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

[1978] O.J. No. 3457

20 O.R. (2d) 510

88 D.L.R. (3d) 161

6 C.C.L.T. 81

[1978] 2 A.C.W.S. 204

Ontario
High Court of Justice

R. E. Holland, J.

May 17, 1978.

R. J. **Sommers** and R. Roth, for plaintiffs, Tony and Jack Yepremian.

R. A. Stradiotto, Q.C., and W. D. T. Carter, for defendant, Scarborough General Hospital.

A. J. Lenczner and M. Koenigsberg, for Dr. Martin M.

Goldbach.

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1 **R. E. HOLLAND, J.**:-- This action is against a doctor and hospital for damages for medical malpractice. Tony Yepremian suffered a cardiac arrest with resultant brain damage at Scarborough General Hospital following the commencement of treatment for a diagnosed diabetic condition.

2 It is alleged that Dr. Martin Goldbach was negligent in failing to diagnose diabetes and that the hospital is liable for the negligence of its employees and staff in failing to diagnose diabetes sufficiently early and in providing inadequate or improper treatment following diagnosis.

3 Tony Yepremian was born in 1951 and at the time of his hospitalization was 19 years old. He

worked as an apprentice bodyshop repairman and lived in a two-bedroom apartment with his parents, sharing the second bedroom with an older brother, Jack, and a younger brother, Joseph. On Friday, October 9, 1970, Tony came home from work as usual. He was not feeling well and did not get out of bed on Saturday or Sunday except to vomit or urinate or to get something to drink. He had increased frequency of urination (polyuria) and increased frequency of drinking (polydipsia) and got progressively weaker as the week- end wore on. Monday, October 12th, was the Thanksgiving holiday and was also Tony's parents' 25th wedding anniversary. His parents had invited a small group of friends to the apartment to celebrate their anniversary starting at about 3 o'clock in the afternoon. Tony's mother was concerned about Tony and since the family doctor was unavailable, she arranged for him to see Dr. Goldbach shortly after noon. Dr. Goldbach obtained his degree in 1969 and was working in research but filled in on some week-ends as a doctor's replacement. Tony was very unwell by this time, although he had no fever and did not complain of any pain. His mother had to help him to get dressed. His brother Jack's fiancee, Lynn, drove him to the doctor's office accompanied by Tony's brother, Joseph. When they arrived at the medical centre Lynn, who is now married to Jack, let Tony and Joseph off at the front door and parked the car. She then helped Joseph support Tony, who by this time could not stand on his own, and they took him to the doctor's office.

4 Once in the office Joseph helped Tony into the examining room and Lynn waited in the reception room. Joseph helped Tony to strip to the waist and Tony sat on the examining table. Dr. Goldbach candidly admitted that he now has no memory of examining this patient. He did, however, make a note of his examination and diagnosis and also gave a note to Joseph and Lynn for Tony's employer. The first note reads under the heading "diagnosis and explanatory notes", as follows:

> Very sick looking 19 year old with Rx of nausea, vomiting for past 2 days. P.E: Dehydrated -- 10% E -- clear N -- clear T -- severe pharyngitis and tonsillitis Neck -- some nodes Chest -- clear B.P. 120/100 mm/Hg. Abd. clear Rx -- tonsillitis -- Rx Eythoromycin 250 8id x 70. Patient seen Tony Year of Birth June 7/ Insurance information 13-962-287. -- Call in 3 weeks.

The second note reads:

5 Toni Yepremian.

> R/ To whom it may concern. Toni will be absent from work for 4 days due to severe tonsillitis.

(signed) Goldbach, M.D.

6 Date 12/10/70.

7 It will be seen that the first note makes no mention of either polyuria or polydipsia. Joseph says that the doctor checked his brother's chest and blood pressure and looked into his brother's throat and asked for a history. Tony was drowsy and unsteady on his feet and was too unwell to answer questions. Joseph testified that he told the doctor about his brother's increased frequency of urination and drinking. As can be seen the doctor diagnosed tonsillitis and pharyngitis and gave a prescription. There was no urinalysis and no blood test. After the examination was over and Tony had been dressed, Joseph and Lynn asked the doctor for a note for Tony's employer and also asked if it was necessary to take Tony to hospital. They were given the note and were told that it was unnecessary to take him to hospital. The doctor, in answer to another question, said that it was all right for Tony to drink soft drinks and ginger ale and he was later provided with these by his mother. After the visit to the doctor Tony was taken home, undressed and put to bed. The prescription was filled and he was started on medication. He continued to drink, urinate excessively and vomit. His parents' guests left at about 11 p.m. and Tony was brought out into the living-room and given some soup by his mother. He spilt the soup over himself and started to hyperventilate; that is, to breathe heavily and at a fast rate through his mouth. It was obvious by this time that he was very ill indeed and his parents decided that he should be taken to hospital immediately. Mrs. Yepremian dressed him and she and her son Jack took him to Scarborough General Hospital. Tony was taken into the emergency department in a wheel-chair as he had now become semi-comatose. He was placed in an examining room and Jack and his mother waited in the reception room. The hospital records show that he was admitted on Tuesday, October 13th, at 1:29 a.m. Mrs. Yepremian testified that a man wearing white asked what was wrong with him and she told him that she did not know but that he had been drinking a lot and vomiting and that he had been given medication. Jack Yepremian said that he spoke to a nurse at the hospital and told her that his brother was vomiting, sick, weak and thirsty and that he was going to the washroom frequently. He was asked about drugs and answered that the only drugs his brother had been taking were the drugs that they had brought with them to the hospital, which were the drugs that were prescribed by Dr. Goldbach. After an hour and a half or so, Mrs. Yepremian and her son were told they could return home.

8 Dr. Roy Chin was the doctor on duty in the emergency department of the hospital when Tony was admitted. He obtained his degree in 1967 and is a general practitioner with certain privileges at the hospital. I think that, due to the passage of time, his memory of the events surrounding the admission of Tony to hospital and to the intensive care unit is unreliable. He says that he got a history from the brother and mother and that he did not ask, nor was he told, about excessive thirst or urination.

9 He testified that if he had been told about these symptoms, the possibility of diabetes would have come to his mind. In any event, there was no urinalysis, and no diagnosis was made by Dr. Chin. Opposite the word "diagnosis" on the emergency record there appears "hyperventilation?" which is a symptom and not a diagnosis. Probably as a result of a telephone call to Dr. Fred Rosen, the internist on call, Tony was admitted to the intensive care unit of the hospital. Prior to the transfer, however, Tony was administered phenobarbital and valium, the effects of which would be a deepening of the coma into which the patient had by this time lapsed.

10 Tony's course in the hospital, until the time of his cardiac arrest, can be followed by considering the partial summary, extracted from the hospital records, hereafter set out:

11 As can be seen, a diagnosis of diabetes was not made until a fruity odour was noticed on Tony's breath by a nurse at 12:20 p.m. on October 13th. A urinalysis taken at that time showed 4+ sugar. The patient was immediately started on insulin. He continued to hyperventilate and remained unconscious or semi- conscious until he suffered a cardiac arrest at about 12:55 a.m. on October 14th.

12 It is of particular note that the patient's potassium level dropped from a normal range of 5.5 at 8 a.m. to a low of 1.4 at 3:10 p.m. By 9 p.m. it was up to 2.1. The patient's blood pressure dropped from 130/90 to a low of 90/40 at 10 p.m. and was 98/50 at midnight.

13 A number of questions must be answered in order to dispose of liability:

1. Was Dr. Goldbach negligent in failing to diagnose diabetes? 2. If he was negligent, then is he liable and, if so, to what extent? 3. Were the nurses or laboratory staff in any way negligent and, if so, is the hospital vicariously liable? 4. Was Dr. Chin negligent in failing to diagnose diabetes or in the treatment that he prescribed and, if so, would he have been liable had he been sued? 5. Was Dr. Rosen negligent in failing to diagnose diabetes before he did or in the treatment of the patient and, if so, would he have been liable if sued? 6. Quite apart from any liability under Q. 3 above, if Dr. Chin and/or Dr. Rosen are found to be negligent and would have been found liable if sued, is the hospital liable for their negligence?

