NOVA SCOTIA COURT OF APPEAL

Citation: *Horne v. Queen Elizabeth II Health Sciences Centre*, 2018 NSCA 20

Date: 20180227
Docket: CA 455575
Registry: Halifax

Between:

Gabrielle Horne

Appellant (Cross-respondent)

v.

Queen Elizabeth II Health Sciences Centre and Capital District Health Authority

Respondents (Cross-appellants)

Judges:	Decision of the Court per MacDonald, C.J.N.S., Fichaud and Bourgeois, JJ.A.
Appeal Heard:	November 14-15, 2017, in Halifax, Nova Scotia
Subject:	Administrative bad faith – damages – appellate review of jury award
Summary:	Dr. Horne was a cardiology researcher at the Queen Elizabeth II Hospital, operated by the Capital District Health Authority. In October 2002, her hospital privileges were summarily varied. Capital Health was ultimately responsible for hospital privileges. As a result, Dr. Horne's research foundered. In September 2006, Capital Health's board of directors determined that the summary variation, four years earlier, had been unjustified. Dr. Horne sued Capital Health for administrative bad faith and breach of contract. There was a trial over 33 days before a jury. Before charging the jury, the presiding judge issued a

preliminary decision that (1) dismissed Dr. Horne's claim in contract, and (2) held that any damages would include loss to her research career, encompassed by damage to her reputation, but would not include the restoration of her research career. On June 17, 2016, the jury awarded Dr. Horne $1.4 million against Capital Health for administrative bad faith.

Dr. Horne appealed. Capital Health cross-appealed.

Issues: On Dr. Horne's appeal, the issues were whether the judge erred by withholding her contract claim from the jury, and by ruling that the restoration of her research career was not a permissible head of expectation damages for breach of contract.

On Capital Health's cross-appeal, the issues were whether the judge erroneously instructed the jury (1) on the principles of administrative bad faith and their application to the actors involved, (2) on the principles of damages, particularly by instructing that reputational loss encompasses impairment of Dr. Horne's research career and (3) by not instructing the jury of his preliminary decision that aspects of Dr. Horne's damages claim were impermissible, leading to an inflated award. Capital Health also says that (4) the jury's award of $1.4 million was a palpable and overriding error.

Result: The Court of Appeal dismissed Dr. Horne's appeal. Her cause of action turned on the wrongful summary variation of her privileges. The contractual documents cited by Dr. Horne did not address the variation of privileges. Section 5 of the *Medical Staff (Disciplinary) Bylaws for the District Health Authorities*, under the former *Health Authorities Act*, S.N.S. 2000, c. 6, provided that the variation of privileges was governed by those bylaws, not by contract. The judge correctly held that breach of contract did not apply and Dr. Horne's claim was limited to administrative bad faith.

The Court of Appeal dismissed Capital Health's cross-appeal against liability. The judge's jury charge, read as a whole,

properly instructed the jury on the principles of administrative bad faith, and properly applied those principles to the actors involved.

The Court of Appeal allowed Capital Health's cross-appeal in part, by reducing the damages award from $1.4 million to $800,000.

The jury charge failed to state in plain and understandable terms the legal distinction between the recoverable and unrecoverable features of loss or impairment to Dr. Horne's research career. The charge failed to caution the jury against use of material – evidence and counsel's comments – that had pertained to Dr. Horne's initial damages claim that the judge had ultimately rejected in his preliminary decision. This material included reference to Dr. Horne's claim of $8.2 million. The Court of Appeal held that the judge's errors of law, in this respect, were reasonably capable of affecting the jury's award and potentially caused a miscarriage of justice.

The Court of Appeal reviewed the authorities on quantification of damages, applied the required deference to the jury's assumed findings, and substituted a damages award of $800,000.

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Judges:	MacDonald, C.J.N.S., Fichaud and Bourgeois, JJ.A.
Appeal Heard:	November 14-15, 2017, in Halifax, Nova Scotia
Held:	Appeal dismissed, and cross-appeal allowed in part respecting damages, per reasons for judgment of the Court
Counsel:	Michael D. Wright, Craig M. Garson, Q.C. and Danielle E. Stampley for the Appellant (Cross-Respondent) Marjorie Hickey, Q.C. Peter Rogers, Q.C. and Ian Dunbar for the Respondents (Cross-Appellants)

Reasons for judgment of the Court:

[1] Dr. Gabrielle Horne is a staff cardiologist at Halifax's Queen Elizabeth II Hospital, operated by the Capital District Health Authority. Her interest is research. Her projects used data from patients with heart failure. The patients presented at the Hospital's Heart Function Clinic. However, Dr. Horne and the Clinic's director had a strained professional relationship. On October 21, 2002, at the Clinic director's urging, Dr. Horne's hospital privileges were summarily varied to restrict her enrollment of the Clinic's patients. Then her research foundered.

[2] The Health Authority's board of directors had the ultimate authority over privileges. Over four years, the variation of Dr. Horne's privileges weaved through advisory committees to the board. In September 2006, the board of directors decided that the summary variation had not been justified, and reinstated Dr. Horne's privileges to their status before October 21, 2002.

[3] Dr. Horne then sued the Capital District Health Authority. She claimed that her privileges had been summarily varied in bad faith and in breach of her contract, causing compensable impairment to her research career. There was a jury trial. The presiding judge made preliminary rulings that: (1) Dr. Horne's claim in contract was unsustainable and would be taken from the jury, leaving administrative bad faith as the only cause of action, and (2) loss of her research career was encompassed by damages for lost reputation, but its restoration was not a separate head of damages. On June 17, 2016, after 33 days of trial, the jury awarded Dr. Horne damages of $1.4 million against Capital Health for administrative bad faith.

[4] Dr. Horne appeals. She says the judge erroneously (1) withheld her breach of contract claim from the jury, and (2) ruled that the restoration of her research career was not a separate head of expectation damages for breach of contract. Capital Health cross-appeals, saying: the judge wrongly instructed the jury (1) on the principles of administrative bad faith and their application to the actors involved, and (2) on the principles for damages, particularly by instructing that reputational loss encompasses impairment of Dr. Horne's research career; (3) the judge erred by not advising the jury of his preliminary ruling that aspects of the damages claim were impermissible, which led to an inflated award; and, in any case, (4) the jury's award of $1.4 million was a palpable and overriding error.

[5] The issues span the range of appellate review of a jury award.

1. Background

[6] Dr. Horne is a physician with a PhD in septal mechanics. In 1996, she completed her residency in cardiology at Dalhousie University's medical school and the Queen Elizabeth II Hospital ("Hospital") in Halifax. From 1996 to 1998, with a fellowship, Dr. Horne undertook research in molecular and cellular strategies for myocardial repair at the University of Indiana's Krannert Institute of Cardiology.

[7] **The terms of Dr. Horne's engagement:** While in Indiana, Dr. Horne was offered a joint position as an assistant professor of cardiology at Dalhousie's Department of Medicine and as a staff physician in the Hospital's Division of Cardiology. The written offer of April 8, 1998 ("Appointment Letter"), was from the Respondent Queen Elizabeth II Health Sciences Centre ("QEII"). The QEII is a body corporate under the *Queen Elizabeth II Health Sciences Centre Act*, S.N.S. 1995-96, c. 15, amended by S.N.S. 2000, c. 6, and is the Hospital's formal entity.

[8] During the critical timeline of this case and the pleadings, the QEII was operated by the Respondent Capital District Health Authority ("Capital Health"), a body corporate under the *Health Authorities Act*, S.N.S. 2000, c. 6. Capital Health managed health services in the Halifax regional district. The same individuals sat on the boards of directors of Capital Health and the QEII. On April 1, 2015, the Nova Scotia Health Authority subsumed Capital Health: *Health Authorities Act*, S.N.S. 2014, c. 32. Nothing in this appeal turns on the corporate reorganization. We will refer to Capital Health, as did the parties in argument.

[9] Dr. Horne accepted the Appointment Letter's offer. Her engagement began in November 1998.

[10] This appeal focuses largely on Dr. Horne's research activity. On that matter, the Appointment Letter included:

> … We expect the approximate allocation of your time to be 30% clinical, 10% teaching and the remaining 60% in research.
>
> **Research Activities**
>
> The research component of your activities will consist of a clinical as well as a basic science component. Principle [*sic*] focus of clinical research will be congestive heart failure with the major emphasis on molecular aspects of congestive heart failure in collaboration with members of the Department of Pharmacology at Dalhousie University. As a new member of the Department of

> Medicine, you will be eligible to apply for startup funding for research through application to the Department of Medicine, University Internal Medical Research Foundation and the Faculty of Medicine. You will be expected to seek extramural funding for both operating and salary support for your research program. To maintain the proposed research profile (60% protected time) you will be expected to secure extramural funding for partial salary support within the first three years of your contract.
>
> …

[11] As the letter says, some initiative was expected from Dr. Horne to maintain her 60% research profile.

[12] Accordingly, in 1999 and 2000, Dr. Horne developed three research projects titled a Lower-Body Negative Pressure Study, a Functional Map of the Remodelled Left Ventricle: The Importance of Septal Mechanics in Systolic Dysfunction, and Septal Mechanics and Resynchronization Therapy in Heart Failure. Capital Health's Research Ethics Committee approved the three research protocols.

[13] Between 1999 and 2002, Dr. Horne was awarded grants approximating $520,000 to fund her research. In May 2001, Dalhousie provided Dr. Horne a $450,000 Clinical Scholar Award.

[14] One issue in this appeal is whether Dr. Horne had a cause of action for breach of contract. So we will summarize the documentary basis of her legal relationship with the other parties, after the Appointment Letter.

[15] The compensation to a multi-functional physician like Dr. Horne, who was a clinician, teacher and researcher, was governed by the Alternative Funding Plan ("AFP"). The initial AFP was a written agreement dated April 1, 2001, between the Province represented by the Minister of Health, the Head of the Department of Medicine ("DOM"), the Medical Society of Nova Scotia, Capital Health, Dalhousie University and the QEII.

[16] The DOM is an unincorporated association of physicians. It periodically negotiates an AFP on behalf of its members, receives aggregate funding for physicians' services and distributes the individual revenue shares to physicians.

[17] The AFP prescribed a remuneration mechanism other than mere fee-for-service. The Department of Health, Dalhousie and Capital Health would provide funds to the DOM which the DOM would distribute according to the terms of the AFP and the DOM's Practice Plan. The AFP required the DOM Head to obtain and

provide to the Minister of Health, each physician's signed declaration that the physician accepted the AFP funding instead of the standard MSI remuneration. Article 16.1 of the AFP said:

> 16.0 INDEPENDENT CONTRACTOR
>
> 16.1 It is understood and agreed that this Agreement is for the performance of services and that the Department Physicians are engaged as independent contractors and are not nor shall be deemed to be employees, servants or agents of the Minister or the District. …

The form of physician's declaration, attached as Schedule C to the AFP, reiterated in article 6 "THAT I understand that I am independent contractor pursuant to section 16 of the Agreement …".

[18] The DOM Practice Plan resembled a partnership agreement. The Practice Plan of December 15, 1999, which applied to Dr. Horne during the critical events in this case, established a compensation formula and directed that each physician's clinical, teaching, research and administrative activity be projected in a Practice Profile. The Practice Plan provided for an adjustment of remuneration based on an evaluation of actual clinical, research and teaching performance, compared to the projection. The Practice Profiles would be updated annually, approved and then would establish the following year's remuneration.

[19] In 2006, there was a new Alternative Funding Plan Agreement, after which the DOM prepared a new 2006 Practice Plan.

[20] Dr. Horne, her Division Head and her Department Head signed Dr. Horne's Practice Profiles. From 2001 to 2008, Dr. Horne's Division Head was Dr. Blair O'Neill and her Department Head was Dr. Elizabeth Cowden. Dr. Horne's Practice Profile of September 17, 2003, under the heading "Department of Medicine Dalhousie University/QEII Health Sciences Centre", said:

> Your obligations as a member of the Department are described in this Practice Profile Statement, which may be amended from time to time by agreement with the Head/Chief of the Division of Cardiology and the Head/Chief of the 100% of the Department of medicine who are responsible for the management of the division and the Department.
>
> Your specific activities and responsibilities will be determined in conjunction with the Head/Chief of the Division of Cardiology and the Head/Chief of the Department of Medicine. Clinical responsibilities will be co-ordinated by Cardiology Service Chief/Program Director for Cardiology. All members of the

division are expected to collaborate, communicate, and consult with each other in a mutually respectful manner. All members are expected to participate actively in clinical/management/patient care meetings in their areas of responsibility and follow divisional/departmental policies.

The approximate allocation of your time is expected to be:

25% Clinical Care/Teaching

5% Teaching

70% Research/Clinical Trials

0% Contract Research

0% Clinical Administration

0% Academic Administration

100% TOTAL

…

3. Research Activities

3.1 General: The University Department of medicine encourages research activities by all its members and you agree to collaborate in research opportunities and projects in the University.

We expect to continue to protect significant portions of time for research, and you will confirm/obtain external funding support in order to reduce the Department's share of pooled revenues. Your research activities will be formally reviewed after 18 months and continuation of this arrangement will depend on satisfactory internal and external reviews and approval by the Division Head/Chief and the Department Head/Chief. There will be a further formal review after two-and-a-half years. If the formal reviews of your research are unsatisfactory, we cannot guarantee continuation of this Agreement.

Deliverables: CIHR – End of Life Care Issues Beyond Cancer Grant

Functional Imaging: Septal Infarct have different mechanics/innervation than non septal

MI group Grant

HSC/CIHR partnership grant

Dalhousie Faculty of Medicine, Clinical Scholar Award

Clinical Scholars are expected to be research leaders in the division and department and will collaborate in a meaningful way with other members of Department and Division

[21] **Dr. Horne's activities at the Heart Function Clinic:** Dr. Horne's research was non-invasive. Mainly, she observed clinical patients with echocardiograms.

[22] Dr. Horne's clinical duties included being on the medical staff of the QEII Heart Function Clinic. The Clinic treated patients with heart failure. Dr. Horne's assistant enrolled willing patients in the Clinic. Her research drew from their data.

[23] Dr. Jonathan Howlett, also a cardiologist, was the director of the Heart Function Clinic from 1999 to 2008. Drs. Horne and Howlett did not get along. Their reasons differed with their perspectives. Dr. Horne viewed Dr. Howlett as irascible, overbearing and intolerant of research as an independent discipline. Dr. Howlett saw Dr. Horne as an uncollaborative lone wolf in a clinical environment that demanded teamwork. Their friction kindled this litigation.

[24] Dr. Horne did not invite Dr. Howlett to participate in her research, while Dr. Howlett curtailed his enthusiasm for Dr. Horne's projects.

[25] In September 2000, Dr. Howlett tried to prevent Dr. Horne from screening Heart Function Clinic charts for her research. In October 2001, Dr. Howlett wrote to Dr. O'Neill, Dr. Horne's Division Head, to complain about Dr. Horne's disrespect and failure to collaborate. Dr. Howlett threatened to resign as Director.

[26] On November 19, 2001, Dr. O'Neill wrote to Dr. Horne. The letter recited Dr. Howlett's concerns, and gave examples of what Dr. O'Neill characterized as a pattern of disrespectful and uncollaborative behaviour by Dr. Horne. The letter gave specific directions to Dr. Horne, including:

> Finally, I wish every member of the heart function group be offered the chance to collaborate with you in any of your research protocols. This offer must include opportunity for substantive, cognitive contributions in your protocols and grant applications.

Dr. O'Neill's letter then broached the subject of hospital privileges:

> … If your pattern of behaviour does not change and you do not commit to this process, you will leave me no option but to be unable to recommend that your privileges be renewed. …

[27] The interpersonal dysfunction at the Clinic worsened. Dr. Howlett admitted that their relationship deteriorated to the point that he "avoided having contact or discussion with Dr. Horne on any matters". From January to October 2002, Dr.

Howlett wrote several letters to Dr. O'Neill and others complaining about Dr. Horne's failures to notify him before enrolling patients, see patients with him, share copies of her research protocols, present research at a meeting and meet with him to discuss his concerns. Dr. Horne testified that, from her perspective, Dr. Howlett appeared to be avoiding contact with her and was ignoring her paged messages, which would hamper her compliance with the directions in Dr. O'Neill's letter of November 19, 2001.

[28] In September 2002, Dr. Howlett confronted Dr. Horne's research coordinator, Ms. Marlene Fairhurst-Vaughan, and directed that one of Dr. Horne's research initiatives would be "halted". Ms. Fairhurst-Vaughan said she felt intimidated. Dr. Horne brought the matter to Dr. O'Neill's attention.

