# HOSPITAL LIABILITY

Hospitals in Manitoba are operated under The Hospitals Act, R.S.M. 1970, H 120.

In order to operate a hospital, it is necessary to obtain a license from the Manitoba Hospital Commission established under the Department of Health Act.

Once licensed, a hospital is obligated to provide hospital care, treatment and service in accordance with the standards set out in the Hospitals Act and Regulations. Hospitals are operated by a Board of Directors or other management group which must enact suitable procedural hospital and medical staff by-laws, regulations and rules for approval by the Manitoba Hospital Commission.

The Hospitals Act does not apply to private hospitals which are covered under the Private Hospitals Act, R.S.M. 1970, P 130. A private hospital is defined under the Act to mean

> ". . . a house or building in which four or more patients are received and lodged at the same time for medical or surgical treatment or for care and treatment in, or in respect of, childbirth, that is licensed by the Commission as a private hospital . . ."

An operator must obtain a licence from the Commission which is good for a period of one year and then may be renewed from year to year.

Hospitals in Manitoba are therefore operated under statutory regulation and authority. In this province all hospitals are funded by the provincial government from revenue generated in whole or in part by public contribution to a compulsory medical and hospital services plan.

Subject to the services available in the hospital and the needs of the patient, every person has a right to be admitted to a hospital for reasonable and necessary hospital or medical treatment therein.

Any practising physician and surgeon licensed with the College of Physicians and Surgeons of Manitoba may apply to a hospital for admitting privileges. The application by that doctor goes to the Board of Directors or other management group and if and when accepted, results in the doctor's becoming a member of the medical staff of that hospital. Depending upon the particular setup of the hospital, a doctor may be an independent contractor practising under the medical plan in force in the province and servicing private patients; in addition he may be a member of the teaching staff of the hospital in which case he would have an appointment to the medical college and in addition he may be an employee of the hospital having a particular capacity in connection with the work of the hospital.

A doctor who is appointed to the medical staff of a hospital may not have his appointment revoked except under the lawful regulation of the hospital then in force and after due observance of the rules of natural justice. If he feels himself aggrieved he may apply for reinstatement, if there is provision for such in the regulations of the hospital, and failing that may apply to the Court for a Declaration or by way of an action for damages and for an injunction to be restored to his position.

In *Andreas* vs. *Edmonton Hospital Board*[1] the Court had occasion to deal with a matter involving a defendant hospital owned by the City of Edmonton and operated by a hospital board under its authority. Under the Board's by-laws appointment of physicians and surgeons to the medical

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1 [1944] 3 W W R 9 (Alberta Supreme Court - Appeal Division)

staff of the hospital was a prerequisite to the right to treat patients therein. Plaintiff's application for inclusion on the staff was rejected by the staff and their action was adopted by the Board. Plaintiff sued for a declaration and for an injunction restraining the Board from preventing him from using the hospital facilities. The trial judge held that principles of "natural justice" had not been observed when the plaintiff's application was refused, and it was ordered that the plaintiff be admitted as a member of the medical staff of the hospital. An interim injunction, which had been granted, was continued. On appeal, it was held that the judgment of the lower court should be reversed:

1. The staff had a legal right, with or without reason, to decline to approve of any applicant as a member thereof; and it was not necessary for any member to give or have any reason for his vote and the Board had an equal right to be guided by the views of the staff;
2. The plaintiff had been given ample opportunity of appearing before both the staff and the Board to press his claim for membership on the staff;
3. There were no charges other than rumours against plaintiff and therefore no charges could be answered by him;
4. Since it appeared then, in adopting the view of the staff, the Board thought it was acting in the best interests of the hospital and its patients, there was no reason for the Court to differ from the Board in this regard.

But what of the liability of the hospital for the acts of its medical and nursing staff? What is the scope of the service that the public may reasonably expect from a hospital? Who are deemed to be employees or agents of the hospital so as to fix the hospital with vicarious liability in the event of negligence? These are questions that have plagued the Courts for many years.

It will be the task of this paper to explore the areas of liability of hospitals and to outline the present state of the law in Manitoba and the other common law provinces of Canada.

Before doing that it may help to outline briefly the problems that confront the patient, the hospital, the members of the medical staff, the nurses and other employees when medical malpractice claims of this kind arise. It will then be appropriate to proceed to the decided cases and the principles of law that have been enunciated by them.

Take the typical case of the person who sees his doctor and is informed that he will require an operation. If the operation is of more than ordinary complexity, a specialist in surgery will probably be consulted. The patient would normally then see the specialist on at least one occasion before an appointment is made for surgery at a specified hospital. Upon going to the hospital the patient is required to fill out certain forms including a consent to surgery and would normally then be visited on the ward by an anaesthetist who would take a pre-operative history and discuss with the patient the type of anaesthetic to be given. The operation would then be performed, usually on the following day after which the patient would normally go to the post-operative recovery room and then back to the ward.

In the cases that result in litigation, the normal pattern is broken by some event during the customary procedure which results in injury to the patient. That injury may be caused by an act or omission before, during or after surgery by any one of a number of persons. It is not until the precise event causing the injury is made known that the identity of the person responsible may be ascertained and the relationship of that person to the patient at the particular time determined.