14 I will answer the questions in order:

1. The negligence, if any, of Dr. Goldbach

15 The doctor was faced with "a very sick looking young man". He judged his patient to be 10% dehydrated. This finding would, according to Dr. Goldbach, have been based, in part, on the patient's history and, particularly, on the patient's fluid intake and output. I accept the evidence of Joseph Yepremian that he told the doctor of his brother's frequency of urination and of his thirst and vomiting. With this history the doctor should have suspected diabetes and should have performed a simple urinalysis. There is no doubt in my mind that Tony Yepremian was suffering from the effects of diabetes at the time of his visit to the doctor and that his condition would have been diagnosed if his urine had been tested. Had his condition been correctly diagnosed, and had he received adequate treatment at that time, he would not have suffered the cardiac arrest and consequent brain damage.

16 In making a finding of negligence against Dr. Goldbach I apply the standard which could reasonably be expected of a normal, prudent practitioner in diagnosis: Gibbons et al. v. Harris, [1924] 1 D.L.R. 923, [1924] 1 W.W.R. 674. The standard to be applied cannot be lowered by reason

of Dr. Goldbach's youth and inexperience. I regret making such a finding against him. Since 1972 he has done well and is now a Fellow of the Royal College of Physicians and Surgeons in cardiovascular and thoracic surgery, practising his specialty in Ontario.

2. Having found Dr. Goldbach negligent then is he liable and, if so, to what extent?

17 This finding of negligence does not automatically impose liability on the doctor since liability can only be imposed for negligence which caused or contributed to the cardiac arrest. In addition the cardiac arrest must have been a reasonably foreseeable consequence of such negligence. If Dr. Goldbach had diagnosed diabetes and if the patient had been properly treated there would have been no cardiac arrest. If Dr. Goldbach failed to diagnose diabetes, as he did, and if the patient had not gone to hospital or obtained any medical treatment, he would have become comatose and died. I must, however, look at what actually did occur and ask myself whether there were any intervening acts of negligence sufficient to insulate Dr. Goldbach from liability. As one witness said, the case involves a tragedy of errors. For reasons that follow later I have concluded that while the hospital employees were not negligent, both Dr. Chin and Dr. Rosen were, and particularly Dr. Rosen was negligent in the treatment and management of the patient following a diagnosis of diabetes.

18 The effective cause of the cardiac arrest was the negligence of Dr. Rosen in the treatment of his patient. If Tony had been properly treated after the diagnosis of diabetes was made at 12:20 p.m. on October 13th, the probabilities are that he would have recovered without harm. From the point of view of Dr. Goldbach it certainly was foreseeable that failing proper treatment, there would be a cardiac arrest, but it was not, in my view, foreseeable that an internist and a specialist in endocrinology would treat this patient negligently. Dr. Goldbach could still be held liable if the negligent treatment provided by Dr. Rosen was in any way contributed to by Dr. Goldbach's failure in diagnosis: Grant v. Sun Shipping Co. Ltd., [1948] A.C. 549 at pp. 563-4; Haynes v. Harwood, [1935] 1 K.B. 146 at p. 156; Price v. Milawski et al. (1977), 18 O.R. (2d) 113, 82 D.L.R. (3d) 130. In this case Dr. Rosen was not, in the treatment that he prescribed, in any way affected by the failure of Dr. Goldbach to correctly diagnose diabetes.

19 For these reasons the action against Dr. Goldbach must be dismissed.

3. The negligence, if any, of the nurses and laboratory staff and the resulting liability of the hospital

20 I say at once that I can find no evidence to indicate any negligence on the part of the laboratory staff. The plaintiff's own witnesses testified that it was in accordance with acceptable standards of hospital care for laboratory reports requested on a routine basis during the night shift of October 12th to 13th not to be processed and returned until some time in the afternoon of the 13th.

21 A urinalysis should have been done on an immediate (stat) basis when the patient was admitted. This was not done. The patient was incapable of giving a sample and a Foley catheter should have been inserted. This required a doctor's order and there can be no negligence attributed

to the nursing staff for this failure.

22 A routine urinalysis was ordered by a nurse in the intensive care unit (ICU). It was suggested that she should have used her own initiative to have this test taken on a stat basis but the evidence indicates that stat orders were only done on doctors' orders. I was favourably impressed by the witness Carmella Angerbauer. She seemed to me to be highly intelligent and devoted to her nursing career. A sick person would, indeed, be fortunate to have such a nurse. She was called as a witness on behalf of the plaintiffs and was critical of the nurses' conduct at the hospital. I think she tended, with hindsight, to set a standard of perfection and I prefer the evidence of the witnesses Reid, Bachel, and Burch as to the standard that existed at the time for a hospital such as the Scarborough General. The nurses followed the doctors' orders and, in my view, cannot be faulted for failing to use their own initiative in the ICU in ordering a stat urinalysis, doing a dipstick urinalysis or placing the patient on a monitor.

23 I, therefore, cannot find any negligence on the part of the nurses or laboratory staff and, accordingly, there is no liability on the Scarborough General Hospital for their conduct.

4. The negligence, if any, of Dr. Chin and his liability if sued

24 I have no hesitation in coming to the conclusion that Dr. Chin was negligent. He was faced with a semi-comatose youth who was hyperventilating and, in my view, the attempt to diagnose the trouble was quite inadequate and the treatment given was contra indicated. He should have had the patient catheterized and should have ordered blood and urine tests on a stat basis. The results of the tests would have led to a diagnosis of diabetes. From the history and condition of the patient he should have suspected diabetes. As in the case of Dr. Goldbach, a finding of negligence does not necessarily lead to a finding of liability. On the evidence, the effective cause of the cardiac arrest was the negligence of Dr. Rosen in the treatment of his patient. This being the case Dr. Chin is also insulated from liability. He could hardly foresee that Dr. Rosen would be negligent and Dr. Chin's diagnosis of hyperventilation could not be said to have contributed to the negligent treatment provided by Dr. Rosen.

5. The negligence, if any, of Dr. Rosen and his liability if sued

25 A serum potassium level below 3.5 creates a serious risk of cardiac arrhythmia leading to cardiac arrest. That is what occurred in this case. It is imperative to note and immediately correct a low potassium level. As I pointed out earlier, this patient's potassium level was normal at 8 a.m. but dropped to 1.5 by 2:10 p.m. The level remained low and at the last reading at 9 p.m. was only 2.1. No potassium replacement was ordered and administered until 3:30 p.m.

26 Dr. Rosen is an internist and a specialist in endocrinology. Diabetes falls within his specialty. As such, he is expected to possess and exercise a greater degree of care and skill in the treatment of diabetes than would a general practitioner:

MacDonald v. York County Hospital Corp. et al., [1972] 3 O.R. 469, 28 D.L.R. (3d) 521; varied on other grounds 1 O.R. (2d) 653, 41 D.L.R. (3d) 321; affirmed [1976] 2 S.C.R. 825, 66 D.L.R. (3d) 530, sub nom. Vail v. MacDonald et al.; McCaffrey v. Hague, [1949] 4 D.L.R. 291, [1949] 2 W.W.R. 539; Wilson v. Swanson, [1956] S.C.R. 804, 5 D.L.R. (2d) 113.

