The Liability of Hospitals in Common Law Canada

I. The hospital as it once was

The earliest hospitals were charitable institutions and protected as such by the courts.[1] They were sustained by endowments and voluntary contributions, which were encouraged in England by the creation of the charitable trust.[2] In order to function hospitals had to purchase supplies of food and equipment, and hire persons to care for the patient and operate the physical plant. Provision was eventually made for some patients to pay for their accommodation.[3] Thus, of necessity, hospitals entered into legal relationships and became accountable under contracts, and by 1907 it was clear that a hospital was liable for the negligence of its employees.[4] But it was also held that a hospital could not be liable for the negligence of employees such as nurses or doctors in the execution of their professional duties, as opposed to administrative functions. The rationale for this limitation was that the hospital neither directed nor controlled the exercise of professional judgment.

In the *Hillyer* case the English Court of Appeal concluded that a hospital undertook certain duties toward a patient:

> The governors of a public hospital, by their admission of the patient to enjoy in the hospital the gratuitous benefit of its care, do, I think, undertake that the patient whilst there shall be treated only by experts, whether surgeons, physicians or nurses, of whose professional competence the governors have taken reasonable care to assure themselves; and, further, that those experts shall have at their disposal, for the care and treatment of the patient, fit and proper apparatus and appliances.[5]

Thus, approximately seventy-five years ago, a patient had some recourse against a hospital: in contract, depending on the terms thereof, or in tort, if the hospital had breached its duty to select competent staff and to supply proper equipment, or by vicarious liability, subject to the restriction in the *Hillyer* case.

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[1] The derivation of "hospital" from *hospitalis*, in Latin meaning "a place for guests", is of some etymological interest: see the *Oxford English Dictionary*.

[2] 43 Eliz. 1, c. 4: see Speller, *The Law Relating to Hospitals and Kindred Institutions*, 4th ed., (1978), 3.

[3] *Ibid.*, 101.

[4] *Hillyer* v. *The Governors of St Bartholomew's Hospital* [1909] 2 K.B. 820 (C.A.).

[5] *Ibid.*, 829.

Nevertheless the protectionist attitude of the courts had taken seed, germinating in the form of immunities which have affected legal analysis and shaped the modern law relating to hospitals. A discussion of this influence in the common law provinces of Canada is the subject of this paper.

II. The hospital as it now is

The modern hospital is big business. According to a recent analysis,[6] the health care system is the largest service industry in Canada. Hospitals cost fourteen billion dollars annually, an amount equal to seven *per cent* of the Canadian gross national product. There are approximately 40,000 physicians and 375,000 workers in about 2,700 institutions, ranging from large hospitals to private nursing homes. The income of the Toronto General Hospital would be 364th among the top 500 companies ranked by the *Financial Post*.[7]

The modern hospital is a very complex organization and is subject to analysis and comment by experts in the field of health care administration.[8] Many of the unique features and problem areas of the hospital identified by these studies, arising primarily from the diverse objectives of the hospital and from its unwieldy power structure, should be of interest to lawyers.

The *raison d'être* of the hospital is the patient but many others depend on it for their livelihood, including the traditional triumvirate of doctors, nurses, and administrators. The growth of medical knowledge has resulted in new members being added to the health care team. There have also been dramatic changes in the nursing profession in the last decade and considerable growth in the number of administrators specializing in health care systems.

A doctor can no longer expect to practise alone in the hospital, and he may see new personnel and any variations in the old as threatening his independence. However, the hospital requires these changes to accommodate its growth.[9] A doctor needs the hospital in order to treat his patients and to earn a living, but the restrictions imposed by the hospital on this privilege may lead to conflicts

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[6] Lilley, *Healing is the Biggest Business* The Financial Post (Nov. 29, 1980), 14, 18.

[7] *Ibid.*, 16.

[8] See, *e.g.*, Georgopoulos, *Organization Research on Health Institutions* (1972): see also Meilicke & Storch, *Perspectives on Canadian Health and Social Services Policy: History and Emerging Trends* (1980).

[9] Blishen, *Doctors & Doctrines: the Ideology of Medical Care in Canada* (1969), 81-4.

with the hospital administrators[10] or even with the doctor's peers. Administrators must be extremely cost-conscious in times of increasing costs and decreasing government support and doctors, because of the organization of the hospital, must vet and review their colleagues' performance. In addition to these potential conflicts the hospital's major role as an education and research facility, and its committee-based administration of these functions, may lead to discord. Many committees are composed of representatives from various groups serving in the hospital and each is expected to reflect the needs and wishes of its constituency; but the decision of a hospital committee often affects an individual, perhaps a doctor's research proposal, or a group, such as the house staff, and may be restrictive in nature. Thus a modern hospital is the forum for personnel of different training and background to work out their diverse objectives.

The authority structure in the modern hospital is shared by the governing body (usually a board of outstanding citizens), the professional administrators and the doctors. Each has a valid basis for demanding control over policy-making and organization. Any conflicts amongst these groups are disruptive of the smooth operation of the hospital.[11] But when this power structure is analyzed from the patient's perspective the potential for conflict seems clear, for while the administration as delegate of the board has the responsibility for the total care of the patient the doctor takes over the actual treatment of the patient. Furthermore, while the decision to grant or vary admitting privileges is made by the board, the recommendations and advice of the committees of doctors is critical.[12] All groups, including the doctors themselves, have expressed some dissatisfaction with this structure. Therefore the scene within the hospital is one of overlapping responsibilities, conflicting goals and fragmented decision-making.[13]

From outside its walls the modern hospital is shaped by legislation and by the principles of corporation law.[14] The great body

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[10] For a description of the position of the hospital administrator, see McKerrow, *The Roles and Responsibilities of a Hospital Administrator* (1980) 1 Health Law in Canada 10: for a discussion of the doctor's position, see Read, *The Physician's Responsibility in Hospital Organization* (1972) 49 Can. Hosp. (August) 53.

[11] *Supra*, note 10, 69-84.

[12] See Rozovsky, *Canadian Hospital Law* (1979), 77-85.

[13] See Kast & Rosenzweig, *Organization and Management: A Systems Approach* (1970), 527-52.

