Fault and Medical Emergencies

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abstract:

In medicine, an emergency is a situation in which a diagnosis and treatment must be carried out very quickly. But what about in law? The doctrine attaches the following definition to it: a situation likely to cause harm due to delay. Beyond that, it is a functional notion in the sense that it is the legal effects it entails that define it.

The interest of this study is to understand the urgency in health law by examining its influence on the responsibility of the doctor in the emergency department.

More than two hundred court decisions have been analyzed for this purpose; it appears that it creates an obligation for the doctor to act quickly and constitutes an exception to the respect of the patient's rights. What impact does this legal standard have, the style on the conditions for invoking the liability of the healthcare professional in a service where time is, by hypothesis, a factor of vulnerability? We find two systems of responsibility with different purposes: Restorative responsibility aims to repair the damage caused to patients, whereas punitive responsibility sanctions the behavior of doctors constituting an offense provided for by criminal law. All of this presents a situation where the patient's life is in imminent danger and where they risk dying due to a lack of rapid and appropriate care. To address this, it is necessary to coordinate the management of life-threatening emergencies within healthcare facilities, develop the

capacity of healthcare professionals to identify a life-threatening emergency, know the first steps and the procedure to initiate care, and limit the occurrence of emergency situations.

For this, it is necessary to establish an organization to ensure the management of vital emergencies and to conduct training and certification for healthcare professionals.

Keywords: Medical liability, Medical malpractice, Medical emergency, Medical negligence, Medical error,Emergency care, Medical ethics, Standard of care, Informed consent, Bodily injury, Vital emergency, Obligation of means, Duty of care, Hospital practitioner, Medical risk.

في الطب، الطوارئ هي حالة يجب فيها إجراء التشخيص والعلاج بسرعة كبيرة. لكن ماذا عن القانون؟ تربط العقيدة بالتعريف التالي، وهو وضع قد يؤدي إلى ضرر بسبب التأخير. علاوة على ذلك، هي مفهوم وظيفي بمعنى أن الآثار القانونية التي تترتب عليها هي التي تحددها. تكمن أهمية هذه الدراسة في تحديد الطوارئ في قانون الصحة من خلال دراسة تأثيرها على مسؤولية الطبيب في قسم الطوارئ

تم تحليل أكثر من مئتي قرار قضائي لهذا الغرض؛ ويتبين أنها تفرض على الطبيب واجب التصرف بسرعة وتشكل استثناءً لاحترام حقوق المريض. ما هو الأثر الذي يتركه هذا المعيار القانوني، الأسلوب حول شروط تفعيل مسؤولية المهني الصحي في خدمة يكون فيها الوقت، افتراضياً، عاملاً من عوامل الضعف؟ نجد نظامين للمسؤولية لهما أهداف مختلفة: تهدف المسؤولية التعويضية إلى إصلاح الضرر الذي لحق بالمرضى، بينما تعاقب المسؤولية العقابية سلوك الأطباء الذي يشكل جريمة منصوص عليها في القانون الجنائي. كل هذا يعرض حالة يكون فيها حياة المريض في خطر وشيك ويواجه خطر الوفاة بسبب نقص الرعاية السريعة والمناسبة، لذلك يجب تنسيق التعامل مع الطوارئ الحيوية داخل المؤسسات الصحية، وتطوير قدرة المهنيين الصحيين على تحديد حالة الطوارئ الحيوية، ومعرفة الخطوات الأولى والإجراءات اللازمة لبدء الرعاية وتقليل حدوث حالات الطوارئ ، لهذا، يجب إنشاء منظمة لضمان التعامل مع الطوارئ الحيوية وإجراء تدريبات وتأهيل المتخصصين في الرعاية الصحية.

INTRODUCTION

It must be noted that the institution of hospital liability has undergone major changes in both quantity and quality. The judge does not stop at an issue of

equity without innovating in the field of hospital liability, which is why the path of the evolution of case law is rich in its pragmatism, allowing it to justly face the difficulties of science, medicine, and its transformation.

This is not specific to the doctor, but it also includes medical assistants. As for the fault. Indeed, this aspect is illustrated not only by hospital liability but also by the notion of joint liability of several public entities involved in the medical act. For this, we will study the notion of fault in the emergency medical service in one paragraph (l) and then, in a second paragraph, the fault in routine care acts. (ll).

I: The fault in the emergency medical service.

