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Anesthetic Malpractice in Canada

John H. Harland*

THE ANESTHESIOLOGIST is perhaps more liable to suit than the practitioner specializing in other fields, for several reasons. Firstly, his most prolonged contact with the patient is made while the latter is asleep. Although there is some opportunity to establish rapport in the pre- and post-operative visits, the relationship is necessarily somewhat tenuous. This is further aggravated by a tendency in the bigger institutions to delegate these duties to residents or internes. A patient is less likely to sue the doctor he knows, who has been treating him and his family over a long period, as compared with one who, for them, hardly exists as a real person at all.

Secondly, the advances in anesthetic technique have been such that anesthesia is now relatively safe. Thus, when something does go wrong, the victim of the accident or his family are much more likely to ask questions than they were a few years ago. In the old days, anesthetic deaths were explained away as "ether allergy," or "status thymo-lymphaticus," diagnoses that would no longer be considered acceptable. Cardiac arrest was assumed until quite recently to be an Act of God; it is now recognized that although not always preventable, it is usually just to infer that it was caused, rather than that it just happened. Small comfort though it may be to the defendant anesthesiologist, he is, to some extent at least, the victim of his own success.

Thirdly, as in the "swab" cases, where damage is caused, the patient-plaintiff can have no knowledge of what transpired, and the thing or instrumentality which caused the damage being so completely under the control of the anesthesiologist, it is perhaps not surprising that the doctrine of *res ipsa loquitur* is applied in many jurisdictions.

The Canadian anesthesiologist, despite all this, is, however, much less suit-conscious than his contemporary in the United States. That this happy insouciance is due to greater skill or fewer accidents may be doubted. It is due in part to the fact that the Canadian public is not inherently litigious; in part to the circumstance that counsel do not handle cases on a contingent basis. Such a practice is not only frowned upon by the Canadian Bar Association as unethical; it would in fact be considered champertuous. Furthermore, the damages awarded in personal injury cases in Canada are relatively paltry, judged by

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Editor's Note: Prof. O. E. Lang of the University of Saskatchewan College of Law was kind enough to read the manuscript of this article, and to approve it as "a very fine job." See also the Comment by Prof. Mewett at the end of this article.

other standards; for example in the anesthetic explosion case, which will be referred to, general and special damages totalled less than \$10,000.00.¹

Finally, there is the effect of the way in which anesthetic malpractice insurance is carried. This will now be gone into.

Professional Malpractice Insurance in Canada

Most Canadian anesthesiologists are members of the Canadian Medical Protective Association, a non-profit organization, functioning under the aegis of the Canadian Medical Association. The Protective Association follows a policy of contesting *every* claim, except those which are manifestly indefensible. This discourages the "nuisance" claims, which the commercial underwriter, taking the short term view, would tend to settle to avoid costly and protracted litigation.

One leading insurance agent in Illinois who underwrites malpractice insurance in the United States and Canada offers insurance to Canadian anesthesiologists at the lower premium rate, at par with the States of Delaware, Nebraska and Vermont. The annual premium rates range from \$102.00 to \$131.00 depending on coverage, as compared with \$461.00 to \$547.00 annually in parts of California.

The premium charged the members by the Protective Association is \$20.00 annually, providing what amounts to unlimited coverage.

It may be of interest to note some further statistics. The Association has between 10 and 11,000 members. In the year 1959-60, only 22 writs were issued against members. During that year four cases went to trial, of which one was lost. Eleven settlements were made. The cost of legal fees and settlements during the same period amounted to some \$65,000.00, but this figure was greater than usual.²

To the malpractice insurance underwriter in New York State or California, Canada may sound like an actuarial paradise. There is, however, every reason to assume that Canadian physicians may anticipate a gradual increase in the number of writs issued against them, following the trend in Great Britain and the United States.

Some Differences Between the Practice of Anesthesia in Canada and the United States

The Nurse Anesthetist. In Canada virtually all anesthetics are administered by doctors, as is the case in Great Britain. In the latter country nurses deliver infants; in the United States nurses give anesthetics. In Canada today they ordinarily do

¹ *Crits v. Sylvester et al.* (1955) 3 D. L. R. 181.

² Annual Report, Canadian Medical Protective Association, June 1960, Ottawa, Can.

neither one nor the other. An instance where a nurse anesthetist was involved will be cited later, but that case is unique.