27 In the first place Dr. Rosen, in my view, was clearly negligent in failing to diagnose diabetes much earlier. The eventual diagnosis was made by a nurse. He was also, in my view, negligent in the care and treatment of his patient. He prescribed sodium bicarbonate at 11 a.m. because he recognized that his patient was acidotic. The dosage was not properly calculated and an excessive amount was administered. This dosage of sodium bicarbonate would tend to lower the serum potassium level. Once diabetes had been diagnosed, Dr. Rosen prescribed massive doses of insulin. Insulin also has the effect of lowering the serum potassium level. He should have been alert to this problem. I find that he was negligent in failing to administer potassium soon enough and in sufficient quantity. The patient's condition remained critical throughout the afternoon and into the evening but his blood sugar level came down to acceptable limits by 5 p.m. as the insulin took effect. Notwithstanding this, additional insulin was administered. It seems to me that Dr. Rosen should have realized that he was faced with a critically ill young man who was not responding properly to treatment and he should have been acutely aware of the danger. He could have started a second intravenous line to provide additional potassium and he should have ordered monitoring by an electrocardiogram. It is my view that Dr. Rosen's negligence in his treatment of Tony Yepremian was the cause of the cardiac arrest. If this young man had been properly treated after the diagnosis had been made, he would, in my opinion, have recovered without harm. I consider Dr. Rosen's negligence to have been extreme and I have no doubt that he would have been held liable if sued.

6. The liability of the hospital, if any, for the negligence of Drs. Chin and Rosen

28 I have already reached the conclusion that Dr. Chin, although negligent, would not have been liable if sued and the hospital cannot therefore be liable for his negligence.

29 A decision concerning liability of the hospital would not be as important to the plaintiff if Dr. Rosen had been sued. The plaintiffs can sue whom they choose and I must be careful in deciding the issue of the liability of the hospital not to let myself be influenced by the result of the failure to sue Dr. Rosen.

30 In many cases a patient is referred by a general practitioner to a surgeon for advice. The patient then retains the surgeon to perform the operation and the surgeon picks the hospital where he has operating privileges. In such a situation it may be that the hospital is only providing the necessary facilities for the use of the surgeon and really is not much more than a specialized kind of hotel; no liability rests on the hospital for the negligence of the surgeon, but only for negligence in connection with the facilities provided. This sort of case may make up a high percentage of admissions. I do not know, but I am sure that many patients are admitted through the emergency

department such as occurred here. Tony Yepremian had no choice of hospitals or doctors. By the time of his admission he was semi-comatose. His mother chose Scarborough General because it was the closest public hospital. In a large city such as Toronto with a population of over two million people, and with many doctors loath to make house calls, people go to the local hospital for care. Such people anticipate a high standard of care. They anticipate the best of equipment, laboratory services, nursing services and, above all, they anticipate competent skilled medical attention and treatment. These people do not, I think, differentiate between a teaching and non-teaching hospital and I do not think that such people would understand that liability might be imposed on a hospital for the negligence of an intern or resident but not for the negligence of a newly-qualified general practitioner in a non- teaching hospital who takes his turn in the emergency department in order to obtain certain admitting privileges. What then is the law in this case where Tony Yepremian's condition was brought about by the negligence of a specialist who is not an employee of the hospital? Dr. Rosen was not paid by the hospital for his services. He billed the patient and, no doubt, was paid by OHIP.

31 Dr. Rosen was a member of the attending specialist staff of the hospital. He presumably made an application for a staff appointment which would have gone to the credentials committee. The committee, having verified the information in the application, would then have forwarded the application to the Medical Advisory Council. This council, no doubt, recommended the appointment of Dr. Rosen to a staff position and this recommendation would have gone to the board of governors of the hospital who, no doubt, appointed Dr. Rosen to his staff position. This appointment is only valid for one year. Members of the Advisory Council are appointed by the board of governors. There is now, but was not then, an appeal from the decision of the board of governors to the hospital appeal board.

32 This right of staff selection is jealously guarded by hospitals and by the Scarborough General Hospital in particular. In Re Board of Governors of Scarborough General Hospital and Schiller (1974), 4 O.R. (2d) 201, 47 D.L.R. (3d) 485; varied 9 O.R. (2d) 648, 61 D.L.R. (3d) 416, the Divisional Court allowed an appeal from the hospital appeal board and restored the order of the board of governors of the Scarborough General Hospital rejecting the application of Dr. Schiller for appointment to the associate staff of the orthopaedic division of the department of surgery at the hospital. Cromarty, J., for the majority, said at p. 225 O.R., p. 509 D.L.R.:

> In exercising its undoubted right to select its own staff, that art which arises out of long study and continuous involvement with the practice of medicine in a hospital, the medical advisory committee and the hospital board must look at the whole man, at his personality traits, at all the circumstances surrounding his application before deciding that he is the man who ought to be on the staff of the hospital.
>
> The hospital board must decide if this applicant is one who will fit in with and

> complement the existing staff, and who will co-operate and work well with his fellows.
>
> A doctor on staff does not work in isolation just with the patients whom he has admitted, but as a member of a complex and highly-skilled team.

Cromarty, J., quoted with approval the reasons of the Appeal Board in the matter of the application of another doctor for appointment to the Department of Obstetrics and Gynaecology of the North York General Hospital, as follows (pp. 224-5 O.R., pp. 508-9 D.L.R.):

> "The Board of Governors of a public hospital is entrusted by its community with the responsibility of providing a program of health care tailored to the particular needs of that community. The Board must establish objectives that are within the capacity of its plant and resources. It must create a balance within its medical staff to ensure a broad base of expertise, and select a staff capable of developing excellence in health care while attaining the most efficient utilization of the facilities and resources of its hospital.
>
> "The public is entitled to expect that every hospital will justify its enormous expenditures of public funds by providing the best health care of which that hospital is capable. Careful choice of personnel is an important aspect of efficient management.
>
> "Clearly, the selection of a medical staff is an art, the development of which arises out of long study and continuous involvement with the practice of medicine in a hospital. The Chief of Staff, the Chiefs of Departments, and the Medical Advisory Committee exercise this art when they consider the education, new and special skills, and the personality traits of a physician applying for appointment to the medical staff of their hospital."

33 The question was dealt with again in Re Macdonald and North York General Hospital (1975), 9 O.R. (2d) 143, 59 D.L.R. (3d) 647, where Weatherston, J., gave the reasons for the Divisional Court and confirmed that it is the responsibility of a board of governors of a public hospital to determine the requirements of the health care in accordance with conditions within its specific community. Certain sections of the Public Hospitals Act, R.S.O. 1970, c. 378, as it was at the time of this incident, are of importance:

> 17(1) Except as is otherwise provided in this Act, no hospital receiving provincial aid ... shall refuse to admit as a patient any person who from sickness, disease or injury or otherwise is in need of active treatment.

. . . . .

41(1) Where the medical staff of a hospital is not divided into medical departments, the chief of the medical staff or, where there is no chief, the president of the medical staff may be made responsible by by-law of the hospital to advise the medical advisory committee with respect to the quality of medical diagnosis, care and treatment provided to the patients and out-patients of the hospital.

(2) Where the medical staff of a hospital is divided into medical departments, the head of each department may be made responsible by by-law of the hospital, through and with the chief of the medical staff or, where there is no chief, through and with the president of the medical staff, to advise the medical advisory committee with respect to the quality of medical diagnosis, care and treatment provided to the patients and out-patients of his department.

(3) Where an officer of the medical staff who is responsible under subsection 1 or 2 becomes aware that, in his opinion, a serious problem exists in the diagnosis, care or treatment of a patient or out-patient, he shall forthwith discuss the condition, diagnosis, care and treatment of the patient or out-patient with the attending physician, and, if changes in diagnosis, care or treatment satisfactory to him are not made promptly, he shall assume forthwith the duty of investigating, diagnosing, prescribing for and treating the patient or outpatient, as the case may be, and shall notify the attending physician, the administrator and, if possible, the patient or out-patient that the member of the medical staff who was in attendance will cease forthwith to have any hospital privileges as the attending physician for the patient or out-patient.

