Date: 20020524
Docket: S.N. No. 1122687

IN THE SUPREME COURT OF NOVA SCOTIA
[Cite as: *Crocker v. Awan,* 2002 NSSC 136]

BETWEEN:

MELINDA LEE CROCKER

PLAINTIFF

- and -

DR. S.I. AWAN

DEFENDANT

D E C I S I O N

HEARD: Before the Honourable Justice A. David MacAdam, in Sydney, Nova Scotia., on May 1 & 2, 2002

DECISION: May 24, 2002 WRITTEN RELEASE: May 24, 2002

COUNSEL: Darlene MacRury, counsel for the Plaintiff
Colin J. Clarke & Kevin Kindred, A/C, counsel for the Defendant

MacADAM, J.

[1] On the morning of December 1, 1998, the plaintiff, Melinda Lee Crocker, (herein "Ms. Crocker"), attended at the Cape Breton Health Care Complex, located in Glace Bay, Cape Breton, Nova Scotia, for day surgery. On recovering from the apparently successful surgery she developed redness and swelling on her left inner forearm which resulted in scaring that has continued to the day of trial. The plaintiff says the defendant, Doctor S. I. Awan, (herein "Doctor Awan"), who applied the anaesthetic agents, was the only person involved with her left arm, during the course of the surgery. She says she entered the surgery without the injury to her left forearm and, since Doctor Awan was responsible for the procedures carried out on her left arm, he is responsible for the injury she has suffered.

[2] The defendant, on the other hand, says he was not negligent in his care and treatment of the plaintiff and any loss that may have been caused to the plaintiff was not caused nor contributed to by his conduct.

BACKGROUND

[3] The plaintiff, following discussions with her family, a friend and her doctor, decided to undergo tubal ligation surgery, based in part on her decision not to have any more children and having suffered pain and cramping due to taking various birth control pills. She was referred to Doctor Brian O'Brien, gynaecologist, in October 1998. She reaffirmed her decision to undergo the day surgery, after having been advised by Doctor O'Brien of risks associated with the surgery, but apparently no specifics as to the risks related to undergoing a general anaesthetic. At the conclusion of the meeting with Doctor O'Brien, she was booked for surgery for December 1, 1998.

[4] Although the evidence is somewhat unclear as to when the plaintiff and the defendant first met, it appears it may have occurred in the operating room after she had walked in and Doctor Awan introduced himself. Although Ms. Crocker had, at best, a vague recall of the conversation with Doctor Awan, it appears from the evidence of Doctor Awan that, in addition to introducing himself, he reviewed her charts and asked her questions concerning her past medical history, particularly as it related to the application of general anaesthetics. It appeared from her history she may have, on three separate occasions, received a general anaesthetic. Doctor Awan testified that his practice during the course of these introductory meetings with the patient is to advise there are risks associated with a general anaesthetic and equating them to the risk of crossing the street, stating most times everything is okay but sometimes unforeseen events occur. He stated his practice then is to ask the patient whether they have any questions.

[5] Doctor Awan indicated, from his general procedure, he would have initially begun by visually examining Ms. Crocker's left hand, adding as she was right-handed his practice was usually to use the left hand for the purpose of introducing the anaesthetic agents. He says he would then have placed a tourniquet on her forearm and then gently tapped the back of her hand to make the veins more visible. He would have then swabbed the area in which he intended to insert the needle and, after the area was clean and dried, he would have picked up the needle with a cannula and inserted it in the back of her left hand and into her vein. Once the needle and the cannula had been inserted into the vein,