[29] On September 30, Dr. O'Neill wrote to Dr. Cowden, asking her to assist because Dr. O'Neill had a conflict:

> … I would like to formally request you to deal with the matter. I feel somewhat in a conflict of interest, either real or perceived in that I have associated with Dr. Howlett socially, both at our place of work and outside of it and therefore could be accused of favoritism. …

[30] On October 7, 2002, Dr. Howlett again wrote to Dr. O'Neill. His letter complained that one of Dr. Howlett's patients had been enrolled in Dr. Horne's research study without Dr. Howlett's approval.

[31] On October 8, 2002, Dr. O'Neill wrote to Dr. Horne. Despite his declared conflict, Dr. O'Neill dealt with the merits. His letter said he had found nothing inappropriate in Dr. Howlett's conduct respecting the September incident with Ms. Fairhurst-Vaughan, and that Dr. Horne had provided Dr. O'Neill with "false and misleading information" on several matters. His letter concluded with a pointed warning about non-renewal of privileges:

> As a result of these concerns, I am formally referring this matter to Dr. Elizabeth Anne Cowden for advice and action but I must insist that any further such occurrence, e.g. failure to comply with divisional or departmental policy, utterance of false allegation in relationship to colleagues, or misinformation or verbal or nonverbal hostility will result immediately in my failure to be able to recommend that your privileges be renewed.

[32] On October 4, 2002, Dr. Howlett had asked Dr. Horne for a meeting. On October 8, 2002, Dr. Horne emailed a positive but conditional reply:

> Re: meeting
>
> Jonathan,
>
> My role in the Heart Function Clinic is a matter that is decided between Blair and myself. Because I am a University Clinical Scholar, a CIHR grantee, and interdisciplinary clinician scientist, this issue has impact on the Hospital and the University. Therefore, if you want to have a discussion of my role in the Heart Function Clinic all the stakeholders must be at the table. Please let me know if you wish to proceed and I will make the arrangements.
>
> GH

[33] On October 10, 2002, Dr. Howlett responded to Dr. Horne, copied to Dr. O'Neill. The letter purported to vary Dr. Horne's privileges:

> Dr. Horne:
>
> I have received your email of October 8, 2002. My understanding is that you do not recognize my role and responsibility (as delegated from the Division Head) as Director of the QEII Heart Function Clinic (HFC) and will not meet with me in my capacity to discuss concerns I have with regards to your behaviour, professional interactions and conduct within the Clinic. You seem unwilling to hear first hand the nature and extent of concern and thereby are unable to provide me with your response and perspective. This failure on your part leaves me with little option if I am to appropriately exercise my role and responsibility.
>
> …
>
> Given your well articulated lack of regard for the role which I have been delegated and disrespect for me personally, I have sought advice from Dr. O'Neill over the past several months on how to best explore with you my concerns and elicit your response and action plan for resolution of these serious performance issues. His suggestion included a meeting with the presence of a neutral third party to facilitate constructive discussion. You appear unwilling to cooperate.
>
> …
>
> You leave me with no option but to terminate effective October 10, 2002 your participation in HFC activities. You will no longer see patients in the HFC and will not have any official standing within the HFC. You or your agents may continue to recruit patients (for research) from the HFC, but only with documented permission from an Attending Staff involved in the HFC. Additionally, this may only occur if protocol of the intended study is supplied to the Medical Director of the Heart Function Clinic. Similarly, you or your agents may not scrutinize the HFC Patient Database or Patient Charts without permission. These privileges are consistent with other groups performing research but who do not have standing within the HFC (such as EP or Respirology services). I will instruct the HFC staff of these changes. ….

[34] Dr. Howlett had no authority to take such steps that effectively varied Dr. Horne's hospital privileges. At the trial, Dr. O'Neill testified:

> **Q.** And then on October 10, 2002, Dr. Howlett told Dr. Horne that she could no longer be an attending physician in the heart function clinic and he told her that her agents could no longer screen patients for research purposes in the heart function clinic, do you recall that?
>
> **A.** Yes.
>
> **Q.** And he was … Dr. Howlett was later advised, I take it by you, that he could no … he could not unilaterally take these steps, is that fair to say?
>
> **A.** That's fair to say.
>
> **Q.** And you described how when you had a caucus with other individuals at Capital Health including legal counsel that the conclusion was that the way to address matters with Dr. Horne in the heart function clinic was through a variation of her privileges, correct?
>
> **A.** That is correct.

[35] Nonetheless, on October 16, 2002, Dr. O'Neill wrote to Dr. Howlett, copied to Dr. Cowden, but not to Dr. Horne:

> Dear Dr. Howlett:
>
> I am in receipt of your letter dated October 10, 2002. In it you underline clearly and succinctly your concerns over Dr. Horne's performance in the Heart Function Clinic, as well as her lack of collegiality within that group. It is with great regret that I must agree with your recommendation that she no longer attend within the Heart Function Clinic. I will recommend to Dr. Cowden, upon your advice that her activities in the Heart Function Clinic be varied in the manner you have suggested. I thank you in advance for bringing this serious matter to my attention.

[36] **The variation of Dr. Horne's privileges:** The tension climaxed. On October 21, 2002, Dr. Cowden wrote to Dr. Horne that the enrollment in Dr. Horne's clinical trials was suspended immediately and Dr. Horne's clinical duties were reallocated. The variation removed Dr. Horne from the medical staff of "team care" clinics, of which the HFC was one. The letter concluded that "[s]ince this redirection of your clinical responsibilities represents a variance in your privileges", Dr. Horne could make submissions to the District Medical Advisory Committee further to section 8 of the *Medical Staff (Disciplinary) Bylaws for the District Health Authorities*.

[37] In a letter of October 22, 2002 to the College of Physicians and Surgeons of Nova Scotia, Capital Health's Acting CEO confirmed the variation of Dr. Horne's privileges.

[38] **Administrative proceedings respecting the variation of Dr. Horne's privileges:** The *Medical Staff (Disciplinary) Bylaws for the District Health Authorities* ("*Disciplinary Bylaws"*) that were in effect at the time, were adopted by the Minister of Health under s. 23(a) of the *Health Authorities Act* of 2000. Section 23(a) is quoted below (para. 71). Section 8 of the *Disciplinary Bylaws*, under which Dr. Horne's privileges were summarily varied, included:

> 8.1 The CEO, the Site Manager, the Site-based Medical Leader, the District Chief of Staff, or the District Department Chief (but not their designates) may suspend or vary the privileges of any member of the Medical Staff at any time where the member has been found to have engaged in conduct which
>
> 8.1.1 exposes or is reasonably likely to expose patients, Medical Staff, employees or the public to harm or injury at any hospital site in the district, or
>
> 8.1.2 is adversely impacting or is reasonably likely to adversely impact the delivery of patient care at any hospital site in the district.

Section 8.2.2 said the suspended physician was to be informed of her right to make submissions to the District Medical Advisory Committee ("District MAC"). The District MAC is an advisory committee that includes medical leaders from the health district.

[39] The *Disciplinary Bylaws* then set out the process and timeline for the assessment of a variation of privileges. The District MAC makes recommendations that are considered by Privileges Review Committee ("PRC"). The PRC is an advisory lay committee that makes a recommendation to Capital Health's board of directors. The board of directors makes the ultimate determination on privileges, subject to a possible appeal to the Provincial Appeal Board. The *Disciplinary Bylaws* included:

> 8.5 The District MAC shall conduct any investigations it deems necessary and submit its recommendation and any submissions that the District MAC received pursuant to clause 8.2.2 to
>
> 8.5.1 the CEO,
>
> 8.5.2 the District Chief of Staff,
>
> 8.5.3 the member, and

8.5.4 the PRC [defined by s. 1.1.17 of the Bylaws as the Privileges Review Committee]

within 10 days of receiving and/or having the member's written and/or oral submissions pursuant to clause 8.2.2 or within 10 days of the member waiving the right to make submissions;

…

8.6 The PRC shall make a recommendation pursuant to subsection 8.11 within 10 days of receiving the submissions of the CEO, the District Chief of Staff or the member pursuant to subsections 8.7 and 8.8.

8.7 The CEO and the District Chief of Staff may make written submissions to the PRC and, with the consent of the PRC, may make oral submissions and both forms of submissions shall be made within 10 days of receiving notice or such other period as the PRC in its discretion may deem appropriate.

8.8 The PRC shall notify the member of his or her right to make written submissions to the PRC, and with the consent of the PRC, to make oral submissions and both forms of submissions shall be made within 10 days of receiving notice pursuant to this subsection, or such other period as the PRC in its discretion may deem appropriate.

…

8.11.1 The PRC shall, subject to final approval by the Board [defined by s. 1.1.2 of the Bylaws as the Board of Directors of the CDHA] and

> 8.11.1.1 subject to a CEO or member seeking a hearing before the Board pursuant to clause 8.12.1; and
>
> 8.11.1.2 subject to a member seeking an appeal or hearing before the Provincial Appeal Board [defined by s. 1.1.19 of the Bylaws as the Board to be established under s. 23(b) of the *Health Authorities Act*] pursuant to subsections 8.16 or 8.17,

make a recommendation with respect to the member's appointment and privileges and inform the member and the CEO of such recommendation.

8.11.2 In making a recommendation pursuant to clause 8.11.1, the PRC may determine that there shall be no variation, suspension or revocation of the member's privileges, that a Proposed Agreement shall take effect, or that there shall be a variation, suspension or revocation of the member's privileges.

…

8.12.1 Within 10 days of receiving the PRC's recommendation pursuant to subsection 8.11, the CEO or the member may give notice of intention to proceed to a hearing before the Board.

8.12.2 In the event that the Board does not receive notice pursuant to clause 8.12.1, then the PRC shall forward its recommendation or the settlement

> agreement to the Board who shall, without having a hearing, make a final determination with respect to the matter, subject to the member's right to a hearing by the Provincial Appeal Board pursuant to subsection 8.17, and the Board shall inform the member and the CEO within 10 days of such determination.
>
> 8.13 Upon the Board receiving notice from the CEO or the member of their intention to proceed to a hearing, the PRC shall forward to the Board all the documentation that it received pursuant to clause 8.5.4 and subsections 8.7 and 8.8 and any additional documentation it has gained through any investigations.
>
> 8.14 In holding a hearing, the Board shall give written notice of the hearing to the member and the CEO and the notice shall include:
>
> 8.14.1 the time and place of hearing,
>
> 8.14.2 the purpose of the hearing, and
>
> 8.14.3 a copy of the Medical Staff (Disciplinary) Bylaws.
>
> 8.15 The Board shall, after holding a hearing, make a decision concerning the member's appointment and privileges, subject to the member's right of appeal to the Provincial Appeal Board.

The *Disciplinary Bylaws* then discussed the procedure for an appeal to the Provincial Appeal Board. In Dr. Horne's case, there was no such appeal.

[40] On February 21, 2003, the District MAC issued its report on the variation of Dr. Horne's privileges. The conclusions included:

> DMAC finds that Dr. Horne has failed to meet a reasonable and required standard of collegiality and interpersonal relations with and among colleagues and co-workers. Furthermore, DMAC feels there is well founded concern that Dr. Horne lacks insight into her own behaviour and the consequences therefrom.
>
> The opinions and insights provided by those interviewed by DMAC, as well as common sense, support the view that safe and excellent patient care in clinic settings such as are found in the Heart Function Clinic and the Adult Congenital Heart Clinic can only be guaranteed if the multidisciplinary members of the clinical team and most particularly the medical staff members operate with mutual respect in an atmosphere of trust and with high regard for communication and clinical dialogue.
>
> DMAC concludes that Dr. Horne's lack of collegiality and poor interpersonal relationships with some colleagues could indeed expose patients to harm in these circumstances. Therefore, at that time Dr. Horne's supervisors in the Division and in the Department of Medicine were justified, in our opinion, to reassign Dr. Horne to clinical duties in areas of cardiology practice where team care is not the model of operation.

> On the other hand, DMAC was not convinced that Dr. Horne's conduct of clinical trials research breached Divisional, Departmental or Research Ethics Board policies or procedures. Dr. Horne's research activities were characterized in documents and oral presentations as inattentive to the feelings of colleagues and co-workers and lacking in common sense to resolve problems and promote cooperation. However, the Division and Heart Function Clinic in particular lacked both structure and processes to satisfactorily discuss and decide on clinical research proposals and activities.
>
> DMAC is very concerned about the impact of these matters on Dr. Horne's career as a Clinician Scientist and as a Clinical Scholar. DMAC heard and supports the view of the Department and Division that Dr. Horne should be able to resume her clinical research and recruitment to her protocols subject to provisos about informing attending physicians of patient recruitment. DMAC feels that this matter is properly within the authorities and responsibility of the Department and Division.
>
> Members expressed the wish that all possible steps should be taken to try and restore Dr. Horne's practice and research activity in the shortest possible time frame with appropriate support, guidance and mentorship, along with stipulations as to expectations of behaviour, follow-up and progress reporting. Every reasonable remedy should be sought and applied.

The District MAC recommended that:

1. Dr. Horne meet with Drs. O'Neill, Cowden and others to explore the resumption of her clinical research;

2. Dr. Horne's clinical research activities resume after revisions were made to the protocol consent form, letter to family and attending physicians and procedure to advise physician colleagues that the patient has enrolled in a clinical trial;

3. Dr. Horne's clinical assignments be reviewed in discussion between Dr. Horne and the Division and Department Chief to reflect the expectations of the departmental profile and expectations of Clinical Scholars;

4. the Departmental Chief establish a process to deal with any problems encountered during Dr. Horne's research activity;

5. Dr. Horne and Department Chief and Division Head resolve outstanding matters relating to the resumption of Dr. Horne's research; and

> 6. all letters that admonish a member physician be automatically copied to the Vice President of Medicine and the Chief of Medical Staff.

[41] On June 6, 2003, Dr. Horne, Dalhousie University and Capital Health's chief executive officer signed Minutes of Settlement. This followed a formal mediation whose participants included a nationally-recognized mediator, Dr. Horne and her counsel, Capital Health's President and CEO, and two of Capital Health's in-house counsel. The terms of settlement included: (1) Dr. Horne would return as an attending physician to the Heart Function Clinic; (2) Dr. Horne would fully cooperate and collaborate with her Heart Function Clinic colleagues; (3) to promote collegiality, Capital Health would appoint a facilitator; and (4) to assist Dr. Horne's reintegration, Capital Health would arrange for Dr. Horne to work with a mentor of Dr. Horne's choice from the Heart Function Clinic's attending physicians.

[42] After the Minutes of Settlement were signed, the parties did not agree on the identity of Dr. Horne's mentor. Dr. Horne applied to enforce the settlement. Capital Health opposed the application. A judge of the Supreme Court of Nova Scotia dismissed Dr. Horne's application because the judge determined that Capital Health's chief executive officer had signed the Minutes of Settlement without authority from Capital Health's board of directors (*Horne v. Capital District Health Authority*, 2005 NSSC 41). The judge commented on the parties' change of heart after signing the Minutes of Settlement:

> [14] … relations between the parties seem to have become strained as time went on and questions arose on each side as to the motives, sincerity and determination of the other in regard to implementing the agreement.

[43] Once the settlement dissolved, the PRC resumed its review of the DMAC's recommendations.

[44] On March 17, 2006, the PRC issued its Report ("PRC Report"). The PRC Report recommended that Dr. Horne's privileges be varied by fifteen conditions, including that she: (1) refrain from making unfounded allegations against her colleagues; (2) maintain collegial relations with members of the Heart Function Clinic; (3) demonstrate willingness to accept advice from more experienced physicians, respect authority and display an attitude of accountability; and (4) provide timely information to colleagues and the Division Chief. Dr. Horne could reintegrate with the Heart Function Clinic if she agreed with the conditions.

[45] At a hearing on September 7, 2006, Capital Health's board of directors considered the PRC Report. Eight members of the board participated. After the hearing, Dr. Horne's counsel moved for a preliminary ruling that there had been insufficient evidence to support the summary variation of Dr. Horne's privileges in the first place, on October 21, 2002.