Who is responsible for the anaesthetist? It is normal in hospitals in larger cities, at least it is in Winnipeg, for hospitals to allow anaesthetists to

practise in the hospital under some group name separate and distinct from the hospital itself as a legal entity. These doctors are members of the medical staff but are partners in the group operated by them. They may charge the particular patient directly for their services or bill the provincial medical service plan in force. They are not paid by the hospital. Are they employees or agents of the hospital? Does the hospital expressly or implicitly hold itself out as providing an anaesthetic service?

THE ENGLISH CASES:

The starting point should be *Gold* vs. *Essex County Hospital*[2]. This case involved the treatment of an infant by a radiographer in the employ of the hospital. Because of his failure to provide adequate screening material in giving a certain kind of x-ray treatment, the infant suffered injury to her face. It was established that the radiographer was fully competent to administer the treatment given to the infant plaintiff. *Gold* is of note because of the way it dealt with *Hillyer* vs. *St. Bartholomew's Hospital*[3], a decision of which Lord Justice Goddard said "there can be few cases in the books which have given rise to such a diversity of judicial statements as to the precise nature of the point decided." Eminent counsel in the person of A. T. Denning, K. C. appeared for Gold (and of whom we shall hear later upon his appointment to the Court of Appeal). Denning in argument commented unfavourably on the decision in *Hillyer*. The subsequent decision in *Gold* provided the foundation for later decisions holding that a hospital is in no different position than any other master or employer and is liable for the negligent acts of its servants. Hardly a startling proposition in this day and age, but at the time diffusion of opinion had resulted from *Hillyer* and the many facets of professional responsibility discharged within the confines of a hospital had not jelled into the clear lines of demarcation which exist today.

In *Gold* the argument for the Hospital was that it was under no obligation to cure but only to supply nurses and others in whose selection it had taken due care. It was submitted that the Hospital authorities perform the administrative functions but they put in professional people to attend to professional and medical matters which are functions which they themselves do not profess to perform. The Hospital is liable only to take reasonable care to provide doctors and nurses who are competent. They are not liable for the negligence of those persons when they are performing acts which require them to use professional skill and knowledge, so the argument went.

It was held that since the radiographer was under a contract *of* service (i.e. an employee) as opposed to a contract *for* services (i.e. an independent contractor) the Hospital was vicariously liable for his negligence under the doctrine *respondeat superior.*

We go now to *Cassidy* vs. *Ministry of Health*[4]. Denning has now moved from his position before the Bench. His views expressed as counsel in *Gold* remain the same.

*Cassidy* involved the case of a man who suffered from a contraction of the third and fourth fingers of his left hand and who was operated upon at the Defendant's hospital by a Doctor Fahrni. Dr. Fahrni was a full time

2 [1942] 2 All E.R. 239 (C.A.)

3 [1909] 2 K.B. 820

4 [1951] 1 All E.R. 574 (C.A.)

Assistant Medical Officer of the Hospital. Following the operation the man's hand and forearm were bandaged and remained in that condition for about two weeks. He complained of pain during this time but neither Dr. Fahrni nor the house surgeon who looked after the plaintiff in the absence of Dr. Fahrni did anything apart from ordering sedatives. Both Dr. Fahrni and the house surgeon were employed by the Hospital under contracts of service. After removal of the bandages all four fingers of the plaintiff's hand were stiff and his hand was for all intents and purposes useless.

At the trial the plaintiff's action had been dismissed. On appeal the plaintiff was successful by unanimous opinion of the Court. Denning, L. J. said:

> "If a man goes to a doctor because he is ill no one doubts that the doctor must exercise reasonable care and skill in his treatment of him, and that is so whether the doctor is paid for his services or not. If, however, the doctor is unable to treat the man himself and sends him to hospital are not the hospital authorities then under a duty of care in their treatment of him? I think they are. Clearly if he is a paying patient, paying them directly for their treatment of him, they must take reasonable care of him and why should it make any difference if he does not pay them directly but only indirectly through the rates which he pays to the local authority or through insurance contributions which he makes in order to get the treatment? I see no difference at all. Even if he is so poor that he can pay nothing and the hospital treats him out of charity still the hopital authorities are under a duty to take reasonable care of him just as the doctor is who treats him without asking a fee. In my opinion authorities who run a hospital be they local authorities, government boards or any other corporation are in law under the self same duty as the humblest doctor. Whenever they accept a patient for treatment they must use reasonable care and skill to cure him of his ailment. The hospital authorities cannot do it by themselves. They have no ears to listen through the stethescope and no hands to hold the knife. They must do it by the staff which they employ and if their staff are negligent in giving the treatment they are just as liable for that negligence as anyone else who employs others to do his duties for him. What possible difference in law, I ask, can there be between hospital authorities who accept a patient for treatment and railway or shipping authorities who accept a passenger for carriage? None whatever. Once they undertake the task they come under a duty to use care in the doing of it and that is so whether they do it for reward or not. It is no answer for them to say that their staff are professional men and women who do no tolerate any interference by their lay masters in the way they do their work. The doctor who treats a patient in the Walton Hospital can say equally with the ship's captain who sails his ship from Liverpool and with the crane driver who works his crane in the docks: "I take no orders from anybody". That "sturdy answer" as Lord Simonds described it in *Mersey Docks and Harbour Board* vs. *Coggins and Griffith (Liverpool) Ltd.*[5] only means in each case that he is a skilled man who knows his work and will carry it out in his own way. It does not mean that the authorities who employ him are not liable for his negligence. The reason why the employers are liable in such cases is not because they can control the way in which the work is done - they often have not sufficient knowledge to do so - but because they employ the staff and have chosen them for the task and have in their hands the ultimate sanction for good conduct - the power of dismissal.
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> "This all seems so clear on principle that one wonders why there should ever have been any doubt about it. Yet for over thirty years - from 1909 to 1942 - it was the general opinion of the profession that hospital authorities were not liable for their staff in the course of their professional duties. This opinion was based on a judgement given by Kennedy L.J. in *Hillyer's* case. When, however, the Court in 1942 was brought face to face with the position of the County Council Hospital which was not dependent on voluntary contributions but was supported by the ratepayers - the position of which was in law indistinguishable from that of a voluntary hospital - this Court rejected the judgment of Kennedy L.J. and held that the hospital authorities were liable for the negligence of the nurses and radiographers in the course of their professional duties (*Gold*). Even the judgment of

5. [1946] 2 All E.R. 353 (H.L.).

> Farwell L. J. in Hillyer's case has not passed unscathed. He took the view that, when a patient went into hospital for an operation which was to be performed (be it noted) by a consulting surgeon whom the patient himself selected and employed, the hospital authorities were not responsible for the negligence of the nurses in the operating theatre. This view was based on the supposition that the nurses while in the operating theatre became temporarily the servants of the consulting surgeon. This was a tenable view so long as *Donovan* vs. *Laing*[6] was an authority but since then the House of Lords in Coggins' case[7] have distinguished Donovan's case almost out of existence and there can be no doubt now that the nurses remain the servants of the hospital authorities even when they are under the direction of the surgeon in the operating theatre. The reason is because the nurses are employed by the hospital authorities, paid by them, and liable to be dismissed by them, and the consulting surgeon has not that "entire and absolute control" over them which is necessary to make them his servants even temporarily. The result therefore is that Hillyer's case can now only be supported on the narrow ground -- namely that the hospital authorities were not liable for the negligence of the consulting surgeon because he was not employed by them and that no case of negligence had been proved against the nurses and carriers.
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> "Relieved thus of Hillyer's case this Court is free to consider the question of principle and this leads inexorably to the result that when hospital authorities undertake to treat a patient and themselves select and appoint and employ the professional men and women who are to give the treatment they are responsible for the negligence of those persons in failing to give proper treatment no matter whether they are doctors, surgeons, nurses or anyone else. Once hospital authorities are held responsible for the nurses and radiographers as they have been in Gold's case I can see no possible reason why they should not also be responsible for the house surgeon, surgeons and resident medical officers on their permanent staff. — 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. Where however the doctor or surgeon, be he a consultant or not, is employed and paid not by the patient but by the hospital authorities, I am of the opinion that the hospital authorities are liable for his negligence in treating the patient. It does not depend on whether the contract under which he was employed was a contract of service or a contract for services. That is a fine distinction which is sometimes of importance but not in cases such as the present where the hospital authorities are themselves under a duty to care in treating the patient."

Denning L. J. went on to concur in the result holding the hospital liable on the basis that the *prima facie* case of negligence had not been displaced. He makes this statement:

> "If the plaintiff had to prove that some particular doctor or nurse was negligent he would not be able to do it but he was not put to that impossible task. He says 'I went into the hospital to be cured of two stiff fingers. I have come out with four stiff fingers and my hand is useless. That should not have happened if due care had been used. Explain it if you can.' "

The hospital did not explain how this could happen without negligence and were held liable.

Having persuaded the Court in *Gold* to overturn nearly half a century of law Denning L. J. in *Cassidy* drove a further nail into the coffin of Hillyer's case thus continuing the momentum of hospital liability to a destination which we shall presently see.

In the case of *Roe* vs. *Ministry of Health*[8] unique facts were brought to the Court of Appeal for consideration. Two men, Cecil Henry Roe and Albert Wooley, patients in the Chesterfield and North Derbyshire Royal Hospital were operated upon on October 13, 1947, after receiving a spinal

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6 [1893] 1 Q B 629

7 [1946] 2 All E R 345

8. [1954] 2 All E R 131 (C A)

anaesthetic consisting of Nupercaine administered by injection into the lumbar spine. The facts disclosed that the Nupercaine was taken from a glass ampoule manufactured by Ciba Laboratories Ltd. On delivery of the ampoules to the hospital the manufacturer notified the authorities that they were septic and therefore Dr. Pooler, the senior anaesthetist, and Dr. Graham, one of the defendants in the case, decided to remove the threat of contamination by keeping the ampoules of Nupercaine firstly for twenty minutes immersed in a one and twenty phenol solution and then for about twelve hours in a glass jar containing a one and forty solution of phenol. Prior to the operation and in accordance with usual practice at the time, the glass ampoules, one for each patient, were removed from the glass jar, the neck was broken, the needle of the syringe inserted and the patient injected. It later became apparent that part of the phenol solution had invaded the Nupercaine ampoules causing each of the plaintiffs to develop spastic paraplegia resulting in their becoming permanently paralyzed from the waist down.