the needle would have been withdrawn and the cannula advanced further into the vein. He says there would be a small flow of blood back into the needle that would confirm that there had been a puncturing of the vein itself. Once the needle had been removed, the I.V. line would then have been connected to the cannula. He says the assisting nurse would then clean the area and tape the I.V. line on the back of Ms. Crocker's hand after first having made a U-bend in the line. After the flow of I.V. fluid was confirmed, he would then have introduced the anaesthetic agent through a bank in the line and would have at the same time insured that the patient had been connected to the various monitoring devices and they were operating. He says, before even proceeding with the introduction of the anaesthetic, it was necessary for him to establish a baseline by obtaining readings on all vitals from the various monitors. Once these have been determined, the anaesthetic is introduced through the I.V. line into the cannula and by the cannula into the vein. He stated the initial agent introduced was Propofol and was for the purpose of putting the patient to sleep. He indicated that in approximately one in four instances it will produce in the patient a burning sensation running from the point of introduction up the arm of the patient. He says Propofol appears milky and is the inducing agent of choice for the purpose of putting patients to sleep. Following introduction of the Propofol he would have disengaged the syringe from the bank on the I.V. line and have obtained and inserted a syringe containing Actracurium, which is used to relax the muscles of the patient. He said he recalls, as he began to introduce the Actracurium, he felt a pressure or resistance at which time he looked at the back of Ms. Crocker's hand and observed puffiness and redness and immediately stopped the introduction of Actracurium. He testified that although he could not recall all details of the operation, he does remember seeing the puffiness and redness on the back of Ms. Crocker's hand and then stopping the introduction of the Actracurium. He says he was then aware there had been an extravasation of the Actracurium to the extent of approximately 1 mm. He says it would have taken less than a second for that quantity of Actracurium to have been introduced into the back of Ms. Crocker's hand.

[6] He testified there was no problem in introducing the Propofol and he is satisfied the extravasation that did occur was the Actracurium and not the Propofol. He also testified the reactions observed in her hand and later the inner forearm of Ms. Crocker were consistent with an extravasation of Actracurium but not consistent with an extravasation of Propofol. He says he immediately withdrew the cannula from the left hand of Ms. Crocker and then proceeded to insert a fresh needle and cannula into the back of the right hand and to introduce the Actracurium. He says he cannot remember saying anything, nor can he remember the patient saying anything at this time and that the introduction of the Actracurium into the back of the right hand proceeded without incident.

[7] Ms. Crocker testified when she entered the operating room she recalls Doctor Awan being there and believes he told her everything would be okay. She says she was then nervous and crying and he was trying to reassure her, as was Doctor O'Brien. She said she laid down on the operating table and laid out her left arm, which was taken by Doctor Awan and everything to that time seemed okay. However, when he inserted the needle in her hand and then the anaesthetic, she felt a "cold burning sensation". She says it involved her whole arm in pain and she started crying from the pain and the burning

which appeared to be inside her arm. She says she voiced concern and was told it was okay. She testified to recalling hearing a conversation between unknown persons stating a vein had been missed.

[8] Doctor Awan says no vein was missed and that in fact the Propofol, which was the first agent introduced into the left hand of Ms. Crocker, proceeded without incident and it was only during the introduction of the Actracurium that the difficulties were observed.

[9] Ms. Crocker testified her next recall is of recovering in the recovery room and at this time her girlfriend came in and as a result of speaking with her she looked at her left arm and then noticed the red area on her inner left arm. She says she initially observed the swelling in her left arm and that it appeared puffed and swollen and when the swelling went down, by the next day, is when she first observed the blistering effect. She says Doctor O'Brien prescribed a cream to be rubbed on the area of her left inner forearm and arranged for her to attend out-patients to have the dressing on her forearm changed, initially daily and later less frequently.

[10] She testified it was on December 2nd when she noticed the blistering and that the injury appeared to get worse until eventually healing began. There was a bubbling and a cracking of the skin once the blister started to dry out. She said it was really sore to the touch and there was no feeling on a white spot that appeared in the center of the injury. She said the blistering went away in about three weeks and she was required during this period to apply cream and to keep bandages on the wound.

[11] Ms. Crocker indicated the injury affected her in carrying out her household chores and that when it was touched she could feel a tingling of pain. She said it affected her in carrying out these chores until the pain eventually diminished, which she estimated to be a period of approximately two months. She was referred to Doctor A.O. Atiyah, a plastic surgeon, who prescribed a different cream but no other medications. She demonstrated to the court the degree of scaring which she now experiences and agreed that by July 1999 the injury had healed although there was the residual scaring. She agreed that although it hurt for quite awhile following the surgery, it no longer hurts, although when in the cold she sometimes can feel something in the area of the injury. She said in the cold it sometimes gets bluish. In the summer she applies sun screen since it is sometimes affected by the sun. She acknowledged that another scar on her left forearm was caused by a biking accident when she was a child and did not take exception to defence counsel's suggestion the biking scar was more visible and pronounced than the scar left by the injury she suffered on December the 1st.

