

Indexed as:

**Williams (Litigation Guardian of) v. North York General
Hospital**

Between

**Javon Williams, by his Litigation Guardian Judy Williams, and
the said Judy Williams, Plaintiffs, and
North York General Hospital, Dr. M. W. Schacter, Dr. C. B.
Edmonds, Dr. S. Comay, Dr. G. Doodnaught, Dr. R. Munn, Dr. N.
Forman, Dr. J. Bain, Dr. G. Eckert, Dr. K. O. Chan, Nurse
Anita Brenner, Nurse Patricia Forrestall, Nurse Carole Dueck,
Nurse, J. Mitchell-Bain, Nurse D. Wooley, Nurse Valerie
Johnston, Nurse Kathi Kerr, Nurse Mildred Rowe and Nurse Nancy
Thompson, Defendants**

[1993] O.J. No. 1721

**Ontario Court of Justice - General Division
Toronto, Ontario**

Van Camp J.

Heard: September 7-22, 1992.

Judgment: July 22, 1993.

(22 pp.)

Medicine -- Medical malpractice -- Negligence -- Standard and duty of care -- Nurse -- Whether defendant doctors exercised standards of professional competence required of specialists in their field -- Failure to properly monitor patient after surgery.

Action for damages for negligence and a cross-claim. The infant plaintiff was admitted into the defendant hospital where C performed a tonsillectomy, adenoidectomy and myringotomy. The anaesthetic was administered and monitored by G. Following surgery, the infant was taken to the tonsil suite for recovery and was later found unconscious with a faint heart beat. As a result, the infant suffered brain damage and remained in palliative care, with no hope of complete neurological recovery. The defendant hospital admitted that there had been negligence on the part of the nurses.

The only issue for the court to decide, whether there was negligence on the part of the two named doctors which caused or contributed to the injury of the plaintiff child.

HELD: The cross-claim was dismissed. Each of the defendant doctors brought to his task a reasonable degree of skill and knowledge and exercised a reasonable degree of care. The doctors also exercised the standards of professional competence required of specialists in their fields. It was the failure of the nurses to observe and assess the importance of the signs and symptoms observed after admission to the tonsil suite and primarily those following the administration of the codeine that caused the damage.

Richard **Sommers** and Robert Roth, for the Plaintiffs.

James A. Sawers, for the Defendant hospital and nurses.

R.G. Slaght and Catherine M. Patterson, for the Defendant doctors.

1 VAN CAMP J.:-- On March 13, 1985, the infant plaintiff, born October 27, 1983, was admitted to the defendant hospital where Dr. Edmonds performed a tonsillectomy, adenoidectomy and myringotomy with insertion of aeration tubes in both ears. The anaesthetic was administered and monitored by Dr. Doodnaught. Following surgery the infant was taken to the recovery room at 9:45 a.m. and from there at 10:45 a.m. to the tonsil suite, a small room forming part of the paediatric unit. At 2:55 p.m. the infant was found unconscious with a faint heart beat, no respiration and blood oozing from the nostrils. The resuscitation unit was called and an airway established. The infant was transferred to the Hospital for Sick Children at 5:10 p.m. in a deep coma. I accept the evidence that the infant suffered brain damage, that there had been respiratory arrest followed by cardiac arrest. In such a combination there is seldom a complete neurological recovery. The infant has remained in palliative care from June, 1985, to the beginning of trial.

2 The plaintiffs withdrew their jury notice. The damages were agreed upon. At the opening of trial the plaintiffs withdrew the claim against the doctors. At the conclusion of the plaintiffs' case counsel for the nurses admitted that there had been negligence by the nurses. Under approved minutes of settlement judgment was recovered against the defendant, North York General Hospital. The action against all other defendants was dismissed except that the crossclaim of the North York General Hospital against the defendants Dr. C. B. Edmonds and Dr. G. Doodnaught was allowed to proceed.

3 That judgment bears no resemblance to the decisions considered in *Wall v. Radford*, [1991] 2 All E.R. 741, and *Nottingham Health Authority v. Nottingham City Council*, [1981] W.L.R. 903 and expressly does not estop the crossclaim herein. The remaining issue then is whether there was negligence on the part of the two named doctors which caused or contributed to the injury to the

plaintiff child. Before considering any negligence of the doctors it is helpful to review the negligence of the nurses.