(4) Where the officer of the medical staff who is responsible under this section is unable to discuss the problem with the attending physician as required by subsection 3, he shall proceed with his duties as prescribed in this section as if he had had the discussion with the attending physician.

(5) The officer of the medical staff who is responsible under this section shall inform two members of the medical advisory committee within twenty-four hours of his action under subsection 3 or 4 and shall file a written report with the secretary of the medical advisory committee within forty- eight hours of his action under subsection 3 or 4.

> (6) The officer of the medical staff who is responsible under this section may delegate any or all of his responsibilities and duties under this section to a member of his medical staff or of his medical department, as the case may be, but he remains accountable to the medical advisory committee for the management of the patient by that member of the medical staff to whom any such responsibility or duty is delegated.
>
> (7) Where the medical advisory committee concurs in the opinion of the officer of the medical staff who has taken action under subsection 3 or 4 that the action was necessary, the secretary of the medical advisory committee shall forthwith make a detailed written report to the administrator of the problem and the action taken.

34 The Public Hospitals Act clearly imposed a duty on a public hospital to admit a person who "is in need of active treatment".

35 Section 41 of the Act clearly reflects the intention that hospitals be directly responsible to their patients for the quality of care provided in the hospitals. In imposing on the designated physician, whether he be the chief of the medical staff or the head of a department, the duties set out in s-ss. (1) to (7), the Legislature recognizes the institutional responsibility for care as opposed simply to a responsibility for providing staff. Indeed, as has been shown, in an extreme case, the attending physician can, even without the consent of or consultation with his patient, be discharged as the attending physician by the designated chief or head acting, surely, in the discharge of the hospital's duty to ensure a high quality of care.

36 An admitted person's doctor has no legal right to require the hospital to allow him to enter to treat his patient. See Henderson et al. v. Johnston et al., [1959] S.C.R. 655 at p. 658, 19 D.L.R. (2d) 201 at pp. 203-4, where Judson, J., for the Court, said:

> The complaint of the plaintiffs is that the Board of Trustees of the hospital in the exercise of its power of management, cannot restrict them in the practice of their profession or determine who may be members of the Courtesy staff. They claim that as members of the medical profession in good standing, they have an absolute right to attend their patients in private or semi-private rooms in the hospital and that no power is vested in the Board to limit this right. ... The claim is unsupported by authority and I am satisfied that there is no such absolute right as the one asserted. No common law or statutory origin was suggested and it cannot come from any statutory or other recognition of professional status. The right of entry into the hospital and the right to use the facilities there provided, in the exercise of the profession of these appellants, must be found in the

> regulations of the hospital authority for, apart from them, it has no independent existence.

37 It is the submission of counsel for the plaintiffs that the hospital is under a non-delegable duty of care in the circumstances that existed in this case and that the hospital cannot escape liability on the basis that a hospital is not vicariously liable for a doctor who is not a servant of the hospital and who is not an employee of the hospital in the traditional sense. It is the submission of counsel for the hospital that although a hospital has a recognized duty to exercise due care in its selection of doctors to whom it grants privileges and to establish an adequate system to monitor the practice of medicine in the hospital, there is no vicarious liability on a hospital for a doctor it does not employ who is negligent in the manner in which he medically treats his patient in the hospital.

38 I will now review the authorities dealing with the problem. I start with English authorities. In Hillyer v. Governors of St. Bartholomew's Hospital, [1909] 2 K.B. 820, the Court of Appeal concluded that the only duty undertaken by the governors of a public hospital towards a patient is to use due care and skill in selecting the medical staff and that the relationship of master and servant does not exist between the governors and the physicians and surgeons who give their services at the hospital. Farwell, L.J., at pp. 825-6, dealt with the matter as follows:

> It is, in my opinion, impossible to contend that Mr. Lockwood, the surgeon, or the acting assistant surgeon, or the acting house surgeon, or the administrator of anaesthetics, or any of them, were servants in the proper sense of the word; they are all professional men, employed by the defendants to exercise their profession to the best of their abilities according to their own discretion; but in exercising it they are in no way under the orders or bound to obey the directions of the defendants. The true relation of the parties is, in my opinion, well stated by the Chief Justice in Glavin v. Rhode Island Hospital, 34 Amer. Rep. 675, 679, where the Chief Justice said: "Here the physicians or surgeons are selected by the corporation or the trustees. But does it follow from this that they are the servants of the corporation? We think not. If A. out of charity employs a physician to attend B., his sick neighbour, the physician does not become A.'s servant, and A., if he has been duly careful in selecting him, will not be answerable to B. for his malpractice. The reason is that A. does not undertake to treat B. through the agency of the physician, but only to procure for B. the services of the physician. The relation of master and servant is not established between A. and the physician. And so there is no such relation between the corporation and the physicians and surgeons who give their services at the hospital. It is true the corporation has power to dismiss them, but it has this power not because they are its servants but because of its control of the hospital where their services are rendered. They would not recognize the right of the corporation, while retaining them, to direct them in their treatment of patients." The only duty undertaken by the defendants is to use due care and skill in selecting their medical staff, a duty

> similar to that undertaken by trustees to their cestui que trust--a duty arising ex contractu: see Ex parte Adamson (1878), 8 Ch. D. 807, at p. 819, namely, to bring such skill and care to bear on the affairs of their cestui que trust as the reasonable man of business brings to his own.

39 It is of some significance in that case that the surgeon in charge of the examination, who had the responsibility of controlling and directing the assistant surgeons and nurses, was chosen by the plaintiff himself.

40 Hillyer v. Governors of St. Bartholomew's Hospital was considered and explained by the Court of Appeal in Gold v. Essex County Council, [1942] 2 K.B. 293. As a matter of interest, I note that Denning, K.C., was senior counsel for the plaintiff. This decision stands for the proposition that a public hospital is liable for the negligence of an employed doctor, even though the doctor is engaged in work which involves the exercise of professional skill on his part. The comments of the Master of the Rolls, Lord Greene, at p. 301 and following, are of interest:

> Apart from any express term governing the relationship of the parties, the extent of the obligation which one person assumes towards another is to be inferred from the circumstances of the case. This is true whether the relationship be contractual (as in the case of a nursing home conducted for profit) or non-contractual (as in the case of a hospital which gives free treatment). In the former case there is, of course, a remedy in contract, while in the latter the only remedy is in tort, but in each case the first task is to discover the extent of the obligation assumed by the person whom it is sought to make liable. Once this is discovered, it follows of necessity that the person accused of a breach of the obligation cannot escape liability because he has employed another person, whether a servant or agent, to discharge it on his behalf, and this is equally true whether or not the obligation involves the use of skill. It is also true that, if the obligation is undertaken by a corporation, or a body of trustees or governors, they cannot escape liability for its breach, any more than can an individual, and it is no answer to say that the obligation is one which on the face of it they could never perform themselves. Nor can it make any difference that the obligation is assumed gratuitously by a person, body or corporation which does not act for profit: Mersey Docks Trustees v. Gibbs, L.R. 1 H.L. 93. Once the extent of the obligation is determined the ordinary principles of liability for the acts of servants or agents must be applied.
>
> The question which presents itself in the present case may, therefore, be formulated as follows: When a patient seeking free advice and treatment such as that given to the infant plaintiff knocks at the door of the defendant's hospital, what is he entitled to expect? He will find an organization which comprises

> consulting physicians and surgeons, presumably also house physicians and surgeons, a staff of nurses, equipment for administering Grenz ray treatment and a radiographer, Mead, employed to give that treatment. So far as consulting physicians and surgeons are concerned, clearly the nature of their work and the relationship in which they stand to the defendants precludes the drawing of an inference that the defendants undertake responsibility for their negligent acts.

It is to be noted that in Gold v. Essex County Council the Master of the Rolls was of the view that a hospital would not be liable for the negligence of a consulting physician because of the nature of his work and the relationship in which a consulting physician stands to the hospital.

