The Standard of Care in Malpractice Cases

Irvin Sherman

Follow this and additional works at: http://digitalcommons.osgoode.yorku.ca/ohlj

Citation Information
http://digitalcommons.osgoode.yorku.ca/ohlj/vol4/iss2/4

This Article is brought to you for free and open access by the Journals at Osgoode Digital Commons. It has been accepted for inclusion in Osgoode Hall Law Journal by an authorized editor of Osgoode Digital Commons.
THE STANDARD OF CARE IN MALPRACTICE CASES

Irvin Sherman

Medical malpractice has been a controversial issue both in the press and in medical and legal circles in recent years. As a result, the public in general and the medical profession in particular have become increasingly aware of the professional conduct of doctors. In California, “malpractice actions have become so prevalent that on the average one out of every four doctors is sued at some time for malpractice.”¹ The situation is not quite as serious in Canada. In 1965, the Canadian Medical Protective Association which represents 78% (15,500 out of 22,000) of Canadian doctors handled just 27 cases involving malpractice.²

It has been stated that, “the practising physician or surgeon is an easy target for the blackmailer. The disgruntled or unscrupulous patient can inevitably destroy the reputation of the most eminent physician or surgeon by an ill-founded action for malpractice.”³ The adverse publicity attributable to a medical negligence case, regardless how unfounded the action may be, can only have a detrimental effect upon the doctor’s career, thus weakening the vital role he can play in contributing to the needs of society. It is therefore of the utmost importance that the law does not act to the prejudice of doctors or their patients.

This paper will attempt to evaluate the standard of care the law imposes upon doctors. It is a breach of this standard, which in certain circumstances will render a doctor liable for malpractice. Special reference will be paid to the Canadian position and, where possible, to the Ontario position in particular.

**Standard of Care**

The standard of care is a legal measuring rod imposed by the courts to which the doctor’s conduct must conform if he is to escape liability for malpractice or negligence. In other words, the courts evaluate the doctor’s conduct according to a standard established by the law. The doctor’s conduct is then assessed by weighing the evidence or facts of each case against this standard. The trial judge (malpractice actions in Ontario are tried before a judge without a jury) will find for the patient if the doctor failed to live up to the standard imposed upon him.

*Irvin Sherman, B.A. (Dalhousie), LL.B. (Osgoode), is a member of the 1966 graduating class.


² Letter from the Canadian Medical Protective Association to writer.

³ Supra, footnote 1, p. 83.
The first reported malpractice suit was *Hills* case in 1374. In that case the court said “if the surgeon had done as well as he was able and had employed all his diligence in administering to the patent, it is not right he should be found culpable”. As the law of negligence developed, this subjective standard of care was replaced by the objective standard of the reasonable man which states that:

Negligence is the omission to do something which a reasonable man guided upon those considerations which ordinarily regulate the conduct of human affairs, would do, or something which a prudent or reasonable man would not do. The defendants might have been liable for negligence, if, unintentionally, they omitted to do that which a reasonable person would have done, or did that which a person taking reasonable precautions would not have done.5

For professional men, the courts have slightly modified this standard to the objective standard of a reasonable member of that profession or calling.

The jury [judge] 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.6

To say that a doctor violated the standard of care is not of itself sufficient to establish his liability for negligence. Before the standard applies there must have been a legal duty on the part of the doctor towards his patient to exercise skill and care. This duty arises as a matter of law when the doctor agrees to take the case and it is independent of contract. It is also necessary that the loss or injury to the patient be directly attributable to the negligent conduct of the doctor. In other words, there must be a causal connection between the doctor’s conduct and the patient’s loss.7 It is clear that the prior negligent conduct of a third party which resulted in injury to the patient will not preclude the patient from recovering from his doctor, if in treating the patient the doctor acted negligently.8 It is essential that the patient’s conduct be assessed for if it is shown that the patient is the author of his own misfortune, he will be precluded from recovering.9 If the patient is not entirely at fault, but only partially so, his recovery will be diminished by the extent of his fault.10

In assessing the professional standard of care, regard must be had to:

(a) the risk involved. Lord Nathan has pointed out that “the degree of care required varies in proportion to the magnitude of the risk... More extensive precautions must be taken where treatment which involves known risks is administered than where no such risk can be reasonably anticipated.”11

---

4 48 Edw. III, f. 6, p. 11.
10 The Negligence Act, R.S.O. 1960, c. 261, s. 4.
(b) the known characteristics of the party exposed to the risk.

(c) necessity. The standard imposed upon a doctor acting in an emergency will not be the same as if he had time to reflect. "What would be ordinary care in one set of circumstances would be negligence in another."12

(d) the physical circumstances of every case. Factors to be considered include the distance from a doctor's office or a hospital and the availability of equipment. For example, in Whitehead v. Hunter it was held that:

Where it is alleged that a complaint could have been successfully diagnosed by the use of a particular apparatus or appliance, regard must be had to the availability of that apparatus or appliance in the particular case in order to decide whether failure to use it amounts to negligence.14

Thus it should be seen that "though there is only one standard of care the actual degree of care required is infinitely varied".15

The objective standard of reasonableness is often proved by showing that the doctor has allowed the customary procedures established by his profession. Indeed, it has been stated that:

... in medical malpractice cases failure to establish non-conformity is fatal to the [patient] and the [doctor] who established conformity is entitled to a directed verdict.16

One American writer goes so far as to state that:

Custom is not conclusive of the care to be taken, but when we examine cases of medical negligence, however, we find that custom does become, almost exclusively, the measure of care.17

Adherence to custom is relevant in weighing or assessing the doctor's conduct with that of the norm. Custom determines the precautions to be taken. If the court found a doctor liable for adhering to the practices of his professional brethren, the result would be disastrous. The standard of care would then become arbitrary and shifting, being either too high or too low. What would be negligent in one set of circumstances would not be negligent in another.

