount of damages.

D. Private wing: A New Frontier for a Federal Hospital's Liability for Doctors

As discussed above, the liability of a federal hospital can be both direct and indirect. The focus of this paper is the latter. In principle, a federal hospital is liable for the official fault of a doctor. This requires, first, establishing the official fault of the doctor, and second, that the federal hospital is liable for this fault. The defendant may raise the defence that the doctor is an independent contractor for whom the federal hospital may not be liable.

[54] Art. 2091 CC.

However, the practice of a civil servant doctor in the private wing opens a new frontier in the liability of a federal hospital for its civil servants. The doctor cannot be simply considered as a civil servant of the federal hospital in the private wing because she is not paid by the hospital for such practice. Neither can a doctor be regarded as an independent contractor for her practice in the private wing by merely considering the fact that she is charging the patients for her service. Therefore, this frontier needs to be examined and a sound approach suggested. In this regard, drawing on insights from other jurisdictions that experience similar or relevant challenges is invaluable. To this end, in the next part of this paper, I will discuss relevant perspectives from Canada and France to ground my analysis and suggestions for the sound interpretation of Ethiopian law to deal with this new frontier.

II. Comparative Perspectives on Vicarious Liability of a Hospital for Doctors

A. Vicarious Liability of a Hospital for Doctors in Canada

Most hospitals in Canada are not-for-profit corporations established by provincial or territorial legislations and significantly financed by the government.[55] Their administration is done by a board of directors or trustees.[56] The composition of the board, mostly consisting of lay persons, reflects community ownership or involvement in the governance of the hospital.[57] The board is assisted in the making of clinical administrative decisions by technical committees, which in most provinces is called a

[55] John J Morris & Cynthia D Clarke, *Law for Canadian Health Care Administrators,* 2nd ed. (Markham, LexisNexis Canada Inc.:2011) at 6.
[56] *Ibid.*
[57] *Ibid.*

Medical Advisory Committee. These committees are largely constituted by staff physicians.[58] Beside the public hospitals, private hospitals, owned and financed by an individual or private organization, are playing an increasing role in the delivery of health care services in Canada. At present, the percentage of their hospital beds is smaller than the total number of beds in public hospitals, though.[59]

Hospitals are liable for the negligence of their employee health professionals on the basis of the common law principle *respondeat superior* ('let the master answer').[60] The classical approach is that a hospital is liable for its employee's negligence committed in the course of employment, but not for an independent contractor practicing on its premise. The following paragraphs from the masterpiece text on Canadian medical malpractice law by Picard and Robertson clearly explains the position of the Canadian law on a hospital's liability for doctors:

> Whether a hospital will be vicariously liable for the negligence of a doctor depends upon the relationship among the hospital, the doctor and the patient. In the great majority of cases, patients engage and pay their doctor … and have the power to dismiss them. The hospital does not employ the physicians nor are they carrying out any of the hospital's duties to the patient. They are granted the privilege of using personnel, facilities and equipment provided by the hospital but this alone does not make them employees. They are independent contractors who are directly liable to their patients, and the hospital is not vicariously liable for their negligence.

[58] *Ibid* at 6 & 12.
[59] *Ibid* at 5.
[60] *Ibid* at 237.

> But with some doctors, the relationship does give rise to vicarious liability on the part of the hospital. The clearest situation is that of doctors employed as house staff (residents or interns) for whom the hospital is vicariously liable. There, the employer-employee arrangement is usually evident from manuals and directives issued by the hospital.
>
> There are doctors whose relationship to the hospital does not fit easily into either of the personal doctor-independent contractor or house staff-employee categories, and in these cases the facts must be carefully analyzed.[61]

Even though the principle that most doctors are independent contractors under Canadian law sharply contradicts the status of doctors in a federal hospital in Ethiopia where they are civil servants, both jurisdictions are challenged by new frontiers in the ever increasing complex relationship among the hospital, the doctor and the patient. Ethiopian hospital liability for doctors is now faced with federal hospital liability for doctors' private wing practice, just like the matter of the vicarious liability of hospitals for doctors practicing in an emergency room of a hospital in Canada raised a legal debate many years back. Indeed, the debate about the vicarious liability of hospitals for doctors' practice in emergency rooms in Canada is yet to be settled. The seminal case on a Canadian hospital's liability for a doctor

[61] Ellen I Picard & Gerald B Robertson, *Legal Liability of Doctors and Hospitals in Canada* 4th ed.(Toronto, Thomson Canada Limited: 2007) at 478-9.

practicing in the emergency room is *Yepremian et al. v Scarborough General Hospital et al*[62] which is discussed below.

1. *Yepremian et al v Scarborough General Hospital et al.*

A patient, Tony Yepremian, who was semi-comatose at the time, was taken to the emergency unit of Scarborough General Hospital. Dr. Chin misdiagnosed the patient's diabetes and prescribed wrong medications which worsened Yepremian's condition. Later on, Yepremian was admitted to the intensive care unit under the care of Dr. Rosen, an internist with visiting privileges in the hospital. Dr. Rosen was on call duty that day. He did not diagnose the diabetes on time and when it was brought to his attention by the nurse, he prescribed an overdose drug. Eventually, Yepremian developed cardiac arrest which caused brain damage. At the trial and appeal, it was decided that Dr. Rosen's negligence was the direct cause of Yepremian's brain damage. The central issue, however, was about the liability of the hospital for Dr. Rosen's negligence.