STANDARD OF CARE

[12] The plaintiff brings this action claiming damages for injuries caused by the negligence of the defendant. The elements required for a successful medical malpractice suit were outlined by Justice Nunn in *Anderson v. Grace Maternity Hospital et al.* (1989) 93 N.S.R. (2d) 141 at p. 156:

> [96] In Young et al. v. St. Rita Hospital and Critchley (1987), 75 N.S.R. (2d) 239; 186 A.P.R. 239 (T.D.), I set forth the general law of medical negligence at pages 241 and 242 as follows:
>
> > "Dean Meredith, in his test Malpractice Liability of Doctors and Hospitals (which test was cited in Cardin v. City of Montreal (1961), 29 D.L.R. (2d) 422) states at p. 61:
> >
> > > 'The success of a malpractice suit founded on negligence, is dependent upon the existence of four conditions:
> > >
> > > First: There must have been a legal duty on the part of the doctor towards his patient to exercise care. This duty arises as a matter of law when the doctor takes on the case, and as already stated, is dependent of contract.
> > >
> > > Second: There must have been negligence on the part of the doctor, i.e. a breach of his legal duty to conform to the standards of proficiency and care required by law.
> > >
> > > Third: The patient must have suffered loss or injury. Negligence not resulting in loss or injury provides no ground for a civil action in damages.
> > >
> > > Fourth: The patient's loss or injury must have resulted directly from the doctor's negligence [sic] In other words, the negligence must have been the determining (as distinct from the indirect or remote) cause of the damage.'
>
> The standard of proficiency and care required of doctors by law is clearly stated by Schroeder, J.A., in Crits and Crits v. Sylvester et al., [1956] 1 D.L.R. (2d) 502, at p. 508:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required off [sic] him than one who does not profess to be so qualified by special training and ability.'"

[13] The defendant, in its pre-hearing submission, in citing similar authorities as the plaintiff, acknowledges the existence of a legal duty as between the defendant and the plaintiff..

[14] The plaintiff says the defendant was negligent in the insertion of the I.V., thereby causing an extravasation of agent into her left forearm, thereby causing her injury and loss, identified by some of the medical witnesses as having the appearance of a second degree burn, that has left her with permanent scaring on her arm. The plaintiff presented no evidence as to the standard of care of a medical practitioner in the position of the defendant and instead suggested, in oral submission, the principles outlined by Justice Sopinka in *Snell v. Farrell* [1990] 2 S.C.R. 311, applicable to a court in finding causation in the absence of direct evidence of causation are equally applicable to finding a defendant has breached the standard of care, where the defendant has been unable to present evidence explaining how the injury could have occurred without a breach of the standard of care on their part. Justice Sopinka at pp. 329-337, made the following observations:

> These references speak of the shifting of the secondary or evidential burden of proof or the burden of adducting evidence. I find it preferable to explain the process without using the term secondary or evidential burden. It is not strictly accurate to speak of the burden shifting to the defendant when what is meant is that evidence adduced by the plaintiff may result in an interference being drawn adverse to the defendant. Whether an inference is or is not drawn is a matter of weighting evidence. The defendant runs the risk of an adverse inference in the absence of evidence to the contrary. This is sometimes referred to as imposing on the defendant a provisional or tactical burden. See: Cross, op.cit, at p. 129. In my opinion, this is not a true burden of proof, and use of an additional label to describe what is an ordinary step in the fact-finding process is unwarranted.
>
> The legal or ultimate burden remains with the plaintiff, but in the absence of evidence to the contrary adduced by the defendant, an inference of causation may be drawn although positive or scientific proof of causation has not been adduced. If some evidence to the contrary is adduced by the defendant, the trial judge is entitled to take account of Lord Mansfield's famous precept. This is, I believe what Lord Bridge had in mind in Wilsher when he referred to a "robust and pragmatic approach to the . . . facts" (at p. 569).

It is not therefore essential that the medical experts provide a firm opinion supporting the plaintiff's theory of causation. Medical experts ordinarily determine causation in terms of certainties whereas a lesser standard is demanded by the law. As pointed out in Louisell, Medical Malpractice, vol. 3, the phrase "in your opinion with a reasonable degree of medical certainty, " which is the standard form of question to a medical expert, is often misunderstood. The author explains, at pp. 25-57, that:

> Many doctors do not understand the phrase . . . as they usually deal in 'certainties' that are 100% sure, whereas 'reasonable' certainties which the law requires need only be more probably so, i.e., 51%.

