

## 'Have you any recollection of what occurred at all?': *Davis v. Colchester County Hospital* and Medical Negligence in Interwar Canada

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### Résumé de l'article

L'histoire des fautes médicales au Canada n'a guère reçu d'attention de la part des historiens du droit ou de la médecine. À partir de l'étude d'un cas survenu en Nouvelle-Écosse dans les années 1930, *Davis c. l'Hôpital du comté de Colchester*, le présent article montre comment l'évolution de la technologie et la transformation des interventions chirurgicales ont créé des situations qui ont à la fois engendré une multiplication des réclamations pour faute professionnelle et compliqué la tâche des patients voulant prouver qu'une négligence médicale ait eu lieu. En outre, des éléments nouveaux dans le droit de la responsabilité délictuelle en ce qui concerne la responsabilité des hôpitaux, ainsi que celle des médecins et des infirmiers ou infirmières qui travaillent avec eux, ont amplement fourni l'occasion aux défenseurs d'éviter la responsabilité légale, même dans les cas où l'existence d'une négligence dans le traitement était évidente. Les témoignages lors du procès, les stratégies juridiques utilisées par les avocats et les décisions judiciaires éclairent également les attitudes de la profession médicale à l'égard de la responsabilité personnelle et de la déontologie. Tout cela montre également comment les avocats et les juges ont mis dans la balance les intérêts des patients, d'une part, et ceux des établissements de santé et des professionnels de la santé, d'autre part.

# 'Have you any recollection of what occurred at all?': *Davis v. Colchester County Hospital* and Medical Negligence in Interwar Canada

R. BLAKE BROWN AND MAGEN HUDAK\*

## *Abstract*

*The history of medical malpractice in Canada has received little attention from legal or medical historians. Through a contextualized study of a Nova Scotia case from the 1930s, Davis v. Colchester County Hospital, this article demonstrates how changes in technology and surgical procedures both created situations that spurred malpractice claims, and made it difficult for injured patients to prove medical negligence. In addition, developments in tort law concerning the liability of hospitals, and the doctors and nurses working within them, provided medical defendants ample opportunity to avoid legal liability, even in cases in which the existence of negligent treatment was obvious. The testimony at trial, the legal strategies utilized by the lawyers, and the judicial rulings also shed light on attitudes of the medical profession toward personal responsibility and ethics, and demonstrates how the interests of patients were weighed against those of medical institutions and professionals by lawyers and judges.*

## *Résumé*

*L'histoire des fautes médicales au Canada n'a guère reçu d'attention de la part des historiens du droit ou de la médecine. À partir de l'étude d'un cas survenu en Nouvelle-Écosse dans les années 1930, Davis c. l'Hôpital du comté de Colchester, le présent article montre comment l'évolution de la technologie et la transformation des interventions chirurgicales ont créé des situations qui ont à la fois engendré une multiplication des réclamations pour faute professionnelle et compliqué la tâche des patients voulant prouver qu'une négligence médicale ait eu lieu. En outre, des éléments nouveaux dans le droit de la responsabilité délictuelle en ce qui concerne la*

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*responsabilité des hôpitaux, ainsi que celle des médecins et des infirmiers ou infirmières qui travaillent avec eux, ont amplement fourni l'occasion aux défenseurs d'éviter la responsabilité légale, même dans les cas où l'existence d'une négligence dans le traitement était évidente. Les témoignages lors du procès, les stratégies juridiques utilisées par les avocats et les décisions judiciaires éclairent également les attitudes de la profession médicale à l'égard de la responsabilité personnelle et de la déontologie. Tout cela montre également comment les avocats et les juges ont mis dans la balance les intérêts des patients, d'une part, et ceux des établissements de santé et des professionnels de la santé, d'autre part.*

## Introduction

Legal historians and historians of medicine have devoted little energy to studying the history of medical malpractice law in Canada.<sup>1</sup> The only publications of significance that tackle the topic are a short case study by Peter J. Mitham and a history of the Canadian Medical Protective Association produced by a medical student, which was later published by the Association.<sup>2</sup> Jacalyn Duffin's assertion in 1990 that a study of the "history and meaning of malpractice inquests in Canada has yet to be written," but would be "of immense value," thus remains true.<sup>3</sup> By contrast, a fair number of scholars have analyzed the history of medical malpractice in the United States.<sup>4</sup>

The sparseness of Canadian literature examining malpractice is unfortunate, as medical negligence is, and historically has been, a significant and contentious social and legal issue in Canada.<sup>5</sup> Given the dearth of existing work, many basic questions remain unanswered, including: How easy was it for patients to successfully sue doctors and how did this change over time, and what medical treatments tended to result in malpractice suits? And, how did the legal regime affect the ability of patients to sue successfully for negligent treatment?

To start addressing these questions, this article employs a medical malpractice case from 1930s Nova Scotia, *Davis v. Colchester County Hospital*. The *Davis* case was in many ways unremarkable. It established no legal precedent, and the facts of the

case seem mundane compared to some, more spectacular, examples of medical negligence. However, such 'average' cases can shed considerable light on the problems patients faced in seeking compensation. As Franca Iacovetta and Wendy Mitchinson have noted, case files offer a "rare window on human interactions and conflict," and "illuminate the ways in which dominant class, gender, and racial ideologies shaped official discourses and action, and relations between experts and clients."<sup>6</sup> *Davis* illustrates how nineteenth-century developments in medicine, combined with the early twentieth-century legal terrain, often disadvantaged injured patients. Advances in surgical practice allowed for more ambitious surgeries, but created new opportunities for negligence claims, and patients who had been unconscious during surgery struggled to prove malpractice allegations. The common law regarding the liability of hospitals, nurses, and physicians also provided ample opportunity for defendants to avoid liability, even in cases in which the existence of negligent treatment was obvious. The testimony at trial, the legal strategies utilized by the lawyers, and the judicial rulings in *Davis* also shed light on the attitude of the medical profession toward personal responsibility and ethics, as well as demonstrating how lawyers and judges weighed the interests of patients against those of medical institutions and professionals.

This article first describes the events that led to the lawsuit against the Colchester County Hospital, located in Truro, Nova Scotia. The resulting malpractice case is then framed within the legal and medical context of the time. This includes the major changes in surgical practice that led to situations prone to malpractice claims, and the developments in tort law concerning the liability of doctors, nurses, and hospitals which tended to complicate a patient's ability to sue for malpractice. Finally, this article examines the judicial consideration of the *Davis* case.

## Treatment

Around 1 July 1931, Mary Davis (formerly Murphy) of Truro consulted her doctor, Francis 'Frank' Charman, about an undisclosed

health concern. He advised her to undergo a major abdominal operation.<sup>7</sup> Mary was a 40-year-old Catholic homemaker and caregiver to her three children. Her husband, Ellis Davis, was a C.N.R. telegraph operator.<sup>8</sup>

An experienced team of doctors undertook Mary's surgery on 23 July 1931 at Truro's Colchester County Hospital. Opened in 1926, the hospital was a respected, modern facility. The *Canadian Medical Association Journal* trumpeted that it was "impressive in its architectural features," and "admirably planned and well equipped," with a modern operating room and x-ray department.<sup>9</sup> Mary's surgery began at approximately 10:30 a.m. and lasted just over two hours. Dr. Charman was the doctor in charge. He was a graduate of McGill University with approximately 25 years of experience. Dr. John Reid assisted, while Dr. Foster Fitch Eaton administered anaesthetic. Dr. Reid was a graduate of Dalhousie Medical School and had been in practice for approximately a decade and a half. Dr. Eaton, in his late sixties, had received his medical degree from the University of New York before conducting post-graduate work in London, England.<sup>10</sup> Two nurses were also present in the operating room: Ira Miller and Gertrude Black.