Medical auxiliaries are public agents subject to the rules of the public health establishment in which they carry out their mission. They also participate alongside doctors in the execution of public hospital service.
In case of fault, it is the responsibility of the public health establishment that is engaged. These mistakes can take various forms. These faults can first of all have a medical character stemming from the medical nature of the act during which the fault is committed. which will allow us to study in (A) the basis of the responsibility of the emergency service, and in (B), the status of liberal collaborators.

A: The basis of the responsibility of the emergency service

Medical assistants provide care at the hospital as prescribed by doctors. In Algeria, as in France, the SAMU is a public service subject to public law regulations and operates in parallel with the public hospital service.

This service as such does not exist in certain countries. Several developments have occurred in the emergency medical assistance service (SAMU) regarding the nature of the fault that engages the public service's liability towards its users, as well as the status of private individuals or entities associated with the execution of the emergency medical assistance service.

Like healthcare assistants who often make mistakes while performing care tasks, considered common and minor acts. The French administrative judge, known for his creativity, just like the Algerian judge, introduced the notion of presumed fault to engage the liability of the public hospital service.

It should be noted that medical assistants perform care tasks prescribed by doctors in the hospital, but a medical assistant can also participate in a service related to the hospital service, that of the emergency medical assistance service. (SAMU).

In Algeria, the SAMU is a public service subject to public law regulations and operates in parallel with the public hospital service. This service does not exist in certain countries, such as Lebanon, for example. But the work of the civil security teams and the firefighters' rescue services is linked to the administrative police.

This emergency medical assistance service has seen several developments regarding the nature of the fault that engages the public service's liability towards its users, as well as the legal status of private individuals, whether natural or legal, associated with the execution of the emergency medical assistance service.

The administrative judge, known for his creativity, introduces the notion of presumed fault to hold the hospital service liable.
The question of the basis of responsibility requires a specific study; often, emergency service agents intervene under difficult conditions. For this reason, the mechanisms of administrative liability for the emergency service are different from those of the public hospital service in general. This question raises two legal issues.
The first concerns the basis of liability, the second, the legal status of private individuals collaborating with the service. This will lead us to study the notion of qualified fault in (a), the recourse to gross negligence (b), and the requirement of a special fault.(c).

a) Notion of qualified fault

The notion of qualified fault emerged with the case law that developed following the famous Tomaso Grecco ruling, during which the Council of State abandoned the principle of state non-liability for police activities.
Moreover, the requirement of a qualified fault to engage the liability of the public authority in certain areas undoubtedly finds its theoretical foundation in the assertion of the Blanco ruling, according to which the liability of public entities "is neither general nor absolute; it has its special rules that vary according to the needs of the service and the necessity to reconcile the rights of the State with private rights."

Unlike what prevails in civil law, where any fault engages the responsibility of its author, any wrongful behavior by a state service does not necessarily engage the responsibility of the latter. In certain areas of public authority activity, defined by law or jurisprudence, the State's liability is only engaged in the case of a qualified fault, that is, a fault presenting a particular degree of severity or obviousness. In a way, the behavior in question must be incapable of being linked to the normal functioning of the service.

Beyond this theoretical foundation that dates back to the origins of public law in France, as in Algeria, several justifications have been put forward in turn to justify the existence of a regime of qualified fault. This justification varies both according to the authors and the relevant fields, which illustrates the heterogeneous nature of the notion of qualified fault. It is, however, possible to isolate three main areas where the notion of qualified fault has developed preferentially.
First of all, the requirement of qualified fault has been imposed for the activities of the State that are classified as sovereign, and which are in fact activities of public authority.

b) Recourse to gross negligence

Secondly, this concerns a field where the recourse to gross negligence in such areas was explained by the administrative judge's concern not to interfere in very technical domains, requiring a very particular expertise. This was essentially the case in the medical field, a domain long characterized by the requirement of gross negligence. Until its abandonment.

It indeed seemed difficult for the administrative judge to specify what in the execution of a medical act could have been faulty or not; he would then limit himself to sanctioning the manifest error, the one that left no doubt, by qualifying it as a serious fault. This brings us to study the requirement of a special fault in a (c).

c) The requirement of a special fault

As for the last domain, it concerns activities presenting a particular difficulty or the requirement of a special fault justified by the judge's intention to grant the administration, when its action is carried out under particularly difficult conditions, "a sort of immunity from liability," to use the expression employed by Jacques Henri Stahl in his conclusions on the Theux ruling.