This is largely a matter of custom and usage, and of course in the remote areas nurses in fact do have to administer emergency anesthetics. The administration of anesthesia by nurses is expressly prohibited by Statute in some Provinces, e.g., Saskatchewan, where in statutory regulations it is ordered:

Except in cases of emergency, general anesthetics shall only be administered by a duly qualified medical practitioner.³

The Physician Anesthetist. Any physician may administer anesthetics provided he is duly licensed to practice medicine by the licensing body in his Province. These bodies are set up under the Medical Acts of the various provinces. For example, the College of Surgeons of British Columbia is incorporated under the terms of "An Act respecting the Practice of Medicine and Surgery."⁴ Further to this, he must, as in most Institutions in the United States, have been accorded anesthetic privileges by the hospital in which he works. These are not held as a right, and may be withdrawn by the hospital authorities under certain circumstances.

Some Aspects of Canadian Tort Law as It Refers to Anesthetic Malpractice

(a) *The Quebec Civil Code and Stare Decisis in the Common Law Provinces of Canada.*

Canada is unique, in that within one federation the codified civil law operates in one province parallel with the uncoded system of common law in the other nine provinces.

In Quebec, civil wrongs are termed "*Delicts*" or "*Quasi-Delicts*" rather than torts,⁵ and are actionable as offending against one or more of the Articles of the Civil Code. As Anglin, C. J., put it, "on the principles enumerated in Articles 1053, 1054 and 1055, depend practically the whole law of torts in Quebec."⁶

The Quebec Civil Code is based essentially on the Code Napoleon of France and, in principle, the Court assesses each case on its merits, uninfluenced by prior decisions; in theory precedent is unimportant.

In the common law provinces, the body of the law rests on the principle of *stare decisis*, as in England and the United States.

Thus it would seem that decisions arrived at in Quebec must

³ Regulations under Hospitals Standards Act (Saskatchewan), Gazetted Sept. 1956.

⁴ Medical Act (1948), 2 Revised Statutes of British Columbia, C. 206.

⁵ Malpractice Liability of Doctors and Hospitals, by W. J. C. Meredith.

⁶ Anglin, J., quoted in *Delicts and Quasi-delicts*, 1923-47 (1948) C. B. R. 95, Meredith, W. J. C.

differ drastically from those reached in the common law provinces.

In fact, the differences are more apparent than real. Friedmann has pointed out that a nominally rigid adherence to *stare decisis* in the common law provinces is tempered by a mildly venturesome habit of "distinguishing" unhappy precedents till they cease to exist for practical purposes.⁷ He quotes Dunfield, J., of the Court of Appeal of Newfoundland (1952)—"We are not here to administer the law according to precedent; we are here to do practical justice, guided in essentials by precedent. The two attitudes are quite different. If precedent hinders practical justice, precedent should be stretched." This enlightened view hardly coincides with the sentiments of Lord Eldon, who, one hundred and fifty years before, said "It is better that the law should be certain, than that every judge should speculate upon improvements on it."⁸

As Friedmann indicates, the Quebec Courts, in applying the Civil Code, work under "a framework dominated by the common law mentality and technique; . . . the highest appeal court for the Courts of Quebec is the Supreme Court of Canada, a majority of whose members are trained in the common law; . . . the technique of judgment of the Quebec Courts is closer to that of the common law than to that of French law."

The result is that "on the whole, cases of deliberate departure from precedent in Quebec are rare," and ultimately there is a remarkable similarity in the workings of these two parallel systems of jurisprudence.

In regard to *stare decisis*: in each province, courts are bound by prior decisions of that court and courts of equal jurisdiction within the province. All courts are bound by decisions of the Supreme Court of Canada, which is now the ultimate authority.

At one time, Canadian courts were bound by the decisions of coordinate and superior courts in England. This is no longer so, but such decisions are still considered highly persuasive. Judgments from other parts of the Commonwealth and from American courts are persuasive to a lesser degree.

(b) *Contributory Negligence*. In some states the old common law rule still holds, whereby if the defendant can show that some negligent act of the plaintiff has contributed to the damage complained of, the plaintiff will lose his case. This is not so in Canada. In all Provinces, including Quebec, as in England,⁹ legislation provides for an apportionment of damages if contributory negligence is shown. In Quebec, this is referred to as the "Common Fault" doctrine.⁵

⁷ *Stare Decisis at Common Law and under the Civil Code of Quebec* (1953), C. B. R. 723, Friedmann.