The operation performed on Mary Davis was successful. Following the procedure, the three doctors moved Mary to hospital room number 21 to recover. Two nurses worked on this floor: Anna Belle Chisholm, who was responsible for four rooms (including room 21) and the nursery, and her sister Margaret Chisholm, who was responsible for all of the other rooms on the floor.<sup>11</sup> At around 12:30 p.m., Anna Chisholm, in accordance with general practice, placed a rubber hot water bottle in the middle of the post-operative bed to heat it, covered it with a blanket, then went about her other duties. She was absent when the doctors arrived with the patient at approximately 12:45 p.m. The head nurse of the operating room, Ira Miller, accompanied the doctors and the patient, opening the door to allow the doctors to wheel the carriage into room 21. The doctors lifted Mary onto the bed. While they did this, Nurse Miller removed the carriage. Mary remained unconscious throughout. With the patient

in the post-operative bed, the doctors left and Nurse Miller waited with Mary for a few minutes until Margaret Chisholm arrived. Margaret waited in the room for less than ten minutes, leaving when Anna Chisholm returned to room 21 at 1:00 p.m. Approximately 20 minutes later, Anna Chisholm removed the operating room blanket covering Mary. She discovered that the hot water bottle was still in the bed, and that it had severely burned the back of Mary's calves. Upon waking up later that day, Mary immediately sensed the burns, reporting that she felt "just as though I was on fire."<sup>12</sup> So severe were her injuries that Mary's hospital stay increased from an anticipated two weeks to five and a half weeks. Each day, her wounds had to be dressed and she received morphine every few hours to ease her burn-inflicted pain — although after two weeks, Mary refused further morphine treatments. Mary experienced little pain from the surgery after she returned home, but substantial pain from the burns. She was bedridden for another month before she could sit upright, and was unable to complete her usual household tasks for some time longer. Mary and her family had to employ a live-in housekeeper for 11 months, which was substantially longer than the one month they had originally anticipated prior to her admittance to hospital.<sup>13</sup>

Even after her burns had 'healed', Mary reported that she had trouble walking to church and getting groceries. She compared the enduring pain in her legs to a toothache, especially in cold weather.<sup>14</sup> She also believed that she had developed 'toxemia' — a condition brought about by burn toxins in her bloodstream which caused her to feel faint and to have fluctuations in her blood pressure readings. In sum, Mary felt that the incident had left her permanently and visibly "lame."<sup>15</sup>

Mary's continued pain and suffering, plus the expenses incurred for extra medical care and household help, led her and her husband to launch a negligence lawsuit against the Colchester County Hospital Trust. In their statement of claim, the two plaintiffs alleged that Mary had "suffered and sustained great pain, and suffered and sustained permanent injuries and disfigurement and was put to great loss of time and expense." The

plaintiffs also claimed that Ellis had lost the services of his wife, therefore obliging him to pay for household assistance. Mary claimed damages of \$5000 for her injuries. Ellis claimed another \$1428.50 — \$280 as compensation for the live-in housekeeper's wages and board, \$148.50 for Mary's additional medical expenses, and \$1000 in general damages.<sup>16</sup>

### The Medical and Legal Context

Given the events of Mary's treatment, one might assume that Mary and Ellis had a strong and straightforward negligence case. However, the litigation shows that the medical and legal context made proving such suits difficult, regardless of the presence of facts pointing towards a seemingly obvious instance of negligence.

As *Davis* would illustrate, changes in surgical practice created situations that could lead to allegations of malpractice. For example, the use of anaesthetics facilitated more advanced surgeries, but also led to situations that sparked lawsuits. Surgeons in the nineteenth century experimented with a variety of chemical agents that allowed the performance of surgeries on patients without causing pain. In 1847, James Young Simpson, a Scot, used chloroform as a clinical anaesthesia. Canadian physicians soon adopted its use. Anaesthetics facilitated more advanced surgeries, since they could render patients unconscious so that they remained still. Surgeons were thus able to take more time conducting procedures without the distraction or risk of patients thrashing about in agony. However, while anaesthesia offered numerous benefits, it also posed certain dangers for patients. Ether, for example, often produced nausea and was highly combustible when mixed with oxygen. Chloroform, even when properly administered, could occasionally result in a patient's sudden death from cardiac irregularity. The early, often imprecise, methods of administering these drugs further increased the chances of a patient's death.<sup>17</sup>

Anaesthesia also created special challenges for surgical patients attempting to sue doctors. Because they were uncon-

scious, patients did not witness the alleged negligence and thus could not give evidence at trial. Typically, as occurred in *Davis*, a patient awoke from surgery to find an unexpected injury. The attending medical professionals were the only people with knowledge of the events leading to the harm in question, meaning that they usually had to admit to their own wrongdoing, or reveal that of a colleague (or have committed an especially grievous injury), for a malpractice case to be successful. Justice Robert Grant Fisher of the Appellate Division of the Ontario High Court of Justice noted this challenge in 1931. A patient “undergoing an operation whilst under an anaesthetic is under a great disadvantage in proving negligence, as usually the only persons present are the surgeon, his assistant, and the nurse, and what is actually done is entirely within their knowledge — the patient knows nothing.”<sup>18</sup> In addition, in situations in which several medical professionals participated in a surgery, the plaintiff was also often unsure as to whom they should sue. As is demonstrated in *Davis*, doctors and nurses sometimes blamed each other for the failure to take proper care of a patient.<sup>19</sup>

The development of antiseptics and, later, asepsis, also permitted more ambitious surgeries. Surgeons had long avoided cutting into torsos out of fear of causing infection, haemorrhage, or shock. However, English surgeon Joseph Lister developed a system of antiseptic surgery in the 1860s. He sprayed carbolic acid on wounds and surrounding areas to prevent infections. Antiseptic surgery quickly gained supporters. Over time, doctors also began to develop aseptic techniques, including the sterilization of instruments, washing hands thoroughly, and wearing masks, caps, gowns, and gloves in the operating room. These developments meant that body cavity surgery became increasingly common, and surgeons performed more ambitious procedures, including non-emergency appendectomies, hernia surgeries, and surgeries on stomachs, livers, and kidneys.<sup>20</sup> Surgeons celebrated their newfound abilities, and projected an image of themselves as “bold, progressive, scientific reformers.” They suggested that surgery was a science with replicable results, and hospital rooms began to resemble laboratories.<sup>21</sup>



These developments improved patients' attitudes towards hospitals, and raised hopes for successful treatment. Patients came to expect cures, rather than mere comfort. People thus stopped avoiding hospitals and, instead, became willing to pay substantial fees for surgical treatments and personalized hospital care. Physicians also became more willing to relieve suffering through surgery so long as procedure involved an 'acceptable' risk to life.<sup>22</sup> More ambitious surgeries, however, increased the possibility of error and led to new situations that became the bases of lawsuits. For instance, courts began hearing cases involving medical professionals who left sponges or surgical instruments inside of patients after performing body cavity surgeries. Moreover, as certain surgical procedures came to be viewed as 'routine', more and more physicians felt confident in their ability to undertake them, which sometimes resulted in poor outcomes.<sup>23</sup>