4 I find that the cardiac arrest followed the respiratory arrest. The negligence of the nurses consisted in part in the failure to properly monitor and diagnose the signs and symptoms in the period following the operation up to 2:00 p.m. The Registered Nursing Assistant (RNA) noted that the vital signs were stable but remained elevated; that the infant was taking fluids poorly; was slow to swallow; that there were signs of pain. Eighteen milligrams of codeine had been administered at 9:55 a.m. in the recovery room. Dr. Edmonds had authorized 18 milligrams of codeine every four hours as the circumstances required. Such an order did not permit the nurse to prescribe more or less than the 18 milligrams, but left it to her judgment as to whether it should be given. Medication is given by the nurse, not by the RNA, who went out to the nursing station to advise the Registered Nurse (RN) that there was pain and that the codeine was due. As designated team leader for the day the RN makes the decision as to medication for the entire paediatric unit when told by the RNA that medication is needed or that there are problems. In this case, as usual, the RN checked the doctor's orders and the entry as to the last administration of the drug. She looked to see how alert the child was, whether there was any outward sign of bleeding and checked his respiration by a head to toe assessment which might seem casual to onlookers. In her opinion the fact that the child was not taking fluid did not require her to call the doctor, who was available. Neither the RNA nor the RN examined the throat at the time the codeine was administered. The RNA thought that she was not expected to examine it. The RN said that it was not the policy of the hospital to look at the throat and she would not have looked as there was not reason for concern about bleeding. I find that the major factor causing the respiratory arrest was the administration of the codeine at 2:25 p.m. by the RN, given the signs and symptoms that breathing was in difficulty. Codeine should have been known to the nurses to depress the ability to breath. The nursing records show that breathing was compromised; the respiration had increased from the prior 32 to 40. Codeine in the circumstances herein would bring about respiratory arrest.

5 The third aspect of negligence by the nurses was the failure to monitor after codeine had been given. The RN did not know that codeine acted as a depressant. The RNA had left the infant to sleep as the pain would be relieved. The general medical evidence was that the child should have been monitored after the administration of codeine every 15 minutes, every 5 to 10 minutes, every 2 minutes. I accept the evidence of Miss Nicholson that codeine itself would not have put the infant "over the edge". It was the effect on the existing respiratory problem that did. It should not have been left to the RNA to recognize the increased need to monitor when codeine was given; the instructions should have been given by the RN.

6 In this case, the RNA was experienced in the care of children. By 1985 she had cared for about 800 children who had had these combined three operations. She had worked with Dr. Edmonds. The average age of the children in her care was 3 to 13 years of age. She could not recall one as young as the infant herein. She impressed me as a very competent person. The tonsil suite had five beds of which only four were filled. Her desk is in the middle so that she can see each child and check if

there is any strange noise. The beds are within 8 to 10 feet. Some 30 minutes after giving the codeine the RNA, who was talking to the parents of another infant in the room about 6 to 8 feet away from the plaintiff infant, realized that she no longer heard any noise of congested respiration. It was her evidence that she went as soon as she heard the change; found blood oozing from the nostrils; there was a patch about the size of a dollar coin on the sheet; the limbs were flaccid; the infant was unconscious; there was not respiration and only a faint heart beat. She began mouth to mouth respiration, rang the emergency bell and the arrest unit came at once.

7 The RNA had been trained to watch for the signs of haemorrhaging, excess swallowing and any increase in the vital signs. In this case her concern was the age and any rise in temperature. Her function was to provide careful care and observation of children who had undergone a tonsillectomy or adenoidectomy procedure. Her role in the tonsil unit was to recognize any respiratory, cardiovascular or haemorrhaging problems. The critical time for this was after the operation as it represented danger to the patient. Dr. Edmonds would have been aware of her role when he attended upon the patient at 1:00 p.m. He was entitled to expect that any such signs would be reported to him and none were.