[14] Rozovsky, *supra*, note 12, 7-14.

of law which sets out the obligations and opportunities for free enterprise applies to the hospital since most Canadian hospitals are operated as corporations; in addition, the hospital corporation is further regulated by a significant volume of legislation. The primary purpose of the provincial legislation is the control and licensing of hospitals and the establishment of basic standards for their operation. But the most potent legislation is that governing the provincial government insurance plans because it is the conduit through which all operating costs of Canadian hospitals flow.[15] Unfortunately this funding scheme requires federal involvement with its attendant policy changes and political tensions.[16]

The policies and organization of hospitals are also affected by decisions of the courts relating to their liability to patients.[17] Since the insurance taken by Canadian hospitals to cover the risk of liability to a patient is contracted with private insurers, no statistics are available,[18] but the marketplace dictates that risks must be reduced and risk-management studies and programs are well established in Canadian hospitals. Indeed, Professor Magnet has suggested that a duty to set up a risk-management system be imposed on Canadian hospitals, and that failure to do so or to use care in designing or administrating it should result in liability in contract or tort.[19]

It is clear therefore that the legislatures and the courts play a role in the development of the Canadian hospital.

III. The patient then and now

The first hospital patients were the cast-offs of society. The middle and upper classes were treated in their own homes by doctors who called on them there and they were cared for by servants and family. It was only the indigent who went to the hospitals, and the hospital and doctor provided their services gra-

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[15] See Linden, *Changing Patterns of Hospital Liability* (1966-67) 5 Alta L. Rev. 212, 218. It is apparent that times have changed in Canada for the hospital and the medical profession.

[16] See Van Loon, "From Shared Cost to Block Funding and Beyond: the Politics of Health Insurance in Canada" in Meilicke & Storch, *supra*, note 8, 342-66.

[17] See Picard, *Legal Liability of Doctors and Hospitals in Canada* (1978), 247-75.

[18] This should be contrasted with the situation of Canadian doctors, for which the reader is referred to the annual reports of the Canadian Medical Protective Association for interesting and valuable statistics.

[19] Magnet, *Preventing Medical Malpractice in Hospitals: Perspectives from Law and Policy* (1979) 3 Leg. Med. Q. 197.

tuitously to such patients. A patient injured by either would have had an extremely difficult time pursuing any compensation through legal action.[20] An action in contract might well have failed for lack of intention, uncertainty of terms or lack of consideration.[21] An action in tort might have been brought in trespass to the person but consent could have been implied rather easily.[22] It was the negligence action of the mid-nineteenth century which first brought an opportunity for a patient to demand, in a court of law, that a hospital be held accountable for its actions. But the scope of such an action was quickly restricted by the courts, as outlined earlier. The two main bases for the liability of a hospital, namely a direct duty of care and vicarious liability, were carefully controlled so as to afford hospitals maximum immunity to the suits of patients.

The situation of the modern patient is very different. Today the hospital is the primary institution for health care. It is in the modern hospital that a patient can receive the best health care available because that is where the skill, knowledge and judgment of health-care professionals may be combined with modern medical equipment and technology. Today a patient comes to hospital not seeking charity, but highly skilled medical treatment and he might well have had his name on a waiting-list before being admitted! The modern patient pays for his hospital care through insurance plans and through taxes, although one study points out that the public lacks an accurate appreciation of the cost of their premiums and the total cost of health care.[23]

But the greatest contrast between patients of the earlier hospitals and of the modern hospital lies in the legal relationships formed with the hospital. Any legal relationship the early patient had with a hospital was tenuous and if it gave rise to legal obligations the courts interpreted them restrictively.[24] The modern patient has strong, well-defined legal relationships with his hospital. He has a contract with the hospital, the terms of which are rarely express but may be implied from legislation, hospital by-laws, conduct of the parties and even public expectations.[25] His relationship, in fact, with a hospital is that of being a patient *of the hospital* and it gives rise to certain duties owed to him by the institution.[26] The hospital must

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[20] See Picard, *supra*, note 17, 17-24.

[21] *Ibid.*, 51-8.

[22] See *Latter* v. *Braddell* (1881) 50 L.J.Q.B. 448 (C.A.).

[23] Le Riche, *People Look at Doctors* (1971), 103.

[24] *Supra*, note 4.

[25] See Picard, *supra*, note 17, 249-50.

[26] See Hamson, "The Liability of Hospitals for Negligence" in *The Law in Action* (1954), 19, 26-7.

not violate his right to be free from unauthorized touching,[27] nor injure him by carrying out its duties in a sub-standard manner. The doctor-patient relationship likewise gives rise to certain duties but it is crucial to any analysis of the patient's position to remember that, while these duties of hospital and doctor may be concomitant, each set of duties is based on a separate and distinct relationship.

There is another relationship to which the patient is not a party but which affects him nevertheless, that between the doctor and the hospital. The doctor-hospital relationship is a contractual one, whether the doctor has an express contract of employment or is a private practitioner with certain rights granted to him by the hospital to admit and treat patients.[28] Thus, the modern patient who has been injured while in hospital may have a cause of action against the hospital in contract or in negligence.[29] He may have an action against his doctor as well.[30]

But the position of the patient in a suit against a hospital and a doctor (or doctors) is awkward. For a portion of the relationship he may have been very ill, or even unconscious.[31] Indeed he may have died and the action taken is being conducted by his estate. The patient or his legal representatives may not know which persons should be named as defendants nor understand their relationship to the hospital. For example, the terms of the contract between the hospital and a doctor will not be known to the patient.[32]

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[27] The action in battery is not discussed in this paper: see Picard, *supra*, note 17, 63-91, esp. 88-91.

[28] More exactly, the hospital offers the "privileges" on certain terms and the doctor accepts. The doctor enjoys the opportunity of using the hospital's facilities and staff in order to treat his patients. The hospital acquires the services of a doctor in fulfilment of the most basic duty it has to its patients, namely, to select competent staff so that patients may be attended by such professionals, and also in fulfilment of the hospital's responsibilities of instruction, supervision and organization. Doctors on committees and on call in emergency rooms are essential to the hospital's operation. Terms of such a contract will be found in hospital policy, by-laws, and provincial legislation: see Rozovsky, *supra*, note 12, 77-83; Louisell & Williams, *Medical Malpractice* (1977), Vol. I, 507-9.