Indeed, when state services must conduct delicate operations, such as maintaining public order or acting in emergencies, often in hostile circumstances, the administrative judge has long sought to prevent a regime of liability that is too generously open from paralyzing the actions of state services, by making even the slightest failure, or even the slightest hesitation, a fault giving rise to compensation. However, traditionally, emergency medical services were subject to a regime of liability for gross negligence.

But starting from the 1990s, a movement to retreat from gross negligence began to take shape. But during the 1990s, the most important rulings number two: the Theux ruling of June 20, 1997, confirmed by the A Méon ruling of March 13, 1998.

The Council of State ruled that the state's liability in the context of emergency medical assistance activities was engaged on the grounds of simple negligence. The case law had never had the opportunity to explicitly rule on the matter of emergency medical assistance, but given the requirement of gross negligence, for firefighting, for flood control, the transposition of this case law to the SAMU carried out by the Administrative Court of Appeal was logical.

By censoring, the Administrative Court of Appeal of the Litigation Section of the Council of State has at the same time abandoned the requirement of gross negligence in the matter of emergency medical transport.

In order to fully understand the issue, it is necessary to precisely recall the subject of the case. The responsibility of the Toulouse hospital is being sought due to the actions of its emergency medical service during the medical transport between the rugby field in Gers and the hospital where Mr. Theux was ultimately operated on.

The medical procedures carried out at the hospital and the organization of the public hospital service itself are not in question. And neither is a medical act that would have been carried out during the medical transport. What is at issue are the conditions of medical transport, essentially the fact that the victim was transported by ambulance and not by helicopter. The responsibility of the Toulouse hospital center is often sought for the actions of its emergency medical assistance unit in the organization and execution of rescue operations.

The regime of gross negligence indeed guarantees the rescue service a margin of maneuver. It is important that the actions of the rescue services are not driven by the fear of committing mistakes that could too easily hold them liable. The shift to simple fault removes the double degree, but above all does not eliminate in our minds the consideration of the difficulty of administrative action.
On the other hand, to determine if a simple fault was committed in the organization or execution of the rescue, the administrative judge must naturally take into account the intrinsic difficulty of the operation and the constraints, particularly the urgency to which the rescue service was confronted. It is not an abstract assessment but a concrete examination.

The balance between faults and non-fault errors could indeed vary, depending on whether the failure causing the damage results from the organization or the execution of the rescue operations; the requirement will be stricter regarding the organization of the rescue operations, at least when it involves the prior planning of operations, in the context of an emergency constraint.

But the issue of medical emergencies also raises questions beyond the basis of liability, particularly regarding the legal status of private individuals collaborating with emergency services. (B).

B: The status of liberal collaborators

Algerian law, like French law, stipulates that public and private healthcare establishments may include units participating in the emergency medical assistance service, called SAMU, whose missions and organization are determined by regulatory means.

She specifies that the SAMUs include a call reception and regulation center and that their operation can be ensured with the assistance of non-hospital practitioners who request it. For this, the two most important situations to study are the immediate access of the population to emergency care (a) and, secondly, whether these liberal regulatory doctors fall under private law or public law.(b).

a) Immediate access of the population to emergency care.

Its centers must guarantee continuously. Immediate access to emergency care for the population, they must also ensure the participation of self-employed doctors in the system. But delicate questions arise regarding liability, particularly in cases where a patient has suffered damage attributed to the fault of a self-employed doctor. Participating in answering calls in an emergency medical service (EMS) affiliated with a public hospital. Should the victim seek the responsibility of the hospital, the doctor, or the association that made them available to the call center? Before which court should the indemnity action be brought?

The question was raised in a famous case in 2006. A private doctor collaborating with the SAMU refers a patient to their primary care physician. In the absence of any medical care, the patient is admitted a few hours later to the emergency department following a second call, where he dies from a diaphragmatic hernia. The doctor is sentenced to three months in prison with a suspended sentence.

The victim's heirs are taking legal action against the Saint-Nazaire hospital center, which the SAMU is part of.

The administrative court holds the hospital center fully responsible, but accepts the guarantee claim directed against the emergency doctors' association from the Loire estuary, which is condemned to compensate for all damages. It is on the occasion of the appeal in cassation, filed against this solution confirmed on appeal, that the Council of State rules on the extent of the liability of the public health establishment for the fault of a private practitioner.