After extensively analyzing the relevant statutes and jurisprudence, the trial judge, Holland J. of the Ontario Supreme Court, rendered judgment on the liability of the hospital for Dr. Rosen's negligence. First, he set out three conclusions in which a hospital's vicarious liability for the actions of doctors may arise. The three conclusions are:

> Except in exceptional circumstances:
>
> 1. A hospital is not responsible for negligence of a doctor not employed by the hospital when the doctor was personally retained by the patient;

[62] *Yepremian et al. v Scarborough General Hospital et al*, 1978 O.J. No. 5457 (available on Lexis Quicklaw); *Yepremian et al. v Scarborough General Hospital et al*, 1980 O.J. No. 3592 (available on Lexis Quicklaw).

2. A hospital is liable for the negligence of a doctor employed by the hospital;
3. Where a doctor is not an employee of the hospital and is not personally retained by the patient, all of the circumstances must be considered in order to decide whether or not the hospital is under a non-delegable duty of care which imposes liability on the hospital.[63]

Holland J. decided that the third conclusion fits Yepremian case that "the case must be considered from the point of view of the patient, the hospital and the doctor."[64] He set out the nature of these relations as follows:

> In so far as this particular patient was concerned, he was semi-comatose on admission. It was not even his decision to go to the hospital; it was the decision of his parents. Tony Yepremian was taken to the hospital because he was obviously seriously ill and in need of treatment. The public as a whole, and Tony Yepremian and his parents in particular, looked to the hospital for a complete range of medical attention and treatment. In this case there was no freedom of choice. Tony Yepremian was checked into the emergency department by Dr. Chin and not by a doctor of his choice. Dr. Chin was required to work for certain periods of time in the emergency department. When Tony Yepremian was admitted to the intensive care department of the hospital, he was admitted under the care of Dr. Rosen. Tony Yepremian had no choice in the matter. The fact that Dr. Rosen happened to be the internist at the time of admission was the luck of the draw so far as the Yepremians were concerned. They

[63] *Yepremian et al. v Scarborough General Hospital et al*, 1978 O.J. No. 5457 (available on Lexis Quicklaw) at para.55.
[64] *Ibid* para.56.

> really, I suppose, had no concern other than an expectation that this hospital would provide not only a room, but everything else that is required to make sure, so far as is possible, that the patient's ailments are diagnosed and that proper treatment is carried out, whether this is done by an employed doctor, a general practitioner or a specialist. From the point of view of the hospital, the hospital, by virtue of the provisions of the Public Hospitals Act … and as a matter of common sense, has an obligation to provide service to the public and has the opportunity of controlling the quality of medical service. From the point of view of the doctor, through the surrender of some independence by reason of the control that may be exercised over him by the hospital and by making his services available at certain specified times, he attains, by accepting a staff appointment, the privilege of making use of the hospital facilities for his private patients.[65]

Holland J. concluded that "in the circumstances of this case, by accepting this patient, the hospital undertook to him a duty of care that could not be delegated. It may be that the hospital has some right of indemnity against the doctor but …. I have come to the conclusion that the hospital is responsible in law for the negligence of Dr. Rosen."[66]

On appeal to the Ontario Court of Appeal, Arnup, J.A., noted that "[i]mplicit in conclusion 3 is the determination that the principle of *respondeat superior* has nothing to do with this case and the liability cannot be founded upon the

[65] *Ibid.*
[66] *Ibid* paras.56-57.

application of the principle."[67] However, Picard and Robertson think that the final conclusion of the trial judge asserts the vicarious liability of the hospital for Dr. Rosen's fault, despite his status as an independent contractor, and this does not fit with the doctrine of vicarious liability.[68] The applicability of the vicarious liability principle was also considered not necessary in the dissenting opinion of Blair, J.A., who held that the hospital shall be liable on the basis of a non-delegable duty.[69] But the *Yepremian* case has continued to influence case law discussion on the vicarious liability of hospitals for doctors.[70] What is clear is the slippery nature of the principle of non-delegable duty and vicarious liability. Both depend on analyzing the facts in a given case, facts which can constitute a separate claim on either principle. Indeed, the plaintiff can increase her success rate by pleading the application of both as alternatives. Though the scope of this paper is limited to the discussion of the liability of a federal hospital to doctors' practice in the private wing, some of the arguments raised about the existence or non-existence of a non-delegable duty are relevant to argue for or against vicarious liability. In this light, in the following paragraphs, I will briefly highlight important arguments arising from the judgement and a dissenting opinion in the *Yepremian* case on appeal.

The trial judgment was overruled by the majority decision of the Ontario Court of Appeal, but two judges dissented. The primary reasons for denying

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[67] *Yepremian et al. v Scarborough General Hospital et al*, 1980 O.J. No. 3592 (available on Lexis Quicklaw) at para.32.