⁸ *Sheddon v. Goodrich* (1803) 8 Ves. 441.

⁹ *Law Reform (Contributory Negligence) Act* (1945), 8 and 9 Geo. 6, C. 28.

(c) *Consent.* As elsewhere, a valid consent is needed before administering an anesthetic.

We are unaware of any instance in Canada of anything analogous to the Oklahoma case,¹⁰ where a patient was given a spinal anesthetic contrary to his expressed wishes.

There is little doubt, however, that the Canadian Courts would take a very serious view of this. Commenting on the circumstances wherein a dentist extracted some teeth other than those the patient desired removed, Estey, J., of the Supreme Court of Canada said that it was for the *patient* to decide "What, if any, operation shall be proceeded with."¹¹ He quoted with approval, the words of Garrison, J.:

No amount of professional skill can justify the substitution of the will of the surgeon for that of his patient.¹²

There was an instance of a patient who sued the surgeon, staff and resident anesthesiologists because of pneumothorax developed after a brachial block. The case for the plaintiff was based in part on the claim that they were expecting the surgeon to give the anesthetic. This was held by the Court to be insufficient reason for allowing the claim.^{13, 14, 15} It is noteworthy that many Canadian Hospitals use consent forms which are open to objection as being too broad in scope. Adopting the attitude that "too broad a consent is no consent at all," similar insinuations in the United States usually have adopted a form of consent which is extremely specific.¹⁶

(d) *Waivers of Non-liability.*

In Quebec, many hospitals incorporate a clause in the form of consent, absolving the doctors and hospitals from claims of damage following treatment. It cannot be said that such releases are absolutely valid—certainly not in cases of *gross* negligence, but the law in Quebec on the matter is not completely settled.⁵

We are unaware of such releases being in use in the other provinces.

(e) *Sovereign Immunity.*

Based on the ancient concept that "the King can do no wrong" it was at one time the case that the Crown could

¹⁰ Woodson et al. v. Huey (1953), 2 C. C. H. Neg. Cases 284 (1953), 261 P. 2d 199 (Okla.).

¹¹ Parmley v. Parmley and Yule (1945) 4 D. L. R. 81.

¹² Bennis v. Parsonnet (1912) 83 N. J. L. R. 20.

¹³ A Legal Pot-pourri, Fisher, T. L. (1954), 70 Can. Med. Ass. J. 576.

¹⁴ Burk v. S., B., and K. (1951), 4 W. W. R. 520 (B. C.).

¹⁵ Burk v. Starr et al. (unreported) Supr. Ct. of British Columbia (1952).

¹⁶ Medicolegal Forms with Legal Analysis. Law Department, American Medical Association, 1957.

not be sued in tort, as is still the case in some States, for example Minnesota.

As against the Federal Government, provision is now made for redress against a civil wrong committed by the Agents of the Crown: "The Crown is liable in tort for the damages for which, if it were a private person of full age and capacity, it would be liable."¹⁷

As against the provincial governments, the position varies. In British Columbia, it is possible to present a Petition of Right to the Attorney General. The Lieutenant Governor may subsequently issue a Fiat, permitting the individual to seek a remedy in the Courts.¹⁸

To our knowledge this has never been done in a malpractice case. Most hospitals are incorporated in such a way that they would be unable to escape their responsibilities by pleading immunity. The exceptions are hospitals run by the Department of Veteran's Affairs and some few provincial mental hospitals and tuberculosis sanitaria.

(f) *Res Ipsa Loquitur*.

This has been dealt with separately elsewhere.¹⁹

(g) *Statutes of Limitations*.

Actions for damages are ordinarily prescribed after one year in all provinces, including Quebec.^{4, 5} This may be compared with the situation in the United States, where in some instances the prescription period is as long as six years.²⁰

In British Columbia, the relevant section of the Medical Act reads: "No registered member of the college shall be liable . . . for negligence or malpractice by reason of professional services . . . unless the action is commenced within one year from the date when in the manner complained of, the professional services terminated. . . ." ⁴

It will be noted that no distinction is drawn between negligence and malpractice. There is variation between provinces, as to when the twelve month period shall start to run. The prescription period might well be extended however if the individual could show that there had been assault or some fraudulent concealment of negligence.

¹⁷ Crown Liability Act (1952-3), Statutes of Canada, 1-2 Eliz 2, C. 30.

¹⁸ Crown Procedure Act (1948), Revised Statutes of British Columbia, C. 86.

