DALAM MAHKAMAH PERSEKUTUAN MALAYSIA DI PUTRAJAYA

(BIDANG KUASA RAYUAN)

RAYUAN SIVIL NO: 02(f)-12-02/2023(B)

ANTARA

SIOW CHING YEE
(MENYAMAN MELALUI ISTERI DAN WAKIL LITIGASINYA, CHAU WAI KIN) **… PERAYU**

AND

COLUMBIA ASIA SDN BHD
(NO. SYARIKAT: 338359-P **… RESPONDEN**

[Dalam Mahkamah Rayuan Malaysia

(Bidang Kuasa Rayuan)

Rayuan Sivil No.: B-02(NCVC)(W)-1175-09/2020

Antara

Siow Ching Yee
(menyaman melalui isteri dan wakil litigasinya,
Chau Wai Kin … Perayu

Dan

1. Dr Megat Shiraz bin Megat Abd Rahim
2. Dr Noor Asilah bt Abdull Rahman
3. Columbia Asia Sdn Bhd … Responden-Responden

Diputuskan oleh Mahkamah Rayuan Malaysia di Putrajaya pada 25 Ogos 2022 oleh Yang Arif Nor Bee binti Ariffin, Yang Arif Lee Heng Cheong dan Yang Arif Mariana binti Haji Yahya)

[Dalam Mahkamah Tinggi Malaya di Kuala Lumpur
Guaman No: BA-23NCVC-27-10/2017
Antara

Siow Ching Yee
(menyaman melalui isteri dan wakil litigasinya,
Chau Wai Kin … Plaintif

Dan

1. Dr Megat Shiraz bin Megat Abd Rahim
2. Dr Noor Asilah bt Abdull Rahman
3. Columbia Asia Sdn Bhd … Defendan-Defendan]

CORAM:

MOHAMAD ZABIDIN BIN MOHD DIAH, CJM

ABDUL RAHMAN BIN SEBLI, CJSS

ZABARIAH BINTI MOHD YUSOF, FCJ

HASNAH BINTI MOHAMMED HASHIM, FCJ

MARY LIM THIAM SUAN, FCJ

MAJORITY JUDGMENT OF THE COURT

[1] This is the majority decision of the Court. My learned brothers, Mohamad Zabidin bin Mohd Diah, CJM and Abdul Rahman bin Sebli, CJSS, and my learned sister Hasnah binti Mohammed Hashim, FCJ have read this judgment in draft and have agreed with the said draft.

[2] The appellant instituted a claim through his wife as he had suffered severe brain damage as a result of treatment rendered by the 1st and 2nd defendants, medical specialists who practised at a hospital managed or operated by the respondent, the 3rd defendant at the High Court. After a full trial, the claim against the 2nd defendant was allowed while the claims against the 1st and 3rd defendants were dismissed. That decision on liability was sustained on appeal although appeal on quantum was allowed and the amount was varied to some extent by the Court of Appeal. Being dissatisfied, the appellant sought leave to appeal.

[3] On 14.2.2023, leave was granted on the following seven questions of law:

1. Whether the owner and manager of a hospital is in law a provider of healthcare and owes a non-delegable duty of care to patients as stated by the English Court of Appeal in the post *Dr Kok Choong Seng & Anor v Soo Cheng Lin & Another Appeal* [2018] 1 MLJ 685 case of Hughes v Rattan [2022] EWCA Civ 107?

2. Whether the judgment of the Federal Court in *Dr Kok Choong Seng* regarding the tort of negligence in a private hospital applies where the owner and manager of the hospital owes separately duties of care in contract and by statute?

3. Whether the owner and manager of a private hospital is liable to patients under a non-delegable duty of care when a doctor practising in the hospital as an independent contractor has insufficient professional indemnity for malpractice?

4. If the answer is yes, whether the owner and manager, as a provider of healthcare, may escape liability for a breach of such duty of care committed by a doctor because the doctor is an independent contractor who has been engaged to practise in the hospital?

5. Whether there is a statutory duty of care, independent of a duty in negligence or contract, owed by the owner and manager of a private hospital under the Private Healthcare Facilities and Services Act 1998 and the subsidiary legislation made thereunder

6. Whether the fees received by a director of a company from the company are 'earnings by his own labour or other gainful activity' under s 28A(2)(c)(i) of the Civil Law Act 1956?

7. In light of the post *Dr Kok Choong Seng* case of *Armes v Nottinghamshire Country Council* [2018] 1 All ER 1 decided by the Supreme Court of the United Kingdom, whether after applying the 5-feature test in *Woodland v Essex County Council* [2014] 1 All ER 482, a Court must additionally apply the test of whether it is fair, just and reasonable to impose a non-delegable duty of care in the circumstances of the case?

[4] Following the grant of leave, the appellant filed a Notice of Appeal appealing against the decision dismissing the claim against the respondent, and in respect of quantum, for having failed to take into consideration the fees earned as director.

[5] The focus in this appeal is in respect of the liability of the respondent; the other defendants at the High Court are not parties to this appeal. Aside from Question 6 which deals with the calculation of damages, all the other questions pertain to the issue of whether a private hospital may be liable for the tort of a medical practitioner who is said to be an independent contractor. In short, whether such an entity itself owes an independent duty which is non-delegable, regardless to whom it may have delegated that duty to, irrespective who may have performed the act or omission complained of, whether under a contract for service or due to the patient's own choice.

[6] This question was substantially addressed in *Dr Kok Choong Seng & Anor v Soo Cheng Lin & Another Appeal* [2018] 1 MLJ 685; 10 CLJ 529; [2017] 6 MLRA 367. However, due to certain developments under English law, which was to a large extent, followed in that decision, we are now invited to revisit this area of jurisprudence.

Factual background

[7] The appellant had undergone a tonsillectomy, palatal stiffening and endoscopic sinus surgery at the Subang Jaya Medical Centre [SJMC] on 10.3.2010. At about 3.30 a.m. on 22.3.2010, the appellant suffered bleeding at the site of the operation. He was brought to the accident and emergency department of the respondent by his family. As mentioned earlier, the respondent is a private hospital.

[8] At the respondent's emergency department, the appellant was examined by a medical officer who then called the 1st defendant, a consultant ear, nose and throat surgeon. The 1st defendant recommended

that the appellant undergo an examination under anaesthesia and wound debridement under general anaesthesia. The 2nd defendant was the consultant anaesthetist who attended to the appellant.

[9] The appellant experienced complications even before surgery started. In the airlock area outside the operating theatre, he started vomiting copious amount of blood and there was profuse bleeding. Despite efforts by the 1st and 2nd defendants, the appellant collapsed and emergency resuscitation had to be executed. Thereafter the intended surgery was performed. It was uneventful. Unfortunately, the appellant suffered hypoxic brain damage. After surgery, he was admitted to the intensive care unit of the respondent for continued post-surgical care and management. At the family's request, the appellant was transferred out to SJMC on 28.3.2010. He is now permanently mentally and physically disabled by reason of the massive cerebral hypoxia.

[10] Through his wife, the appellant initiated a suit against the two consultants and the respondent. The suit is founded in contract and in tort, for negligence; and for breach of duties under the Private Healthcare Facilities and Services Act 1998. At paragraph 29 of the Statement of Claim, the appellant alleged that the respondent is "vicariously liable for the negligence of the 1st and 2nd defendants and is also directly liable for breach of its non-delegable duty".