[29] In the common law provinces the negligence action is more likely: see Keith, *Claims Arising Out of the Relationship between Hospital and Patient* [1963] Law Soc'y of Upper Canada Special Lectures 203. Magnet (*supra*, note 19, 198) has concluded that there is no difference between the two.

[30] For a discussion of this action, see Picard, *supra*, note 17, 91-166.

[31] *Yepremian* v. *Scarborough General Hospital* (1980) 28 O.R. (2d) 494 (C.A.), *rev'g* in part (1978) 20 O.R. 510 (H.C.). A settlement out of court precluded an appeal of this case to the Supreme Court of Canada: see The Globe and Mail (Jan. 17, 1981), 1.

[32] Speller, *supra*, note 15, 224.

But if the patient is unable to point to a defendant causing his injury he may be precluded from relying on *res ipsa loquitur*.[33] And even if he succeeds in ferreting out all defendants, the mass of conflicting evidence raised by them in their attempts to heap liability on each other may be enough to confound a judge.[34] Furthermore, the source of knowledge regarding the occurrence that caused his injury is within the institution he must sue and he may have to take the hospital to court in order to obtain copies of his hospital record.[35] The proof of causation is exceptionally complex when the human body is involved[36] and to succeed in such proof the patient needs the assistance from other members of the medical profession who may be reluctant witnesses.[37] In summary, the modern patient attempting to obtain compensation for an injury suffered in a hospital is in an unenviable position. He may have extreme problems of proof and because he may be seen by some to be biting the hand that extended charity to him he may have to probe the gauze curtain set up by the courts to protect the hospital from liability.

In general the hospital's immunity has resulted from a restrictive approach to the duties of care owed by hospitals, and a narrow interpretation of the test for vicarious liability. These will now be discussed.

IV. **Limits to the hospital's liability: the gauze curtain**

A. *The action in negligence*

The liability of a hospital to a patient is most often determined within the framework of the negligence action.[38] As is the case with any person or institution, a hospital may be liable because it has been sub-standard in carrying out a duty it owes to a patient, or it may be liable for the negligence of another on the basis of vicarious liability. While it is important not to confuse the two, as the nature and origin of the hospital's liability in each case is quite distinct,[39] they have in common the requirement that negligence be found.

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[33] See Linden, *supra*, note 15, 224.

[34] Hamson, *supra*, note 26, 19.

[35] *Stradzins* v. *Orthopaedic & Arthritic Hospital* (1979) 22 O.R. (2d) 47 (H.C.); *Mitchel* v. *St Michael's Hospital*, unreported (Ont. H.C.), June 6, 1980, *per* Maloney J.

[36] The difficulties are clear in *Yepremian* v. *Scarborough General Hospital*, *supra*, note 31.

[37] See Picard, *supra*, note 17, 214-8.

[38] See Keith, *supra*, note 29.

The ordinary principles of negligence law ought to apply to hospitals. There is no basis upon which to hold that modern hospitals should not be subject to its purview. As one author has suggested:

> surely a hospital ought not to be run much more carelessly than a factory?[40]

This means that to be successful in a suit against a hospital a paaient must prove that:

— the hospital owed him a duty of care;
— the hospital breached the requisite standard of care in carrying out its duty;
— he suffered a loss thereby;
— the hospital's action was the cause in fact and the proximate cause of his injury.

The hospital then has all of the usual defences available to it: the expiry of the limitation period, error of judgment, adherence to approved practice and contributory negligence of the patient. There does appear to be an anomaly in Canadian law in that the proof by a hospital that it was following approved practice may be a conclusive defence. By contrast, the effect of this defence for other defendants is merely to raise a *prima facie* case that the standard of care has been met.[41]

An analysis of the negligence action in general has been undertaken in other writings,[42] but the critical first principle of duty of care merits examination in more depth because it is a potent control-device by which the courts may restrict liability.[43]

B. *The duties owed by hospitals to patients*

A duty of care is found where there is a relationship between the parties such that each is required to avoid acts or omissions which could be foreseen as likely to injure the other. In each case, including those where the purported relationship is with a hospital, the relationship must be examined closely; for while the finding

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[39] See *Salmond on Torts*, 17th ed. (1977), 459-60. One author has pointed out that an undue concentration on vicarious liability has meant that the hospital's "direct" liability has been obscured: see Magnet, *Corporate Negligence as a Basis for Hospital Liability* (1978) 6 C.C.L.T. 121.

[40] Hamson, *supra*, note 26, 19.

[41] See Picard, *supra*, note 17, 178-80.

[42] See Rozovsky, *supra*, note 12; Picard, *supra*, note 17.

[43] For an excellent analysis of the use and abuse of the duty concept, see Smith, "The Mystery of Duty" in Klar, *Studies in Canadian Tort Law* (1977), 1.

of a duty is a matter of law the scope of that duty is a matter of fact. Hence the necessity that a court carefully review the patient, the hospital and the relationship between them in each case. As one authority noted[44] there has been a tendency of the courts not to make this individual assessment but to generalize and impose uniform obligations on hospitals without taking into account the unique features of each case. This seems particularly inappropriate when it is true that each patient has a contract with his hospital with terms unique to their relationship.

What information might be relevant to the decision as to whether a hospital owes a duty of care to a patient? A statute may create a duty or support the creation of a duty and may affect the scope given to it.[45] There is a large body of law and commentary on the effect of statutes in negligence law and this is applicable to the hospital-patient cases.[46] In Canada, relevant statutes would include the provincial hospital acts, health insurance acts and, of course, the attendant regulations.[47] By-laws of the hospital or regulations of professional bodies ought also to be scrutinized.[48] The justification for reference to these sources and perhaps for reliance on them is that they reflect the needs and expectations of the population and the commitments of institutions and professions. However, it should be recognized that these sources are inert and consequently may be slow to reflect such needs and expectations.