¹⁹ Application of *Res Ipsa Loquitur* to Anesthetic Malpractice Cases in Canada, Harland, J. H. (in preparation).

²⁰ Law of Hospital, Physician and Patient, Hayt, E., Hayt L. R., Groeschel, A. H., 2nd ed., Hospital Textbook Co., New York (1952).

(h) *The Corporate Practice of Medicine.*

Unlike some jurisdictions in the United States,²¹ some corporations cannot practice medicine in Canada. Only a real individual registered with the provincial licensing body has this privilege; nor is it extended to include the case of Clinics whose members are registered practitioners.²² The patient is billed by the individual physician.

(i) *Responsibility of others for the torts of the anesthesiologist.*

(1) *The surgeon.* In the general case, in Canada, as in the States, there is no legal relationship between the surgeon and the anesthesiologist. In particular, there is not now, nor ever was a master-servant relationship existing between them.²³ The only instance where the Courts felt impelled to comment on this relationship was in Ontario in 1945. Mr. Justice LeBel said:

No authority has been cited to me that holds as a matter of law, that the physician is responsible for the negligence of the anesthetist of his choice. It seems to me that the physician should always satisfy himself that the anesthetist is duly qualified with the skill and experience necessary for the performance of the professional services he undertakes to perform; having done that, the physician or surgeon is not responsible, as a matter of law, for any action or omission on the part of the anesthetist.²⁴

(2) *The Hospital.* In England, *Hillyer's* case,²⁵ is the leading authority for the idea that the hospital is not responsible for the professional activities of the physician.

The creation of the National Health Service in that Country resulted in a situation, where in the general and most usual circumstances, the patient did not privately engage a physician himself, had no free choice of physician and received no bill from the physician. Under these circumstances the absence of vicarious liability on the hospital's part became open to doubt. The doctor was no longer a professional man, ultimately responsible to no person other than the patient—he had degenerated into an underpaid civil servant.

Hillery, J., in *Collins v. Hertfordshire County Council*,²⁶ de-

²¹ Study on Corporate Practice of Medicine in the United States, American Medical Association (1956).

²² *Carruthers Clinic Ltd., v. Herdman* (1956), 5 D. L. R. (2d) 492.

²³ Legal Relationship between the Surgeon and the Anaesthetist, Harland, J. H., and Mewett, A. W. (1959), 6 Canad. Anaes. Soc. J. 299.

²⁴ *Walker v. Bedard and Snelling* (1945), 1 D. L. R. 529.

²⁵ *Hillyer v. Board of Governors of St. Bartholomew's Hospital* (1909) 2 K. B. 820.

²⁶ *Collins v. Hertfordshire County Council* (1947), 1 K. B. 598.

cided, albeit with some hesitation, that the hospital authorities were not vicariously liable for the negligence of a surgeon, who was in their part-time employ. He based this on the fact that the authorities, from lack of knowledge, could not give the surgeon orders regarding *how* his work should be done. He was of the opinion, furthermore, that they could not tell him *what* to do.

Hillyer's case has since been distinguished almost out of existence.^{27, 28, 29} It is now fairly settled law, in England, that the National Health Service is vicariously liable for the tortious acts of physicians, of whatever seniority, working under it, whether they work under a contract of service or a contract for services. This was decided in *Cassidy v. The Ministry of Health*. Somervell, *L.J.*, said:

The principle of *respondeat superior* is not ousted by the fact that a 'servant' has to do work of a skillful or technical character, for which the servant has special qualifications.²⁸

Denning, *L.J.*, said in the same case, in discussing vicarious liability:

The reason why the employers are liable in such cases, is not because they can control the way the work is done—they often have not sufficient knowledge to do so—but because they employ staff and have chosen them for the task, and have, in their hands, the ultimate sanction for good conduct—the power of dismissal . . . I take it to be clear law, as well as good sense, that where a person is himself under a duty to use care, he cannot get rid of his responsibility by delegating the performance of it to someone else, no matter whether the delegation be to a servant under contract of service, or to an independent contractor, under contract for services . . .

It has been said by no less an authority than Goddard, *L.J.*, in *Gold's* case,²⁷ that the liability for doctors on the permanent staff depends on whether there is a contract of service and that must depend on the facts of any particular case. I venture to take a different view. I think it depends on this—who employs the doctor or surgeon? Is it the patient or the hospital authorities? If the patient himself selects and employs the doctor or surgeon, as in *Hillyer's* case, the hospital authorities are, of course, not liable for his negligence because he is not employed by them.