[68] *Supra* note 61 at 483. Picard & Robertson said that, "[a]lthough this was couched in terms of *direct* liability, that is, liability for breach of the hospital's own non-delegable duty to provide reasonable treatment, in effect the trial decision really imposes a type of vicarious liability- the hospital was held liable for the negligence of the doctor."

[69] *Supra* note 67 at para 173.

[70] *Supra* note 61 at 486.

the claim of a non-delegable duty against the hospital can be summarized as the absence of a statutory duty on the hospital to provide competent medical care, except "to see such care is provided";[71] public expectation from the hospital is no more than getting "a good doctor";[72] the hospital does not control the practice of specialist doctors;[73] and also the issue calls for decision on the allocation of public resources which is a policy matter necessitating legislative intervention.[74]

The dissenting opinion of Blair J.A. heavily relied on the public expectation that hospitals should provide medical services, to hold that they owe a non-delegable duty.[75] Blair J.A. also endorsed the following view of Picard and Robertson on the basic elements necessary to establish the vicarious liability of a hospital for doctors in grey areas.

> [T]here are some factors which can be identified as being common in those cases where a hospital has been found liable for a doctor's negligence. The patient has generally not chosen the doctor; he has been provided by the hospital as part of certain services. There may be a public expectation that such a doctor or service will be provided by the hospital. There is an absence of control by the patient, usually stemming from the fact that the patient was not the one who engaged the doctor. Also, the doctor may not be described as being an integral part of the hospital organization rather than an accessory to it. Most

[71] *Supra* note 67 at para.30
[72] *Ibid* at paras. 35-6.
[73] *Ibid* at para. 38.
[74] *Ibid* at paras. 67 & 108.
[75] *Ibid* at para.171.

> obvious, but not necessarily most important, a stipend or salary received from the hospital is often a factor.[76]

Given the changes in the health system in the last three decades and in particular in the trend towards employment of doctors in hospitals, some commentators suggested a departure from continued adherence by the Canadian courts to the *Yepremian* case. Though the Prichard Report did not suggest an extension of the vicarious liability of hospitals to non-employee doctors, it had called for increased hospital responsibility in the provision of medical treatment.[77] Lorain Hardcastle, in her 2010 publication, reviewed the major health system changes in Canada since the decision in the *Yepremian* case.[78] She argued that the changes in the health system warrant the claim that a hospital should be held vicariously liable for its doctor's negligence.[79] Of these changes, she emphasised "[p]olicy shifts toward tying remuneration to performance, board or management involvement in privileging and shared accountability for quality and clinical decision making."[80] These changes

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[76] *Ibid* at para.169; see also *supra* note 61 at 481.

[77] A Report to the Conference of Deputy Ministers of Health of the Federal/Provincial/Territorial Review on Liability and Compensation Issues in Health Care, *Liability and Compensation in Health Care* (Toronto, University of Toronto Press:1990) (J. Robert S. Prichard, Chairman) at 27. In particular, the report called for increasing preventive measures for medical malpractice including mandatory quality assurance, risk management and peer review. These mechanisms may prove to establish a certain degree of control over doctors; hence, strengthening the argument that the hospitals will owe a patient in emergency a non-delegable duty of care.

[78] Lorain Hardcastle, "Institutional Vicarious Liability for Physicians: have we reached the tipping point?" (2010) 23:3 Health Management Forum 106 at 107-8.

[79] *Ibid* at 108.

[80] Ibid; see also *supra* note 29 at 146-7. Professor Dickens also noted this trend of moving "towards salaried employment by hospitals, being paid by provincial government or by regional health authorities. Provinces often prefer this system of pre-set annual funding to the open-ended principle of fee-for-service billing, in which physicians may, for instance, increase their income 50 percent by requiring patients' follow-up visits at four-, eight- and twelve –month intervals. Salaried employment also allows physicians to undertake teaching responsibilities and unfunded research without loss of income derived from patient care. Legal implications are that the contractual relationship between patients and physicians no

show the increasing role of hospitals in patient care. Moreover, she suggested instrumentalist justifications, i.e., ensuring that an injured patient gets compensation, and that the deterrence effect of vicarious liability law must be promoted by pushing for the vicarious liability of hospitals for doctors' negligence.[81]

Nonetheless, the Supreme Court of Canada has adopted a contextual approach or the totality of the relationship test to identify employee from an independent contractor.[82] The application of this test to hospital vicarious liability to doctors is yet to be seen. However, this decision generally presents the contemporary test used by the common law courts to identify an employee from an independent contractor.[83] In what follows, this approach is discussed.

2. The Contextual Approach

Justice Major, writing the judgment of the Supreme Court of Canada in *6771122 Ontario Ltd v Sagaz Industries Canada Inc*, made a thorough review of the evolution of different tests to identify if a given person is an employee, or acts as an independent contractor. These tests include the control test, entrepreneur test, organization or integration test, modified entrepreneur test, and enterprise risk test. It is beyond the scope of this paper to discuss each of these tests, but it suffices to present the relevant evaluation by Major J. after considering the various tests. The absence of "one

longer exists, perhaps encouraging courts to develop jurisprudence binding physicians to patients through fiduciary duties, and that hospitals may bear vicarious liability for salaried physicians' negligence."

[81] *Supra* note 78 at 108.

