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The Negligent Doctor

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THE NEGLIGENT DOCTOR

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I *Introduction*

Tort law seeks to supervise the quality of medical practice. Whether it is successful or not in its efforts is an unanswered question,[1] but this has not stopped tort law from trying. Dissatisfied with self-regulation alone, a series of rather general guidelines have evolved over the years to guide not only doctors but the members of all other professional groups.

As long ago as 1838 Chief Justice Tindal articulated the principle that survives to this day:

> Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. He does not undertake, if he is an attorney, that at all events you shall gain your cause, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill. There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable, and competent degree of skill. . . .[2]

A similar test has issued from Lord Chief Justice Hewart who once stated that:

> If a person holds himself out as possessing special skill and knowledge . . . . [he undertakes] to use diligence, care, knowledge, skill and caution in administering the treatment . . . . The law requires a fair and reasonable standard of care and competence.[3]

In all of these cases, the courts are balancing the interests of the clients or patients in receiving skilled service as well as the interests of professional men in a certain degree of autonomy in their dealings with the community. As always, an uneasy compromise has been reached.

II *The Standard of Care*

The standard of care demanded of doctors, like that of lawyers,[4] rests on a contractual foundation, but "a physician, even a specialist, gives no guarantee

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[1] D. Kretzmer, *The Malpractice Suit: Is It Needed?* (1973), 11 Osgoode Hall Law Journal 55; Haines, *The Medical Profession and the Adversary Process* (1973), 11 Osgoode Hall Law Journal 41.

[2] *Lamphier* v. *Philpos* (1838), 8 C. & P. 475 at 478.

[3] *Rex* v. *Bateman* (1925), 41 T.L.R. 557 at 559.

[4] Fleming J., *Developments in the English Law of Medical Liability* (1959), 12 Vand. L. Rev. 633; Haines, *Courts and Doctors* (1952), 30 Can. Bar Rev. 483; McCoid, *The Care Required of Medical Practitioners* (1959), 12 Vand. L. Rev. 549; Sherman, *The Standard of Care in Malpractice Cases* (1966), 4 Osgoode Hall Law Journal 222; Thomson, "Claims Arising Out of the Relationship Between Doctor and Patient", printed in *Special Lectures of the Law Society of Upper Canada on Medical Liability* (1963) at 185. See generally, Nathan, *Medical Negligence* (London: Butterworths, 1957); Meredith, *Malpractice Liability of Doctors and Hospitals* (Toronto: Carswell Company, 1956); Louisell & Williams, *Trial of Malpractice Cases* (Albany: M. Bender, 1960).

of success".[5] In undertaking the treatment of a patient, a doctor gives no implied warranty that he will effect a cure, and, hence, he is not an insurer, unless, of course, there is an *express* agreement to this effect.[6]

The physician is liable for malpractice if he fails to conduct himself like a reasonably prudent doctor. This is an objective standard, which takes into account the extra knowledge possessed by the actor. In *Wilson* v. *Swanson*[7] Mr. Justice Rand explained that a surgeon undertakes that he "possesses the skill, knowledge and judgment of the generality or average of the special group or class of technicians to which he belongs and will faithfully exercise them". What he must do is engage in an "honest and intelligent exercise of judgment". If a "substantial opinion" in his profession confirms his judgment, even though it was wrong, the mishap will be considered only an error of judgment, not "unskilfullness".[8]

Another widely-accepted formulation of the standard demanded of medical practitioners, which echoes the classic statement of Lord Chief Justice Hewart,[9] was expressed by Mr. Justice Schroeder in *Crits* v. *Sylvester*[10] as follows:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing. . . .

In short, physicians must conform to the "accepted standards of the day".[11]

III *Custom*

If a physician's conduct complies with the customary practices of his profession he is virtually assured of being exonerated when something goes wrong.[12] This defence is not conclusive,[13] however, although it was thought to be at one time.[14]

Doctors are frequently relieved of liability on the ground that they have acted in accordance with approved methods. Understandably, evidence of general practice is accorded more respect in medical matters[15] than it receives in

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[5] *Johnston* v. *Wellesley Hospital*, [1971] 2 O.R. 113 at 111 (*per* Addy J.).