In the early twentieth century, a patient who launched a civil suit for medical negligence had to fulfill well-established legal tests. A plaintiff first had to show the existence of a 'duty of care' to the patient — that is, an obligation to conform to a certain standard of conduct for the protection of another against an unreasonable risk of harm. Physicians also had to exercise 'ordinary' skill and care in treating patients. However, the degree of skill and care that the justice system expected from medical professionals depended on several factors. Courts, for instance, held specialists to a higher degree of care. Proof of a bad result of treatment did not, by itself, provide evidence of negligence. There was, to quote Ontario Justice William Glenholme Falconbridge, "no implied warranty on the part of a physician or surgeon that he will effect a cure."<sup>24</sup> While the doctor had to exercise his (or her) judgement according to the expected standard of care, he could not be sanctioned merely because treatment resulted in a poor medical outcome. To recover damages, the plaintiff had to show that the doctor's negligent actions were the immediate, or 'proximate', cause of his or her injury.<sup>25</sup>

In *Davis*, the hospital, its doctors, and its nurses, clearly had a duty of care to the patient. It was also clear that the standard of care had been breached by someone. However, what was

less clear was who had been negligent. Adding to the practical challenges of securing evidence, noted above, doctrinal developments concerning the liability of hospitals and — because of their legal relationship with the hospital — doctors and nurses, further challenged Mary and Ellis' ability to receive compensation through a tort suit.

A 1909 English Court of Appeal case, *Hillyer v. St Bartholomew's Hospital*, shaped the respective legal responsibilities of hospitals, and the doctors and nurses that worked within them, in cases such as *Davis* in interwar Canada. The *Hillyer* case became authority for several rules. First, it stood for the principle that the relation of master and servant did *not* exist between a hospital board and the surgeons and physicians whom it supplied for the treatment of patients. In practical terms, this meant that plaintiffs could not sue a hospital for the negligence of its doctors. In *Hillyer*, the court concluded that a hospital had to appoint competent staff, but it was not liable for the negligence of doctors because it did not oversee them in their professional responsibilities. The case also stood for the proposition that nurses on hospital staffs were so immediately subject to a surgeon's control while assisting them during procedures that they, too, were not servants of the hospital authority. This part of the ruling reflects a dominant view in the early twentieth century that nurses were a doctor's "handmaidens," and were to perform as "the 'physician's hand.'"<sup>26</sup> Finally, the hospital was not responsible for nurses who acted negligently while completing matters requiring 'professional' skills, with which the governors of the hospital could not properly interfere. On the other hand, hospitals were responsible for nurses who were not under the direction of a physician and who acted negligently in completing 'administrative' duties at the hospital. Such duties included attending to ward patients, calling for aid in emergencies, and supplying food.<sup>27</sup> Canadian medical professionals were quick to note *Hillyer's* implications. The *Canadian Practitioner and Review* called *Hillyer* a "remarkable decision" for it "amounts to a declaration that, on the ground of public policy, a hospital cannot be sued for damages."<sup>28</sup>

Canadian lawyers picked up on the case immediately in defending against malpractice claims, and many judges seemed keen to employ the *Hillyer* decision to reduce the liability of hospital authorities.<sup>29</sup> For example, in *Jarvis v. International Nickel Co.* (1929), the High Court Division of the Ontario Supreme Court extended *Hillyer* to a hospital operated by the International Nickel Company for the benefit of its employees.<sup>30</sup> Similarly, in *Hamilton v. Phoenix Lumber Co.* (1930), the Appellate Division of the Alberta Supreme Court relied on *Hillyer* to deal with an even more complicated situation concerning workplace medical care. In this case, the defendant company hired a physician to serve its employees. That physician then contracted a second doctor to attend a work camp. The contract doctor failed to correctly diagnose an outbreak of smallpox — he believed the men had fallen ill with influenza — and, as a result, an employee caught smallpox and suffered long-term damage to his eye. The employee sued the company, but lost at trial. The appeal court then dismissed the plaintiff's appeal by applying *Hillyer*. The company had arranged for a qualified physician “on whose judgment the company would be entitled to rely.”<sup>31</sup>

On the other hand, the potential harshness of the *Hillyer* rule sometimes led courts to enunciate various exceptions. One example is the Supreme Court of Canada's decision in *Nyberg v. Provost Municipal Hospital Board* (1929). The *Nyberg* case arose in Alberta in 1924 when the plaintiff underwent surgery at the Provost Municipal Hospital after suffering a ruptured appendix. As a part of the treatment, nurses placed heated hot water bottles in the patient's bed to keep the patient warm after surgery. The next morning it was discovered that the patient's left leg had been severely burned by one of the bottles. The patient proceeded to sue the hospital for damages, winning at trial. The hospital appealed the trial court's decision to the Appellate Division of the Alberta Supreme Court, where it was overturned under the *Hillyer* principle. The Appellate Division found that the hospital was not liable for the injuries incurred by the plaintiff on the ground that the hospital had hired competent staff. However, the Supreme Court of Canada, in a 4–2 decision, overturned the

Alberta appeal court, asserting that the Provost Municipal Hospital was indeed responsible for the plaintiff's burn injuries. Chief Justice Frank Anglin maintained that *Hillyer* was not applicable to the case because the nurses had acted as servants of the hospital. The hospital had undertaken to nurse the patient, not just supply properly qualified nurses. Chief Justice Anglin reasoned that the burning of the plaintiff occurred after the operation had been completed, and thus the nurses were no longer under the direction of the surgeon.<sup>32</sup> The *Nyberg* decision could help Mary and Ellis' case against the hospital — *if* they could prove that the nurses at the hospital had been negligent and had not been under the direction of the doctors.

### The Trial

Mary and Ellis Davis had their case heard before the Supreme Court of Nova Scotia on 8 and 9 November 1932. "Much interest was evident in the case," reported the *Truro Daily News*, which covered the litigation on its front page.<sup>33</sup> Newspapers in both Truro and Halifax seemed intrigued by the involvement of several prominent physicians and lawyers. The lawyer for the plaintiffs was Gilbert Hugh Vernon, K.C. Then in his mid-fifties, Vernon was a prominent trial lawyer in Truro later remembered as a "clever debater."<sup>34</sup> Laurence Arthur Lovett, K.C., a Dalhousie Law School graduate and member of the prominent Halifax law firm McInnis, Lovett & MacDonald, defended the hospital. One member of the province's legal elite described Lovett as "the leading litigator at the bar,"<sup>35</sup> and Lovett had some expertise defending hospitals in malpractice suits, having handled a similar case concerning the Colchester County Hospital ten years earlier.<sup>36</sup> Hearing the case, without a jury, was Justice Robert Henry Graham. Born in New Glasgow, Nova Scotia in 1871, Graham was a graduate of Dalhousie Law School. Like many judges of his time, he had a background in politics, having served as a town councillor, and then as the mayor, of New Glasgow. He had also sat as a member of the Nova Scotia legislature prior to receiving an appointment to the Supreme Court of Nova Scotia in 1925.<sup>37</sup>

Given the *Hillyer* precedent, the plaintiffs sought to prove that the negligence of Mary's attending floor nurses, rather than the actions of her doctors, had caused the burns. Suing the nurses directly was likely unappealing, as they presumably had shallower pockets than the hospital, which had an insurance policy to cover malpractice awards. The hospital, on the other hand, argued that the burns had been caused by the negligence of their *own physicians*. According to *Hillyer*, the hospital only had to hire competent physicians, and thus there was a chance that it could avoid liability if it could prove that the doctors had violated their standard of care for the patient. The legal terrain thus resulted in the hospital's nurses providing evidence contradicting that of the doctors, and vice and versa.<sup>38</sup>