In *Roe's* case it was also held that the Ministry of Health were vicariously liable for their employee anesthesiologist.²⁹ In England, if the patient privately engaged the physician, the hos-

²⁷ *Gold v. Essex County Council* (1942), 2 All E. R. 237.

²⁸ *Cassidy v. Ministry of Health: Fahrni, Third Party* (1951), 1 All E. R. 574.

²⁹ *Roe v. Ministry of Health: Woolley v. the same* (1954), 2 All E. R. 131.

pital would however not be responsible for the doctor's negligence. This is the ordinary situation in Canada, where the anesthesiologist is almost always privately engaged by the patient or on the latter's behalf.

In *Crits v. Sylvester*,³⁰ Schroeder, J.A., indicated that the hospital was not responsible for the privately engaged anesthesiologist. He enunciated a further principle that had been stated in *Anderson v. Chasney*:³¹

The hospital cannot be held liable if the doctors thus employed [i.e., by the patient], fail to use the equipment it has provided. It is too much to say that a hospital should employ overseers to ensure that the anesthetists and surgeons of proved ability, who are privately engaged, use the appliances which are on hand.

(3) *Intern and resident anesthesiologists.* A Junior Anesthesiologist of this status would, of course, owe a direct duty of care to the patient. The question as to whether vicarious responsibility for his negligence would lie with the hospital, his general master or with the supervising anesthesiologist has never arisen in Canada. The latter might well be considered the 'special' master of the resident, albeit not his employer. The answer would depend on the facts, and would be contingent on where immediate control of the resident was considered to be vested.

There is sound English authority for saying that the Staff Physician is not liable for the mistake made by the resident doctor, if it involves 'routine' care.³² However, although residents in anesthesia are chiefly occupied in administering anesthetics, it is open to question whether the courts would regard an anesthetic as 'routine.' In the United States, in view of the legality of the corporate practice of medicine in some States, and the use of nurse-anesthetists, it is presumed that the administration of anesthesia by a resident under supervision would be quite reasonable. It would not be necessary for the anesthesiologist to be present in the room, since he is not personally billing the patient. He might reasonably supervise the anesthetics in two or more rooms simultaneously. Some forms of consent imply that the anesthesiologist is only working in a supervisory capacity.¹⁶ In Canada it is thought, however, that where the patient is receiving a personal account from the anesthesiologist, if something went wrong during the procedure, his absence from the scene might be difficult to explain: if it were shown that at the material time he was occupied with another patient, his position would be almost indefensible.

³⁰ *Crits and Crits v. Sylvester et al.* (1956), 1 D. L. R. (2d) 602.

³¹ *Anderson v. Chasney* (1949), 4 D. L. R. 71.

³² *Morris v. Winsbury-White* (1937), 4 All E. R. 494.

(j) *Standard of Care.*

Lord Hewart's summation of the standard of care the law requires, has often been quoted in Canadian judgments:

If a person holds himself out as possessing special skill and knowledge, and he is consulted as possessing such skill and knowledge by, or on behalf of, a patient, he owes a duty to the patient to use due caution in undertaking the treatment. . . . He owes a duty to the patient to use diligence, care, knowledge, skill and caution in administering the treatment. No contractual relationship is necessary, nor is it necessary that the service be rendered for reward . . . The jury should not exact the highest or a very high standard, nor should they be content with a very low standard. The law requires a fair and reasonable standard of care and competence. This standard must be reached in all the matters above mentioned.³³

In an Ontario decision, Judge Advocate Schroeder had this to say:

The practitioner "is bound to exercise that degree of care and skill which could be reasonably expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one, who does not profess to be so qualified by special training and ability."³⁰

Plaxton, J., said in *Crysler v. Pearse*:

At the same time it is to be borne in mind that a surgeon does not become an actual insurer: he does not undertake that he will perform a cure, nor will be liable in negligence because someone else of greater skill and knowledge would have prescribed different treatment or operated in a different way.³⁴

It will be apparent that Canadian common law as it refers to the topic under discussion is not very different from that in most American jurisdictions. Relative to the number of cases in American law reports, there is a relative paucity of material in Canada. We will now proceed to briefly review the Canadian cases.