The trial judge dismissed the action and his finding was upheld on appeal.

Lord Justice Denning, one of the three justices on appeal, made these remarks:

> "No one can be unmoved by the disaster which has befallen these two unfortunate men. They were both working men before they went into the Chesterfield Hospital in October, 1947. Both were insured contributors to the hospital, paying a small sum each week, in return for which they were entitled to be admitted for treatment when they were ill. Each of them was operated on in the hospital for minor trouble, one for something wrong with the cartilage in his knee, the other for a hydrocele. The operations were both on the same day, October 13, 1947. Each of them was given a spinal anaesthetic by a visiting anaethetist, Dr. Graham. Each of them has in consequence been paralyzed from the waist down.
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> "The judge has said that those facts do not speak for themselves, but I think they do. They certainly call for an explanation. Each of these plaintiffs is entitled to say to the hospital: While I was in your hands something has been done to me which has wrecked my life. Please explain how it has come to pass. The reason why the Judge took a different view was because he thought the hospital authorities could disclaim responsibility for the anaesthetist, Dr. Graham; and as it might be his fault and not their the hospital authorities were not called on to give an explanation. I think that reasoning is wrong. In the first place I think that the hospital authorities are responsible for the whole of their staff, not only for the nurses and doctors but also for the anaesthetists and surgeons. It does not matter whether they are permanent or temporary, resident or visiting, full time or part time. The hospital authorities are responsible for all of them. The reason is because even if they are not servants they are the agents of the hospital to give the treatment. The only exception is the case of consultants or anaesthetists selected and employed by the patient himself. I went into the matter with some care in Cassidy's case and I adhere to all I there said. In the second place I do not think that the hospital authorities and Dr. Graham can both avoid giving an explanation by the simple expedient of each throwing responsibility on the other. If an injured person shows that one or other or both of two persons injured him but cannot say which of them it was, then he is not defeated altogether. He can call on each of them for an explanation: See *Baker* vs. *Market Harborough Industrial Cooperative Society*[9].
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> "I approach this case therefore on the footing that the hospital authorities and Dr. Graham were called on to give an explanation of what has happened. But I think they have done so. They have spared no trouble or expense to seek out the cause of the disaster. The greatest specialists in the land were called to give evidence. (His Lordship then stated the facts as found by the learned Judge and continued:) That is the explanation of the disaster and the question is: Were any of the staff negligent? I pause to say that once the accident is explained no question of *res ipsa*

9. [1953] 97 SOL. JO. 861.

> *loquitur* arises. The only question is whether on the facts as now ascertained anyone was negligent."

Counsel for the plaintiff advanced two theories of liability: one was that the hospital staff were negligent in not colouring the phenol with a deep dye which would leave a residue in the glass and inside the Nupercaine ampoule to show contamination, and the other in cracking the ampoules.

Both these theories were rejected by the Court of Appeal on the basis that deep tinting was not accepted by competent anaesthetists to counteract the unknown danger existing at the time. As Denning L. J. put it:

> "If the anaesthetists had foreseen that the ampoules might get cracked with cracks that could not be detected on inspection they would no doubt have dyed the phenol a deep blue; and this would have exposed the contamination. But I do not think their failure to foresee this was negligence. It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness and then it is put right. That is just what happened here. Dr. Graham sought to escape the danger of infection by disinfecting the ampoule. In escaping that known danger he unfortunately ran into another danger. He did not know that there could be undetectable cracks but it was not negligent for him not to know it at that time. We must not look at the 1947 accident with 1954 spectacles . . ."

In dealing with the second theory of liability advanced by the plaintiffs, namely the cracks in the ampoules, the Court of Appeal held, even if it were assumed that the cracks arose by reason of negligence on the part of members of the hospital staff, such negligence did not cause the injury.

Denning, L. J. commented on the basis of liability as follows:

> "In all these cases you will find that the three questions, duty, causation and remoteness run continually into one another. It seems to me that they are simply three different ways of looking at one and the same question which is this: Is the consequence fairly to be regarded as within the risk created by the negligence? If so, the negligent person is liable for it: but otherwise not . . . instead of asking three questions I should have thought in many cases it would be simpler and better to ask the one question: Is the consequence within the risk? And to answer it by applying ordinary plain common sense. . ."