[82] *671122 Ontario Ltd v Sagaz Industries Canada Inc*, 2001 S.C.J. No. 61 (available on Lexis Quicklaw).

[83] *Supra* note 1 at 73.

conclusive test which can be universally applied to determine whether a person is an employee or an independent contractor"[84] was underscored. Rather, examining "the total relationship of the parties" is found to be very important.[85] This test, which recognizes the importance of control as one factor to be considered in the determination of employee-independent contractor status, is termed as a "contextual approach."[86] Major J. summarized the basic tenet of this approach in the following two paragraphs:

> The central question is whether the person who has been engaged to perform the services is performing them as a person in business on his own account. In making this determination, the level of control the employer has over the worker's activities will always be a factor. However, other factors to consider include whether the worker provided his or her own equipment, whether the worker hires his or her own helpers, the degree of financial risk taken by the worker, the degree of responsibility for investment and management held by the worker, and the worker's opportunity for profit in the performance of his or her tasks.
>
> It bears repeating that the above factors constitute a non-exhaustive list, and there is no set formula as to their application. The relative weight of each will depend on the particular facts and circumstances of the case.[87]

[84] *Supra* note 82 at para 46.
[85] *Ibid.*
[86] *Supra* note 78 at 106.
[87] *Supra* note 82 at paras.47-8.

B. A Hospital's Liability for Doctors in France

Like Canada's public health care system, the French public sector plays significant role in the provision of medical services. In France, about 86 percent of the salaried health professionals are working in the public sector.[88] Furthermore, the public hospitals account for 65 percent of hospital beds and 53.6 percent of doctors are employed at public or private hospitals.[89] A hospital liability for doctors may arise under contract, tort, administrative, criminal laws. In all of these cases, the tort principle stipulated in Article 1384 (5) of the French CC is important. It reads that "[m]asters and principals [are liable] for damage caused by their domestics and employees in the functions for which they have been employed."[90] Though the provision does not include the fault of the employee, traditionally courts have interpreted the provision so that the plaintiff has to establish the employee's fault.[91]

Article 2037 of Ethiopia's CC is framed based on the French doctrine of *non-cumul* (non-accumulation of actions).[92] The doctrine requires a plaintiff to have a contractual or tort cause of action, but not both at the same time.[93] This doctrine seems to limit the application of Article 1384 (5) for tort cases. However, courts often apply this tort principle to establish the contractual liability of a hospital to its salaried doctors.[94] This approach is similar with

[88] Florence G'Sell-Macrez, "Medical Malpractice and Compensation in France- Part I: The French Rules of Medical Liability since the Patients' Rights Law of March 4, 2002" 86:3 Chicago-Kent Law Review 1093 at 1093.
[89] *Ibid.*
[90] John H. Crabb, *The French Civil Code*, Rev Ed. (as amended to 1 July 1994) (USA, Fred B. Rothman & Co.:1995).
[91] *Supra* note 1 at 27.
[92] *Supra* note 30 at 144.
[93] *Supra* note 1 at 44.
[94] *Ibid* at 45.

the writer's argument that the application of Art.2652 of Ethiopia's CC calls for the use of tort principles to determine a hospital's liability for its employee doctors.

The concept of *service public* (public service) is the hallmark of French administrative law.[95] It emerged in the late nineteen century after a tribunal ruled that the Civil Code governing private relations cannot be applicable to establish liability of the State in public service delivery. [96] This has established different treatment of the state and public bodies with the private sector.[97] A public body is an institution set up to carry out public service function in the public interest.[98] A public hospital is a public body whose liability for its salaried doctors is governed by administrative law principles.[99] The French administrative law is basically developed by the judge made law, especially by the *Conseil d'Etat*, the highest administrative court. [100] The basic principle of the tort aspect of administrative law distinguishes the *faute de service* (fault in service) and the personal fault of the civil servant.[101] This principle is what the drafters of Ethiopia's CC incorporated in establishing the tort liability of state for its civil servants in Art.2126 (1) and (2).[102] Accordingly, the French public hospital is liable for its salaried doctor's professional fault.

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[95] John Bell, Sophie Boyron & Simon Whittaker, *Principles of French Law* 2nd ed. (New York, Oxford University Press: 2008) at 169.
[96] Christian Dadomo & Susan Farran, *French Substantive Law: Key Elements* (London, Sweet & Maxwell Ltd: 1997) at 170.
[97] *Supra* note 95 at 172.
[98] *Ibid.*
[99] *Supra* note 1at 52; *See supra* note 96 at 181.
[100] *Supra* note 1 at 52.
[101] *Ibid*; *See supra* note 88 at 1104.
[102] *Supra* note 30 at 51.