[6] *Town* v. *Archer* (1902), 4 O.L.R. 383 at 388 (*per* Falconbridge C.J.).

[7] [1956] S.C.R. 804 at 811.

[8] *Id.*, at 812. See also *Ostrowski* v. *Lotto*, [1971] 1 O.R. 372 at 382 aff'd 31 D.L.R. (3d) 715 (S.C.C.).

[9] *Supra*, note 3.

[10] [1956] O.R. 133 at 143, aff'd [1956] S.C.R. 991. See also *Gent & Gent* v. *Wilson*, [1956] O.R. 257 at 265 (*per* Schroeder J.A.).

[11] *Ostrowski* v. *Lotto*, [1969] 1 O.R. 341 at 355 (*per* Keith J.) rev'd on another point, [1971] 1 O.R. 372 (C.A.), aff'd 31 D.L.R. (3d) 715 (S.C.C.).

[12] *Vancouver General Hospital* v. *McDaniel*, [1934] 4 D.L.R. 593 at 579 (*per Lord Alness).*

[13] *Cavanagh* v. *Ulster Weaving Co.*, [1960] A.C. 145.

[14] *Vancouver General Hospital* v. *McDaniel, supra,* note 12; *Marshall* v. *Lindsey County Council,* [1935] 1 K.B. 516 at 540 affirmed [1937] A.C. 97.

[15] Weiler, *Groping Towards a Canadian Tort Law: The Role of the Supreme Court of Canada* (1971), U. of T. L.J. at 324 says it is conclusive. See *Ostrowski* v. *Lotto, supra,* note 8 at 382 (*per* Aylesworth J.A.) quoting *Bolam* v. *Friern Hospital,* [1957] 2 All E.R. 118.

other types of cases, because there is greater judicial trust in the reasonableness of the practices of a sister profession than there is in the methods of commercial men. Further, in the professional cases, the contractual undertaking made is only to employ customary treatment methods. In an early case, *Jewison* v. *Hassard,*[16] a sponge was left behind in a patient after surgery. The action against the doctor was dismissed on the ground that, since the surgeon was "too busy with his work to keep count of the sponges", he properly delegated this responsibility to a competent and experienced nurse, which was the usual practice. Mr. Justice Haggart also concluded that the operation was "performed in accordance with up-to-date clinical surgery".[17] In *McFadyen* v. *Harvie,*[18] a doctor applied a cautery during surgery to an area that had been washed down with iodine and alcohol, burning the patient. No liability was incurred for, according to Robertson C.J.O., the doctor had "followed the recognized practice"[19] in relying upon his assistants in this regard. Mr. Justice Gillanders also agreed to absolve the defendant, who had used the "recognized and approved method".[20] The Supreme Court of Canada, in affirming the Ontario Court of Appeal, merely asserted that it was in accord with the Chief Justice of Ontario.

The same principles apply to diagnosis as well as treatment. According to Mr. Justice Schultz in *Penner* v. *Theobald,*[21] "it is by the methods and practices which characterize his school that (a medical man) must be judged in determining whether or not he was negligent in his diagnosis." Although the court held the defendant chiropractor liable for his negligent *treatment* because "his own testimony was conclusive as to the unwisdom of the practice he followed",[22] it felt that his *diagnosis* was acceptable because it was "thorough and complete by the standards of that profession".[23] In this decision, Mr. Justice Schultz recognized the true role of custom in negligence law, when he explained that:

> While it is true that in the great majority of alleged malpractice cases a charge of negligence can be met by evidence to the effect that what was done was in accordance with general and approved practice, nevertheless, it is the courts and not the particular profession concerned which decide whether negligence is established in a particular case.[24]

The practices of the medical profession are, however, not inviolable. If medical men follow procedures that are shown to be inadequate, the courts may adjudge them to be negligent. Naturally, before they shatter a medical custom, the courts will insist upon clear evidence of its impropriety. In *Anderson* v. *Chasney,*[25] a sponge was left behind by the defendant during a tonsil and

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16 (1916), 28 D.L.R. 584 at 585, (*per* Richards, J.A.) (Man. C.A.). See also *Whiteford* v. *Hunter,* [1950] W.N. 553 (H.L.); *Karderas* v. *Clow,* [1973] 1 O.R. 730.