Harvey, Medical Malpractice, the learned author states at p. 169:

> Some courts have assumed an unrealistic posture in requiring that the medical expert state conclusively that a certain act caused a given result. Medical testimony does not lend itself to precise conclusions because medicine is not an exact science.

[15] In respect to the standard of care or duty, counsel refers to the decision of Justice McGillivray in *Villeneuve v. Sisters of St. Joseph* (1971), CarswellOnt 606, [1972] 2 O.R. 119, where the court upheld the finding the anaesthetist had breached the standard of care. However, it is noteworthy that in the reasons of Justice McGillivray he considered whether there was evidence before the trial judge substantiating the finding of negligence against the defendant anaesthetist. He confirmed the finding of the trial judge there was evidence of the sudden movement of the plaintiff child's arm having affected the direction of the needle which was being inserted and that there was substantial evidence the parties had had marked difficulty in restraining the child prior to the injection. Justice McGillivray stated, on this basis, it was open to the trial judge to find there was negligence by the defendant in proceeding with the injection in such circumstances. He also found there was evidence supporting a finding the defendant was negligent in not seeing the blanching of the plaintiff's arm caused by the injection of the Pentothal which would have amounted to a warning signal of the presence of Pentothal in the artery or, if the defendant had seen it, in not then demanding the surgery be abandoned and remedial measures undertaken for the impaired circulation.

[16] The plaintiff says when she presented herself for surgery there was no injury to her left hand or arm and following the surgery she had puffiness and swelling, followed by blistering and now a scar to her left inner arm, that the defendant had sole responsibility for all procedures relating to her left hand and arm and, in the absence of any explanation as to how she received these injuries, without negligence on the part of Doctor Awan, she is entitled to succeed on the basis of her claim in negligence against him.

[17] The defendant, in its pre-hearing submission, references *Malpractice Liability of Doctors & Hospitals, supra*, at pp. 63- 64, in support of the proposition that physicians are not insurers and do not guarantee cures.

> One cannot, therefore, assume negligence merely because an operation was unsuccessful, or because a patient sustained injury through medical treatment. And to hold a doctor responsible in damages, it is not sufficient to show that his diagnosis was incorrect, or that he adopted one of several recognized methods of treatment rather than another, or that complications followed an operation unless in each instance it is also shown that he failed to exercise the degree of skill and care required by law.

[18] Counsel's brief then notes the comments of Justice Taschereau in *Cardin v. City of Montreal, supra*, at p. 494:

> The doctor is not a guarantor of the operation which he performs or the attention he gives. If he displays normal knowledge, if he gives the medical care which a competent doctor would give under identical conditions, if he prepares his patient before operation according to the rules of the art, it is difficult to sue him in damages, if by chance an accident occurs. Perfection is a standard required by law no more for a doctor than for other professional men, lawyers, engineers, architects, etc. Accidents, imponderables, what is foreseeable and what is not, must necessarily be taken into account.

[19] In *Lloy v. Milner* (1981), Carswell Man. 274, Justice Hamilton, of the Manitoba court of Queen's Bench, after referencing the responsibility of doctors as outlined by Justice Taschereau in *Cardin v. City of Montreal, supra*, cites Justice Ritchie of the Supreme Court of Canada in *Wilcox v. Cavan* (1974), 50 D.L.R. (3d) 687, for his statement that even in the circumstances of the application of the rule of *res ipsa loquitur* to medical malpractice "there must be reasonable evidence of negligence". Justice Ritchie went on to adopt the language of Sir Lyman P. Duff, C.J.C. in *United Motor Services Inc. v. Hutson et al.*, [1937] 1 D.L.R. 737, at p. 738, that:

> Broadly speaking, in such cases, where the defendant produces an explanation equally consistent with negligence and with no negligence, the burden of establishing negligence still remains with the plaintiff.

[20] The Supreme Court of Canada in *Fontaine v. British Columbia (Official Administrator)*, [1998] 1 S.C.R. 424, in the reasons of Justice Major on behalf of the court, suggested *res ipsa loquitur* should now be treated as expired. He states the principle of *res ipsa loquitur* is no longer applicable in determining whether there has been a breach of any standard of care owed by one party to another.

[21] At paras. 26-27, Justice Major, on behalf of the court, stated:

> Whatever value res ipsa loquitur may have once provided is gone. Various attempts to apply the so-called doctrine have been more confusing than helpful. Its use has been restricted to cases where the facts permitted an inference of negligence and there was no other reasonable explanation for the accident. Given its limited use it is somewhat meaningless to refer to that use as a doctrine of law.