[46] On September 8, 2006, the board of directors issued its unanimous decision. The board acknowledged there had been reason for concern. But the board viewed the summary process under article 8 of the *Disciplinary Bylaws* as an emergency power to safeguard immediate patient care, that did not govern Dr. Horne's circumstances. The decision said:

> 7. The Panel is satisfied that Dr. Horne has a considerable history of difficult relationships with doctors who are in a supervisory position to her. Further, the Panel readily accepts that the Administration had reason to take some action to try to correct Dr. Horne's behaviour. Previous efforts to correct the behaviour were, apparently, unsuccessful. The question is whether there was sufficient evidence to invoke Article 8.1 of the Disciplinary Bylaws.
>
> …
>
> 10. The provision of quality patient care is contingent upon effective communication among caregivers, especially where more than one physician is involved in a patient's care. The Panel feels that the evidence supports that corrective action was needed with respect to Dr. Horne's interactions with her colleagues, specifically her lack of collegiality. The Panel finds, however, that Dr. Horne's lack of collegiality was not sufficiently problematic to invoke the "emergency variation" pursuant to article 8.1 on October 21, 2002.
>
> …
>
> 12. The Panel's decision is that Dr. Horne reverts to the status she held on the meeting of October 21, 2002. …

[47] **Dr. Horne's research after the variation of privileges:** Accordingly, Dr. Horne's privileges were summarily varied, wrongly as it turned out, from October 21, 2002 to September 8, 2006. One issue in this litigation is how her research suffered during that period and afterward.

[48] In late October 2002, Drs. Cowden and O'Neill agreed that Dr. Horne could continue to recruit patients. The difficulty was that the suspension of Dr. Horne's privileges with the Heart Function Clinic curtailed her access to patients. Drs. Cowden and O'Neill permitted Dr. Horne to recruit other cardiologists' patients by

means of an "interim recruitment process", and appointed Dr. Howlett to oversee the interim recruitment.

[49] The interim recruitment process did not work out well. Before the variation of her privileges, Dr. Horne's staff had reviewed charts and coordinated with Heart Function Clinic nurses to identify potential enrollees, and the patients would be approached first by the Clinic's nurse and next by Dr. Horne's staff. Dr. Horne's research nurse, Ms. Fairhurst-Vaughan, testified that, before the variation of privileges, about one or two patients per week were recruited. Afterward, this dropped to one or two patients per year.

[50] This left the enrollment below the critical mass needed for funded research. As Dr. Horne's grants required productive research, in June 2004 Dr. Horne terminated the employment of her graduate student and Ms. Fairhurst-Vaughan, and her lab shut down.

[51] **The litigation:** On November 29, 2006, Dr. Horne sued Capital Health and others. Her Statement of Claim alleged breach of contract and bad faith in the summary variation of her privileges and restrictions on her research.

[52] The trial was heard by a jury in the Supreme Court of Nova Scotia. Justice Allan Boudreau presided. The trial lasted 33 days in April through June 2016. The jury heard 17 witnesses, including Drs. Horne, Howlett, O'Neill, Cowden and Ms. Fairhurst-Vaughan. June 8 was the last day of testimony.

[53] Before charging the jury, Justice Boudreau received submissions on the issues to be left with the jury. On June 13, 2016, the judge issued his Decision that is subject to the appeal (2016 NSSC 169) ("Preliminary Decision"). The Preliminary Decision said, among other things, that: (1) Dr. Horne's cause of action was limited to administrative bad faith or malice, but not breach of contract; (2) restoration of Dr. Horne's research career was not a separate head of damages; but (3) loss to her research career was encompassed in damages for injury to reputation. Justice Boudreau's jury charge of June 16, 2016, respecting quantification of damages, instructed the jury on point (3) but said nothing of point (2). Later we will discuss the Preliminary Decision's reasons and the jury charge.

[54] The judge charged the jury to answer specific questions. On June 17, 2016, after a day's deliberation, the jury returned with its answers:

> **THE COURT:** ... Has the plaintiff, Dr. Horne, proven on a preponderance of the evidence that Capital Health acted in bad faith or with malice when it varied her privileges? What is your answer?
>
> **JURY FOREPERSON:** Yes.
>
> **THE COURT:** Then, question number 2, has the plaintiff, Dr. Horne, proven on a preponderance of the evidence that Capital Health caused her to incur legal expenses in the administrative process? Answer?
>
> **JURY FOREPERSON:** Yes.
>
> **THE COURT:** Yes. Thank you. Question 2(b), had the Plaintiff, Dr. Horne, proven on a preponderance of the evidence that Capital Health caused her a loss of reputation which may include a loss of research career? Answer?
>
> **JURY FOREPERSON:** Yes.
>
> **THE COURT:** Question 2(b), sub-question, what amount do you award for loss of reputation, including loss of research career?
>
> **JURY FOREPERSON:** 1.4-million.
>
> **THE COURT:** Thank you. Question 3, has the plaintiff, Dr. Horne, proven on a preponderance of the evidence that an award of punitive damages is warranted?
>
> **JURY FOREPERSON:** No.
>
> **THE COURT:** Question number 4, has the plaintiff, Dr. Horne, proven on a preponderance of the evidence that she was wrongfully under-remunerated by the Department of Medicine, the DOM?
>
> **JURY FOREPERSON:** No.

[55] At Capital Health's request, the jury was polled. Each member confirmed the foreperson's answers.

[56] On August 15, 2016, the Supreme Court of Nova Scotia issued the Order.

[57] On September 19, 2016, Dr. Horne filed a Notice of Appeal. On October 4, 2016, Capital Health filed a Notice of Cross-appeal.

2. Issues

[58] **Appeal:** Dr. Horne says the judge erred in his Preliminary Decision by:

1. ruling that Dr. Horne's claim in contract should not be left to the jury;
2. ruling that restoration of Dr. Horne's research career was not a separate head of damages for breach of contract; and

3. ruling that damages for restoration of Dr. Horne's research career were not reasonably foreseeable.

[59] **Cross-appeal:** Capital Health's cross-appeal says the judge erred by:

1. improperly instructing the jury on the principles respecting Dr. Horne's claim for bad faith or malice;
2. improperly instructing the jury that Dr. O'Neill's conduct could be attributed to Capital Health for the jury's assessment of whether Capital Health acted in bad faith or with malice;
3. ruling in his Preliminary Decision, and then instructing the jury that damages for injury to reputation encompassed loss to Dr. Horne's research career loss;
4. failing to instruct the jury that the judge had ruled that Dr. Horne's claim for damages for restoration of her research career was legally unsupportable; and
5. improperly instructing the jury on the principles to quantify damages for loss of reputation.

Capital Health also cross-appeals on the ground:

6. the jury made a palpable and overriding error in its $1.4 million quantum of damages.

Finally, the parties agree that:

7. if liability is undisturbed but this Court overturns the quantum on the cross-appeal, the Court should substitute its view of an appropriate quantum, rather than remit the quantification of damages to another jury.

3. Standards of Review

[60] Correctness governs the presiding judge's rulings on issues of law. These include, on Dr. Horne's first and second grounds of appeal, whether: (1) from the undisputed facts and documents, there was a contractual provision that governed Capital Health's allegedly offending conduct; (2) subordinate legislation excluded a claim for breach of contract; and (3) the judge erred law by ruling that restoration of Dr. Horne's research career was an impermissible head of damages.

[61] Dr. Horne's third ground of appeal, based on reasonable foreseeability, involves an issue of mixed fact and law. Unless there is a severable error of law, which is assessed for correctness, the appeal court reviews the judge's findings for palpable and overriding error, meaning a clear error that affected the outcome.

[62] Points 1 through 5 of Capital Health's cross-appeal contend that the judge misdirected the jury. The jury charge need not be perfect, but must be proper. Briefly, this means:

1. The appeal court assesses whether the jury was given a proper explanation of its role and of the case before them, and was equipped to understand fully the claims and defences advanced.
2. In particular, the jury should be left with a clear and unconfused appreciation of the factual issues to be decided by them, along with the legal principles, positions of the parties and key evidence related to those issues.
3. In undertaking its task, the appeal court reviews the entire charge, not just piecemeal passages, to appraise the charge's general effect. The court focuses on substance. The mere failure to recite formulaic phraseology is not fatal to the charge.
4. The appeal court's approach is functional, meaning the court considers how the actual instructions responded to the trial's course of events. Those events include the theories and evidence presented to the jury and the positions stated by counsel to the judge. The appeal court does not simply impose idealized standard instructions.
5. The appeal will be allowed only if the misdirection, viewed reasonably, was capable of affecting the jury's verdict or, put another way, potentially caused a substantial wrong or miscarriage of justice. This standard originated in a former rule of court in Nova Scotia, and continues as an appellate principle of review.

These points on appellate review of jury directions are summarized from: *Hawley v. Wright*, 1906 CarswellNS 174, 39 N.S.R. 1 (S.C. *in banco*), paras. 16 and 43; *Leech v. Lethbridge (City)* (1921), 62 S.C.R. 123, at pp. 127 and 130, per Idington and Anglin, JJ.; *Leslie v. Canadian Press*, [1956] S.C.R. 871, at pp. 873 and 875, per Kerwin, C.J.C.; *Earle v. Smith*, 1971 CarswellNS 46, 2 N.S.R. (2d) 572 (S.C.A.D.), para. 25; *R. v. Cooper*, [1993] 1 S.C.R. 146, at p. 163, per Cory, J. for the majority; *R. v. Jacquard*, [1997] 1 S.C.R. 314, paras. 2, 30-32, 62, per Lamer,

C.J.C. for the majority; *R. v. Malott*, [1998] 1 S.C.R. 123, paras. 14-17, per Major, J. for the majority; *R. v. Daley*, [2007] 3 S.C.R. 523, paras. 28-31, 55-58, per Bastarache, J. for the majority; *R. v. Araya*, [2015] 1 S.C.R. 581, para. 39, per Rothstein, J. for the Court; *R. v. P.J.B.*, 2012 ONCA 730, paras. 40-53, per Watt, J.A. for the Court; *Robar v. Weagle*, [1955] 2 D.L.R. 541 (N.S.S.C. *in banco*), at pp. 543, 554-55, per Parker and Macdonald, JJ; *Barkhouse v. Vanderploet* (1976), 16 N.S.R. (2d) 445 (S.C.A.D.), at p. 472, per Cooper, J.A. for the Court; *Sklar-Peppler Furniture Corp. v. George C. Sweet Agencies Ltd.* (1995), 138 N.S.R. (2d) 101 (C.A.), paras. 16-18; *March v. Hyndman*, 2010 NSCA 100, at paras. 20-22, per Farrar, J.A for the Court, adopting *Campbell v. Jones* (2002), 209 N.S.R. (2d) 81, at paras. 197-98, per Saunders, J.A. dissenting; *Bevis v. Burns*, 2006 NSCA 56, para. 19, per MacDonald, C.J.N.S.; *R. v. Melvin*, 2016 NSCA 52, para. 31, per Farrar, J.A.; *R. v. Cromwell*, 2016 NSCA 84, paras. 25-26, per Van den Eynden, J.A.

[63] Capital Health's third point also challenges the Preliminary Decision's ruling that damages for impaired reputation encompass loss to Dr. Horne's research career. The parties agree, as do we, that whether the judge improperly conflated or combined these possible heads of damages is an issue of law, governed by correctness.

[64] Capital Health's sixth point frontally challenges the jury's award of $1.4 million. In *Young v. Bella*, [2006] 1 S.C.R. 108, the Chief Justice and Justice Binnie for the Court said:

> 64 … Damage assessments are questions of fact for the jury. Jury awards of damages may only be set aside for palpable and overriding error. It is a long-held principle that "when on a proper direction the quantum is ascertained by a jury, the disparity between the figure at which they have arrived and any figure at which they could properly have arrived must, to justify correction by a court of appeal, be even wider than when the figure has been assessed by a judge sitting alone". *Nance v. British Columbia Electric Railway Co.*, [1951] A.C. 601 (P.C.), at p. 614. …

This means the appeal court does not intervene unless the jury's award is "so plainly unreasonable and unjust" or "wholly disproportionate" that "it shocks the conscience of the court": *Hill v. Church of Scientology of Toronto*, [1995] 2 S.C.R. 1130, para. 163, per Cory, J; *Young v. Bella*, paras. 64-66; *Sharpe v. Abbott*, 2007 NSCA 6, paras. 109-10.

[65] Lastly, the parties agree that, if this Court does not disturb liability but overturns the quantum, the Court should re-quantify the damages rather than remit quantification to another jury. The court's re-quantification involves a measure of deference to the jury's findings that we will discuss later (para. 179).

4. Dr. Horne's appeal issue #1 – Breach of contract

[66] Justice Boudreau's Preliminary Decision held that contract law did not apply, and the only cause of action for the jury's consideration would be administrative bad faith or malice. He said:

> [60] The law appears to be that, absent any clear indication in the documentation surrounding the granting of physicians' privileges, the law which applies is administrative law, not private law, and that damages will only result from a bad faith or malicious application of a health board's by-law powers.
>
> …
>
> [62] It must be remembered that Dr. Horne, or any physician for that matter, must apply to be appointed to a positon at a CDHA hospital. In that application the physician must sign a "Declaration" to abide by and be bound by the Medical Staff By-laws, which Dr. Horne did, as I indicated earlier in this decision. Does the fact that Dr. Horne's application is approved and is granted privileges at a teaching hospital change the law which governs the granting or variation of hospital privileges?
>
> [63] I find that it does not. I find that the annual Practice Profiles do not constitute contracts in the traditional sense. They are simply one of the tools employed to give effect to the AFP, and the resulting Practice Plan by which to remunerate physicians.
>
> …
>
> [66] Dr. Horne has argued that it has not been shown that there are any policy considerations which would support limiting the applicability of ordinary tort or negligence law in the application or enforcement of quasi-judicial functions under Medical Staff (Discipline) By-laws. Common sense would dictate that exposing the decisions of quasi-judicial administrators or bodies to civil law liability would have a chilling effect on those entities. Here they involve not only Dr. Cowden, but the DMAC and the PRC reviews. There appears to be no question that public administrative law would apply to those latter two entities. There is no logical reason to differentiate between Dr. Cowden, the DMAC and the PRC.
>
> …
>
> [69] In the final analysis, I find that the law which governs, and should govern, this case is the line of authorities such as *Shephard* and *Rosenhek* [discussed

> below, paras. 67-68] which state that the granting or variation of hospital privileges to a physician does not create traditional contractual relationships but that it is the administrative law relating to quasi-judicial bodies exercising a statutorily mandated disciplinary by-law process which governs.
>
> [70] Therefore, the test is whether the plaintiff can prove bad faith or malice against the defendant CDHA, on a balance of probabilities, when it varied Dr. Horne's privileges on October 21, 2002. As I stated earlier, this case, from the pleadings through to the vast majority of the evidence presented, has been primarily an allegation of bad faith or malice.

[67] On the appeal, Dr. Horne submits that the judge should have left breach of contract with the jury.

[68] To analyze Dr. Horne's submission, the point of departure is *Harris v. The Law Society of Alberta*, [1936] S.C.R. 88, at pp. 104-5. The Supreme Court held that, unless there is bad faith, a statutory decision-maker is not liable for its quasi-judicial determination. Justice Rinfret said:

> It is obvious that the benchers were acting in good faith. They were only "endeavouring to do their duty to the public and the profession." Now, provided they take the proper course, and within the conditions specified by the statute, the benchers have the power to order the striking of the name of a member from the rolls of the Society. In the exercise of those powers, they perform a function not merely ministerial, but discretionary and judicial.
>
> Like the trial judge, we are convinced, upon all the circumstances disclosed in the record, that the benchers honestly believed they were adopting the report of a properly constituted committee; they "were intending in what they did to do what they were entitled to do, viz., to perform the public duties imposed upon them by the Act." They gave the order in what they *bona fide* believed to be the exercise of a judicial discretion, and they, or the Law Society which they represent, are not subject to an action in damages, because the report which they adopted as the foundation of their order happened, without their actual knowledge, to lack authority and validity. …

[69] In *Rosenhek v. Windsor Regional Hospital*, [2007] O.J. No. 4486 (Sup. Ct.), appeal dismissed 2010 ONCA 13, the Ontario Court of Appeal recited the intervening authorities and held that *Harris*'s principle applies to the revocation of hospital privileges:

> [20] Counsel for the appellant submits that the trial judge's finding of liability stands or falls on the bad faith finding. We agree. If the finding is set aside, then neither basis on which the trial judge found in favour of Dr. Rosenhek can stand.

