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

[1980] O.J. No. 3592

28 O.R. (2d) 494

110 D.L.R. (3d) 513

13 C.C.L.T. 105

3 A.C.W.S. (2d) 484

Ontario
Court of Appeal

Mackinnon, A.C.J.O.,
Arnup, Houlden, Blair
and Morden, JJ.A.

June 27, 1980.

R. A. Stradiotto, Q.C., and W. D. T. Carter, for appellant, respondent by cross-appeal, Scarborough General Hospital.

R. J. **Sommers** and R. Roth, for plaintiffs, respondents, appellants by cross-appeal.

D. K. Laidlaw, Q.C., A. J. Lenczner and M. M. Koenigsberg, for respondent, appellant by cross-appeal, Dr. Goldbach.

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1 ARNUP, J.A.:-- This appeal raises important questions as to the liability of a public hospital for the negligence of specialists on its staff in the medical treatment of patients admitted to the hospital. Also involved is the liability of such hospital for the negligence of a general practitioner on the staff taking his turn of duty in the emergency department, the liability of a general practitioner for negligence prior in time to the negligence of the doctor in emergency and the specialist called in by him; whether the nursing staff in the intensive care unit ("I.C.U.") was negligent; whether the

hospital was directly negligent in failing to require certain tests to be done on all patients admitted; and three questions as to the damages awarded by Mr. Justice R.E. Holland, who tried the action without a jury. By leave, a cross-appeal by the plaintiffs was enlarged to raise a question as to interest on the judgment. The defendant Dr. Goldbach, the general practitioner who treated Tony Yepremian as a family doctor, raised but did not pursue an appeal from the damages awarded in the event that the plaintiffs' cross-appeal against him was successful.

2 In October, 1970, Tony Yepremian was 19 years old. As the trial Judge did, I will call him "Tony". He lived with his parents, as did his older brother, Jack, and a younger brother, Joseph. Tony worked as an apprentice body shop repairman. When he came home from work on Friday, October 9th, he was not feeling well and stayed in bed Saturday and Sunday. He was troubled with vomiting, increasing frequency of urination and was very thirsty. He got weaker and by Monday, October 12th (Thanksgiving Day, and also his parents' 25th wedding anniversary), he was obviously a sick man.

3 His mother tried to reach the family doctor, who was unavailable but had arranged for the defendant Dr. Goldbach to be on call for him. Dr. Goldbach had obtained his degree the previous year and was engaged in research, but on occasion filled in for family doctors on week-ends. (He has since become a successful cardio-vascular surgeon.) Dr. Goldbach agreed to see Tony at once, and Joseph Yepremian and Jack Yepremian's fiancee took Tony to the doctor's office. By this time he could not stand unassisted.

4 Dr. Goldbach diagnosed Tony's problem as severe sore throat and tonsillitis and prescribed an antibiotic. Tony was too unwell to answer questions, so Joseph gave the history. He testified he told the doctor about Tony's increased frequency of urination and thirst. There was no urinalysis or blood test. In answer to inquiry, the doctor said it was unnecessary to take Tony to the hospital.

5 Tony was taken home and put to bed. The prescription was filled, and Tony was started on the medication. He continued to drink, urinate excessively, and vomit. By 11:00 p.m. he started to hyperventilate (to breathe heavily and at a fast rate, through his mouth). He was obviously very ill. His mother and his brother Jack dressed him and took him to Scarborough General Hospital. He was by now semi-comatose and was taken into the emergency department in a wheelchair. It was about 1:00 a.m. on October 13th.

6 The doctor on duty in the emergency department was Dr. Roy Chin, a general practitioner with hospital privileges as such. Tony's mother and brother each testified to having told someone in emergency about Tony's vomiting, drinking and urination. The trial Judge found Dr. Chin's memory of the events -- seven years before -- to be unreliable. In any event, Dr. Chin made no diagnosis but telephoned Dr. Fred Rosen, the internist on call, at his house. Dr. Chin also prescribed Phenobarbitol and shortly afterwards, Valium. Someone in emergency suspected (wrongly) that Tony was suffering from a drug overdose. At all events, the sedatives administered simply deepened Tony's comatose condition.

7 Dr. Rosen did not come to the hospital, but, after being called a second time, directed that Tony be transferred to the I.C.U. of the hospital. This was done at 3:35 a.m. At 4:20 a.m., a Foley catheter was inserted and in due course a urine specimen was sent to the hospital laboratory on a "routine" basis (as contrasted with a "stat" basis). Dr. Rosen saw Tony at 8:00 a.m. and a short time later talked to Jack Yepremian. Tony was still hyperventilating. Dr. Rosen saw him again at 10:00 a.m. and prescribed 5% sodium bicarbonate intravenously because he saw that Tony was acidotic, and asked a neurologist to see Tony, which he did at 11:00 a.m., with negative results.

8 Around 12:20 p.m., a nurse detected a "fruity" odour on the patient's breath, which she recognized as a strong indication of diabetes. She reported this to Dr. Rosen shortly thereafter. Dr. Rosen at once instructed that insulin be administered intravenously. In retrospect, there is no doubt that Tony had been suffering from the effects of acute diabetes for at least the preceding four days.

9 At this point in the narrative the focus of attention switches to Tony's serum potassium level. A range around 5.5 is normal. A level below 3.5 creates a serious risk of cardiac arrhythmia which can lead to cardiac arrest. Sodium bicarbonate tends to lower the serum potassium level. The dosage prescribed by Dr. Rosen (to counteract recognized acidosis) was wrongly calculated and excessive. Insulin also has the effect of lowering the serum potassium level, and potassium must be administered to prevent this happening.

10 Tony's level was 5.5 at 8:00 a.m. It had fallen to 1.4 by 3:10 p.m. By 9:00 p.m., it was up to 2.1. These levels were noted on the patient's chart. The trial Judge found that Dr. Rosen, within whose specialty diabetes fell, was negligent in not administering potassium soon enough and in sufficient quantity. None was administered until 3:30 p.m.

11 Tony's blood sugar had come down to acceptable limits by 5:00 p.m. as the insulin took effect. Notwithstanding this, additional insulin was administered at 10:00 p.m. Tony remained semi-conscious. At 12:55 a.m. on October 14th Tony had a cardiac arrest. The usual alarm was given and his life was saved. As a result of the cardiac arrest he suffered permanent brain damage. I cannot do better than to quote from the judgment of Mr. Justice R.E. Holland, 20 O.R. (2d) 510 at pp. 535-6, 88 D.L.R. (3d) 161 at pp. 185-6, 6 C.C.L.T. 81:

> 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.

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.

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.

12 Neither Dr. Rosen nor Dr. Chin was sued. Both gave evidence at the trial as witnesses called by counsel for the hospital.

The trial judgment

13 My summary of the facts has been taken largely from the careful and detailed recounting of these tragic events by the trial Judge, and where the evidence at trial was conflicting, I have adopted his findings of fact. No serious challenge to those findings was made by any of the counsel before us, although there were submissions as to the legal results that flowed from those findings. I summarize the conclusions of the trial Judge as follows:

(1) Dr. Goldbach was negligent. He was given the significant details of Tony's symptoms by Jack Yepremian. From that history, Dr. Goldbach should have suspected diabetes, and done a simple urinalysis. If there had been a correct diagnosis and adequate treatment, Tony would not have suffered the cardiac arrest and consequent brain damage. Nevertheless, the effective cause of the cardiac arrest was the negligence of Dr. Rosen. It was foreseeable by Dr. Goldbach that, without proper treatment, there would be a cardiac arrest but it was not foreseeable that an internist and specialist in endocrinology would treat the patient negligently. Dr. Rosen was not affected in any way in his treatment by the failure of Dr. Goldbach to diagnose diabetes. Accordingly, the claim against Dr. Goldbach was dismissed.

(2) There was no negligence on the part of either of the laboratory staff or the nursing staff of the I.C.U.

(3) Dr. Chin was negligent. His diagnosis was inadequate and the treatment given was "contra indicated". He should have ordered blood and urine tests on a "stat" basis; the results would have led to a diagnosis of diabetes, which should have been suspected anyway, from the history and clinical symptoms. But here also, his negligence was not the cause of the cardiac arrest and he was "insulated from liability" by the negligence of Dr. Rosen, which he "could hardly foresee".

(4) Dr. Rosen was negligent in failing to diagnose diabetes much earlier, and in the care and treatment of his patient. He should have administered potassium sooner and in sufficient quantity. The negligence in treatment caused the cardiac arrest. If Tony had been properly treated after the diagnosis of diabetes had been made, he would have recovered without harm.

I pause here to say that, before this Court no one disputed the findings of negligence against Drs. Goldbach, Chin and Rosen, but of course, the latter two were not represented, since they were not parties to the action.

(5) The hospital was responsible in law for the negligence of Dr. Rosen. Since this finding raises the central issue on this appeal, and it will be necessary to examine in detail the reasons of the trial Judge for reaching this conclusion, I will not discuss them at this point.

(6) The damages were assessed at $390,262.11, plus interest. The breakdown was:

Expenses to date of trial for hospitalization, medical attention and treatment	$ 4,085.00
Loss of income to date of trial after contingency deduction of 15%	55,507.11 a

Costs of future care	Nil	
Care provided by Tony's mother to his present state	4,880.00	bring him to
Allowance for future care by Tony's	Nil	mother
Present value of future income loss, contingency deduction of 15%	250,790.00	after a
Non-pecuniary general damages	75,000.00	$ 390,262.11

14 Interest from January 19, 1978 (the date of written notice of such a claim), was allowed pursuant to s. 38 of the Judicature Act, R.S.O. 1970, c. 228, enacted 1977, c. 51, s. 3(1), together with costs of the action. The action against Dr. Goldbach was dismissed without costs.

Issues on the appeal

15 The hospital appealed the finding of liability against it. Mr. Laidlaw, although appearing for Dr. Goldbach, supported the hospital's appeal against liability. The plaintiffs cross- appealed from the dismissal of the action against Dr. Goldbach. Since Mr. Laidlaw did not challenge the finding of negligence made against Dr. Goldbach by the trial Judge, this aspect of the cross-appeal was confined to the correctness of the finding that Dr. Goldbach's negligence was not a cause of Tony's damages.

16 The plaintiffs also asserted that the judgment against the hospital could be supported on grounds other than those stated by the trial Judge, namely, the negligence of the hospital's own staff in the I.C.U., the hospital's alleged failure to provide proper training to its I.C.U. nurses, and vicariously through the negligence of Dr. Chin. These submissions were included in the plaintiffs' "Notice of Appeal and Cross- Appeal", but were really additional grounds for supporting the trial judgment.

17 The plaintiffs further appealed from the assessment of damages, under three headings: the inadequacy of the allowance to Tony's mother, both up to the date of trial and in the future; the inadequacy of the assessment of Tony's future loss of income because of the discount rate used in

arriving at present values; and the excessive deduction for contingencies. There was also a claim for interest from the date of trial on the lump sum allowed for Tony's future loss of income, on the principle laid down in Fenn et al. v. City of Peterborough et al. (1979), 25 O.R. (2d) 399 at pp. 459-63, 104 D.L.R. (3d) 174 at pp. 234-8, 9 C.C.L.T. 1. Counsel agreed prior to the argument that interest at 10% per annum from the date of trial to the date of payment should be paid on whatever amount was awarded for future loss of income; hence, it was not necessary to argue this aspect of the cross-appeal.

18 Counsel for the hospital supported the plaintiffs' cross- appeal against Dr. Goldbach but carried their argument to the point of submitting that his negligence was the sole cause of the damage, and that all subsequent acts of Dr. Chin, Dr. Rosen and the I.C.U. staff were the acts of "rescuers".

19 Finally, Dr. Goldbach served what might be termed a "conditional notice of cross-appeal" to the effect that, in the event Dr. Goldbach should be found liable, the damages assessed by the trial Judge were too high. However, as already stated, when this branch of the argument was reached, Mr. Laidlaw said he was not pressing this appeal.

The liability of the hospital

20 At the conclusion of the submissions on behalf of the plaintiffs that the hospital was liable by reason of alleged negligence of the nursing staff, in emergency and in the I.C.U., or by reason of the hospital's alleged failure to give proper training to nurses before assigning them to the I.C.U., we were all of the view that no case had been shown that required an answer. The issue remaining is that stated by the trial Judge in item 6 of his reasons, at p. 522 O.R., p. 172 D.L.R.: "The liability of the hospital, if any, for the negligence of Drs. Chin and Rosen".

21 The trial Judge concluded that Dr. Chin, although negligent, would not have been liable if sued, and the hospital could not therefore be liable for his negligence. In summary, the trial Judge found that the cause of Tony's damages was the cardiac arrest, and the effective cause of the cardiac arrest was the negligence of Dr. Rosen in the treatment of his patient. Having so found, the trial Judge said Dr. Chin (like Dr. Goldbach) was "insulated from liability". I take this to mean that Dr. Chin's negligence was not an effective cause (or not one of the effective causes) of the cardiac arrest. In my view this finding was open to the trial Judge and should not be disturbed in this Court on the evidence: see Schreiber Brothers Ltd. v. Currie Products Ltd. et al., released by the Supreme Court of Canada March 27, 1980, 108 D.L.R. (3d) 1, 31 N.R. 335.

22 Dr. Chin's legal position parallels that of Dr. Goldbach, which I discuss later in these reasons.

23 The matter thus narrows down to the question of whether the hospital is liable to the plaintiffs by reason of the negligence of Dr. Rosen. The legal issue must be examined against the background of certain undisputed facts (all stated as of October, 1970):

(1) The Scarborough General Hospital opened in March, 1955, under the auspices of an Ontario corporation called The Sisters of Misericorde. In 1970 it was still under those auspices. It was a public hospital within the meaning of the Public Hospitals Act, R.S.O. 1970, c. 378, but was not a teaching hospital associated with the University of Toronto.

(2) Only three doctors were employed by the hospital; they were the medical director (Dr. O'Hara) and two pathologists.

(3) The hospital had general practitioners and a wide variety of specialists "on its staff". To become a member of the staff, a doctor made a written application to the medical director. The application was referred to the credentials committee of the medical staff, who checked it over for accuracy and verified its facts by reference to the College of Physicians and Surgeons or other appropriate sources of information. If the application appeared to be in order and its facts correct, it was forwarded to the medical advisory committee, whose function in connection with the application was to make a recommendation to the board of governors of the hospital. The medical advisory committee consisted of the president, vice-president and secretary of the medical staff, plus the chiefs of ophthalmology, otolaryngology, obstetrics and gynaecology, medicine, surgery, radiology and pathology. The recommendation might be that no additional staff was required in the field of the applicant, or that the applicant should or should not be appointed. All appointments to the staff were made by the board of governors. An appointment was for a term of one year. No doctor who had not been appointed to the staff could practise in the hospital or admit patients to it.

(4) Only a member of the specialist staff could admit a patient to the I.C.U., although a member of the staff who was a general practitioner could get authority by telephone from a specialist on staff, and the patient was admitted to the I.C.U. as a patient of the specialist. On Dr. Rosen's evidence, this is what happened with respect to Tony.

(5) The hospital did not have post-graduate medical students as such. It did have some students in fourth year of the Faculty of Medicine of the University of Toronto. The medical director, Dr. O'Hara, said in evidence that the hospital had "first year rotating interns" but not "post-graduate interns doing second year residency". This was not further developed in evidence, and in any event appears to have no significance in the present case.