[11] All the allegations were denied. In particular, the respondent pleaded that the first two defendants carried out their respective medical practice at its hospital as independent contractors under contracts for services. As such, all diagnosis, medical advice including material risks and known complications, medical treatments, operations and referrals are the

responsibility of these defendants. The respondent averred that its responsibility as owners and managers of the hospital was "merely to ensure the provision of facilities and medical equipment, including nursing staff".

Decisions of the High Court & Court of Appeal

[12] The learned trial Judge dismissed the claim against the 1st defendant because "from the evidence as a whole, the plaintiff had simply failed to establish any causal link between D1's acts and/or omission and the injuries that he suffered. His brain damage had no connection with any intervention or alleged failure to intervene by D1… the acts or omissions complained of did not amount to negligence that would warrant a finding or apportionment of liability against D1".

[13] On the other hand, the learned trial Judge found against the 2nd defendant; that there were "indisputably other emergency, life-saving procedures which D2 in line with expert opinion, ought to have considered but she failed to do so. Importantly, she did not even discuss the said options, which were within her purview and professed expertise, with D1". From His Lordship's analysis of the facts, opinions and evidence material to the issues in dispute, His Lordship was satisfied that "negligence ought to be ascribed to D2 as it had become plainly obvious that her conduct had fallen below the standard of skill and care expected from an ordinary competent doctor professing the relevant specialist skills based on which she was entrusted to treat the plaintiff".

[14] As for the respondent, the High Court found that the appellant "had failed to adduce any credible, let alone sufficient, evidence to prove the

above particulars of negligence against D3". On the issue of vicarious and direct non-delegable duty, the learned Judge found that the 1st and 2nd defendants were "at all material times not as employees, servants or agents of the hospital but as independent contractors…Their contracts were evidenced by the Resident and Consultant Agreements produced in Court". According to the High Court, the appellant "seemed to admit in his pleadings that D1 and D2 had held themselves as independent contractors. Hence, he could not now contend that there was a private agreement or arrangement between them and D3 without the knowledge of the patient". Aside from those observations, there was really not much deliberations on this question of whether the respondent owed a non-delegable duty to the appellant which duty was breached when there was negligence found on the part of the 2nd defendant.

[15] Both the appellant and the 2nd defendant appealed. The appellant's appeal was in respect of all the defendants and also on the matter of quantum.

[16] At the Court of Appeal, the appeal against the respondent was dismissed whereas the appeal in respect of quantum was allowed in part, as against the 2nd defendant. The appellant withdrew the appeal against the 1st defendant. The 2nd defendant's appeal was dismissed.

[17] The appeal now concerns the respondent alone.

Analysis and determination

[18] The appellant's claim against the respondent is premised on the existence of a non-delegable duty of care; that the respondent had

breached that duty as well as its contractual, statutory and/or other duties. The appellant further claimed that the respondent was vicariously liable for the 2nd defendant's tort. The argument on vicarious liability was abandoned at the Court of Appeal and it is no longer in issue in this appeal. The law in this respect was however discussed in the Court of Appeal decision of *Vincent Manickam s/o David (suing by himself and as administrator of the estate of Catherine Jeya Sellamah, deceased) & Ors v Dr S Hari Rajah & Anor* [2018] 2 MLJ 497; [2017] 8 CLJ 27; [2017] 5 MLRA 244 – see paragraphs 26 to 75.

[19] Further discussions may be found in the Federal Court decisions of *Dr Kok Choong Seng & Anor v Soo Cheng Lin & Another Appeal* [*supra*], and *Dr Hari Krishnan & Anor v Megat Noor Ishak b Megat Ibrahim & Anor and another appeal* [2018] 3 MLJ 281; [2018] 3 CLJ 427; [2018] 1 MLRA 535. Also, see *Mohamud v VM Morrison Supermarkets plc* [2016] UKSC 11, [2017] 1 All ER 15; *X and Others (minors) v Bedfordshire County Council; M (a minor) and another v Newham London Borough Council and others; E (minor) v Dorset County Council and other appeals* [1995] 3 All ER 353; *BXB v Trustees of the Barry Congregation of Jehovah's Witnesses and another* [2023] 3 All ER 1; and *Armes v Nottinghamshire County Council* [2018] 1 All ER 1. The two principles are distinct and discrete, though frequently deployed to the same set of facts in order to found some measure of liability in tort. That, however, is for another occasion.

[20] In this appeal, the central issue is whether the respondent owes a non-delegable duty of care to the patient, the appellant. The Private Healthcare Facilities and Services Act 1998 [Act 586] and the Regulations made thereunder are relied on to amplify and support the contention that such a duty of care exists in law and was established on the facts; in which

case, the questions must be answered in the appellant's favour and the appeal allowed.

[21] This issue has become particularly important given the proliferation and burgeoning of private hospitals or private healthcare, seen now almost as a necessary and vital complement to the public hospital system. The growth of such private hospitals or private healthcare is not confined to the capital city but can be readily seen in many of our larger towns. It may even be said that one is spoilt for choice when it comes to such care and facility. It is also now offered as a tourist package or health tourism, as described by *amicus curiae* for the Association of Private Hospitals of Malaysia.

[22] In Malaysia, private hospitals are said to "alleviate the public healthcare system by providing an alternative to patients to seek appropriate healthcare as they see fit and because of their access to resources, are also said to be able to act as standard setters as they are able to employ new technologies and implement measures for efficient delivery of care to patients". With the added dimension of complex corporate venture structures as most of these private hospitals are operated and managed, this issue of liability of those who manage and operate these hospitals or healthcare facilities in relation to the medical practitioners who practice within these establishments through some contractual arrangement or other but who are the persons actually rendering the health care and treatment to patients, becomes rather acute and urgent.

(i) The principle of non-delegable duty of care

[23] The appellant's claim is grounded on the tort of negligence. It is fault-based which means the tort, wrongdoing or omission complained of is committed by the tortfeasor and the claim is brought against that tortfeasor personally. Ordinarily, the law does not impose a personal liability for what others do or fail to do. This principle is however displaced with the imposition of liability on this other person or entity under certain conditions or circumstances; this liability is more conventionally known as a non-delegable duty of care.

[24] This principle, particularly in the field of medical negligence or in certain jurisdictions known as the law on bioethics, is not new to our jurisdiction. In *Dr Kok* [*supra*] [*Dr Kok*], the Federal Court recognised and adopted this principle of non-delegable duty of care as propounded in *Woodland v Swimming Teachers Association & Others* [2014] AC 537 [*Woodland*]. Shortly after, the Federal Court revisited the issue in *Dr Hari Krishnan & Anor v Megat Noor Ishak b Megat Ibrahim & Anor and another appeal* [*supra*] [*Dr Hari Krishnan*]. Both decisions concerned claims of medical negligence and the liability of the private hospitals where the events took place was scrutinised. Recently, this Court once again revisited this principle in the case of *Hemraj & Co Sdn Bhd v Tenaga Nasional Berhad* [2023] 1 MLJ 785; [2023] 1 CLJ 651; [2023] 2 MLRA 25 [*Hemraj*], this time in respect of dangerous or hazardous works. In all these cases, the defence was primarily that the tortfeasor is an independent contractor for which the defendant was not liable, vicariously or directly. The latter expression of direct liability is where the term, non-delegable duty is generally or commonly used.