The Cases in the Common Law Provinces

1. *Hughston v. Jost* (1942) Ontario High Court³⁵

The plaintiff-patient sued the anesthesiologist because damage resulted from the inadvertent injection of pentothal around, rather than into, a vein in the arm.

³³ *R. v. Bateman* (1925), 41 T. L. R. 557.

³⁴ *Crysler et al. v. Pearse* (1943), 4 D. L. R. 738.

³⁵ *Hughston v. Jost* (1943), 1 D. L. R. 402.

The Court held that the accident was in effect a hazard inherent in the procedure. Hope, J., said that "reasonable, not extraordinary care and diligence were required of a medical man." At the time this accident occurred it was customary to use pentothal in 5% strength. Nowadays it is the practice to use a weaker solution—2 or 2.5% strength, which will rarely cause damage to the tissues.

This was the first time that an anesthesiologist had been sued in Canada, and sued alone. The surgeon was not a co-defendant.

The accidental injection of pentothal into the tissue is not an uncommon occurrence. It may be of interest to note that in a recent English case, where the fact situation was similar, the anesthesiologist was held liable in the trial court, largely because he failed to ask the patient if she felt any pain, when he commenced injection. In the appellate court this decision was reversed. Ormerod, *L.J.* said:

There are risks in most forms of medical treatment, and anesthetics is certainly no exception. All one can ask of a practitioner is that he should keep those risks to that minimum, to which reasonable skill and reasonable care can reduce them. If he does this, no injury which occurs, however serious, will be actionable.³⁶

2. Walker v. Bedard and Snelling (1945) Ontario High Court³⁷

A patient was given a spinal anesthetic prior to removal of the gall bladder; she collapsed and died before surgery was commenced. The husband of the victim sued the surgeon and anesthesiologist. The Court found for both defendants.

In a statement previously quoted Mr. Justice LeBel ruled that the surgeon was not responsible, as a matter of law, for the negligence of the anesthesiologist. The latter had in this instance been unsuccessful in introducing the needle into the spinal canal; this was subsequently accomplished by the surgeon. Whether this fact implicated the surgeon in the administration of the anesthetic was not dealt with.

The judge was a man of broad human sympathies, as is evidenced by his penultimate words:

I am convinced that there is little likelihood this action would have been commenced, but for Dr. B's unsatisfactory answers at the time of the inquest, and for an unfortunate remark he made to the plaintiff on another occasion, probably when both parties were in an agitated frame of mind.

³⁶ *Williams v. North Liverpool Hospital Management Committee*. The Times, January 17th, 1959.

³⁷ *Walker v. Bedard and Snelling* (1945), 1 D. L. R. 529.

. . . It is a tragedy, accentuated almost to the breaking point for a layman to lose his wife and the mother of his children, and to be led to believe by unguarded words or actions on the part of medical men, that her death may have been caused by negligence or want of care and skill. It is no wonder that a man has recourse to law in such circumstances.

The lesson that the physician, if not the attorney also, may draw from this is obvious. *Cave quis dicis, quando, et cui* (Be careful what you say, and where, and to whom).

3. **Burk v. S. B. and K. (1952) British Columbia Supreme Court**

In this case, the patient had injured a finger. This was set right using the anesthetic technique of brachial block. Local anesthetic is injected above the collar bone onto the first rib to anesthetise the nerves running to the arm. An occasional, and ordinarily harmless complication is a partial collapse of the lung (pneumothorax) due to puncturing that organ with the needle. This complication occurred in this case and the patient despite a prompt and uneventful recovery sued surgeon, resident anesthesiologist and supervising anesthesiologist.

The Court found for all defendants. It was in effect held that a pneumothorax is a hazard inherent in this procedure.

4. **Crits v. Sylvester (1955), Ontario High Court (1): (1956), Ontario Court of Appeals (30): (1956), Supreme Court of Canada³⁸**

A five year old infant was burned about the face by an ether explosion, just prior to tonsillectomy. The father sued the anesthesiologist, the surgeon and the hospital.

In evidence it appeared that the child was being anesthetized with ether in a can, which led by a rubber tube to a valve attached to a rubber tube inserted in the wind-pipe. (The Flagg technique.) The child's color becoming unsatisfactory, the anesthesiologist filled a bag with oxygen and attached it to the tube in the trachea, and, by inflating the child's lungs therewith, restored the color to normal. While doing so he placed the tube from the oxygen tank in the ether can. On preparing to resume the administration of ether, he removed the bag from the tube in the trachea at which point the explosion occurred, induced, it is almost certain, by static electricity.