In France, a private hospital is liable for the professional fault of its salaried doctors under contract law.[103] This arises where the patient does not have a contract with doctor but with the private hospital.[104] If the patient has a contract with the doctor, the private hospital will only be responsible for accommodation, food and paramedical services.[105] A visiting doctor in the private hospital is an independent contractor who is directly liable for the patient under contract law.[106] Due to the private hospital's absence of authority or control over doctors for their professional independence, salaried doctors were not regarded as employee as per Article 1384 (5). It was said that "[the hospital] is with regard to surgeons, doctors or interns without authority or control concerning the practice of their professional skills."[107] French courts had been reluctant to consider doctors an employee of the private hospital.[108]

This loyalty to control test in identifying employer/employee relationship has been challenged by the complex employment relationship and its inapplicability to professional practices. As a result, civil law countries have adopted more flexible approach to control test which is responsive to modern employment practices. More recent case law in French shows a flexible approach to control test, most importantly, "one can have authority over a subordinate, despite the absence of technical knowledge."[109]

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[103] *Supra* note 1 at 63.
[104] *Ibid.*
[105] *Ibid.*
[106] *Ibid* .
[107] This was the translation of the judgment of Parts Court of Appeal in 1950, in *supra* note 1 at 62.
[108] *Ibid* at 62.
[109] *Ibid* at 66.

In 1992, the Criminal chamber of the *Cour de cassation*, in establishing contractual liability of the Red Cross for an anaesthetist hired for brief period, considered the anaesthetist an employee under Article 1384 (5) of the French CC. The court recognized his professional independence but also considered him as an employee. Some view this understanding as a radical abandonment of the principle of independence of doctors. Others view the change "as a recognition that a salaried doctor may be considered part of the hospital staff, and thereby a 'subordinate', without relinquishing his or her professional independence."[110] It is also noted that the court's conception of employee is consistent with the broader definition of employee in French labour law.[111]

Further, some leading authors showed how recent cases show more flexible interpretation of control test by shifting the focus from the power to give instruction, to determining whether the performance of the act was for the employer's purpose or not. [112] Prof. Giliker summarized this flexible interpretation of the control test as follows:

> To speak in terms of 'authority', 'control' and 'subordination' is, therefore, to refer only to general guidance to the question whether the person deemed in authority should be held responsible for the wrongs of another whom he is deemed to control. What is clear is that, despite adherence to the 'authority/subordination' formula, the courts have nevertheless responded to changes in employment practices, even in the traditionally sensitive field of liability for physicians.[113]

[110] *Ibid* at 67.
[111] *Ibid* at 68.
[112] *Ibid* at 68.
[113] *Ibid.*

C. Lessons for Ethiopia

There is a major difference between the status of doctors practicing in hospitals under French and Ethiopian law. French law has for long been considered a salaried doctor in the public and private hospitals neither as an independent contractor nor employee. Rather, the salaried doctor was considered professionally independent who is not subject to the authority and control of the hospital. However, the public hospital is liable for the fault in service of the salaried doctor under administrative law principles, while the private hospital is contractually liable for its salaried doctor, too. Nonetheless, recently, salaried doctors in public and private hospitals are considered employees under the tort principle under Article 1384 (5). Most commentators noted that, practically, there is little technical difference in the liability of the hospital in contract, administrative and tort law. This was the main reason that the traditional control test in Article 1384(5) was interpreted to mean a salaried doctors is an employee of the private hospital by the Criminal chamber of the *Cour de cassation* decision in 1992.

In contrast with French law, Ethiopian law and health care system clearly shows that most doctors' practice in the hospitals is based on employment relationship. Doctors in the public hospitals are civil servants while doctors, except some specialists working as independent contractors, in the private hospitals are employees governed by the labour law. That is why Art.2651 specifically referred to the doctors, for whom the hospital is civilly liable, as an employee of the hospital. This does not, however, mean doctors in Ethiopia do not have professional independence. Indeed, the hospital cannot dictate a doctor as to her clinical practice. The fact that most doctors in Ethiopia are employees of hospitals implies that the apparent control test in Art. 2134 of Ethiopia's CC should be interpreted broadly. Its literal

interpretation would render doctors independent contractors even in the presence of employment relationship.

Moreover, the control test is not applicable to doctors where their employer cannot provide direction to them due to the high expertise and technicality of their professional knowledge and skills, and in view of the profession's established autonomy in practice.[114] Generally speaking, control test "can no longer be said to represent many employment relationships accurately and a more sophisticated test is required." [115] Prof. Giliker, after thorough comparative analysis of tests used to identify contract of employment, concluded that contextual approach is preferred option as follows:

> As seen in relation to the civilian system which seek to maintain a test based on subordination or the right to give instructions, it may appear to avoid the uncertainties of the multi-faceted common law test, but changes in the workplace and increased use of technology have led the courts to interpret the test loosely, requiring only the possibility of some form of control. It has been objected that this renders the test a formality, described as being simultaneously ambiguous and inadequate, whilst raising difficulties in relation to professional whom it is difficult to encompass within any test based solely on control. On this basis, despite its uncertainties, the 'totality of relationship' test is to be preferred. It highlights the complexities of modern employment practices, the key distinction between

[114] Ellen Picard, "The Liability of Hospitals in Common Law Canada" (1981) 26 McGill LJ 997 at 1016 -7; *see* also P.S. Atiyah, *Vicarious Liability in the Law of Torts* (London, Butterworths:1967) at 46.
[115] *Supra* note 1 at 78.