> It would appear that the law would be better served if the maxim was treated as expired and no longer used a separate component in negligence actions. After all, it was nothing more than an attempt to deal with circumstantial evidence. That evidence is more sensibly dealt with by the trier of fact, who should weigh the circumstantial evidence with the direct evidence, if any, to determine whether the plaintiff has established on a balance of probabilities a prima facie case of negligence against the defendant. Once the plaintiff has done so, the defendant must present evidence negating that of the plaintiff or necessarily the plaintiff will succeed.

[22] In *Lloy v. Milner, supra*, Justice Hamilton was presiding over an allegation of medical malpractice against an anaesthetist who had given an injection of sodium Pentothal to the plaintiff. The plaintiff suffered injury to her hand when the needle became removed from the vein and enabled the sodium Pentothal to enter the tissues of her hand. Expert evidence was called in support of the defendant's position that a needle can become removed from a vein even where the most expert medical practitioner is exercising great care. On the evidence, the defendant had stopped the injection immediately upon discovering that the sodium Pentothal was entering the tissues of the hand rather than the vein. The similarities with the present case are striking. Justice Hamilton, at para. 14, made the following observation:

> [14] The evidence further indicates that that result can occur to the most expert medical practitioner and with the exercise of greatest care, that is, without negligence on the part of the doctor. While there was evidence that if the injection was not stopped immediately, that would amount to a lack of reasonable care, in this case the evidence is that the injection was stopped as soon as it became evident to Drs. Milner and Ong that some of the material had gone interstitially. I accordingly conclude that Dr. Ong, and through him Dr. Milner, was not negligent in the manner in which the injection to Mrs. Lloy was given. The unfortunate result falls into the category of misadventure, rather than negligence and is not one for which the defendant can be held responsible.

[23] There was no evidence tendered criticizing the conduct or care of the defendant in administering the anaesthetic agents to Ms. Crocker. Doctors Awan and W. D. Robertson, who was qualified as an expert in anaesthesiology, both testified that on the evidence they were satisfied the cannula with the needle entered a vein on the back of Ms. Crocker's left hand. Both stated that in their opinions the vein was not missed. Their opinions were based on both the fact Ms. Crocker received the Propofol which put her to sleep and would not have done so if the vein had been missed and secondly, the nature of the effects on Ms. Crocker suggested an extravasation of Actracurium, rather than Propofol, and that the Actracurium was injected following the injection of the Propofol. Doctor Robertson testified Doctor Awan had provided "superior care" in providing anaesthetic services to Ms. Crocker.

[24] As observed, there was no expert evidence called on behalf of the plaintiff, nor any evidence criticizing Doctor Awan as to what he did or did not do in injecting the anaesthetic agents into the left hand and subsequently the right hand of Ms. Crocker.

There was therefore no evidence of a breach of any standard of care since, on the only evidence introduced, Doctor Awan met the standard of care required of a specialist in the field of anaesthesiology.

[25] However, the evidence goes further in that both Doctors Awan and Robertson expressed, by way of example, events that may occur that could result in the extravasation of an anaesthetic agent. Doctor Awan testified that such an extravasation could occur in circumstances where the needle had punctured the side of the vein and created thereby a second hole in the vein or a vein may burst as a result of the injection of the anaesthetic fluid or there may be a leak from the initial puncturing of the vein, or the cannula may have come out of the vein and added that sometimes the cause is just not known. He noted in injecting a needle, once it penetrates the skin of the hand, the anaesthesiologist is no longer able to see where it continues under the skin.

[26] Doctor Robertson testified in more detail about the possibility of either a leak at the point at which the needle enters the vein or a second hole being created by the needle or the cannula. He testified the cannula, which is made of plastic, and fitted over the needle, may have the end burred by its penetration through the outer skin and this would not be observable to the person injecting the needle. This burr may either tear the vein as the needle enters the vein, thereby causing the possibility of leakage or the burred end of the cannula may on the insertion of the needle continue and strike the inside of another portion of the vein thereby causing the potential for a tear or a further hole and consequently the possibility of leakage of the analgesic agent. These examples were not advanced as necessarily the cause of the extravasation in the circumstance of Ms. Crocker, but simply examples of how extravasation can occur without any necessary breach of the standard of care by the anaesthetist. The evidence is that what happened to Ms. Crocker is simply not known, other than that there was an extravasation of the Actracurium during the course of its injection into the back of her left hand.