17 *Id.,* at 587.

18 [1941] 2 D.L.R. 663 (Ont. C.A.) affirmed [1942] 4 D.L.R. 647 (S.C.C.).

19 *Id.,* at 668 (in C.A.)

20 *Id.,* at 670 (in C.A.)

21 Schultz J.A. in *Penner* v. *Theobald* (1962), 35 D.L.R. (2d) 700 at 708 (Man. C.A.).

22 *Id.,* at 712.

23 *Id.,* at 708.

24 *Id.,* at 712, citing *Anderson* v. *Chasney.*

25 [1949] 4 D.L.R. 71 (Man. C.A.), affirmed [1950] 4 D.L.R. 223 (S.C.C.).

adenoid operation. In the Court of Appeal it was contended that one of two existing security methods, that is, sponge counting or using sponges with tapes, should have been adopted, although it was not proved that it was customary to do this. "If a practitioner refuses to take an obvious precaution, he cannot exonerate himself by showing that others also neglect to take it", asserted Mr. Justice Coyne in a *dictum*.[26] The Supreme Court of Canada affirmed the result on the ground that a careless search had been conducted. In *Crits* v. *Sylvester*,[27] the Ontario Court of Appeal held liable an anaesthetist for an explosion that occurred during an operation. The decision rested on the finding that the defendant was not following "his general approved practice in pursuing the course of action outlined by him", but in a *dictum*, Mr. Justice Schroeder stated that, even if he were following the standard practice, "such evidence is not necessarily to be taken as conclusive on an issue of negligence".[28] Custom, therefore, is influential, but it does not rule.

If a plaintiff establishes that a doctor failed to conform with the general practice of his profession, he will probably recover. According to Professor Fleming, "failure to adopt the general practice is often the strongest possible indication of want of care".[29] Dean Prosser, too, asserts that "the omission of a customary precaution may, in a particular case, be negligence in itself, especially where it is known that others may rely on it".[30] Thus, if a doctor fails to sterilize the needle after each inoculation in accordance with the accepted procedure, he is liable to any patient infected as a result of this.[31] This is justifiable because evidence of what most of the people in a profession do is evidence of what is considered reasonable in the circumstances.[32] Moreover, there is no problem of unfeasibility since, if most are already complying with a custom, it must be practicable for those who are not yet conforming thereto.

Nevertheless, sub-conformity with usage is not conclusive of negligence. The Lord President of the Court of Sessions, Lord Clyde, has explained in *Hunter* v. *Hanley*,[33] that "a deviation from ordinary professional practice is not necessarily evidence of negligence". "It would be disastrous if this were so", he contended, "for all inducement to progress in medical science would then be destroyed". In other words, experimentation with new methods must be permitted if tort law is to avoid thwarting the advancement of science. Thus, it

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[26] *Id.*, at 85-86. Weiler, *supra*, note 15, treats this as a case of non-medical judgment, an exception to a rule of absolute immunity of doctors who conform to custom.

[27] (1956), 1 D.L.R. (2d) 502.

[28] *Id.*, at 514. See also *Johnston* v. *Wellesley Hospital*, [1971] 2 O.R. 112 at 113 (*per* Addy, J.).

[29] J. G. Fleming, *The Law of Torts* (4th ed. Sydney: Law Book Co., 1971) at 117.

[30] W. L. Prosser, *Handbook of the Law of Torts* (4th ed. St. Paul: West. Pub. Co., 1971) at 168.

[31] *Forsbrey* v. *Bremner* (Nov. 24, 1967, Ont. H.C., Brooke J.), unreported on this point.

[32] 2 Wigmore, *Evidence* (3rd ed. Boston: Little, Brown & Co., 1940) S. 461; Morris, 42 Colum. L.R. 1147 at 1161.