In the court of first instance, argument was advanced that the failure to wear conductive shoes and the non-use of an inter-

³⁸ Sylvester v. Crits (1956), 5 D. L. R. (2nd) 502.

coupling device constituted negligence. The Court rejected this point of view and found for all defendants.

In the appellate court, the plaintiff withdrew his case against the surgeon and the hospital. Schroeder, J.A., in reversing the decision as to the anesthesiologist, said:

It seems logical to assume that there would be an even heavier concentration [of anesthetic mixture] around the ether can while the oxygen was flowing into the can, and was *not being absorbed by the patient* (emphasis supplied). If any heat were generated in the vicinity of this heavier concentration of gas, which admittedly is highly inflammable, it does not require one to have the skill or knowledge of an expert to know what the result would be

and later:

Has the defendant Sylvester given an explanation which is as consistent with the absence of negligence, as with negligence on his part? In my opinion he has not. I regard his conduct, on which I base this finding, not as conduct involving a matter of technical skill and experience, but rather as an omission to take proper precautions in circumstances and in relation to a matter, as to which any sensible layman is competent to determine, without the assistance of expert evidence, whether such conduct was negligent or not.

With respect, we would point out that the "logical assumption" made by the Court is predicated upon the false notion that the patient "absorbs" the ether-oxygen mixture after the manner of a sponge, thus removing it from the surrounding air. In fact, even on exhalation, such a mixture remains highly explosive. However, we can but speculate as to whether a clearer understanding on this point would have altered the finding of the Court.

The anesthesiologist carried his case to the Supreme Court of Canada, which upheld the decision of the Court of Appeal. Considering the fact that the ether can had been placed only six inches from the child's head, the Court accepted the expert testimony that such a practice was reasonable. Rand, J., said:

The practice followed here was approved by Dr. Gordon [a highly qualified expert witness] and it would be extremely dangerous for a Court to attempt, in such a matter to proscribe a step for technicians, where their general experience approves it, and it is not clearly unnecessary and unduly hazardous.

The Court felt, however, that allowing the oxygen to flow into the can and so set the stage for an explosion, constituted an unnecessary hazard and, for this reason, found for the plaintiff.

5. The "Novacaine" Cases

(a) *Bugden v. Harbour View Hospital*.³⁹ A doctor treating a dislocated thumb, asked for 'Novacaine'—a local anesthetic—and was in error given a solution containing epinephrine (adrenalin or suprarenin). On injecting this into the hand, the patient died. The doctor was not held liable, although he had failed to read the label on the bottle.

(b) *Pollard v. Chipperfield*.⁴⁰ In this Saskatchewan case, the fact situation was very similar to the Nova Scotia case just mentioned. In this instance, however, the surgeon was held liable, because he had omitted to assure himself personally that the drug he proposed to inject was the drug he had asked for.

Ducharme v. Royal Victoria Hospital et al.^{41, 42}

This is, so far as we know, the only reported instance of a case of anesthetic malpractice in Quebec.

In 1935 a patient was treated for a fractured leg. A competent nurse anesthetist gave a nitrous oxide anesthetic, during the course of which the patient died. The case was heard before the Superior Court in 1939 and the Court of Appeal in 1950. In the latter instance Barclay, J., said:

[It was pled] that a nurse, an employee of the defendants and under their orders, practiced and participated in the giving of an anesthetic, contrary to law . . .

It is a very controversial question, not yet decided by the Courts, as to whether or not the giving of an anesthetic by a trained nurse under a doctor's orders, can be called the "practice of medicine," . . . and it is not necessary to decide that question in this case. If it did constitute the illegal practice of medicine, the nurse or hospital which employed her, might be guilty of an infraction of the law . . . , but it has no relation to the issue in this case, which is an action founded in fault . . .

The learned trial Judge, apparently impressed by the evidence of some of the doctors, agrees with the theory that the employment of a nurse instead of a doctor as anesthetist is a fault *per se*. I refer to it as a "theory," because it is quite evident that it is one, and not a "fact," so far as the evidence goes in this case.

In commenting on the expert testimony as to the pros and cons of nurse anesthetists, he further said:

³⁹ *Bugden v. Harbour View Hospital* (1947), 2 D. L. R. 338.

⁴⁰ *Pollard v. Chipperfield* (unreported), but see (1952), 7 W. W. R. (N. S.) 596.