> employees and independent contractors, and the economic framework within which employment operates.[116]

Neither the control test nor its flexible interpretation by French courts is, thus, adequate to determine the status of the civil servant doctors' practice in the private wing. The basic reason is the concept of authority or subordination has less to do with doctor's practice in the private wing. Rather, the understanding of the total relationship of the doctor and hospital is important to determine independent contractor-civil servant status of the doctor practicing in the private wing. Thus, the Canadian contextual approach should be preferred in Ethiopia to interpret Art.2134. Its elements provide the basic factors to consider in deciding whether the doctor in the private wing is an independent contractor or a civil servant of the federal hospital. The next part analyses the private wing practice through this contextual approach.

III. Contextual Approach to Understand a Doctor's Practice in Private Wing

A. Justifying Contextual Approach

As discussed above, the central issue to determine regarding the liability of a federal hospital for private wing practice is to establish the status of the doctor practicing in the private wing as either a civil servant or an independent contractor. The law has defined a civil servant as "a person employed permanently by a federal government institution."[117] Based on this definition, to consider the doctor practising in the private wing of a federal

[116] *Ibid* at 78-9.
[117] *Federal Civil Servants Proclamation*, Ethiopia 2007, no.515 art.2(1).

hospital as a civil servant of the hospital is simplistic and indefensible. Obviously, the doctor is a permanent employee of the federal hospital. However, the doctor does not receive any payment from the hospital for her service in the private wing. If she were considered a civil servant of the hospital according to the civil servants law, her practice should be considered as overtime work for which she is entitled to compensatory leave or payment from the hospital.[118] But in fact, the doctor receives income from her practice in the private wing by charging her patients. Thus, if applying the definition of a civil servant does not easily determine the status of a doctor practising in the private wing, how could such status be determined?

The argument that considers a doctor working in the private wing as an independent contractor would rely on Art. 2134 of the CC which provides a test to identify an independent contractor. This provision stipulates that a person carrying out work for another person where the latter does not control the former, and where the former "is to be considered as having retained his independence," is considered an independent contractor. If by this the doctor is not an independent contractor, she should be considered a civil servant of the federal hospital for her private wing practice, too. Consequently, the federal hospital will be liable for the doctor's fault in the private wing practice.

As I argued in Section 2.3 above, the Canadian contextual approach is a persuasive option for Ethiopia to interpret Art.2134 of the CC to determine the status of the doctor in the private wing. There are two more reasons that justify the use of the contextual approach. First, the last phrase of Art.2134

[118] *Ibid* art. 34 (2). A civil servant is entitled for compensatory leave or payment based on her choice for her overtime work for the employer government institution.

of the CC, i.e., "is to be considered as having retained his independence," confers discretionary power on the court to consider the merit of each case, in addition to considering control as a factor, and determine whether the doctor retains independence to discharge her responsibility. Thus, Ethiopian law is framed in a manner to accommodate dynamic and novel circumstances arising in the future, such as private wing practice.

Second, the use of a contextual approach to interpret Art.2134 of the CC will render the federal hospital liable for the doctors' practice in the private wing (to be discussed below). There are compelling policy reasons in Ethiopian law to justify this result. These policy reasons are compensation, loss distribution and deterrence. A brief discussion of these policy considerations and how they justify the liability of a federal hospital for doctors' practice in the private wing now follows.

1. Compensation

The classical purpose of the vicarious liability of an employer for the fault of his employee is to ensure that a victim who sustained damage due to the latter's fault gets adequate compensation. A hospital has deeper pockets than its doctor employee, and thus, is in a better position to compensate the victim who suffered injuries because of the negligent conduct of a doctor.[119] However, in Canada, both the hospital and the doctor are insured, and as the insurer is the one bearing the liability, this theory is hardly defensible. Nonetheless, in Canada, the theory of compensation is still considered a

[119] Joseph Eliot Magnet, "Preventing Medical Malpractice In Hospitals: Perspectives from Law and Policy" (1979) 3:3 Leg Med Q 197 at 199.

sound justification to increase the low rate of compensation for victims of negligent conduct.[120]

Prof. Krzeczunwicz justified the Ethiopian law of liability for others on this theory that the employer is "better situated" to compensate the victim of its employee's fault.[121] This theory is more applicable in Ethiopia than its insignificant application in Canada, where the doctor and the hospital are equally insured. In Ethiopia, there is no legal obligation or voluntary assumption of insurance protection by doctors. Indeed, due to the rarity of legal actions against a hospital for its employee doctor's fault, it is uncommon for a federal hospital to have liability insurance coverage. However, it is generally known that a federal hospital is financially better able to compensate the injured patient than its civil servant doctors can. A federal hospital liability for the private wing practice of doctors ensures patient access to compensation.