The plaintiffs called nine witnesses. These included Mary and Ellis, Dr. Charman and Dr. Reid, as well as the two surgical nurses, Gertrude Black and Ira Miller. The hospital's superintendent, Anna Gilmour, also gave evidence for the plaintiffs. Mary began her testimony by describing the pain she had suffered. She recalled waking up from surgery and feeling "terrible pains in both legs." When she was able to talk, she asked Anna Chisholm what was wrong with her legs, but Anna said that she did not know. Mary reported that all of the nurses subsequently refused to disclose the cause of her injury: "I asked right away, of course, — and nobody knew."<sup>39</sup> She also alleged that, at one point, Dr. Charman had suggested that her injuries had stemmed from an ether burn. It was not until Anna Gilmour returned from a summer vacation that Mary found out the true cause of her burns. Dr. Charman continued to treat Mary in the hospital, as well as after she returned home. For his part, Ellis testified that Mary had "suffered something terrible" from the burns, and that she was unable to complete her household work for some time.<sup>40</sup>

The examination and cross examination of Mary's doctors became heated. The *Truro Daily News* reported a "verbal battle" between the defence and Dr. Charman,<sup>41</sup> while the *Halifax Chronicle* observed that there was "much difference of opinion between doctors giving evidence as to what responsibilities the medical men have in connection with a patient taken to the hos-

pital.”<sup>42</sup> Dr. Charman was the first doctor to give evidence for the plaintiffs. He sought to show that he had not been negligent, but rather that the nurses were to blame, and therefore the hospital should compensate Mary and Ellis. Dr. Charman claimed that upon entering room 21, along with the two other operating room doctors, he had found the hot water bottle lying *on top* of the blankets on the bed. He reported that he had moved it out of harm’s way, placing it at the foot of the bed on top of the blankets. He could not, however, provide any explanation for how the bottle eventually ended up under Mary’s calves. He also insisted that he had not covered up the patient with a blanket, thus hiding the bottle and preventing the nurses from noticing it.<sup>43</sup> Following Mary’s transfer to room 21, Dr. Charman (and the two other doctors) left, for, as he stated, “My responsibility and province ceases at that time.”<sup>44</sup> In other words, he argued that the injuries Mary had sustained were due to the inaction of the nurses who took charge of the patient after her transfer.

The responsibility of nurses, doctors, and hospitals for a negligent incident, as defined by *Hillyer*, thus shaped much of the proceedings. Notably, the hospital’s lawyer, Lovett, objected to Dr. Charman’s claim that his responsibility to care for Mary had ceased once she had been transferred to room 21. Lovett believed that this was a matter of law upon which Dr. Charman should not comment. It was a “rather crucial point in this action,” Lovett reminded the court. Dr. Charman nevertheless insisted that many tasks fell to the nurses, which therefore rendered the hospital, not the doctors, responsible. To choose a few examples, he told the court that doctors were not responsible for preparing post-operative beds for their patients, or even for ensuring that nurses were on hand to complete such tasks. He also asserted that doctors were not responsible for removing blankets before patients were placed into their beds, nor for covering them with blankets. He maintained that a doctor’s responsibility for a patient “ceases when the patient leaves the operating room.” In Mary’s case, he argued that a “nurse should have been there to remove it [the hot water bottle], if it was not already taken out.” Justice Graham responded rather coldly to

Dr. Charman's claims, bluntly stating: "If I thought that was the law I would try to have the legislature amend it." Since Dr. Charman's evidence was meant to support the lawsuit, he went on to emphasize the severity of Mary's burns, suggesting to the court that they had caused "very marked disfigurement on the legs." He attested to the presence of large, discoloured scars that interfered, somewhat, with the healthy functioning of Mary's legs, and he suggested the scars would continue to cause her pain for a long time.<sup>45</sup>

In an aggressive cross-examination, Lovett took aim at Dr. Charman's truthfulness, motivations, and manliness. In questioning his truthfulness, Lovett repeatedly asked whether Dr. Charman had, in fact, seen and moved the water bottle, given that it would have been very unusual for the bottle to be lying on top of the bed in plain sight. Lovett also spent considerable time questioning Dr. Charman as to where he had placed the bottle if, in fact, he had moved it at all. He thus sought to suggest that Dr. Charman, and the two accompanying doctors, had simply placed Mary on top of the bottle or moved it to a dangerous place. Lovett also asked Dr. Charman if he was accurately reporting whether he, or one of the other doctors, had covered Mary with a blanket, thus hiding the bottle:

A. No.

Q. How do you know you didn't?

A. I presume the nurse covered her; they always cover them; they always do.

Q. Never mind that. Did you leave that patient uncovered?

A. No.

Q. Who covered her?

A. I am not saying; that is not my function.

Q. Didn't you cover her?

A. No.

Q. Didn't you pull the clothes up around that patient?

A. No.

Q. Are you in earnest?

A. Absolutely.

Q. On your oath?

A. Yes, on my oath.<sup>46</sup>

This intense questioning, however, eventually led Dr. Charman to hedge his answer. He admitted that he may have helped tuck the covers around Mary. Justice Graham grew frustrated at the doctor's evidence at this point, intervening to ask: "Have you any recollection of what occurred at all?" "No," the doctor replied, before once again adding "that it not my business" as a way of shifting the blame onto the nurses. This led Justice Graham to suggest that Dr. Charman was, indeed, at fault. "My impression is that the thing occurred through you putting that hot water bottle somewhere," he declared. In response to the doctor's continued persistence that his duty to Mary had ceased, Justice Graham retorted: "I don't know whose the neglect was but it seems to me you put that bottle in a place where the nurse didn't notice it for some reason or other, and as a result this woman was burnt."<sup>47</sup> In Justice Graham's view, Dr. Charman was lying.

In his questioning of Dr. Charman's motivation, Lovett focused on the potential effect of the case upon the doctor's pocket-book and reputation. After all, giving evidence against the hospital ensured that the plaintiffs would not sue Dr. Charman personally. In addition, Dr. Charman indicated that he had visited Mary 55 times to treat her injuries, and the defence hinted that he was motivated by a desire to ensure he received payment for this work. Lovett asked Dr. Charman whether so many visits were truly necessary, leading the doctor to admit that he knew an insurance company might pay for them, should the hospital be found liable.<sup>48</sup> Lovett also procured testimony hinting that Dr. Charman desired to protect his future income. Prior to the surgery, Dr. Charman had discussed with Mary the preference of some patients to have procedures completed at other, larger hospitals. In fact, he admitted that he had convinced Mary to have the surgery at the Colchester County Hospital. To dissuade her from travelling to a hospital in Halifax, he had refuted claims of "some busybodies" who had told Mary about "all the dire things that happened" in the Colchester County Hospital.<sup>49</sup> Dr. Char-



man expressed concern that if everyone had routine operations completed in Halifax or Montréal, the number of procedures completed in Truro would decline. Since paying patients could choose their hospital and their doctor, and patient fees still comprised a substantial portion of hospital budgets and doctors' incomes, doctors (and hospitals) had to defend reputations or suffer pecuniary losses. This was a special concern in the Depression era when the number of paying patients declined at hospitals.<sup>50</sup>

In questioning Dr. Charman's manliness and professionalism, Lovett repeatedly attacked the doctor's efforts to blame the nurses for Mary's injury. "Is it part of the duty or privilege of the nurses to shoulder the mistakes of the medical men?," he asked.<sup>51</sup> Later, Lovett further poked fun at Dr. Charman:

Q. I suppose under all circumstances the nurse gets the blame?

A. She gets blamed for nursing, and the doctor for the medical part of it; any orders I give the nurse I take the blame for; anything she does in nursing routine she takes it.