(6) Dr. Rosen was a fully-qualified medical specialist in internal medicine, with particular expertise in endocrinology, and had received his Fellowship in the Royal College of Physicians in 1967. He had applied for admission to the medical staff, and had been appointed by the board of governors on July 1, 1970. No one suggests, and there is no evidence, that there was any want of care by the board in appointing him or permitting him to practise in the hospital as a staff specialist in internal medicine. (There were about nine other internists on the staff.) While he was found to be negligent in the case, it is not suggested that he was an incompetent specialist.

(7) Dr. Chin had a "courtesy appointment in the department of general practice", granted in

1969. The nature of such an appointment was not explored in evidence. Again there is no evidence to show any lack of care by the board in making the appointment, and it is not suggested that he was an incompetent doctor.

(8) Neither Dr. Rosen nor Dr. Chin was an employee of the hospital. Neither received any remuneration from the hospital, although the right to practise there and make use of the hospital facilities was obviously a benefit to them, with correlative responsibilities to take their turn in the emergency department, and doubtless to attend staff meetings and so on. Each billed O.H.I.P. for services rendered to patients in the hospital or if the patient had no coverage, billed the patient. They paid nothing to the hospital.

(9) Dr. P.J. O'Hara, the medical director of the hospital in 1970, testified that the person in charge of or in control of the standard of treatment given to patients in the hospital was the head of the service -- in this case, the chief of medicine -- and that "the overall responsibility resided in the Medical Advisory Council".

On cross-examination by Mr. Sommers, Dr. O'Hara testified:

MR. SOMMERS: Q. As I understand it, the operation of the Emergency Department was provided for the benefit of the community by the hospital?

A. Correct.

Q. And signs were set up all around the hospital and leading from the highways to the hospital, marked with a big blue H?

A. Yes. They also went to Centennial.

Q. Of course, they would go to many hospitals.

A. Right.

Q. But there is no question that your hospital had these signs leading to it. Correct?

A. Correct.

Q. And the reason the emergency service was provided was to enable people, who for one reason or another were in need of medical care, urgent medical care, to be able to come to the hospital to receive that medical care?

A. Yes.

Q. And this could have happened for any number of reasons, either because they did not have a family doctor or because their family doctor might have been away, or simply because they might have been involved in an accident near the hospital?

A. Yes.

Q. So it was the undertaking of the hospital to the community to provide this service of providing medical care?

A. Yes. I think that -- I prefer to look at it as a, really a sort of health care service to the community because it covers a great many things.

Probably the, only 25 per cent of the people who come into Emergency are real emergencies. Now, the rest of the people who come in are, come in there for various other reasons, they can't obtain their own doctor, they themselves think that they are emergencies or else they don't feel well and they know eventually they will see someone there.

Q. And they would also be looked at? They wouldn't be thrown out on the street?

A. That's right.

Q. Whoever was looking after the Emergency Department at the particular time would look at them. If he felt that there was no urgency he would tell them so and tell them to go and see somebody else, or that there was no need for alarm?

A. Right.

Q. So was it really a total health care, as you put it, that the hospital intended to provide for the community?

A. Yes.

Q. Now, the organization of the actual Emergency Department, as I understand it, was on the basis of rotation? General practitioners who were on the staff of the hospital would take turns in running the department, from day to day, from shift to shift?

A. Correct.

Q. And it would be only those physicians, only those general practitioners who had privileges, who had been appointed to the staff of the hospital, that would be entitled to run the Emergency Department?

A. True.

Q. And each doctor who was in charge of the Emergency Department from time to time was entitled to charge each patient who came into the Emergency Department for whatever services he rendered?

A. Correct.

Q. And this would either take the form of a direct billing to the patient, if the patient did not have insurance under the Ontario Hospital Insurance Plan --

A. Yes --

Q. -- or a billing to the Ontario Hospital Insurance Plan directly?

A. Yes.

Q. And in addition to that the hospital itself was entitled to bill the Ontario Hospital Insurance Plan a certain sum for the care that was provided that particular patient on the emergency visit occasion?

A. Yes.

24 The trial Judge at p. 522 O.R., p. 172 D.L.R., commented:

> 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.
>
> (I do not understand this last observation. Assuming it refers to Dr. Chin, I have seen no evidence that he or any other general practitioner was "taking his turn in the emergency department in order to obtain certain admitting privileges". The evidence is silent on the admitting privileges of general practitioners except for evidence that they cannot admit patients to the I.C.U., but the Regulations obviously contemplate that a general practitioner on staff may admit patients to the hospital.)

25 The trial Judge referred to ss. 17(1) [since rep. & sub. 1972, c. 90, s. 11] and 41 of the Public Hospitals Act. Section 17(1) provides that no public hospital receiving provincial aid and classed in the Regulations as (among others) Group B (Scarborough's category) shall refuse to admit as a patient any person who from sickness ... is in need of active treatment. Section 20 requires hospitals such as Scarborough General to provide such facilities as the Regulations require for ... medical students and interns. Section 21 provides that no person shall be employed as an intern unless registered under the Medical Act, R.S.O. 1970, c. 268 (my emphasis). The relevant parts of s. 41 are:

41(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 out-patient, 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.

26 Counsel for the plaintiffs have emphasized the use of the word "treatment" in ss. 1(f), (h), (l) and (r), 22(1) and (2) [rep. & sub. ibid., s. 13], 33(1) [am. ibid., s. 17(1)] and 37 [am. ibid., s. 19]. The word is defined in s. 1(r) as:

> (r) ... the maintenance, observation, medical care and supervision and skilled nursing care of a patient ...

I do not find the reference helpful in arriving at an answer to the question we face on this appeal. Beyond doubt a patient admitted to a hospital expects to receive not only accommodation, food and competent nursing care but also competent medical care. The question still remains: does the hospital undertake to provide that medical care, or does it undertake to select competent doctors who will provide it?

27 Revised Regulations of Ontario 1970, Reg. 729, was made under the authority of the Public Hospitals Act. It deals at length with the organization, management and administration of hospitals, including authority to pass by-laws for the granting of hospital privileges to doctors appointed to the medical staff. By-laws must be passed by hospital boards providing that the medical advisory committee shall make recommendations to the board of governors concerning the quality of medical care provided in the hospital and shall provide supervision over the practice of medicine in the hospital (s. 6(6)(a)(vii) and (b). Sections 26, 27 [rep. & sub. O. Reg. 100/74, s. 4] and 28 were referred to. They read (in 1970):

> 26. If a member of the active medical staff is unable to perform his duties in the hospital, he shall notify the president or secretary of the medical staff who shall notify the superintendent and arrange for another member of the active medical staff to perform the duties.
>
> 27. When a member of the medical staff who is attending a patient other than a public-ward patient is unable to perform his duties in the hospital, he shall arrange for another member to perform his duties and notify the superintendent.
>
> 28. If the superintendent believes that a member of the medical staff is unable to perform his duties in the hospital, the superintendent shall notify the president or secretary of the medical staff and thereupon the president or secretary, as the case may be, shall arrange for another member of the medical staff to perform the

duties.

28 It will be observed that the substitute or replacement doctor in all three instances dealt with in these sections is arranged for by a member of the medical staff (the president or secretary in ss. 26 and 28, the attending doctor in s. 27). The superintendent or administrator of the hospital is notified but he has no function to perform in arranging for another doctor.

29 Section 37 of Reg. 729 comes closest to prescribing some form of control by the hospital over its medical staff, although its primary purpose appears to be to ensure that proper records are kept for every patient. Section 38 [am. O. Regs. 353/71, s. 2; 100/74, s. 7] supports this view; it enumerates what must be included in a patient's medical record. Section 37 reads:

> 37(1) Within seventy-two hours after the admission of a patient, the board shall cause a medical practitioner to,
>
> (a) write a medical history of the patient;
>
> (b) make a physical examination of the patient and record his findings; and
>
> (c) make and record a provisional diagnosis of the patient's condition.
>
> (2) Within thirty-six hours after the admission of a patient for treatment by a dentist, the board shall cause the attending dentist to,
>
> (a) write a dental history relative to the cause of admission;
>
> (b) make a dental and oral examination of the patient and record his findings;
>
> (c) make and record a provisional diagnosis of the patient's dental condition; and
>
> (d) write a proposed course of dental treatment for the patient.

30 In summary, neither the Public Hospitals Act nor Reg. 729 expressly imposes any statutory responsibility on a public hospital for the negligence of a specialist on its medical staff in his treatment of a patient in the hospital. While neither the Act nor the Regulation imposes upon a

public hospital in express terms an obligation to provide competent medical care to patients admitted to the hospital, both are premised, in my view, on the existence of an obligation to see that such care is provided. Neither furnishes any real assistance, in my view, in answering the crucial question: how does a hospital satisfy that obligation?

31 The trial Judge reviewed at length the decided cases in England and Canada, and one American decision, and then stated these conclusions (pp. 533-5 O.R., pp. 183-4 D.L.R. (the paragraphing is mine)):

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

32 No one questioned conclusions 1 and 2 on the appeal, but they have no relevance save as background. Implicit in conclusion 3 is the determination that the principle of respondeat superior has nothing to do with this case and the liability of the hospital cannot be founded upon the application of the principle. With this conclusion, I agree.

33 The trial Judge has founded liability upon a breach of the hospital's own duty -- not that of an employed doctor, or of a doctor chosen by it to be on its staff, but an independent duty of its own, which is breached if there is a failure by a specialist on its staff to use reasonable skill and competence in the treatment of a patient in the hospital under his care. I agree that unless there exists in law a "non-delegable duty of care" owed by the hospital to the patient, the hospital is not liable in this case.

34 No Court in Canada has ever found before that such a duty exists, and with great respect to the trial Judge, I am not persuaded by his reasons that there is such a duty. I am not dismissing those reasons perfunctorily, nor intending to denigrate them, when I say that he seems to me to be saying, in substance, "In all the circumstances, the hospital ought to be liable." In my view, if the criterion is to be what is fair and reasonable, it would be fair and reasonable that the highly-skilled doctor whose negligence caused the damage should be called upon to pay for it. As the trial Judge did, I must put out of my mind that the plaintiffs chose not to sue him.

35 I agree with the trial Judge (and have said this earlier in my reasons) that the Yepremians had every right to expect that a large public hospital like Scarborough General would provide whatever

was required to treat seriously ill or injured people, but I do not think it follows that the public is entitled to add the further expectation: "and if any doctor on the medical staff makes a negligent mistake, the hospital will pay for it".

36 Rather, I think, a member of the public who knows the facts is entitled to expect that the hospital has picked its medical staff with great care, has checked out the credentials of every applicant, has caused the existing staff to make a recommendation in every individual case, makes no appointment for longer than one year at a time, and reviews the performance of its staff at regular intervals. Putting it in layman's language, a prospective patient or his family who knew none of the facts, would think: "If I go to Scarborough General, I'll get a good doctor."

37 The background facts of this case, including the absence of any choice by the Yepremians as to the doctor in emergency or as to the internist called in, are quite consistent with my statement of what they could reasonably expect to be available. There being no finding that Dr. Rosen was unqualified or incompetent, nor that there was anything other than careful consideration and good judgment on the part of the hospital before appointing him to the staff, the hospital fully discharged its obligation to provide competent internal medicine services to Tony Yepremian following his admission to the hospital.

38 Apart from his view of the obligation of the hospital, based on the Public Hospitals Act "and as a matter of common sense", to provide service to the public, the trial Judge refers only to the hospital "having the opportunity of controlling the quality of medical service". I do not know upon what evidence he bases this view, if it is intended to reflect some ongoing supervision by the hospital of the quality of medical service after a doctor is appointed to the medical staff. There is some evidence that if a member of the medical staff appears to be neglecting his patient, in the sense of not seeing the patient as often as expected, or at all, a nurse may report this to the superintendent, who would doubtless communicate with the doctor, the chief of the service, or the chief of staff. But a nurse, or a superintendent for that matter, who suggested that some different medical treatment from that being followed by a staff specialist might be preferable would be going beyond any hospital practice established by the evidence. Specialists would, I think, find it impossible to carry on under such a practice.

39 I make the same comment with respect to the statement of the trial Judge that the doctor (on specialist staff) surrenders "some independence by reason of the control that may be exercised over him by the hospital". I suggest that any control over a staff specialist that affects his independence is exercised by his peers (including the chief of the service and the chief of staff) and not by the hospital.

40 I turn now to the decided cases to see whether the view I have expressed as to the liability of the hospital is consistent with them. In doing so, I make these general comments:

(1) Great care must be exercised in considering the English cases. The interrelationships of the State, the medical profession, the hospitals and their patients have developed along

different lines from those in Ontario. This note of caution was injected by Aylesworth, J.A., in Aynsley et al. v. Toronto General Hospital et al., [1969] 2 O.R. 829 at p. 844, 7 D.L.R. (3d) 193 at p. 208; affirmed [1972] S.C.R. 435 sub nom. Trustees of Toronto General Hospital v. Matthews et al., 25 D.L.R. (3d) 241, where he said that "[T]he introduction into England of nationalized medicine probably has greatly altered the factual situation in that country ...".

(2) No assistance, except perhaps some negative inference, is to be gained for this case by those decisions that have found the negligent doctor (or nurse) to be an employee of the hospital. Those are true respondeat superior cases, and have no application here. This class of case includes Fleming v. Sisters of St. Joseph of Diocese of London, [1937] O.R. 512, [1937] 2 D.L.R. 121; affirmed [1938] S.C.R. 172, [1938] 2 D.L.R. 417 (nurse); Gold v. Essex County Council, [1942] 2 K.B. 293 (radiographer); Cassidy v. Ministry of Health, [1951] 2 K.B. 343 (two surgeons, both full-time employees of the hospital); Roe v. Minister of Health et al.; Woolley v. Minister of Health et al., [1954] 2 Q.B. 66 (anaesthetist), on which I must comment further; Vancouver General Hospital v. Fraser, [1952] 2 S.C.R. 36, [1952] 3 D.L.R. 785 (intern), and Martel v. Hotel-Dieu St-Vallier; Vigneault v. Martel, [1969] S.C.R. 745, 14 D.L.R. (3d) 445 (anaesthetist).

41 The trial Judge in his enunciation of category 3 states that "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". I examine next the cases binding on this Court to see what is the object of the consideration of "all the circumstances of the case". I do not propose to add my commentary upon the controversial and much-discussed judgment of Kennedy, L.J., in Hillyer v. Governors of St. Bartholomew's Hospital, [1909] 2 K.B. 820 at p. 829, to the scores of pages devoted to it by English and Canadian Judges and learned authors. The discussion of Hillyer's case by Davis, J., in Sisters of St. Joseph of Diocese of London v. Fleming, supra, and by Aylesworth, J.A., in Aynsley v. Toronto General Hospital, supra, is a convenient new starting-point in Canada.

42 In the Sisters of St. Joseph's case, Davis, J., after discussing many of the English and Canadian cases, said at pp. 190-1 S.C.R., p. 433 D.L.R.:

> After the most anxious consideration we have concluded that, however useful the rule stated by Lord Justice Kennedy may be in some circumstances as an element to be considered, it is a safer practice, in order to determine the character of a nurse's employment at the time of a negligent act, to focus attention upon the question whether or not in point of fact the nurse during the period of time in which she was engaged on the particular work in which the negligent act occurred was acting as an agent or servant of the hospital within the ordinary scope of her employment or was at that time outside the direction and control of the hospital and had in fact for the time being passed under the direction and control of a surgeon or physician, or even of the patient himself. It is better, we think, to approach the solution of the problem in each case by applying primarily

> the test of the relation of master and servant or of principal and agent to the particular work in which the nurse was engaged at the moment when the act of negligence occurred.