> [21] We are satisfied that a bad faith exercise of a statutory, public power can, in law, provide a basis for a tort claim by Dr. Rosenhek against the hospital: see *Harris v. The Law Society of Alberta*, [1936] S.C.R. 88; *Brown v. Waterloo Regional Board of Commissioners of Police* (1983), 43 O.R. (2d) 113 (C.A.), at pp. 121-22; *Odhavji v. Estate v. Woodhouse*, [2003] 3 S.C.R. 263, at paras. 23-32; *Freeman-Maloy v. Marsden* (2006), 79 O.R. (3d) 401 (C.A.), leave to appeal to S.C.C. refused, [2006] S.C.C.A. no. 201, [2006] 2 S.C.R. ix; *Roncarelli v. Duplessis*, [1959] S.C.R. 121. The Board's power to revoke Dr. Rosenhek's privileges is found in s. 33(c) of the *Public Hospitals Act*. That power, in turn, is part of a comprehensive statutory scheme governing the operations of public hospitals. Hospitals are funded largely through the public purse. A purposive reading of the statutory provisions relating to the power to revoke privileges demonstrates that it is exercised having regard to various public-interest factors relating to, in particular, the quality of care provided by the hospital. Having regard to these features, we think that the exercise of the revocation power is properly characterized as public in nature.

[70] This Court has applied the principle. In *Shephard v. Colchester Regional Hospital Commission*, [1995] N.S.J. No. 5, 137 N.S.R. (2d) 81 (C.A.), a physician sued for damages for the suspension and non-renewal of hospital privileges. The Court of Appeal overturned the trial judge's award of damages. Justice Chipman for the Court said:

> 124 The privilege of membership in the medical staff in this case is, in my opinion, analogous to the type of licensing which a professional body accords to its members pursuant to legislative authority to do so.
>
> 125 It is generally accepted that initially, there is no obligation upon a hospital to admit an applicant to its medical staff. This is generally considered to be an administrative action by the hospital board for which no reason need be given and no appeal allowed unless specifically authorized by legislation. However, the decision of a hospital board relating to reappointment or variation or termination of privileges or appointment is a judicial or quasi-judicial function requiring a hearing to ensure that the principles of natur[al] justice are not violated. See the decision of this Court in *Aucoin v. Sacred Heart Hospital* (1991), 106 N.S.R. (2d) 389.

Justice Chipman (paras. 126-35) cited *Harris*, quoted Justice Rinfret's passage set out earlier, discussed later authorities that had applied the principle and concluded:

> 138 The actions of the Board which are at issue in this matter were things done in its judicial or quasi-judicial capacity. In my opinion, the principles of natural justice were not violated by the Board in its dealings with the respondent. … No malice or bad faith was involved at any stage of the proceedings.

[71] The approach is apposite to Dr. Horne's case. The variation of Dr. Horne's privileges on October 21, 2002 was further to article 8.1 of the *Disciplinary Bylaws* (quoted above, para. 38), that were enacted under s. 23(a) of the *Health Authorities Act*, S.N.S. 2000:

> **Ministerial by-laws**
>
> 23 The Minster shall make by-laws
>
> (a) respecting the granting, variation, suspension and revocation of medical staff privileges;
>
> …

[72] The variation of Dr. Horne's privileges purported to exercise a quasi-judicial power authorized by subordinate legislation. Subject to our comments below concerning contract, any civil liability for an erroneous exercise of that power requires a finding of bad faith.

[73] Dr. Horne cites four agreements that she says establish her contract with Capital Health, *i.e.* the Appointment Letter (above, para. 10), the AFP (above, paras. 15-17, 19), the DOM Practice Plan (above, paras. 18-19) and Dr. Horne's Practice Profiles (above, para. 20). Dr. Horne submits that the grant of her privileges left intact any contractual obligations of Capital Health that stemmed from those agreements. As authority, she cites *Ready v. Saskatoon Regional Health Authority*, 2017 SKCA 20, para. 173:

> … A grant of status and privileges … does not require an employment relationship. The majority of doctors in the health region who have status and privileges are not employees. Correspondingly, a grant of status and privileges may be an incidental requirement or term of any employment contract (as it was in this case). However, that fact does not merge the relationships *qua* employee and *qua* practitioner.

[74] Dr. Horne points out that a contract is not incompatible with Capital Health's quasi-judicial function to assess the variation of her privileges. She cites *Wells v. Newfoundland*, [1999] 3 S.C.R. 199, per Major, J., for the Court:

> 16 The respondent, as a member of the Board, held a senior public position of quasi-judicial responsibility. Both the terms of the statute governing his appointment, and his specific negotiations with the government's representatives established that the fundamental terms of his appointment were that he would serve until age 70, subject to good behaviour.

> 17 This agreement plainly meant that the Crown could not terminate the respondent's employment unless he did something which rendered him unfit to continue serving as a Public Utilities Commissioner. No misbehaviour was alleged against the respondent, but his position was eliminated. In the private sector, this would clearly constitute a breach of the respondent's contract of employment, and he would be entitled to damages. His status as an employee of the Crown, in the circumstances, should not be different.
>
> …
>
> 20 The status of junior non-unionized government employees was examined in *Attorney General of Quebec v. Labrecque*, [1980] 2 S.C.R. 1057. … Beetz J. said at pp. 1082-83:
>
> > … faced with the necessity of qualifying and regulating a given legal relationship in public law, the jurist of the Anglo-Canadian tradition must necessarily carry out this function with the concepts and rules of the ordinary law, unless statute or prerogative require otherwise. Confronted by a legal relationship having all the characteristics of a contract, as in the case at bar, the Anglo-Canadian jurist must consider and deal with it as contract, subject to legislation and prerogative.
> >
> > …
> >
> > I cannot see in this Regulation anything preventing application of the ordinary law of contract. …
> >
> > Accordingly I conclude, like the Provincial Court and the Superior Court, that respondent was a contract employee. …
> >
> > [Justice Major's underlining]

[75] The Appointment Letter, with its acceptance by Dr. Horne, is a contract that governs her appointment according to its terms. The AFP is a contract among its parties and deals primarily with the aggregate funding of physicians' compensation. The DOM Practice Plan, which is like a partnership agreement, and its subordinate Practice Profiles, may well be contracts among physicians for work allocation and sharing of the aggregate funding, though it is unnecessary that we rule on the point.

[76] We agree that the mere grant of privileges does not merge or nullify a physician's subsisting contracts, and that a quasi-judicial officer may have a contract coincident with his or her office, as stated in *Ready* and *Wells* respectively.

[77] However, those conclusions are insufficient to establish a basis for breach of contract. There must be a contractual provision that Capital Health ostensibly breached with its wrongful act.

[78] Dr. Horne essentially submits that, as the Appointment Letter and her Practice Profiles provided that Dr. Horne was expected to conduct research, then her reduced access to subjects at the Heart Function Clinic after October 21, 2002 is a breach of contract by Capital Health.

[79] We respectfully disagree. Dr. Horne has not identified a term in any agreement that Capital Health has allegedly breached. The Appointment Letter, AFP, DOM Practice Plan and Practice Profiles did not promise conditions either for Dr. Horne's activity in the Heart Function Clinic, or her access to subjects at the Clinic. Dr. Horne's claim relies on the summary variation of her privileges as Capital Health's wrongful act. The Appointment Letter, AFP, DOM Practice Plan and Practice Profiles avoided the topics of privileges and their variation. Those instruments left the process, standards and propriety of any variation of privileges to be regulated comprehensively by the legislated administrative framework, not by contract.

[80] The legislated framework confirmed that approach. The subordinate legislation provided that the variation of Dr. Horne's privileges would be for the *Disciplinary Bylaws*, not contract. Section 5 of the *Disciplinary Bylaws* said:

> 5 APPOINTMENT OF MEDICAL STAFF
>
> **General**
>
> …
>
> 5.2B Any physician or dentist whose relationship with the Board is established solely through granting of privileges **shall be subject to these by-laws** and the provisions of Section 23 of the Act **with respect to the variation**, suspension, revocation or other non-renewal **of privileges**.
>
> 5.2C
>
> 5.2C.1 **Any physician** or dentist (or Affiliated Medical Staff in Capital Health) **who has a relationship with the Board established by means of a contract or a contract and privileges**, whereby the Board provides compensation to that person for services, either as an independent contractor or as an employee, **shall have** the renewal, extension and termination of that contract and, if applicable, **the variation**, suspension, non-renewal, extension, and termination **of privileges** pursuant to that contract **determined in accordance with the terms of that contract.**

> Without restricting the generality of the foregoing, **in Capital Health**, the Clinical Associates, Clinical Trainees, Residents, and Affiliated Medical Staff **shall have** the renewal, extension and termination of their contract and, if applicable, **the variation**, suspension, non-renewal or revocation **of privileges** pursuant to that contract **determined in accordance with their contract** and shall not be entitled to access the provisions of these bylaws and the DHA's Medical Staff (General) Bylaws, unless their contract otherwise provides.
>
> 5.2C.2 For greater clarity,
>
> …
>
> 5.2C.2.2 **an agreement** pursuant to the *Health Services and Insurance Act*, **for alternative funding arrangements** to which the Province of Nova Scotia and the Medical Society of Nova Scotia are included as parties, or **agreements with physicians made pursuant thereto**, **shall not be interpreted as being a contract for purposes of this section**.
>
> [emphasis added]

[81] Under s. 5, a variation of privileges is subject either to contract or to the administrative process in the *Disciplinary Bylaws*, but not both. By s. 5.2C.2.2, the variation of privileges of an AFP physician, such as Dr. Horne, is the province of the *Disciplinary Bylaws*, and not the agreements that Dr. Horne cites for her contractual claim. This was an advertent policy choice of the legislators.

[82] Contractual terms applied to Dr. Horne's appointment under the Appointment Letter, to funding under the AFP, and to income sharing under the DOM Practice Plan and her Practice Profiles. But Dr. Horne's hospital privileges were regulated entirely by a comprehensive scheme of subordinate legislation that operated independently of contract.

[83] In *Rosenhek*, the Ontario Court of Appeal cited the comprehensive scheme:

> [29] Counsel for the appellant submits that the trial judge's finding of liability stands or falls on the bad faith finding. We agree. If that finding is set aside, then neither basis on which the trial judge found in favour of Dr. Rosenhek can stand.
>
> [21] We are satisfied that a bad faith exercise of a statutory power can, in law, provide a basis for a tort claim by Dr. Rosenhek against the hospital: [citations omitted]. The Board's power to revoke Dr. Rosenhek's privileges is found in s. 33© of the *Public Hospitals Act* [R.S.O. 1980, c. 410]. That power, in turn, is part of a comprehensive statutory scheme governing operations of public hospitals. …

[84] Similarly, in *Shephard*, this Court held that there was no contractual basis for hospital privileges, meaning the physician's cause of action for non-renewal of privileges turned on the tort of administrative bad faith. Justice Chipman said:

> 119 In my opinion, the status of the respondent as a member of the medical staff of the appellant does not give rise to a contractual relationship. I am not prepared to accept the argument that by implication there is a contract that in consideration of the provision of facilities and personnel by the hospital, the respondent was to provide anesthesia services there. There is nothing in the by-laws which points to a contractual relationship. …
>
> 122 There is no basis for assessing damages for breach of contract.

[85] The wrongfulness of the summary variation of Dr. Horne's privileges is to be assessed administratively, not contractually. Justice Boudreau correctly concluded that the only appropriate cause of action was administrative bad faith.

[86] We dismiss this ground of appeal.

5. Dr. Horne's appeal issue #2 – Expectation damages for restoration of research career

[87] This ground of appeal assumes that Dr. Horne has a claim for breach of contract. Dr. Horne seeks expectation damages resulting from Capital Health's non-performance of the alleged contractual bargain. The claim is for monetized specific performance. Dr. Horne's factum sets out the contractual framework of her submission:

> **Issue 2: Damages to Restore Dr. Horne's Research Career are Recoverable**
>
> 130. As this Honourable Court recognized recently in *Brine* [*Industrial Alliance & Financial Services Inc. v. Brine*, 2015 NSCA 104 (CanLII), para. 147], the fundamental principle of contract damages set out in *Hadley v. Baxendale* – "the court should ask 'what did the contract promise?' and provide compensation for those promises" – remains good law. This rule applies regardless of whether the contract promises a psychological or material benefit. "In all cases, these results are based on what was in the reasonable contemplation of the parties at the time of contract formation." [citing *Brine*, para. 147].
>
> …
>
> 133. The Trial Judge determined that Dr. Horne's claim for damages to restore her research career were [*sic*] not grounded in the law, and were "in effect … at best part of the loss of reputation claim". This decision gave no consideration to the fundamental question "what did the contract promise?"

…

> 137. In sum, CDHA and Dr. Horne had a contract pursuant to which CDHA promised Dr. Horne time, support, and remuneration for her research, and Dr. Horne promised CDHA to develop research protocols, obtain research grants and partial salary support, and conduct research. She did those things. …
>
> …
>
> 138 In *Fidler* [*Fidler v. Sun Life Assurance Co. of Canada*, [2006] 2 S.C.R. 3], the Supreme Court of Canada considered whether damages for mental distress were compensable in a breach of contract action. The determinative factor was whether the contract in question promised mental security or satisfaction as part of the bargain. This Court examined the *Fidler* decision with approval in *Brine*.
>
> 139. The research aspects of Dr. Horne's contract with CDHA are as much a benefit of her bargain as peace of mind is to an insured who purchases an insurance policy.

[88] As explained earlier, Dr. Horne's claim for breach of contract was properly withheld from the jury. The premise for her second ground is absent. We dismiss this ground of appeal.

6. *Dr. Horne's appeal issue #3 – Reasonable foreseeability of damages*

[89] Justice Boudreau's Preliminary Decision said:

> [85] With regard to Dr. Horne's claim for restoration of her research career, she could not point to any authority which supports such a claim. … As I said earlier, it must be remembered that none of Dr. Horne's research grants or activities, as of themselves, add any amount of money to Dr. Horne's personal income. In law, Dr. Horne's claim in this regard is neither reasonably foreseeable nor is it reasonable. …

[90] Dr. Horne's third ground of appeal challenges the judge's ruling. As with her second ground, Dr. Horne's submission assumes she may claim for breach of contract. Her factum says:

> **Issue 3: Dr. Horne's Research Damages Were Foreseeable and Reasonable**
>
> 145. The foreseeability of breach of contract damages typically turns on whether the damages claimed would have been within the reasonable contemplation of the parties if they had turned their minds to the breach when they entered the contract.
>
> …

> 148. As discussed above, contract damages are not limited to economic damages. Parties may contract for intangible benefits and recover damages when that contract is breached as long as those damages are tied to the benefits of the contract.
>
> …
>
> 152. Here, the Trial Judge likewise failed to consider what consequences the parties would have reasonably contemplated if they had turned their minds to CDHA's breach of its obligations and frustration of Dr. Horne's research to the point that her research lab shut down and she lost her grants.

[91] As discussed, there is no basis for contractual liability, meaning Dr. Horne's third ground of appeal fails.

7. Summary – Dr. Horne's appeal

[92] We dismiss Dr. Horne's appeal.

8. Capital Health's cross-appeal issue #1 – Instructions on bad faith

[93] Capital Health submits that the jury charge mistakenly defined bad faith and malice.

[94] As noted earlier respecting the standard of review, the appeal court is to consider the entire charge, not just isolated phrases taken out of context. The jury charge's explanation of bad faith and malice comprised:

> Question number 1 is: Has the plaintiff, Dr. Horne, proven on a preponderance of the evidence that Capital Health acted in bad faith or with malice when it varied her privileges? It's a simple yes or no answer. …
>
> …
>
> Members of the jury, bad faith or malice in civil lawsuits has a wider meaning than its popular sense. Bad faith and malice certainly includes the popular sense of acting out of spite, ill will, or hatred. In general terms, it includes acting out of any motive other than the honest fulfilment of that person's duty and obligation as required by their, in this case, administrative positions. Bad faith or malice includes making statements which, in their ordinary meaning, the defendants know to be untrue or are reckless as to whether or not they are untrue. It also includes acting out of spite or ill will or with an unjustifiable intent to harm

the plaintiff. It is for you, the jury, to decide as a question of fact whether there was, indeed, bad faith or malice in this case.

On the facts you accept, you must consider whether the plaintiff Dr. Horne has proven to you that the defendant Capital Health acted in bad faith or out of malice or ill will in the variation of Dr. Horne's privileges. You have to decide whether the defendant Capital Health, through the actions of Dr. O'Neill and Dr. Cowden, acted in good faith and were simply and honestly fulfilling their duty, or whether it has been proven that they acted in bad faith for the purpose of inflicting harm on Dr. Horne.