The court distinguishes between issues which are matters of professional competence and issues which are within the common knowledge of laymen (for example, counting sponges). In the latter case, the court adopts the objective standard of the reasonable man which has the effect of lowering the burden of proof.18 Nor will the court permit doctors to rely on expert evidence and custom, where

16 C. Morris, Custom and Negligence (1942), 42 Col. L.R. 1147, at p. 1163.
professional procedure fails to make provision for obvious risks. The reason is that if a profession adopts careless procedures, a member of that profession will not be relieved of liability if he follows a careless procedure. For example, where an operating room explosion which injured the patient, was attributable to oxygen cylinders being improperly located, the court refused to accept customary practice in other hospitals as a defence, as such practices were found to be negligent.19

The Canadian courts have applied the standard of care as defined by the English courts.20 In the leading case of 

Lanphier v. Phipps,21 Tindal C.J. defined the standard thus:

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 case, nor does a surgeon undertake to use the highest degree of skill. There may be persons who have greater education and greater advantage than he has, but he undertakes to bring a fair, reasonable, and competent degree of skill....

This statement of the law has been referred to by the Ontario Court of Appeal as the classical statement in the law as to malpractice.22

Implicit in this definition is that a "medical man does not in point of law guarantee the recovery of his patient."23 The doctor just promises to use reasonable skill and care. This standard will be applied whether the doctor acted gratuitously or not, for the doctor held himself out to possess such skill and knowledge, and it was his duty to act reasonably after he accepted the responsibility.24

A doctor need not follow the procedures adopted by a unanimous majority of doctors. If a doctor follows a procedure adopted by a reputable minority of practitioners, it will suffice to disprove any inference of negligence. This principle has been expounded by the Ontario courts since 1878.25 More recently it was applied in the case of Davy v. Morrison26 where Riddell J. A. said:

In this the only specific evidence concerning the operation it is stated that the method pursued is an established practice but that some surgeons do not approve of it. This is not enough to establish malpractice.

---

22 Sweetman v. Law (1925), 28 O.W.N. 62, affd. 28 O.W.N. 433, per Latchford C.J.
23 James v. Crockett, supra, footnote 20, per Tuck C.J., at p. 542.
To upset the facts as found by the trial judge, the appellate court must not merely entertain doubts whether the decision below is right but be convinced that it is wrong.\(^{27}\)

As the plaintiff (usually the patient) bears the onus of proving negligence, it is not difficult to understand why the courts have said that

\[
\ldots \text{in law if a physician or surgeon was properly qualified} \ldots \text{the presumption was, until the contrary is shown, that he was competent and the treatment was correct.} \quad \text{\textsuperscript{28}}
\]

**Locality Rule**

The American definition of the standard of care has been defined as “the reasonable or ordinary degree of skill and learning commonly possessed and exercised by members of the profession who are of the same school and who practice in same or similar localities.”\(^{30}\) This is similar to the Anglo-Canadian definition except that the American case law places additional emphasis upon the practice or custom followed by doctors of a particular geographical area. This additional qualification was added to protect the country physician who usually lacked the opportunity to acquire wide experience and knowledge. Professor Fleming states that this qualification was introduced to protect the medical profession “against the blackmailing tactics to which it is so particularly vulnerable.”\(^{31}\)

Non-acceptance of the “locality” rule by our courts may be attributable in part to the fact that there “is less pressure for techniques to protect the medical man against spurious claims, due partly to the disappearance of juries.”\(^{32}\) Furthermore, the Canadian Medical Council was formed by Federal statute\(^ {33}\) to ensure uniform qualifications for all practitioners regardless in what part of Canada they practice. Examinations called “Dominion Councils” set by the Council, are written each year by medical students in their last year of studies. These examinations help set uniform standards throughout Canada.

It appears however that the American courts are beginning to “widen” the locality rule. In fact, the rule has been called an “anachronism.”\(^ {34}\) Judicial disapproval for such a rule may be found by examining the Ontario case of *Town v. Archer* where Falconbridge C.J. stated:


\(^{28}\) See *The Medical Act*, R.S.O. 1960, c. 234.


\(^{30}\) A. H. McCoid, *op. cit.*, supra, footnote 17.


\(^{32}\) *Ibid.*

\(^{33}\) Canada Medical Act, R.S.C. 1952, c. 27.

\(^{34}\) J. G. Fleming, *op. cit.*, supra, footnote 31.
... [A]ll men practising 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.\textsuperscript{35}

This reasoning seems to offer sufficient justification for the exclusion of the locality rule from our jurisprudence. In fact, in \textit{Taylor v. Gray},\textsuperscript{36} six doctors who attended six different medical schools in six different provinces or states gave evidence at trial.

There is a diversity of opinion as to whether the standard of care expected of a rural practitioner should be similar to that expected of urban practitioners.