8 The medical witnesses called with respect to the negligence of the doctors were two anaesthetists, Dr. Fisher and Dr. Lerman, three otolaryngologists, Drs. Freeman, MacRae and Friedberg, a staff paediatrician and toxicologist, Dr. Koren, and the recent Chief of Staff and Medicine at Scarborough General Hospital, Dr. Gorman. They were working with hindsight on what was not a normal case to try to define for the court what the defendant doctors should have done and what caused the brain damage, and their opinions differed on the several questions raised.

9 The first question raised by counsel for the nurses in the crossclaim is whether the doctor and the anaesthetist should have decided to perform the triple operation.

10 Dr. Lerman noted the difficulty in the treatment of a child from that of an adult. The three systems, respiratory, heart and blood, are not just smaller but differ in function as the child develops. The airway is smaller and shorter and the narrowest part cannot be seen as it is below the narrow vocal chords. A child will not struggle to continue breathing.

11 There seems little question as to the myringotomy and even the operation on the adenoids but as early as 1985 there were questions raised about tonsillectomies because of the bleeding that accompanied them. I find that each of these two doctors have the skill and knowledge of his respective specialist class. Dr. Edmonds, who had received his medical degree in 1962, had been the Chief of the Department of Otolaryngology at North York General Hospital from 1975 to 1984 and has continued to have staff privileges. In addition, he was a lecturer at the University and had a weekly clinic teaching residents. That hospital was a general hospital but it also had a paediatric hospital attached to it. Dr. Doodnaught is fully qualified as an anaesthetist. He had been at North York General Hospital since 1982, where a large part of his practice was paediatric.

12 Dr. Edmonds had seen the infant plaintiff at his clinic on February 27, 1985. The child had

been referred to him by the family doctor. The history given by the mother to Dr. Edmonds was one of recurring ear and throat infections, of noisy breathing at night, and of breathing through his mouth most of the time. Antibiotics for the problem had been given from time to time. There was also the question as to whether he was hearing properly. He was otherwise well in the opinion of the mother.

13 On his examination Dr. Edmonds had found fluid in the middle ear spaces with discoloured tympanic membranes on both sides; the anterior nasal passages were filled with mucus; the tonsils were enlarged and showed signs of chronic infection. There were also signs of some moderate bilateral cervical adenopathy. The hearing tests showed hearing loss on both sides. There was need, then, for the surgical incision of the ear drums (myringotomy) to permit the fluid from the middle ear to escape. The bilateral serious otitis (inflammation of the ear) also gave cause for the operation on the adenoids to prevent obstruction of the inner ear; to assist the problem of the noisy breathing at night and the breathing through the open mouth; the runny nose and the use of the antibiotics for cold symptoms.

14 Three days before the operation the child was examined again. The tonsils were found to be enlarged but not inflamed. The enlarged tonsils could also account for the noisy respiration.

15 Dr. Edmonds saw this report by the locum for Dr. Shackter as he wanted confirmation of what he had been told by the mother and also the examination to show that the child was fit for the operation. On the morning of the operation the temperature was slightly elevated (37.9; 38 would be unacceptable) but was expected from a child with ear and chronic tonsillitis problems. The pulse and weight were satisfactory for his age. The respiration was very slightly elevated. There was no visible shortness of breath. The child was active that morning. The significant reason for the operation was the obstruction of the respiration with its long-term effects. The tonsils were removed quickly to minimize the bleeding; the doctor used a special medicated pack to stop the bleeding immediately and to prevent constriction in the throat. What saliva and blood was there was suctioned out to a calibrated cylinder where the fluid from the ear was also suctioned.

16 It was his practice after the operation to satisfy himself by looking to see that there was no significant bleeding and checking how much had been suctioned out. Dr. Edmonds said that the majority of those whom he sees with tonsil problems do not go to surgery. Those under three years of age are a minority and one operates only if one has to. He recognized that in 1985 there was much controversy as to whether one should perform a tonsillectomy. It was his evidence that he did not do the operation because of the recurrent tonsillitis. The problem here was the significant respiratory obstruction. There was not necessarily an urgent reason for the operation; there was no malignancy, no malocclusion from the open mouth, no shortness of breath. He recognized the problems of operating on a child under three because a loss of blood would be serious when there is such a small blood volume. Moreover, the child is unable to understand, to cooperate or to report. When there is a significant loss of volume of blood the whole system closes down to compensate. There will be capillary loss over several days but what one looks for is the arterial bleeding as the

tonsils and adenoids are a potential source of excess bleeding.