The plaintiff must prove to you that when Dr. O'Neill communicated the information about Dr. Horne, he knew it was untrue or that he did not care if it was true or not and that he was reckless; in other words, that he was extremely negligent in trying to find out the information, if the information about Dr. Horne was true or not. On the other hand, if you are satisfied that Dr. O'Neill honestly believed in the information that he passed on to Dr. Cowden, then his honest belief would go a long way towards establishing that he was not acting maliciously.

So the question is, has the plaintiff proven to you that Dr. O'Neill acted so recklessly out of anger or out of some other improper motive in passing on the information complained of to Dr. Cowden. It is a question of fact for you to decide whether or not there has been bad faith or malice. Bad faith or malice must be proven. You should not conclude that just because of the totality of the allegations there must be malice on the part of Dr. O'Neill or bad faith. It is necessary that the malice or bad faith be borne out of some aspects of the evidence and you must be satisfied that actual or express malice existed, and I should say malice or bad faith existed in the variation of Dr. Horne's privileges, and not only that malice or bad faith existed but that that was the motive for recommending that Dr. Horne's privileges be varied.

You should also apply the same reasoning when assessing the actions of Dr. Cowden, the Chief of Medicine at Capital Health, in performing her own investigation and ultimately deciding to vary Dr. Horne's privileges. It is agreed by all concerned that Dr. O'Neill and Dr. Cowden, that the actions of Dr. O'Neill and Dr. Cowden would be those of Capital Health because they were acting within their roles in authority at Capital Health. While the focal point may be on the variation of privileges by Dr. Cowden, you can consider the evidence of what occurred before and after the variation in deciding if Dr. Horne has proven that bad faith or malice existed in the variation of her privileges and that that was the motive for her variation.

Other evidence that is outside the actual variation of privileges is called extrinsic evidence, that is, outside of Dr. Cowden's decision and letter of October 21st, 2002. If you find evidence of bad faith or malice before or after October 21st, 2002, then you might conclude or draw an inference that bad faith or malice was the motive for the variation of privileges.

It is not sufficient that persons dislike each other. That happens all the time. You have to be convinced on a balance of probabilities, that is, on the preponderance of evidence, that the dislike was the dominant motive for Dr. O'Neill recommending and for Dr. Cowden varying Dr. Horne's privileges. This must be proven to you on a preponderance of the evidence. As I said, the same applies to Dr. Cowden's decision, the same analysis applies […] to vary Dr. Horne's privileges. It is a question for you to determine whether the evidence of what occurred before and after the variation leads to a reasonable inference, namely, that bad faith or malice has been proven to exist and that that was the motive for varying Dr. Horne's privileges.

I can tell you in no uncertain terms that making an honest mistake does not, of itself, amount to bad faith or malice. In this case, the Capital Health Board decided that Dr. Cowden should not have used the emergency procedures in Section 8.1 of the Medical Staff Discipline Bylaws on an emergency basis. The District Medical Advisory Committee, the DMAC, and the Privileges Review Committee, PRC, did not say that was a mistake on the part of Dr. Cowden. They apparently did not disapprove of the procedure invoked by Dr. Cowden. The Board decided that Dr. Cowden made a mistake by invoking the emergency varying procedures in the bylaws, which, unfortunately, took almost four years to correct. As I said, such a mistake, of itself, does not constitute bad faith. Bad faith or malice requires much more than a mistake.

The burden of proof is on the plaintiff Dr. Horne to prove that recklessness or dishonesty existed in the variation of her privileges. It is up to you to decide if the plaintiff has proven this to you. In this regard, you might ask yourselves whether Dr. O'Neill's actions were done in good faith as opposed to recklessly based on the facts before him. As I said, the same applies to the actions of decisions of Dr. Cowden. If you find that it has not been proven that bad faith or malice existed in the variation of Dr. Horne's privileges, then you would answer no to question number 1.

I will later briefly review some of the evidence with regard to bad faith and malice when I review with you the questions which you are being asked to answer.

…

Another witness for the Defendant Capital Health was Dr. Blair O'Neill.

[… review of evidence omitted]

Dr. O'Neill denied any ill feelings towards Dr. Horne and stated he was one of her staunch promoters at first. …

You will have to decide for yourselves whether Dr. O'Neill acted in good faith out of a genuine concern for the quality of patient care in the Division of Cardiology or in bad faith and with malice when he recommended to Dr. Cowden that Dr. Horne's privileges in the Heart Function Clinic should be varied.

> Another witness regarding this issue of behavior, attitude, the lack of collegiality was Dr. Elizabeth Cowden.
>
> […review of evidence omitted]
>
> She testified that she agreed that Dr. Horne's privileges needed to be varied because of a concern for the potential impact on the quality of patient care. You will have to decide whether Dr. Cowden acted out of a genuine concern for the quality of patient care in the variation of Dr. Horne's privileges or whether she was so reckless or extremely negligent in her investigation that she acted in bad faith or malice or spite toward Dr. Horne.
>
> …
>
> In the end, you will have to weigh all of the evidence I've mentioned plus all of the evidence that was presented. I cannot possibly go over all of the evidence that was presented, but it is all for you to consider. In deciding question 1, which is has the plaintiff Dr. Horne proven on a preponderance of the evidence that Capital Health acted in bad faith or with malice when it varied her privileges ….

[95] Capital Health submits that the charge misstated the test for administrative bad faith. According to Capital Health, the judge effectively instructed the jury that significant objective negligence equates to subjective bad faith, which Capital Health says conflicts with *Hinse v. Canada (Attorney General)*, [2015] 2 S.C.R. 621.

[96] Before discussing *Hinse*, it is necessary to examine the earlier ruling in *Finney v. Barreau du Québec*, [2004] 2 S.C.R. 17. The issue was whether the Barreau du Québec could rely on s. 193 of Quebec's *Professional Code*, which excluded liability for "acts done in good faith in the performance of their duties" (see para. 13 of the Supreme Court's reasons). Justice LeBel for the Court said:

> 39 These difficulties nevertheless show that the concept of bad faith can and must be given a broader meaning that encompasses serious carelessness or recklessness. Bad faith certainly includes intentional fault … . However, **recklessness implies a fundamental breakdown of the orderly exercise of authority, to the point that absence of good faith can be deduced and bad faith presumed.** The act, in terms of how it is performed, is then inexplicable and incomprehensible, to the point that it can be regarded as an actual abuse of power, having regard to the purposes for which it is meant to be exercised … .
>
> 40 An immunity provision such as the one set out in s. 193 of the *Professional Code* [excluding liability for "acts done in good faith in the performance of their duties" – see para. 13 of Justice LeBel's reasons] is intended to give professional orders the scope to act and the latitude and discretion that they need in order to

> perform their duties. In the case of duties relating to the management of disciplinary cases, it would be contrary to the fundamental objective of protecting the public set out in s. 23 of the *Professional Code* if this immunity were interpreted as requiring evidence of malice or intent to harm in order to rebut the presumption of good faith. **Gross or serious carelessness is incompatible with good faith.**
>
> …
>
> 42 … The attitude exhibited by the Barreau, in a clearly urgent situation in which a practicing lawyer represented a real danger to the public, was one of such negligence and indifference that it cannot claim the immunity conferred by s. 193. The **very serious carelessness it displayed amounts to bad faith,** and it is liable for the results. …
>
> [emphasis added]

[97] Eleven years later in *Hinse*, Justices Wagner, as he then was, and Gascon for the Court, held that the federal Minister of Justice could be liable for bad faith in the exercise of the Minister's discretionary mercy power to rectify a miscarriage of justice under the *Criminal Code*. Wagner and Gascon, JJ. explained bad faith as follows:

> [48] In Quebec civil law, the concept of bad faith is flexible, and its content varies from one area to another: *Entreprises Sibeca Inc. v. Frelighsburg (Municipality)*, 2004 SCC 61, [2004] 3 S.C.R. 304, at para. 25. In *Finney*, this Court defined the scope of a statutory immunity according to which the Barreau du Québec could not be prosecuted for acts carried out in good faith. The Court held that bad faith is broader than just intentional fault or a demonstrated intent to harm another: para. 37. It also encompasses serious recklessness. LeBel J. wrote the following:
>
> > … recklessness implies a <u>fundamental breakdown of the orderly exercise of authority, to the point that absence of good faith can be deduced and bad faith presumed.</u> The act, in terms of how it is performed, is then <u>inexplicable and incomprehensible</u>, to the point that it can be regarded as an actual abuse of power, having regard to the purposes for which it is meant to be exercised. [emphasis of Wagner and Gascon, JJ.]
>
> [49] In *Sibeca*, this Court applied the definition of bad faith from *Finney* in the context of the qualified immunity that protects a municipality when exercising its regulatory discretion. …
>
> …
>
> [51] In our opinion, a standard of bad faith that encompasses serious recklessness as defined in *Finney* and applied in *Sibeca* is consistent with the logic of Quebec's principles of civil liability. …

…

> [53] In sum, decisions of the Minister that are made in bad faith, including those demonstrating serious recklessness – as defined in *Finney* and *Sibeca* – on the Minister's part, fall outside the Crown's qualified immunity. Bad faith can be established by proving that the Minister acted deliberately with the specific intent to harm another person. It can also be established by proof of serious recklessness that reveals a breakdown of the orderly exercise of authority so fundamental that absence of good faith can be deduced and bad faith presumed. …

[98] *Finney* stated, and *Hinse* reiterated that "recklessness implies a fundamental breakdown of the orderly exercise of authority to the point that absence of good faith can be deduced and bad faith presumed", because otherwise the act is "inexplicable and incomprehensible". Whereas *Finney* referred to "recklessness" and "serious carelessness", *Hinse* referred to "serious recklessness".

[99] We turn to Justice Boudreau's charge.

[100] The judge began by citing purely subjective standards – "spite, ill will or hatred", "intent to harm", "for the purpose of inflicting harm on Dr. Horne" – to guide the jury's assessment of bad faith.

[101] Next, the judge said that "reckless" or "extremely negligent" behaviour might support a finding of bad faith. Capital Health points out that the judge did not join the adjective "serious" to "recklessness", as did the Supreme Court in *Hinse*. Instead, Justice Boudreau appended "extremely" to "negligent", which is equivalent to *Finney*'s earlier formulation: "Gross or serious carelessness is incompatible with good faith". Capital Health submits that Justice Boudreau's failure to adopt the Supreme Court's adjusted placement of the adjective misled the jury to believe that a high degree of objective negligence was bad faith.

[102] Justice Boudreau did not stop with that comment. Neither should we. As noted earlier, it is the appeal court's mandate to appraise the general effect of the charge as a whole. The court does not just dice extracts and parse them for formulaic phrasing. In *Araya*, Justice Rothstein for the Court said:

> 39 … The cardinal rule is that it is the general sense which the words used must have conveyed, in all probability, to the mind of the jury that matters, and not whether a particular formula was recited by the judge. The particular words used, or the sequence followed, is a matter within the discretion of the trial judge and will depend on the particular circumstances of the case. …

[103] Justice Boudreau proceeded to elaborate. He repeatedly qualified the standard with mandatory directions requiring subjective criteria (absence of honest belief, anger, dominant motive, actual or express malice, dishonesty, spite). He said:

> honest belief would go a long way to establishing that he was not acting maliciously.
>
> the question is, has the plaintiff proven to you that Dr. O'Neill acted so recklessly out of anger or out of some other improper motive…
>
> you must be satisfied that actual or express malice existed" and "not only that malice existed but that it was the dominant motive…
>
> you can consider … if Dr. Horne has proven that bad faith or malice existed in the variation of her privileges and that was the motive for her variation.
>
> It is not sufficient that persons dislike each other. … You have to be convinced on a balance of probabilities, that is on the preponderance of evidence, that the dislike was the dominant motive…
>
> It is a question for you to determine whether … that bad faith or malice has been proven to exist and that was the dominant motive …
>
> I can tell you in no uncertain terms that making an honest mistake does not, of itself, amount to bad faith or malice.
>
> The Board decided that Dr. Cowden made a mistake by invoking the emergency varying procedures in the bylaws, which, unfortunately, took almost four years to correct. As I said, such a mistake, of itself, does not constitute bad faith. Bad faith or malice requires much more than a mistake.
>
> The burden of proof is on the plaintiff Dr. Horne to prove that recklessness or dishonesty existed in the variation of her privileges.
>
> You will have to decide whether Dr. Cowden acted out of a genuine concern for the quality of patient care in the variation of Dr. Horne's privileges or whether she was so reckless or extremely negligent in her investigation that she acted in bad faith or malice or spite toward Dr. Horne.

[104] The overall message to the jury was: (1) at the end of the day, bad faith needs a finding of subjective advertence; and (2) insofar as recklessness is relevant to that issue, the jury would have to decide whether Dr. O'Neill "acted so recklessly out of anger or out of some other improper motive", and whether Dr. Cowden "was so reckless or extremely negligent in her investigation that she acted in bad faith or malice or spite toward Dr. Horne". The charge channelled recklessness into whether, to the jury's mind, there was subjective advertence. This

is the crux of the *Finney*/*Hinse* test, *i.e.* that advertent bad faith may be presumed or inferred from an inexplicable or incomprehensible degree of recklessness.

[105] The general effect of the charge, read as a whole, did not misstate the standard. Further, any ambivalence between isolated passages in the charge, when reasonably viewed, cannot be taken as having affected the jury's verdict.

[106] We dismiss this ground of Capital Health's cross-appeal.

9. Capital Health's cross-appeal issue #2 – Dr. O'Neill's conduct

[107] The jury charge said:

> You have to decide whether the defendant Capital Health, through the actions of Dr. O'Neill and Dr. Cowden, acted in good faith and were simply and honestly fulfilling their duty, or whether it has been proven that they acted in bad faith or malice for the purpose of inflicting harm on Dr. Horne.

[108] Capital Health submits that Dr. O'Neill's conduct could not implicate Capital Health. Its factum explains:

> 38. The Learned Trial Judge further incorrectly stated that a cause of action could arise from Dr. O'Neill knowingly or recklessly providing incorrect information to Dr. Cowden in the course of her investigation. Dr. O'Neill's role in that process was of a witness providing information to a quasi-judicial authority, Dr. Cowden. As such, he was entitled to common law witness immunity. We refer to the decision of Justice Cromwell in *Elliott v. Insurance Crime Prevention Bureau* [2005 NSCA 115, para. 102] where he stated:
>
> > Witnesses are immune from civil liability for what they say and do in a judicial or quasi-judicial proceeding. This is the core of witness immunity. Outside that core, the immunity may also extend to things witnesses (and even potential witnesses) say and do out-of-court, provided that the extension is necessary in order to make the protection of testimony effective. …

[109] As noted for the standard of review, the court assesses the charge functionally in the context of the trial as it unfolded. That context comprises the competing theories presented to the jury, the evidence for those theories and the positions expressed by counsel to the judge. See *Jacquard*, paras. 32-41 and 62, per Lamer, C.J.C.

[110] From this context, two conclusions emerge:

1. Dr. Horne's theory was that Dr. O'Neill was not just a witness, but a key actor in the decision-making that precipitated the variation of Dr. Horne's privileges, and that decision-making was motivated by physicians' personal relationships rather than patient care. Her theory was supported by substantial evidence that we will review below.

2. Dr. O'Neill's actions were on behalf of Capital Health, as Capital Health's counsel explicitly acknowledged to the judge in the submissions that preceded the jury charge. We will set this out below.

[111] First is the evidence that Dr. O'Neill played a central active role:

1. On November 19, 2001, Dr. O'Neill's letter to Dr. Horne cited Dr. Howlett's concerns, imposed specific sanctions and warned that failure to comply would jeopardize her privileges:

> … If your pattern of behaviour does not change and you do not commit to this process, you will leave me no option but to be unable to recommend that your privileges be renewed. …

2. On September 30, 2002, when the tension between Drs. Howlett and Horne had peaked, Dr. O'Neill asked Dr. Cowden to take over because Dr. O'Neill had a conflict of interest:

> … I would like to formally request you to deal with the matter. I feel somewhat in a conflict of interest, either real or perceived in that I have associated with Dr. Howlett socially, both at our place of work and outside of it and therefore could be accused of favoritism. …

3. Nonetheless, Dr. O'Neill continued to act. Dr. O'Neill testified:

> **Q.** … So you wrote this to Dr. Cowden and essentially you were asking her … to take over is that fair to say?
>
> **A.** That is fair to say.
>
> **Q.** After you'd been dealing with the issues between Dr. Howlett and Dr. Horne and other issues involving Dr. Horne for about a year?
>
> **A.** That's correct.
>
> **Q.** And after you wrote this letter, you continued to deal with Dr. Howlett and Dr. Horne on their differences, correct?
>
> **A.** Yes, that's correct.