The late Dean W. G. J. Meredith of the McGill University Law School stated:

\ldots [A] physician or surgeon practising in a country village should not ordinarily be held to the same standard of proficiency as physicians or surgeons practising in a big city.\textsuperscript{37}

On the other hand, Lord Nathan adopts the view of the South African court in \textit{Van Wyk v. Lewis} where it was stated:

The ordinary medical practitioner should \ldots exercise the same degree of skill and care whether he carries on his work in the town or country, in one place or another.\textsuperscript{38}

Modern means of communication and travel have destroyed the defence that rural doctors need protection because their comparative isolation prohibits their ability to keep abreast of current medical knowledge. As Professor Fleming states, "it is \ldots a matter of grave concern whether the law should lightly abandon its role of actuating constant improvements of professional standards."\textsuperscript{39}

It is therefore submitted that the standard of care expected of a rural doctor should be the same as that of an urban doctor. In assessing the standard, regard must be had to the particular circumstances of every case. The standard of care remains the same in each case but the degree of skill and care required to comply with that standard is conditioned by the circumstances. This approach was adopted by the court in \textit{Zinkler v. Robertson}\textsuperscript{40} where it was stated:

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 a city surgeon, provided with an operating room, nurses and all the aids of a modern hospital.

\begin{itemize}
\item \textsuperscript{35} (1902), 4 O.L.R. 383, at p. 388.
\item \textsuperscript{36} \textit{Supra}, footnote 18.
\item \textsuperscript{38} [1924] \textit{App. D. 438}, \textit{per} Innes J., as quoted by Lord Nathan, \textit{op. cit.}, \textit{supra}, footnote 11, p. 21.
\item \textsuperscript{39} Fleming, \textit{op. cit.}, footnote 31, p. 641.
\item \textsuperscript{40} (1897), 30 N.S.R. 61, at p. 70.
\end{itemize}
The courts have also considered such factors as the availability of equipment\textsuperscript{41} in a rural area, the distance between a doctor’s office and his patient’s home and the condition of rural roads.\textsuperscript{42}

**Other Health Professions**

Medical doctors are not the only professional group whose object is to diagnose and treat human ailments. Similar objects are professed by such schools as chiropracty, chiropody, optometry and osteopathy. Generally speaking, the standard of care expected of a member of a “particular school” is the objective standard of a reasonable practitioner of that school according to the circumstances of each case.\textsuperscript{43} The standard appears to be similar in Canada and the United States.

An exception will be found where the particular school does not demand uniformity of practice of its members. For example, in Nelson \textit{v. Harrington}\textsuperscript{44} evidence of the customary practice of a spiritualist or clairvoyant physician was not accepted by the court as the members of that school treat their patients by means of a trance and no uniform standard of procedure was possible.

The law does not favour any particular school or system of medicine. Therefore, evidence given by a member of a different school which disapproves of the treatment rendered will not be accepted by the court as proof of negligence.\textsuperscript{45} However, where a member of a particular school of medicine uses a piece of equipment not common to any particular school (for example, an X-ray machine) the standard of care expected of such a person is that of the “ordinary standard of a competent manipulator” for such equipment is available for all schools and for all purposes.\textsuperscript{46} Furthermore, evidence tendered by a member of a different school will be accepted by the court where such evidence tends to show negligence in diagnosis. The courts distinguish between diagnosis and treatment for there can be disagreement among schools of medicine as to the proper course of treatment but “diagnosis is the process of discovering what is actually in real truth the exact physical nature of the trouble. Here there cannot be any question of different schools of opinion.”\textsuperscript{47}

What assurance does a patient have that the objective standard of care attributable to a particular school of medicine is not arbitrary or too low? Lord Nathan submits that the school of medicine must be widely recognized as such before it is entitled to be judged by its own standards. Licensing statutes\textsuperscript{48} regulate the qualifications and

\textsuperscript{41} Whiteford \textit{v. Hunter}, supra, footnote 14.
\textsuperscript{44} (1888), 72 Wis. 591, 40 N.W. 283.
\textsuperscript{45} Penner \textit{v. Theobald}, supra, footnote 43.
\textsuperscript{47} Gibbon \textit{v. Harris}, supra, footnote 43, per Stuart J.A., at p. 676.
\textsuperscript{48} For example, The Chiropody Act, R.S.O. 1960, c. 57; The Optometry Act, R.S.O. 1960, c. 283.
conditions of entrance into a particular school. It is submitted that the Alberta court in the Gibbons case\textsuperscript{49} equated the diagnosing skill of a chiropractor to that of a physician. It would therefore logically follow that if we accept the objective standard of physicians, we should accept a similar standard for chiropractors in the field of diagnosing spinal injuries (that being the area of specialization of that particular school).

The eminent American attorney, Melvin Belli,\textsuperscript{50} states that when practitioners of drugless healing or other members of the unconventional schools of medicine find that the required treatment is beyond their license or ability, they have a duty to refer their patient to a qualified doctor. This appears to be sound reasoning and ought to be adopted in Canada. However, the Ontario High Court in Jarvis \textit{v.} International Nickel Co. Ltd.\textsuperscript{51} held that a general practitioner is under no duty to refer his patient to a specialist when he is unable to diagnose and treat the ailment.

It is a well-known rule of law that a practitioner is required to attain that degree of skill and care which he expressly or impliedly represents that he possesses. Therefore, if a layman undertakes a task requiring the skill and knowledge of a doctor, the layman must bring to the performance of that task, the skill and knowledge of a reasonable doctor.\textsuperscript{52} It would appear however that absence of a license to practice is of itself no evidence of lack of skill and care.\textsuperscript{53} An exception to this principle arises when a layman renders aid in an emergency. In such a situation the layman is expected to possess the skill and care of the reasonable man. He will be held negligent where he renders aid or treatment, which he knew or ought to have known was outside his competence and which resulted in damage.

To be contrasted with the above, is the situation where a person demands medical or quasi-medical treatment from another who he knows does not possess the proper qualification to give the treatment requested. The classic example is of a woman who is injured as a result of requesting a jeweller to pierce her ears, the injury being attributable to the improper sterilization of instruments.

In such circumstances,\textsuperscript{54} it has been held that the jeweller must exhibit the standard of care expected of a reasonable jeweller. If the lady desired the precautions and techniques employed by a doctor, she should have visited a doctor.