Another significant basis of a duty is the undertaking of a party, such as a hospital, to provide a service to a patient especially when the patient relies on the undertaking.[49] It is interesting to note that a contractual relationship between parties may reinforce the establishment of a duty in negligence.[50] There is a very practical reason for finding a duty in such circumstances: the party relying on the undertaking does not look further for his needs. If he relies on another, and does so reasonably and to his detriment, basic principles of tort law support his right to be compensated.[51]

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[44] Nathan, *Medical Negligence* (1957), 133: see also Fleming, *Developments in the English Law of Liability* (1959) 12 Vanderbilt L. Rev. 633, 637.

[45] For the situation in England, see Speller, *supra*, note 2, 13-7.

[46] See Linden, *Canadian Tort Law*, 2nd ed. (1977), 155-218.

[47] See *Yepremian* v. *Scarborough General Hospital, supra*, note 31.

[48] For a comment on the U.S., see Magnet, *supra*, note 39, 124-7.

[49] *Barnett* v. *C. & K. Hosp. Management Committee* [1969] 1 Q.B. 428; Linden, *supra*, note 46.

[50] *Baxter & Co.* v. *Jones* (1903) 6 O.L.R. 360 (C.A.).

[51] *Cf. Hedley, Byrne & Co.* v. *Heller* [1964] A.C. 465 (H.L.) and the myriad cases that follow it: see Linden, *supra*, note 46.

There is modern authority for the statement that a hospital assumes a duty of care to a patient when it undertakes to do anything which can be construed as covering the scope of the duty of care in issue.[52] The nature of the undertaking is the hard question. In theory, a hospital could undertake to provide a wide range of services and care to its patient. Some would no doubt encroach on the undertakings of the other party whose relationship is present, namely a doctor. This might detrimentally affect his means of independent income and violate the rules of his association.[53] It might also appear to provide overlapping obligations to the patient in that a service offered by a hospital would also be offered by the medical profession and the appropriate insurance would be taken by each to cover any possible negligence. Should any of these factors be compelling enough to destroy or sterilize the duty that would otherwise be owed by the hospital to a patient? If the answer be yes, then even if the patient will be compensated from other sources, the hospital is enjoying a favoured position in tort law.

Occasionally in tort law there is a recognition by a judge that a new duty must be created because of the values and interests and relationships that merit the protection of the law. Cases such as *Donoghue* v. *Stevenson*,[54] *Hedley Byrne & Co.* v. *Heller*,[55] *Dutton* v. *Bognor Regis*[56] and in Canada *Bhadauria* v. *Seneca College*[57] come to mind. A court faced with the challenge of bringing forth a "new" duty of care often labours under the burdens of old jurisprudence and obsolete ideas. What it requires is an updating of its information and the introduction of new evidence, to show that critical relationships have changed, institutions have evolved, and so new law must be made. When the duty in issue is of a hospital to a patient one author has expressed this expectation:

> When the case of, say a visiting hospital surgeon comes before the House [of Lords] for determination, it will, it is hoped, be the occasion for the establishment of one of the most important relationships governed by common law on firm, modern foundations, in a manner comparable to the modern statement of the tort of negligence in *Donoghue* v. *Stevenson*.[58]

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[52] Nathan, *supra*, note 44, 13: see also Speller, *supra*, note 2, 253-4.

[53] There is a prohibition against anyone but a licensed physician practising medicine, according to the various provincial statutes governing physicians.

[54] [1932] A.C. 562 (H.L.).

[55] *Supra*, note 51.

[56] [1972] 1 Q.B. 373 (C.A.).

[57] *Bhadauria* v. *Board of Governors of Seneca College* (1979) 27 O.R. (2d) 143 (C.A.), *rev'd* June 22, 1981 (S.C.C.).

[58] Grunfeld, *Recent Developments in the Hospital Cases* (1954) 17 M.L.R. 547 (fn. omitted).

These sources have given rise to courts holding that specific duties are owed by hospitals to patients.

The earliest duty of care held to be owed by a hospital to a patient was to select competent staff in order that patients would be attended by skilled persons. At first this duty was very narrowly interpreted. A hospital had only to ascertain that its professionals were qualified and competent. This seemed to be the scope of its direct or personal or corporate duty of care.[59] The hospital then assumed liability for the administrative acts of such professionals and eventually for their professional actions, provided they were employees. Such liability was not, however, of the direct type but was based on the concept of *respondeat superior*. This vicarious liability for professional employees finally came about in 1942 and an obvious and expansive immunity enjoyed by hospitals was dropped.[60]

The scope of the direct duty was expanded, first to include the instruction and supervision of personnel employed by the hospital and then to the provision of the systems and organization to coordinate these activities so that the patient received reasonable care.[61] Since a patient is treated in a physical plant with equipment and medical tools, it is not suprising that hospitals were also given a direct duty to provide and maintain proper facilities and equipment.[62]

There is some authority for the existence of other duties but often it is not clear whether the court was basing the hospital's accountability on grounds of direct liability or vicarious liability. These include a duty to establish procedures to prevent patients from harming themselves or being injured by other patients.[63] There are some older cases from which it might be concluded that a hospital has a duty to set up aseptic procedures and to protect patients and even visitors from infection.[64]

Though in theory it is possible for further duties to be created, a review of the cases[65] reveals that the courts have been most

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[59] While the three terms are synonymous and refer to the "normal" duty of care, all are used by various authors who wish to be understood as differentiating this from vicarious liability.

[60] See Picard, *supra*, note 17, 261-4.

[61] *Ibid.*, 251-9. The duty to provide organization could be expanded to include the provision of medical treatment by doctors who are not employees: see Nathan, *supra*, note 44, 144.

[62] *Picard, supra*, note 17, 259-61.

[63] *Ibid.*, 257-8.

[64] *Ibid.*, 257: see Nathan, *supra*, note 44, 103.