17 Dr. Edmonds did not expect any complications as the child seemed fit and healthy on that day. There was no infection in the ears, no acute tonsillitis. The operation was necessary to eliminate the continued use of antibiotics and continuing infection, the problems for which his doctor had referred the child. In addition the noisy breathing suggested some occlusion, some trouble in getting oxygen and there was the need for the incision of the ear drum to permit the pressure to escape. The reasons were there for the adenoidectomy and for the insertion of the ear tubes which are usually done at the same time. If it had been a question only of a tonsillectomy, the usual indications for such in a child of this age were not present but the report by the child's doctor that the tonsils, though not inflamed, were enlarged, together with the noisy breathing, would support the decision to have that operation when the other operations were taking place in the same area.

18 Dr. Koren, a staff paediatrician and pharmacist who was called with respect to the codeine, would not have submitted a child of this age to this combination. He had never seen such a child but recognized that one looked at the individual child and that there could be occasion for such a combination.

19 The evidence of Dr. Koren was that it was usual to do a tonsillectomy at the same time as an adenoidectomy and that the history of this child could support the need for a tonsillectomy when another operation was being done at that time. The haemoglobin level would not be a major threat to oxygenation although it was the low side of normal and, although there was a somewhat elevated temperature, those are not uncommon. They are not ominous signs; they may become so only if there is a subsequent obstruction. In summary, there was no preexisting condition that would predispose the child to what occurred.

20 Dr. Koren concluded that the cause of the brain damage was respiratory arrest from the accumulation of carbon monoxide when not breathing quickly enough to compensate for some occlusion. The classic signs showed the increased effort to get oxygen to the brain. He found no evidence of profound shock.

21 Dr. Lerman saw no reason to postpone the combined operations and Dr. Friedberg would have done them with such a history of upper airway obstruction. Dr. Freeman an otolaryngologist was not sure whether he would have operated but would have insisted on an I.V. in the immediate postoperative period and post-operative monitoring because of the preoperative factors of age, temperature and low blood volume, and the usual overnight lack of liquid. His assessment of the temperature, the normal of which would be in his opinion 37 degrees but which varies in hospitals, was an indication to him of a pending or present infection with an increased blood flow to the area. He accepted that the rectal temperature of the child might be somewhat higher. He agreed that there were two schools of thought about the decision that would be made on the basis of the preoperative condition. In cross-examination he said that a temperature of 37.9 might perhaps indicate infection or nothing at all.

22 It was the evidence of Dr. MacRae, who had done about 2,000 of these combined operations, that 16 months was young for a tonsillectomy, although not for the other operations. The decision as to a tonsillectomy in 1985 was controversial. One would have expected some four to five incidences of tonsillitis in the prior year before one would elect at this age to avoid any repetition. He would have expected a more recent taking of the haemoglobin level within seven days of admission rather than two weeks before. He recognized that a sickle cell test had been given for this child and the negative test here indicated much less risk of a fast dehydration and less oxygen.

23 Dr. MacRae said the negative sickle cell test made it more likely that the child would run the normal course. I respected the care and experience in his opinion that there was not negligence by the doctors in the medical sense. There were a range of standards given the information they had. It was a judgement call as to whether there should be three operations; some would reasonably proceed after seeing that it was likely to be done later.

24 One of the other factors in the decision to operate is said to be the failure of the anaesthetist to inspect the prior records of the child. He had seen the child running around as he entered the hospital, had reviewed the questionnaire made by the admitting nurse, the history given by the physician and the check list used by the operating room nurse. He had noted the temperature, pulse and respiration rate and the weight, and as a result thereof he recorded the fitness as the top level of classification I. He had noted that there had been no reactions from a prior hernia operation. He had acted as an anaesthetist in this combination of three operations before; had recognized the risk of complications in the younger child who was more prone to be affected by changes, and he had taken into account the risk of the tonsillectomy operation with its risk of bleeding.