\textsuperscript{49} Supra, footnote 43.
\textsuperscript{50} Melvin Belli, 3 Modern Trials (1954), p. 2009.
\textsuperscript{51} Supra, footnote 20.
\textsuperscript{52} For the standard of care for a person who holds himself out to be a dentist, see \textit{R. v. Slavik} (1955), 15 W.W.R. 504 (B.C.C.A.).
\textsuperscript{53} \textit{Brown v. Slyne} (1926), 242 N.Y. 176 and quoted by Prosser, \textit{op. cit.}, supra, footnote 48, p. 132.
\textsuperscript{54} Phillips \textit{v. Wm. Whiteley Ltd.}, [1938] 1 All E.R. 566.
Specialists

Those who have taken special studies in a particular field of medicine and who thereby profess to have special skill and training are called specialists. The Supreme Court of Canada has stated that a specialist should "possess the skill, knowledge and judgment of the generality or average of the special group of class of technicians to which he belongs and will [should] faithfully exercise them." In other words, the standard of care expected of a specialist is that of the reasonable doctor who possesses such special knowledge.

There is Canadian authority for the logical proposition that "a higher standard of care is expected of one who holds himself out to be a specialist than is expected from a general practitioner." If this were not so a person with such skill and knowledge would be judged by a lower standard than the law permits, for a person, who holds himself out to possess special skill and knowledge, must live up to the objective standard expected of similar persons with the same skill and knowledge.

A specialist's standing does not deprive him of the protection of the rules of law relating to the standard of care. Like the general practitioner, the specialist is not an insurer. He does not guarantee results. As will be pointed out later, the specialist will not be held liable for a mistake in judgment where he has the exhibited skill, care and knowledge of a reasonable and similar specialist. However, a specialist is an expert in one narrow field. He cannot assume the duties of a specialist in a different and equally narrow field without exhibiting the standard of care expected of such a specialist. It has been suggested that the same standard is expected of a specialist regardless if he practices in a large city or a small town.

By the very nature of their practice, general practitioners infringe upon the fields usually reserved for specialists. It is not an uncommon practice for a family doctor to remove tonsils or deliver babies; work reserved to throat specialists and obstetricians respectively. This raises the question whether a general practitioner doing the work of a specialist should be judged by the standard applicable to specialists.

The California case of Sinz v. Owens holds that a general practitioner will not be judged by specialists' standards unless the general practitioner realized or should have realized the skill of a specialist was required. This case appears to answer the question in a logical fashion.

---

57 Wilson v. Swanson, supra, footnote 12.
58 Ibid.
60 (1949), 33 Cal. 2d 749.
It would not be in the public interest to unduly restrict the work of our family doctors.

In Ontario there is no duty for the general practitioner to refer his patient to a specialist. The reason, as stated by Wright J. in *Jarvis v. International Nickel Co. Ltd.*, is that

... when the doctor brings to bear upon the treatment of the patient a reasonable degree of skill and care under all circumstances he has discharged his duty.\(^{61}\)

This proposition does not hold true in other jurisdictions. Mr. Belli states that a doctor has the legal duty to inform his patient and advise the services of other doctors if he lacks the skill and knowledge to treat his patient properly.\(^{62}\) Indeed, the American position\(^{63}\) is that if specialists reside in the area where the doctor practices, it is the duty of the doctor to possess that degree of skill and learning ordinarily possessed by such specialists. This would place a higher standard upon the general practitioner in diagnosing, and as a matter of prudence, if he wishes to avoid liability he should refer his patient to a specialist.

It is respectfully submitted that the *Jarvis* case is bad law. How can it be said that a doctor “brings to bear upon a patient a reasonable degree... of care” if the doctor knows he is unable to treat his patient who requires the attention of a specialist? Is it asking too much of a busy doctor to refer his patient to a specialist? Dean Meredith strongly advised that if a doctor is uncertain about a case he should act immediately and consult another practitioner.\(^{64}\) Lord Nathan doubts that the *Jarvis* rule would be applied in England.\(^{65}\)

The extra-legal practice of hospitals restricting their facilities to accredited specialists has the two-fold result of requiring general practitioners to refer to specialists more often thus raising the duty of care and of confining the general practitioner to office and home treatment.\(^{66}\) It would thus seem to lead to the conclusion that the procedures adopted by the medical profession itself would require a general practitioner to refer difficult cases to specialists.

It is submitted that the case of *Fraser v. The Vancouver General Hospital* \(^{67}\) would provide judicial authority for a Canadian court to overrule the *Jarvis* case. In the *Fraser* case, a hospital employee (an intern) failed to read an X-ray properly and as a result of the improper diagnosis the patient died. The hospital was held liable for negligence for it should have called in a radiologist to compensate for the intern’s inexperience. If a specialist is needed to diagnose a problem given to an inexperienced man, it would only seem reasonable that a general

\(^{61}\) *Supra*, footnote 20, at p. 571.


\(^{63}\) McCoid, op. cit., *supra*, footnote 17, at pp. 567-568.

\(^{64}\) *Op. cit., supra*, footnote 37, at p. 69.


\(^{66}\) McCoid, op. cit., *supra*, footnote 17, at p. 569.

\(^{67}\) [1952] 2 S.C.R. 36.
practitioner (lacking expertise in a particular field as an intern does) should be compelled to refer a problem to a specialist if he realized or should have realized that the skill of a specialist might be required.

It would also be possible for a Canadian court to confine the Jarvis case to its own set of facts. It must be remembered, Jarvis arose in rural Ontario (Copper Cliff) and was decided in 1929 when there were few specialists. Since 1929, the number of specialists has risen and better means of communication and transportation are available today.