43 Two things distinguish the Aynsley case from the case at bar. First, in that case Dr. Porteous, the junior anaesthetist whose negligence was relied on as bringing liability on the hospital, was an employee of the hospital; second, the acts of negligence occurred in the operating room. Aylesworth, J.A., reviewed Sisters of St. Joseph and many of the English cases, and at pp. 844-5 O.R., pp. 208-9 D.L.R., said, in a passage approved by the Supreme Court of Canada, at pp. 439-40 S.C.R., pp. 844-5 D.L.R. (with emphasis added by Hall, J., to the last three lines):

> "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 inquiries 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."

44 I observe that what Aylesworth, J.A., said depended upon the particular facts of the case was "the liability of a hospital for the negligent acts or omissions of an employee vis-a-vis a patient". There was an express finding by Aylesworth, J.A., that "the hospital undertook to furnish to the patient as part of the hospital service an operating theatre, the required equipment in good order and the services free from negligence of a properly qualified assistant to the patient's anaesthetist" (p. 845 O.R., p. 209 D.L.R. [emphasis added]). Later, on the same page, he said: "The negligence of Dr. Porteous, in my view, was a failure by the hospital staff itself to discharge efficiently its undertaking to the patient ...".

45 Three cases in the Supreme Court of Canada require consideration. I have already mentioned Martel v. Hotel-Dieu St-Vallier; Vigneault v. Martel, [1969] S.C.R. 745, 14 D.L.R. (3d) 445, as an example of the application of what the common law calls respondeat superior. There the hospital

was fixed with liability by reason of the negligence of an anaesthetist, described by Pigeon, J., for the Court, as a "resident physician". A majority of the Quebec Court of Appeal [[1968] Que. Q.B. 389] had allowed the hospital's appeal on the ground that the anaesthetist could not be considered an employee of the hospital. The Supreme Court of Canada held that "the ordinary rule respecting the employee relationship" applied to doctors, that the anaesthetist was the salaried employee of the hospital, and at the relevant time "anaesthesia services were services supplied by the hospital and did not constitute a separate undertaking" (p. 752 S.C.R., p. 450 D.L.R.). Hence the hospital's employee had been negligent in the carrying out of the hospital's contract with the patient to provide him with anaesthesia services, and the hospital was liable as well as the doctor.

46 Villemure v. l'Hopital Notre-Dame et al., [1973] S.C.R. 716, 31 D.L.R. (3d) 454, was also an appeal from Quebec. There the plaintiff's husband fell to his death from a window of a semi- private room after being transferred by order of a psychiatrist. The Supreme Court of Canada in a 3-2 decision reversed the majority decision of the Court of Appeal of Quebec [[1970] Que. C.A. 538], and restored the trial judgment against the hospital and the psychiatrist. Pigeon, J., dissented, but in his judgment in Hopital Notre-Dame de l'Esperance v. Laurent et al., [1978] 1 S.C.R. 605, 3 C.C.L.T. 109, 17 N.R. 593, with which the other four members of the Court agreed, he said [at p. 613] that the dissenting judgment of Choquette, J.A., in the Court of Appeal in Villemure, which was adopted in toto by the majority of the Supreme Court, had been based on Martel, supra, which (Pigeon, J., said) was still the law and that the "very basis of the decision in Martel [was] that it is by the ordinary rules applicable to all workers generally that, in each particular case, it is to be decided whether a doctor acted as an employee of a hospital".

47 In Villemure the trial Judge had held that the hospital was not liable for the acts of omission or commission of Dr. Turcot (which consisted of transferring the patient from the window-barred psychiatric wing to a semi-private room in an ordinary wing) but was liable for the negligence of its nurses. Dr. Turcot was not the patient's psychiatrist, but he was an assistant to the chief of psychiatry, who was absent on the day in question. While saying he saw no reason to interfere with the trial Court's decision (at p. 540) Choquette, J.A., observed that the evident object of the family physician and of the patient's wife was to secure hospitalization for the plaintiff, and not to provide Dr. Turcot with a private patient; they did not know him. He then stated that in his function and its implications, Dr. Turcot acted as the '"prepose" of the hospital, especially with respect to a patient admitted to the public section of the psychiatry service.

48 I take this to mean that Choquette, J.A., was of the view that the doctor was acting on behalf of the hospital in deciding where the patient was to be given a bed.

49 The latest case in the Supreme Court is Hopital Notre-Dame de l'Esperance, supra. There the hospital was held liable for the negligence of a surgeon on duty in the emergency room. The female plaintiff had fallen while curling. The surgeon, Dr. Theoret, was one of five doctors in the emergency room from 2:00 p.m. to 6:00 p.m. Monday to Friday. His attendance was not a condition of being "attached to the hospital". Without ordering an X-ray, Dr. Theoret diagnosed Mrs.

Laurent's problem as a simple contusion. He had a sedative (Demerol) administered by injection, prescribed an analgesic, and told her to call him in a few days to let him know how she was progressing. When she telephoned him a week later, he simply renewed the prescription. Three months later another surgeon diagnosed her problem as a fracture of the neck of the femur.

50 The hospital and the surgeon were both held liable at trial. Contributory negligence by reason of the delay in seeking other treatment was found against the plaintiffs. The Court of Appeal of Quebec, [1974] Que. C.A. 543, affirmed the judgment (with an immaterial deduction); they said they were following Martel, but went on to say that it made no difference that the doctor in Martel was a salaried employee and Dr. Theoret was not. Mayrand, J.A., appears to have regarded Martel as authority for the proposition that the hospital was committed to provide medical treatment to its patients, and the staff physicians were its agents to do so (p. 546). He went on to hold that even if the doctor was not the agent of the hospital, the hospital was liable for the faulty execution of its own contractual obligation to the patient. He referred to the confusion resulting from evolving jurisprudence and from a contract between the hospital and the patient whose terms lay in tacitly expressed intentions. (I have not used any quotation marks as I have been relying on an unofficial translation.)

51 In his concurring judgment, Gagnon, J.A., said there was an analogy between the undertaking of the hospital in Martel to provide anaesthesia services and the provision by the hospital in the case before him of emergency services (p. 551). He said the emergency room made available to the public was also a hospital service. He too described the status of Dr. Theoret as that of prepose of the hospital. The doctor was the dispenser of services which the hospital had undertaken to provide. It made no difference that he was a specialist.

52 Dube, J.A., agreed with Mayrand, J.A., save that he would not have found any part of the damages to be attributable to the fault of the plaintiffs.

53 All five Judges of the Supreme Court of Canada agreed that the judgment against the hospital could not be supported. The case was argued on the basis that Dr. Theoret was negligent. Pigeon, J., writing the judgment of the Court, said (at pp. 610-1 S.C.R.) that it was apparent that the negligence which caused the damage was not limited to the failure to make the initial correct diagnosis but included the failure to appreciate the need to see Mme Laurent again, to obtain an X-ray, and to make a more thorough examination as the pain continued. Pigeon, J., said he could not see how the hospital could be responsible for the faults subsequent to the original diagnosis. (Of course Mme Laurent was in the hospital only on the first attendance.)

54 As to the initial fault, the Court said the judgment against the hospital appeared to be without foundation. Pigeon, J., said at p. 611:

> It [the hospital's liability] would have to be based on the last paragraph of art. 1054 C.C.:

> "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."

This law is not peculiar to the Civil Code of Quebec. It is a precise statement of the common law doctrine of respondeat superior: see, for example, Smith, A Treatise on the Law of Master and Servant, 8th ed. (1931) at pp. 222-4, and the case note, "Liability of a Hospital for the Negligent Acts of Professionals--A Comment on Hopital Notre-Dame de l'Esperance v. Laurent" by Professor Magnet, 3 C.C.L.T. 135 (1977-78).

55 Pigeon, J., continued at pp. 611-4:

> 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. Accordingly, the legal situation was not the same as in Martel v. Hotel-Dieu St-Valier.
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> As Rinfret J. said in Moreau v. Labelle, [1933] S.C.R. 201 (at p. 206): [TRANSLATION] "Each case in this area must thus be decided on its own facts." As he pointed out in Grimaldi v. Restaldi, [1933] S.C.R. 489 (at p. 491):
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> [TRANSLATION] "It (this contention) undoubtedly raises a mixed question of fact and of law, but the solution depends essentially on a proper appreciation of the special circumstances of the case under review." In Martel, this Court unanimously rejected (at p. 752) the theory according to which [TRANSLATION] "the application to doctors of the ordinary rule regarding the master and servant relationship is irreconcilable with a proper concept of the responsibility in question". The hospital was found liable for the damage, but only after it had been noted (at p. 752) that:
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> (1) [TRANSLATION] "The plaintiff had no say in the choice of his anesthetist. The latter was selected by the director of the hospital's anesthesia department."

(2) "The anesthesia department was at that time a department of the hospital and not a separate undertaking."

(3) "The anesthetist in question provided his care as he was obliged to by his contract of employment with the hospital and as did the other members of the staff: radiologists, laboratory technicians, nurses, orderlies and so on."

In Villemure v. Turcot et al., [1973] S.C.R. 716, where the majority adopted the dissenting opinion of Choquette J.A. in the Court of Appeal, [1970] C.A. 538, the latter based his reasoning on Martel and considered that despite any differences there might be in the facts, the conclusion should be the same. I do not think that from this, it should now be concluded that the majority, in endorsing this opinion, rejected the very basis of the decision in Martel, that it is by the ordinary rules applicable to all workers generally that, in each particular case, it is to be decided whether a doctor acted as an employee of a hospital.

. . . . .

The hospital contract is not to be interpreted a priori, but by considering the legal effect of the relations established between the parties. The Court is not called upon in the case at bar to determine the legal status of the emergency room, any more than that of the operating room. It only has to decide whether, in the circumstances, Dr. Theoret was acting as an employee of the hospital when he treated Dame Laurent. As we have seen, the evidence on this point is unequivocal: it was as a physician acting on his own account that the doctor received this patient and undertook to treat her, also telling her to get in touch with him after a certain length of time. On the same day an entirely different legal situation may well have arisen in other hospitals. In fact, on the basis of what one witness said of the operation of another emergency department at the time, it is quite possible that a different conclusion would be reached in its case. In the case at bar, the medical care was given to Dame Laurent under a contract, not with the hospital, but with Dr. Theoret. Since it was noted in Curley v. Latreille [(1920), 60 S.C.R. 131] that the Quebec rule is identical on this point to the common law, I will take the liberty of quoting the following statement of Aylesworth J.A. of the Ontario Court of Appeal, cited by Hall J. in The Trustees of the Toronto General Hospital v. Matthews, [1972] S.C.R. 435, (at p. 439):

"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 Laurent case was criticized by Professor J.E. Magnet in the case note already referred to (3 C.C.L.T. 135) on the ground that it dealt too superficially with the contractual obligations of the hospital to the patient, but Professor Magnet leaves no doubt as to what the case actually decided. His view of the ratio decidendi accords with my own.

56 The Laurent case is in some respects a clearer situation than we have in the Yepremian case, particularly because Tony was never in a position to "engage" any doctor. Nevertheless I take the Laurent case as deciding that the basic inquiry, in Quebec and in the common law Provinces, is whether the negligent doctor was an employee of the hospital at the time of his negligent treatment. It is found here, and on undisputed evidence, that Dr. Rosen was not an employee of the hospital. Since I find no support, either in the case-law or in the facts of this case, for the proposition that Scarborough General Hospital assumed or had imposed upon it a "non-delegable duty of care" to patients admitted for medical treatment, I am of the opinion that the hospital is not liable for the damages suffered by Tony Yepremian through the negligence of Dr. Rosen.

57 I close this portion of these reasons with certain comments on the law. Some of the cases, it will have been noticed, use the expression "master and servant or principal and agent". [Emphasis added.] If there came into existence a non-delegable duty of care, it does not matter whether the negligent doctor was an employee or an agent. It is equally immaterial if the hospital assumed a contractual obligation to provide non-negligent medical services of a specialist in internal medicine. But care must be taken not to imply such a contractual obligation simply because the medical treatment was carried out by someone authorized by the hospital to treat patients admitted to the hospital.

58 I indicated earlier that I wished to comment on Roe v. Minister of Health et al., [1954] 2 Q.B. 66. This was the third of three cases in which the present Lord Denning, M.R., played a prominent role. In Gold v. Essex County Council, [1942] 2 K.B. 293, he was counsel in the Court of Appeal for the successful plaintiff. The local authority carrying on a public hospital was held liable for the negligence of a radiographer in the hospital's employ. He treated the plaintiff for warts by Grenz rays. The Court of Appeal (Lord Greene, M.R., MacKinnon and Goddard, L.JJ.) accepted Mr. Denning's argument that Hillyer v. Governors of St. Bartholomew's Hospital, [1909] 2 K.B. 820, should be re-examined, that some of the dicta of Kennedy, L.J., therein should not be followed and that the judgment of Farwell, L.J., was to be preferred. Lord Greene said at p. 302 that "[s]o far as consulting physicians and surgeons are concerned, clearly the nature of their work and the relationship in which they stand to the defendants [the hospital authority] precludes the drawing of an inference that the defendants undertake responsibility for their negligent acts".

59 MacKinnon, L.J., said that under ordinary principles of master and servant, the hospital would

be liable for the negligence of the radiographer, unless the latter was only doing what he was told to do by Dr. Burrows, the "visiting dermatologist", in which case the plaintiff could only recover if Dr. Burrows was the servant of the hospital (pp. 304-5). Goddard, L.J., said (at p. 310) that "visiting surgeons and physicians are not the servants of the hospital governors", and that no one would question the decision in Hillyer's case that the hospital was not liable for acts of the surgeon. He too preferred the judgment of Farwell, L.J., to that of Kennedy, L.J. At p. 313 Goddard, L.J., said that the reason hospitals were "not liable for the doctor's negligence is due simply and solely to the fact that he is not their servant".

60 By the time Cassidy v. Ministry of Health, [1951] 2 K.B. 343, reached the Court of Appeal, Mr. Denning, K.C., had become Denning, L.J. The plaintiff sued the Ministry (as successor to the operators of a hospital) seeking to hold the hospital liable for the negligence of a Dr. Fahrni, a surgeon, described as "a whole-time assistant medical officer of the hospital", or for the negligence of the house surgeon, or of the nursing staff. The Gold case was relied on by the defence with respect to the alleged negligence of the doctors; it was obviously relevant, because of the passages I have quoted. Denning, L.J., expressed views considerably at variance with those enunciated in Gold, and blamed himself (qua counsel) for not having brought to the attention of the Court in Gold the propositions he was now advancing (p. 363). Somervell, L.J., put the case on the basis that the two doctors concerned were "employed, like the nurses as part of the permanent staff of the hospital" (p. 351), while holding that if a patient is treated by a "visiting or consulting surgeon or physician" he is treated by someone who is not a servant of the hospital. Singleton, L.J., took the view that the negligence alleged was in the post-operational treatment, and those responsible for it "were all full-time employees of the corporation" (p. 355) and that "if the plaintiff's injury was caused by negligence on the part of anyone employed by the corporation in relation to the post-operational treatment of the plaintiff, responsibility falls in the first instance upon the corporation, the employers" (p. 358).

61 Denning, L.J., went well beyond these views, as is illustrated by these passages at p. 360:

> 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:
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> 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.