2. Loss Distribution

According to this theory, the employer is in a better position to absorb the cost of liability and insurance premium and to distribute it to society through increasing the cost of its services or products.[122] This principle is closely connected with compensation justification as it reaffirms the higher capacity of the employer to compensate, and its ability to easily absorb the cost and to distribute its loss. A hospital can easily pass on to patients through health care service fee increases, its costs of insurance premium. In Canada, given

[120] *Supra* note 78 at 108; see also *supra* note 61 at 532.
[121] *Supra* note 30 at 38.
[122] Atiyah proposed this theory as a modern theory justifying vicarious liability. *See supra* note 114 at 22-8; Kurt J.W. Sandstrom, "Personal and Vicarious Liability for Wrongful Acts of Government Officials: An Approach for Liability under the Charter of Rights and Freedoms" (1990) 24 U B C L Rev 229-274 at 233.

that both hospitals and doctors are insured, this theory is criticized as incompatible with the purpose of the liability of hospitals, which is "efficiency in …loss allocation," *i.e.*, discouraging insurance duplication.[123]

The Ethiopian law of liability for others seeks to compensate the victim of an injury caused by the civil servant of the hospital through voluntary subscription to liability insurance coverage.[124] Such an insurance scheme socializes the risks of the hospital among the same group of insured through the payment of premium.[125] Therefore, establishing vicarious liability on a federal hospital for doctors' fault in private wing practice is justified on the theory of loss distribution for two main reasons. First, the federal hospital has deeper pocket to buy a liability insurance plan. Secondly, the federal hospital can pass on the cost of its liability insurance plan for its private wing practice to service fees. The hospital, not the doctors, can set the fees for health care services provided in its private wing.

3. **Deterrence**

A hospital can reduce the occurrence of medical malpractice through quality assurance mechanisms, risk management and peer review.[126] Thus, the vicarious liability of a hospital will ensure it improves its management, working procedures and implements quality assurance systems to prevent the occurrence of medical malpractice.[127] In short, the vicarious liability of a

[123] *Supra* note 119 at 197.
[124] *Supra* note 30 at 31.
[125] *Ibid* at 30.
[126] *Supra* note 77 at 26.
[127] *Supra* note 78 at 108; *supra* note 119 at 197. In *Sagaz* case the Supreme Court of Canada observed that "vicarious liability is deterrence of future harm as employers are often in a position to reduce accidents and intentional wrongs by efficient organization and supervision." *Supra* note 82 at para.32.

hospital has a deterrent effect to prevent the occurrence of medical malpractice in the hospital.[128] Deterrence is also an important policy consideration to establish the liability of a federal hospital for its doctors' practice in the private wing. It supplements compensation and loss distribution, and in this way, establishes the liability of a federal hospital for doctors' practice in the private wing on solid theoretical and policy justification.

Altogether, the flexible wording of Art.2134 of the CC allows the court to consider new developments or frontiers in the law of liability for others; thus, warranting the use of the type of contextual approach. The result, that is, holding a federal hospital liable for private wing practice, complies with the underlying policy reasons for the law of liability for others in Ethiopia.

Next, I will show how the interpretation of Art.2134, using the contextual approach of distinguishing an independent contractor from a civil servant, yields the result that a doctor in private wing practice is not an independent contractor but a civil servant of the federal hospital.

B. Application of the Contextual Approach

On whose account does the private wing operate? The private wing is defined as "a system established within a federal hospital" implying that the unit is an integral part of the federal hospital. As such, there is neither a separate legal personality for the private wing, nor any legal requirement to register the unit as a business entity. Rather, it uses the legal personality of the federal hospital (which also uses the legal personality of the Federal

[128] *Supra* note 78 at 108.

Ministry of Health or the University, whichever it is accountable to). Therefore, the doctors practicing in the private wing are under the legal umbrella of the federal hospital. Nonetheless, the fee they collect from patients is kept in a bank account that is separate from that of the federal hospital's account.[129] However, this account is not operated as if the doctors were the owners of the private wing. The fees are collected through the use of federal government receipt recognized by the Ministry of Finance and Economic Development.[130] Any procurement for the private wing is made in accordance with federal government procurement laws.[131] Moreover, annual internal and external audits of the financial statement of the private wing are undertaken under the auspices of the Board.[132] Even the doctors do not have the right to hire or recruit the cashier and accountants of the private wing.[133] This lack of the minimum administrative and management privileges to run the activities of the private wing illustrates that the doctors cannot be regarded as if they are practicing as independent private contractors.

Degree of federal hospital control over the doctor in the private wing: The degree of control the hospital exercises over the private wing and doctors' practice there is significant. Practice in the private wing is supervised by the Head of the private wing who is accountable to the hospital CEO.[134] The Head is responsible for planning, program setting and their implementation;[135] and to recommend to the CEO, the appointment of

[129] *Supra* note 21 arts.5(2) & (3).
[130] *Ibid* art. 5 (1). All federal government revenue or income shall be collected by the receipt recognized the Ministry of Finance and Economic Development.
[131] *Ibid* art. 6 (2).
[132] *Ibid* art. 5 (5).
[133] *Ibid* art.5 (4).
[134] *Ibid* art. 3(1).
[135] *Ibid* art. 3(2 (5)).

doctors to the private wing[136]. To be recommended for such appointment, a doctor must have a good evaluation for the performance in her regular employment with the federal hospital.[137] After being appointed to the private wing, the rules governing the civil service apply to the doctor and her performance evaluated by the Head, and this is essential for the doctor to continue providing her services in the private wing.[138] The doctors have no capacity to determine the fee the patient shall pay for their services; the fee is determined by the Board upon the recommendation of the CEO based on the proposal submitted by the Head of the private wing.[139] The net income of the private wing is distributed among the doctors and other health professionals not by the decision of the doctors but by the CEO upon the recommendation of the Committee. Thus, a doctor in the private wing does not enjoy control over her practice, in contrast to a doctor who is an independent contractor and controls the administration and management of the health care services she provides.