**Legal Duty**

This is no legal duty for a physician to render professional services if requested to do so. If a contract for professional services can be proved, the doctor may be found liable for breach of contract if he failed to render aid upon request. The doctor will assume a duty and potential tort liability the moment he agrees to treat his patient. Liability will not be confined to negligence in prescribing drugs, administering treatment, or the management of the patient but will cover all acts performed by a doctor from the time the patient comes under his instructions. Thus a doctor has been found negligent where he failed to set up an X-ray table properly.

The doctor's duty to look after his patient remains until, (1) the patient unilaterally dismisses the doctor; (2) treatment is no longer required; (3) the doctor-patient relationship is dissolved by mutual consent; or (4) the doctor gives his patient reasonable notice and an opportunity to retain a new physician.

A doctor is unable to devote his constant attention to his patient. However, liability will be imposed upon a doctor if the lack of attention leads to an “avoidable deterioration of the patient's condition”. A doctor may be found negligent in not attending his patient properly. Regard must be had to the nature of the situations and previous commitments incurred by the doctor. The test is reasonableness in the circumstances. This may be illustrated by examining the case of Smith v. Rae. In that case a doctor was summoned to attend the delivery of his patient's baby. The doctor arrived late, and in the interim, the patient died. It was held that the doctor was not negligent because the critical condition of the mother had not been communicated to him and the delivery was not expected at that particular hour.

---

68 Hurley v. Eddingfield (1901), 156 Ind. 416.
70 Todlock v. Lloyd (1918), 65 Colo. 40 “when a physician makes no effort to inform himself of the condition of his patient or the progress of his malady, he will be liable if unforeseen damages occur.” See Belli, op. cit., supra, footnote 50, pp. 2007-2008.
71 Lord Nathan, op. cit., supra, footnote 11, p. 42.
73 (1919), 46 O.L.R. 518 (Ont. C.A.).
A doctor has been found negligent in failing to tell his replacement the extent of the patient’s condition. A doctor will not be held liable if he failed to supervise routine matters such as those performed by hospital attendants upon or for his patient.

Diagnosis

The doctor-patient relationship usually commences as the doctor begins his diagnosis. The case law indicates that a doctor should have a reasonable opportunity for examining the patient and he should exercise ordinary care and diligence in discovering the nature of the ailment or injury. Failure to exercise care and diligence in diagnosis will render the doctor liable for negligence.

This does not mean however that a doctor will be liable if he made a wrong or mistaken diagnosis. In Wilson v. Swanson, a doctor mistakenly diagnosed his patient’s illness as cancer. During a subsequent operation, the doctor removed what he thought to be cancerous organs. Further tests revealed that the patient did not suffer from cancer. The patient sued. In the Supreme Court of Canada, Rand J. stated:

In a given situation some may differ from others in that exercise [of skill, knowledge and judgment] depending on the significance they attribute to the different factors in the light of their own experience. The dynamics of the human body of each individual are themselves individual and there are lines of doubt and uncertainty at which a clear course of action may be precluded.

... An error in judgment has long been distinguished from an act of unskillfulness or carelessness or due to lack of knowledge. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.

Implicit in these remarks is the proposition that the treatment prescribed by the doctor cannot be condemned because somebody of perhaps greater skill would have pursued another course.

An X-ray machine is a great aid in diagnosis. A doctor need not take an X-ray in every case, otherwise years of study and experience would be cast aside as negligible. Factors to be considered include

74 Farquhar v. Murray (1901), 3 F. (Ct. of Sessions) 859, as quoted by Lord Nathan, op. cit., supra, footnote 11, p. 42.
77 Supra, footnote 12; Waldon v. Archer, supra, footnote 12; Hamilton v. Phoenix Lumber Co. Ltd., [1931] 1 W.W.R. 43; see generally, Meredith, op. cit., supra, footnote 37, p. 53.
78 Hodgins v. Banting (1906), 12 O.L.R. 117.
the patient's condition, the character of the injuries and the availability of the apparatus.80

**Duty to Follow Medical Developments**

Since a skilful diagnosis obviously depends upon the skill, care and knowledge of the doctor, a doctor should take reasonable steps to keep abreast of the times.81 As far back as 1853, it was pointed out that the standard of ordinary skill is on the advance and "he who would not be found wanting, must apply himself with all diligence to the most accredited sources of knowledge."82 Although liability will arise if a doctor fails to keep abreast, he will not be held liable because he failed to read an article published a year ago and which might have warned him of the existence of risks he would have encountered in the treatment rendered. As Denning L.J. (as he then was) stated: "It would place too high a burden on a medical man to say he must read every article in the medical press."83 A doctor will not be deemed to be negligent for failing to use apparatus which was rare and unavailable.84 Assuming the diligent doctor has kept abreast of the latest medical techniques and as a result of such diligence the doctor uses a new instrument, what standard of care will the law demand? There is Canadian authority for the proposition that where the properties of the treatment are not fully known or understood the doctor must use "very great care and failure in that regard is negligence".85 It is submitted that where the new instrument or new treatment pattern has been thoroughly tested the practitioner should familiarize himself with the instrument or treatment pattern and he would be expected to use only a reasonable amount of care.