25 He had not looked at the chart of the October 1984 double hernia operation which showed an ASA classification of II by another anaesthetist, now deceased, indicating a higher risk level at that time. At both times the temperature was at the upper limit of the range for one to three year olds. In 1984 the pulse rate had been higher. On the information recorded in 1984 Dr. Doodnaught would have given a classification of I. The classification II would indicate a mild systemic disease but none such was seen at the time of this operation. The risk of bleeding depends on the signs of temperature and infection but at this time there was no sign of infection in the tonsils nor in the fluid in the ears. On the evidence I can see no indication of negligence in the preoperative examination.

26 The question was raised as to whether this child had been dehydrated, which leads to a reduction in the blood fluid and the supply of oxygen to the brain. The history had shown that the last food and fluid had been taken at midnight, which is not unusual. The nurse's report showed that the infant had voided before the operation. No I.V. was used by the anaesthetist during or after the operation. Dr. Doodnaught used a butterfly tube for the anaesthetic which would have permitted the use of I.V. if required and which with a syringe gave some fluid, 20 to 40 cubic centimetres, though not enough to reverse any deficit. He saw no reason to continue, so took the butterfly tube out before the child went to the recovery room. The child remained there for one hour at the end of which time he appeared alert and orientated. The anaesthetist had taken him to the recovery room

and had probably been back at least once. He could have given an I.V. at any time while in the recovery room but there was no concern expressed. After the transfer to the tonsil suite the child had been given bits of popsicle and had voided again. He continued to take fluids fairly well until sometime between 1:00 and 2:00 p.m.

27 Dr. Freeman agreed that it was not routine in 1985 to start with an I.V.; the decision would be made in the immediate post-operative period, but in this case he would not wait and would supplement until the child was drinking. His opinion was that on the factors before him there was perhaps a post-operative mild dehydration. Given the age of the child he thought there should have been a little more concern.

28 Dr. MacRae said that age alone would not influence a decision as to I.V. fluid but there was the age combined with the over-night period without food which is long for that age, and the tonsillectomy required extra time without fluid. Dehydration affects the cardiovascular system, the pulse, the blood pressure and possibly the respiratory rate. He would have ordered the I.V. after the surgery and a documentation of intake and output and tylenol instead of codeine for pain.

29 In 1985 the use of I.V. in the operating rooms was standard in many centres but others did not use it; some would at the end of the surgery, although it was not a universal practice. One could follow to the recovery room and see if the I.V. were needed. In this case the temperature came down by the time they reached the recovery room. A very capable nurse was in the recovery room and on her evidence one would be reassured as to no need for I.V.

30 It was the opinion of Dr. Friedberg that it was not routine in 1985 to administer an I.V. and in his opinion there was no indication that it should be done. It was also the opinion of Dr. Lerman, the anaesthetist in Chief of the Hospital for Sick Children, that there was no reason in this case to administer fluids.

The Blood Loss:

31 The temperature on admission could possibly suggest an upper respiratory infection which would lead to increased bleeding over and above that expected from the tonsil operation. Dr. Lerman said most will bleed after a tonsil operation but in varying degrees. I accept that the circulating blood for this infant would be about one litre or one thousand cubic centimetres. Both nurses attending the operation said that it was a normal operation without complications and no excessive bleeding. The blood loss was recorded in the calibrated cylinder as 70 cc. (The other fluids suctioned out would form only a small part of that). Dr. Lerman said that 30 to 40 per cent could be foam with air in it. I accept that the reading would cause no concern. In addition, there would be a loss of blood volume from dehydration over the 9 hours before the operation. The voiding in the recovery room and the child standing up are indications that any dehydration was not severe. The nurse had noted that at noon he was warm to touch and at the time of arrest his lips were pink, which would indicate no problem with circulation. Dr. Fisher computed the loss over the 9 hours at 416 millilitres for a child of this weight, of which one-third or 130 would be