[65] See generally Picard, *supra*, note 17, 248-61.

cautious when contrasted with their attitude respecting negligence law in general.[66]

In summary, the precedents support these possible direct duties of a hospital to a patient:

a) to select competent and qualified employees
b) to instruct and supervise them
c) to provide proper facilities and equipment
d) to establish systems necessary to the safe operation of the hospital.[67]

Since the other components of tort law apply, the hospital has to carry out these duties as competently as the reasonable hospital in the circumstances and, even if found sub-standard, would have to be found to have caused the patient's injuries before liability would result. All of the protection of tort law normally available to defendants is available to the hospital.[68]

The quality of the duties owed by a hospital has led to their sometimes being referred to as "non-delegable."[69] This has the significant effect of making the employer of an independent contractor strictly liable for any negligence of the contractor in carrying out the duty of care which was the employer's but which he had contracted or delegated to the independent contractor. This is an exception to the general rule that an employer is not liable for the negligence of an independent contractor employed by him. A brief look at the history of a non-delegable duty of care and the controversy surrounding it[70] may assist in understanding its implications for hospital liability.

The first case in which a duty was held to be non-delegable was *Pickard* v. *Smith*[71] in 1861. The plaintiff had fallen into a hole left open by coal merchants employed by the defendant to deliver coal. The trial judge set out the general law:

> Unquestionably, no one can be made liable for an act or breach of duty, unless it be traceable to himself or his servant in the course of his or their employment. Consequently, if an independent contractor is employed to do a lawful act, and in the course of the work, he or his

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[66] Linden, *supra,* note 46, 264.

[67] See Picard, *supra,* note 17, 251-6; Rozovsky, *supra,* note 12, 16-7.

[68] Picard, *supra,* note 17, 169-95.

[69] *Yepremian* v. *Scarborough General Hospital, supra,* note 31; *Gold* v. *Essex County Council* [1942] 2 K.B. 293, 297 (C.A.) *per* Lord Greene, M.R.; *Cassidy* v. *Minister of Health* [1951] 2 K.B. 343, 359 *per* Denning L.J.; see also Nathan, *supra,* note 44, 123, 129, 132.

[70] See Atiyah, *Vicarious Liability in the Law of Torts* (1967), 327-50.

[71] (1861) 10 C.B.N.S. 470, 142 E.R. 535 (C.P.) (hereinafter cited to E.R.).

> servants commit some casual act of wrong or negligence the employer is not answerable.

But he went on to describe the nature of a duty that would be non-delegable:

> The rule is, however, inapplicable to cases in which *the act which occasions the injury is one which the contractor was employed to do;* nor, by a parity of reasoning, to cases in which the contractor is entrusted with the performance of *a duty incumbent upon his employer,* and neglects its fulfilment, whereby an injury is occasioned.[72]

The non-delegable duty of care concept was also being formed in cases involving statutory duties,[73] but it was in 1881 in the case of *Dalton* v. *Angus*[74] that the concept came to life, albeit in a rather skeletal form. Lord Blackburn said:

> a person causing something to be done, the doing of which casts on him a duty, cannot escape from the responsibility attaching on him of seeing that duty performed by delegating it to a contractor. He may bargain with the contractor that he shall perform the duty and stipulate for an indemnity from him if it is not performed, but he cannot thereby relieve himself from liability to those injured by the failure to perform it.[75]

Atiyah comments[76] that this *dictum* has been used to justify the imposition of liability for the acts of independent contractors in a wide variety of circumstances.

Therein lies the greatest problem with the characterization of a duty as non-delegable.[77] It is impossible to predict with certainty when it will happen. Williams, who is the greatest critic of the concept, says:

> The truth seems to be that the cases are decided on no rational grounds, but depend entirely on whether the judge is attracted by the language of nondelegable duty.[78]

Chapman[79] (now Mr Justice Chapman), whose strong support for the concept helped breathe life into it, agreed that it is not easy to discriminate between delegable and non-delegable duties but said the test should be:

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[72] *Ibid.*, 539 (emphasis added).

[73] Atiyah, *supra,* note 70, 328-9: note that the learned author observes that in one case a court "prayed in aid the analogy of contract". The hospital-patient relationship is, of course, a contractual one and may be affected by statute.

[74] (1881) 6 App. Cas. 740 (H.L.).

[75] *Ibid.*, 829.

[76] *Supra,* note 70, 332.

[77] Fleming, *The Law of Torts,* 5th ed. (1977), 377-8.

[78] Williams, *Liability for Independent Contractors* [1956] Camb. L.J. 180, 186.

[79] Chapman, *Liability for the Negligence of Independent Contractors* (1934) 50 L.Q.R. 71.

> whether there is imposed on the person *by the nature of the acts* he is getting done a duty to those people whom as a reasonable man he ought to foresee as being affected by the performance of those acts.[80]

Thus the test refers to the "nature of the acts" undertaken by the employer. Fleming[81] discusses the kinds of cases where non-delegable duties have been found and notes that the list is "long and diverse" extending from dangerous situations, hazardous substances, fire, lateral support for land, maintenance of premises abutting a highway to instances where the duty would normally be to use reasonable care but where the designation of the duty as non-delegable assures that care will be taken (provision of a safe system of work, compliance with statutory safety standards, responsibilities of occupiers of land to certain others and of hospitals to care for their patients). Fleming includes hospitals in the latter category because of the judgments in *Cassidy* v. *Minister of Health*[82] and *Roe* v. *Minister of Health.*[83] In the *Cassidy* case Denning L.J., in deciding the scope of a hospital's duty to a patient for medical treatment, said:

> 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* (67) [(1876) 1 Q.B.D. 314, 319] *Dalton* v. *Angus* (68) [(1881) 6 App. Cas. 740, 829] and *Hughes* v. *Percival* (69) [(1883) 8 App. Cas. 443, 446]; and so have other great judges, see *per* Parke, B., in *Grote* v. *Chester and Holyhead Ry. Co.* (70) [(1848) 2 Ex. 251, 254], and in *Pickard* v. *Smith* (71) [(1861) 10 C.B. (N.S.) 470, 480]; see also *per* Lindley, L.J., in *Hardaker* v. *Idle District Council* (72) [[1896] 1 Q.B. 335, 340] and *per* this court in *Woodward* v. *Hastings Corporation* (73) [[1945] K.B. 174, 182].[84]

What justification is there for construing the nature of a duty to be delegable or non-delegable? Glanville Williams[85] has said there is none and called the non-delegable duty a logical fraud. But Atiyah points out[86] that most learned American writers not only find it valid to impose liability for the acts of independent contract-

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[80] *Ibid.*, 76. For a strong criticism, see Williams, *supra*, note 78, 194 (emphasis added).