At pp. 362-5 Denning, L.J., set out to show that the distinction between a contract of service and a contract for services was artificial in hospital cases (it had been expressly made by Goddard, L.J., in Gold), and concluded at p. 365:

> Turning now to the facts in this case, this is the position: the hospital authorities accepted the plaintiff as a patient for treatment, and it was their duty to treat him with reasonable care. They selected, employed, and paid all the surgeons and nurses who looked after him. He had no say in their selection at all. If those surgeons and nurses did not treat him with proper care and skill, then the hospital authorities must answer for it, for it means that they themselves did not perform their duty to him. I decline to enter into the question whether any of the surgeons were employed only under a contract for services, as distinct from a contract of service. The evidence is meagre enough in all conscience on that point. But the liability of the hospital authorities should not, and does not, depend on nice considerations of that sort. The plaintiff knew nothing of the terms on which they employed their staff: all he knew was that he was treated in the hospital by people whom the hospital authorities appointed; and the hospital authorities must be answerable for the way in which he was treated.

62 Two years later the Court of Appeal decided Roe v. Minister of Health et al.; Woolley v. Minister of Health et al., [1954] 2 Q.B. 66. There the injury to the two plaintiff workmen was caused by the injection of a spinal anaesthetic stored in vials in a solution of phenol. Phenol

percolated through invisible cracks or flaws in the vials and caused permanent paraplegia. The hospital and the anaesthetist were sued. In the end, the actions failed because what had occurred was not foreseeable in 1947, when the events occurred.

63 However, McNair, J., at trial had discussed the liability of the hospital for the negligence of the anaesthetist, and had followed the judgment of Lord Greene, M.R., in Gold's case, which, he said, had been the same basis as that upon which Somervell and Singleton, L.JJ., had proceeded in Cassidy's case. He then added (at p. 69):

> No useful purpose would be served by my expressing my own views upon the judgment of Denning L.J. in the latter case, which states the hospital's obligation in much wider terms, except to say that there is in my judgment much force in the criticism directed by Mr. Berryman against Denning L.J.'s reading of the decision in Mersey Docks and Harbour Board v. Coggins and Griffiths (Liverpool) Ld. which apparently forms the basis of this judgment.

(Mr. Berryman was leading counsel for the Minister of Health.)

64 The arrangements between Dr. Graham (the anaesthetist) and the hospital are quoted by Somervell, L.J., from the trial judgment, at p. 79; he then expressed his view on the legal position:

> "In October, 1946, he was with Dr. Pooler, who had taken his diploma of anaesthesia some years earlier, appointed as a visiting anaesthetist to the hospital. He and Dr. Pooler between them were under obligation to provide a regular anaesthetic service for the hospital, it being left to him to decide how to divide up the work. In fact, apart from emergencies, they worked at the hospital on alternate days. 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 as the participants might decide. Dr. Graham participated in this fund but otherwise received no remuneration from the hospital. He was at all times allowed to continue his private anaesthetic practice."

> The judge referred to Gold v. Essex County Council and Cassidy v. Ministry of Health. He assimilated Dr. Pooler and Dr. Graham to the "consulting physicians and surgeons" referred to by Lord Greene in Gold's case. The line suggested in that case and in Cassidy's case in the judgments of Singleton L.J. and myself may not be a very satisfactory one, but I would have regarded Dr. Pooler and Dr. Graham as part of the permanent staff and, therefore, in the same position as the orthopaedic surgeon in Cassidy's case. Like him they are, of course, qualified, skilled men, controlling as such their own methods. The positions of surgeons and others under the National Health Service Act, 1946,

> will have to be decided when it arises. The position of hospitals under that Act may or may not be different from when they were voluntary or municipal hospitals.

Denning, L.J., described Dr. Graham as a "visiting anaesthetist". On the legal issue of hospital responsibility, he was content to repeat the broad sweep of his judgment in Cassidy, saying at p. 82:

> ... 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. I went into the matter with some care in Cassidy v. Ministry of Health and I adhere to all I there said.

There may well be some question whether this has been accepted as being the law of England (see Speller's Law Relating to Hospitals and Kindred Institutions, 6th ed. (1978) at p. 254) and, in the light of our Supreme Court of Canada decisions, it is certainly not the law of Canada.

65 The third judgment in Roe was that of Morris, L.J. He quoted extensively from the judgment of Lord Greene, M.R., in Gold's case, and said the inference drawn in that case that the hospital had undertaken to give the Grenz ray treatments by the hand of a competent radiographer was a natural and reasonable one to be drawn "from the way in which those running the hospital conducted their affairs and from the nature of the engagement of the radiographer" (p. 90). He then said at pp. 90-1:

> If a patient in 1947 entered a voluntary hospital for an operation it might be that if the operation was to be performed by a visiting surgeon the hospital would not undertake, so far as concerned the actual surgery itself, to do more than to make the necessary arrangements to secure the services of a skilled and competent surgeon. The facts and features of each particular case would require investigation. But a hospital might in any event have undertaken to provide all the necessary facilities and equipment for the operation and the obligation of nursing and also the obligation of anaesthetizing a patient for his operation. The question in the present case is whether the hospital undertook these obligations. In my judgment they did. There can be no doubt that they undertook to nurse the plaintiffs and to provide the necessary facilities and equipment for the operations. I think they 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 as were the defendants in Gold v. Essex County Council for the negligence of the radiographer or as were the defendants in Cassidy v. Ministry of Health.

66 I refer back to my note of caution in applying the English cases. What, in the Canadian context, constitutes the "permanent staff"? What did Morris, L.J., mean by "members of the 'organization' of the hospital"? As long ago as 1966, Professor Allen Linden (now Linden, J.) considered whether the English authorities should be adopted in Canada, in the light of "different attitudes and practices" in Canada, and suggested that because of such differences, the reception of "the English rule" might not be justified: see "Changing Patterns of Hospital Liability in Canada", 5 Alta. L. Rev. 212 at p. 217 (1966-67). Clerk & Lindsell on Torts, 14th ed. (1975) [at p. 131], in discussing the modern tendency in England to treat the question of the hospital's liability as raising questions of primary as well as vicarious liability, refers to the duty imposed upon the Minister of Health by s. 3 of the National Health Service Act, 1946 to provide "medical, nursing or other services required at or for the purposes of hospitals" and "the services of specialists". No similar duty has been imposed upon Ontario hospitals by the Public Hospitals Act, with respect to the services of specialists or other medical practitioners.

67 The Government exercises a substantial degree of control over public hospitals, through Regulations and especially through the hospitals' finances. If liability is to be imposed upon hospitals for the negligence of its medical staff, including specialists, not employed by the hospitals, whether directly or by imposing a statutory duty to provide such services, it should be the function of the Legislature, as a policy question, to decide whether and under what conditions such liability is to attach.

68 I would accordingly allow the appeal of the hospital and dismiss the action against it, but without costs.

The liability of Dr. Goldbach

69 As I have stated, the trial Judge held that Dr. Goldbach, although he was negligent in his failure to diagnose Tony's diabetic condition on October 12, 1970, was "insulated from liability" by the subsequent negligence of Dr. Rosen, which negligence the trial Judge held to be the effective cause of the cardiac arrest which, in turn, resulted in Tony's brain damage.

70 I agree with the trial Judge's conclusion on this issue. He found that the effective cause of the cardiac arrest was the negligent treatment of Tony's diabetes after it was diagnosed at 12:30 p.m. on October 13th. The evidence amply supports this finding and does not reasonably support any additional finding that the earlier negligence of Dr. Goldbach was a contributing cause of the cardiac arrest.

71 The probable cause of the cardiac arrest, according to Dr. Steele and Dr. Gorman (both of whom were called as witnesses by the plaintiffs), was the way Dr. Rosen treated the diabetes after it had been diagnosed. This treatment resulted in Tony's serum potassium level reaching a dangerously low level and the blood sugar level also being too low. (There was an issue at trial whether the administration, by Dr. Rosen, of sodium bicarbonate at 10:00 a.m. on October 13th, before the diagnosis of diabetes, was a factor causing the cardiac arrest. This will be dealt with later in these reasons.)

72 If the cardiac arrest which occurred was part of the natural consequences of untreated diabetes, or even of ineffectively- treated diabetes, then I do not think that the negligence of Dr. Rosen would have prevented Dr. Goldbach's negligence from resulting in his liability. In such circumstances Dr. Goldbach could not rely on Dr. Rosen's failure to rescue Tony from the consequences of Dr. Goldbach's negligence as an exculpatory circumstance. However, the negligence of Dr. Rosen was not of this nature. The evidence was that at 12:30 p.m. on October 13th, if proper treatment had been given, Tony would not have suffered the cardiac arrest and that the treatment which was given, although bringing Tony's dangerously high blood sugar down to acceptable levels and correcting his acidotic condition arising from the diabetes, actively caused the irritation to the heart which resulted in the cardiac arrest.

73 Thus the possible effects of Dr. Goldbach's negligence had no causal relationship with the cardiac arrest. It was not a result of an untreated condition, or a merely ineffectively treated one, but rather the negligent infliction of treatment. This being the case, there is no reason to consider the issues of the foreseeability by Dr. Goldbach of, or the intervening cause aspects of, Dr. Rosen's conduct, since such issues do not arise if Dr. Goldbach's negligence is not a cause in fact of the cardiac arrest: Prosser, Handbook of The Law of Torts, 4th ed. (1971) at p. 270.

74 The cross-appellants have submitted that there is a causal connection between Dr. Goldbach's negligent diagnosis and the negligent treatment by Dr. Rosen in that the misdiagnosis increased the risk of making Tony more susceptible to improper treatment. On the evidence in this case is is very difficult to find that Dr. Rosen was in any way influenced in the way he treated Tony by the earlier diagnosis of Dr. Goldbach. On the contrary it appears more probable that he was not so influenced.

Dr. Chin, who saw Tony in the emergency department when he first arrived at the hospital and who reported to Dr. Rosen, specifically said that he was not misled by what Tony's family had informed him as to the treatment prescribed by "the family doctor" (Dr. Goldbach).

75 The evidence of Dr. Steele, Dr. W.T.W. Clarke (who was called as a witness by Dr. Goldbach) and Dr. Gorman is to the effect that if the treatment had been administered properly after 12:30 p.m. (Dr. Steele and Dr. Clarke) and even 2:10 p.m. (Dr. Gorman) Tony would not have suffered the cardiac arrest.

76 The submission has been made that Dr. Goldbach's failure to diagnose diabetes was a cause of part of the improper treatment administered by Dr. Rosen which, in turn, resulted in the cardiac arrest. Reference is specifically made to the administration by Dr. Rosen at 10:00 a.m. on October 13th of 500 c.c.s of sodium bicarbonate and to evidence that this in itself would have had the effect of lowering the potassium level, in addition to the effects of the administration of insulin later that day.

77 The difficulty with this submission is that there is a general finding of the trial Judge against it -- "[i]n 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" -- and the evidence on the point is such that it cannot be said that the trial Judge clearly erred in this finding [at p. 519 O.R., p. 169 D.L.R.].

78 Dr. Rosen in his evidence did say that if he had known from Dr. Chin around 1:00 a.m. on October 13th that Tony was suffering from diabetes he "would have gone in and started active treatment at that time for diabetes". While Dr. Rosen appeared to be of the view that this probably would have averted the cardiac arrest, the preponderance of the evidence, accepted by the trial Judge, is that the active treatment which he did administer resulted in the cardiac arrest and it is not clear that he would not also have administered sodium bicarbonate in the amount that he did for Tony's acidotic condition. (Dr. Rosen was not questioned specifically on this.) Dr. Clarke said that the amount of sodium bicarbonate which was administered at 10:00 a.m. was excessive, although some quantity of it was not necessarily wrong. It is not clear that Dr. Rosen would have shared this view. In his evidence he said that he thought that the danger of hypokalemia (reduced potassium level) was overrated. Accordingly it cannot be concluded that the trial Judge erred in finding that Dr. Rosen was not affected by the failure of Dr. Goldbach to diagnose diabetes.

79 I would accordingly dismiss the cross-appeal against Dr. Goldbach, but since he made the first negligent diagnosis, the dismissal should be without costs.

Damages

80 I have had the benefit of reading the reasons of Morden, J.A., on this aspect of the case, raised by the plaintiffs' cross-appeal. I am in complete agreement with his reasons and have nothing to add.

Conclusion

81 The appeal of Scarborough General Hospital should be allowed and the action against it dismissed, both without costs. The cross-appeal of the plaintiffs against Dr. Goldbach should be dismissed, without costs.

82 MORDEN, J.A.:-- I agree with the conclusions, and the reasons therefor, of my brother Arnup relating to the hospital's appeal and to the plaintiffs' cross-appeal respecting Dr. Goldbach.

83 As Arnup, J.A., has said, the plaintiffs cross-appeal, and the defendant Dr. Goldbach, contingently, cross-appeals, against the award of damages. Notwithstanding the disposition which I would make with respect to the issue of liability, it is still necessary to consider, and express an opinion upon, the subject of damages.

84 The learned trial Judge assessed special damages at $4,085 for hospital and medical expenses (this was uncontested) and at $55,507.11 for loss of income to the date of the judgment. He assessed non-pecuniary general damages at $75,000. The present value of Tony's future loss of income was assessed at $250,790, using a discount rate of 3% per annum. The amount of $4,880 was awarded to cover the care provided by Tony's mother for a period of eight months, calculated on the basis of $20 a day. This could well have been treated as part of the special damages. The trial Judge refused to award an amount for the cost of future care.

85 The total award was, then, $390,262.11. Interest was awarded at 8.25% from January 19, 1978, to the date of judgment under s. 38 of the Judicature Act, R.S.O. 1970, c. 228, as re-enacted by 1977, c. 51, s. 3(1).

86 In their appeal the plaintiffs submit that the trial Judge erred: (1) in refusing to make an award for the cost of care for the full period to the date of judgment and for the future, (2) in using a discount rate of 3% instead of 0.7%, or lower, (3) in deducting a contingency factor of 15% in arriving at the award for loss of future income, and (4) in not allowing interest at the rate of 10% on the sum awarded in respect of loss of future income from the date of judgment, in accordance with the decision of this Court in Fenn et al. v. City of Peterborough et al. (1979), 25 O.R. (2d) 399 at pp. 459-63, 104 D.L.R. (3d) 174 at pp. 234-8, 9 C.C.L.T. 1. This latter claim is conceded by the defendant hospital.

87 Mr. Laidlaw, on behalf of Dr. Goldbach, made no submissions in support of the cross-appeal, and, in effect, abandoned it, but resisted the plaintiffs' appeal on damages. It is not necessary, therefore, to consider the grounds set forth in the cross-appeal.

88 I turn now to those grounds of appeal that are in dispute.

1. The cost of care -- past and future

89 Tony suffered serious brain damage as a result of the negligence found in this case. Its immediate effects are described in the trial Judge's reasons which have been quoted by Arnup, J.A. As I have said, $4,085 was awarded for the claim for Tony's mother's care of him, probably for the eight months following his return from the hospital. This would cover the period from about January 1, 1971 to August 31, 1971. No further amount was allowed for care. The following are the trial Judge's reasons (20 O.R. (2d) 510 at pp. 538-9, 88 D.L.R. (3d) 161 at pp. 188-9, 6 C.C.L.T. 81):

> 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.
>
> . . . . .
>
> 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 to 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.

90 The uncontroverted evidence makes it clear that Tony, to quote from that given by Dr. J.J. Goldsmith, a psychologist who examined him in 1975, "will never be able to be an independently functioning member of the community ...". He went on to say that "he needs to be under what I would regard as modified institutional care ...". Dr. John G. Humphrey, who gave Tony a neurological assessment in late 1973, reported that "[i]t seems likely that he will continue to require a protective home situation and this, of course, is all the more important for him because of the care and concern that must be taken for control of his diabetes as well".