4. Notably, on October 8, 2002, Dr. O'Neill wrote to Dr. Horne. Despite the conflict from his personal relationship with Dr. Howlett, Dr. O'Neill squarely addressed the merits. His letter said that he found nothing inappropriate in Dr. Howlett's behaviour and that Dr. Horne's information was "false and misleading". He reminded Dr. Horne that her privileges were in jeopardy:

> As a result of these incidents, I am formally referring this matter to Dr. Elizabeth Anne Cowden for advice and action but I must insist that any further such occurrence, e.g. failure to comply with divisional or departmental policy, utterance of false allegation in relationship to colleagues, or misinformation or verbal or nonverbal hostility will result immediately in my failure to be able to recommend that your privileges be renewed.

5. Dr. O'Neill's view was that action was required to address Dr. Howlett's self-evident concerns, without any need to consult Dr. Horne:

> **Q.** … My question is when you were investigating these complaints and, in particular, with respect to the ones that you substantiated, based on what Dr. Howlett told you and others you may have spoken to, you never actually asked for Dr. Horne's side of the story on those complaints, did you?
>
> **A.** I did not. I thought the facts spoke for themselves, in those cases, and that's why I didn't.
>
> **Q.** The facts spoke for themselves and you never reviewed those facts with Dr. Horne to see if she agreed with the facts, correct?
>
> **A.** I thought we reached the point where action was required and not words, at that point.

6. On October 16, 2002, Dr. O'Neill wrote to Dr. Howlett, copied to Dr. Cowden but not to Dr. Horne:

> Dear Dr. Howlett:
>
> I am in receipt of your letter dated October 10, 2002. In it you underline clearly and succinctly your concerns over Dr. Horne's performance in the Heart Function Clinic, as well as her lack of collegiality within that group. It is with great regret that I must agree with your recommendation that she no longer attend within the Heart Function Clinic. I will recommend to Dr. Cowden, upon your advice that her activities in the Heart Function Clinic be varied in the manner you have suggested. I thank you in advance for bringing this serious matter to my attention.

7. Dr. O'Neill participated in the meeting of October 21, 2002, where Dr. Horne's privileges were varied. Dr. Cowden explained that Dr. O'Neill could not opt out of his responsibility as Division Head:

> **Q.** … Now Dr. O'Neill stayed involved despite his request for you to deal with the matter, he stayed involved in the issue of Dr. Horne's privileges after September 30, 2002, didn't he?
>
> **A.** Yes.
>
> **Q.** And, in fact, he attended the meeting where Dr. Horne's privileges were varied on October 21st, didn't he?
>
> **A.** Yes, he did.
>
> **Q.** And why is it the case that that happened if he was asking you to deal with the matter because he had expressed that he felt somewhat in a conflict of interest?
>
> **A.** I …I think that what he felt a conflict of interest in was related to these specific issues. He was the head of the division …
>
> **Q.** Right.
>
> **A.** And, therefore, was responsible for the ongoing performance of all the members of the division.
>
> **Q.** Right.
>
> **A.** That wasn't something he could opt out of but I think because this issue focused on this occasion as opposed to the past when there were whole variety, more particularly the issue between Dr. Howlett and Dr. Horne in terms of the protocol …
>
> **Q.** Right.
>
> **A.** … and the intellectual property and I think he felt that that … in that instance it could be misperceived if he was involved in reviewing it. He was still ultimately responsible for the performance.

8. Also on October 21, 2002, Dr. O'Neill emailed several individuals to report on Dr. Horne's status. His email to Capital Health's vice-president of research, Mr. John Ruedy (copied to Dr. Cowden but not to Dr. Horne), repeatedly identified the decision-makers (Drs. Cowden and O'Neill) as "we":

> … Dr. Cowden and I are sufficiently concerned about this and also allegations of entering patients without informing their attending cardiologist that we have recommended to Gail Eskes that we suspend enrollment in her clinical trials until we can sort out the

> process issues and assure all involved that the protocols are scientifically valid and safe and tripartite policies being followed. We were unsure of process for such a suspension, and Gail thought it was within our prevue to do so and to notify you and her.
>
> We will be asking Dr. Horne to formally present her protocols to Clinical Trials and address concerns about recruitment, and follow up in her protocols. Once we are satisfied that the protocols are safe, attending cardiologists informed and involved in care, we can recommend continuing. On the other hand, if these conditions can not be met, we will have no option but to recommend permanent suspension.

9. On October 24, 2002, Dr. O'Neill attended a meeting of ten cardiologists in the Department. Dr. Horne presented her research. Further to the conditions of variation, Dr. O'Neill testified that he was "laying down the law":

> **Q.** Okay. And then halfway through the second paragraph, you were quoted as saying or reported as saying: Dr. O'Neill … Dr. O'Neill indicated that he had ultimate responsibility for signing off on all research proposals and was no longer willing to do so unless the research in question had been presented to divisional members for discussion and review and indicated that henceforth all clinical research projects involving patient care would have to be vetted at a clinical research meeting. So henceforth means from now on, right?
>
> **A.** Yes, it looks like I was laying … laying down the law.
>
> **Q.** Right, as of October 24th?
>
> **A.** Right.
>
> **Q.** Three days after Dr. Horne's privileges were varied?
>
> **A.** Yes.

[112] The second point is Dr. O'Neill's authority to act for Capital Health:

1. Dr. Horne's lawsuit named Dr. O'Neill as a co-defendant. The same counsel jointly represented Dr. O'Neill and Capital Health. At the conclusion of the testimony, those counsel moved for an order dismissing the claim against Dr. O'Neill. The joint brief of Capital Health and Dr. O'Neill, dated June 8, 2016, dealt with this motion and other matters, saying:

> 1. The Defendants Queen Elizabeth II Health Sciences Centre, the **Capital District Health Authority** (collectively the "Health

> Authority") and Dr. Blair O'Neill (collectively, the "Defendants") **file this brief in support of their position** on the legal issues to be decided prior to settling the jury questions at the close of trial.
>
> …
>
> Issue 6: The Court should decide that the personal claim against Dr. O'Neill should be dismissed, as **his actions were those of the Health Authority**
>
> …
>
> 81. The undisputed evidence at trial shows that **at all times Dr. O'Neill acted as Division Head** of the Division of Cardiology, and **acted to fulfill his responsibilities for the Health Authority** in that role. There is no evidence that any of his actions has any separate "identity or interest" which would bring him outside that role.
>
> [emphasis added]

2. On June 9, 2016, counsel for Capital Health and Dr. O'Neill said:

> **MR. DUNBAR:** From our perspective, My Lord, and I think this is reflected in our jury questions, the question the jury should be asked to answer is **did the Health Authority act in bad faith. And if my friend wants to say, well, that's it acted in bad faith and that's because of Dr. O'Neill, I think that's something that he can say,** but it doesn't change or require a separate question to the jury about should Dr. O'Neill be held bad faith for a particular … Otherwise, we're breaking down every event into a series of jury questions, which, you know, writ large this is a case about the variation of privileges, writ large there's an allegation that the Health Authority, whether … I mean, **it's certainly identified that it's Dr. O'Neill that acted** to vary the privileges on information that they knew to be false. **So I think all of that is wrapped up together into the question, Did the Health Authority act in bad faith** or with malice with respect to the variation of Dr. Horne's privileges? And I don't think that excludes any aspect of that from being captured within the ambit of that question, if that …
>
> **THE COURT:** So that's open for argument, **that's open for argument, you say?**
>
> **MR. DUNBAR: I think it's open for argument, my Lord**, but I don't think a question of putting a very specific proposition to the jury, like, did Dr. O'Neill, should he have supplied different, or did he know information was false or should have known, and, in bad faith, supplied that information, because then we're down to …

…

> **MR. DUNBAR:** … But at least, with respect to Dr. O'Neill, it's certainly our position that any conduct that's being attributed to him, there's no personal aspect. There's never been any personal pleaded claim against Dr. O'Neill that he acted maliciously outside his duties as division head. It's that he acted maliciously in his role as division head, which is a world of difference, from our perspective, when it comes to including him as a personal defendant.
>
> [emphasis added]

3. Justice Boudreau's Preliminary Decision adopted Capital Health/Dr. O'Neill's position. The judge ruled:

> Issue No. 3:
>
> Is Dr. Blair O'Neill a proper named defendant on the facts and circumstances of this case?
>
> [71] There can be no question that, on all of the evidence presented, at all material times Dr. O'Neill was acting in his role as Head of the Division of Cardiology for CDHA. He was acting with the actual authority of CDHA. I would go so far as to say that Dr. O'Neill was not only acting within the scope of his authority at CDHA, but he was also acting with its approval. Therefore, **it is clear that at all material times, Dr. O'Neill was acting as an agent of CDHA. All of his actions were the actions of CDHA.**
>
> [72] There is nothing in the evidence which indicates that Dr. O'Neill had a "separate identity or interest" at any time. There is also nothing in the pleadings or the evidence which would suggest otherwise. In fact the pleadings reinforce this conclusion.
>
> [73] Therefore, Dr. O'Neill shall be removed as a party defendant.
>
> [emphasis added]

4. Similarly, the jury charge adopted Capital Health/Dr. O'Neill's position, naming only Capital Health in the jury question:

> Has the plaintiff, Dr. Horne, proven on a preponderance of the evidence that Capital Health acted in bad faith or with malice when it varied her privileges?

5. Finally, the judge's charge incorporated Capital Health/Dr. O'Neill's acknowledgement, in Mr. Dunbar's oral submission, that Dr. Horne could put to the jury her theory that Dr. O'Neill's conduct be

attributed to Capital Health as evidence of Capital Health's bad faith. The charge also noted:

> … It is agreed by all concerned that Dr. O'Neill and Dr. Cowden, that the actions of Dr. O'Neill and Dr. Cowden would be those of Capital Health because they were acting within their roles in authority at Capital Health.

[113] In the Court of Appeal, Capital Health essentially submits that, by adopting the acknowledgement stated by Capital Health/Dr. O'Neill's joint counsel, the judge erred in law.

[114] We turn to the authorities.

[115] In *Finney*, Justice LeBel's key passage, later endorsed by *Hinse*, said:

> 39 … However, recklessness implies a fundamental breakdown of the orderly exercise of authority, to the point that absence of good faith can be deduced and bad faith presumed. …

[116] The fundamental breakdown of the orderly exercise of authority is an unruly state of affairs, to which actors other than just the titular decision-maker may have contributed. This is apparent from *Finney* and *Rosenhek*.

[117] In *Finney*, Justice LeBel said:

> 42 … The attitude exhibited by the Barreau, in a clearly urgent situation in which a practising lawyer represented a real danger to the public, was one of such negligence and indifference that it cannot claim the immunity conferred by s. 193. The very serious carelessness it displayed amounts to bad faith, and it is liable for the results. This is apparent on a quick review of all the facts.

To exemplify the Barreau's bad faith, Justice LeBel then cited the conduct of the Barreau's investigators (paras. 43-45).

[118] In *Rosenhek*, a cardiologist's privileges had been revoked, then restored after administrative review. The cardiologist, Dr. Rosenhek, then sued the hospital for administrative bad faith. The Ontario Court of Appeal upheld the trial judge's finding of liability for bad faith. The Court of Appeal (para. 32) noted "the existence of an oblique or improper motive for the revocation of Dr. Rosenhek's privileges", and found that "the oblique motive permeates the conduct of the Hospital and is probably the most significant reason supporting a finding of bad faith by the Hospital".

[119] The evidence for the oblique motive included that "Dr. Rosenhek found himself at odds with those specialists who had opposed the plans to establish a critical care unit", and "difference of opinion, and interpersonal differences, made Dr. Rosenhek an outsider ..." (para. 32). The Court of Appeal (para. 33) cited conduct by the Chief of Medicine, who the Court said "was very much in the forefront of those who denied Dr. Rosenhek access to a coverage group". The Court (para. 35) concluded "there was ample evidence before the trial judge to support his finding that the Board acted in bad faith".

[120] Dr. Horne's theory was that, for the variation of her privileges, the orderly process of decision-making had fundamentally broken down, which prompted the presumption or inference of bad faith that the Supreme Court posited in *Finney* and *Hinse*. According to Dr. Horne, the fracture allowed Dr. O'Neill, despite his declared conflict of interest, to act as a protagonist by injecting his friend Dr. Howlett's agenda in the process that culminated with the variation, while Dr. Cowden assented. Dr. Horne's proposition was that the variation stemmed from cronyism rather than patient care. That was the bad faith, or "oblique motive" as the Court in *Rosenhek* termed it.

[121] Whether or not that actually occurred in this case was for the jury. But the proposition pertained to a theory, supported by evidence, that the presiding judge properly left with the jury, and Dr. O'Neill was in the midst of it.

[122] We dismiss this ground of Capital Health's cross-appeal.

10. Capital Health's cross-appeal issues #3, #4 and #5 – Instructions on damages for impairment of Dr. Horne's research career

[123] Capital Health submits the judge erred by: (1) ruling and then instructing the jury that damages for loss to Dr. Horne's research career were encompassed in damages for loss to reputation; (2) failing to instruct the jury that he had ruled Dr. Horne's damages claim for restoration of her research career was legally unsupportable; and (3) failing to properly instruct the jury on the legal principles surrounding a loss of reputation claim. As these grounds overlap, we will address them together.

[124] Essentially, Capital Health says the judge's Preliminary Decision conflated loss of the research career, cost to restore the research career and loss of reputation, and then the charge confused the jury by not explaining the relationship among those concepts.

[125] The judge's instructions that led to the jury's $1.4 million award for damage to reputation, or loss of research career, were:

> Damages, now we go on to the question of damages, if you find that Capital Health acted in bad faith or with malice. I will discuss with you, first, general damages. In cases like the present one, that is, if you answered yes to question number 1, there is a presumption that some damages necessarily flow from a finding of bad faith or malice. But first you have to have found that Capital Health acted with bad faith or out of malice. These kinds of damages are compensatory. That is, they are meant to compensate the plaintiff for any harm done to her reputation and/or research. These damages are assessed at large. This means you pick an amount of money that you find is reasonable to compensate the plaintiff for the wrong and the harm done to her reputation and to her research career.
>
> If you have found that Dr. Horne has proven that Capital Health acted in bad faith or with malice in this case, you can consider the amount of the award for loss of reputation and loss of research career. In this case, Dr. Horne has not advanced a claim for mental distress or suffering. Also, you must keep in mind that Dr. Horne's research activities or grants did not add any additional money to her personal income. This part of the claim is not about loss of income. That claim only arises out of the claim for under-remuneration and it's found in question number 4.
>
> You must always keep in mind, in all of the questions regarding damages, that there must be a causal connection between the damages claimed and the damages awarded, and that any wrong or harm … and that the damages awarded and that any wrong or harm had been done by the defendant Capital Health was caused, was the cause of the damage. And Dr. Horne must prove that the variation of her privileges was the cause of her alleged loss of reputation and loss of research career.
>
> The burden is on Dr. Horne to prove all of those allegations regarding loss of reputation and loss of research career. You, the jury, must honestly endeavor, as representatives of the community, to arrive at a figure that will compensate the plaintiff for any harm which she has, in fact, suffered. And in assessing these damages, you should, as nearly as possible, award the sum of money which will compensate the plaintiff for any damages she has suffered. Again, of course, this is only if you have found that bad faith or malice existed in question number 1.
>
> As I said, if you have found that bad faith or malice was a motive, then some damage and injury for loss of reputation are presumed to arise, and it is for you to decide to what extent. However, in all those cases, there has to be a causal connection, which means that Dr. Horne must prove that the alleged loss of reputation or loss of research was caused by the bad faith or malice of Capital Health.

I would just like to remind you again that your decision cannot be based on sympathy nor prejudice for any party. Everyone is the same before the courts. Having said that, Dr. Horne's prior reputation or status are relevant to assessing the amount of any harm to her reputation or to her research career caused by bad faith or malice on the part of Capital Health.

The defence says that no actual financial loss was proven. The defence says that as far as everyone was concerned, the Capital Health Board decision of September 2006 vindicated Dr. Horne and that Capital Health did not cause any harm to Dr. Horne's reputation or to her research. That when you consider all of those facts, the defence argues that there should only be a small amount of general damages, if any, for loss of reputation or loss of research career, that is, if you decide that bad faith or malice was the motive for the variation.