Q. When does the nurse give the doctor orders?

A. Never.

Q. That is what I thought....<sup>52</sup>

Lovett also asked Dr. Charman about the simple steps that the doctors might have taken to prevent the injury. For example, he asked why Dr. Charman had not checked that the nurse responsible for Mary's room had returned before he left his patient.<sup>53</sup> Dr. Charman fell back on the excuse that the water bottle was the nurses' responsibility, not his, which led Lovett to mock his answer:

Q. You cannot get the nurse out of the doctor's mind –

A. That is what they are there for.

Q. To take all the blame?

A. To do their own nursing.<sup>54</sup>

Through this line of questioning, Lovett sought to take legal advantage of the patriarchal assumptions that existed about the

relationship between doctors and nurses. During the 1920s and 1930s, many doctors resisted efforts of nurses to claim professional status, and emphasized the leadership role of physicians in hospital settings.<sup>55</sup> Doctors asserted a role akin to a father-figure. They were to wield their authority in a firm, yet generous manner, and treat their nurses kindly, as if they were symbolic wives and daughters. In return, the nurses were expected to be deferential towards, and subordinate to, the male doctors.<sup>56</sup> With his testimony, Dr. Charman risked being seen as violating this doctor-nurse relationship — abusing his position of authority by blaming members of his own 'family'. Lovett thus attempted to portray Dr. Charman as unchivalrous and unmanly before the court.

The other doctors involved in the surgery gave evidence similar to that of Dr. Charman. Dr. Reid only remembered a few details about the transfer of the patient, but adamantly asserted that the nurses were responsible for removing hot water bottles and covering the patient. Dr. Eaton claimed no responsibility for Mary's burns and could not explain who had covered the patient. "I have nothing to do with the covering up" of the patient, he told the court.<sup>57</sup> Justice Graham again expressed displeasure at the apparently poor memories of the doctors.

Hospital superintendent Anne Gilmour also gave evidence for the plaintiff. She told the court that it was, indeed, the nurses' responsibility to remove water bottles and to draw sheets over patients.<sup>58</sup> However, under cross examination, Gilmour gave testimony that risked tainting the purity of Dr. Charman's motivations. She noted that the incident had not been immediately reported to the hospital board because Dr. Charman "didn't want the patient worried" or to face "any publicity." When asked to clarify this statement, Dr. Charman claimed that he had been referring to, and acting in, the best interests of "the hospital and patient, of course," before adding "I never even thought of myself."<sup>59</sup> The most positive interpretation, then, is that Dr. Charman wanted to avoid giving local 'busybodies' more to gossip about. The fact that a similar case had occurred in 1924 at the same hospital also may have motivated the effort to protect

the hospital's reputation. In the earlier case, *Logan v. The Colchester County Hospital Trust*, a female plaintiff received \$1500 in compensation from the hospital after she awoke from surgery with severe burns on her feet caused by a hot water bottle. The hospital had appealed the trial judgment against it, taking the case to the Appeal Division of the Nova Scotia Supreme Court, which confirmed the lower court's decision.<sup>60</sup> Charman knew about the *Logan* case (he discussed it during the *Davis* trial) and he likely wanted to avoid the negative publicity that might arise from a similar injury occurring more than once.

The Colchester County Hospital's defence rested on demonstrating that the doctors, rather than its nurses, had harmed the patient through their negligent actions. In his cross-examination of the plaintiffs' witnesses, Lovett tried to procure evidence that contradicted that of the doctors. For example, under Lovett's questioning, one of the surgical nurses, Ira Miller, revealed that when the doctors had left room 21, Mary was already covered with a blanket. However, she claimed that she had no knowledge as to which doctor had covered the patient.<sup>61</sup> Miller further reported that Dr. Charman had said "something about keeping it [the injury] quiet," again making it sound like he was intent on covering up his own wrongdoing.<sup>62</sup>

In her testimony for the defence, Anna Chisholm explained the normal procedure for patient post-operative care, including the process of placing one hot water bottle under the covers of the bed to warm it for the patient arriving from the operating room. Because she had several patients under her care on the day of Mary's surgery, Anna had not waited in room 21. Normally, she would be told of the patient's transfer or would come when she heard the carriage rolling down the hallway. In this instance, however, Anna, while en route to the hospital's nursery, noticed around 1:00 p.m. that Mary had arrived in her room. She proceeded to take charge of the room from Margaret Chisholm. With Margaret off duty from 1:00 p.m. until 3:00 p.m., Anna had to attend to the whole floor. Hampered by other responsibilities, she did not take the operating room blanket off Mary until 1:20 p.m., thus discovering the hot water bottle and the

burns.<sup>63</sup> She informed Dr. Charman of the incident at 1:30 p.m., at which point he told her "God help us, or something to that effect."<sup>64</sup> Vernon, the plaintiffs' lawyer, responded by suggesting that Anna had failed to meet the required standard of care. He asked her whether she had looked for the hot water bottle immediately upon taking charge of her patient. Anna acknowledged that she had not done so, explaining that she had assumed someone else had already removed the bottle, and that she had been too busy to check.<sup>65</sup>

Margaret Chisholm, in her testimony for the hospital, indicated that the patient had already been covered when she arrived at around 12:50 p.m. Vernon also questioned why she had not looked for the bottle. "I took it for granted it had been taken out by whoever put the patient in bed," Margaret replied. Vernon attempted to challenge her response, but Justice Graham intervened and came to her defence. "She had no responsibility," asserted Justice Graham.<sup>66</sup>

The hospital also questioned the severity of Mary's injuries. Lovett tried to raise doubt about whether the burns had long-term health consequences, including toxemia and fluctuating blood pressure.<sup>67</sup> The hospital's insurance company, Thompson, Adams & Co. of Halifax, had two doctors assess Mary and provide evidence for the defence. The company first employed Dr. W. Alan Curry to examine Mary. Dr. Curry was a well-respected Halifax surgeon who eventually served as the President of the Medical Society of Nova Scotia and as the Head of Dalhousie's Department of Surgery. In August 1931, he reported to the insurance company that Mary's injuries were healing well, and he concluded that her fainting spells were unrelated to her burns. Dr. Curry believed that Mary would continue to suffer from a "white unsightly scar," but added that "stockings will cover the scars absolutely" as a means of diminishing the impact of the burns.<sup>68</sup> At the trial, he asserted that the burns had not affected the underlying muscles and were "soundly healed." He further assured the court that Mary would not remain physically lame, and he rejected the plaintiffs' claim that the burns had caused toxemia or fainting spells. In fact, he went so far as to

suggest that Mary's burns would not have caused her significant pain. "As a rule," he asserted, the type of burns she had experienced only caused pain "for a day or two."<sup>69</sup> A second doctor, Dr. Silas Fulton, also conducted an examination of Mary and gave evidence at trial for the defence. Dr. Fulton found that the plaintiff's burns had healed, and that her leg muscles had escaped unscathed. He also insisted that her blood pressure and heart readings remained sound. However, in contrast to Dr. Curry, he believed that the burns had likely caused a certain degree of toxemia in the blood.<sup>70</sup>