Indeed, this situation leads to two distinct analyses regarding the consequences in terms of liability. One could consider that the agreements related to the call reception and regulation center delegate to associations of liberal doctors the execution of part of the public service, emergency medical assistance.

In the present case, the agreement would be interpreted as delegating to AMUEL the receipt of specific calls, with the responsibility of ensuring the assistance of private doctors.
The damages caused to third parties do not engage the liability of the public entity that granted the delegation. and the association's liability should be pursued by the victims before the judicial court.

It should be noted that, in this approach, liberal regulatory doctors could only have a private law relationship with the association.
Such an analysis, in our view, does not reflect the reality of the legal relationships between the actors providing emergency services. But it seems that third-party victims of damages caused by the operation of the center should always recognize the possibility of seeking the hospital's liability before the administrative jurisdiction if it is a public establishment. The question that would be interesting to ask, and which concerns liberal regulatory doctors, is whether it falls under private or public law?(b)

b) Do liberal regulatory doctors fall under private law or public law?

Indeed, in this approach, the question that arises is whether the liberal regulatory doctors are solely bound to the association by a relationship that can

only fall under private law, or if a public law relationship is established between them and the hospital. The stakes of this question are twofold.
On the one hand, if the doctor is considered a public agent, he remains exposed to criminal sanctions, but his financial liability cannot be pursued before the judicial jurisdiction if the fault is not separable from the service.

The second issue concerns whether the hospital's liability is engaged, under the Cames jurisprudence, towards a liberal regulatory doctor who is a victim of an accident while performing their duties.

In this case, the Court of Cassation, criminal chamber, noted in its ruling of December 2, 2003, that a liberal regulatory doctor is a public agent whose financial liability can only be pursued before the administrative court.

But the administrative court of appeal in Nantes precisely held that voluntary liberal practice doctors "are associated with the organization and functioning of the emergency medical assistance service, which is one of the public service missions of public hospital establishments."

The French legislator, in 2009, recognized the victim's right to hold the hospital liable, regardless of the stipulations of the agreement concluded between the public health establishment and the private legal entity.

He provided for the coverage of the activities of the private doctor, ensuring the regulation of calls within an emergency medical assistance service (SAMU), hosted by a public health establishment, under the regime of administrative liability that applies to the agents of this public establishment, specifying that any clause of an agreement contrary to the principles set forth in this article is null and void.

The paramedical fault committed by medical assistants can also occur within the public health establishment, regardless of the state of the urgent or normal medical intervention. The poorly performed routine care act is the most obvious example that allows for the administrative liability of the public health hospital to be engaged. (II).

II : Fault in Routine Medical Procedures

It is the responsibility of the healthcare teams to provide the patient with attentive, conscientious care that is in accordance with the established scientific knowledge.

A : Caring, attentive, and conscientious

These are obligations stipulated by the medical code of ethics. This means giving patients all the attention their condition requires, monitoring the progression of their health throughout their stay in the service, and ensuring that the therapeutic actions and gestures performed produce the expected effects, where medical follow-up is very important.

Thus, an accident occurring to a newborn who did not receive sufficient medical follow-up when particular vigilance was required following a difficult delivery engaged the responsibility of the public hospital service.
The patient admitted to the hospital must receive appropriate medical monitoring before and after the medical procedure.

After the diagnosis and the performance of the therapeutic procedure, the follow-up of postoperative patients is also likely to engage the liability of the healthcare institution. After chemotherapy, the patient who leaves the hospital without information on the need to stay hydrated and who is unable to obtain guidance on what to do, despite serious health issues, is a victim of a failure in the service's operation.
But what about medical procedures, performed by doctors and the names of doctors (a) and the evolution of this distinction that we will study in (b).

a) Medical procedures, performed by doctors and non-doctors.

It would be important to first define the act of care, which dates back to the Rouzet ruling of 1959. This is in accordance with the distinction set out in the ministerial decree, delineating the different categories of acts that can or cannot

be performed by doctors, or by non-doctors. Acts that can be performed by qualified medical assistants and only on the doctor's prescription, but outside the presence of the doctor.
This distinction, which has long been the basis for the application of different liability regimes, is still relevant because the administrative judge still distinguishes between medical fault and fault in routine and minor care acts.