⁴¹ *Ducharme v. Royal Victoria Hospital et al.* (1938), 76 Que. Superior Court 309.

⁴² *Ducharme v. Royal Victoria Hospital et al.* (1940), 69 King's Bench (C. A.) 162.

It is quite apparent [that] . . . we are in the realm of a purely medical matter, in which medical opinion is divided and that a Court is not justified in deciding as to which of two medical opinions is correct. . . . To say that a doctor, or a hospital, because they adopt one of two prevailing medical opinions rather than the other, is by that fact alone, at fault, is something which I am not prepared to do.

In this case, it is apparent that nurse anesthetists were being used in Montreal, at least as late as 1935, when the patient lost his life. At that time, such a practice was not contrary to the law in Quebec. I am informed however, by Dr. Alan Noble, the present Director of Anesthesia at the Royal Victoria Hospital, Montreal, that today all anesthetics in Quebec are administered by physicians. This he believes resulted from changes in the wording of the Medical Act.⁴³

Conclusion

Making allowance for the tenfold difference in population between Canada and the United States, it is evident that litigation arising from anesthetic malpractice is very much less common in the former country. We have attempted to give some of the reasons for this discrepancy.

The fact situations covered, with the possible exception of that in *Burk's* case,¹⁵ can be paralleled by American examples, but they have been briefly outlined. The principles of Canadian tort law will in the main be familiar and the use of a different system of jurisprudence in Quebec raises few difficulties.

Anesthetic malpractice is considered a faintly scatological topic by one's medical colleagues, who fail to share an eccentric but harmless passion for browsing in law libraries. Our interest in the subject is that of a working anesthesiologist, whose legal illiteracy is relieved only by a haphazard reading of the relevant judgments. This paper is the result of those researches, and it may be that we have been unnecessarily discursive, especially in point of quoting some of the judgments rather extensively. We have ventured to do so, however, since we are persuaded that although most of the concepts and sentiments judicially expressed therein will be familiar, the exact manner of their expression probably is not. Although similar to opinions delivered by the Courts in the United States, they may perhaps offer a fresh perspective on some aspects of the topic under discussion. Although, in our view, tort law, as it relates to anesthetic malpractice, differs in few significant respects between our two countries, we hope that this article will prove of some interest to the American reader, since even in things alike there is diversity.

⁴³ Dr. Alan Noble, Personal Communication (1960).

[*Editor's Note:* Associate Prof. of Law Alan W. Mewett of Queen's University, Kingston, Ontario, wrote the following Comment on Dr. Harland's article:]

Comment

Alan W. Mewett, LL.B., B.C.L., LL.M., S.J.D.

Perhaps I, as a lawyer, may be permitted to make one observation on Dr. Harland's paper which might be of general interest. Liability of all "specialists" whether surgeons, anesthetists, or general practitioners, depends upon their being found guilty of malpractice, which, after all, merely means their doing something which they should not do, or not doing something which they should. While the courts decide whether or not the specialist—in Dr. Harland's paper the anesthetist—has been guilty of malpractice, the crucial problem is to determine the criteria by which they can come to a decision.

By and large, the courts of the British Commonwealth have consistently permitted the profession itself to determine its own standards of professional conduct. If you are dealing with cases of "professional" negligence, and if by "negligence" you mean acting unreasonably in the circumstances, then obviously the "profession" itself is the only body which can adequately determine whether or not one of its members has been unreasonable. The outsider (and in this context a judge or jury is as much an outsider as anyone else) is patently inadequate to express any opinion on the reasonableness of something he does not understand. The serious danger in this approach lies in the "ganging-up" of the professional man to protect a colleague. Who of us likes to testify, in effect, that a colleague has been unreasonable? And this is the result, even if he only says, "Well, I myself would not have done that."

It is apparent that this danger has been realized in the United States. Here, there is a marked tendency for the courts to intervene and to impose their own standards of what is reasonable. In short, to find a professional defendant liable because his conduct seems, to the ordinary man who knows nothing of the difficulties of the situation, unreasonable. This they have had to do because of the refusal of expert witnesses to testify against a colleague. The result is bound to be that the professional defendant in the United States is much more likely to be found guilty of malpractice than in other parts of the common-law world.

But is this not your own fault? We all realize that no one likes to testify against a colleague. But each time you say a colleague's obviously negligent conduct is not negligent, you are forcing the courts to adopt this more stringent policy.