41 In Cassidy v. Ministry of Health, [1951] 2 K.B. 343, the Court of Appeal appears to have gone a little further. Denning, L.J., considered the matter at pp. 359-60, as follows:

> If a man goes to a doctor because he is ill, no one doubts that the doctor must exercise reasonable care and skill in his treatment of him: and that is so whether the doctor is paid for his services or not. But if the doctor is unable to treat the man himself and sends him to hospital, are not the hospital authorities then under a duty of care in their treatment of him? I think they are. Clearly, if he is a paying patient, paying them directly for their treatment of him, they must take reasonable care of him; and why should it make any difference if he does not pay them directly, but only indirectly through the rates which he pays to the local authority or through insurance contributions which he makes in order to get the treatment? I see no difference at all. Even if he is so poor that he can pay nothing, and the hospital treats him out of charity, still the hospital authorities are under a duty to take reasonable care of him just as the doctor is who treats him without asking a fee. In my opinion authorities who run a hospital, be they local authorities, government boards, or any other corporation, are in law under the selfsame duty as the humblest doctor; whenever they accept a patient for treatment, they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot, of course, do it by themselves:
>
> they have no ears to listen through the stethoscope, and no hands to hold the surgeon's knife. They must do it by the staff which they employ; and if their staff are negligent in giving the treatment, they are just as liable for that negligence as is anyone else who employs others to do his duties for him. What possible difference in law, I ask, can there be between hospital authorities who accept a patient for treatment, and railway or shipping authorities who accept a passenger for carriage? None whatever. Once they undertake the task, they come under a duty to use care in the doing of it, and that is so whether they do it for reward or not.

> It is no answer for them to say that their staff are professional men and women who do not tolerate any interference by their lay masters in the way they do their work. The doctor who treats a patient in the Walton Hospital can say equally with the ship's captain who sails his ship from Liverpool, and with the crane driver who works his crane in the docks, "I take no orders from anybody". That "sturdy answer", as Lord Simonds described it, only means in each case that he is a skilled man who knows his work and will carry it out in his own way; but it does not mean that the authorities who employ him are not liable for his negligence. See Mersey Docks and Harbour Board v. Coggins and Griffith (Liverpool) Ld., [1947] A.C. 1, 20. The reason why the employers are liable in such cases is not because they can control the way in which the work is done--they often have not sufficient knowledge to do so--but because they employ the staff and have chosen them for the task and have in their hands the ultimate sanction for good conduct, the power of dismissal.
>
> This all seems so clear on principle that one wonders why there should ever have been any doubt about it. Yet for over thirty years--from 1909 to 1942--it was the general opinion of the profession that hospital authorities were not liable for the negligence of their staff in the course of their professional duties.

And again, at p. 362:

> Relieved thus of Hillyer's case [[1909] 2 K.B. 820] this court is free to consider the question on principle: and this leads inexorably to the result that, when hospital authorities undertake to treat a patient, and themselves select and appoint and employ the professional men and women who are to give the treatment, then they are responsible for the negligence of those persons in failing to give proper treatment, no matter whether they are doctors, surgeons, nurses, or anyone else. Once hospital authorities are held responsible for the nurses and radiographers, as they have been in Gold's case [[1942] 2 K.B. 293] I can see no possible reason why they should not also be responsible for the house surgeons and resident medical officers on their permanent staff.
>
> It has been said, however, by no less an authority than Goddard, L.J., in Gold's case [at p. 313], that the liability for doctors on the permanent staff depends "on whether there is a contract of service and that must depend on the facts of any particular case". I venture to take a different view. I think it depends on this: Who employs the doctor or surgeon --is it the patient or the hospital authorities?

> If the patient himself selects and employs the doctor or surgeon, as in Hillyer's case, the hospital authorities are of course not liable for his negligence, because he is not employed by them. But where the doctor or surgeon, be he a consultant or not, is employed and paid, not by the patient but by the hospital authorities, I am of opinion that the hospital authorities are liable for his negligence in treating the patient.

And further, at p. 363:

> 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 services.

42 In Jones v. Manchester Corp. et al., [1952] 2 Q.B. 852, the Court of Appeal accepted the responsibility of the hospital board for the negligence of an employed anaesthetist without question.

43 In Roe v. Minister of Health et al.; Woolley v. Minister of Health et al., [1954] 2 Q.B. 66, Lord Denning, in the Court of Appeal, went further. This case concerned an allegation of negligence against an anaesthetist who carried on a private anaesthetic practice but was under an obligation to provide a regular service for the hospital. The hospital set aside a sum of money out of their funds derived from investments, contributions and donations for division among the whole of the medical and surgical staff including visiting and consulting surgeons. The anaesthetist participated in this fund but otherwise received no remuneration from the hospital. The trial Judge was of the view that the hospital was not responsible for the anaesthetist. This view was discussed by Lord Denning, at pp. 81-2, where he said:

> I think that that reasoning is wrong. In the first place, I think that 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 the 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.

44 The question was also discussed by Lord Justice Morris. At p. 89 he said:

> A hospital might assume the obligation of nursing: it might on the other hand merely assume the obligation of providing a skilful nurse. But the question as to what obligation a hospital has assumed becomes, as it seems to me, ultimately a question of fact to be decided having regard to the particular circumstances of

> each particular case: the ascertainment of the fact may require in some cases inference or deduction from proved or known facts.

And further, at pp. 90-1:

> I think they [the hospital] further undertook to anaesthetize the plaintiffs. The arrangements made between the hospital and Dr. Pooler and Dr. Graham, together with the arrangements by which a resident anaesthetist was employed, had the result that the hospital provided a constantly available anaesthetic service to cover all types of cases.
>
> It is true that Dr. Pooler and Dr. Graham could arrange between themselves as to when they would respectively be on duty at the hospital: and each was free to do private work. But these facts do not negative the view, to which all the circumstances point, that the hospital was assuming the obligation of anaesthetizing the plaintiffs for their operations. I consider that the anaesthetists were members of the "organization" of the hospital: they were members of the staff engaged by the hospital to do what the hospital itself was undertaking to do. The work which Dr. Graham was employed by the hospital to do was work of a highly skilled and specialized nature, but this fact does not avoid the application of the rule of "respondeat superior". If Dr. Graham was negligent in doing his work I consider that the hospital would be just as responsible ...

45 An Australian authority of some interest is Samios v. Repatriation Com'n, [1960] W.A.R. 219. In that case a radiologist who was a private practitioner was negligent. The X-rays had been referred to this radiologist by the hospital and the Court held the hospital vicariously liable for the negligence of the radiologist. Jackson, S.P.J., at pp. 227-8, had this to say:

> I turn now to consider the negligence alleged against the Commission. I should say at once that, in my view, the Commission is, in law, vicariously responsible for the negligence of Dr. Fraser as a member of the clinic which was, at the material time, the agent of the hospital for the purpose of interpreting the X-ray films of the plaintiff. The evidence shows that the Commission undertook to provide for the plaintiff full hospital and medical treatment including examination by X-rays. For that purpose the hospital supplied a medical and nursing staff and in the normal course of events the hospital's own employee, Dr. Grant, would have pronounced upon the X-rays. In his absence the hospital employed the clinic and its partners to do so, and it seems to me as a matter of law that that makes no difference at all so far as the plaintiff is concerned.

46 I was referred to many American decisions but quote from only one, the decision of the Supreme Court of Illinois in Darling v. Charleston Community Memorial Hospital (1965), 211 N.E.

2d 253, where, at p. 257, Schaefer, J., quoted Fuld, J., in Bing et al. v. Thunig (1957), 2 N.Y. 2d 656 at p. 666, 163 N.Y.S. 2d 3 at p. 11, 143 N.E. 2d 3 at p. 8, as follows:

> "The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes, as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of 'hospital facilities' expects that the hospital will attempt to cure him, not that its nurses or other employees will act on their own responsibility."