91 Tony cannot be left alone for any significant period. While he can check his own urine, his family does it more often and his family give him his insulin shots. Because of his poor memory he can eat one meal very soon after another, which is bad for his diabetic condition. He has to be kept from food that could harm him. He has to be watched. To this extent, he requires constant care.

92 While it is a matter of degree, it appears to be reasonably clear that the necessary demands resulting from Tony's condition impose a substantial burden of supervision on his family, which burden has fallen, for the most part, on his mother. She testified that she was at home all the time and had "sacrificed all my life for my son". With respect, I do not think that the demands can properly be characterized as "minor" even if they are substantially less than they were during the first eight months following Tony's return from the hospital. If the mother did not meet them when Tony is at home then help in the form of something akin to a paid baby-sitter would have to be obtained. Tony's entitlement to recover for the reasonable cost of such care cannot be denied because the necessary care and assistance has been provided by a member of his immediate family: Teno et al. v. Arnold et al. (1976), 11 O.R. (2d) 585 at p. 597, 67 D.L.R. (3d) 9 at p. 21 [varied [1978] 2 S.C.R. 287, 83 D.L.R. (3d) 609, 3 C.C.L.T. 272]; Hasson et al. v. Hamel (1977), 16 O.R. (2d) 517, 78 D.L.R. (3d) 573; and Richards v. B & B Moving & Storage Ltd. et al., Ont. C.A., September 8, 1978 [summarized [1978] 3 A.C.W.S. 113].

93 A reasonable amount, in my view, to compensate for this part of the plaintiffs' claim would be $200 a month. Accepting that the plaintiffs have already been compensated in this regard for the first eight months of 1971, these amounts should run from September 1, 1971, to the date of judgment and thereafter for the period of Tony's life expectancy.

94 The following are the calculations: $4,880 (awarded by the trial Judge); September 1, 1971 to December 31, 1971 -- $800; January 1, 1972 to May 17, 1978 (the date of the trial judgment) -- $15,310, resulting in a total of $20,990.

95 Later in these reasons I accept the trial Judge's discount rate of 3% per annum with respect to the calculation of the present value of the loss of future income. It is appropriate to use the same discount rate in the calculation of the present value of future costs -- on the basis of a life expectancy of 39 years (to age 65). The actuarial evidence adduced is that $1,000 a year discounted at 3% per annum for 39 years is $23,222. The total amount would be, therefore, $23,222 x 2.4 = $55,732.80, which should be rounded off to $55,750.

The discount rate

96 As I have said, the trial Judge used a discount rate of 3% per annum in calculating the present value of the loss of future income. Mr. Sommers submits that this discount rate is not justified by the evidence adduced and that a proper amount, on the evidence, is 0.7%, or even lower. This evidence was given by H.B.M. Connell, an economist called by the plaintiffs. The amount was based on subtracting from a rate of return on investments of 9.66% (National Housing Act mortgages for the years 1967-77) the following: an inflation rate of 5.96% (for the same 10-year

period, 1967-77); 2% for annual increases in the real income of Tony; and 1% for administration costs.

97 In his reasons the trial Judge said [at p. 539 O.R., p. 189 D.L.R.]: "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." Before saying this he had referred to the statement of Dickson, J., in Andrews et al. v. Grand & Toy Alberta Ltd. et al., [1978] 2 S.C.R. 229 at p. 259, 83 D.L.R. (3d) 452 at p. 474, [1978] 1 W.W.R. 577 (where the discount rate selected was 7%): "The result in future cases will depend upon the evidence adduced in those cases."

98 While the trial Judge did not give specific reasons for his selection of the 3% discount rate it is reasonably clear that the difference between his result and that proposed in the plaintiffs' evidence is accounted for by little or nothing being allowed for in the judgment for increases in the real income of Tony. While evidence for the plaintiffs was being given by the actuary, J.B. Patterson, the trial Judge expressed some doubt on that aspect of the evidence relating to future real increases in income over inflation. Before us it was submitted on behalf of the defendants that, by reason of Tony's poor pre-accident academic and work record, he did not have "the rosiest prospects" as far as earning a living was concerned. The evidence justifies this submission. Further, the cross-examination of Mr. Connell showed the possibility of higher yields on some investments than those upon which his opinion was based.

99 Having regard to the foregoing and recognizing that the selection of an appropriate discount rate involves many matters of estimation and opinion, and not pure mathematical calculation, I am unable to conclude that the trial Judge's finding discloses any error which would require interference by this Court.

The 15% deduction for contingencies

100 The principal argument that this deduction is too high is based on the income tax liability on the investment income from the proposed fund. Such liability could only be relevant to that portion of the fund relating to the cost of future care:

> Andrews et al. v. Grand & Toy Alberta Ltd. et al., supra, at pp. 259-60 S.C.R., p. 475 D.L.R. Nothing under this heading was awarded at trial. The trial Judge took into account such contingencies as sickness, accident and unemployment. There is no basis, in my view, for interfering with his decision on this point.

101 Since he had made no award for the cost of future care there was no occasion for the trial Judge to consider the question of contingencies in this area. As Dickson, J., said in Andrews such contingencies are distinct from those relating to loss of future income. "They relate essentially to duration of expense and are different from those which might affect future earnings, such as unemployment, accident, illness" (p. 249 S.C.R., p. 467 D.L.R.).

102 In this case the factor relating to duration and the contingencies relating thereto has been substantially taken into account in the statistical evidence, modified somewhat by the medical evidence, that if Tony subjected himself to a variety of measures to maintain his good health he should reach the age of 65. No complaint has been made of the trial Judge's acceptance of the actuarial evidence that the working life expectancy to age 65 would be 36.162 years (i.e., that the contingency deduction should have reflected something for the contingency of Tony dying sooner than age 65) and therefore I do not think that it would be warranted to deduct something for this in this part of the case. I would make no allowance for contingencies relating to the cost of future care.

103 Having regard to the foregoing, I would assess the total damages as follows:

Special damages Hospital and medical expenses $ 4,085.00 Loss of income to date of trial 55,507.11 Claim for care to date of trial judgment 20,990.00

General damages

Non-pecuniary damages $75,000.00 Cost of future care 55,750.00 Loss of future income 250,790.00 $462,122.11

104 Since the defendant hospital concedes the applicability of the Fenn interest component principle to that part of the damages relating to the loss of future income, such concession should be equally applicable to the part relating to the cost of future care. Accordingly, I would direct that the plaintiff should have interest on both of these items (which total $306,540) at 10% from May 17, 1978, to the day of payment. This allowance of 10% would be in lieu of post-judgment interest otherwise payable under the Judicature Act or the Rules: Fenn et al. v. City of Peterborough et al., supra, at pp. 463-4 O.R., pp. 238-9 D.L.R. While the total amount of the judgment should be paid into Court under Rule 542 it would be appropriate to direct that $20,990 should be received in trust for Tony's mother: Teno et al. v. Arnold et al. (1974), 7 O.R. (2d) 276 at p. 314, 55 D.L.R. (3d) 57 at p. 95; affirmed 11 O.R. (2d) 585 at p. 597, 67 D.L.R. (3d) 9 at p. 21.

105 Since liability has not been established, effect cannot be given to the plaintiffs' cross-appeal and it should be dismissed, without costs.

106 MACKINNON, A.C.J.O.:-- I agree with the conclusions, and the reasons for those conclusions, reached by Arnup, J.A., but I would like to add the following observations.

107 It was pressed upon us, and I think properly, that the medical profession and hospitals have ordered their professional lives and practices in a particular way in this Province for many years. The practice of medicine and the operation of hospitals have been conducted on the understanding and belief that the law established and supported the independence of the medical profession, in the manner in which they practised, free from the control and direction of hospital boards, unless they

were servants or employees (as those words are commonly understood) of the hospital. The Courts hitherto have supported this view.

108 No matter how much our sympathies may be engaged in a particular case, in my view to reverse the long-standing experience and law would be to enter into a matter of policy, the consequence of such entry being unexamined and unknown to us, and which requires public debate and consideration. I do not view the issue as a novel one -- quite the contrary. It is an issue which, if change were to be effected, would now require the legislative intervention based on a consideration of all the ramifications of such change, particularly its effect on public institutions and on a profession which has cherished its independence. To alter the legal position now by judicial legislation would not, in my view, be appropriate.

109 The present legal situation, even though one might conclude it would be "better" or "fairer" or "more logical" to fix hospitals with responsibility for the negligence of doctors who are carrying out their medical duties by virtue of having been granted "hospital privileges", does not, of course, prevent injured parties from suing the negligent doctors. If that had been done in the instant case the Court would not, I am sure, have been faced with the task of seeking to establish a new principle by destroying an old one and declaring a liability relationship based on facts and circumstances that have long existed in this Province and which have hitherto been otherwise interpreted.

110 BLAIR, J.A. (dissenting in part):-- The novel issue raised by this appeal is whether a hospital is liable for the negligent treatment of a patient by a doctor who was a member of its medical staff but not an employee. I agree with the judgment of the learned trial Judge, R.E. Holland, J. (20 O.R. (2d) 510, 88 D.L.R. (3d) 161), that the hospital is liable and respectfully disagree with the contrary views of my brothers MacKinnon, Arnup and Morden. I concur, however, with the judgment of Arnup, J.A., on all other matters relating to liability and also with that of Morden, J.A., on the assessment of damages. The facts have been fully stated by Arnup, J.A., and I intend to refer to them only to the extent necessary to explain my conclusions.

111 The problems in this case arise inevitably from life in a large city. Perhaps in a smaller place and a simpler age a desperately-ill person could always obtain the assistance of a family physician. This is not so in Metropolitan Toronto. Consequently hospital services are organized there to provide medical services when emergency strikes.

112 The Scarborough General Hospital (the Hospital) purposely provided this essential emergency medical service and held itself out to the public as doing so as Dr. O'Hara, its medical director, stated in his evidence. Because of its importance, I repeat the main parts of that evidence, which Arnup, J.A., has also quoted, as follows:

> MR. SOMMERS: Q. As I understand it, the operation of the Emergency Department was provided for the benefit of the community by the hospital?

A. Correct.

Q. And signs were set up all around the hospital and leading from the highways to the hospital, marked with a big blue H?

A. Yes. They also went to Centennial.

Q. Of course, they would go to many hospitals.

A. Right.

Q. But there is no question that your hospital had these signs leading to it. Correct?

A. Correct.

Q. And the reason the emergency service was provided was to enable people, who for one reason or another were in need of medical care, urgent medical care, to be able to come to the hospital to receive that medical care?

A. Yes.

Q. And this could have happened for any number of reasons, either because they did not have a family doctor or because their family doctor might have been away, or simply because they might have been involved in an accident near the hospital?

A. Yes.

Q. So it was the undertaking of the hospital to the community to provide this service of providing medical care?

A. Yes. I think that -- I prefer to look at it as a, really a sort of health care service to the community because it covers a great many things. Probably the, only 25 per cent of the people who come into Emergency are real emergencies. Now, the rest of the people who come in are, come in there for various other reasons, they can't obtain their own doctor, they themselves think that they are emergencies or else they don't feel well and they know eventually they will see someone there.

Q. And they would also be looked at? They wouldn't be thrown out on the street?

A. That's right.

113 In order to provide its complete, round-the-clock services to the community, the Hospital utilized the services of doctors in private practice who were members of its medical staff but not salaried employees. Each specialist member of the staff, as a condition of his appointment, was required to take his turn on a roster of duty doctors so that the services of that specialty would be available to the public at all times.

114 Dr. Rosen, whose negligence caused the injury to Tony Yepremian (Tony), was the internist on duty when Tony was admitted. He became responsible for Tony's treatment because, as he said, as soon as Tony was admitted, he was "under my care". In a very real sense, Tony was turned over by his family to the Hospital for treatment. This fact is underlined by the consent signed on the admission form by his brother, which states: "I consent to necessary examination and treatment by the doctors." There was no disclaimer by the Hospital of responsibility for the doctors' treatment. The Hospital provided the doctors who took full control of Tony's treatment and it never occurred to anyone, least of all Tony's family, that there was any alternative but to accept the doctors and the treatment supplied by the Hospital. Indeed, as part of the medical routine in the Hospital, and without any consultation with Tony's family, he was referred to a neurological specialist for diagnosis and an opinion. All of this was part of the service provided by the Hospital. The usual niceties of choice of doctor and informed consent to treatment could not and did not apply to Tony upon his admission as an emergency patient.

115 It is difficult to envisage a situation where the life of an individual was so completely entrusted to the care of an institution as that of Tony was to the Hospital. In these circumstances, Mr. Justice Holland correctly found the Hospital liable for the negligence of Dr. Rosen. His reasons, which I adopt, are set forth in his judgment at pp. 533-5 O.R., pp. 183-4 D.L.R. as follows:

> In my opinion certain principles can be deduced from a review of the Public Hospitals Act [R.S.O. 1970, c. 378] 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.
>
> 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.
>
> For the above reasons I have come to the conclusion that the hospital is responsible in law for the negligence of Dr. Rosen.

116 In examining the judgment of Holland, J., and the submissions made to us, I will first review the situations in which it is undisputed that hospitals are either vicariously or directly liable for injuries suffered by their patients. I will then consider both the special circumstances of this case, which, as I have already indicated, is one of first impression in this Court, and the application to it of the principles deductible from the authorities. Finally, I will outline the reasons why I consider the Hospital is liable. Throughout, I should emphasize, my approach will be modest as suggested by the argument of Mr. Laidlaw. He candidly stated that no principle of law barred recovery and that all that was in issue was whether the facts disclosed in evidence justified a finding of liability. The

length and complexity of the case coupled with the unexplained decision to sue the Hospital rather than the doctor presented many difficulties. At bottom, however, the decision does not involve a quest for new jurisprudence but rather the more prosaic task of analyzing established principles and applying them to the facts.

Vicarious liability of hospitals

117 Unquestionably, the Hospital would have been liable vicariously for the negligence of Dr. Rosen had he been a paid employee. The oft-told tale of how the Courts in a period of less than 50 years eliminated the anomaly which exempted hospitals from the ordinary rules of liability for negligence of doctors, nurses and other professionals acting within the scope of their employment need not be repeated. The retreat from Hillyer v. Governors of St. Bartholomew's Hospital, [1909] 2 K.B. 820 (C.A.), was highlighted in a number of important cases in this country, including Sisters of St. Joseph of Diocese of London v. Fleming, [1938] S.C.R. 172, [1938] 2 D.L.R. 417; Vancouver General Hospital v. Fraser, [1952] 2 S.C.R. 36, [1952] 3 D.L.R. 785, and Aynsley et al. v. Toronto General Hospital, [1969] 2 O.R. 829, 7 D.L.R. (3d) 193; approved [1972] S.C.R. 435 sub nom. Trustees of Toronto General Hospital v. Matthews et al., 25 D.L.R. (3d) 241, and several important English Court of Appeal decisions, to which I will refer later. Collectively, these cases provide an interesting chapter of legal history, in which the Courts, in the words of Lord Denning, L.J., in Cassidy v. Ministry of Health, [1951] 2 K.B. 343 at p. 362, [1951] 1 All E.R. 574 at p. 586, were "relieved" of the burden of the rule in Hillyer's case.