Justice Graham gave the court some sense of his impressions of the trial as it came to a conclusion. He again critiqued the doctors, especially for their tendency to blame Mary's injuries on the nurses. For example, he said that a doctor was not "absolved by saying there was an eighteen year old girl to take the bottle away." He also bristled when one doctor claimed that physicians only moved patients as a "matter of courtesy." "You can call it a matter of courtesy," Justice Graham remarked, "but you are a man of sense and training" and if "you undertake to do something" then "you are responsible for what you do, whether it is a matter of courtesy or a service for which you are paid." Justice Graham went on to critique the suggestion that Anna Chisholm should have been waiting in room 21 for the patient to return. He recognized that the nurses were responsible for many tasks and that the Colchester County Hospital could not provide sufficient staff "to have a nurse sitting in that room waiting until the patient returns from the operating room."<sup>71</sup>

Justice Graham's comments were not good news for the plaintiffs. After all, if the Court were to find the doctors responsible for the injury, then the Davis' case against the hospital would fail. Yet, while Justice Graham seemed to have little faith in the testimony of the doctors, he left open the possibility that he might find for the plaintiffs. During the trial, he said that it seemed to him that the doctors had been negligent and "the only other question in my mind is whether or not there was not negligence on the part of somebody else who should have looked to see what became of it [i.e. the bottle]."<sup>72</sup>

## Trial Decision

Despite his harsh statements during the trial about the actions and testimony of the doctors, in his written decision Justice Graham found for the plaintiffs. He noted that all of the doctors denied any wrongdoing; they “do not know who put the clothes over the patient” but “each for himself denies that he did.” Justice Graham even insinuated that Dr. Charman had lied during his testimony. The “facts strongly suggest that the doctors never thought about a bottle being in the bed, and inadvertently put the patient on top of it.” Justice Graham believed that Dr. Charman refused to accept his responsibility. Dr. Charman “unwittingly argues himself into a belief contrary” to the facts due because of his belief that it was “the nurse’s duty.”<sup>73</sup> Such judicial criticism of a physician in a malpractice suit was extremely unusual in this period, as members of the legal profession tended to accord the testimony of doctors much respect.

Justice Graham’s belief that the doctors had likely acted negligently, however, did not lead him to find for the hospital, despite the holding in *Hillyer* that hospitals were not responsible for the negligence of its physicians. Instead, in a very brief analysis, Justice Graham reasoned that the actions of the doctors “did not relieve the nurses from their responsibility to see that the bed was safe.” Justice Graham then fudged, for the testimony at the trial had not shown much evidence of negligence on the part of the nurses, other than that they might have checked for the water bottle under the blanket a few minutes sooner. “If there was negligence on their part, which directly contributed to cause the injury,” Justice Graham suggested, then “the hospital is liable for the damages.” However, Justice Graham did not explicitly address how each of the nurses had either acted, or not acted, negligently, asserting that it was “not material to find which of the nurses in the circumstances failed in [their] duty.” In other words, he believed that one of the nurses should have checked Mary’s bed, but he did not say which one. He awarded Mary Davis \$500 in damages, and her husband \$300 in damages, plus costs. This was a sizable amount, although much less than Mary and Ellis had originally demanded.<sup>74</sup>

## Court of Appeal

Believing that \$800 plus legal costs was insufficient compensation for their hardships and expenses, Mary and Ellis decided to appeal the trial judgment to the appellate level of the Nova Scotia Supreme Court. Launching an appeal was not without risk. The hospital cross-appealed, meaning that the appellate court might overturn the trial judgment. L.A. Lovett once again represented the hospital. He opposed the argument that Justice Graham had insufficiently compensated Mary and Ellis, and argued that the judge had erred in finding that the plaintiffs had shown negligence on the part of the nurses. Instead, he claimed that the doctors had failed to fulfill *their* duty to remove the bottle from the bed. Thus, the doctors' actions were the 'proximate' cause of the injury, and, in light of the *Hillyer* decision, the plaintiffs' action should have failed at trial.

Three members of the Nova Scotia Supreme Court considered the appeal: Humphrey Mellish, and two former Nova Scotian attorneys general: W.F. Carroll and William H. Hall. In a 2–1 decision, the appeal court upheld the trial judgment. Justice Mellish dismissed both the appeal and cross-appeal. Like Justice Graham at the trial court, Justice Mellish glossed over the doctrinal complexity of the issue. He noted that the hospital was "bound to see that the patient was not exposed to any such dangers or risks as would arise from placing a superheated water bottle" in Mary's bed "without taking due care that the patient should not come in contact with it." According to the evidence, asserted Mellish, "such care was not I think taken, whatever the duty of the attendant physicians or surgeons may have been, and whether they performed their duties or not."<sup>75</sup> Justice Mellish seemed untroubled by the issue of who, exactly, had been negligent, and what they had done negligently. He made no mention of the *Hillyer* rule that hospitals had to hire competent physicians, but were not responsible for supervising them. Justice Carroll agreed with Justice Mellish in this result.

Justice Hall's dissent demonstrated the problem that *Hillyer* could pose to patients suing hospitals. For Justice Hall, the case

hinged “upon what transpired while the doctors were in room 21,” for it was “settled law” that a surgeon was not a servant of the hospital. He noted that the nurses, at the time of the incident, were not assisting in an operation and were thus servants of the hospital. However, Justice Hall concluded that it “cannot be contended that there was any negligence on the part of the defendant prior to the doctors entering the room with the patient.” He believed that Anna Chisholm had followed the usual practice of placing the hot water bottle under the covers, and that “she could not reasonably be expected to wait in room 21” for the patient’s return.<sup>76</sup>

Like Justice Graham, Justice Hall had sharp words for the doctors, yet he would have found against Mary and Ellis. He believed that the actions of the doctors warranted close scrutiny, but noted that there was “an amazing dearth of evidence as to what happened while the doctors were in the room.” Dr. Reid, Justice Hall noted, recalled that all three doctors rolled the patient in “but can remember no further details.” Similarly, Dr. Eaton remembered transferring the patient to room 21, but could not speak as to whether the bed had been made or who had covered the patient. Justice Hall made a point of saying that this “failure of recollection on the part of the doctors merits some comment,” as he found it “difficult to understand” the doctors’ “almost complete loss of memory with respect to [the] vital incidents that occurred in room 21.” He could fathom only one explanation: “Possibly their reticence is professional etiquette.”<sup>77</sup> This was a roundabout way of calling them liars. In Justice Hall’s view, the doctors had acted negligently and thus he would have overturned the trial judgment and dismissed the action.

It is not known what Mary and Ellis thought of the appeal judgment. Despite her injuries, Mary Davis lived to a ripe old age, passing away in 1976. She outlived Ellis by 30 years — he had died in 1946, at 54 years of age, after an illness had led to him to retire from his post as chief dispatcher of C.N.R.’s Truro branch.<sup>78</sup>



## Conclusion

The *Davis* case highlights some of the challenges faced by patients attempting to sue for medical negligence in the first half of the twentieth century. First, patients under anesthetic could not offer evidence regarding their treatment, and instead had to rely on medical professionals to honestly report their own mistakes. Second, patients had to assert their claims against well-respected members of the community. Doctors asserted their professionalism, and sought to tamp down suggestions that hospital care and ambitious surgeries entailed uncertainty and risk. They made references to scientific medical studies, issued bold assertions about their own qualifications, and employed highly technical language. Judges usually expressed faith in the honesty, professionalism, or skill of doctors. Only in exceptional circumstances, such as in *Davis*, did judges question the truthfulness of doctors. Finally, doctrinal developments also allowed some negligent parties to escape responsibility. Patients had to overcome the complications imposed by *Hillyer*, including that injured patients could fail if they sued the wrong defendant. Many patients were not as fortunate as Mary and Ellis, who seemed to benefit from the judge's desire to provide them with some compensation, particularly given the questionable veracity of the evidence given by the doctors.