[81] Fleming, *supra*, note 77, 378: citations to relevant case law may be found therein.

[82] *Supra*, note 69.

[83] [1954] 2 Q.B. 66 (C.A.).

[84] *Supra*, note 69, 363 (footnotes included). Note that he cites all the old authorities regarding non-delegable duty.

[85] Williams, *supra*, note 78, 193.

[86] Atiyah, *supra*, note 70, 333.

ors but they would extend liability even further. The critical question as they see it is who should shoulder the risk. Should it be the employer, as is the case when a duty is set as non-delegable, or should it be the independent contractor as is the case otherwise? References to the reasons enunciated for the doctrine of *respondeat superior*, wherein an employer is responsible for the torts of his employee, would seem to suggest that it should be the employer, since the employer benefits from the contractor's work, he chooses the contractor, he can set up the relationship on terms satisfactory to him, and so on. Furthermore, the employer can make arrangements to cope with a risk for which he may have to pay because, as Atiyah notes,[87] the employer of an independent contractor is entitled to be indemnified for liabilities imposed by the contractor on the employer. In describing one justification for making an employer liable for an independent contractor's negligence by way of the non-delegable duty, Atiyah uses the example of the hospital.

> There is another factor, too, which ought to be borne in mind. We have already called attention to the way in which the man in the street tends to personify an organisation and treat it as a composite entity which ought in justice to pay for damage which "they" have caused. In many circumstances there is little doubt that the man in the street would find it hard to grasp the law's fine distinctions between a servant and an independent contractor, and would not wish to enquire too closely into the precise relationships existing in one organisation. This is particularly true where the liability is of a contractual or semi-contractual nature, as *e.g.* in the case of hospitals. A person injured through the negligence of someone in a hospital tends to think of the hospital as a unit which ought to be responsible for the consequences, and he is unlikely to be impressed by arguments that the negligent party was, say, a visiting consultant who ought to be treated as an independent contractor.[88]

An interesting corollary to the proposition stated by Atiyah is the point made earlier that the patient injured in a hospital often has a complex problem in sorting out the cause of his injury and the persons involved.

With this background it is possible to come to an opinion as to whether it is appropriate that a particular duty of care owed by a hospital to a patient should be of the non-delegable type. Once again the point must be made that this decision must be made for each case and only after a thorough examination of the hospital-patient relationship involved.[89] A recent case provides an excellent opportunity to examine such a relationship.

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[87] *Ibid.*: it is interesting to note the comments of Holland J. to the same effect in *Yepremian, supra*, note 31, 534.

[88] *Supra*, note 70, 335.

[89] See text at notes 40 and 41, *supra*.

In *Yepremian* v. *Scarborough General Hospital*[90] a comatose patient nineteen years of age was brought to the emergency department of the hospital by his parents. He was clearly very ill and was transferred to the intensive care unit under the name of Dr Rosen, not because he or his family had chosen Dr Rosen but because the organization by the hospital corporation put Dr Rosen on call in emergency at the critical time. Dr Rosen was held by all judges to be negligent and as a result of his negligence the patient suffered a cardiac arrest and serious permanent injury. Dr Rosen was not an employee of the hospital but had admitting privileges there.[91] He was not sued. The issue on appeal was whether the hospital was liable for Dr Rosen's negligence. The trial judge held it was while the Court of Appeal, by a three-to-two majority, held it was not. On analysis it seems that the six learned justices who heard the case (five on appeal plus the trial judge) agreed that the appropriate duty of care, namely to provide non-negligent medical services to Yepremian, was of the non-delegable type, but they split equally on the issue of whether the relationship between Yepremian and the Scarborough General Hospital created such a duty.

The relationship between the patient and the hospital arose when the very ill patient was taken into the hospital's emergency department by hospital employees.[92] The duties the hospital then assumed would have been those set out earlier,[93] including a duty to set up such systems as are necessary for the proper treatment of the patient. The system which the hospital had set up for treating a patient such as Yepremian included assigning the internist on call to his case. Dr Rosen was the internist and was on call as part of his contract with the hospital for privileges. Could this duty include an undertaking by the hospital to provide proper or non-negligent medical treatment? The answer is that it has been so held in some cases where the medical treatment was given by an employee of the hospital.[94] But the facts of the case were that the medical treatment was given by an independent contractor. Thus, the consequence of finding a duty to provide medical treatment *by an independent contractor* in the Yepremian case, if the duty

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[90] *Supra*, note 31.

[91] As Dr Rosen's negligence was found to be the effective cause, two other doctors found negligent were protected from liability; see Picard, [*Comment*] *Yepremian* v. *Scarborough General Hospital* (1980) 14 C.C.L.T. 81.

[92] *Barnett* v. *C & K Hospital Management Committee, supra*, note 49.

[93] *Yepremian* v. *Scarborough General Hospital, supra*, note 31, 522-3.

[94] See, *e.g.*, *Aynsley* v. *Toronto General Hospital* [1972] S.C.R. 435; *Fraser* v. *Vancouver General Hospital* [1952] 2 S.C.R. 36.

was held to be non-delegable, would be to make the Scarborough General Hospital liable to Yepremian for the negligence of Dr Rosen, a specialist on call with privileges at the hospital. There is no precedent for the liability of a hospital on such a basis although various authorities have been predicting it for many years.[95]

Thus, the decision as to whether the duty was non-delegable determined the liability of the hospital. The only way to assure the hospital's immunity to liability would be to hold that there was no duty to provide medical treatment owed by the hospital to the patient. This, indeed, was the conclusion of the majority of the Court of Appeal of Ontario in the *Yepremian* case.