118 This history is of more than academic interest because the Courts, while striving to escape the harsh consequences of Hillyer's case, found alternative grounds for fixing hospitals with liability where the ordinary rules of master and servant could not apply. Now, there is a tendency to sweep all such cases under the rubric of vicarious liability. This, however, does not detract in appropriate cases from the validity of alternative grounds for liability such as implied contract or non-delegable duty. The vitality of these alternative grounds for liability remains and their application is important to the decision in this case.

Direct liability of hospitals

119 It is also well established that the hospital is liable to a patient directly for failure to provide what, in other areas of tort liability, would be called a "safe system". Thus a hospital is liable for injury to the patient from inadequate or improperly maintained equipment: Vuchar v. Trustees of Toronto General Hospital, [1937] O.R. 71, [1937] 1 D.L.R. 298 (C.A.); for failure to provide proper measures for protecting a disturbed person from injuring himself or other patients:

> Lepine v. University Hospital Board (1964), 50 D.L.R. (2d) 225, 50 W.W.R. 709 and 765n (Alta. S.C.) [varied 54 D.L.R. (2d) 340, 53 W.W.R. 513 and 704; reversed [1966] S.C.R. 561, 57 D.L.R. (2d) 701, 57 W.W.R. 5], and Wellesley Hospital v. Lawson, [1978] 1 S.C.R. 893, 76 D.L.R. (3d) 688, 15 N.R. 271; for failure to provide sufficient personnel to permit rotation of nurses without danger

> to patients, as exemplified in the "coffee-break" cases: Laidlaw et al. v. Lions Gate Hospital et al. (1969), 8 D.L.R. (3d) 730, 70 W.W.R. 727 (B.C.S.C.); Krujelis et al. v. Esdale et al. (1971), 25 D.L.R. (3d) 557, [1972] 2 W.W.R. 495 (B.C.S.C.). In some cases, the line is blurred between injury caused by the failure of the hospital to provide proper equipment or organization and injury caused by the negligence of employees; none the less, the principle of direct liability is well established by the authorities. It is particularly demonstrated by the common law principle, accepted in Hillyer's case and elaborated by statute, that a hospital is responsible for the proper selection of qualified doctors to serve on its staff.

120 This outline of direct hospital liability reflects what Professor Picard in Legal Liability of Doctors and Hospitals (Toronto, Carswell Company Limited, 1978) at p. 275, has described as the traditional "hotel-employment agency" concept of a hospital. This is the foundation of the Hospital's position in this case. It contends that its responsibility to the patient is simply to ensure the provision of medical services by properly-qualified doctors without accepting any responsibility to the patient for the manner in which doctors perform those services.

121 In the view I take of this case, nothing substantial turns on the manner in which the Hospital originally selects and, on an ongoing basis, reviews the competence of its medical staff. The Public Hospitals Act, R.S.O. 1970, c. 378, s. 41, contemplates that this important function will be performed by the medical staff itself, through the medical advisory committee and the chiefs of the various services. Further, it is unnecessary to decide whether the Hospital has any opportunity to control the quality of medical services provided by the medical staff or whether, by its practices and requirements, it causes the medical staff to surrender some independence to the Hospital. Whatever the relationship between the Hospital and its medical staff, the Hospital itself remains responsible for the proper operation of the Hospital system and the related functions of record-keeping and the effective transmission of information within the institution. However the system operates, the Hospital, in the final analysis, is responsible for it and must accept liability in the event of its failure.

The novelty of the issue

122 It is conceded by all parties that the issue presented to this Court is novel. There is no authority binding on the Court which establishes that the Hospital is either liable or not liable in the circumstances of this case.

123 What all the cases reveal is the procedural convenience and administrative simplicity of holding hospitals liable only for the negligence of doctors employed by them and making other doctors on their staffs directly answerable to their patients for their negligence. The uniformity of this practice has a practical explanation well known to the legal profession. Under the present regime of public insurance for medical expenses, hospitals and doctors bill the insurance authority separately. In addition, hospitals have a no "deeper" pocket than doctors from which to pay

damages because of the universality of medical liability insurance coverage. From the doctors' standpoint this practice has a further advantage, much emphasized in argument; it recognizes that their professional responsibility is to their patient. It maintains their independence from interference with their medical treatment of and their relations with their patients. The departure from the accepted pattern of litigation by the respondents in this case creates complications and may induce judicial exasperation, but this in itself does not provide a reason for denying a claim which is otherwise valid.

124 On countless occasions, common law Courts have asserted that the novelty of an issue is not a defence. If the Courts had followed the policy of rejecting cases because they had never occurred before, it is obvious that the common law would have atrophied and would not have expanded, as it has done over the many centuries, to meet new problems as society developed and changed. The past half-century has been marked by the expansion of the law of tort and, especially, responsibility for negligence. No citation of authority is necessary to show that, in order to meet new situations in a rapidly-changing society, Courts have greatly expanded the concept of the duty owed to others by persons and institutions.

125 This Court recently decided that novelty was no bar to a claim in recognizing a cause of action for the new tort of discrimination. In Bhadauria v. Board of Governors of Seneca College of Applied Arts & Technology (1979), 27 O.R. (2d) 142, 105 D.L.R. (3d) 707, a highly-qualified East Indian woman claimed she was discriminated against because of her ethnic origin when she applied for a teaching position at the college. Instead of seeking redress under the Ontario Human Rights Code, R.S.O. 1970, c. 318, she issued a writ claiming damages for discrimination and for breach of the Code. After reviewing the authorities, Madam Justice Wilson stated at pp. 149-50 O.R., pp. 714-5 D.L.R.:

> In my view, they give rise to a cause of action at common law. While no authority cited to us has recognized a tort of discrimination, none has repudiated such a tort. The matter is accordingly res integra before us.
>
> Prosser in his text, Handbook on the Law of Torts, 4th ed. (1971), at pp. 3-4, states:
>
> "The law of torts is anything but static, and the limits of its development are never set. When it becomes clear that the plaintiff's interests are entitled to legal protection against the conduct of the defendant, the mere fact that the claim is novel will not of itself operate as a bar to the remedy."
>
> The plaintiff has a right not to be discriminated against because of her ethnic origin and alleges that she has been injured in the exercise or enjoyment of it. If

> she can establish that, then the common law must, on the principle of Ashby v. White et al. [(1703), 2 Ld. Raym. 938, 92 E.R. 126], afford her a remedy.
>
> I do not regard the Code as in any way impeding the appropriate development of the common law in this important area.

This case recognized a new ground for liability in tort. It was a much more significant step than the one we are invited to take in this case of extending an existing duty of care to a new factual situation.

126 The traditional approach of the Courts to a novel problem is set forth by Croom-Johnson, J., in Best v. Samuel Fox & Co., Ltd. et al., [1950] 2 All E.R. 798 at pp. 800-1:

> It is admitted that a claim of this nature is completely novel. It has not, apparently, arisen before, and there is no case which indicates that anything of this sort has ever been canvassed before. That has been properly pressed on me at the Bar, but the law of England is a living law. It develops, and must develop, according to changes in the social life and social outlook. It has long since been pointed out that under our system of law the novelty of a claim is no answer to it. In Chapman v. Pickersgill (1762), 2 Wils. 145; 95 E.R. 734; 1 Digest 24, 193, PRATT, C.J., in answer to an objection that the action was of a novel description said (2 Wils. K.B. 146): "... so it was said in Ashby v. White (1703), 1 Bro. Parl. Cas. 62; 1 E.R. 417; 1 Digest 23, 187. I wish never to hear this objection again." Some years later, perhaps, with great respect to that learned judge, I may be permitted to echo his sentiments. In the course of Ashby v. White [supra] this question whether novelty can be an objection was a little further examined. In SMITH'S LEADING CASES, 13th ed., vol. 1, p. 280, the principle is stated in effect that where a legal right is infringed a court, if possible, will find a remedy for the wrong so suffered. Reference is there made to Russell v. Men of Devon (1788), 2 Term. Rep. 667; 100 E.R. 359, 26 Digest 587, 2780, in which ASHHURST, J., said (2 Term. Rep.):
>
> "It is a strong presumption that that which never has been done cannot by law be done at all. And it is admitted that no such action as the present has ever been brought, though the occasion must have frequently happened."
>
> The same judge is quoted as saying in Pasley v. Freeman (1789), 3 Term. Rep. 15; 100 E.R. 450; 26 Digest 31, 186 (3 Term. Rep. 63):

> "Another argument which has been made use of is, that this is a new case, and that there is no precedent of such an action. Where cases are new in their principle, there I admit that it is necessary to have recourse to legislative interposition in order to remedy the grievance: but where the case is only new in the instance, and the only question is upon the application of a principle recognised in the law to such new case, it will be just as competent to courts of justice to apply the principle to any case which may arise two centuries hence as it was two centuries ago; if it were not, we ought to blot out of our law books one fourth part of the cases that are to be found in them."
>
> I take that passage as my direction to myself on the correct approach to this topic. However attractive the last suggestion made by ASHHURST, J., may be to one who has authority cited to him daily about all sorts of topics, I must not allow that will of the wisp to lead me over the wrong moor. It seems to me that, applying that principle as I must, the question is whether the present case is new in principle or new in the instance, and that involves an examination of what the suggested principle is and the authorities which give rise to it.

127 It is not necessary on this occasion to enter into a complex discussion of the judicial process in dealing with a novel situation beyond saying that which is obvious. Judges, as a rule, prefer, as Croom-Johnson, J., said in Best v. Samuel Fox & Co. Ltd., supra, to proceed carefully and by way of analogy in extending the reach of the law and they shrink from characterizing the extension as representing a new principle. In the language of Ashhurst, J., in Pasley v. Freeman, cited by Croom-Johnson, J., the present case does not call for the recognition of a right which is new in principle but rather one which is new in its instance.

128 Regardless of the legal formula used, Courts now frankly acknowledge that whether a duty of care exists or not in a novel situation unavoidably involves a policy decision. This is so even if the Court merely wishes to analogize or otherwise assimilate the novel situation to other cases where a duty of care has been recognized. The process was openly recognized by MacDonald, J., one of Canada's foremost legal scholars, in Nova Mink Ltd. v. Trans-Canada Airlines, [1951] 2 D.L.R. 241, 26 M.P.R. 389, 66 C.R.T.C. 316, where he states at p. 256:

> ... [T]here is always a large element of judicial policy and social expediency involved in the determination of the duty- problem, however it may be obscured by use of the traditional formulae.

His view was echoed by Lord Pearce in Hedley Byrne & Co. Ltd. v. Heller & Partners Ltd., [1964] A.C. 465 at p. 536, when he said:

> How wide the sphere of the duty of care in negligence is to be laid depends ultimately upon the courts' assessment of the demands of society for protection

> from the carelessness of others.

It is not surprising that Lord Denning, M.R., has also, in his usual forthright language, described the modern judicial approach to a novel problem. In Dutton v. Bognor Regis Urban District Council, [1972] 1 Q.B. 373 (Eng. C.A.), he said at p. 397:

> This case is entirely novel.
>
> . . . . .
>
> > In previous times, when faced with a new problem, the judges have not openly asked themselves the question: what is the best policy for the law to adopt? But the question has always been there in the background. It has been concealed behind such questions as: Was the defendant under any duty to the plaintiff? Was the relationship between them sufficiently proximate? Was the injury direct or indirect? Was it foreseeable, or not? Was it too remote? And so forth.
>
> Nowadays we direct ourselves to considerations of policy.

129 I have been at some pains to describe the problem which confronts this Court because the word "policy" has a pejorative content. There may be a tendency to think that only a decision which extends the ambit of legal liability is a "policy" decision. This, of course, is not so. When confronted with a novel situation, the Court makes a policy decision whether it decides to expand the area of liability or refuses to do so. It expresses a view, in either case, as to what "ought" or "ought not" to be done. Whatever decision is made in this case will be open to legislative review, but that fact does not, in my respectful opinion, relieve the Court of its obligation to reach a decision on the case presented to it. Indeed, it is notorious that Legislatures are loath to revise private law and I am not the first to note that the vast expansion of the modern law of tort fills the void that otherwise would exist because of the inability of Legislatures to react quickly to societal changes. The duty of decision cannot be avoided in this case by classifying the review of the Hospital's duty as a legislative and not a judicial responsibility: vide, C.P.R. v. Province of Alberta et al., [1950] S.C.R. 25, [1950] 2 D.L.R. 405, 64 C.R.T.C. 129.

No duty of care from statute

130 The problem that remains is to determine whether the Hospital in this case was under a duty to provide non-negligent medical treatment. If such a duty exists, it must be grounded in statute, contract or tort. It may, of course, be based on any or all of these grounds because they are not mutually exclusive.

131 I agree with my brother Arnup that in Ontario no duty to provide non-negligent medical treatment arises from statute. The Public Hospitals Act, by s. 17(1) [since rep. & sub. 1972, c. 90, s. 11], obliges a hospital to admit "any person who from sickness, disease or injury or otherwise is in

need of active treatment" but that statute does not require a hospital to provide such treatment. Several sections of the statute contemplate the provision of medical treatment, including medical and nursing care, by a hospital. Nothing in the statute prohibits treatment by a hospital, but nothing requires it. In this respect the Public Hospitals Act differs from the comparable statute of the United Kingdom, the National Health Service Act, 1946 (U.K.), c. 81, which, by s. 3(1), imposes upon the Minister of Health the obligation to provide medical services, including the services of specialists, in hospitals. The sweeping effect of this statutory obligation was considered by Lord Denning, M.R., in Razzel v. Snowball, [1954] 3 All E.R. 429, 1 W.L.R. 1382, in which he stated, at p. 432 All E.R.:

> ... it is the duty of the Minister to provide all necessary services at the hospitals. He is to do it by means of doctors and nurses ... and by means of specialists ... He does not discharge his duty merely by appointing competent doctors and nurses and competent specialists. He has not merely to provide the staff. He has to provide their services: and inasmuch as their services consist of treating the sick, it is his duty to treat the sick by means of their services.

132 In Medical Negligence (1957) (London, Butterworth & Co.), Lord Nathan at p. 144 concludes from a consideration of this and other cases that the obligation imposed on the Minister of Health by the United Kingdom statute makes the Minister liable not only for the negligence of full-time employees of a hospital, but also for that of visiting or consulting surgeons and physicians. However, Lord Nathan qualifies this proposition at p. 145 in a distinction which is important for the present case:

> The position is different, however, where a patient ... [has made] arrangements to be treated as a private patient by a particular surgeon or physician. ... In such cases the hospital will clearly not be responsible for any negligence on the part of the surgeon, physician or anaesthetist, as the case may be, notwithstanding that these may be employed as consultants at the hospital in question. The reason is that the surgeon, physician or anaesthetist must be regarded as being employed, in so far as the treatment of private patients is concerned, by the patient himself rather than by the hospital; and the fact that they are employed by the patient leads inevitably to the inference that the hospital assumes no obligation with regard to the provision of their services.

133 It is easy to find in the United Kingdom statute a statutory basis for hospital liability for medical treatment; there is no need to seek other foundations for it: see Salmond on The Law of Torts, 17th ed. (1977), p. 460. For this reason, care must be taken in applying in Ontario the results of English cases on the liability of hospitals. However, the fact that liability in the United Kingdom now rests on a clear statutory foundation does not detract from the value of the discussions in English cases of alternate bases for liability. The English cases are still capable of elucidating the problem presented in this case.