intravascular. The total, then, would represent a 20 per cent loss. Dr. Lerman's calculation for this child of deficit from the 9 hours was 375 millilitres but a drink at midnight would have been absorbed and lessen the deficit. Dr. Doodnaught said that fluid 9 hours before would lessen the deficit of 410 cubic centimetres from dehydration to 260, of which only one-quarter is intravascular, so that there would not even be mild dehydration. Dr. Lerman would find a loss of over 10 per cent significant. The signs of a lowered oxygen level can happen quickly but a child may compensate even at 17 per cent. Dr. Fisher said the range of loss during the operation would be 30 to 80 cubic centimetres; 70 was acceptable. A loss of 23 per cent of blood volume would lead to a state of shock and cardiac arrest as the organs shut down or respiratory arrest or both. Dr. Gorman disagreed, as children's blood vessels react quickly. He thought that a 23 per cent loss would not put in shock and stop the breathing. Dr. Fisher had said 20 per cent, and noted that there would be shock if further loss. Over 10 per cent the heart rate is up and the blood pressure falls but a healthy child can compensate. Dr. Friedberg had thought 70 cubic centimetres of loss during the operation was somewhat higher than average for this age but it would not indicate there would be subsequent bleeding.

32 In addition there had been found a spot of blood on the sheet about the size of a loony coin and some oozing from the nostrils at 2:55 p.m. The notes of the nurse indicated that there was no sign of bleeding before 10:45 a.m. In Dr. Friedberg's opinion, the bleeding would have begun about one-half to one hour before the arrest when the note showed that the vital signs, though stable, remained elevated and he was taking fluids poorly and appeared to be in pain.

33 The question remains whether there was an additional loss through bleeding as shown from an analysis of the contents of the stomach. It was the opinion of Dr. Friedberg that the 200 millilitres of the contents described as the coffee ground material would be most unlikely to be all blood; probably one-half. It would be a marked blood loss when added to the 70 cc. lost during the surgery and it could stress the patient to some form of cardiac embarrassment. Dr. Gorman said the description normally relates to some blood loss. A small amount of blood is expected and would give a lot of stain and coffee ground description. Dr. Korman had agreed. He said excessive amounts of blood would have caused vomiting. Dr. Fisher said that the blood in the 200 millilitres of coffee ground material would be some of the loss during the operation but would be mainly post operative loss of blood. It was referred to as old blood. Some could be gastric fluid but there had been no food for some time. A few clots of blood could clump in the gastric fluid but would not colour all the material and would not merit this description of coffee grounds. Dr. Edmonds said that a small amount would give a coffee ground appearance. The problem is that none of these witnesses saw the material and they are giving the evidence on the basis of someone's use of the word "coffee grounds".

Credibility:

34 This case has meant not so much a finding of fact but rather an assessment of the respect that should be given to the differing opinions on the facts that are recognized. There is no question of the

qualifications of the different medical witnesses. I looked rather at the nature of their experience. Dr. Gorman was careful in his evidence to state that his patients were adult patients; his interests in medicine had been in the field of diabetes; he would not give opinions on the fields in which he did not have experience. Dr. Koren's interest has been as a paediatric pharmacist and toxicologist with a special interest in the affect of drugs on children. Dr. Freeman's work has been as a professor in clinical work and research as an otolaryngologist. He has been at Mount Sinai Hospital since 1980 and an assistant professor at the University of Toronto for that period. His publications have been in the fields of thyroid, plastic surgery and cancer. His specialty is an otolaryngologist. Both he and Dr. Fisher lost somewhat of their authority in the course of cross-examination. Dr. Fisher has been the anaesthetist in chief at Mount Sinai Hospital from 1990. Both Dr. Friedberg and Dr. Lerman were experienced and knew their fields of otolaryngology and anaesthesia but I looked carefully at their evidence because of their complete self confidence as witnesses in a matter where there was room for respect of the other witnesses. I make these comments with the knowledge that all of these witnesses were trying to be as helpful as possible in a difficult matter.

The Standard of Care:

35 In *Wilson v. Swanson*, [1956] S.C.R. 804 at p.817, Abbot J. said:

The test of reasonable care applies in medical malpractice cases as in other cases of alleged negligence. As has been said in the United States, the medical man must possess and use that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases, and it is the duty of a specialist such as appellant, who holds himself out as possessing special skill and knowledge, to have and exercise the degree of skill of an average specialist in his field: ...