Assuming, as the other three learned justices did, that there is such a duty, were all six justices correct in concluding it should be non-delegable? By the best test available,[96] one must look at "the nature of the acts" undertaken by the employer. The hospital undertook to provide what the patient was seeking and required and what, by statute, it was required[97] to give. Thus there were contractual and statutory aspects to the acts. The nature of the undertaking by the hospital, to provide basic, critical diagnosis and treatment would seem to bring it within the ambit of cases outlined by Fleming,[98] wherein it must be assured that care will be taken. This, of course, has been forcefully argued by Lord Denning.[99]

Did the nature of the undertaking justify placing on the hospital the risk of the injury suffered by Yepremian? The hospital as an institution offered Dr Rosen those privileges that he had and the "on call" system was a benefit to him for the patients he obtained through it; it was also a benefit to the hospital for it helped the hospital fulfill its duty to operate emergency services and allowed it to admit persons in need of active treatment. Furthermore, it was the hospital-employer rather than the independent contractor-doctor who was in the best position to monitor risks and improve the systems involved.[100] Since the granting of privileges at the Scarbo-

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[95] See Speller, *supra,* note 2, 253-4; Nathan, *supra,* note 44, 144-5.

[96] See Chapman, *supra,* note 79, 76.

[97] See *Yepremian, supra,* note 31, 524-5 *per* Holland J. In the Court of Appeal, however, Arnup J.A. says (*supra,* note 31, 512) that there is no express obligation in acts or regulations to provide competent medical care but that these are predicated "on the existence of an obligation to see [that] such care is provided."

[98] *Supra,* note 77, 378.

[99] *Cassidy* v. *Minister of Health, supra,* note 69; *Roe* v. *Minister of Health, supra,* note 83.

[100] See Linden, *supra,* note 15, 224.

rough General Hospital, as with most hospitals, was for a term of one year, the hospital was in a position to withdraw or renegotiate these privileges.[101] It could have arranged in a formal way for the doctor to have undertaken to indemnify the hospital. The trial judge, Holland J., noted the possibility of such a right in the *Yepremian* case.[102] Of interest in this regard is the arrangement in England between the Medical Defence Union, which acts as an insurer of doctors, and the hospitals. When a doctor who is a member of the Union is sued the hospital joins in defending the case. If liability is found the two parties bear the proportionate share that they have agreed upon or, in the absence of agreement, an equal share.[103]

Atiyah has made the point set out earlier[104] that the nature of the hospital as a complex institution about which the patient knows very little would justify making an employer liable as for a non-delegable duty. It seems then that the learned justices were correct in concluding that the duty, if found, should be non-delegable.

But the Scarborough General Hospital was exonerated because the majority of the Ontario Court of Appeal held that there was no duty of care owed by it to Yepremian in the circumstances. The concerns of Mr Justice Arnup (with whom Mr Justice Morden concurred on this point) and McKinnon A.C.J.O. about creating such a duty are best expressed by the Associate Chief Justice:

> 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.
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> No matter how much our sympathies may be engaged in a particular case, in my view to reverse the longstanding 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

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[101] *Re Schiller and the Board of Governors of the Scarborough General Hospital* (1975) 9 O.R. (2d) 648 (C.A.).

[102] *Supra*, note 31, 535.

[103] See Grunfeld, *supra*, note 58, 554; Speller, *supra*, note 2, 262.

[104] *Supra*, note 88.

> the legal position now by judicial legislation would not, in my view, be appropriate.
>
> 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.[105]

Mr Justice Blair dissented and after a most thorough analysis of all the relevant cases and authorities decided that a duty of care could and did exist. He said:

> 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.[106]

About the concern that judges should not change the law to reflect a change in society, he said:

> 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, on 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.[107]

Mr Justice Houlden also dissented and, like Arnup J.A., held there was a duty of care.[108]

It is submitted that the majority of the Court of Appeal of Ontario were loathe to find that the hospital owed the patient a duty of care because they were unprepared to find the hospital

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[105] *Yepremian, supra,* note 31, 535-6 (C.A.). For a comment expressing concerns about expanding hospital liability, see Magnet, *supra,* note 39, and, by the same author, *Liability of a Hospital for the Negligent Acts of Professionals* (1977) 3 C.C.L.T. 135.

[106] *Yepremian, supra,* note 31, 560-1.

[107] *Ibid.,* 545.

[108] *Ibid.,* 562-4.

liable. An alternative for them would have been to find a duty but hold that it could be delegated to an independent contractor.

Thus, even today, when the hospital is a complex business entity rather than a house of charity, and the patient pays for the services (both directly and indirectly) and is not a gratuitous guest, the hospital is protected by its history.

C. *Vicarious liability of hospitals*

An alternative basis for the liability of a hospital is based on the doctrine of *respondeat superior*. It is an older and more settled area of law in regard to hospitals than that of direct, or personal or corporate duty.[109] All of the principles of the law of vicarious liability are applied to hospitals, but therein lies the problem. Those principles, set up for masters and servants, shop keepers and clerks, do not fit the hospital and its professional staff. But most courts doggedly try to stretch the old garments to fit the new flesh. The concept that was the material measurement of vicarious liability, the control test, no longer covers modern hospital-doctor relationships. The new, more viable organization test, has yet to be worked into Canadian law. The reluctance of courts to move toward the more modern approach has resulted in a restriction in the liability of hospitals.[110]

The reasons for making an employer jointly liable for the torts of his employees are generally said to be that: the person whose economic interests are advanced should have to pay for any loss and will be in a better position to do so than his employee; the employer will be motivated to set up accident prevention programs and choose the most competent employees; the employer has the choice of hiring and dismissing his employee.[111] But authorities[112] agree that the concept of vicarious liability with the banner of *respondeat superior* is a vehicle to achieve a goal that seems fair and necessary. If X "sets up a situation" whereby through Y he achieves an end he needs or desires, should not X be held accountable for the consequences? When the concept was first introduced the master's control over the servant was the justification for holding the master answerable for what occurred through the acts of his servant.[113] But control of that type is most uncommon today. Indeed

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[109] See Grunfeld, *supra*, note 58, 549-50.

[110] See Magnet, *Vicarious Liability and the Professional Employee* (1978) 6 C.C.L.T. 208: see also Kahn-Freund, *Servants and Independent Contractors* (1951) 14 M.L.R. 504.

[111] Fleming, *supra*, note 77, 355.