Contractual duty of care

134 The possibility of a hospital becoming liable in contract for professional negligence has never been disputed. This was clearly established while the Courts struggled to escape the Hillyer decision that hospitals were not vicariously liable for the negligence of professionals in their employment. An early example is afforded by Lavere v. Smith's Falls Public Hospital (1915), 35 O.L.R. 98, 26 D.L.R. 346 (C.A.), where it was determined that a hospital had entered into an express contract with the patient to provide her with "board and attendance and nursing". The hospital was held liable for injuries caused to a patient by the negligence of a nurse. Riddell, J., stated at p. 105 O.L.R., p. 352 D.L.R.:

> The test is, did the defendants undertake to nurse, or did they undertake only to supply a nurse? The matron herself says that the $9 paid per week was to include nursing; and this concludes the defendants from denying that they contracted to nurse the patient.

135 The Supreme Court of Canada expanded the contractual basis of liability to a case where a contract to nurse was implied from the mere admission of the patient to a hospital. In Nyberg v. Provost Municipal Board, [1927] S.C.R. 226, [1927] 1 D.L.R. 969, the hospital was held liable for the negligence of a nurse for the reasons given by Anglin, C.J.C., at p. 232 S.C.R., p. 973 D.L.R.:

> The obligation undertaken by the hospital authority ... was not merely to supply properly qualified nurses, but to nurse the plaintiff ... It was negligence of their servant in the discharge of that contractual obligation that caused the severe injury of which the plaintiff complains.

136 Contractual liability for negligent treatment in hospitals has received -- and is likely to receive -- little consideration in common law jurisdictions in Canada or elsewhere. The need to resort to claims based on breach of contract substantially disappeared when hospitals became vicariously liable for professional negligence. In addition, there is always difficulty -- if not artificiality -- in implying terms in contracts for hospital care. The unequal bargaining positions of hospitals and patients also makes contract a less satisfactory basis for liability. A person requiring emergency treatment is in no position to dispute the terms of any documents that have to be executed as a condition of admission. The modern law of negligence provides a more responsive and flexible instrument than contract for determining liability in hospital cases: see Picard, Legal Liability of Doctors and Hospitals in Canada (1978), p. 250 et seq.

137 The contractual basis for liability of hospitals appears to have received more attention in Quebec cases decided under the civil law. Such decisions cannot bind common law Courts, but they assist in delineating the issues. In Hopital Notre-Dame de l'Esperance v. Laurent et al., [1978] 1 S.C.R. 605, 3 C.C.L.T. 109, 17 N.R. 593, the plaintiff patient had fallen while curling, and had been taken to the emergency room of the hospital. The doctor on duty examined her, and diagnosed a simple contusion. He did not admit her to the hospital but prescribed medication. When the patient

consulted him later by telephone, he renewed the prescription. After months of pain, the woman consulted a second doctor, who correctly diagnosed the fracture from which she had suffered since the accident. As a result of the delay, the necessary surgical treatment was long and complicated, and the resulting permanent disability was increased.

138 The doctor on duty was not employed by the hospital, but was a member of its medical staff. This gave him the privilege of practising medicine there. He voluntarily took his turn attending in the emergency department of the hospital. In contrast to the present case, such attendance was not a condition of association with the hospital.

139 The Quebec Court of Appeal ([1974] Que. C.A. 543) upheld the trial Judge's decision that the hospital had contracted with the patient to provide medical treatment, and on that basis was liable for the negligent treatment by the doctor. Mayrand, J.A., rejected the hospital's submission that the patient's only contract was with the doctor. At p. 546, he said (translation):

> ... [T]he respondent-petitioner did not know Dr. Theoret; she arrived at the Outpatient Clinic of the appellant-hospital to receive the treatment she needed. There was a contract between the respondent-petitioner and the appellant-hospital which designated Dr. Theoret to provide her with this treatment. When this physician came to provide this treatment to the respondent, who accepted it, no contract distinct from the hospital contract was concluded, the parties were simply proceeding with the execution of the hospital contract which had already been set up and according to which the appellant- hospital was committed to provide the patient with the medical treatment required by her condition.

140 The Supreme Court of Canada reversed this decision, finding that no contract had been made between the hospital and the patient. Pigeon, J., stated at pp. 613-4:

> [The Court] only has to decide whether, in the circumstances, Dr. Theoret was acting as an employee of the hospital when he treated Dame Laurent. As we have seen, the evidence on this point is unequivocal: it was as a physician acting on his own account that the doctor received this patient and undertook to treat her, also telling her to get in touch with him after a certain length of time. On the same day an entirely different legal situation may well have arisen in other hospitals ... In the case at bar, the medical care was given to Dame Laurent under a contract, not with the hospital, but with Dr. Theoret.

141 I do not interpret the judgment in Laurent as holding that a hospital can only become bound in contract to provide medical treatment through the agency of a doctor in its employment. On the specific facts of the Laurent case a contract was not made between the hospital and the patient, but the passage quoted above contemplates that a different result could occur under different circumstances.

142 In the Laurent case, Pigeon, J., focused his attention on the relationship between the doctor and the hospital. In cases like the present one, much greater consideration must be paid to the relationship between the hospital and the patient. The weight to be given to the two relationships varies with the circumstances of each case as Professor J.E. Magnet states in his comment on "Liability of a Hospital for the Negligent Acts of Professionals -- A Comment on Hopital Notre-Dame de l'Esperance v. Laurent", 3 C.C.L.T. 135 (1977-78). A contractual relationship between a patient and a hospital, despite the fact that it may be formed on behalf of the hospital through the instrumentality of a staff doctor, should not be affected by the relationship, contractual or otherwise, between the doctor and the hospital.

143 In the present case I consider that the Hospital's responsibility to provide medical care can be founded on a contract implied from all the circumstances. The Laurent decision does not preclude such a result. The Hospital held itself out as offering emergency medical service to persons in Tony's condition. It became contractually bound to provide such service in a non-negligent manner when its offer was accepted by the admission of Tony and his complete submission to its care.

Duty of care in tort

144 In my opinion, the basis for liability in contract and tort is coextensive in this case and the use by Holland, J., of the word "undertaking" as describing the obligation of the Hospital is prudent because it covers both situations. The Laurent case provides a link between the contractual and tortious concepts of liability. Laurent shows that, absent a contractual relationship establishing liability between the hospital and the patient, the only basis for liability in the Province of Quebec is the master-servant relationship provided for in art. 1054 of the Civil Code. This is not the case at common law, which recognizes, as an additional ground for liability, that persons who undertake to perform an act that gives rise to a non-delegable duty of care are liable for its negligent performance by independent contractors who are not their servants.

145 A non-delegable duty gives rise to direct and not vicarious liability. The nature of that duty is described in Salmond on the Law of Torts, 17th ed. (1977), at p. 486 as follows:

> The liability of the employer of an independent contractor is not properly vicarious: the employer is not liable for the contractor's breach of duty; he is liable because he has himself broken his own duty. He is under a primary liability and not a secondary one. Hence it is misleading to think of the law on this point as a general rule of non-liability subject to a more or less lengthy list of exceptions. The real question is whether the defendant is, in the circumstances of the particular case, in breach of a duty which he owes to the plaintiff. If the plaintiff proves such a breach it is no defence to say that another has been asked to perform it. The performance of the duties, but not the responsibility for that performance, can be delegated to another. This seems to be all that is meant by talk of "non- delegable duties." The relevant principles were thus summarised by

> Denning L.J. "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. Lord Blackburn laid that down on many occasions:
>
> see Tarry v. Ashton (1876), 1 Q.B.D. 314, 319; Dalton v. Angus (1881), 6 App. Cas. 740, 829 and Hughes v. Percival (1883), 8 App. Cas. 443, 446; and so have other great judges."

146 Two questions arise in determining whether in this case the Hospital was under a duty to provide non-negligent medical treatment. The first is whether a hospital could have undertaken such a duty. The second is whether it did. In my view, both questions must be answered in the affirmative.

147 The theory upon which such direct liability is founded appears from the judgments of the English Court of Appeal in the famous trilogy of cases: Gold v. Essex County Council, [1942] 2 K.B. 293; Cassidy v. Ministry of Health, [1951] 2 K.B. 343, [1951] 1 All E.R. 574, and Roe v. Minister of Health et al., [1954] 2 Q.B. 66, [1954] 2 All E.R. 131.

148 In Gold a hospital was held liable for the negligence of a radiologist employed by it in administering treatment to a patient resulting in burns to that patient. The result in this case is important because it was the first English decision making a hospital liable for the negligence of a professional employee. The majority of the Court, MacKinnon and Goddard, L.JJ., held that since the radiologist was a servant employed by the hospital, it was vicariously liable for his negligence and the decision is generally regarded as authority for this principle. Goddard, L.J., distinguished a contract of service which governs the relationship between master and servant, and a contract for services which an independent contractor, such as a consulting doctor, might have with a hospital.

149 Lord Greene, M.R., however, did not proceed on the theory of vicarious liability. His approach was to determine the nature of the direct obligation undertaken by the hospital to the patient. He said at p. 301:

> 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.

He continued at p. 302:

> 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.

150 The distinction made by all three Judges between employed doctors and visiting surgeons and consultants has been greatly emphasized by the appellant in this case.

151 The importance of the difference between the approach of Lord Greene and the other members of the Court is explained by Lord Nathan, op. cit., at p. 128:

> It is clear that LORD GREENE ... was approaching the question of hospital liability on the basis that the problem to be solved was not that of the extent of a hospital's vicarious liability but that of the extent of the direct or "personal" obligations undertaken by it. Such an approach makes it unnecessary to inquire whether the relationship of master and servant existed between the hospital and the individual whose negligence is complained of; for, although the existence of a master-servant relationship is a prerequisite to the imposition of a vicarious liability upon the master, where the complaint is that the hospital was in breach of its personal duty towards the patient it matters not whether the individual at fault was a servant or an independent contractor -- the hospital has failed in its duty and that is an end of the matter. On this basis the only problem is to ascertain firstly the extent of the obligation assumed by the hospital towards the patient and secondly whether that obligation has been complied with.

152 Lord Greene also recognized that there might be a statutory obligation on the hospital to

provide treatment. He deliberately chose not to decide the case on the basis of the hospital's statutory powers and obligations which he considered too "narrow a ground" because they constituted only one of the relevant determinants of the hospital's responsibility. He said at p. 303:

> The nature of those powers is one of the relevant circumstances to be considered in determining the extent of their obligation. Indeed, it might well be regarded as conclusive, but I prefer not to rest my judgment on so narrow a ground.

153 In Cassidy v. Ministry of Health, supra, the hospital was held responsible for the negligence of a house surgeon employed by it in performing an operation. Here again, two members of the Court of Appeal, Somervell and Singleton, L.JJ., found the hospital liable on the simple ground that it was vicariously responsible for the negligence of its servant. This, in itself, was a considerable advance in the law because it represented the first important English case where liability had been imposed on a hospital authority for a doctor's negligence in a surgical operation. As in Gold's case, both of the learned Justices distinguished the position of employed doctors and consulting doctors.

154 Denning, L.J., who had been the patient's counsel in Gold's case, based liability on a broader ground in which he further developed the concept of direct liability enunciated by Lord Greene in Gold. He said at pp. 359-60 (K.B.):

> 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. ... 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.

He continued at p. 362 (K.B.):

> Relieved thus of Hillyer's case, 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 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, 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. It does not depend on whether the contract under which he was employed was a contract of service or a contract for services. That is a fine distinction which is sometimes of importance; but not in cases such as the present, where the hospital authorities are themselves under a duty to use care in treating the patient.

> 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.

At pp. 363-4 (K.B.) he expressed regret that he had not argued this proposition in Gold's case and said:

> It is unfortunate that the principle which I have enunciated was not drawn to the attention of the court in Gold's case, but that was my fault, because I was counsel in the case. It was plain there that, if the radiographer was employed under a contract of service, the hospital authorities were liable for his negligence; and I contented myself with showing that he was, citing even workmen's compensation cases for the purpose. This was a bad example, for I see that workmen's compensation cases figured prominently in the later case of Collins v. Hertfordshire County Council. Hence the courts have drifted almost unconsciously into the error of making the liability of hospital authorities depend on whether the negligent person was employed under a contract of service or a contract for services. The judgment of Lord Greene, M.R., in Gold's case, however, gives no countenance to this error. He made the liability depend on what was the obligation which rested on the hospital authorities. He showed [[1942] 2 All E.R. 243] that hospital authorities were under an obligation to use reasonable care in treatment ... whence it follows, on the authorities I have just cited, that they cannot get rid of that obligation by delegating it to someone else, not even to a doctor or surgeon under contract for services.

155 In the last case in the trilogy, Roe v. Minister of Health et al., supra, the majority of the Court of Appeal definitely shifted towards the acceptance of a wider basis for liability than the traditional master-servant relationship. In this case, anaesthetists who carried on private practices were under an obligation to provide regular anaesthetic service for the hospital. The hospital set aside a sum of money out of funds derived from investments, contributions and donations for division among the whole of the medical and surgical staff including visiting and consulting surgeons. Anaesthetists participated in this fund, but otherwise received no remuneration from the hospital. The trial Judge had held that the hospital was not responsible for injuries to patients resulting from the negligence of the anaesthetist, but this view was rejected by the Court of Appeal, which nevertheless dismissed the appeal for the other reasons referred to by Arnup, J.A. Lord Denning said at pp. 81-2 (Q.B.):

> 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 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.

156 Somervell, L.J., had difficulty in viewing the case as a simple master-and-servant relationship, but ultimately did so by treating the anaesthetists "as if" their position were similar to that of the house surgeon in Cassidy's case. He said at pp. 79-80 (Q.B.):

> The line suggested in that case and in Cassidy's case in the judgments of Singleton L.J. and myself may not be a very satisfactory one, but I would have regarded Dr. Pooler and Dr. Graham as part of the permanent staff and, therefore, in the same position as the orthopaedic surgeon in Cassidy's case. Like him they are, of course, qualified, skilled men, controlling as such their own methods. The positions of surgeons and others under the National Health Service Act, 1946, will have to be decided when it arises. The position of hospitals under that Act may or may not be different from when they were voluntary or municipal hospitals.

157 Lord Justice Morris also had difficulty in treating the anaesthetists as if they were servants of the hospital in the ordinary sense and had this to say at p. 89 (Q.B.):

> 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 (Q.B.):

> 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 as were the defendants in Gold v. Essex County Council ...

158 The effect of Gold and Cassidy was finally to displace the rule in Hillyer's case and make hospitals vicariously liable for the negligence of doctors employed by them. That this is the ratio decidendi derived from the majority judgments in both cases is beyond dispute. The principle deducible from the opinions of the Court of Appeal in Roe is less clear. What is important in the present case is not the rule of vicarious liability which these cases establish but the other views on liability expressed by the Judges. Their dicta have been examined meticulously as if they were scriptural texts in the careful arguments addressed to us. Two opposing arguments are based on them.

159 The respondents argue that the broad basis of liability propounded by Lord Greene in Gold and Lord Denning in Cassidy and Roe supports the judgment of Holland, J. The appellants contend that the opinion expressed by several Judges that the position of consultants is different from that of employed doctors precludes any action based on the negligence of Dr. Rosen, who was a non-salaried member of the medical staff. It is conceded that these expressions of opinion were not necessary to the decision in any of these cases and neither issue was decided by them. It is necessary now to consider the degree to which the principles expressed in these dicta can apply in this case.