[33] [1955] S.C. 200 at 206 (new trial ordered where jury found for defendant after being told departure from custom was "gross negligence". Two judges relied on the gross negligence point alone.)

is only where deviation from a customary norm is shown to be "one which no professional man of ordinary skill would have taken if he had been acting with ordinary care", that negligence is established. Nor is the extent of deviation the test here; it matters not how far or little the defendant departs from the general practice. What is vital, however, is whether his conduct is negligent. The Lord President declared that *three* matters must be proved by the plaintiff: first, there is a usual and normal practice; second, the defender has not adopted that practice; third, no professional man of ordinary skill would have so acted if he had been acting with ordinary care.[34]

Lord Clyde's first two requirements are unassailable, but in the third too heavy a burden is placed on the plaintiff. Evidence of deviation from custom should be prima facie negligence.[35] Once deviation from custom is proved, the defendant should be expected to explain why he departed from the usual practice. In any event, one cannot escape the conclusion that failure to take the precautions ordinarily taken in the circumstances will be most influential upon the court or jury, even if it is not binding upon them.

IV *Specialists and Novices*

Specialists, as might be expected, must perform at a higher level than general practitioners. They, after all, represent themselves as possessing superior skills and additional training. Their fees normally reflect this. Consequently, according to Mr. Justice Abbott in *Wilson* v. *Swanson,*[36] a specialist must "exercise the degree of skill of an average specialist in his field". Mr. Justice Schroeder has also declared that if a doctor "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".[37]

But even a specialist does not have to achieve perfection. If an operation, though unsuccessful, is conducted in a way "consistent with good orthopedic surgical practice", no liability will ensue.[38] Similarly, a dermatologist escapes responsibility if the procedure he adopts is in "accordance with generally accepted good medical practice in the field of dermatology".[39]

On the other hand, a dermatologist may be liable if he burns a patient while treating eczema with a dosage that is too high and of too long duration.[40] Similarly, a surgeon, who removed more of a patient's insides than was required because he mistakenly believed that there was a malignancy, was exonerated.[41]

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[34] *Id.*

[35] *Brown* v. *Rolls Royce,* [1960] 1 All E.R. 577, 1 W.L.R. 210.

[36] [1956] S.C.R. 804 at 817.

[37] *Crits* v. *Sylvester,* [1956] O.R. 133 at 143, aff'd [1956] S.C.R. 991; *Gent* v. *Wilson,* [1956] O.R. 257 at 265, (*per* Schroeder J.A.). In *McCaffrey* v. *Hague,* [1949] 2 W.W.R. 539 at 542, Campbell J. said, "A higher degree of skill is required from one who holds himself out to be a specialist". See also *MacDonald* v. *York County Hospital* (1972), 28 D.L.R. (3d) 521 at 533, *per* Addy, J.; *Karderas* v. Clow, [1973] 1 O.R. 730 at 738 *per* Cromarty, J. (Obstetrics and Gynaecology).

[38] *Ostrowski* v. *Lotto, supra,* note 11 at 381 (in C.A.)

[39] *Johnston* v. *Wellesley Hospital, supra,* note 5 at 116.

[40] *McCaffery* v. *Hague,* [1949] 2 W.W.R. 559 (Man. K.B.).

[41] *Wilson* v. *Swanson,* [1956] S.C.R. 804.

So too, was a pediatrician absolved when a vaccination he administered spread infection to other parts of a patient's body.[42]

Although it has toughened its general standard for specialists tort law has not diluted it for inexperienced doctors. Hence, a "novice surgeon", who had not performed a particular operation before, was made liable when he severed a nerve.[43] Internes are given no special dispensation if they hold themselves out to be fully qualified. It is, however, still an open question whether a lower standard of care would be acceptable if an interne identified himself as such to the patient. In *Vancouver General Hospital* v. *Fraser*,[44] two internes, licenced to practice within the confines of a hospital, wrongly read some X-rays of a car accident victim that came to their hospital, talked to his family doctor and then sent him away. The patient later died as a result of complications from a broken neck, which their examination failed to detect. Their employer, the hospital, was held vicariously liable for their blunder. Mr. Justice Rand based his decision on the fact that the internes' conduct was cloaked with "all the ritual and paraphernalia of medical science". An interne had to be "more than a mere untutored communicant between [the family doctor] and the patient".[45] He must exercise the "undertaken degree of skill and that cannot be less than the ordinary skill of a junior doctor". One of the most vital things he must have is an "appreciation of his own limitations". By failing to notify a radiologist that was on call at the hospital and relying on their own imperfect knowledge, they acted negligently.