**Experimentation**

It is possible that a doctor might develop his own new techniques and wish to experiment on his patient. It has been suggested that a doctor may "innovate somewhat ... if it was done for the benefit of the patient after the established methods of treatment have proven unsuccessful".86

In the recent case of Male v. Hopmans,87 after previous methods of treatment proved unsuccessful, the defendant doctor administered an antibiotic, "Neomycin", for nineteen days, despite warnings from the manufacturer that neomycin treatment should not continue past ten days. The drug manufacturer also warned against renal and auditory

---

82 McCandless v. McWha (1853), 22 Pa. (10 Harris) 261, at p. 269 as quoted by McCoid, op. cit., supra, footnote 17, p. 575.
83 Crawford v. Charing Cross, as quoted by Nathan, op. cit., supra, footnote 11, p. 27.
86 McCoid, op. cit., supra, footnote 17, p. 583.
87 As yet unreported, December 7, 1965. (Ont. H.C.).
side-effects. The doctor was aware of these warnings yet he continued to give treatment without making use of the equipment available in order to check against the possible renal and auditory consequences. It subsequently developed that the plaintiff (patient) became almost totally deaf as a result of taking the neomycin. The patient sued and recovered damages from the defendant doctor. During the course of judgment Gale C.J.H.C. stated:

... In conducting a new and dangerous course of treatment for the first time, [the doctor] neglected to take the elementary precautions of which he was admittedly aware to prevent the result which actually occurred.

... It was incumbent upon Dr. Hopmans, having once determined to embark upon an admittedly radical programme of treatment, to exert the utmost for the safety of his patient.

To be contrasted with the above, is the situation wherein a doctor experiments without knowing any of the possible consequences. A doctor will be found liable if his experimentation amounted to a "rash action". The courts distinguish between experimenting with a new and untried technique and the "utilization of a new advance which carries with it unforeseen dangers and difficulties". It would thus seem that liability will be imposed upon a doctor at the line which the court draws between initiative and experimentation. The courts must develop a policy in this regard which will not stifle initiative and discourage advances in techniques while keeping to the fore the health and safety of the patient.

Delegation of Duties

During the course of the doctor-patient relationship, it will often be necessary for the doctor to delegate duties. A doctor cannot delegate responsibility to another doctor where the patient has not consented. If the patient is to appoint an assistant doctor, and the doctor instead appoints his own assistant, the patient will not be responsible for paying the assistant's fees. It has long been held that a doctor will be vicariously liable for the negligence of his "apprentices", interns and students, and servants (technicians and nurses). A chief surgeon will not be vicariously liable for the negligence of doctors who are assisting at an operation where the presence and participation of such assistants are proper and the assistants are duly qualified, possessing the skill and experience necessary for the work entrusted to them.

---

89 Nathan, op. cit., supra, footnote 11, p. 28.
91 Lindsay v. Freda (1923), 56 N.S.R. 210.
In delegating duties to the patient or his family the doctor should give clear and unambiguous instructions, explaining what is to be expected of them and, furthermore, he should warn of any foreseeable and serious consequence. The extent of such delegation depends upon the nature of the risk involved, the patient's condition and the ability to adequately comprehend the instructions given. For example, in Marshall v. Rogers,\textsuperscript{96} a doctor drastically reduced his patient's insulin requirements while putting the patient on a rigid diet. This was an admittedly dangerous course of treatment. The doctor was held negligent in delegating to the patient the duty of deciding from his subjective symptoms, without daily tests by the physician, what his real condition was. But where a doctor delegated the task of administering heat treatments (wrapped warmed bricks) to members of the patient's family, and the patient was subsequently burned as a result of the heat treatment, the doctor was found not negligent in delegating duties which required no special knowledge or skill.\textsuperscript{97}

\textit{Duty to Inform}

It was well-established\textsuperscript{98} that a doctor has a duty to inform and warn his patient of all the pertinent facts of the case. Failure to do so might constitute a lack of consent and the doctor might be liable for technical assault, or trespass as well as for negligence. The duty to inform does not arise if the patient does not wish to be informed, if he is incapable of understanding the true significance of the treatment about to be undertaken or if he is of unsound mind.\textsuperscript{99}

A doctor is under no obligation to describe in great detail all the possible consequences of the treatment to be rendered, nor is he under a duty to warn his patient of risks which are inherent or obvious. In Murrin v. Janes\textsuperscript{100} the patient alleged his dentist was negligent in failing to warn of the consequences of excessive blood loss following an extraction. The dentist was found not negligent as "any adult of sound mind must be considered to be aware of the danger of continued loss of blood".

Failure to warn may be a cause of action in itself. Furthermore, it might be sufficient to prevent the limitation period (one year) from running if such failure amounted to fraudulent concealment. Finally, it might be relevant in cases involving claims for unauthorized treatment or assault.

American authority\textsuperscript{101} indicates that a physician has an obligation to disclose to his patient the fact that the treatment which he has

\textsuperscript{96} [1943] 2 W.W.R. 545; Ball v. Howard, supra, footnote 75.
\textsuperscript{97} Marchand v. Bertrand (1911), 39 S.C. 49 as quoted by Meredith, op. cit., supra, footnote 37, p. 88; see also Nathan, op. cit., supra, footnote 11, p. 47.
\textsuperscript{99} See generally, Meredith, op. cit., supra, footnote 37, p. 88 ff.; Male v. Hopeman, supra, footnote 87.
\textsuperscript{100} (1949), 23 M.P.R. 377 (Nfld.).
\textsuperscript{101} Kelly v. Carroll (1950), 212 P. 2d 658; Baldour v. Rogers (1955), So. 2d 658, as quoted by McCoid, op. cit., supra, footnote 17, p. 572.
undertaken is not effective or will not be effective. No such duty exists in Ontario. It is submitted that the Ontario courts ought to follow the American position. However a doctor may deliberately tell his patient a falsehood concerning the state of his patient’s health, if in the exercise of his professional judgment the truth would have an adverse effect upon the health of the patient.