160 There is a clear line linking the views of Lord Greene in Gold and those of Lord Denning in Cassidy, and Lord Denning and Morris, L.J., in Roe. Taken together they constitute a developing and yet unified approach to the question of a hospital's obligations. Lord Greene in Gold considered that the extent of the obligation undertaken by the hospital had to be determined on the basis of the facts in each case. Lord Denning in Cassidy and Roe went further and endeavoured to lay down a general principle of law imposing a duty of care on the hospital except where the patient was served by his own doctor. Morris, L.J., in Roe preferred Lord Greene's approach and as Lord Nathan in Medical Negligence states at p. 132:

> ... he clearly indicated that in his view the exact extent of a hospital's obligations can only be decided by considering the circumstances of each particular case in which the question arises.

161 In my opinion Lord Nathan, op. cit., correctly concluded that the effect of these decisions is to establish that in some cases a hospital can undertake a direct duty to provide treatment to patients. His conclusion is stated at pp. 132-3 as follows:

> In these circumstances it can be stated with some confidence that the weight of modern authority favours the view that a hospital authority by receiving a patient undertakes a personal obligation or duty towards that patient, for the breach of which it cannot escape liability by saying that it employed competent persons to discharge the obligation or duty on its behalf; but that the exact extent of the duty is a question of fact in each particular case. This of course leaves unsolved the question, by what criteria is the extent of the obligation or duty to be determined? An examination of the decided cases shows that amongst the relevant considerations for this purpose may be the status of the hospital, the nature of the arrangements it makes for the provision of staff, and the relationship between the hospital and the patient. It will be seen, however, that in past cases the Courts have been inclined to impose uniform obligations upon hospitals, regardless of any differences in status and irrespective of whether the patient in question paid for his treatment or not; so it may well be that the exact consideration of circumstances prescribed by LORD GREENE and MORRIS, L.J., will lead to the same generalised conclusion as that contended for by DENNING, L.J.

162 Fleming, The Law of Torts, 5th ed. (1977), states the same proposition more emphatically at the conclusion of the description of erosion of the rule in Hillyer's case at pp. 361-2:

> Thus hospitals became successively liable for the negligence of their nurses, resident medical officers, radiographers, and even part-time anaesthetists and special consultants. The uncontrollability of such professionals in the performance of their tasks no longer precludes recovery, so long as they are part of the hospital organization and not employed by the patient himself. Indeed, according to a view which has lately gained increasing support, the distinction between servants and independent contractors may really be irrelevant in this context, because a hospital by receiving a patient assumes a non-delegable, personal duty to ensure that he receives careful treatment at the hands of such staff as it provides, including even visiting specialists and other independent consultants.

163 This broader basis for direct liability of hospitals is acknowledged in other decisions which have been expressed in more conventional language. I have already referred to the judgments of Somervell and Morris, L.JJ., in Roe's case where with the greatest of difficulty they dealt with the anaesthetists "as if" they were employees. The language of Morris, L.J. [at p. 91], provides a parallel for the present case in that he described the anaesthetists as "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".

164 The attenuation of the employment relationship on which vicarious liability is based is evidenced in other decisions. In Australia, the case of Samios v. Repatriation Com'n, [1960] W.A.R.

219, is illustrative. A radiologist normally on staff at the hospital was unavailable and X-rays had been referred to a radiologist in private practice who was negligent in interpreting them. The Court held the hospital vicariously liable for the negligence of the radiologist. Jackson, S.P.J., at pp. 227-8 stated:

> 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.

165 The expansion of direct liability of hospitals for negligent medical treatment by doctors who are not employees is also evident in the United States. In Mduba v. Benedictine Hospital (1976), 384 N.Y.S. 2d 527, the New York State Supreme Court, Appellate Division, held a hospital liable for negligent treatment by an emergency room physician. The physician was under contract to operate the emergency room of the hospital and his contract specified that he would do so "not as an employee". The Court held that, notwithstanding, the hospital was liable because it held itself out to the public as an institution furnishing doctors, staff and facilities for emergency treatment, and patients were not bound by secret limitations contained in a private contract between the hospital and the doctor. Greenblott, J.P., stated at p. 529:

> Assuming, arguendo, that Dr. Bitash was an independent contractor, we reach the conclusion that the hospital would nevertheless be responsible for his negligence. This is not a situation where the decedent engaged Dr. Bitash in defendant's hospital. The decedent entered the hospital for hospital treatment. The defendant hospital undertook to treat decedent for a charge and furnished the doctors and staff to render that treatment. Defendant having undertaken to treat decedent, which included both the necessary treatment and the furnishing of blood and other medicine needed in that treatment, was under a duty to do so effectively. Patients entering the hospital through the Emergency Room could properly assume that the treating doctors and staff of the hospital were acting on behalf of the hospital. Such patients are not bound by secret limitations as are contained in a private contract between the hospital and the doctor.

166 These cases illustrate the trend, referred to by Nathan and Fleming, to broaden hospital liability. In some cases the principle of vicarious liability has been stretched almost beyond the

breaking-point to make hospitals liable for the negligence of doctors who appear to have been more like independent contractors than servants. It is preferable, in my opinion, to recognize the true position of the doctors in these cases as not being servants of the hospital rather than to found vicarious liability on a fictional master-servant relationship. The true view of the law in Canada, as well as in England, seems to me to be properly stated in Speller's Law Relating To Hospitals, 6th ed. (1978) at p. 254:

> Thus the majority judgments in the Court of Appeal in Cassidy's case appeared to make liability or non-liability of the hospital authority depend on the nature of its contract with the surgeon or physician concerned, a most unreal distinction, which left the patient's possible recourse against the hospital for negligent injury to be determined by reference to a contract to which he was not a party and of the terms of which he could know nothing. Fortunately the difficulties created by the majority judgments in Cassidy's case seem now to have been largely removed by the judgments delivered in the Court of Appeal in Roe v. Minister of Health, Woolley v. Same.

167 In England, the difficulty of determining a hospital's liability may be lessened by the special statutory obligations placed upon hospitals. Direct liability, however, does not depend solely on statute, as both Lord Greene, M.R., in Gold's case and Lord Nathan emphasized in the passages I have already quoted. It is but one of the relevant considerations to be taken into account. There is no reason why a hospital could not assume the duty of treating the patient through a non-paid member of its medical staff. The absence of a statutory obligation to treat the patient does not prevent the hospital from undertaking such an obligation.

168 No case binding on this Court has held that hospitals are liable only for the negligence of doctors employed by them. Some reservations have been expressed in the English cases, as I have noted, about a hospital's liability for the negligence of doctors variously described as visiting surgeons or consultants. There is no evidence before this Court that such positions in English hospitals are comparable to the positions of the medical staff in Ontario hospitals, and counsel were unable to assist us in this matter. However, assuming that the positions are roughly comparable, it is still the case that the reservations expressed in the English cases are mere obiter dicta. They do not preclude this Court from considering whether the Hospital may be liable for the negligence of a member of its medical staff. Because of this Lord Nathan's comments on the liability of visiting consultants are illuminating. He said at pp. 143-4:

> If the liability of hospitals for the negligence of their staff were in truth a purely vicarious liability, there would, of course, be a great deal to be said for the view that they could escape liability for the negligence of visiting surgeons, for such surgeons might well fall within the category of "independent contractors" and not within that of servants; although it should be observed that the fact that a person has only a part-time appointment is not necessarily incompatible with his being a

> servant. But if it is accepted that the liability of a hospital is a personal liability depending upon the extent of the obligation undertaken by the hospital towards the patient, it is surely difficult to come to any other conclusion than that the hospital's obligation extends to treating the patient by the hands of the staff comprised in its organisation, including visiting surgeons and physicians.

169 In the circumstances of this case, it is the relationship between the patient and the Hospital which is paramount in ascertaining the extent of the Hospital's duty. In other cases, the relationship between the doctor and the hospital may be more important. No general rule can be laid down but there can be no dispute that the effect of the cases is fairly stated by Professor Picard in Legal Liability of Doctors and Hospitals in Canada at p. 267:

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

170 There is little doubt that the perception of the roles of hospitals and doctors is changing. My brother Arnup has referred to the article of Professor Linden, as he then was, entitled "Changing Patterns of Hospital Liability in Canada" and published more than a decade ago ((1966-67), 5 Alta. L. Rev. 212), which questioned whether the "English rule" should apply to Canada because of the differences in medical and hospital practice in the two countries. Practices and attitudes change and undoubtedly the pace has been accelerated by the introduction of universal medical insurance since the article was published. I consider that Professor Picard's text, op. cit., published in 1978, more accurately reflects the current state of the law and public attitudes towards it in the following passage at p. 275:

> In summary, the responsibilities of the hospital to the patient have expanded greatly in breadth and depth in this century. Hospitals have become much more than the hotel-employment agency they once were but with their greater size and sophistication has come an impersonal approach often aggravated by poor public relations. Public attitudes to hospitals have changed partially, the consequence no doubt of the removal of barriers to liability but largely due to the apparent means of hospitals, through government funding, to compensate. Public expectations that hospitals will provide total care and make all arrangements are influencing courts in determining the responsibilities of hospitals. If the hospital is to bear

> more responsibility for the doctor, present systems and organization may have to be reviewed. It is clear that the doctor-hospital relationship has never been more important and it must be improved.

171 The recognition of a direct duty of hospitals to provide non- negligent medical treatment reflects the reality of the relationship between hospitals and the public in contemporary society. This direct duty arises from profound changes in social structures and public attitudes relating to medical services and the concomitant changes in the function of hospitals in providing them. It is obvious that as a result of these changes the role of hospitals in the delivery of medical services has expanded. The public increasingly relies on hospitals to provide medical treatment and, in particular, on emergency services. Hospitals to a growing extent hold out to the public that they provide such treatment and such services.

172 At the outset of my review of the Hospital's duty in tort I asked whether the Hospital could have undertaken a direct duty to provide medical treatment, and whether in the circumstances of this case it did. From the foregoing I conclude that the common law does recognize that hospitals can in certain circumstances be directly liable to patients for the negligent performance of medical services, as held by Holland, J. As Lords Greene, Morris and Nathan have observed, whether and to what extent a hospital assumes a direct duty depends upon the circumstances of the particular case. I am of the opinion that in the circumstances of this case the Hospital is liable. It is unnecessary to refer again to the facts which I have quoted from the judgment of Holland, J. In the emergency, the Hospital provided, as it held itself out to do, the only means of obtaining medical care for Tony. His life was placed completely in the Hospital's hands. He and his family relied entirely on the Hospital to use its resources of equipment and skilled, but anonymous, personnel to restore his health. With the greatest of respect for those who hold the contrary view, I believe that, in the circumstances of this case, the Hospital's obligation to Tony could not be limited merely to placing a qualified doctor at his disposal. The Hospital assumed and would be expected to assume complete responsibility for Tony's treatment.

173 Having reached this conclusion, it is unnecessary for me to consider the alternate submission made on behalf of the respondents. It was that, in all the circumstances, Drs. Chin and Rosen were in law servants of the Hospital and the Hospital was, therefore, vicariously responsible for their negligence. As I have indicated, the concept of vicarious liability has been greatly extended in some cases but I refrain from expressing any view on this question, which may arise in another case where it is vital to the decision.

174 I would, therefore, dismiss the appeal with costs and allow the cross-appeal against the Hospital with costs.

175 HOULDEN, J.A. (dissenting in part):-- I have had the benefit of reading the reasons for judgment of the other members of the Court, and while I agree with the disposition of the appeal proposed by my brother Blair, I would like very briefly to state my own reasons for arriving at this

result.

176 The trial Judge reviewed Canadian, English, Australian and American jurisprudence, and analysed the Public Hospitals Act of Ontario, R.S.O. 1970, c. 378. From this review and analysis, he deduced the following principles [20 O.R. (2d) 510 at pp. 533-4, 88 D.L.R. (3d) 161 at pp. 183-4, 6 C.C.L.T. 81]:

> 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.

He concluded that the present case fell in the third category and that the hospital was responsible in law for the negligence of Dr. Rosen.

177 While I agree with the trial Judge's general approach to the issue of liability, with deference, I believe that his third category leaves the legal responsibility of a hospital to a patient for the negligence of a physician in an uncertain and unsettled state. In my opinion, the duty of care owed by the hospital to a patient should be expressed in a manner that is consistent with the role and function of a general hospital in our present-day society. And I believe, if this is done, the duty can be expressed in clear and simple terms so that all concerned -- patients, doctors and hospitals -- will have no doubt as to the circumstances that give rise to legal liability.

178 As I see it, the functions performed by general hospitals can be divided into two classifications, and I believe these classifications can be used to determine the duty of care owed by a hospital to a patient. I should make it clear, before turning to my classifications, that I am not concerned about vicarious liability. The vicarious liability of a hospital for the negligence of a doctor is well established, but it has no relevance for this case. Turning then to the classification of functions, I believe that they are the following.

179 First, a general hospital may function as a place where medical care facilities are provided for the use of a physician and his patient. The patient comes to the hospital because his physician has decided that the hospital's facilities are needed for the proper care and treatment of the patient. This use of the hospital is made possible by an arrangement between the hospital and the physician by which the physician is granted hospital privileges. Where a hospital functions as merely the provider of medical care facilities, then, as the trial Judge pointed out, a hospital is not responsible for the negligence of the physician. The present case does not, of course, come within this

classification.

180 Second, a general hospital may function as a place where a person in need of treatment goes to obtain treatment. Here the role of the hospital is that of an institution where medical treatment is made available to those who require it. The present case falls in this second classification. Tony Yepremian was brought to the Scarborough General Hospital because he was in need of treatment. Does a hospital in these circumstances have the duty to provide proper medical care to a patient? In my judgment, it does.

181 Significant steps have been taken in Canada towards achieving a system of universal health care. At the same time, the mobility of our population has increased. These social changes, together with the ever-increasing fragmentation of the medical profession into specialties, have weakened the reliance on the "family doctor" and have increased the reliance on hospitals as places where medical treatment can be obtained. Indeed, hospitals have recognized this change in their function by the provision of family, out-patient and various other clinics, as well as by the posting of signs and symbols to indicate the location of hospital facilities.

182 The provision of a wide range of medical services is thus an integral and essential part of the operation of a modern, general hospital. This is so regardless of the way in which the hospital has structured its relationship with the professional personnel who provide those services. While the negligent act may be committed by a particular individual, that act is part of the over-all medical care provided by the hospital. It is medical care that is sought by the patient; and it is proper medical care that should be provided. The primary responsibility for the provision of this medical care is, in my opinion, that of the hospital, and the hospital cannot delegate that responsibility to others so as to relieve itself of liability.

183 I would therefore define the duty of care of a general hospital in Ontario in this way: Where a person goes to a general hospital to obtain treatment and the hospital accepts him as a patient, the hospital has a non-delegable duty to use reasonable care and skill in treating him. This duty will, of course, be carried out by the members of the hospital's staff, and if breached, the hospital will be liable to the patient even though the physician who committed the negligent act was not an employee of the hospital and even though the hospital used all due care in granting hospital privileges to the physician.

184 It was submitted by counsel for the hospital that the creation of such a duty will require hospitals, in order to protect themselves from liability, to supervise and scrutinize the practice of medicine by physicians. In turn, this could interfere with the independence of physicians, as well as inhibit innovation and experimentation. Progress in medical science and the provision of novel and imaginative medical services would be retarded. I find these submissions unpersuasive. I see no reason why, with diligent effort, tolerance, and compromise, these problems, if they arise, cannot be solved. However, the issue in this case is not the finding of a solution for these problems, but who should bear the responsibility for the negligent treatment that was given to Tony Yepremian. In my

opinion, the hospital must bear that responsibility.

185 For these reasons, I would dispose of the appeal in the manner proposed by my brother Blair.

Appeal by defendant hospital allowed;
plaintiffs' cross-appeal dismissed.