V *Locality Rule*

It was once thought that a doctor was protected from tort liability if he merely lived up to the standard of the profession in his own community or similar localities.[46] Someone in "country practice" did not have to be as proficient as an urban physician.[47] This idea still clings to life, but it is dying. In the recent case of *McCormick* v. *Marcotte*,[48] a doctor was held liable when he performed an obsolete type of operation on the patient because he was unable to do the one recommended to him by a specialist. Mr. Justice Abbott imposed liability, but formulated the standard of care as if the locality rule still survived. His Lordship suggested that a doctor was required to "possess that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases". Mr. Justice Abbott, however, quoted from the trial judge to the effect that this was a "hospital in a well-settled part of the

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[42] *Gent & Gent* v. *Wilson*, *supra*, note 10.

[43] *McKeachie* v. *Alvarez* (1970), 17 D.L.R. (3d) 87 at 100 (*per* Wilson J.) (B.C.); see also *Challand* v. *Bell* (1959), 1 D.L.R. (2d) 150; *Walker* v. *Bédard*, [1945] O.W.N. 120 at 124.

[44] [1952] 2 S.C.R. 36.

[45] *Id.*, at 46.

[46] See Meredith, *supra*, note 4 at 62; see Abbott, J. in *Wilson* v. *Swanson*, *supra*, note 41 at 817; *Challand* v. *Bell*, *supra*, note 43. See generally Waltz, *The Rise and Gradual Fall of the Locality Rule in Medical Malpractice Legislation* (1969), 18 De Paul L. Rev. 408.

[47] *Hodgins* v. *Banting* (1906), 12 O.L.R. 117 (Boyd C.)

[48] (1971), 20 D.L.R. (3d) 345 (S.C.C., Quebec appeal) at 346.

province [Quebec] within easy reach of the largest centres of population". This *obiter dictum* need not, therefore, prevent the demise of the locality rule.

It would be preferable if the locality rule were abandoned. This would reflect the improvements in modern communications, medical education and the uniformity of examinations for doctors in Canada.[49] In the case of *Town* v. *Archer*,[50] as long ago as 1902, Chief Justice Falconbridge criticized the "locality rule" on the ground that "all the men practicing in a given locality might be equally ignorant and behind the times, and regard must be had to the present advanced state of the profession and to the easy means of communication with, and access to, the large centres of education and science . . ." In *Town* v. *Archer* the community in question was Port Perry, which at that time was only two hours from Toronto, then a city of a quarter of a million people, with three medical colleges and numerous hospitals. Communications and access to information has improved greatly since then, so that there is even less reason to differentiate between localities. Moreover, a principle that permits an inferior brand of medicine for rural Canadians cannot be countenanced. A single standard for all Canadian doctors might encourage an upgrading of the quality of medical practice across the country.

In practice, however, one cannot expect all the sophisticated equipment of a large city hospital to be available in every hospital throughout Canada.[51] Nor can anyone expect the same speed in providing care by a doctor if he has to travel longer distances.[52]

The nature of the difficulty has been outlined in *Zinkler* v. *Robertson:*

> It surely cannot be that the skill of a physician attending a patient in a private house [in a rural area] with few conveniences and no assistants, is to be measured by the same standard as the city surgeon, provided with an operation room, nurses and all the aids of a modern hospital.[53]

But this does not mean that there must be a varing standard of care depending on the location of the treatment. The same disadvantageous conditions exist when a doctor is forced to minister to a patient in a private home in Winnipeg or at the roadside on the Don Valley Parkway in the heart of Toronto. The difference is not in the *standard of care* demanded of the physician, but in his limited *access* to facilities and equipment. One cannot expect as good results from treatment in primitive conditions as one can under the best of circumstances. The rural-urban distinction retains significance in this regard, but it should not be allowed to create a double standard for Canadian doctors based on geography.