47 I will now deal with some of the Canadian authorities.

48 The question of the liability of a hospital for the negligence of a nurse was considered by the Supreme Court of Canada in Sisters of St. Joseph of Diocese of London in Ontario v. Fleming, [1938] S.C.R. 172, [1938] 2 D.L.R. 417. The authorities were reviewed, including Hillyer's case, supra, and Davis, J., with whom Duff, C.J., and Kerwin and Hudson, JJ., agreed, concluded that, on the facts, the nurse, when she committed the negligent act, was acting as the agent or servant of the hospital and, that being the case, that the hospital was liable. In Vancouver General Hospital v. Fraser, [1952] 2 S.C.R. 36, [1952] 3 D.L.R. 785, the Supreme Court of Canada upheld a finding of liability against the hospital for the negligence of its interns. At p. 45 S.C.R., p. 791 D.L.R., Rand, J., said this:

> That primary undertaking [the undertaking of the hospital toward the patient], symbolized in the scope of real or apparent authority of the interne, is to be gathered from all the circumstances of the entrance of the patient into the hospital, of what is sought by him and the nature of what is done to and for him.

49 Lepine v. University Hospital Board (1964), 50 D.L.R. (2d) 225, 50 W.W.R. 709, was a case where liability was imposed on a hospital for damages sustained by an epileptic plaintiff who suffered from attacks of automatism and who jumped from a fourth floor window of the hospital. On appeal the liability of the hospital was affirmed, 54 D.L.R. (2d) 340, 53 W.W.R. 513 and 704. This decision was reversed in the Supreme Court of Canada, [1966] S.C.R. 561, 57 D.L.R. (2d) 701, 57 W.W.R. 5, on the basis that the event was not reasonably foreseeable. Farthing, J., thoroughly reviewed the authorities and said, at pp. 267-8 D.L.R., p. 756 W.W.R.:

> Nor is it incumbent upon the plaintiff to designate just which members of the staff of the defendant failed in their duties and so brought about the tortious act or incident with resulting injury for which he seeks redress. The plaintiff, like the

> overwhelming majority of hospital patients, has little or no knowledge of hospital management. In an action against, e.g., a public carrier for injuries sustained by one of its passengers, is the plaintiff expected to specify just what was wrong with the manner in which the defendant discharged its contractual obligation? Obviously, the breach of such obligation is all that such plaintiff must establish to shift the onus to defendant. Then why should a much heavier burden be placed upon a hospital patient in an action such as this?

50 Martel v. Hotel-Dieu St. Vallier; Vigneault v. Martel, [1969] S.C.R. 745, 14 D.L.R. (3d) 445, is another case where the Court imposed liability on a hospital for the negligence of an anaesthetist employed by the hospital.

51 In Johnston v. Wellesley Hospital et al., [1971] 2 O.R. 103, 17 D.L.R. (3d) 139, Addy, J., held that the doctor was not negligent. The doctor had been retained by the plaintiff and tended the patient in the out-patient department of the hospital. In dealing with the liability of the hospital Addy, J., said the following in obiter, at pp. 116-7 O.R., pp. 152-3 D.L.R.:

> Dr. Williams was on the active staff of the hospital, which entitled him to admit his patients to and treat them at the hospital and also entitled him to a certain number of beds. He at no time received any salary or emolument of any kind from the hospital, but received all of his medical income from fees for which he billed his patients directly. This applied also, as in the present case, to patients who consulted him at or were referred to him at the outpatients department.
>
> Counsel for the plaintiff argued that, as the doctor was on the staff of the hospital, he was accorded certain privileges, that is, the right to use and benefit from the equipment and staff of the hospital and the right to admit and treat his patients there and that, therefore, this constituted a consideration passing from the hospital to the doctor which, although it was not money consideration, was sufficient to constitute either a relationship of master and servant, or at least of principal and agent, sufficient to render the hospital vicariously responsible for his actions when treating patients at the hospital, especially those who had been referred to him by other members of the hospital staff.
>
> In order to be able to treat patients at the hospital, all doctors who are not residents or interns or employees on the permanent staff, must be on either the active, associate, consulting, courtesy or temporary courtesy staff. In all such cases, the doctors, of necessity, enjoy special privileges which might well be termed a certain consideration for the benefit of their presence in the hospital. If

> the argument of the plaintiff were to prevail, then in all cases where patients are treated by doctors at hospitals, the hospitals would be liable for their actions. This is certainly not the law in this Province nor in any other common law jurisdiction that I know of. The nature of the relationship between doctors and hospitals and the legal consequences of these relationships were extensively reviewed and analyzed by both the trial Judge, my brother Morand, J., and also by the Court of Appeal in the case of Aynsley et al. v. Toronto General Hospital et al., [1968] 1 O.R. 425, 66 D.L.R. (2d) 575; varied [1969] 2 O.R. 829, 7 D.L.R. (3d) 193. In neither report is there even the slightest argument or suggestion that the hospital might be responsible for the actions of the senior anaesthetist doctor who was on the active staff, but the question turned solely on whether the hospital might or might not be responsible for the actions of the other doctor who was the assistant anaesthetist, and in the actual employ of the hospital, and who was assisting in administering the anaesthetic.
>
> Therefore, even if I had found negligence on the part of Dr. Williams, I would not have held the hospital vicariously liable for his actions since he was employed by the plaintiff and not the hospital.

52 In Aynsley et al. v. Toronto General Hospital et al., [1968] 1 O.R. 425, 66 D.L.R. (2d) 575 (Ont. H.C.); affirmed [1969] 2 O.R. 829, 7 D.L.R. (3d) 193 (Ont. C.A.); affirmed [1972] S.C.R. 435 sub nom. Toronto General Hospital v. Matthews et al., 25 D.L.R. (3d) 241, the Court dealt, in part, with the vicarious liability of a hospital for the negligence of a senior resident in anaesthesiology. In the Court of Appeal, Aylesworth, J.A., for the Court, said at pp. 844-5 O.R., pp. 208-9 D.L.R.:

> The cases under review both in this country and in England make it clear, I think, that the liability of a hospital for the negligent acts or omissions of an employee vis-a-vis a patient, depends primarily upon the particular facts of the case, that is to say, the services which the hospital undertakes to provide and the relationship of the physician and surgeon to the hospital. The introduction into England of nationalized medicine probably has greatly altered the factual situation in that country with respect to the enquiries I have just mentioned, but each case there, I take it, will turn upon its particular facts. Similarly, I think in Ontario vicarious liability will be driven home to the hospital or plaintiffs will fail in that attempt, depending upon the peculiar facts of each case.
>
> In this regard, I cannot refrain from observing that the more modern cases in England at the appellate level would seem to be drawing ever nearer to the principle, so far as nurses are concerned, enunciated in the Supreme Court of Canada in the St. Joseph case and, as I have already said, in my view it is open to

> this Court to apply those principles expressed as to nurses, to physicians and even to physicians in the operating theatre.
>
> . . . . .
>
> The negligence of Dr. Porteous, in my view, was a failure by the hospital staff itself to discharge efficiently its undertaking to the patient and I would allow the judgment against the hospital to stand; he was, I think, under a contract of service with the hospital but, in my view, the legal result would be the same if his had been a contract for services.

53 In Serre et al. v. de Tilly et al. (1975), 8 O.R. (2d) 490, 58 D.L.R. (3d) 362, Stark, J., held that a hospital is not liable for the negligence of the patient's own physician.

54 In Hopital Notre-Dame de l'Esperance v. Laurent et al., [1978] 1 S.C.R. 605, 17 N.R. 593 sub nom. Laurent v. Theoret; Laurent et al. v. Hopital Notre-Dame de l'Esperance, a decision of the Supreme Court of Canada, the Court allowed an appeal of the hospital from the Court of Appeal for Quebec [[1974] Que. C.A. 543] and dismissed the action against the hospital. The surgeon was negligent and the Superior Court and the Court of Appeal had both concluded that the hospital should bear responsibility for his actions. The Supreme Court of Canada came to the opposite conclusion. Pigeon, J., gave the judgment of the Court and reviewed art. 1054 of the Civil Code which reads [in part] as follows:

> Masters and employers are responsible for the damage caused by their servants and workmen in the performance of the work for which they are employed.