[25] Despite these pronouncements, it appears the law on non-delegable duty or rather its application remains challenging in various respects, especially in medical negligence claims against private hospitals. Perhaps, the process of distinction described by Lady Hale may have failed to "make sense to ordinary people" [see *Woodland,* [29]]. Leave was thus granted under section 96 of the Courts of Judicature Act 1964 [Act 91]; more so to determine if there is any change or development in the light of some recent decisions in this regard in the UK.

[26] In the light of *Dr Kok* and *Dr Hari Krishnan*, it is timely to take stock of where the law is in this regard; to see if common law as "a dynamic instrument" needs to develop and adapt to meet the new situations presented in this appeal; or must we proceed with caution, incrementally by analogy with existing categories and consistently with some underlying principle as cautioned by Lady Hale in *Woodland*. Further, as opined by the Supreme Court in *Armes v Nottinghamshire County Council* [2018] 1 All ER 1, 13, paragraph [36], "the criteria articulated by Lord Sumption may need to be re-considered or possibly refined, in particular contexts".

[27] It must be emphasised that for this principle of non-delegable duty to have any relevance and impact on the outcome of the appeal, it must first be shown the presence of negligence. That, is not in issue in this appeal. The High Court found the 2nd defendant negligent and those findings have been affirmed on appeal.

[28] Back to the principle of non-delegable duty of care. First, to understand what that principle entails. Lord Sumption in *Woodland* opined that there is no "single theory" on when or why there is this principle of non-delegable duty of care. Nevertheless, there are helpful discussions on the

principle in *Dr Kok* and in the recent decision of *Hemraj*. Both decisions return to *Woodland* although in *Hemraj*, the discussion took a slightly different course as the facts concerned the first of the two broad categories of case in which such a duty has been held to arise, as identified by Lord Sumption in *Woodland*. That category being those cases where an independent contractor is engaged to perform some function which is either inherently hazardous or liable to be so in the course of the work. Incidentally, the law appears to have first developed in this type of cases – see *Hemraj*.

[29] It is however, the second category which is of concern in this appeal. Again, I turn to Lord Sumption who explained that:

> [7] The second category of non-delegable duty is, however, directly in point. It comprises cases where the common law imposes a duty upon the defendant which has three critical characteristics. **First, it arises not from the negligent character of the act itself but because of an antecedent relationship between the defendant and the claimant. Second, the duty is a positive or affirmative duty to protect a particular class of persons against a particular class of risks, and not simply a duty to refrain from acting in a way that foreseeably causes injury. Third, the duty is by virtue of that relationship personal to the defendant.** The work required to perform such a duty may well be delegable, and usually is. But the duty itself remains the defendant's. Its delegation makes no difference to his legal responsibility for the proper performance of a duty which is in law his own. In these cases, the defendant is assuming a liability analogous to that assumed by a person who contracts to do work carefully. The contracting party will normally be taken to contract that the work will be done carefully by whomever he may get to do it: *Photo Production Ltd v Securicor Transport Ltd* [1980] 1 All ER 556 at 566, [1980] AC 827 at 848 (Lord Diplock).
>
> [**emphasis added**]

[30] Here, Lord Sumption identified the first three characteristics where the law imposes a non-delegable duty of care: the antecedent relationship between the plaintiff and the defendant; a positive or affirmative duty to protect a particular class of persons against a particular class of risks; and the relationship is personal to the defendant. These three characteristics were later developed into and formed part of the five defining features, more commonly known as the "Woodland features".

[31] Lord Sumption identified the genesis of the principle of non-delegable duty, traced it from the law of nuisance to the present state where it is generally invoked to impose an assumption of responsibility in situations "where by virtue of some special relationship, the defendant is held to assume positive duties"; that the classic example is "a duty to perform professional services arising out of a special relationship equivalent to contract but not contractual" [see *Henderson v Merret Syndicates Ltd, Hallam-Eames v Merrett Syndicates Ltd, Hughes v Merret Syndicates Ltd, Arbuthnott v Feltrim Underwriting Agencies Ltd, Deeny v Gooda Walker Ltd (in liq)* [1994] 3 All ER 506, [1995] 2 AC 145]; whilst another example would be where there is a sufficient degree of dependence, or even non-reliance as in *Home Office v Dorset Yacht Co Ltd* [1970] 2 All ER 294; [1970] AC 1004; *White v Jones* [1995] 1 All ER 691. Lord Sumption then noted that this principle had been considered in a number of cases involving employees, hospital patients, school pupils and invitees, where the negligent act was by a person for whom the defendant is not vicariously liable. Each of those categories was then discussed together with Australian case law before His Lordship opined that the "time has come to recognise that Lord Greene in *Gold v Essex CC* and Denning LJ in *Cassidy v Ministry of Health* were correct in identifying the underlying principle".

[32] It is that underlying principle in respect of the second category of cases which was given a framework by Lord Sumption. In His Lordship's opinion, a non-delegable duty will arise if the following defining features are present:

(a) the claimant is a patient or a child, or for some other reason is especially vulnerable or dependent on the protection of the defendant against the risk of injury;

(b) there is an antecedent relationship between the claimant and the defendant, independent of the negligent act or omission itself, which-

(i) places the claimant in the actual custody, charge or care of the defendant, and

(ii) from which it is possible to impute to the defendant the assumption of a positive duty to protect the claimant from harm, and not just a duty to refrain from conduct which will foreseeably damage the claimant. It is characteristic of such relationships that they involve an element of control over the claimant, which varies in intensity from one situation to another, but is clearly very substantial in the case of schoolchildren;

(c) the claimant has no control over how the defendant chooses to perform those obligations; i.e. whether personally or through employees or through third parties;

(d) the defendant has delegated to a third party some function which is an integral part of the positive duty which he has assumed towards the claimant, and the third party is exercising for the purpose of the function thus delegated to him, the defendant's custody or care of the claimant and the element of control that goes with it;

(e) the third party has been negligent not in some collateral respect but in the performance of the very function assumed by the defendant and delegated by the defendant to him.

[33] These five defining features, generally referred to as the five Woodland features, incorporate the three critical characteristics earlier mentioned.

[34] This Court in *Dr Kok* explained the principle of non-delegable duty of care in the following terms:

> [36] **The nature of a non-delegable duty is, in essence, a positive duty to ensure that reasonable care is taken**. Viewed in its proper context thus, non-delegable duties are not an anomaly in the law of negligence without a common basis, but founded on established concepts rooted in the general principles of the law of negligence itself. **An assumption of responsibility may be inferred from the creation of a special risk, or a special antecedent relationship between him and the claimant**. The assumption of responsibility gives rise to a positive duty to protect the claimant from harm, and forms the rationale for imposing a more onerous duty of care on the defendant. Indeed, the concept of assumption of responsibility has been posited as the unifying basis that may serve to explain both Lord Sumption's first and second categories of cases (see J Murphy, Juridical foundations of common law non-delegable duties in JW Neyers et al, Emerging Issues in Tort Law (Oxford: Hart, 2007)).
>
> [37] **The defining features, including the claimant's vulnerability or dependence and the defendant's control or custody over the claimant, are factors well-recognised to require a higher standard of care**. Where a particular combination of such factors (as identified by Lord Sumption) exists, the standard of care is exceptionally heightened so that the requirement of reasonable care is not met simply by delegating the function to a competent contractor, but by ensuring that due care is exercised in the performance of that function by

whomever is appointed to do so. However, liability for breach of a non-delegable duty does not amount to strict liability for any injury or damage caused in the performance of that function. The duty is discharged as long as reasonable care is taken by the delegatee (see *Roe v Minister of Health* [1954] 2 QB 66).