VI *The Need to Seek Specialist's Advice*

A general practitioner should enlist the help of a specialist, if a reasonably prudent physician would consider it necessary in the circumstances. For example, a physician must call in a radiologist to read x-rays if he is not capable

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[49] Uniform exams called "Dominion Councils" are set nationally each year under the Canadian Medical Act, see Sherman, *supra,* note 4 at 226.

[50] (1902), 4 O.L.R. 383 at 388. See also *Van Wyk* v. *Lewis* (1924), App. Div. (S. Af.) 438.

[51] See *Whiteford* v. *Hunter* (1950), 94 Sol. J. 758.

[52] See *Rickley* v. *Stratton* (1912), 22 O.W.R. 282.

[53] (1897), 30 N.S.R. 61 at 70.

of doing so himself.[54] A general practitioner need not, however, exhibit the expertise of a radiologist.[55] In one early case, *Jarvis* v. *International Nickel Ltd.*,[56] a company doctor in the mining town of Copper Cliff, Ontario, failed to call in a specialist, despite the urgings of his patient, because he felt it premature. As a result he failed to diagnose a mastoiditis condition in the ear. Mr. Justice Wright observed that "most medical men would have" called in a specialist and that to do so would have been a "more prudent course".[57] Nevertheless, he dismissed the action since he could not find any authority imposing a legal obligation to seek the advice of a specialist. On the facts, however, it was probably not negligent to refuse to call a specialist in the circumstances, and, in any event, there was a lack of evidence of causal connection in the case. There is another case, *Kunitz* v. *Merei*[58] where blindness resulted from a haemorrhage which followed an operation to remove some polyps from a patient's nose. It was alleged that, if an ophthamologist had been consulted earlier, the blindness might have been avoided. In the circumstances, however, it was held that there was no negligence and, in any event, it was unlikely that an earlier consultation would have averted the danger.[59] Because specialists are more numerous these days, general practitioners tend to rely upon them more than ever. Liability should follow if a doctor fails to call in a specialist, when a prudent practitioner would deem it advisable.[60]

VII *Negligence or Error of Judgment*

The burden of proof rests on the patient to establish substandard conduct that amounts to negligence.[61] He must overcome a presumption that a licensed and qualified physician is competent and that his treatment is correct.[62]. Malpractice liability is, consequently, rarely found. Claimants have been successful, however, when someone was burned during a dermatology treatment,[63] when an explosion occurred during the administration of an anaesthetic,[64] and when a sponge was left behind in the patient during a tonsilectomy.[65] Similarly, if a gauze swab chokes someone during dental surgery,[66] if someone's knee cap is broken during exercise treatment,[67] and if the wrong organ is removed,[68]

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[54] *Vancouver General Hospital* v. *Fraser, supra,* note 44.

[55] *Abel* v. *Cooke,* [1938] D.L.R. 170.

[56] (1928-29), 63 O.L.R. 564.

[57] *Id.,* at 570-71.

[58] [1969] 2 O.R. 572 (Stark J.)

[59] *Id.,* at 578.

[60] McCoid, *supra,* note 4 at 567-68.

[61] *Walker* v. *Bédard,* [1945] O.W.N. 120 at 122.

[62] *Id.,* at 124.

[63] *McCafferey* v. *Hague,* [1949] 2 W.W.R. 539. See also *McFadyen* v. *Harvie,* [1941] O.R. 90.

[64] *Crits* v. *Sylvester, supra,* note 37.

[65] *Chasney* v. *Anderson,* [1949] 4 D.L.R. 71 (S.C.C.). See also *Gloning* v. *Miller* (1953), 10 W.W.R. 414 (forceps); *cf. Jewison* v. *Hassard* (1916), 26 Man. R. 571 (sponge); *Mahon* v. *Osborne,* [1939] 1 All E.R. 535; *Karderas* v. *Clow, supra,* note 37.

[66] *Holt* v. *Nesbitt,* [1951] 4 D.L.R. 478 (Ont. C.A.).

[67] *Guaranty Trust Co.* v. *Mall Medicare Group,* [1969] S.C.R. 541.