In Furniss v. Pitchett a husband instructed his family doctor to write a medical report on his medically unstable wife. One year after the husband received the report, in an application for maintenance hearing, counsel for the husband confronted the wife with the medical report. The wife, hitherto ignorant of the report, suffered shock as a result of reading the report and sued the doctor. The court, in holding for the wife, stated that a doctor’s duty of care to his patient involved a duty not to give a third party a report concerning the patient, if it was reasonably foreseeable that the report would come to the patient’s attention and cause her physical harm. Professor Fleming has criticised this decision as inconsistent with the cases allowing recovery for mental shock. Certainly one ought not to recover for suffering nervous shock as a result of reading the truth about one’s self. This decision places an additional burden upon the doctor’s shoulders. It might also hinder parents and spouses from receiving confidential information about their immediate family.

In the recent case of Smith v. Auckland Hospital Board a doctor was held liable for negligently informing his patient about the nature of the risk involved in the pattern of treatment the doctor hoped to follow. The New Zealand court laid down no general rule as to what a doctor should tell his patient but based its decision upon the specific inquiry of the patient regarding the risk.

. . . The specific inquiry transformed the legal situation for it then becomes the doctor’s duty, if he embarked on any answer at all, to give a careful answer, not merely to offer reassurances, however well-intentioned.

Turner J. stated that a doctor must use due care in answering his patient’s questions, “where the patient to the knowledge of the doctor intends to place reliance on that answer in making a decision as to the treatment or procedure to which he is asked to consent”.

In Male v. Hopmans Gale C.J.H.C. held that in the circumstances of the case (the patient being too ill and unable to comprehend the significance of the course of treatment planned), failure to warn the patient did not constitute negligence. In addition, the learned Chief Justice

---

107 Quoted by Mathieson, What Should a Doctor Tell a Patient (1965), 28 M.L.R. 595.
108 Ibid.
109 Supra, footnote 87.
held that, "there is no evidence to show that Dr. Hopman's failure to explain all of the attendant risks at the time the plaintiff asked about the warning on the bottle was an effective cause of the damage which was done to him".

It has been suggested that a doctor should not be obliged to elaborate upon the risk in great detail. It would be undesirable to compel doctors to discuss possibilities, under the apprehension of liability for negligence, should things go wrong. Thus, the court's action in limiting liability to specific requests seems logical.

The duty to warn should be measured by the same standard and upon the same principles applicable to technique. This is subject to the qualification that the "patient must realize, like all of us, there can be no part of medical practice which is infallible; contingencies are inseparable from human affairs." This is consistent with the rules of law which state that a doctor does not guarantee his patient's recovery and will not be liable for a mistake in judgment if the mistake was made while exercising proper skill, care and knowledge.

Doctors are obliged to make reports and keep certain records for the purposes of the federal and provincial governments and failure to report in certain circumstances will result in criminal prosecution. As a result of the Smith case the Crown might have an additional remedy (a civil suit) against the doctor. Liability would result if it can be proven that the negligent statement of the doctor detrimentally affected a course of action adopted by the government, which was based on the doctor's report.

A doctor's conduct may be so negligent as to render the doctor liable for criminal negligence under s. 191 of the Criminal Code of Canada. To convict a doctor of criminal negligence it must be shown that his negligence or incompetence showed a disregard for the life and safety of his patient as to amount to a crime against the state and conduct deserving punishment.

Evaluating the Standard of Care

The standard of care expected of medical practitioners is difficult to assess and cannot be considered in isolation. Many factors have to be taken into account. A standard of care would be irrelevant and would be nothing more than some philosophic absolute if it was impossible to prove a departure therefrom. Of what use is a standard of care if doctors refuse to give the same objective evidence in a malpractice suit (where a doctor's conduct is at issue) as they would

110 Supra, footnote 107, p. 597.
111 Ibid., p. 599.
113 See generally, R. v. Gordon (1923), 54 O.L.R. 355, Mens rea necessary.
114 Supra, footnote 106.
115 S.C. 1953-54, c. 51.
give in a case involving personal injury (where a doctor's conduct is not being assessed)? In addition to the evidentiary problem, the social problem must be assessed. A patient in trying to prove negligence is faced with complex, uncertain and expensive litigation. An impecunious patient just cannot afford to sue his doctor. Neither a rich nor a poor patient will recover if the doctor is impecunious or uninsured. Therefore, the standard of care is not the isolated consideration.

There is a diversity of opinion as to the effectiveness of the present laws relating to medical malpractice. Professor A. A. Ehrenzweig states that

... both patient and those entrusted with his care are poorly served by the present rules relating to liability for medical malpractice.\(^\text{117}\)

On the other hand, the Attorney-General's (Ontario) Report states: It can hardly be said that the law as now administered in Ontario is in any sense burdensome.\(^\text{118}\) The Commissioners and other Ontario writers indicate that the real safeguard in present Ontario law is that malpractice actions are tried before a judge without a jury. This practice precludes plaintiff's counsel from adopting overly-emotional trial techniques designed to sway a lay jury. The rule forbidding contingency fees keeps our courts from being burdened with a multiplicity of negligence cases, and reduces the size of damage awards. It is apparent that the problem of medical malpractice is more serious in the United States than in any of the Canadian jurisdictions.

The present standard of care is based primarily upon the customary practice of doctors in cases and in circumstances similar to the one on trial. This means that expert evidence is used in assessing the standard of care. Custom became the standard of care for two reasons, one historical, the other practical. In the days before the present objective standard was developed, the courts imposed liability upon those who held themselves out to the public as possessing special knowledge and skill. Secondly, custom was adopted because it was thought the lay jury and the bench would be unable adequately to comprehend and evaluate the professional conduct of a doctor. Today, customary practice provides a convenient measure or guide for the trial judge to follow. The judge is not compelled to accept the established practice of doctors as proof of the issue. The professional standard is disregarded when the trial judge considers the customary practice to be careless. Thus, judicial policy and discretion precludes the imposition by the medical profession of its own uncontrolled standards to the detriment of the public. However, because the courts, in most cases, accept customary practice in assessing the doctor's conduct, the doctor is thereby reassured that his conduct is being

\(^{117}\) Ehrenzweig, Hospital Accident Insurance: A Needed First Step Towards the Displacement of Liability for Medical Malpractice, 31 U. of Chicago L.R. 279.