…

Question 4(b) [*sic* – 2(b)] Has the plaintiff Dr. Horne proven on a preponderance of the evidence that Capital Health caused her a loss of reputation which may include a loss of research career? Here again, we have, for the plaintiff, Dr. Horne's testimony, where she says failing to get the letter of exoneration that she was requesting from Capital Health, aside from the various rulings and decisions which the Board made in September of 2006 that she could not continue her research, she said she was of the opinion that having had her privileges varied was a significant impact on her reputation which would severely negatively impact any applications for funding by way of grants or subsidies. She says any of the arrangements that were proposed to try to continue recruitment of patients and continue with the studies were not satisfactory, were not reasonable and, therefore, she could not proceed.

We have heard evidence about the alternate recruiting plans that were put in effect, but, because they involved Dr. O'Neill and Dr. Howlett in monitoring those in the Heart Function Clinic, Dr. O'Neill was of the opinion that she could not successfully continue to recruit patients in the Heart Function Clinic under the conditions that were proposed.

We have Dr. West, who testified on behalf of the plaintiff on the question of research career and grant funding. He spoke somewhat about revenue shares, but he spoke mostly about how grants and research and payments occur. He testified as to how long it takes to get a grant, how difficult it is to get a grant, how competitive it is to get a grant, and one has to have a track record and, by inference, a good reputation to continue to obtain grants for research.

…

Another witness with regard to loss of reputation and research career was a witness who was classified as an expert witness, Dr. Roy Poses. I'm sorry, my notes on Dr. Roy Poses seems to have escaped ... Sorry, it's here; I just didn't notice the ... He was classified as an expert in the field of grants for biomedical research and clinical research, and he spoke extensively on how applications for

> grant funding work, what you have to show to get grant funding, how long the process is, how important a track record of research is. Of course, he accepted that publications are a significant element of research, clinical, investigative and clinical research. He testified that a variation of privileges would significantly impact a cardiologist's or any doctor's ability to obtain research or grant funding.
>
> The defendant called witnesses on the issue of loss of reputation, which may include loss of research career. The letters, the testimony of Dr. O'Neill, Dr. Johnstone, Dr. Cowden was led for the purpose of showing that Capital Health was positive towards trying to continue Dr. Horne's research and providing the ability to recruit patients. Many letters were introduced where there were expressions of positive support to do that. However, those never came to fruition, for some reasons which we know and some which we don't.
>
> On the issue of loss of reputation, it was mentioned numerous times in this trial that the Capital Health, through its CEO, incorrectly categorized the Capital Health Board decision of September 2006. That's the decision which said that Dr. Cowden should not have employed the emergency procedures to take corrective action against Dr. Horne. In my view, it is not entirely correct ... Excuse me. In my view, it is not entirely incorrect to classify the Capital Health Board's decision of September 2006 as being decided, at least in part, on a procedural issue, because the effect of that decision is that Dr. Cowden, the District Medical Advisory Committee, and the Peer Review Committee used the wrong procedure, namely, the emergency procedure to take corrective action against Dr. Horne. So there certainly is a procedural element to that decision.
>
> The defendants also called several of the witnesses I just mentioned, who spoke about possible alternate sources of recruitment for patients in Dr. Horne's studies. They also called testimony, and I forget where the chart is, but there was a chart about how recruitment was moving along in the two or three years that Dr. Horne had been engaged in those studies, and that the numbers were continuously reducing, and that was primarily because the pool of available possible patients had been, as was referred to, pretty well exhausted. That evidence was led by Dr. ... several of the doctors, Dr. O'Neill and Dr. Rudy, I believe, in support of the defendants' claim that the loss of the research career through lack of recruitment was not caused by the variation of privileges. However, it is for you to decide that.

[126] We agree that the judge’s instructions were flawed to the degree that they were reasonably capable of affecting the jury’s award of $1.4 million. We say this for the following reasons.

[127] The Preliminary Decision and jury charge combined to generate some nebulous propositions on the quantification of damages, as we will explain.

[128] The judge's Preliminary Decision rejected Dr. Horne's damages claim for "restoration of her research career", and held that "loss of research career … would be encompassed in her loss of reputation and is not a proper separate head of damages". The ruling contemplates that a loss to her research career would be recoverable only if the loss was occasioned by injury to her reputation:

> [83] Dr. Horne has also claimed damages for loss of research career and for restoration of her research career.
>
> [84] I find that both these claims are for non-pecuniary damages and that as far as loss of research career is concerned, it is the same as loss of reputation. Therefore, that claim would be encompassed in her loss of reputation and is not a proper separate head of damages.
>
> [85] With regard to Dr. Horne's claim for restoration of her research career, she could not point to any authority which supports such a claim. Such a claim would be akin to an actor or musician claiming that a wrongful act caused him or her to lose an acting or musical career and claim large sums of money to permit them to acquire their own theatre or movie studio or their own recording studio. We would find such claims unreasonable even though actors and musicians profit financially from their endeavors, unlike Dr. Horne's research activities. As I said earlier, it must be remembered that none of Dr. Horne's research grants or activities, as of themselves, add any amount of money to Dr. Horne's personal income. In law, Dr. Horne's claim in this regard is neither reasonably foreseeable nor is it reasonable. Extending the concepts of foreseeability and causation to the extent contended by Dr. Horne would be to rewrite the law of damages.
>
> [86] In effect this claim is at best part of the loss of reputation claim and, therefore, I will not be instructing the jury on this claim or this head of damages.

Yet the jury charge several times instructed the jury to assess reputational loss "or" loss of research career, treating "loss of research career" independently.

[129] The Preliminary Decision distinguished "restoration" from "loss" of Dr. Horne's research career, and rejected the former as a head of damages. But the jury charge neither cautioned against assessing damages for the rejected approach, nor explained how damages for "loss" differed from damages for "restoration".

[130] The Preliminary Decision's distinction between loss and restoration is unclear. One measure of a loss is replacement cost, though sometimes with adjustments drawn from the circumstances. Aspects of this measure resemble elements of restoration.

[131] As noted earlier, the Preliminary Decision said that reputational loss "encompassed" loss of research career, as a subset. Jury question 2(b) reflected this view by asking about reputational damage that may "include a loss of research career". Yet much of Dr. Horne's claimed loss to her research career was a direct outcome of her restricted access to research subjects in the Heart Function Clinic after the variation of her privileges (above, paras. 47-50). That aspect of her loss would not flow from damage to reputation. This was not explained to the jury.

[132] Nor is it evident why a proven loss – including impairment of one's research career – that was caused directly by the defendant's actionable conduct, should be unrecoverable unless it flows from, or accompanies reputational harm.

[133] The judge may have meant to reject the monetized form of specific performance, or expectation damages that were included in Dr. Horne's dismissed contract claim. But the jury charge did not explain the distinction between that approach and the appropriate measure of recoverable loss.

[134] The jury charge said that loss of Dr. Horne's research career should be quantified "at large", subject to causation, but without guidance on the incongruities we have cited.

[135] Not surprisingly, the jury appeared to be confused. The jurors wondered if they had to give a dollar amount. They asked the judge:

> For question 2(b), we have questions on how to answer the question if we say yes. Do we need to put an amount at the bottom?'

[136] The judge said yes, but without guidance:

> The answer to your question is if you answer yes to question 2(b), number 2(b), then you are required to put an amount at the bottom. That amount can be anywhere from zero or upwards.

[137] As noted for the standard of review, the jury should be left with a clear picture of the factual issues they are to decide, along with the legal principles related to those issues. In *Daley*, Justice Bastarache for the majority put it this way:

> [32] The trial judge must set out in plain and understandable terms the law the jury must apply when assessing the facts. This is what is meant when it is said that the trial judge has an obligation to instruct on the relevant legal issues.

[138] This means the charge should explain the judge's distinction between unrecoverable restoration of Dr. Horne's research career and recoverable loss to Dr. Horne's research career, and the latter's connection to reputational harm.

[139] However, the charge did not inform the jury that he had ruled restoration of Dr. Horne's research career to be unrecoverable in law. The judge explained neither that he had made a distinction, and the effect of any distinction, nor how the unrecoverable features differed from the recoverable ones so the jury could address the distinction in the jury room with a finding of fact. His instruction on the connection of compensable loss to reputational harm was, at best, ambivalent.

[140] Consequently, a significant portion of the $1.4 million (1) may quantify the restoration – as opposed to the loss – of Dr. Horne's research career, and (2) may not be "encompassed" by reputational harm. Either outcome would contradict the Preliminary Decision.

[141] If a presiding judge's mid-trial ruling dismisses what, from the trial's earlier trajectory, the jury had understood to be a key issue, then normally the jury should be apprised of the development and its implications for the jury's function. If the jury was not informed, the appeal court considers whether the non-instruction was sufficiently misleading and prejudicial that it may reasonably be expected to have affected the outcome: *e.g., R. v. Romano*, 2017 ONCA 837, paras. 3, 5-6, 47, 50, 53-62, per Paciocco, J.A. for the Court. As noted earlier, the appeal court's functional approach considers how the judge's instructions responded to the trial's course of events, including the parties' theories, the evidence and submissions of counsel: *Jacquard*, paras. 32-41, 62. Counsel's comments to the jury may contribute to the misleading and prejudicial effect: *R. v. Romeo*, [1991] 1 S.C.R. 86, para. 95, per Lamer, C.J.C. for the majority; *R. v. Rose*, [1998] 3 S.C.R. 262, para. 127, with para. 62; *R. v. A.T.*, 2015 ONCA 65, para. 38; *R. v. Clause*, 2016 ONCA 859, paras. 38-39.

[142] The course of events at this trial is telling.

[143] In his opening statement to the jury, Dr. Horne's counsel said that $8.2 million dollars was needed to retrace her lost ground as a researcher. The jury was urged to consider this amount as a virtual book entry:

> Dr. Horne is also claiming that because her privileges were wrongfully varied and because that meant that her research was interfered with and, ultimately, it terminated, the defendants need to make her whole by funding the

> recommencement of her research. And so Dr. Horne has claimed damages for the cost to provide her with the time, research space, equipment, and staff needed to restart her research, the research she was hired to do and which was part of the agreement she entered into when she joined in 1998.
>
> The claim for damages for these various things is because the Health Authority has not agreed to provide any funding, space, staff or equipment to Dr. Horne. She needs to provide all of these things herself and, as her evidence will show, she is not at this point a suitable candidate for grants, as her prior grants, as I said earlier, did not generate results, because the variation of her privileges prevented the research from being completed.
>
> So I need to say two things about this part of the damages claim: first, it's important to keep in mind that Dr. Horne is not seeking to personally benefit from this part of the claim, and, in fact, the largest part of the claim, which she will explain to you, is to fund her time to do the research, so money that will be paid back to the Health Authority to buy Dr. Horne's time, if it permits her to do that. She's asking for money from the Health Authority so that she can pay the Health Authority for the time she needs to take away from seeing patients so that she can do research. Second, she is claiming that will sound like a lot of money to do this. Dr. Horne is claiming $8.2 million to restart her research career. You'll hear the evidence, research is expensive.

[144] Dr. Horne called expert evidence to support her claim for damages to restore her research career. Dr. Roy Poses summarized in his report what Dr. Horne would have to do to restore her research career:

> 4. The premier government funding source for biomedical and clinical research in Canada is the Canadian Institutes of Health Research (CIHR). Research proposals to the CIHR are evaluated according to five criteria. Similar criteria are also used by most other large medical or clinical funding organizations to assess applications for research grants. Given the events outlined in this report, it would be very difficult for Dr. Horne to put forth grant applications that met these criteria today. Therefore, it would be difficult for her to acquire grant funding to return to or renew her research projects.
>
> 5. In particular, it would be difficult for her to show that her research into the role of the septum in patients with congestive heart failure was feasible, given the fact that her earlier research projects were never fully completed, and did not lead to publications. It would also be difficult for her to show that her research was "original", as it depended largely on technology that is now outdated. Furthermore, it would be difficult for her to show that she could find and retain suitably trained personnel to assist in her research activities or that she could have access to a suitable environment in which to find and observe research subjects.
>
> 6. To be competitive again for research funding, Dr. Horne would have to demonstrate that she could manage and execute research projects, and then

> disseminate the results from her research. To accomplish this, she would need sufficient funding over time to complete all the tasks required in a complicated, biomedical research project. This would have to include funding to hire and train qualified research personnel, as well as access to a patient cohort to participate in her research.

[145] The judge's jury charge said Dr. Poses' evidence pertained to damages for loss to Dr. Horne's research career:

> Another witness with regard to loss of reputation and research career was a witness who was classified as an expert witness, Dr. Roy Poses. …

[146] Dr. Horne testified that, before her privileges were varied, she enjoyed "protected time" to do her research. She then listed all the steps she would have to take to restore that aspect of her work. For example, she would have to secure space and equipment, hire new research staff and upgrade her skills.

[147] Capital Health's opening statement, made before the Preliminary Decision, also mentioned the matter:

> Lady and gentlemen of the jury, you've already heard a lot of evidence. Some of it was probably difficult to fit into the right time sequence. Some of it you probably wondered why it was entered at all. By the end of the trial, I hope some of the questions you may have about those things may be answered. However, some may never be.
>
> You're probably wondering, as we certainly are, sitting at our bench, how this can be a big claim, whether it's the $8-million claim that Mr. Wright spoke of in his opening, or the $10-million, $10.3-million in Dr. Horne's brief to the learned trial judge.

[148] Capital Health's pre-charge submissions urged the judge to caution the jury that Dr. Horne's elevated numbers were misleading, given the Preliminary Decision's disallowance of the head of damages for restoration of Dr. Horne's research career:

> There has been no guidance provided to the jury by the court or counsel to assess the amount of "at large" damages. The Plaintiff claimed $8 million for a lost research career in the opening and that impression on quantum has never been corrected. Our concern is that this leaves it open to the jury to award multiple millions in "at large" damages as it has no concept of what a large amount would be, or what a small amount would be. We had understood throughout that there would be guidance given to the jury on the quantum of damages, and in light of that we did not make submissions on the point, although Civil Procedure Rule

> 52.12 expressly permits both the court and counsel to address this issue with the jury.
>
> Plaintiff's counsel did not advise us prior to his submission of yesterday at 1:00 p.m. that he opposed a range of damages being presented to the jury. We note that his pre-trial brief asks for damages for loss of reputation of $300,000, as did the handout which he attempted to present to the jury during the examination of Dr. Horne. We also addressed quantum in our pre-trial brief. This is inconsistent with the position now taken by Plaintiff's counsel, which apparently is that it is impossible to agree on an upper limit for these damages and the jury should have no guidance whatsoever.

[149] Nonetheless, the charge did not inform the jury that the premise for the elevated numbers – damages for "restoration" of Dr. Horne's research career – had been lifted from the table. Nor did the judge caution the jury to disregard any evidence they had heard or comments in the opening statements that derived from the dismissed theory of damages.

[150] In the jury room, perhaps the jury was unimpressed by Dr. Horne's damages claim and decided to award only a fraction of the requested $8.2 million. Or the award may reflect the jury's sympathy to Dr. Horne by generously applying a more restrained premise that is unconnected to the $8.2 million. The jury may or may not have concluded that its award was encompassed by reputational harm. Of course, the jury is entitled to select its reasoning path. But the charge should not puzzle the jury on the legal premise for its selection.

[151] In our respectful view, the Preliminary Decision failed to properly distinguish the claimable and unclaimable features of the impairment to Dr. Horne's research career. Similarly, the jury charge failed to state in plain and understandable terms the legal distinction between those claimable and unclaimable damages. The charge failed to caution against the jury's use of evidence and counsel's comments that had pertained to the ultimately rejected approach for the quantification of damages. These are errors of law.

[152] The task of an "at large" assessment coupled with confusing directions in the jury charge, would attract the jury to the refuge of an available fixed number – *i.e.* the $8.2 million, which the Preliminary Decision had rejected. In our view, the judge's errors of law were reasonably capable of affecting the jury's award, and potentially caused a substantial wrong or miscarriage of justice.

[153] We allow the cross-appeal on quantum, and set aside the award of $1.4 million.

11. Capital Health's cross-appeal issue #6 – The jury's quantum

[154] With our ruling that the quantum should be overturned based on the misdirection, it is unnecessary to discuss this ground.