[68] *McNamara* v. *Smith,* [1934] O.R. 249, no liability because no damage suffered by erroneous removal of uvula.

negligence may be found. Liability has also been visited on doctors for misuse of a cautery,[69] for bungling an anaesthetic[70] and for other negligent forms of treatment.[71]

A mere error of judgment does not yield tort damages. No liability has been imposed where a patient died of shock as a result of a nupercaine anaesthetic injection,[72] where someone's leg ended up shorter as a result of an operation,[73] where some organs were removed in error,[74] and where a vaccination went wrong.[75] In *Clark* v. *Wansborough*[76] a doctor was sued for failing to discover a dislocated shoulder, after a fractured arm had been x-rayed and treated. No liability was imposed since such a condition was "almost an unheard of thing, it is unique" in that type of fracture. The court indicated that an x-ray examination must always be a question of circumstances depending on the condition of the patient, the character of the injury and the availability of the apparatus.[77] Doctors have also been exonerated when a patient leaped out of a hospital window,[78] when deafness resulted from the use of a drug,[79] and when a skin treatment caused more pain than usual.[80]

The guidelines laid down by negligence law are sensible; they offer considerable protection to patients without threatening the ordinarily capable physician. Our doctors are aware of the general standard whereby their acts are evaluated[81] and seem willing to abide by it. Unless a convincing case is made out for its abolition, and until a superior replacement is discovered, the medical malpractice suit should be allowed to survive.

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[69] *Crysler* v. *Pearse,* [1943] O.R. 735, excess of alcohol in high frequency diathermy caused fumes to ignite and burn patient; *Gray* v. *LaFlèche* (1949), 57 Man. R. 397, misuse of cautery during circumcision causing serious injury.

[70] *Jones* v. *Manchester Corp.,* [1952] 2 All E.R. 125 (C.A.), pentathol administered too quickly. *Cf. Hughston* v. *Jost,* [1943] O.W.N. 3 (abcess formed).

[71] *Marshall* v. *Rogers* (1943), 2 W.W.R. 545 (B.C.C.A.), diabetic not watched properly during dangerous treatment; *MacDonald* v. *York County General Hospital* (1972), 28 D.L.R. (3d) 521, negligent care of cast; *Badger* v. *Surkan* (1971), 16 D.L.R. (3d) 146 (Sask. Q.B.), negligent post operative treatment; *Crichton* v. *Hastings,* [1972] 3 O.R. 859, failure to inform patient about side-effects of anti-coagulant drug; c.f., *Bolan* v. *Friern Hospital,* [1957] 2 All E.R. 118, electro-convulsive therapy caused broken bones, but case dismissed.

[72] *Walker* v. *Bédard,* [1945] O.W.N. 120.

[73] *Hodgins* v. *Banting* (1906), 12 O.L.R. 117; *Ostrowski* v. *Lotto, supra,* note 11, aff'd S.C.C. See also *Town* v. *Archer, supra,* note 5.

[74] *Wilson* v. *Swanson, supra,* note 36.

[75] *Gent & Gent* v. *Wilson,* [1956] O.R. 257. See also *Ostash* v. *Sonnenberg* (1968), 67 D.L.R. (2d) 311 (Alta. C.A.), no liability for failure to detect carbon monoxide poisoning.

[76] [1940] O.W.N. 67 at 70.

[77] See also *Moore* v. *Large* (1932), 46 B.C.R. 179, *Sabapathi* v. *Huntley,* [1938] 1 W.W.R. 817.

[78] *University Hospital Board* v. *Lepine,* [1966] S.C.R. 561. See also *Child* v. *Vancouver General Hospital* (1970), 71 W.W.R. 656 (S.C.C.), nurse and hospital not liable when patient fell out of hospital window.

[79] *Male* v. *Hopmans,* [1967] 2 O.R. 457.

[80] *Johnston* v. *Wellesley Hospital, supra,* note 5.

[81] 96 per cent identified correctly the standard expected of them in a recent survey done by Professor R. J. Gray and Gilbert Sharpe at the Osgoode Hall Law School.