He then proceeded [at pp. 611-2]:

> Since Curley v. Latreille (1920), 60 S.C.R. 131, it is settled law in Quebec that, in the French version of the Code, the words "dans l'execution des fonctions" are to be given a literal interpretation, a literal meaning corresponding to the English version: "in the performance of the work". It was expressly noted that this meaning is also that of the common law rule. The broad meaning which the French courts have given the words "dans les fonctions" in art. 1384 C.N., and which results in liability being fixed for acts that are merely performed "on the occasion of work" and are connected to it only by circumstances of time, place or service, has thus been rejected.
>
> In the case at bar the evidence shows no master and servant relationship between Dr. Theoret and the hospital with respect to the professional services rendered by him in the emergency room. The extracts I have quoted show that this was in fact a situation where the doctors who chose to attend were really

> independent professionals to whom the hospital merely provided an opportunity to establish relations with patients who came to seek their services. No doubt these doctors agreed among themselves on the day and time each would be on duty, but they were not there under the orders of a director. They were therefore not employees of an employer.

55 In my opinion certain principles can be deduced from a review of the Public Hospitals Act and the authorities. Except in exceptional circumstances:

> 1. A hospital is not responsible for negligence of a doctor not employed by the hospital when the doctor was personally retained by the patient; 2. A hospital is liable for the negligence of a doctor employed by the hospital; 3. Where a doctor is not an employee of the hospital and is not personally retained by the patient, all of the circumstances must be considered in order to decide whether or not the hospital is under a non-delegable duty of care which imposes liability on the hospital.

56 The present case falls into the third category. I think the case must be considered from the point of view of the patient, the hospital and the doctor. In so far as this particular patient was concerned, he was semi-comatose on admission. It was not even his decision to go to the hospital; it was the decision of his parents. Tony Yepremian was taken to the hospital because he was obviously seriously ill and in need of treatment. The public as a whole, and Tony Yepremian and his parents in particular, looked to the hospital for a complete range of medical attention and treatment. In this case there was no freedom of choice. Tony Yepremian was checked into the emergency department by Dr. Chin and not by a doctor of his choice. Dr. Chin was required to work for certain periods of time in the emergency department. When Tony Yepremian was admitted to the intensive care department of the hospital he was admitted under the care of Dr. Rosen. Tony Yepremian had no choice in the matter. The fact that Dr. Rosen happened to be the internist at the time of admission was the luck of the draw so far as the Yepremians were concerned. They really, I suppose, had no concern other than an expectation that this hospital would provide not only a room, but everything else that is required to make sure, so far as is possible, that the patient's ailments are diagnosed and that proper treatment is carried out, whether this is done by an employed doctor, a general practitioner or a specialist. From the point of view of the hospital, the hospital, by virtue of the provisions of the Public Hospitals Act above referred to, and as a matter of common sense, has an obligation to provide service to the public and has the opportunity of controlling the quality of medical service. From the point of view of the doctor, through the surrender of some independence by reason of the control that may be exercised over him by the hospital and by making his services available at certain specified times, he attains, by accepting a staff appointment, the privilege of making use of the hospital facilities for his private patients. I have come to the conclusion that in the circumstances of this case, by accepting this patient the hospital undertook to him a duty of care that could not be delegated. It may be that the hospital has some right of indemnity against the doctor but that is not before me.

57 For the above reasons I have come to the conclusion that the hospital is responsible in law for the negligence of Dr. Rosen.

Damages

58 I now deal with the assessment of damages. I am satisfied on the evidence that, as a result of the cardiac arrest, Tony Yepremian suffered serious permanent brain damage. At the present time his memory is poor and his general intellectual ability is diminished. He is capable of limited work under supervision but could not manage on his own. He will never be able to successfully compete for employment in today's society. He is able to go to the store by himself and buy one or two items. He spends a great deal of time just sitting and talking to himself and has fantasies of being married with children. He cannot drive a car but he can help a little bit at his brother's service station performing simple tasks, such as sweeping the floor, but he cannot be trusted to service customers because he forgets how much gas to pump and cannot make change.

59 After his release from hospital he was looked after by his parents, particularly his mother. When he first came home from hospital he was like a "vegetable". Mrs. Yepremian through her devoted care brought him back to his present state. Unfortunately, his father died recently.

60 Tony's family described him before the accident as being a normal, happy, outgoing young man. He was on his way to becoming a motor body mechanic. He was particularly interested in cars and had a girl-friend, but his school record was poor. For the 1965-66 year at junior high school there is a record of an I.Q. of 73, failing marks and a transfer to a grade 8 vocational school. At age 18, Tony was in grade 10 at vocational school. The Ministry of Colleges and Universities, Industrial Training Branch record contained a report from an employee of an auto body shop where Tony had been employed.The report indicated that Tony was discharged for lack of reliability and assessed his attitude and co-operation as being poor, his efforts and work qualifications were evaluated as being fair and his progress was good. To summarize, prior to the cardiac arrest, Tony's abilities were limited in that he was below normal in intelligence and apparently in attitude. He was, however, capable of caring for himself and he was employable; such is not the case at the present time.

> The Yepremian family arrived in this country as immigrants from Israel in 1966, being of Arab-Armenian background. The achievements of his brothers are noteworthy. Jack has progressed from working in a service station to owning his own service station and body shop while Joseph is completing his bachelor of arts degree at the University of Toronto and plans to become a chartered accountant.

61 Three recent decisions in the Supreme Court of Canada have a great bearing on the assessment of damages in a case of this kind. These decisions are Arnold et al. v. Teno et al. (1978), 83 D.L.R. (3d) 609; Thornton et al. v. Board of School Trustees of School District No. 57 (Prince George) et al. (1978), 83 D.L.R. (3d) 480, [1978] 1 W.W.R. 607, and Andrews et al. v. Grand & Toy (Alberta)

Ltd. et al. (1978), 83 D.L.R. (3d) 452, [1978] 1 W.W.R. 577.

62 From a consideration of these decisions, it appears to me that certain principles should be applied to the assessment of damages in the present case. These principles are as follows:

1. The method of assessing general damages in separate amounts is a sound one; 2. It is reasonable that large amounts should not be awarded once a person is properly provided for in terms of future care for his injuries and disabilities and prospective loss of earnings; 3. Dedicated relatives who look after the injured are not expected to do so on a gratuitous basis; 4. Although the capitalization rate applied in these cases was 7%, the result in future cases, which of course includes this case, will depend upon the evidence adduced in the case; 5. In computing future lost earnings there is no deduction for tax and no allowance for increased tax liability for taxes on the capital sum; 6. It is an error in law to regard the ability of the defendant to pay as a relevant consideration in the assessment of damages; 7. On the facts in the three cases before the Supreme Court of Canada, $100,000 was awarded for non-pecuniary general damages.

63 In assessing damages in the present case I intend to do so under the following heads:

Special damages

(a) The cost to date for hospitalization, medical attention and treatment; (b) loss of income to date.

General damages
(a) the estimated cost of future care, if any;
(b) the claim for care provided and to be provided by Mrs. Yepremian;
(c) present value of loss of income in the future;
(d) non-pecuniary general damages.

I now proceed with the assessment.