[38] **Non-delegable duties have been erroneously considered as a 'kind of vicarious liability'**, and adopted as part of the test to determine vicarious liability in some cases. This is a misconception. The two doctrines are similar in effect, in that they both result in liability being imposed on a party (the defendant) for the injury caused to a victim (the plaintiff) as a result of the negligence of another party (the tortfeasor). However, it bears emphasis that non-delegable duties and vicarious liability are distinct in nature and basis. The former imposes personal liability on the defendant for the breach of his own duty towards the plaintiff, based on the relationship between the defendant and the plaintiff, regardless of whom the defendant has engaged to perform the task. The latter imposes vicarious liability on the defendant for the tortfeasor's breach of duty towards the plaintiff, based on the relationship of employment between the defendant and the tortfeasor.

[39] The doctrine of non-delegable duties has an independent scope of application apart from the realm of vicarious liability. A number of scenarios illuminate the distinction. Non-delegable duties, or positive duties to ensure that reasonable care is taken, may exist in situations where there is no vicarious liability: for instance where harm is caused as a result of a system failure and no individual tortfeasor can be identified, or where harm is caused by a third party to a plaintiff under the defendant's custody. Conversely, vicarious liability can operate in the absence of a non-delegable duty, in cases where the elements of a special hazard or a relationship of vulnerability or dependence are absent (eg an employee who negligently hits a pedestrian, while driving a vehicle in the course of employment). The two doctrines are conceptually and practically distinct.

[emphasis added]

[35] Thus, the principle of non-delegable duty is actually "founded on established concepts rooted in the general principles of the law of negligence itself. An assumption of responsibility gives rise to a positive duty to protect the claimant from harm, and forms the rationale for imposing a more onerous duty of care on the defendant". The obligation or liability is imposed because of the existence of an antecedent relationship between the parties apart from that between the plaintiff and the tortfeasor(s). The duty that is imposed is a positive duty to protect the plaintiff who is of a particular class against particular risks. That duty arises because of the relationship which is personal to the defendant. Under these conditions, such a defendant is treated in law as having assumed responsibility for the exercise of due care by anyone to whom he may delegate its performance.

[36] In *Dr Kok*, this Court had added that because non-delegable duties impose more onerous obligations, it would heed the *proviso* in *Woodland*', that such duty should only be imposed where it is fair, just and reasonable to do so based on the particular circumstances of the case, and developed incrementally from existing categories and consistently with underlying principles [see paragraph [40]]. This was reiterated in *Dr Hari Krishnan*, paragraph [142].

[37] I will address this 'proviso in *Woodland*' shortly, but first, it is important to bear in mind that *Woodland* was not a case of medical negligence where a private hospital was sued on the ground that it owed a non-delegable duty to its patients. This aspect is relevant as it explains some of the remarks and observations made by both Lord Sumption and Lady Hale in the course of their respective reasonings. That was a case where the appellant, a young pupil at a school managed by the respondent education authority sustained serious brain injury as a result of a swimming mishap. Both the

swimming teacher and the lifeguard on duty at the pool where the lessons were being conducted were not employed by the respondent, the former being an independent contractor who had contracted with the education authority to provide swimming lessons to its pupils. The issue was whether the respondent owed the appellant a non-delegable duty of care which if answered in the affirmative meant that the respondent was liable for the negligence of the swimming teacher and the lifeguard.

[38] In adopting the *Woodland* features, this Court in both *Dr Kok* and *Dr Hari Krishnan* set about applying the five features to the particular facts of the case. Having done that, the Federal Court in *Dr Kok* found the second feature not met whilst in *Dr Hari Krishnan*, this Court found all five features present in respect of Dr Namazie, the anaesthetist but not in respect of Dr Hari. This Court further found the hospital not vicariously liable for both specialists, that both were independent contractors.

[39] In its penultimate analysis, this Court in *Dr Kok* touched on the issue of whether private hospitals should or should not generally be held liable for the negligence of their doctors. This Court refrained from making a broad pronouncement on the liability of all private hospitals in medical negligence cases on the basis of policy alone as it would "risk over-generalising the nuances of modern business relationships, and result in an unprincipled approach to liability". Has this changed? In this regard, I heed back to my earlier remarks of the observations of Lord Reed in *Armes*, that the criteria or five features "may need to be re-considered or possibly, refined in the particular contexts".

(ii) Proviso in Woodland

[40] Here, I return to the matter of the 'proviso in *Woodland*'; that a non-delegable duty should only be imposed only so far as it would be fair, just and reasonable to do so. This so-called 'proviso' was remarked by Lord Sumption after citing several decisions which had rejected the imposition of a non-delegable duty in the particular facts. According to Lord Sumption-

> [25] The courts should be sensitive about imposing unreasonable financial burden on those providing critical public services. A non-delegable duty should be imputed to schools only so far as it would be fair, just and reasonable to do so.

[41] His Lordship then proceeded to offer at least six reasons why he did not "accept that any unreasonable burden would be cast on them by recognising the existence of a non-delegable duty on the criteria which I have summarised above". The "criteria" being the five defining features while the "them" refers to the school authorities.

[42] In my view, this so-called *proviso* does not arise and has in fact been misunderstood. When Lord Sumption suggested that the imposition of non-delegable duty should only be where it would be fair, just and reasonable, His Lordship was actually referring to the context of that appeal where the local authority in question and the like were providing "critical public services". In that context, His Lordship cautioned the need for the Courts to be sensitive about imposing unreasonable financial burdens. This is borne out by the six reasons offered; that "schools are employed to educate children, which they can do only if they are allowed authority over them… when the school's own control is delegated to someone else for the purpose of performing part of the school's own educational function, it is wholly

reasonable that the school should be answerable for the careful exercise of its control by the delegate… that schools provide a service either by contract or pursuant to a statutory obligation, and while LEA schools do not receive fees, their staff and contractors are paid professionals".

[43] When Lady Hale's supporting judgment is examined, it will be seen that Her Ladyship agreed with Lord Sumption but did not repeat that same "proviso", opining that "recognising the existence of a non-delegable duty in the circumstances described above would not cast an unreasonable burden upon the service providers for all the reasons that he gives". Instead, Lady Hale's subjected her agreement to the principle to apply in the circumstances described by Lord Sumption subject to the "usual provisos that such judicial statements are not to be treated as if they are statutes and can never be set in stone". Her Ladyship took pains to explain that there should be no distinction between parents who paid for their children's education and those who do not; that "In the context of a necessary service, such as education, this does not seem a compelling distinction… All three girls have at least these features in common: (i) they have to go to school – their parents may be criminally liable if they do not and in extreme cases they may be taken into care if they refuse to go to school; (ii) when at school they have to do as the teachers and other staff say, with various sanctions if they do not; (iii) swimming lessons are part of the curriculum which the school has undertaken to provide; (iv) neither the children nor their parents have any control or choice about the precise arrangements made by the school to provide them with swimming lessons; (v) they are all young people who need care and supervision (as well as to be taught how to swim) for their own safety".

[44] At paragraph [34], Lady Hale in fact compared the situation of the appellant child with a patient at a hospital, explaining that "the reason why the hospital or school is liable is that the hospital has undertaken to care for the patient, and the school has undertaken to teach the pupil, and that the responsibility is not discharged simply by choosing apparently competent people to do it. The hospital or school remains personally responsible to see that care is taken in doing it".