[27] Justice Grange in *Videto et al v. Kennedy* (1980), 27 O.R. (2d) 747, Ontario (H.C.), rev'd on other grounds at 33 O.R. (2d) 497, made the following observation:

> I realize how difficult it is for the patient to establish negligence in such a case, but it is of vital importance that a doctor be not condemned in the absence of proof of negligence. Even if I had found *res ipsa loquitur* to apply here, it does not shift the over-all burden of proof. There is simply no evidence of negligence except the result. I remain suspicious, but my suspicion may be largely grounded in ignorance, and anyway suspicion is not enough.

[28] In the present circumstance there was also no evidence of negligence on the part of Doctor Awan. The plaintiff attended for surgery, and during the injection of the anaesthetic agents in the back of her left hand experienced swelling to the back of her hand and her left inner forearm. On the evidence, Doctor Awan, while injecting the Actracurium and feeling resistance to the injection, immediately stopped and noticing the puffiness or swelling in the back of her hand, ceased further injections of the Actracurium, removed the intravenous needle and cannula and commenced a new I.V. with subsequent introduction of Actracurium in the back of her right hand without further incident. Like Doctor Milner in *Lloy v. Milner, supra,* on the evidence, Doctor Awan

had stopped the injection as soon as it became apparent there was a problem and there is no evidence that either in the injection or in his conduct following the realization that something had gone wrong, he failed to meet the standard of care of a specialist in his field.

CAUSATION

[29] Also, raised by the defendant is the issue of causation. The plaintiff says the only evidence of any administrations to her left arm were under the responsibility of Doctor Awan and the injury that was observed, particularly on the morning of December 2nd, was therefore caused by the only agents that were administered to her, namely, the intravenous anaesthetic agents. The defendant's evidence is that neither Propofol, nor Actracurium are known to cause the type of injury, namely the blistering and scaring to the inner forearm of Ms. Crocker that was observable in this case. Doctors Awan and Robertson stated they had never seen such an effect, although they had seen swelling in circumstances of extravasation, particularly of Actracurium which contains a Histamine that, when injected outside a vein, can cause the type of swelling observed on the left arm and hand of Ms. Crocker. However, to a large extent, the observations of both Doctors Awan and Robertson were based on their not having noticed such an effect as occurred with Ms. Crocker in their own experiences, nor, in the case of Doctor Robertson, from his readings of the literature about these anaesthetic agents. Although there was no evidence suggesting these opinions were in error and on the balance of probabilities, it would appear on the only evidence presented, these agents could not have had the effect observed on Ms. Crocker, I prefer to rest my decision and reasons on the basis the evidence does not disclose a breach of the standard of care on the part of Doctor Awan, rather than on whether these agents have the capability of causing the type of injury incurred by Ms. Crocker. In this regard, I am also aware that in his report Doctor Robertson had suggested:

> The patient was noted, on arrival in the Recovery Room at 1345, to have a swollen left hand and forearm. She was extubated by Dr. Awan. The swelling was described as an urticarial hive at 1400, to be unchanged at 1430, and to be fading by 1510. The patient's pulse rate in Recovery Room was stable, and the changes in her blood pressure were due to adequate control of pain. In light of the urticarial hive on her arm Dr. Awan recommended she be observed for 8 hours and she was therefore admitted to the hospital. Her initial course in hospital was normal (some nausea and vomiting in the first few hours afer a tubal ligation is not uncommon). The only unusual aspect was the occurrence of widespread itchiness and swelling at 0130 of the 2nd of December. It is unlikely that this was due to the Actracurium as delayed reactions normally occur within 3 hours of administration of a medication, not 13 hours later. She was not at this time hypotensive or tachycardiac. I feel it is more likely that this reaction was due to some contact allergen such as the laundry detergent.

[30] In his report, Doctor Robertson seems to have accepted statements by Doctor A. O. Atiyah, a plastic surgeon, who examined Ms. Crocker and commented that she had

received a second degree burn and statements by Doctor O'Brien, who had performed the surgery and was her treating physician following the surgery, to the effect it appeared Ms. Crocker had received a second degree burn. Doctor O'Brien indicated, in the Discharge Summary, that the area of the allergic type wheel on her left inner . . .