\(^{118}\) Op. cit., supra, footnote 1, p. 82.
judged by his professional brethren. This means that the question of liability will not be left to one who has no medical training. Customary practice also prevents an arbitrary and shifting standard from being set. Otherwise a doctor would be more interested in protecting himself from liability than in the welfare of his patient. Initiative would be stifled. A happy balance must be reached between a doctor being overly cautious and not cautious enough. The present standard of care provides the means of achieving this happy balance.

The general duty to use skill and care is composed of many small but important duties. To illustrate, a doctor owes a duty to inform his patient, to exercise skill and care in diagnosis and in rendering treatment. If the doctor fails to use reasonable care in the performance of any of these duties, he will automatically be in breach of the general duty. The multi-duty theory affords the patient additional protection because each act is independently evaluated. The general standard of care will not be attained until each specific duty has been assessed and found to be correct.

Three additional courses could be pursued by the courts in assessing professional standards. The courts could abolish the professional standard and replace it with the ordinary objective standard of the layman. This approach would run contrary to history and precedent. It would only result in injustices to both doctors and their patients. Confidence and initiative would be lost and this, in turn, would result in a deterioration of professional competence. Such an approach is untenable.

The courts could use the doctrine of strict liability. Strict liability is applied by the courts in cases involving dangerous and abnormal activity. Medical practice cannot be classified as such. Imposition of strict liability would place an unfair burden upon the medical profession. Doctors would be found liable for conduct that is both safe and normal if the patient suffers.

Finally, the court could adopt the theory of negligence without fault which seems to be the trend in tort law today. The effect of such a course is to place less emphasis upon the admonitory and deterrent theory of tort law and place more emphasis upon the compensation of victims. Under this scheme, a patient would receive compensation regardless of fault. This is usually accomplished by providing a scheme of insurance analogous to workmen's compensation. The whole segment of an industry, both employers and employees, or doctors and patients, bear the responsibility for compensation. Professor Ehrenzweig advocates such a scheme for the limited area of hospital liability for the torts of their doctors and technical personnel. Professor Ehrenzweig states that his plan would provide for the assurance and easy determination of equal minimum awards and would eliminate the threats, gambles, stigmas and expenses.

119 See generally, Mathieson, op. cit., supra, footnote 109.
120 Ehrenzweig, op. cit., supra, footnote 118.
attached to litigation. Furthermore, it would promote care and safety. The physician would be relieved of concern which impairs the progress and effectiveness of medical practice.

Conclusion

The law of professional negligence stands in contrast to the tendency favouring the collectivisit principle of loss distribution. The fault theory, with admonishing and deterring functions, predominates despite universal liability insurance. As Professor Fleming states:

Liability insurance fails to eliminate the punitive sanctions of an adverse judgment because it cannot afford protection against inevitable damage to professional standing. In consequence the law of negligence still performs in this context the task of controlling conduct and cannot afford to yield readily to the pressures which elsewhere have led to a decline in moral fault as a significant determinant of liability.1

The close association arising by virtue of the doctor-patient relationship necessitates adherence to the fault theory of tort law. If the loss distribution theory were applied to doctors, there would inevitably follow a deterioration of the doctor-patient relationship. Consequently, “courts have shown little inclination to condone attenuations of the fault requirement owing to the repercussions of adverse verdicts on the reputation and future of professional defendants.”

It is the constant threat of a malpractice suit that keeps the medical standard of care high. The professional standard as applied by our courts does not seem to have impeded medical progress. Professor Ehrenzweig’s concern that the present rules impede progress seems to be of little consequence when one considers the tremendous advances in medical science in recent years.

Professor A. H. McCoid1 in referring to the loss distribution of tort law and medical malpractice points out that the cost of medical service is not distributed on a pro rata basis. Patients with adequate resources will compensate for the loss of fees sustained in administering to charity or “reduced-fee” patients. Distribution of loss is unlikely to be equal or related to the risk to the individual patient. Liability in malpractice cases involves more than loss distribution for a doctor who is sued for malpractice immediately comes under suspicion. Unless the present standard of care and customary practice are retained, loss distribution principles would have a tendency to undermine public confidence in the medical profession.

Professional negligence is a constantly recurring theme in the popular press, radio and television. The public is becoming increasingly aware of the problem of medical malpractice. This, in turn, can only remind a doctor that his conduct is being publicly analysed. A doctor is forced by public pressure into adopting safe and reasonable

121 Fleming, op. cit., supra, footnote 31, p. 634.
122 Ibid.
123 McCoid, op. cit., supra, footnote 17, p. 609.
practices. Furthermore, the annual average award for damages incurred in a malpractice suit is approximately $30,000 per year. In a pamphlet sent to doctors, the Canadian Medical Protective Association states that for the past fourteen years a total of $418,000 was paid out in damages and $229,000 was paid out in legal fees.

The present law relating to the standard of care in medical cases appears adequate and ought to be retained since it protects both doctors and patients. Apparently society does not demand, nor does it seem practical, for loss distribution principles to be applied to medical malpractice cases. Few malpractice cases get to trial. The amount paid out each year in compensation under the present system is very small. Threats to initiate a malpractice suit usually mean a quick and quiet settlement. Finally, the excessive publicity given to the subject of medical malpractice will keep the standard of care high. A doctor loses much if he loses his reputation!