> "Asking myself therefore, what was the risk involved in careless handling of the ampoules, I answer by saying that there was such a probability of intervening examination as to limit the risk. The only consequence which could reasonable be anticipated was the loss of a quantity of Nupercaine, but not the paralysis of the patient. The hospital authorities are, therefore, not liable for it. When you stop to think of what happened in this case, you will realize that it was a most extraordinary chapter of accidents. In some way the ampoules must have received a jolt, perhaps while a nurse was putting them into the jar or while a trolley was being moved along. The jolt cannot have been severe. It was not severe enough to break any of the ampoules or even to crack them so far as anyone could see. But is was just enough to produce an invisible crack. The crack was the kind which no one in any experiment has been able to reproduce again. It was too fine to be seen, but it was enough to let in sufficient phenol to corrode the nerves while still leaving enough Nupercaine to anaesthetize the patient. And this very exceptional crack occurred not in one ampoule only but in two ampoules used on the self same day and in two successive operations and none of the other ampoules was damaged at all. This has taught the doctors to be on their guard against invisible cracks. Never again it is to be hoped will such a thing happen . . ."

> "One final word, These two men have suffered such terrible consequences that there is a natural feeling they should be compensated. But we should be doing a disservice to the community at large if we were to impose liability on the hospitals and doctors for everything that happened to go wrong. Doctors would be led to think more of their own safety than of the good of their patients. Initiative would be

> stifled and confidence shaken. A proper sense of proportion requries us to have regard for the conditions in which hospitals and doctors have to work. We must insist on due care for the patient at every point but we must not condemn as megligence that which is only misadventure."

For a long time hospitals were considered not to be liable beyond the selection of competent professionals to perform tasks within the hospitals. This attitude was rejected by *Gold*, putting the position of liability on a normal master-servant basis. In *Roe* the Court of Appeal would have held the hospital liable for Dr. Graham's conduct if he had been negligent. Be it noted however, that Dr. Graham was under an obligation to provide a regular anaesthetic service for the hospital in conjunction with the senior anaesthetist, Dr. Pooler. The hospital had set aside a sum of money out of its funds derived from investments, contributions and donations for divisions among the whole of the medical and surgical staff including visiting and consulting surgeons in accordance with the decision of the participants in that fund. Dr. Graham participated in this fund. He, as well, conducted a private anaesthetic practice. Somervell, L.J. would have put Dr. Graham in the same position as the orthopaedic surgeon in Cassidy's case. In other words, he would consider Dr. Graham as part of the permanent staff of the hospital. That being so, *Roe* is unexceptional in the area of vicarious liability because Dr. Graham was held to be an employee of the hospital. As Denning, L.J. held in *Cassidy,* it is not the type of contract with the hospital that matters but who employs the tortfeasor that decides the issue of vicarious liability.

But are notions of employment still valid? The patient who presents himself for an operation at a hospital and who contributes to a hospital and medical insurance scheme by deduction from his pay cheque would no doubt be surprised to learn that he was the employer of the surgeon and anaesthetist who attended him. Whether it is the subjective attitude of the patient, however reasonably held, or the objective basis of the relationship that determines finanical responsibility for negligence is a burden which this article will attempt to discharge.

For the moment let us consider what the law is in Canada.

## THE CANADIAN CASES:

The most recent judgment of the Supreme Court of Canada on the subject of hospital liability is *The Trustees of the Toronto General Hospital-vs. Matthews and Aynsley.*[10]

The reader with a taste for more complete facts should look at the trial judgment of Morand J. reported in [1968] O.R. 427, pages 427 to 436. It is sufficient for the purpose of this paper to state the following facts. The plaintiff, Elizabeth Aynsley, was admitted to the Toronto General Hospital in January, 1962 for the surgical repair of a heart condition referred to as an atrial septum defect, being an opening between the right and left atria of the heart. The operation was scheduled for January 11, 1962. The operation was somewhat complex in that it involved a sidetracking of the blood system to an artificial heart lung pump to permit the heart to be opened up and the opening between the left and right atria closed. The operation, during which the recording of the arterial and venous blood pressure was required, started about 8:55 a.m. The accident giving rise to the lawsuit took place at approximately 9:45 a.m. The operation was of a type known as a "heart lung pump operation". The procedure was pioneered in Canada

10 [1972] S.C.R. 435

at the Toronto General Hospital in the year 1959, and had resulted in the saving of numerous lives.

Prior to the opening of the heart the actual conduct of the operation required the connecting of the venous system of the patient to a monitor to record *inter alia* venous blood pressure in the patient. The recording took place by way of a machine situated in a room next to the operating room and permitted a view to the surgeons conducting the operation through a window. The procedure involved the insertion of a needle into one of the patient's veins. A clear plastic line filled with a saline solution was connected from the hypodermic needle to a machine called a transducer. The plastic line had a total length of approximately five feet, consisting of two pieces each approximately two and a half feet long connected in the middle with a three way stopcock. The transducer was connected to the monitor machine in the adjacent room. In order to obtain the necessary readings the monitor had to be calibrated, which required one of the anaesthetists to pump a machine similar to a blood pressure instrument to a certain height on the scale. The other anaesthetist then calibrated the machine in the adjacent room. Without describing the function of the stopcock in detail, suffice it to say that the plaintiff alleged that one of the anaesthetists was negligent in permitting air to escape from the blood pressure instrument of the transducer and into her venous system.