[112] See *Salmond on Torts*, *supra*, note 39, 457.

almost from the moment the control test went into service its deficiencies were obvious.[114] There is a strong consensus among authorities that it is in respect of its application to professional persons that the control test has broken down.[115] An employer of a professional such as a doctor may know nothing about the practice of medicine. He is not only not in a position to control the doctor but if he attempts to do so will find that the employee has exercised his own form of control over the situation and quit.

That the control test alone is ineffectual in the hospital setting has been clear since the case of *Cassidy* v. *Minister of Health*,[116] where it was held that a hospital is liable for the negligence of a doctor employed on a fulltime basis by it. One author has suggested that the *Cassidy* case discarded the traditional control test,[117] while another has said the hospital cases have emphasized the bankruptcy of the control test.[118]

In Canada there are now cases[119] where a hospital has been held liable for professionals such as doctors and nurses over whom it could not be said it had control in the traditional sense of being able to tell the professional what to do and how to do it.

Thus it seems the control test is not providing a credible, reliable measure of when there should be a shift in bearing the loss from the professional who has caused the negligence to the institution responsible for entering into a relationship with him in order to carry out its functions. Put succinctly, the hospital (X) is achieving many of its ends through professionals (Y). In terms of the "rough justice"[120] sought to be achieved through the concept of vicarious liability, when should X (a hospital and in law a reasonable person) be held accountable for the negligence of Y (a professional)? Surely the answer is when Y is an integral part of X and is making it possible for X to fulfill its duties and obligations. This theory for determining whether liability should be borne by X has been given a name: the organization test. Fleming[121] has described the organization test as asking whether Y's work was subject to coordinated control as to the *when* and the *where* rather than the *how*.

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[113] See Atiyah, *supra*, note 70, 40.

[114] *Ibid.*, 41-4.

[115] *Ibid.*, 46. See also Fleming, *supra*, note 77, 360; *Salmond on Torts*, *supra*, note 39, 462; Nathan, *supra*, note 44, 123.

[116] *Supra*, note 69: see also Kahn-Freund, *supra*, note 110.

[117] See Fanjoy, Comment (1952) 30 Can. Bar Rev. 423.

[118] Grunfeld, *supra*, note 58, 550.

[119] See Picard, *supra*, note 17, 265-6, 271-4; Rozovsky, *supra*, note 12, 18.

[120] *Salmond on Torts*, *supra*, note 39, 457.

This test has been accepted and appplied by the Supreme Court of Canada,[122] and in a recent case[123] in the Supreme Court of Ontario it was used by Linden J. to find one dentist to be the employee of another. The learned justice's decision in that case highlighted the need to examine all of the evidence in each case and to avoid the temptation to generalize about relationships involving hospitals. These cases have been adjudged "good law" by Professor Magnet.[124]

However, Atiyah[125] warns against attempting to formulate an ultimate test for differentiating between those for whose negligence an employer will be liable (employees, those in a contract of service) and those for whom he will normally not be liable (independent contractors, those in a contract for services). Indeed, various authorities have suggested formulating a flexible set of guidelines to be considered in judging each case.[126] Professor Magnet has put it in this way:

> We need to keep a steady eye on what we have got for, applied blindly, in latin, vicarious liability can do great damage and cause enormous uncertainty; applied in harmony with principle, as a transmogrified and innovative doctrine, it can further the great ideals of justice current in our time.[127]

In *Yepremian* v. *Scarborough General Hospital*[128] the possibility of vicarious liability of the hospital was not pursued by any of the six learned justices. The trial judge noted that Dr Rosen was not paid by the hospital but by the patient through the health care plan, and concluded that Dr Rosen was not an employee of the hospital.[129] The majority of the Court of Appeal accepted this conclusion,[130] while Mr Justice Blair in his dissenting judgment said:

> 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.[131]

From examining the evidence reported in the case it can be argued that Dr Rosen would have been an employee had the or-

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[121] *Supra*, note 77, 36; Atiyah, *supra*, note 70, 47.

[122] *Co-op Insurance Assn* v. *Kearney* [1965] S.C.R. 106. The employee was an insurance agent.

[123] *Kennedy* v. *C.N.A. Assurance* (1978) 20 O.R. (2d) 674 (H.C.).

[124] *Supra*, note 110, 226.

[125] *Supra*, note 70, 38.

[126] *Ibid.*; Kahn-Freund, *supra*, note 110, 507; Magnet, *supra*, note 110, 220.

[127] *Supra*, note 110, 226.

[128] *Supra*, note 31.

[129] *Ibid.*, 522 (H.C.).

[130] *Ibid.*, 513 (C.A.) *per* Arnup J.A.

[131] *Ibid.*, 558 (C.A.).

ganization analysis been applied by the courts, because the systems in operation in the Scarborough General Hospital subjected Dr Rosen to co-ordinated control as to the when and the where in regard to his medical treatment of Yepremian. Dr Rosen was the internist on call at the time Yepremian was admitted (the when) to the Scarborough General Hospital emergency department and thence to the intensive care unit by virtue of the privileges Dr Rosen was granted (the where). It is important to remember that under the concept of vicarious liability the liability of the employer and employee is joint and thus the employee is liable too. The employer has the right to be indemnified. Therefore a hospital could seek indemnification from a negligent doctor held to be an employee.[132] The point is not to conclude that there should have been vicarious liability for Dr Rosen's negligence but that the issue should have been addressed more freely.

Thus today, with a longstanding recognition that vicarious liability should be determined from analyses far broader in scope than that of the control test, the liability of hospitals is being decided by reference to a narrow, outdated test that by its very nature protects the hospital from liability for a large number of professionals who facilitate the achievement of hospital objectives.

The issues raised by the *Yepremian* case highlight the alternatives for the modern Canadian hospital: continued immunity or a new accountability to the public.[133]

Ellen Picard*

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[132] See Fleming, *supra*, note 44, 639. Note the arrangement made in England by hospitals and doctors (see note 103, *supra*).

[133] There was no appeal of this case to the Supreme Court of Canada: see note 31, *supra*. For future purposes, perhaps the recent decision of that Court on consent involving the doctor-patient relationship augurs well for the patient in the hospital-patient relationship: see *Reibl* v. *Hughes* (1980) 114 D.L.R. (3d) 1 (S.C.C.).

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