Special Damages

(a) The cost to date for hospitalization, medical attention and treatment

64 I assess this claim at the uncontested figure of $4,085.

(b) Loss of income to date

65 Had it not been for the accident, it appears to me that Tony would have successfully completed his auto body repairman training and quite probably would be employed by his brother as an auto body repairman at the present time. There was evidence adduced at trial as to the rate of

pay for flat rate work and hourly paid work and it seems to me that it is more realistic to calculate the loss of income on the basis of the prevailing hourly rates. This calculation is as follows:

Salary -- Remainder of 1970

480 hours
= 12 weeks Average salary 1970
= $119.00 Apprentice rate
= 60% Salary--$119.00x12x.6 = $ 856.80

Salary -- 1971

752 hours
= 18.8 weeks Average salary
= $106.00 Apprentice rate
= 60% Salary -- $106.00x18.8x.6
= $1,195.68

Remainder of year 1971

1328 hours
= 33.2 weeks Average salary
= $106.00 Apprentice rate
= 80% Salary -- $106.00x33.2x.8
= $2,815.36

TOTAL 1971 SALARY: 4,011.04

Salary -- 1972

472 hours
= 11.8 weeks Average Salary
= $140.00 Apprentice rate
= 80% Salary -- $140.00x11.8x.8

= $1,321.60

Remainder of year 1972

1608 hours
= 40.2 weeks Average salary
= $140.00 Apprentice rate
= 90% Salary -- $140.00x40.2x.9
= $5,065.20

TOTAL 1972 SALARY: 6,386.80

Salary -- 1973

192 hours
= 4.8 weeks Average salary
= $150.00 Apprentice rate
= 90% Salary -- $150.00x4.8x.9
= $648.00

Remainder of year 1973

1888 hours
= 47.2 weeks Average salary
= $150.00 Apprentice rate
= 100% Salary -- $150.00x47.2
= $7,080.00

TOTAL 1973 SALARY: 7,728.00

Salary -- 1974

52 weeks Average salary
= $153.00 Salary -- $153.00x52 = 7,956.00

Salary -- 1975

52 weeks Average salary
= $184.00 Salary -- $184.00x52 = 9,568.00

Salary -- 1976

52 weeks Average salary
= $219.00 Salary -- $219.00x52 = 11,388.00

Salary -- 1977

52 weeks

Average salary = $236.52 (arrived at by applying 8% increase to 1976 salary) Salary -- $236.52x52 = 12,299.04

Salary -- 1978

20 weeks

Average salary = $255.44 (arrived at by applying 8% increase to 1977 salary) Salary -- $255.44x20 = 5,108.80 TOTAL WAGES LOST (October 12, 1970 to May 20, 1978) = $65,302.48

66 It is necessary to deduct from this figure a sum which takes into consideration contingencies which might have affected these earnings such as illness, accident and unemployment brought about by other causes. I bear in mind that the economic effect of the loss of employment these days is considerably lessened by such things as unemployment insurance. I also bear in mind Tony Yepremian's somewhat limited initiative and have decided that it would be fair to apply a 15% contingency to this figure, leaving a net figure for loss of income to date of $55,507.11.

67 Tony Yepremian is in receipt of a disability pension. In view of the decision of the Court of Appeal in Boarelli v. Flannigan, [1973] 3 O.R. 69, 36 D.L.R. (3d) 4, I make no deduction for any such disability payments.

General damages

(a) Estimated cost of future care, if any

68 As I already indicated, Tony Yepremian is being looked after by his mother. He needs little care at the present time, just some minor supervision. His mother is 50 years old and is apparently in good health. It was suggested that Tony Yepremian be sent to an institution such as Ashby House where he can work in a modified institutional setting. The cost of maintaining a person at Ashby House is $29 a day. I feel quite sure that Mrs. Yepremian will continue to look after her son so long as she is able to and there was no evidence that the family had any intention of placing Tony in an institution. It is impossible to look into the future with any great degree of accuracy but I think it is probable that some time in the future, possibly 25 years or so from now, Mrs. Yepremian, through sickness or for some other reason, will have to give up looking after her son. I got the impression, however, that the Yepremian family is a tightly-knit family and it may well be that this load of minor supervision will be taken over by another member of the family. Giving this aspect of the claim the most careful consideration that I can, I have come to the conclusion that it would be unfair to award any amount for the cost of future care.

(b) The claim for care provided and to be provided by Mrs. Yepremian

69 Mrs. Yepremian gave her son devoted care and trained him back to his present state. The present demands upon Mrs. Yepremian's time, as the result of the condition of her son, are minor and I do not think that these demands are such as require a monetary award. Certainly the original demands upon her time were considerable and I assess the claim at $20 a day for eight months for a total of $4,880.

(c) Present value of loss of income in the future

70 There is an undoubted loss of earning capacity and it is necessary to establish the present value of this loss. In order to do this it is necessary to consider the loss of earnings for the length of the estimated working life and capitalize this sum. It is then necessary to make some deduction for contingencies. I estimate that Tony Yepremian would have been earning $13,282 a year at the present time had he not been injured. He has a working life expectancy of 36.162 years. These figures multiplied out, without applying any discount rate for present value, produce $480,303.

71 Much evidence was adduced and much argument was presented concerning the appropriate discount rate. As Mr. Justice Dickson pointed out in Andrews v. Grand & Toy (Alberta) Ltd. et al. (1978), 83 D.L.R. (3d) 452, [1978] 1 W.W.R. 577, the result depends upon the evidence adduced in the case. I have come to the conclusion from listening to the evidence and considering the inherent probabilities of the situation that 3% as a discount rate is more than fair to the defence. It costs $22,214 to produce $1,000 per year discounted at 3% over 36.162 years. I have already estimated the loss of income at the present time at $13,282 per year. To discount this loss of income I must therefore multiply $22,214 by 13.282. This produces $295,046.

72 Had I made an award for the cost of future care that included an allowance for room and board, and possibly clothing, then I would have made a deduction from the future loss of income for such room, board and clothing. Such is not the case here and it seems to me that the capitalized value of the loss of future income is the amount that should be allowed less a deduction for contingencies such as sickness, accident and unemployment for other reasons. Again, it appears to me that a fair rate to apply is 15%. This produces $250,790 and I assess the claim for future loss of income at this sum.

(d) Non-pecuniary general damages

73 It is particularly difficult to assess non-pecuniary general damages in a case of brain injury. I have no doubt that Tony Yepremian has suffered a terrible loss. He will not marry in the future and has lost so much in life. To make the matter even more tragic he must realize this loss that he has sustained. No money can ever compensate someone for serious personal injury and it has been pointed out that, to some extent, these awards that we make must be conventional awards. Certainly in the three decisions of the Supreme Court of Canada it appears that that Court has, at the present time, placed a limit of $100,000 for the most serious type of injury and $100,000 for poor Diane Teno, with a 66-year life expectancy, was described as "a very generous award". I assess the non-pecuniary general damages in this case at $75,000.

Summary of damage assessment
Special damages (a)
Cost to date $4,085.00 (b)
Loss of income
to date 55,507.11
General damages (a)
Cost of future care nil (b)
Claim for care
provided by Mrs.
Yepremian 4,880.00 (c)
Present value of
loss of income in
the future 250,790.00 (d)
Non-pecuniary general
damages 75,000.00
Total $390,262.11

Conclusion

74 Herant Yepremian died and an order will go changing the style of cause to substitute Mary Yepremian for Herant Yepremian.

75 A new s. 38 was introduced into the Judicature Act, by the Judicature Amendment Act, 1977

(No. 2), c. 51, s. 3(1), effective November 25, 1977. This section provides for interest. Notice in writing of the claim for interest was given on January 19, 1978, and the judgment will bear interest from that date to the date of judgment in accordance with the provisions of the Act. If there is any difficulty calculating the amount due I may be spoken to.

76 For the above reasons the plaintiff will have judgment against Scarborough General Hospital for $390,262.11, together with interest as set out above, together with costs, such costs to include the reasonable costs of the actuarial evidence adduced at trial. The action against Dr. Martin M. Goldbach will be dismissed without costs.

Judgment for plaintiffs against defendant hospital; action against defendant doctor dismissed.