[45] I find further support from Lord Reed's observations in *Armes* [*supra*], that the question arises actually in relation to vicarious liability and not, non-delegable duty:

> "[36] … That does not, however, mean that it is routinely necessary for the judge to determine what would be fair and just as a second stage of the analysis. As was made clear by this Court *in Cox v Ministry of Justice* [2016] UKSC 10, [2017] 1 All ER 1, [2016] AC 660 (para [41]), in relation to vicarious liability, having recourse to a separate inquiry into what is fair, just and reasonable is not only unnecessarily duplicative, but is also apt to give rise to uncertainty and inconsistency".

[46] What is the position in Singapore? It differs slightly. In *Management Corporation Strata Title Plan No 3322 v Tiong Aik Construction Pte Ltd and another* [2016] SGCA 40, while it expressed approval of the five Woodland features, the Singapore Court of Appeal said:

> "In our judgment, moving forward, to demonstrate that a non-delegable duty arises on a particular set of facts, a claimant must minimally be able to satisfy the court either that; (a) the facts fall within one of the established categories of non-delegable duties; or (b) the fact possess all the features described at [58] above [the five defining features in Woodland]. However, we would hasten to add that (a) and (b) above merely lay down threshold requirements for satisfying the court

that a non-delegable duty exist – the court will additionally have to take into account the fairness and reasonableness of imposing a non-delegable duty in the particular circumstance, as well as the relevant policy considerations in our local context".

[47] It would appear that Singapore does not require the satisfaction of the *Woodland* features in every case; and even then, the requirements are only "threshold" with fairness and reasonableness and "relevant policy considerations" seen as additional matters to be taken into account. Care however, must be exercised as this pronouncement was not in the context of a medical negligence case. Similarly, the decision in *Ng Huat Seng v Munib Muhammad Madni* [2017] SGCA 58. Both cases actually are of the first broad category of cases, like *Hemraj* [*supra*]. The position in relation to healthcare is still left open and not decided since negligence was not established on the facts. At the High Court however, the existence of non-delegable duty of care was rejected because of Singapore's statutory regime – see *Hii Chii Kok v Ooi Peng Jin London Lucien* [2016] 2 SLR 544.

[48] Consequently, the imposition of this fair, just and reasonable condition in the second category of cases concerning medical negligence does not arise. In any case, the respondent in this appeal is not rendering a public service as used and understood in the English cases, reliant on public funds through the system of taxation or voluntary contributions. It is a private business entity set up for the specific purpose of rendering private healthcare facilities and services; quite clearly for profit. When the statutory regime governing private healthcare facilities and services is scrutinised, this becomes even clearer. This statutory framework actually forms or creates the necessary relationship for which a non-delegable duty of care may be deemed to have been assumed.

[49] In the context of private hospitals, and for the added reasons to follow, the rationale of any non-delegable duty owed by such hospitals is quite well-put by Lord Dyson LJ in *Farraj v King's Healthcare NHS Trust* [2009] EWCA Civ 1203, (2009) 111 BMLR 131, [2010] 1 WLR 2139:

> "…the hospital undertakes the care, supervision and control of its patients who are in a special need of care. Patients are a vulnerable class of persons who place themselves in the care and under the control of a hospital and as a result, the hospital assumes a particular responsibility for their well-being and safety".

[50] Going back to *Dr Kok*, this Court had also found favour with similar *obiter* statements made in several decisions. First, the view expressed by Lord Greene MR in *Gold v Essex County Council* [1942] 2 KB 293, that once the extent of the obligation assumed by a defendant hospital is discovered, he cannot escape liability because he has employed another, whether as servant or agent to discharge it on his behalf; that the hospital's duty is not confined to administrative matters, providing proper facilities and selecting competent staff:

> "When a patient seeking free advice and treatment such as that given to the infant appellant knocks at the door of the respondents' hospital, what is he entitled to expect?"

[51] Lord Green MR was of the view that a hospital's duty included the treatment of patients with reasonable care, and such duty is not discharged by delegation, whether or not any special skill was involved.

[52] Following in the same stead is Lord Denning who in *Cassidy v Ministry of Health* [1951] 2 KB 343, departed from the majority in the Court

of Appeal who found the hospital liable in a medical negligence suit based on the principle of vicarious liability, and chose to find liability on the principle of non-delegable duty of care:

> "I take it to be clear law, as well as good sense, that, where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under a contract of service or to an independent contractor under a contract for service".

[53] I can only hazard a guess that Lord Denning had himself learnt the full purport of the principle after *Gold v Essex* [*supra*] as he was counsel in that case. In *Cassidy*, His Lordship chided himself for not having drawn this principle of non-delegable duty to the attention of the Court there. According to Lord Denning, Lord Green gave "no countenance to this error. He made the liability depend on what was the obligation which rested on the hospital authorities. He showed that hospital authorities were under an obligation to use reasonable care in treatment, whence it follows, on the authorities I have just cited, that they cannot get rid of that obligation by delegating it to someone else, not even a doctor or surgeon under a contract for services". His Lordship made no distinction between persons engaged under a contract of service and a contract for services:

> "… the liability of the hospital authorities should not, and does not, depend on nice considerations of that sort. The plaintiff knew nothing of the terms on which they employed their staff; all he knew was that he was treated in the hospital by people whom the hospital authorities appointed; and the hospital authorities must be answerable for the way in which he was treated."

[54] In *Roe v Minister of Health* [1954] 2 QB 66, Lord Denning revisited this principle in a case concerning the liability of a hospital for alleged negligence of a part-time anaesthetist:

> "… the hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors, but also for the anaesthetists and the surgeons. It does not matter whether they are permanent or temporary, resident or visiting, whole-time or part-time. The hospital authorities are responsible for all of them. The reason is because, even if they are not servants, they are agents of the hospital to give the treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself."

[55] All these statements were *obiter* made in the context of cases involving staff employed in public hospitals under a statutory duty to provide treatment for patients, as observed by the Federal Court in *Dr Kok*. However, the Court noted that the hospitals were nevertheless held to be under a non-delegable duty to patients regardless their status of employment or relationship with the hospital itself. This aspect becomes particularly relevant when Act 586 and the related Regulations are examined.

(iii) Act 586 – the statutory framework

[56] I move next to the matter of statute, that the statutory regime was a relevant consideration in *Woodland* and other cases. In *Woodland*, this may be gathered from Lord Sumption's concerns on imposing too burdensome a financial duty given the authority under which public service of education operate – see paragraph [25]. This is even more apparent in Lady Hale's judgment, see paragraph [30].

[57] In fact, statutory framework almost always is a relevant and necessary consideration in determining the issue of non-delegable duty of care – see *Roe v Ministry of Health* [*supra*] per Somerville LJ at p 135 cautioning position of surgeons and others under the National Health Services Act may differ from voluntary or municipal hospitals. See also *Armes v Nottinghamshire County Council* [*supra*] where Lord Reed reminded that while non-delegable duty of care may be deemed to have been assumed voluntarily, "it is of course possible for the necessary relationship to be created by statute… But everything turns on the particular statute. The point is illustrated by the decision of the Court of Appeal in *Myton v Wood* (1980) 79 LGR 28, where a claim was made against a local education authority for the negligence of a taxi firm employed by the authority to drive children to and from school. The authority had no statutory duty to transport children, but only to arrange and pay for it. The claim was therefore dismissed". The legislations under scrutiny in *Armes* were the Children and Young Persons Act 1969, the Child Care Act 1980 and the Boarding-Out of Children Regulations 1955, SI 1955/1377.