These legal and social factors thus placed substantial limits on the ability of many patients to express displeasure with their treatment through lawsuits. As Wendy Mitchinson notes, female patients had some agency when dealing with physicians in the first half of the twentieth century, despite the generally unequal nature of the patient-doctor relationship. Women sometimes refused to see a physician, rejected suggested treatments, or left hospitals earlier than recommended. Mary Davis demonstrated her agency in dealing with the burns. She demanded to know how she had been injured and decided when to stop receiving morphine. Taking a malpractice case to court was another means of challenging the authority of medical professionals.<sup>79</sup> However, as the *Davis* case demonstrates, successfully proving negligence

was difficult, even in seemingly obvious cases of poor treatment. Alleging malpractice also had risks. The cost of suing could escalate quickly. In addition, if plaintiffs lost at trial, which often occurred, they could appear as nothing more than blackmailers (as many doctors of the time claimed them to be) trying to shake down physicians for their own benefit. The patient-physician relationship thus remained, and would continue to remain, an unequal one.

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## Endnotes

- 1 In fact, there has been a lack of critical inquiry into most areas of Canadian tort law by legal historians. For examples, see James Muir, "Instrumentalism and the Law of Injuries in Nineteenth-Century Nova Scotia" in *The Supreme Court of Nova Scotia, 1754–2004: From Imperial Bastion to Provincial Oracle*, eds. Philip Girard, Jim Phillips, and Barry Cahill (Toronto: University of Toronto Press and the Osgoode Society, 2004), 361–91; Jennifer Nedelsky, "Judicial Conservatism in an Age of Innovation: Comparative Perspectives on Canadian Nuisance Law, 1880–1930" in *Essays in the History of Canadian Law, Volume 1*, ed. David H. Flaherty (Toronto: Osgoode Society, 1981), 281–322; R. Blake Brown and Noelle Yhard, "'The harshness and injustice of the common law rule ... has frequently been commented upon': Debating Contributory Negligence in Canada, 1900–1949," *Dalhousie Law Journal* 36 (2013): 137–69; Peter Karsten, *Between Law and Custom: 'High' and 'Low' Legal Cultures in the Lands of the British Diaspora — the United States, Canada, Australia, and New Zealand, 1600–1900* (Cambridge: Cambridge University Press, 2002).
- 2 Peter J. Mitham, "'Very Truly and Undisturbedly Yours': Joseph Workman and a Verdict of Malpractice against John Galbraith Hyde," *Canadian Bulletin of Medical History* 13 (1996): 139–49; Iain McCormick, *Practical Sympathy: The Malpractice Trial of Dr. J.M. Conerty and the Formation of the Canadian Medical Protective Association* (Ottawa: Canadian Medical Protective Association, 2002). Also see Jennifer Dunlop, Geertje Boschma, and Rosella Jefferson, "Nursing and Anaesthesia: Historical Developments in Canada," *Canadian Operating Room Nursing Journal* 27, no. 2 (June 2009): 16–27. There are some studies, however, that consider coroners' inquests that examined the death of patients because of allegedly poor medical treatment. For examples, see Jacalyn Duffin, *Langstaff: A Nineteenth-Century Medical Life* (Toronto: University of Toronto Press, 1993), 221–2; Jacalyn Duffin, "The Death of Sarah Lovell and the Constrained Feminism of Emily Stowe," *Canadian Medical Association Journal* 146, no. 6 (1992): 881–8; Jacalyn Duffin, "In View of the Body of Job Broom: A Glimpse of the Medical Knowledge and Practice of John Rolph," *Canadian Bulletin of Medical History* 7 (1990): 9–30.
- 3 Duffin, "In View of the Body of Job Broom," 10.
- 4 For examples, see Kenneth Allen De Ville, *Medical Malpractice in Nineteenth-Century America: Origins and Legacy* (New York: New York University Press, 1990); James C. Mohr, *Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America* (New York: Oxford University Press, 1993); Allen D. Spiegel and Florence Kavalier, "America's

- First Medical Malpractice Crisis, 1835–1865,” *Journal of Community Health* 22, no. 4 (1997): 283–308; Chester R. Burns, “Malpractice Suits in American Medicine Before the Civil War,” *Bulletin of the History of Medicine* 43 (1969): 41–56; James C. Mohr, “American Medical Malpractice Litigation in Historical Perspective,” *Journal of the American Medical Association* 283, no. 13 (2000): 1731–7; Neal C. Hogan, *Unhealed Wounds: Medical Malpractice in the Twentieth Century* (New York: LFB Publishing, 2003).
- 5 By way of example, Canada’s primary organization for providing legal defence and liability protection to physicians, the Canadian Medical Protective Association, had over 91,000 members in 2014 and an investment portfolio valued at over 3.1 billion dollars. In that same year, it paid out approximately 400 million dollars in awards, settlements, legal costs, and experts. Many Canadian physicians complain about the cost of malpractice insurance, while patients often notice the various efforts made in hospitals, clinics, and doctors’ offices to avoid potential liability. Canadian Medical Protective Association, *Canadian Medical Protective Association — 2014 Annual Report* (Ottawa: Canadian Medical Protective Association, 2015), 8, 16; Colleen M. Flood, “Canadian Medical Malpractice Law in 2011: Missing the Mark on Patient Safety,” *Chicago-Kent Law Review* 86 (2011): 1053–92; Tom Blackwell, “Inside Canada’s Secret World of Medical Error: ‘There is a lot of lying, there’s a lot of cover-up,’” *National Post* (16 January 2015), <<http://news.nationalpost.com/health/inside-canadas-secret-world-of-medical-errors-there-is-a-lot-of-lying-theres-a-lot-of-cover-up>>.
- 6 Franca Iacovetta and Wendy Mitchinson, “Introduction: Social History and Case Files Research,” in *On the Case: Explorations in Social History*, eds. Franca Iacovetta and Wendy Mitchinson (Toronto: University of Toronto Press, 1998), 6.
- 7 The legal materials do not disclose the nature of the operation. The doctors and lawyers in the trial used discretion in describing the operation.
- 8 *1921 Census of Canada*; “Bert Davis Dead After Long Illness,” *Truro Daily News* (23 March 1946); Nova Scotia Archives, Nova Scotia Supreme Court at Halifax, Case files, Box 829, Case SC4791, Ellis H. Davis and Mary B. Davis v. The Colchester County Hospital Trust, trial transcript, 1.
- 9 “Nova Scotia,” *Canadian Medical Association Journal* 16, no. 12 (December 1926): 1552.
- 10 “Dr. F.F. Eaton,” *Truro Daily News* (20 January 1941); “Dr. F.D. Charman Passes Suddenly,” *Truro Daily News* (10 August 1946); “Late Dr. Charman Has Large Funeral,” *Truro Daily News* (13 August 1946); *Maritime Reference Book: A Biographical and Pictorial Record of Prominent Men and Women of the Maritime Provinces* (Halifax: Maritime Reference Book,