12. Capital Health's cross-appeal issue #7 – The appropriate quantum

[155] The parties agree that, if this Court dismisses the grounds of appeal and cross-appeal respecting liability but overturns the damages award, we should determine an appropriate quantum without ordering a retrial. Given the fulsome evidentiary record, and that the misdirection did not impact upon other integral findings made by the jury, we agree this approach is appropriate. The Court has jurisdiction to substitute an award: *Civil Procedure Rule* 90.48(1); *Jessen v. CHC Helicopters International Inc.*, 2006 NSCA 81, leave to appeal refused [2006] S.C.C.A. No. 385; *Sklar-Peppler Furniture Corp.*, *supra*, paras. 19-21; *Morash v. Purdy*, 2011 NSCA 123, para. 39; *Cook v. Nova Scotia Light & Power Co. Ltd.*, [1930] 1 D.L.R. 836 (N.S.S.C. *in banco*).

[156] We are asked to assess, as general damages, a non-pecuniary lump sum to compensate Dr. Horne for her suffering from Capital Health's actionable conduct. It is not an arithmetically calculated pecuniary loss. It is not lost income. After her privileges were varied, Dr. Horne continued to earn income as a cardiologist. The jury charge said:

> Also, you must keep in mind that Dr. Horne's research activities or grants did not add any additional money to her personal income. This part of the claim is not about loss of income.

Nor is it to punish Capital Health for its bad faith. The jury declined to award punitive damages.

[157] Dr. Horne's claim for general damages has two components: for loss of reputation and what the trial judge called "loss of research career". The two may partly overlap, but neither is the *sine qua non* of the other. In this respect, we disagree with the passages in the Preliminary Decision and jury charge which say that loss to the research career must be encompassed by, and included in reputational damage. Though ultimately we will assess Dr. Horne's damages globally, it is helpful to consider the two components in turn.

[158] First is reputational damage.

[159] The parties presented the Court with several authorities that assessed damages arising from a loss of reputation for defamation, negligence actions, or tortious bad faith. The principal authorities cited are *Hill v. Church of Scientology*, *supra*, *Young v. Bella*, *supra*, and *Leenen v. Canadian Broadcasting Corporation*, [2001] O.J. No. 2229, 54 O.R. (3d) 612 (C.A.). The parties' factums have adjusted these awards for inflation to the date of trial in 2016.

[160] In *Hill*, the jury in 1991 awarded $300,000 as general damages for defamation of (now Justice) Casey Hill, then a Crown counsel. The amount is adjusted for inflation to $467,679 in 2016.

[161] Dr. Horne's counsel notes that the defamation accompanied contempt of court proceedings against Mr. Hill that, within months, were determined to be baseless, and Justice Hill's career has flourished thereafter. Dr. Horne's vindication has taken much longer, and she suffers ongoing impairment of her research career.

[162] In *Hill*, Cory, J. discussed the importance of reputation:

> 107 The other value to be balanced in a defamation action is the protection of the reputation of the individual. Although much has very properly been said and written about the importance of freedom of expression, little has been written of the importance of reputation. Yet, to most people, their reputation is to be cherished above all. A good reputation is closely related to the innate worthiness and dignity of the individual. It is an attribute that must, just as much as freedom of expression, be protected by society's laws. In order to undertake the balancing required by this case, something must be said about the value of reputation.
>
> 108 Democracy has always recognized and cherished the fundamental importance of an individual. That importance must, in turn, be based upon the good repute of a person. It is that good repute which enhances an individual's sense of worth and value. False allegations can so very quickly and completely destroy a good reputation. A reputation tarnished by libel can seldom regain its former lustre. A democratic society, therefore, has an interest in ensuring that its members can enjoy and protect their good reputation so long as it is merited.

[163] Cory, J. also took note of the particular nature of Mr. Hill's professional reputation:

> 118 In the present case, consideration must be given to the particular significance reputation has for a lawyer. The reputation of a lawyer is of paramount importance to clients, to other members of the profession and to the judiciary. A lawyer's practice is founded and maintained upon the basis of a good reputation for professional integrity and trustworthiness. It is the cornerstone of a lawyer's

> professional life. Even if endowed with outstanding talent and indefatigable diligence, a lawyer cannot survive without a good reputation. . . .

[164] In *Young v. Bella*, as a result of the defendant's negligent investigation, the plaintiff, a student, had been wrongfully red-flagged as a potential sexual abuser. The jury awarded $430,000 non-pecuniary damages primarily for reputational loss. The Chief Justice and Justice Binnie for the Court confirmed that the cap on general damages for personal injuries did not apply when there was no personal injury (para. 65). They said "the damages are higher than we would have awarded in the circumstances." (para. 66) But the jury had been properly directed (para. 64), and the award did not "shock the conscience of the court" (para. 66). So the Supreme Court upheld the award.

[165] The award has been adjusted for inflation to $573,333 in 2016.

[166] Capital Health cites *Young v. Bella*'s quantum as the high watermark of general damages for reputational loss.

[167] Dr. Horne's counsel responds that in *Young v. Bella* the erroneous report was not circulated to the media and was corrected within three years. Dr. Horne's case was widely reported, and has continued to limit her research opportunities for over a decade. Further, Dr. Horne is a tertiary specialist with more to lose than a student.

[168] In *Leenen*, the court found that the CBC had defamed a physician, who was a cardiologist and researcher like Dr. Horne. The trial judge awarded $400,000 general damages, $350,000 aggravated damages and $200,000 punitive damages. The Court of Appeal dismissed the appeal.

[169] *Leenen*'s award of $400,000 in 2000 has been adjusted for inflation to $551,957 in 2016.

[170] Dr. Horne's counsel points out that Dr. Leenen's privileges were not varied, his research recruitment received fewer referrals but was not closed, and his judicial vindication occurred much quicker than the almost 12 years for Dr. Horne.

[171] The second component is impairment to Dr. Horne's research career.

[172] Capital Health argued at trial that this loss should be taken as analogous to diminished earning capacity in a personal injury action, and its appeal factum likens the head of damages to loss of amenities. Capital Health cites *Padfield v.*

Martin, (2003), 64 O.R. (3d) 577 (C.A.), a personal injury case, where the jury had awarded $500,000 non-pecuniary damages, reduced by the trial judge to the personal injuries general damages cap of $274,000, then further reduced by the Court of Appeal to $150,000 to compensate for lost opportunity. The Court of Appeal said (para. 49) that "even with the assumption of facts most favorable to the plaintiff", the trial judge's $274,000 was "inordinately high".

[173] We agree that, in one sense, a claim for diminished earning capacity resembles Dr. Horne's claim for loss to her research career. Both consider lost opportunities along with the foregone future consequences of those opportunities. However, it is also clear that, like reputational loss, interference with one's career can be deeply personal, touching the heart of one's personal identity and enjoyment of life. In an oft-quoted passage, Chief Justice Dickson, in dissent, described the value of work in *Reference re Public Service Employee Relations Act (Alta)*, [1987] 1 S.C.R. 313 as follows:

> 95 Work is one of the most fundamental aspects in a person's life, providing the individual with a means of financial support and, as importantly, a contributory role in society. A person's employment is an essential component of his or her sense of identity, self-worth and emotional well-being. Accordingly, the conditions in which a person works are highly significant in shaping the whole compendium of psychological, emotional and physical elements of a person's dignity and self-respect. In exploring the personal meaning of employment, Professor D.M. Beatty, in his article "*Labour is not a Commodity*" in Reiter and Swan (eds.), **Studies in Contract Law** (1980), has described it as follows, at p. 324:
>
> > As a vehicle which admits a person to the status of a contributing, productive, member of society, employment is seen as providing recognition of the individual's being engaged in something worthwhile. It gives the individual a sense of significance. By realizing our capabilities and contributing in ways society determines to be useful, employment comes to represent the means by which most members of our community can lay claim to an equal right of respect and of concern from others. It is this institution through which most of us secure much of our self-respect and self-esteem.

[174] The Supreme Court has endorsed Chief Justice Dickson's passage: *Wallace v. United Grain Growers Ltd.*, [1997] 3 S.C.R. 701; *McKinley v. BC Tel*, 2001 SCC 38; *Newfoundland (Treasury Board) v. N.A.P.E.*, 2004 SCC 66; *Potter v. New Brunswick (Legal Aid Services Commission)*, 2015 SCC 10. In *Wallace*, Justice Iacobucci for the majority described the significance of work as follows:

> 94 Thus, for most people, work is one of the defining features of their lives. Accordingly, any change in a person's employment status is bound to have far-reaching repercussions.

See also *Smith v. Nova Scotia (Attorney General)*, 2003 NSSC 126 at para. 17, aff'd 2004 NSCA 106, leave to appeal ref'd [2004] S.C.C.A. No. 498.

[175] The deeply personal value of work extends to pursuit of one's chosen career. In *Lento v. Castaldo,* [1993] O.J. No. 2446, leave to appeal refused, [1994] 1 S.C.R. vi, a personal injury claim, the Ontario Court of Appeal considered the plaintiff's inability to pursue his chosen career path as relevant to whether his injuries were "serious" within the provisions of the Ontario *Insurance Act*. The Court wrote:

> 107 In this case, the financial impact upon the life of the injured person is substantial. But even if it were not, we are of the opinion that the frustration of an injured person's chosen career path generally should be considered to be a serious matter. One can contemplate a permanent impairment of an important bodily function which might force an injured person into a career path, different from the chosen one, but which turns out to be economically more advantageous. It might not however, give the same personal satisfaction. An artist may be driven by an injury to practice law. The question of the economic loss or the lack of it is something which would bear upon the quantum of damages to be assessed. Where an injured person has invested years of his or her life in study, training and gaining experience to pursue a chosen career, an impairment of an important bodily function which frustrates the pursuit of that career, regardless of the financial consequences, is capable of being found to be a serious impairment within the meaning of those words as found in s. 266(1)(b).

In *Kern v. Steele*, 2003 NSCA 147, a personal injury case, this Court considered deprivation of a chosen career as a factor in general damages.

[176] The exercise of a statutory power in bad faith is a tort, as is defamation. Here, as in *Hill*, we have a mix of reputational damage and injury to career. In our view, the authorities and considerations cited above apply to Dr. Horne's general damages arising from Capital Health's bad faith.

[177] As we blend these two components – damage to reputation and to research career – we enter what normally would be the jury's province. Absent the misdirection, our function would be limited to deciding whether the award shocks the conscience. In *Hill*, Justice Cory explained the jury's function:

> 182 The factors which should be taken into account in assessing general damages are clearly and concisely set out in *Gatley on Libel and Slander* (8th ed.), *supra*, at pp. 592-93, in these words:
>
> SECTION 1. ASSESSMENT OF DAMAGES
>
> **1451. Province of the jury.** In an action of libel "the assessment of damages does not depend on any legal rule." The amount of damages is "peculiarly the province of the jury," who in assessing them will naturally be governed by all the circumstance of the particular case. They are entitled to take into their consideration the conduct of the plaintiff, his position and standing, the nature of the libel, the mode and extent of publication, the absence or refusal of any retraction or apology, and "the whole conduct of the defendant from the time when the libel was published down to the very moment of their verdict. They may take into consideration the conduct of the defendant before action, after action, and in court at the trial of the action," and also, it is submitted, the conduct of his counsel, who cannot shelter his client by taking responsibility for the conduct of the case. They should allow "for the sad truth that no apology, retraction or withdrawal can ever be guaranteed completely to undo the harm it has done or the hurt it has caused". They should also take into account the evidence led in aggravation or mitigation of the damages.

[178] That said, we turn to the facts.

[179] The jury found that Capital Health had acted in bad faith or with malice towards Dr. Horne when it varied her privileges. It also found that Capital Health had caused her a loss of reputation which may include loss to research career. In approaching the task of determining the resulting damages, we will assume the facts that support these findings and which were reasonably available to the jury on the record. This deference is the appeal court's toll for passage in the jury's province. Many authorities have stated that such an approach is appropriate for assessing or reassessing a jury's quantification of damages: *e.g.*, *Padfield v. Martin*, *supra*; *Taraviras v. Loving*, 2011 BCCA 200; *Abbott v. Sharpe*, 2007 NSCA 6. In *Abbott*, Justice Saunders reviewed the authorities, then put it this way:

> [132] Accordingly, I would hold that the proper approach when assessing and analysing facts and to support a jury's award is to ask whether in fixing damages, the findings that must have led the jury to such a conclusion are reasonable, and are open to it, based on the evidence. Whenever such findings are reasonable, and available to the jury on the record, we must ask then whether the jury's findings are capable of supporting its assessment of damages, having regard to the contingencies that arise in the circumstances of that particular case.

[180] We will not canvass all of the evidence of this 33-day trial. Much of it has been extracted or summarized above. The following findings are reasonable and available from the record and in our view precipitated the jury's award:

1. Dr. Howlett's treatment of Dr. Horne, including his repeated complaints were, at least in part, motivated by animosity.

2. Dr. O'Neill, despite recognizing a personal conflict in assessing the complaints made by Dr. Howlett, continued to participate in the process of decision-making that ostensibly was conducted by Dr. Cowden.

3. Dr. O'Neill's participation involved the incorporation of Dr. Howlett's agenda into the decision-making process that led to the summary variation of Dr. Horne's privileges.

4. Dr. Cowden was aware of Dr. O'Neill's personal conflict but continued to involve Dr. O'Neill in the decision-making process, and assented to his agenda.

5. Given the wording of s. 8.1 of the *Disciplinary Bylaws* under which Dr. Horne's privileges were summarily varied on an "emergency" basis, it would be understood by colleagues, staff, patients and the public that she had been found to be a physician that did, or would likely expose patients to harm or injury, and whose conduct negatively impacted the delivery of patient care.

6. Dr. Horne's conduct did not constitute a risk to patient safety, nor did it negatively impact the delivery of patient care.

7. Capital Health reported the variation of privileges to the College of Physician and Surgeons, with further negative impact to Dr. Horne.

8. An "emergency" variation, particularly one based on concern for patient safety, is viewed as being very serious, must be disclosed when seeking to renew an appointment and can have a long-term deleterious impact on a physician's reputation.

9. The variation of privileges remained in place for nearly four years until set aside by Capital Health's board of directors. That decision of the board did not dispel the lingering erroneous impression that Dr. Horne had jeopardized patient safety or care.

10. The variation of Dr. Horne's privileges contributed significantly to the decline and termination of her three research projects, including the loss of

> grant funding, that she had developed and was carrying out at the time of the variation.
>
> 11. The four-year impediment to Dr. Horne's ability to conduct meaningful research negatively impacted her professional development as a researcher, and will impact her ability to compete successfully for future grants and funding.

[181] We are satisfied that Capital Health's bad faith caused significant and lasting damage to Dr. Horne's reputation. Just as being unethical afflicts the core of a lawyer's professional integrity, being termed a risk to patients pierces the heart of what is expected of a physician. It is hard to imagine a more vital blow to a medical professional's station. We are further satisfied that the consequences will follow Dr. Horne well into the future.

[182] Dr. Horne is a scientist. She wanted to devote her talents and energy to conducting research. Capital Health says she is doing just that, having found success in new research projects, and that she has lost little in terms of her ability and desire to be a researcher. We disagree. Dr. Horne wanted to devote herself to the three projects she developed in 1999 and 2000. However, those projects were rendered obsolete by the time she was able to return to meaningful research pursuits. Her ability to forge onward did not replenish her lost opportunity.

[183] On the other hand, as we have discussed, it is reasonable to conclude that the jury's award of $1.4 million was inflated by material that a properly instructed jury would not have considered, *i.e.* the evidence and comments of counsel respecting the ultimately dismissed $8.2 million claim. The charge's equivocal instructions likely dispatched the jury to the anchorage of a firm number. The jury was not told that the Preliminary Decision had removed the $8.2 million from consideration.

[184] Dr. Horne is entitled to substantial compensation that takes account of the range of awards in the authorities and counsel's submissions on their applicability. At the end of the day, Dr. Horne's award depends on the circumstances. There is no legal matrix for this non-pecuniary assessment.

[185] From the above considerations, we assess Dr. Horne's general damages for loss of reputation and loss to her research career, at $800,000.

13. Conclusion

[186] We dismiss Dr. Horne's appeal. We dismiss Capital Health's cross-appeal against liability. We allow Capital Health's cross-appeal on damages, overturn the award of $1.4 million and substitute an award of $800,000.

[187] Counsel asked that we reserve our ruling on costs until after the filing of further submissions. The parties should each file and serve a submission on costs by three weeks from the date of the order that accompanies these reasons. Each party will have a further two weeks to file and serve a response.

MacDonald, C.J.N.S.

Fichaud, J.A.

Bourgeois, J.A.