[58] This exercise of examination of the relevant legislation is also reflected in *Hughes v Rattan* [2023] 1 All ER 300 where the Court examined the relevant agreements and contracts of the several dentists who had attended to the patient against the National Health Service (General Dental Services Contracts) Regulations 2005, SI 2005/3361, as amended before concluding on the five Woodland features. In *Gulf View Medical Centre Ltd v Tesheira (The executrix of the estate of Russell Tesheira) (Trinidad and Tobago) & another appeal* [2022] UKPC 38, the Privy Council opined that a non-delegable duty can arise under statute, citing *Armes*. However, the issue was not further elaborated as the allegation of non-delegable duty was admitted on the pleadings. Both cases are post *Dr Kok* but a closer

look at *Hughes v Rattan* shows that the law has really remained unchanged under *Woodland* save for the caution expressed by Lady Hale was repeated in slightly different terms by Lord Reed in *Armes*.

[59] While the boundaries are not clear cut and will have to be examined on a case by case basis, the five Woodland features in the context of our legislative regime is the right place to start the determination of the existence and imposition of this non-delegable duty of care. Rightly so as legislative schemes determine a myriad of issues including the scope of application, interpretation and most of all, the intent of the legislation.

[60] So, what is the legislative regime in this country? For this, I once again turn to both *Dr Kok* and *Dr Hari Krishnan* where this was addressed. In *Dr Kok*, this Court examined the Private Healthcare Facilities and Services Act 1998 [Act 586] and the related Regulations – see paragraphs [56] to [61] before concluding at paragraph [61] as follows:

> "[61] Read in its entirety, we do not consider that the relevant legislation warrants the interpretation that private hospitals are mere providers of facilities and not medical treatment. On the contrary, the **legislative scheme clearly envisages that the function of private hospitals includes generally the 'treatment and care of persons who require medical treatment or suffer from any disease', and considers the services of medical practitioners as part of that function**. The notion that the duty of a hospital is confined only to its facilities and staff selection has long been rejected in the common law. Such a notion is also incongruent with societal expectations of private hospitals as healthcare service providers; most patients do not perceive hospitals as providers of all the utilities and backup services except medical treatment. Adopting Lord Greene's formulation, it is precisely medical treatment that patients expect when they knock on the door of the hospital".
>
> [**emphasis added**]

[61] In *Dr Kok*, sections 2 and 78 of Act 586 were examined in detail before the Court rejected the hospital's submission that it owed only a duty to take care of the facilities and not the treatment of Mr Soo. However, on the facts, this Court found the second feature of *Woodland* was not fulfilled, that there was no antecedent relationship between Mr Soo and the hospital because Mr Soo saw Dr Kok at his clinic outside of the hospital, both before and after the surgery and that the hospital merely provided the facilities. That being so, there was no assumption of responsibility for the treatment to pin any non-delegable liability on the hospital.

[62] It is only appropriate that the whole legislative scheme be examined but first, it must be made clear that it is not the intention of this Court to say that the intent of the legislative scheme is any different from that already expressed in *Dr Kok*. It must be reiterated and emphasised that the legislative scheme clearly envisages that the function of private hospitals includes generally the 'treatment and care of persons who require medical treatment or suffer from any disease', and considers the services of medical practitioners as part of that function. This is consistent with the intent of Act 586, which in turn reflects and incorporate policy, that it is an Act to provide for the regulation and control of private healthcare facilities and services and other related health-related facilities and services and for matters related thereto. Interpreting legislation according to its purposive intent as provided by section 17A of the Interpretation Acts 1948 & 1967 [Act 188] has been consistently applied by this Court in a long line of cases. See for instance *Tan Kah Fatt v Tan Ying* [2023] 2 MLJ 583; [2023] 2 CLJ 169; [2023] 2 MLRA 525; *Bursa Malaysia Securities Bhd v Mohd Afrizan Husain* [2022] 3 MLJ 450; [2022] 4 CLJ 657; [2022] 4 MLRA 547; *AJS v JMH & Another Appeal* [2022] 1 MLJ 778; [2022] 1 CLJ 331; [2022] 1 MLRA 214.

[63] The Act regulates and controls all private healthcare facilities and services. That regulation and control is through a system of registration and licensing of all private healthcare facilities and services – see sections 3 and 4; regardless whether the provision of healthcare facilities or services is by a sole proprietor, partnership or body corporate – see section 6. Contravention of these provisions amount to an offence – see section 5.

[64] The Act has 19 Parts; Part I – Part XIX:

Part I :	Preliminary
Part II :	Control of Private Healthcare Facilities and Services
Part III:	Approval to Establish or Maintain Private Healthcare Facilities or Services Other Than a Private Medical Clinic or a Private Dental Clinic
Part IV:	Licence to Operate or Provide Private Healthcare Facility or Services Other Than Private Medical Clinic or Private Dental Clinic
Part V:	Registration of a Private Medical Clinic and a Private Dental Clinic
Part VI:	Responsibilities of a Licensee, Holder of Certificate of Registration and Person in Charge
Part VII:	General Provisions Relating to Approval Licence and Registration
Part VIII:	Suspension and Revocation of Approval and License, Refusal to Renew the License, and Suspension, and Revocation of Registration
Part IX:	Closure of Private Healthcare Facilities or Services
Part X:	Blood Bank
Part XI:	Blood Transfusion Services
Part XII:	Mortality Assessment
Part XIII:	Quality of Healthcare Facilities and Services
Part XIV:	Board of Management and Advisory Committee
Part XV:	Managed Care Organization
Part XVI:	Enforcement
PART XVII:	Power of Minister

Part XVIII: Miscellaneous

Part XIX: Saving and Transitional Provisions

[65] As can be seen, the Act is fairly comprehensive and extensive in its ambit and scope, covering matters such as registration and setting up of healthcare facilities or services to the multitude of detailed matters that must be put in place, be it of facilities or personnel, in both quantitative and qualitative terms.

[66] From the definitions in section 2 of various terms such as “healthcare facility”, “healthcare services”, “healthcare professional”, “private healthcare services”, “private healthcare facility”; “private hospital”, just to name a few, it is also clear that the Act has very extensive application:

> “healthcare facility” means any premises in which one or more member of the public receives healthcare services;
>
> “healthcare services” includes-
>
> (a) medical, dental, nursing, midwifery, allied health, pharmacy and ambulance services and any other services provided by a healthcare professional;
> (b) accommodation for the purpose of any service provided under this Act;
> (c) any service for the screening, diagnosis, or treatment of persons suffering from, or believed to be suffering from any disease, injury or disability of mind of body;
> (d) any service for prevention or promotive of health purposes;
> (e) any service for curing or alleviating any abnormal condition of the human body by the application of any apparatus, equipment, instrument or device or any other medical technology; or
> (f) any health-related services.