Mr. Justice Morand made the following findings of fact as to what happened on the morning of the operation:

> "A nurse prepared the plastic line and three way stopcock by assembling them and then filled the line with a saline solution. She then turned the line wrapped in a sterile towel (over) to Dr. Matthews." (Word in brakets added.) "The plaintiff Elizabeth Aynsley at this time had been given an anaesthetic and was unconscious."Dr. Matthews inserted a hypodermic needle in an anticubital vein of the patient. He then connected the plastic line . . . to the hypodermic and to the transducer. He set the three-way stopcock at a position which he thought was a completely closed position . . ."

One of the anaesthetists was privately employed by and responsible to the infant plaintiff while the other was an employee of the hospital assigned to assist the senior anaesthetist and under his direction.

After having connected the line the senior anaesthetist (Dr. Matthews) connected the monitor to the transducer.

After telling his assistant (Dr. Porteous) that they would calibrate the monitor, Dr. Matthews went into the next room where the monitor was located.

Dr. Porteous was at the head of the patient where the transducer and manometer (blood pressure instrument) were located.

To calibrate the monitor it was necessary to pump the manometer to a pressure of 30 on the scales. While Dr. Porteous pumped the manometer up to 30 Dr. Matthews was to calibrate the monitor. According to the evidence two or three very light squeezes of the manometer bulb are required to bring the pressure up to 30. Upon a signal from Dr. Matthews, the pressure was so pumped by Dr. Porteous. The pressure in the manometer, however, fell back to zero. The procedure was followed again either once or twice by Dr. Porteous and then Dr. Matthews returned to the operating room and according to the evidence of Dr. Porteous, pumped the manometer button several times. The surgeons reported they could hear air in the heart of the patient and she suffered a cardiac arrest. She was kept alive by emergency procedures.

Evidence diclosed that the three-way stopcock was allowing air to go from the manometer to the patient.

After the event Dr. Matthews noticed that the valve on the stopcock was not at the 45° angle but slightly off, which according to evidence indicated that air could leak through the stopcock.

The Judge found that Dr. Porteous, had he been looking, would have been able to see the air going through the line to the patient.

On the basis of the decision in *Roe* counsel for Dr. Matthews submitted that the danger likely to be produced by the closeness of tolerance of the three-way stopcock was not known to the doctors and therefore Dr. Matthews should not be found liable.

Morand J. then went on to discuss the activities of Dr. Matthews and Dr. Porteous and found both liable. At page 438 and following of the report of the trial judgment Morand J. states:

> "The sole remaining question to be dealt with on negligence, was whether or not Toronto General Hospital is liable for the negligence of Dr. Porteous. Counsel for the hospital placed great stress upon the fact that there is no reported decision in England or Canada where a hospital has been held liable for the acts of nurses, interns or residents while assisting in the operating room, where the surgeon or anaesthetist has been privately employed by the patient and control is that of the private surgeon. I am satisfied, however, that in this particular case Dr. Porteous was an employee of the hospital and the hospital should be held vicariously liable for the negligence of Dr. Porteous. Dr. Porteous was not a mere intern - an unskilled person who was carrying out an order of a skilled trained person - but a highly skilled trained anaesthetist who was assisting Dr. Matthews in the necessary calibrating of the monitor. While under the orders of Dr. Matthews, he was to carry out these orders in a manner consistent with his training. As I have stated before, this he did not do. Since in my view, he was an employee of the hospital and supplied as part of its services to the patient, even though under the direction of Dr. Matthews, I hold that the hospital is vicariously liable for his negligence.
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> "Many cases were cited to me dealing with the vicarious liability of a hospital for a doctor. Without dealing in detail with all of these cases, it would appear that the basis for the statement that hospitals are not liable for negligence of doctors in mainly founded on the case of *Hillyer* v. *Governors of St. Bartholomew's Hospital*... In my view, the cases of *Cassidy* v. *Ministry of Health* ... and *Gold* v. *Essex County Hospital* . . . clearly distinguish the *Hillyer* case and place the question of vicarious liability of a hospital for a doctor's negligence in the same position as all other cases of vicarious liability."

Morand J. then goes on to deal with the question of whether the direction and control of Dr. Porteous which had been turned over to Dr. Matthews was sufficient to relieve the employer of Porteous from liability, and citing *Mersey Docks and Harbour Board* v. *Coggins & Griffiths (Liverpool) Ltd.*[11] held that Dr. Porteous's negligence arose out of his employment with the hospital in that he failed to exercise a reasonable degree of professional skill in the conduct of his duties and that the hospital was vicariously liable.

The judgment was appealed to the Court of Appeal for Ontario.[12].

Aylesworth, J.A. in giving the unanimous opionion of the Court of Appeal, agreed with Morand, J. that Dr. Matthews and Dr. Porteous had both been guilty of negligence in causing injuries to the plaintiff.

The Court of Appeal refused to interfere with the apportionment of fault by Morand, J. which had been 60% to Dr. Matthews and 40% to Dr. Porteous.