But it previously determined the application of a different liability regime. As the Council of State had ruled in the Rouzet decision, the distinction between care acts and medical acts was not based on organic criteria derived from the quality of the act's author, but on criteria derived from the nature of these acts, their intrinsic difficulty, which either required or did not require that they could only be performed by doctors or, for some of them, by medical assistants, but under the responsibility and direct supervision of a doctor.
This distinction has evolved under the influence of several factors. (b).

b) Jurisprudential evolution related to this distinction.

It should be noted that this distinction has evolved under the influence of several factors. Firstly, while the judge favored the criterion of the nature of the act in question, the boundary between care acts and medical acts has become increasingly difficult to delineate.

Medical technique has evolved and has moved what could have been considered medical art in the past into the category of simple care. Thus, from digital technology to biotechnology, including robotics, the sciences are innovating to provide better treatments for patients. The modification of living organisms has opened up new possibilities for treating serious diseases, and patients are becoming increasingly connected. They benefit from a wide variety of applications that help them stay in shape. While robots have made their way into operating rooms, 3D printers are creating prosthetics, tissues, and soon who knows, organs.

Does the deployment of new technologies risk excluding certain patients from care, or conversely, does it represent an opportunity to improve access to care? And what ethical questions will different countries have to answer in the face

of this new technology? Secondly, case law has gradually reduced the distinction between gross negligence and simple negligence, while simple negligence is sufficient to hold healthcare institutions liable for acts of care, the proof of this negligence is not always within the victim's reach.
To avoid situations of harm that could not be remedied, "for lack of evidence, of fault," which the government commissioner Jouvin described as "feelings, scandal" and indignation in his conclusions in the Dejous case. The administrative judge has established a system of presumption applicable in several cases.

In its ruling of March 19, 1969, the French Council of State addressed an important issue; it concerned a person who had undergone an intravenous injection in a public hospital, the consequences of which had proven disastrous.

The question arises as to whether the responsibility of the Public Assistance administration was engaged and on what basis?
On the merits, neither the extent nor the severity of the harm to the hospital was disputable or disputed. It remains to be seen whether the hospital's responsibility was involved. It seems that the victim was unable to prove any fault on the part of the individuals for whom the hospital is responsible.

The administrative judge faced several questions: first, should the request be rejected, which seems contrary to fairness? Or should we, on the contrary, have judged the hospital's liability as being engaged without fault? These two solutions were unacceptable, the first for reasons of fairness and the second for analyzing the hospital's obligation as a result-oriented obligation towards patients.

The only solution, therefore, is to maintain fault as the basis of liability, but by correcting the strictness of this solution through the admission of a presumption of fault that reverses the burden of proof. Thus, in the Dejoux ruling, it is indeed a presumption not of liability, but of fault, because what the multiplicity of infections observed in vaccinated individuals during the same session reveals. "It's a malfunction of the public service."

Its defective nature is to blame, although it is currently impossible to precisely determine and locate a human error given the state of the investigation. There is someone in the department who did not take all the necessary precautions to prevent any accidents, or the checks did not work properly.

The Council of State, in the Sieur Meier ruling, which reveals the persistence of the administrative jurisprudence's recourse to the presumption of faults, uses the same reasoning, but this time the wording is explicit: "regarding a routine and minor intervention, the disturbances caused by this injection can only be regarded as revealing a fault committed in the organization of the service's operation." (B)

B : The fault lies in the organization and functioning of the service.

In this context, it is important to say that the presumption mechanism is limited to routine care acts, excluding various acts that can also affect the functioning of the public hospital service. This trend thus reveals the distinction of various acts according to the objective criterion, initiated by the Rouzet ruling since 1959, which will allow us to distinguish, in the first instance, between simple negligence, the abolished gross negligence (a) and (b) the assimilation of negligence in the act of care, practiced by a physician themselves, to negligence in the organization and functioning of the service, and in a third instance, we will see the lack of organization of patient care.(c)

a) Distinction between simple fault and gross fault abolished

The fault in the organization and functioning of the service, an administrative concept by origin, has long been, in the hospital context, subject to the distinction between simple fault and gross fault. Some rulings ended the general requirement of gross negligence in hospital liability matters, indeed starting from 1935, they had to split the liability regime.
This duplication underwent a rapid evolution before settling. The fault in the organization and functioning of the service, removing a simple fault, whereas the medical fault required a serious fault.