"healthcare professional" includes a medical practitioner, dental practitioner, pharmacist, clinical psychologist, nurse, midwife, medical assistant, physiotherapist, occupational therapist and other allied healthcare professional and any other person involved in the giving of medical, health, dental, pharmaceutical or any other healthcare services under the jurisdiction of the Ministry of Health;

"private healthcare facility" means any premises, other than a Government healthcare facility, used or intended to be used for the provision of healthcare services or health-related services, such as a private hospital, hospice, ambulatory care centre, nursing home, maternity home, psychiatric hospital, psychiatric nursing home, community mental health centre, haemodialysis centre, medical clinic, dental clinic and such other healthcare or health-related premises as the Minister may from time to time, by notification in the Gazette, specify;

"private healthcare services" means any services provided by a private healthcare facility;

"private hospital" means any premises, other than a Government hospital or institution, used or intended to be used for the reception, lodging, treatment and care of persons who require medical treatment or suffer from any disease or who require dental treatment that requires hospitalisation;

[67] Put simply, Act 586 applies to all healthcare facilities and services which are not provided by the government through public hospitals or institutions. In *Vincent Manickam s/o David (suing by himself and as administrator of the estate of Catherine Jeya Sellamah, deceased) & Ors v Dr S Hari Rajah* [2018] 2 MLJ 497, the Court of Appeal described private hospitals in the following terms:

[73] It is undeniable that in law, the second respondent is not a mere building or an ordinary company incorporated under the Companies Act 1965; or even a landlord; it is a healthcare facility where healthcare services regulated by and under the law, are provided to members of the public and to persons such as Catherine and the appellants. Any business arrangements that it structures to operate or best earn profits or even enable it to be a successful corporate sole, are of no relevance when it comes to the question of accountability and liability in law for the business of healthcare services. **That core business that the second respondent proffers can only be rendered through healthcare professionals such as the first respondent, the medical officer and the nurses in the instant appeal. Under such circumstances, the second respondent owes a duty of care to the clients or patients with whom the second respondent accepts and agrees to provide healthcare**.

[**emphasis added**]

[68] Similar views were expressed by the Court of Appeal in *Dr Hari Krishnan*:

[58] In our view, Hospital is an institution that provides medical service and treatment to sick patients. Such services can only be given by doctors, nurses and other support staffs. A hospital cannot exist without doctors. The learned JC was correct to say that whatever arrangement entered between the doctors and the hospital, is purely internal. The negligence of the doctors cannot absolve the liability of the hospital by mere internal arrangement. When a person presents himself at the hospital for treatment he is seeking treatment from that hospital, knowing that the service would be provided through a doctor or someone at the hospital. A hospital on the other hand is nothing but a provider of medical care and services and would never exist independently without the service provider such as the doctors and nurses. **The relationship between doctors and the hospital is inextricable.**

[**emphasis added**]

[69] See also the *Chai Beng Hock v Sabah Medical Centre Sdn Bhd & Ors* [2011] MLJU 1548; [2011] 2 AMR 742 as discussed at paragraphs [65] to [70] in *Vincent Manickam* [*supra*].

[70] All these reasonings accord with the observations of the Federal Court in *Dr Kok* on how Act 586 is to be read and is echoed again in this judgment; that a reading of the Act in its entirety yields an understanding of the inter-relational obligations and functions between the hospital and those who actually render treatment and care to the patients; that hospitals are and remain, providers of both the facilities for the treatment and care of patients as well as the treatment and care rendered.

[71] Several other provisions in Act 586 also point to this reading; sections 31 and 35. Section 31 provides for the responsibilities of the licensee or holder of a certificate of registration of a private healthcare facility or service. Amongst the responsibilities, the licensee or holder must ensure that persons employed or engaged by the licensed or registered private healthcare facility or service are registered under any law regulating their registration, or in the absence of any such law, hold such qualification and experience as are recognised by the Director General. This is amplified in regulation 13 of the Private Healthcare Facilities and Services (Private Hospitals and Other Private Healthcare Facilities) Regulations 2006 [The Regulations]. The statutory regime already recognises that a private hospital may employ or engage other persons in its premises, healthcare facility or service. Regardless the engagement or employment, these persons must be properly registered or qualified.

[72] Section 35 goes on to provide for the availability of a policy statement with respect to the obligations of the licensee or holder of the certificate of

registration to patients using the facilities or services. This policy statement shall be made available on admission or registration and must cover such matters as may be prescribed. In fact, the policy statement has to be exhibited in a conspicuous part of the private healthcare facility or service. Again, these matters are further amplified in regulations 21 to 27 of the Regulations.

[73] Part XIII concerning "Quality of Healthcare Facilities and Services" further provide in section 74 that every private healthcare facility or service shall have programmes and activities to ensure the quality and appropriateness of healthcare facilities and services provided. The information on such programmes and activities shall be furnished to the Director General as and when required by him. In fact, section 75 empowers the Director General to give the licensee or the holder of a certificate of registration in respect of such facility or service "such directions in writing as he thinks necessary for the observance of the requirement or standard and shall state in the directions the period within which the holder of the approval, licensee or the holder of the certificate of registration is required to comply with the directions" where the Director General is of the opinion that any prescribed requirement or any prescribed standard which applies to the private healthcare facilities or service has not being observed. Section 108 further prohibits a private healthcare facility or service from publishing in any advertisement in such a manner as to mislead the public on the type or nature of the healthcare facilities or services or health-related facilities or services provided; or which is contrary to any direction on advertisement issued by the Director General. Act 586 unusually contains many instances where directions may be given by the Director General (such as the instant provision) or the prescribing of duties, responsibilities or even policy statement – see sections 31(1)(d) and 35(2).

[74] Next, section 38 and Part XVII of the Regulations further provides for "Special Requirements for emergency care services". This is of particular relevance in this appeal.

[75] Section 38(1) provides that every licensed and registered private healthcare facility or service shall at all times be capable of instituting, and making available, essential life saving measures and implementing emergency procedures on any person requiring such treatment or services. In regulation 230, a private healthcare facility or service shall have a well-defined care system for providing basic outpatient emergency care services to any occasional emergency patient who comes or is brought to the private healthcare facilities or services by chance. Regulation 230(3) further requires immediate emergency care services which include life-saving procedures when life, organ or limb is in jeopardy and management of emergency psychiatric conditions must be provided. The assessment of a patient's condition to determine the nature, urgency and severity of the patient's immediate medical need and the timing and place of the patient's care and treatment in the private healthcare facility shall be done by amongst others, a registered medical assistant. Regulations 230(8) and (9) anticipate the patient being transferred elsewhere for treatment and care; that pending such transfer, the patient shall be rendered resuscitative and life-support procedures.

[76] However, where the emergency care services are provided on a regular basis, as was the case in the respondent, regulation 231 applies. In such a situation, regulation 231(12) requires "additional healthcare professional and other ancillary staff if the circumstances demands" shall be made.

[77] All these provisions fortify the understanding that the hospital is and remains responsible for not just the efficacy of premises or facilities but also for the treatment and care of the patients; regardless how and who the responsibility may have been delegated to. This is the intent of the legislative scheme, to the extent that the policy of the private hospital or healthcare facility or service is required to be placed in a conspicuous place of the premises so that persons coming to the hospital or healthcare facility or service is aware of such policy. Implicit in this structure and legislative scheme is already the balance and incorporation of the elements of fairness, just and reasonableness which need not be reconsidered as an entirely separate exercise or consideration. Persons approaching, using and relying on the treatment and healthcare rendered in these facilities and services should never have to concern themselves with issues of responsibility and separate accountability as negligence and mishaps would be furthest from their minds.