36 In the cases cited by Mr. Justice Rand there is the statement that he is not to be judged by the result nor is he to be held liable for an error of judgement. His negligence is to be determined by reference to the pertinent facts existing at the time of his examination and treatment of which he knew or in the exercise of due care should have known. At p.811, Rand J. said:

What the surgeon by his ordinary engagement undertakes with the patient is that he possesses the skill, knowledge and judgment of the generality or average of the special group or class of technicians to which he belongs and will faithfully exercise them. In a given situation some may differ from others in that exercise, 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.

There is here only the question of judgment; what of that? The test can be no more than this: was the decision the result of the exercise of the surgical intelligence professed? Or was what was done such that, disregarding it may be the exceptional case or individual, in all the circumstances, at least the preponderant opinion of the group would have been against it? If a substantial opinion confirms it, there is no breach or failure.

Informed Consent:

37 Counsel for the nurses raised this question: there was little or no evidence as to what information had been given to the mother. The plaintiffs did not raise this issue. There was a written consent. One would infer from the evidence that it was not discussed by Dr. Edmonds on the morning of the operation. I am left uncertain whether the referring doctor discussed the matter with the mother. It would be a reasonable inference from what evidence is before me that she would have been guided by the opinion of her doctor or the specialist. Counsel submits that a general negligent attitude that morning might be inferred from the failure to discuss this with the mother that morning but the general lack of evidence on the point does not raise that inference.

Conclusions:

38 I find that each of the defendant doctors brought to his task a reasonable degree of skill and knowledge and exercised a reasonable degree of care; that they exercised the standards of professional competence required of specialists in their field. I find that the decision to perform the three operations together in 1985 on this child in these circumstances was a judgement call that a substantial opinion of their respective professions confirms as reasonable at that time. I find that they took cognizance of the factors which had influenced their decision; that there were indications which would call for the operations at that time, and that the health of the child was such on that day that it would not prevent the operation. It is probable that in hindsight with the knowledge of the present Dr. Edmonds would not repeat such a triple operation, but that is not the standard. It would be an exercise of undue caution in light of his prior experience. I find that the anaesthetist was not negligent in proceeding without an I.V. except for that in the needle. Nor was he negligent in not calling for an I.V. in the recovery room in light of the condition of the child there. When this child left the recovery room there was no sign of dehydration. By the time the breathing stopped, there was probably a mild dehydration but it resulted from the unexpected failure of the child to take sufficient liquids which was not properly analyzed by the nurses in light of the other symptoms. I find that there was no obligation in the circumstances to attend in the recovery room or the tonsil suite but each of these doctors did so. It was the responsibility of the nurses who have their own expertise to monitor, observe and analyze the need for the calling of the doctor. I find that the order for the two doses of codeine was within the normal limits for this child. I find that the cause of the brain damage was respiratory arrest some time after 2:25 p.m.; that there were clinical signs of distress in breathing as the child was not receiving enough oxygen and was making more effort to

get oxygen to the brain. I accept the opinion of Dr. MacRae that it was a combination of many things: a swelling of the airway, the membranes thickening, some unknown obstruction, which is not unusual, and the codeine depressing the respiratory drive. I find that there was no unusual bleeding until about 2:00 p.m., that the loss from the nine hours before the operation, combined with the blood lost during the operation, would not have put this child in shock and stopped him breathing. The onus was upon those asserting the crossclaim and the evidence leaves me unable to say what amount was lost or if it were sufficient to have led to a state of shock and cardiac arrest even on the balance of probability. It was the respiratory arrest which affected the heart and brain and ultimately led to the cardiac arrest.

39 It was the failure of the nurses to observe and assess the importance of the signs and symptoms from admission to the tonsil suite at 10:45 a.m. and primarily those following the administration of the codeine that caused the damage. If the doctor had been called at any time during that period, the obstruction could have been found, an airway cleared and breathing restored. Bleeding after a tonsillectomy was something to be watched for. By itself it is no indication of negligence on the part of the surgeon.

Judgment:

40 The crossclaim is dismissed. Counsel may speak to me on the question of costs. Otherwise those asserting the crossclaim should pay the costs of those defending if demanded.

VAN CAMP J.

---- End of Request ----

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