It was on this distinction, repeatedly applied, that the jurisprudence of the French Council of State remained frozen for more than four years, while the judicial courts, competent to judge disputes arising in a private healthcare establishment, did not operate in medical matters, making no distinction according to the severity of the fault. Today, the distinction between gross negligence and simple negligence has been abolished, at least in appearance. Negligence in the organization and functioning of the service not only persists and maintains its autonomy compared to other types of negligence, but also invites it self into disputes concerning private healthcare establishments and reveals a pluralistic nature.

Being a concept with difficult-to-define boundaries, fault in the organization of services in public and private healthcare establishments manifests in several ways. If it is used in administrative law, as private law, the fault in the organization and operation presents in these two sectors a distinct nature.
Originating from public law, the fault in the organization and functioning of the service is one of the multiple manifestations of service fault and, in this respect, has a statutory dimension.

In this context, the latter appears as the failure of an administration to meet its obligations. However, while it is relatively easy to grasp its various manifestations, several major authors have encountered the difficulty of providing a precise definition and criteria.

A concept developed by Mr. Hauriou. "Right to the proper functioning of the service" seems more appropriate to us for justifying the fault in the organization and functioning of the public service.
The rather flexible nature of the definition has led to extensive interpretations regarding public hospital services, which can even equate a fault in the act of care, committed by a doctor themselves, with a fault in the organization and functioning of the service. (b).

b) Assimilation of the fault in the act of care, committed by a doctor himself, to a fault in the organization and functioning of the service.

One can, in this regard, cite a ruling qualifying such a fault as an error in anesthesia.
For public health facilities to fulfill their obligations, they must have an adequate organization not only to welcome users safely but also to ensure the quality of the care provided to them. Indeed, if the technical organization of care belongs solely to the doctors, it is the responsibility of the concerned establishment to provide the means for the latter to offer conscientious and attentive care to the patients.

For G. Memetau, the establishment must perform two main services: first, receive, house, and feed the patient, ensuring the safety of their person and belongings during their stay; second, provide hospitalized patients with the care required for their condition. Because the mission of healthcare institutions is dual. Because the fault in the organization of the service's operation takes on different forms, this will lead us to study in section (c), the lack of organization in patient care.

c) Failure to organize patient care

This lack of organization in care can be understood as a shortage of staff present, as well as an absence of qualified personnel. It is up to the administration to make the necessary decisions to meet what resembles a calibrated obligation of result, based on the size of the institution, its missions, and the objective difficulty of the situation.

The first aspect is well illustrated in French administrative jurisprudence. The French Council of State was thus able to consider that the absence of a doctor in the case of a dystocic delivery, taking place under the supervision of a midwife, justified the engagement of the liability of the public hospital service on the basis of a defect in the organization and functioning of the public service.

This ruling constitutes an important evolution in the case law regarding the organization and functioning of the public hospital service, and more specifically the obligation for an on-call obstetrician to be present to assist midwives in the event of an unforeseen complication. Revisiting a long-standing decision.

The Council of State rules that "the absence of doctors in such circumstances constitutes a failure in the organization and functioning of the service, engaging the responsibility of the public hospital service."

It is true that the solutions provided by the trial judges were, to say the least, disparate; some rulings acknowledged the existence of a fault, while others dismissed it in similar factual circumstances.The implications of this case law on the organization of hospital services should be significant since it practically entails the presence of an on-call doctor in all hospitals performing deliveries.

The Council of State has determined that the absence of an anesthetist in a hospital center deprives the patient of the medical guarantees they were entitled to expect from the public hospital service, which reveals a shortcoming in the organization of the healthcare facility. Another case that can also be the cause of a flaw in the organization of public hospital services is the lack of qualified personnel.

These deficiencies can be not only in terms of qualified personnel but also in terms of equipment.

In conclusion, it can be said that the emergence of a right to health security, the increasingly frequent enactment of minimum health standards, particularly in the application of hospital legislation and the planning of medical activities, precisely defines the equipment that establishments must have. There is no doubt that damage attributable to non-compliance with these standards would engage the liability of the public hospital service: the use of the public service must be able to rely on the highest quality of professionalism, organization, and operation.

It is sometimes difficult to distinguish between organization and functioning, a structural problem ultimately resulting in a functioning problem. Decisions sometimes mix the two concepts.

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