[78] On the facts in this appeal, the respondent is no doubt a private healthcare facility as it is a private hospital used and intended to be used for the reception, lodging, treatment and care of persons who require medical treatment or suffer from any disease. The respondent had also made the following statement to the appellant and to all persons using its healthcare facilities and services, available on its website concerning amongst others its facilities, treatment, care and procedures:

> Patients benefit from advanced medical diagnostics, treatment and the personal care that only comes in facilities where the focus is on each patient. Our facilities are comprehensive so you can rest assured that we have all that you need for your treatments and procedures. State-of-the-art equipment ensures that we are up to date with medical technology and updates. To find out what we have to offer, please the list below:
>
> As a patient of Columbia Asia Hospital, you can expect:

- To be informed of your medical treatment and care
- To be treated with courtesy and respect
- To be provided with adequate information and informed consent
- To be provided with a channel to address your feedback
- To be informed of the estimated charges
- To see an itemised bill upon request
- To know the identity and professional status of your care provider
- To be ensured the privacy and confidentiality of your medical record
- To receive care in an environment conducive to good health

[79] From the reading of all these provisions, it is clear as daylight that the legislative scheme intends private hospitals such as the respondent to remain responsible for the treatment and care of the patients regardless to whom they may have employed, engaged or delegated that task or responsibility. This remains so even if the hospital is rendering emergency care services. In the case of the respondent, it renders such services on a routine basis.

[80] As for the five Woodland features, I have no hesitation in finding them met. The first condition is easily fulfilled in the case of medical negligence such as the present appeal. The appellant is indeed in a vulnerable position and is totally reliant on the respondent for his care and treatment; more so when the appellant was admitted to its emergency services. As for the second feature of an antecedent relationship, this is well met by the both statutory framework which puts into place a relationship which deems an assumption of a non-delegable duty of care; and also from the factual circumstances. I have already dealt with the statutory relationship.

[81] On the facts, the appellant was admitted to and in the respondent's emergency facilities and treated by its medical officer, prior to being referred to the 1st and 2nd defendants. The reference to these defendants

was by the respondent's own medical officer. These defendants are also part and parcel of the necessary professionals who must be available if the respondent was to provide emergency services on a routine basis – see regulation 231. More important, the negligent act complained of took place during the care and treatment rendered within the respondent's premises using its facilities and services. It did not happen anywhere else; and this appears to have been overlooked in the case of *Dr Kok*. While Mr Soo may have been seen by Dr Kok both before and after the operation at his clinic outside Sunway Medical Centre, the operation where the medical negligence and cause of action took place was well within the walls of the hospital.

[82] In any case, given the extensive provisions in Act 586 and the Regulations made thereunder, it cannot be ignored that the intent of legislation is that the respondent assumes a non-delegable duty of care to the appellant and it remains liable personally for the negligence of the 2nd defendant. It makes no difference the presence of the other defendants, save that the tort of negligence must always first be proved on the facts.

[83] In this appeal, that is not an issue. The elaborate, extensive and detailed provisions in both the parent Act and the Regulations are enacted for the purpose of ensuring patient safety and care whilst being treated in our private hospitals, private healthcare facilities and services, always remains paramount and to be observed by the private hospital or private healthcare facility or service itself. Not only does common law no longer see hospitals as mere providers of premises, utilities, facilities or backup services for such treatment and care of the patient, the law provides that private hospitals are themselves providers of such care and treatment of the patient in which case, the private hospitals or healthcare facilities or

services owe a non-delegable and personal duty of care to persons who knock on their door and seek treatment and care.

[84] As for the third and fourth features, it is clearly evident that the appellant had no control over how the respondent was to perform its function of rendering emergency care and treatment; whether it would be rendered personally or through employees or some third parties such as the professionals it had engaged and to whom it had delegated the integral function of treatment and care of patients at its emergency services. In fact, having assumed a positive duty of care to the appellant in respect of emergency services, the respondent had delegated to its medical officer, and to the 1st and 2nd defendants, the performance of its obligations and these persons were indeed performing those delegated functions at the material time.

[85] As for the fifth feature, it is undeniable that the 2nd defendant was negligent in the performance of the very function of rendering proper emergency care and treatment of the appellant that was assumed by the respondent but delegated to her by the respondent.

[86] With all five features satisfied, it is clear that the respondent has assumed a non-delegable duty of care that it owes personally to the appellant, a patient that is admitted to its emergency services. The defence of independent contractor thus is not sustainable in law and on the facts and ought to have been rejected by the Courts below.

Loss of earnings

[87] The appellant was awarded compensation for loss of earnings based as follows:

i. Special damages totalling RM265,200.00 calculated on a multiplicand of RM2,600.00 per month x multiplier of 90 months
ii. Pre-trial damages totalling RM88,380.00 calculated on a multiplicand of RM2,946.00 per month x multiplier of 30 months

[88] At the time of the incident, the appellant was 35 years of age. According to section 28A(2)(d)(ii) of the Civil Law Act 1956 [Act 67], the multiplier for his loss of earnings would be 10. There is no issue in this regard.

[89] However, in respect of the multiplicand, the High Court fixed it at RM2,600.00 per month. This figure is said to disregard the appellant's earnings derived from allowances, fees and monthly salaries received as a director of two family owned companies for which tax had been paid. The multiplicand only recognised his basic salary. It will also be noticed that different multiplicand was used, depending on whether it was pre-trial loss or special damages.

[90] In this regard, the respondent had argued that this aspect is not appealable given that it is the sole respondent in this appeal. There is no appeal against the second defendant, the principal tortfeasor.

[91] Dealing first with the matter with whether the appeal in respect of quantum is still available to the appellant. With respect, the respondent's

argument is not tenable. The appeal against the respondent is in respect of both liability and quantum. This is clear from the Notice of Appeal filed. This is sufficient for this Court to deal with the whole issue of quantum. I must add that there is no suggestion that there is accord and satisfaction, whether in fact or in law, to deprive the appellant of this appeal. The respondent's submission here is thus without merit.

[92] Having examined the law and the facts, I agree with the appellant's submissions that the Courts below fell into error in disregarding these earnings when computing the multiplicand, and in recognising different multiplicand. These earnings, for which tax has been paid. are clearly within the meaning of "earnings by his own labour or other gainful activity" under section 28A of the Civil Law Act 1956 [Act 67] and should thus be recognised. As for the multiplicand, that should be constant. I therefore agree with the submissions made by learned counsel for the appellant on the correct award, that it should be a constant sum of RM8,750.00 per month with the multipliers as suggested by the appellant.

[93] As for the element of interest, there is no reason to disturb the exercise of discretion of awarding interest at the rate of 4% per annum for the relevant periods.

[94] Finally, a note on indemnity. The respondent has invited this Court to order that the second defendant indemnify the respondent in the event that it is found liable. I do not find this to be right or available in law.

[95] First, the 2nd defendant is not a party to this appeal. More importantly, it flies in the face of the earlier findings that the respondent owes a non-delegable duty of care and it remains liable regardless to whom it may have

employed or engaged to carry out that duty of care. The principle imposes a personal liability on the respondent, over and above that against the tortfeasor.

[96] With the deliberations as set out above, I do not see the need to specifically answer the questions as posed. The Woodland features have to be refined in the context of our Act 586 in the manner discussed above.

Conclusion

[97] For the above reasons, the appeal is allowed. Judgment is entered against the respondent for the full sum as submitted by the appellant subject to the considerations earlier mentioned.

Dated: 23 February 2024

Signed

(MARY LIM THIAM SUAN)
Federal Court Judge
Malaysia

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