... arm had decreased in size but the erythematous reaction which I had seen earlier now showed some peeling in the center and would suggest this might be ischemic and almost like a second degree burn.

[31] Doctor O'Brien, in testifying, stated that what he observed had the appearance of a second degree burn but because he could not explain from what had happened in the operating room how there could be a burn, he was not stating it was a second degree burn.

[32] Doctor Atiyah, first saw the plaintiff some two weeks following the surgery and was never examined on his statement that, "the patient had a small area of second degree burn". He was not questioned as to whether he had concluded there was a second degree burn or the injury simply had the appearance of a second degree burn or whether he was relying on the hospital records that suggested that what had occurred had the appearance of a second degree burn, including the statement to this effect by Doctor O'Brien in his discharge summary. In the circumstances, I do not conclude that whatever occurred on the left forearm of Ms. Crocker, was or was not caused by the extravasation of the Actracurium. In view of my finding in respect to the conduct of Doctor Awan meeting the standard of care, it is unnecessary to conclude, even on a balance of probabilities, whether the injury to the left forearm of Ms. Crocker was or was not caused by the Actracurium.

INFORMED CONSENT

[33] The plaintiff also advances the argument that she was not advised of the risk of injury or damage resulting from the introduction of the general anaesthetic and therefore her consent was not an "informed consent". In referencing the decision of Justice Lofchik in *De Vos v. Robertson*, 2000 CarswellOnt 44, she says the defendant is liable on the basis physicians are required to disclose the nature and gravity of proposed operations, including any "material" circumstances and the defendant failed to do so in the present circumstance.

[34] Clearly Ms. Crocker was never advised of the risk of receiving what had the appearance of a second degree burn to her left inner forearm. On the evidence of Doctors Awan and Robertson, such advice would never be given since neither had observed nor were aware the injection of the anaesthetic agents anticipated in the course of the surgery could have had such an effect. However, both testified that extravasation of injected fluids by I.V. lines does occur and in the case of Actracurium such an extravasation can cause puffiness or swelling. They both testified, however, that they would have expected, within four hours or less, the swelling or puffiness would have resolved itself. They noted that in the present circumstances, on the evidence, it appeared this occurred in respect to Ms. Crocker, at least in respect to the puffiness on the back of her left hand and her left inner forearm. Doctor Awan testified he has inserted I.V.'s, in various

patients during the course of his practice, on more than 30,000 occasions and estimated experiencing extravasation to December 1, 1998, at a rate probably less than .1%. Doctor Robertson testified he has done approximately 25,000 anaesthetic injections and missed the vein about 2% of the times. In respect to extravasations he testified he has had approximately ten, also, therefore, resulting in a rate substantially less than 1%.

[35] The extent of the duty on a physician to disclose the material risk of a procedure was outlined by Chief Justice Laskin in *Hopp v. Lepp* (1980), 112 D.L.R. (3d) 67, at p. 77:

> *Kenny v. Lockwood* is important as much for what it portended as for what it actually decided. It indicated that a surgeon who recommends an operation which involves known risks, that is probable risks, or special or unusual risks, is under an obligation to his patient to disclose those risks and, if he fails to do so, and injury results from one of the undisclosed or not fully disclosed risks, the patient's consent to the operation will be held to be not an informed consent, although the operation itself was competently performed. Apart from situations of this kind, a surgeon need not go into every conceivable detail of a proposed operation so long as he describes its nature, unless the patient asks specific questions not by way of merely general inquiry, and if so, those questions must be answered, although they invite answers to merely possible risks. If no specific questions are put as to possible risks, the surgeon is under no obligation (although he may do so) to tell the patient that there are possible risks since there are such risks in any operation.

[36] Counsel for the defendant suggests, on an allegation of a "failure to obtain informed consent", there is a three pronged defence available to a defendant:

1. Was the risk disclosed to the patient - if so, the defendant is successful;

2. If the risk was not disclosed, is it a material risk - if answered in the negative, the defendant is successful;

3. If the risk was not disclosed and was a material risk, the Court must determine on an objective analysis, whether a reasonable person in the plaintiff's position would have proceeded with surgery despite knowledge of the risk - if the reasonable person would have agreed to the surgery then the defendant is successful.