11. [1947] A.C. 1
12. [1969] 2 O.R 829.

Commencing at page 836 of the report, Aylesworth, J.A. comes to grips with the point concerning us. He states:

> "I now turn to the most troublesome and, as a matter of general application, by far the most important aspect of the appeal, namely, the position of the Toronto General Hospital on the facts of this case concerning the negligence of Dr. Porteous.
>
> "There would appear to be no decision either here or in England fastening liability upon a hospital for negligent performance of their duties by either physicians or nurses during the course of an operation. As will be seen there are decisions as to negligence committed by such individuals outside of the operating room; they reveal a confusing complexity of views as to the true basis of liability for such acts. For the purposes of the present appeal it will be necessary to refer to a few only of those decisions.
>
> "One should begin with the famous *Hillyer* case — in many respects the very font and origin of the jurisprudence on this subject ... I do not consider it helpful in the case at bar to attempt to analyse the *Hillyer* decision in detail, particularly in view of what was said about it by the Supreme Court of Canada in the *Sisters of St. Joseph of Diocese of London in Ontario* v. *Fleming*[13]. In that case the plaintiff was admitted as a patient to the defendant's hospital under a contract for board, nursing and attendance. Defendants maintained and operated for profit in the hospital an equipment for diathermic treatments. Plaintiff's physician order the nurse supervising the floor on which plaintiff was located to see that he was given such a treatment and the treatment was given by a nurse who was a permanent member of the hospital staff and in charge of such treatments. The plaintiff was severely burned and alleged that the burn was caused by the negligence of the nurse. He recovered upon this ground. The judgment was affirmed by this Court [1937] O.R. 512, and the appeal from this Court to the Supreme Court of Canada was dismissed. Davis, J. who delivered the judgment of Duff, C.J., Davis, Kerwin and Hudson, JJ. after extensively reviewing the *Hillyer* case, and subsequent cases criticizing, distinguishing or limiting its application, had this to say concerning the *Hillyer* case . . .:
>
> > 'The statement of Lord Justice Kennedy in Hillyer's case as to the difference between ministerial or administrative duties, on the one hand, and matters of professional care or skill, on the other hand, is entitled to great weight and respect, but even the decision in the case is not binding upon this Court.' "

Aylesworth, J.A. then quotes the further statement of Davis, J. in Fleming's case about the judgment in *Hillyer:*

> "After the most anxious consideration we have concluded that, however useful the rule stated by Lord Justice Kennedy may be in some circumstances as an element to be considered, it is a safer practice, in order to determine the character of a nurse's employment at the time of a negligent act, to focus attention upon the question whether or not in point of fact the nurse during the period of time in which she was engaged on the particular work in which the negligent act occurred was acting as an agent or servant of the hospital within the ordinary scope of her employment or was at that time outside the direction and control of the hospital and had in fact for the time being passed under the direction and control of a surgeon or physician, or even of the patient himself. It is better, we think, to approach the solution of the problem in each case by applying primarily the test of the relation of master and servant or of principal and agent to the particular work in which the nurse was engaged at the moment when the act of negligence occurred."

Aylesworth, J.A. then (at page 839) proceeds with this statement of his own:

> "I respectfully adopt that principle as binding upon this Court and in the statement thereof by Davis, J., I perceive no limitation of the application of the principle to acts by a nurse outside the operating theatre or not committed by her during the course of an operation. While it well may be that a nurse is seldom, if ever, while acting in course of an operation, to be considered for the time being as an employee of the hospital, that is a question of fact in each case and does not impinge upon the principle itself. I also conclude that by analogy, at least, the same principle applies to a physician or surgeon, not only outside of the operating room but within it and that

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13 [1938] S.C.R 172

in each case it is a question of fact to be determined whether or not the physician or surgeon, a member of the staff of the hospital and, generally speaking, an employee of that hospital is at the time of the commission of the act complained of, an employee of the hospital or acting in a different capacity. Certainly for all that was said in the *St. Joseph* case, it is open to this court so to decide."

Aylesworth, J.A. then goes on to deal with the decisions which he refers to as being of "persuasive significance" decided by the Court of Appeal, namely *Gold, Cassidy* and *Roe.*

At page 844 and following Aylesworth, J.A. then makes this statement:

"The cases under review both in this country and in England make it clear, I think, that the liability of a hospital for the negligent acts or omissions of an employee vis-a-vis a patient, depends primarily upon the particular facts of the case, that is to say, the services which the hospital undertakes to provide and the relationship of the physician and surgeon to the hospital. The introduction into England of nationalized medicine probably has greatly altered the factual situation in that country with respect to the enquiries I have just mentioned, but each case there, I take it, will turn upon its particular facts. Similarly, I think in Ontario vicarious liability will be driven home to the hospital or plaintiffs will fail in the attempt, depending upon the peculiar facts of each case.

"In this regard, I cannot refrain from observing that the more modern cases in England at the appellate level would seem to be drawing ever nearer to the principle, so far as nurses are concerned, enunciated in the Supreme Court of Canada in the *St. Joseph* case and, as I have already said, in my view it is open to this Court to apply those principles expressed as to nurses, to physicians and even to physicians in the operating theatre."