Who provides the premise and equipment? The federal hospital provides the practice premise. Medical laboratory and radiography services are done using the federal hospital's equipment and in accordance with a program that would not prejudice the provision of the regular services of the hospital.[140] Surgical equipment, sterilization machines and other limited resources of the federal hospital are also utilized to provide private wing services in accordance with a program that would not prejudice the regular services of

[136] *Ibid* art. 3(2(8)).
[137] *Ibid* art. 4(1(2)).
[138] *Ibid* art. 4(1(5)).
[139] *Ibid* art. 9(2(5)).
[140] *Ibid* art. 7(2(3)).

the hospital.[141] The federal hospital also provides beds for in-patient services of the private wing, which may not exceed 10 per cent of the total hospital beds.[142] The only medical equipment the doctor may bring to the private wing is her stethoscope. This test strengthens the doubt if a doctor practicing in the private wing could be considered an independent contractor.

Can a doctor hire an assistant in the private wing? To be regarded as an independent contractor, a doctor should be able to hire assistants, such as a nurse, laboratory technician and x-ray technician. However, in the private wing, the recruitment of all health professionals and support staff is approved by the CEO upon the recommendation of the private wing Head. Thus, a doctor in the private wing has no right to hire an assistant. However, in most cases, a doctor who is an independent contractor can hire assistants.

Who bears the financial risk for the private wing? The initial capital required to set up a private wing that meets the expectations of patients is provided by the federal hospital.[143] Thus, the financial risk rests with the hospital. A doctor has no investment in the private wing. If the private wing could not attract adequate market to generate income to sustain its running costs, there is no financial loss to the doctor.

Is the private wing a profit making enterprise for the doctor? The more patients the doctor treats, the more the income the private wing will make. Thus, as the net income of the private wing increases, the amount the doctor receives increases too. However, no direct profit accrues to the doctor's

[141] *Ibid* art. 7(2(4)).
[142] *Ibid* art. 7(2(2)).
[143] *Ibid* art. 7(1(1)).

pocket, and the doctor may not consider the private wing as a profit making enterprise, but only as a source of modest income. Indeed, the whole purpose of the private wing is not profit making but to ensure motivation and retention of the doctor in the federal hospital.

All in all, for the reasons described above, a doctor practicing in the private wing cannot be an independent contractor. Thus, it can be concluded that a doctor practicing in the private wing of a federal hospital is still a civil servant of the hospital. Consequently, the federal hospital will be liable for the doctor's official fault in the private wing. As described above, this conclusion has sound policy justifications, too.

The counterargument against the thesis of this paper may claim that doctors in the private wing should be considered independent contractors. I said that part-time practice by specialists in private hospitals is considered to be practice by independent contractors, and which is, governed by contract law. Consequently, it may be argued that Art. 2134 of the CC should be interpreted by analogy so that the practice of the doctors in the private wing of a federal hospital is similar to the part-time practice of a specialist in a private hospital. The patient chooses the specialist who practices part-time in a private hospital; similarly, the patient has the right to choose the doctor in the private wing. The specialist in part-time practice gets a percentage of the hospital income from his service; similarly, the doctor in the private wing gets a share of the income the private wing generates in accordance with the decision of the CEO of the hospital. Both practices are usually undertaken outside regular working hours of the private and federal hospitals. In addition, the public understands that the private wing is a separate entity in the federal hospital because of the requirement of higher fee than the regular service fee,

the right to choose a doctor, and the outside of regular working hours that the private wing maintains. Indeed, the nomenclature 'private' conveys to the public the message that the health care service of the private wing is like that of private hospitals.

Nonetheless, I would argue that the analogy focuses on the similarity between the part-time practice of a specialist in the private sector, and a doctor in the private wing, a perception that ignores the basic differences between the two forms of practice. The most important difference is that in the part-time practice of a specialist in the private sector, she enjoys higher independence and control over her practice, while the doctor in the private wing is significantly subjected to the control of the federal hospital, as discussed above.

Conclusion

Art.2134 of the Ethiopian CC should be interpreted using the contextual approach so that examining different aspects of a given relation would explain the status of a doctor practicing in the private wing in her relations with the federal hospital. A doctor in the private wing does not practice entirely on her own account. To start with, she is subjected to control by the federal hospital in terms of her recruitment, performance evaluation and dismissal from the private wing. In addition, she does not provide the initial capital to start private wing services, the room or equipment for the practice. Also, she cannot hire an assistant for her private wing practice and does not bear any financial risk for practicing in the private wing.

On the other hand, the private wing cannot also be considered as a profit making enterprise. This is because the doctor is not primarily there to make money but to address the human resource retention problem, namely doctor attrition and lack of motivation to practice in federal hospitals. The totality of the relationship between the doctor practicing in the private wing and the government hospital, thus, unfolds that the doctor should not be considered as an independent contractor, but a civil servant. Accordingly, the federal hospital must be liable for her official fault in the private wing.