[37] Defence counsel says the second and third prongs are here present in that there was neither a material risk and, if on the other hand there was, a reasonable person in the plaintiff's position would have proceeded with the surgery even with knowledge of the risk. Plaintiff counsel does not dispute the suggested three pronged defence available to a person accused a of failure to provide informed consent but says in the present

circumstance there was a material risk and in light of the injuries occasioned to the plaintiff she may not have proceeded with the surgery.

[38] On the issue of what is material, defence counsel refers to the decision of Justice Donnelly of the Ontario Superior Court of Justice in *Prossler v. Carroll*, [199] O.J. No. 5070, at paras. 45, 46 and 48:

> [45] ...These authorities identify that "material" in this context is governed by frequency and gravity. A high probability of occurrence can render a minor complication material. A risk constituting a mere possibility need not be disclosed unless that occurrence carries serious consequences of the order of death, disability or paralysis.
>
> [46] Cutaneous necrosis is a very rare result. On the uncontradicted evidence in this case and on the authorities it is not a serious consequence. (. . .)
>
> . . .
>
> [48] It follows there was no breach of duty by Dr. Carroll in failing to disclose the risk of skin necrosis. It is unnecessary to make a finding on the causation aspect of the test. However, given the strong motivation to deal with the long standing cosmetic condition, aggravated by swelling and occasional stinging and the risk of being so remote, the likelihood is that a fully informed, reasonable person would have proceeded with the sclerotherapy.

[39] Although Ms. Crocker has suffered injury, it is clear it did not carry "serious consequences of the order of death, disability or paralysis." Having in mind the low probability and the degree of injury, I am satisfied the risk was not, in these circumstances, material and the defendant has successfully established the second of the "prongs".

[40] With respect to the third, the plaintiff responded on cross-examination that if she had been informed by Doctor O'Brien there was a 5% chance she would suffer the burns she would go ahead but may have taken more time to think about it and that if Doctor O'Brien had said a 1% chance she probably would have definitely gone ahead with the surgery. She was referred to her discovery where she testified that if Doctor O'Brien had said there was a 40% chance of suffering the burns she probably would not have gone ahead with the surgery, if there was a 5% chance she probably would have gone ahead because she wanted the surgery done and if there was a 1% chance she definitely would have gone ahead with the surgery.

[41] On the evidence, the risks, as reduced to percentage terms by Doctors Awan and Robertson, were certainly considerably less than even 1% that there would be an extravasation of any anaesthetic agent, and consequently the risk of the type of injury incurred by Ms. Crocker would have been even less since neither doctor has ever seen such an injury from injections of either Propofol or Actracurium. Clearly, the defence has established the third "prong", namely, that in these circumstances a reasonable person in the plaintiff's position would have proceeded, even after being advised of the risks as

identified by Doctors Awan and Robertson of an extravasation, notwithstanding the risk would not have also included potential for an injury in the nature of the second degree burn she apparently suffered. Additionally, both Doctors Awan and Robertson testified that they have never had a patient decline an anaesthetic because of the risk of an extravasation.

DAMAGES

[42] The plaintiff suffered injury to the back of her left hand which resolved within four hours and swelling to her left inner forearm which also resolved within the same four-hour period. What did not resolve completely was the "wheel" observed by Doctor O'Brien in the center of the redness area on her left inner forearm which although reduced in size has not completely disappeared as of the date of trial. The pain and suffering, with the impact on carrying out her household duties, has resolved although, as noted earlier, she experiences an effect sometimes in the cold and, at other times, from the area being exposed to the sun.

[43] Justice Hamilton in *Lloy v. Milner, supra*, stated that if she had found for the plaintiff she would have fixed general damages at $3,500.00, having considered she suffered " . . . considerable pain in her hand for a month or so, until a skin graft repaired the open canker." She noted the hand was still sensitive to cold and possibly there was some lack of strength. In her reasons, at para. 15, she continued:

> [15] . . . Ten days after this operation, the hand was still stiff, but movement and use gradually returned. The grafting repaired the open area to the point that when the plaintiff showed me the back of the hand, I could not see anything unusual until some small darkened areas were pointed out. There is no resulting disfigurement. (. . .)

[44] As noted, the degree of disfigurement to Ms. Crocker could not be described as substantial and in fact is somewhat less than the scar left by her childhood bike accident. Nevertheless, she has suffered some injury, has endured pain and suffering, has had some activities curtailed or limited for some period of time following the operation and even today has some degree of mild scaring. In the circumstances, had I found for the plaintiff, I would have fixed general damages at $5,000.00.

MacAdam, J.