In proceeding to dispose of the appeal Aylesworth, J. A. stated:

"What then was the relationship between Dr. Porteous and the hospital? Dr. Porteous, as has been noted already, was a highly skilled, trained anaesthetist - a specialist with several years experience in this his chosen line of work. As such he was a full time member of the hospital staff, paid by the hospital, and assigned by the hospital to assist from time to time consulting anaesthetists in the operating rooms of the hospital. The equipment was supplied by the hospital and a charge was made to the patient for the use of the operating room; in other words, the hospital undertook to furnish to the patient as part of the hospital service an operating theatre, the required equipment in good order and the services free from negligence of a properly qualified assistant to the patient's anaesthetist. A perusal of the medical evidence makes it abundantly clear that in the type of operation under review the safety of the patient and the success of the operation required the participation of two anaesthetists; it was of necessity a team effort, each anaesthetist had many tasks to attend to individually and concurrently with the other anaesthetist. While the senior, Dr. Matthews, was in charge and control in the sense that he could and did either assign or decide upon the divison of the work, he could not and did not control everything Dr. Porteous was required to do or his manner of doing it; each of them of necessity acted in many tasks on his own responsibility and judgment. One such task, it is plain, was the manometer end of the calibrating procedure attended to by Dr. Porteous in the operating theatre proper while Dr. Matthews, in another room, "calibrated" the monitor. The negligence of Dr. Porteous, in my view, was a failure by the hospital staff itself to discharge efficiently its undertaking to the patient and I would allow the judgment against the hospital to stand; he was, I think, under the contract of service with the hospital but, in my view, the legal result would be the same if his had been a contract for services. In addition to what I have already said on this subject, I wish to concur in the following observations taken from the reasons for judgment of the learned trial Judge . . .

'Dr. Porteous was . . . a highly skilled trained anaesthetist who was assisting Dr. Matthews in the necessary calibrating of the monitor. While under the orders of Dr. Matthews, he was to carry out these orders in a manner consistent with his training . . . Since, in my view, he was an employee of the hospital and supplied as part of its services to the patient, even though under the direction of Dr. Matthews, I hold that the hospital is vicariously liable for his negligence.'

'In the case in question, Dr. Porteous was directed by Dr. Matthews to assist in calibrating the machine, but it was in the pumping of the manometer as part

> of his duties as an assistant anaesthetist employed by the hospital that Dr. Porteous was negligent and this was done while Dr. Matthews was in the next room.'
>
> 'In the instant case, however, Dr. Porteous was obviously expected to use his training and abilities aside from following direct orders of Dr. Matthews. Since the calibration required Dr. Matthews to be out of the room and out of view of the action of Dr. Porteous at the time he, Dr. Porteous, pumped the manometer, it appears clear to me that Dr. Porteous would be expected to use professional skill in the manner in which the manometer was pumped. This, in my view, he failed to do and as a permanent employee of the hospital, the hospital is vicariously liable for his negligence.' "

The Court of Appeal therefore dismissed the appeal of both Dr. Matthews and of the hospital.

On appeal to the Supreme Court of Canada[14] the sole question was the vicarious liability of the hospital for the negligence of Dr. Porteous. The Supreme Court unanimously dismissed the appeal and approved the statements of Davis, J. in *Fleming* and of Aylesworth, J.A. referred to above. It is interesting to note that Davis, J. in *Fleming* was a harbinger of things to come in England. It was not until 1942 that the Court of Appeal in *Gold* also turned its back on the decision in *Hillyer's* case.

The decision of the Supreme Court in Canada in *Aynsley* may be regarded as the most recent authoritative decision in Canada on the liability of hospitals.

But what does it actually decide?

We come back to these two statements:

(a) That of Davis, J. in *Fleming:*

> ". . . It is better, we think, to approach the solution of the problem in each case by applying primarily the test of the relation of master and servant or of principal and agent to the particular work in which the nurse was engaged at the moment when the act of negligence occurred." and

(b) Of Aylesworth, J. A. in Aynsley:

> ". . . I perceive no limitation of the application of the principle to acts by a nurse outside the operating theatre or not committed by her during the course of an operation . . . I also conclude that by analogy, at least, the same principle applies to a physician or surgeon, not only outside of the operating room but within it and that in each case it is a question of fact to be determined whether or not the physician or surgeon, a member of the staff of the hospital and, generally speaking, an employee of that hospital is, at the time of the commission of the act complained of, an employee of the hospital or acting in a different capacity . . ."

The law in Canada is therefore the same as it was in England when *Roe* was decided. The test for the determination of the liability of a hospital therefore depends upon the factual determination of the relationship of the negligent person to the hospital at the time the injury is caused. If the person guilty of negligence is either the servant of the hospital acting within the course of his employment or the agent of the hospital acting at the time within the scope of his authority, the hospital will be vicariously liable.

R. R. Brock

Winnipeg, Manitoba.

September, 1974.

14. [1972] S.C.R. 435.