- 1931), 70, 85; Provincial Medical Board of Nova Scotia, *The Medical Register* (Halifax, NS: Royal Print & Litho, 1932), 7, 8, 14.
- 11 Trial transcript, 137.
  - 12 Trial transcript, 4.
  - 13 Trial transcript, 8–17.
  - 14 Trial transcript, 11, 18.
  - 15 Trial transcript, 11. Also see trial transcript, 18.
  - 16 Nova Scotia Archives, Nova Scotia Supreme Court at Halifax, Case files, Box 829, Case SC4791, Statement of claim of Ellis Davis and Mary Davis, 29 April 1932.
  - 17 Charles G. Roland, “The First Death from Chloroform at the Toronto General Hospital,” *Canadian Anaesthetists’ Journal* 11, no. 4 (1964): 437–39; Akitomo Matsuki and Elemér K. Zsigmond, “The First Fatal Case of Chloroform Anaesthesia in Canada,” *Canadian Anaesthetists’ Journal* 20, no. 3 (1973): 395–97; Harold Ellis, *The Cambridge Illustrated History of Surgery*, 2<sup>nd</sup> ed. (Cambridge: Cambridge University Press, 2009), 73–82; Owen H. Wangensteen and Sarah D. Wangensteen, *The Rise of Surgery: From Empiric Craft to Scientific Discipline* (Minneapolis: University of Minnesota Press, 1978), 275–300.
  - 18 *Davy v. Morrison*, [1932] *Ontario Reports* 1 at 26.
  - 19 To overcome the difficulties of proving the particulars of the negligent behaviour while they were unconscious, plaintiffs sometimes sought to employ the *res ipsa loquitur* maxim (which literally translates to ‘the thing speaks for itself’). Plaintiffs invoked it in the hope that courts would find for them even if they could not provide affirmative evidence of negligent treatment beyond the evidence that an injury had occurred. Some Canadian judges applied the *res ipsa loquitur* maxim in the 1930s. For examples, see *Harkies v. Lord Dufferin Hospital*, [1931] 2 *Dominion Law Reports* 440; *Taylor v. Gray*, *Fortnightly Law Journal* 6 (15 February 1937): 212–3. The overall judicial trend in Canada, however, was to limit the use of *res ipsa loquitur* in medical negligence cases. See *McTaggart v. Powers*, [1927] 1 *Dominion Law Reports* 28; G.C.T., “The Lost Tooth: Was the Dentist Negligent?,” *Canadian Bar Review* 5 (1927): 66–7. Canada’s leading tort law scholar of the period, Cecil Wright, urged caution in extending the use of *res ipsa loquitur* to such cases. C.A.W., “Negligence — Surgeons — Failure to Remove Swabs,” *Canadian Bar Review* 17 (1939): 268–76; R. Blake Brown, “Cecil A. Wright and the Foundations of Canadian Tort Law Scholarship,” *Saskatchewan Law Review* 64 (2001): 205–8.
  - 20 J.T.H. Connor, “Listerism Unmasked: Antisepsis and Asepsis in Victorian Anglo-Canada,” *Journal of the History of Medicine and Allied Sciences* 49 (1994): 207–39; Ellis, *The Cambridge Illustrated History of Surgery*, 73–124; Wangensteen and Wangensteen, *The Rise of Surgery*, 301–25;

- De Ville, *Medical Malpractice in Nineteenth-Century America*, 220; Charles G. Roland, "The Early Years of Antiseptic Surgery in Canada," *Journal of the History of Medicine and Allied Sciences* 22 (1967): 380–91.
- 21 Annmarie Adams and Thomas Schlich, "Design for Control: Surgery, Science, and Space at the Royal Victoria Hospital, Montréal, 1893–1956," *Medical History* 50 (2006): 307.
- 22 Martin S. Pernick, *A Calculus of Suffering: Professionalism and Anesthesia in Nineteenth-Century America* (New York: Columbia University Press, 1985); David Gagan and Rosemary Gagan, *For Patients of Moderate Means: A Social History of the Voluntary Public General Hospital in Canada, 1890–1950* (Montréal and Kingston: McGill-Queen's University Press, 2002), 4–5, 28–9.
- 23 For example, in 1926, the *Canadian Medical Association Journal* warned of this tendency with tonsillectomies. "Precautions in Tonsillectomy," *Canadian Medical Association Journal* 16, no.6 (1926): 701–2.
- 24 *Town v. Archer*, [1902] 4 *Ontario Law Reports* 383 at 388.
- 25 For overviews of how doctors understood their legal responsibilities, see A.J. Murray, "Malpractice," *Maritime Medical News* 10, no. 3 (March 1898): 85–9; J.S. Bentley, "The Relation of the Physician to the Law," *Maritime Medical News* 22, no. 2 (February 1910): 44–51.
- 26 Kathryn McPherson, "Science and Technique: Nurses' Work in a Canadian Hospital, 1920–1939" in *Caring and Curing: Historical Perspectives on Women and Healing in Canada*, ed. Dianne Dodd (Ottawa: University of Ottawa Press, 1994), 72.
- 27 *Hillyer v. St Bartholomew's Hospital*, [1909] 2 *King's Bench* 820 (Eng. CA).
- 28 "Responsibility of Hospitals," *Canadian Practitioner and Review* 34, no. 5 (May 1909): 315.
- 29 For an example of an early use of *Hillyer* in Canada, see *Booth v. Toronto General Hospital and I.H. Cameron* (1910), 17 *Ontario Weekly Reports* 118.
- 30 *Jarvis v. International Nickel Co.*, [1929] 2 *Dominion Law Reports* 842.
- 31 *Hamilton v. Phoenix Lumber Co.*, [1931] 1 *Dominion Law Reports* 777 at 783.
- 32 *Nyberg v. Provost Municipal Hospital Board*, [1927] *Supreme Court Reports* 226; *Nyberg v. Provost Municipal Hospital*, [1926] 2 *Dominion Law Reports* 563. Also see *Thompson v. Columbia Coast Mission*, [1914] 15 *Dominion Law Reports* 656; *Lavere v. Smith's Falls Public Hospital*, [1915] 26 *Dominion Law Reports* 346; "A Hospital's Liability for the Negligence of a Nurse," *Canada Lancet* 49, no. 5 (January 1916): 196–202. The *Nyberg* case proved useful for some plaintiffs in subsequent cases. See *Beatty v. Sisters of Misericorde of Alberta*, [1935] 2 *Dominion Law Reports* 804; "Hospitals [sic] Liability for Negligence of Nurses, and Other Employees Whether Interne, Agent of Patient," *Nova Scotia Medical Bulletin* 15 (1936): 376–7. For discussions of the law of hospital liability in this era,

- see Allen M. Linden, "Changing Patterns of Hospital Liability in Canada," *Alberta Law Review* 5 (1966–67): 212–25; William C.J. Meredith, *Malpractice Liability of Doctors and Hospitals (Common Law and Québec Law)* (Toronto: Carswell, 1956).
- 33 "\$5,000 Suit Against C.C. Hospital Opens in Supreme Court," *Truro Daily News* (8 November 1932).
- 34 "Obituary: G.H. Vernon," *Truro Daily News* (21 September 1936).
- 35 Barry Cahill, ed., *Frank Manning Covert: Fifty Years in the Practice of Law* (Montréal and Kingston: McGill-Queen's University Press, 2005), 40; Harry Flemming, *A Century Plus: History of McInnis Cooper & Robertson* (Halifax, NS, 1989), 47–8; Charles G.D. Roberts and Arthur Leonard Tunnell, eds., *The Canadian Who's Who, Volume II: 1936–1937* (Toronto: Times Publishing Company, 1936), 649.
- 36 *Logan v. The Colchester County Hospital Trust* (1928), 60 *Nova Scotia Reports* 62.
- 37 "Mr. Justice Graham Dies at Age 85," *Halifax Mail-Star* (28 May 1956).
- 38 Medical historians have examined the efforts of practitioners to assert authority over aspects of medical treatment. "Creating, defending, and negotiating professional boundaries," Peter Twohig notes, "are contentious issues with deep historical roots." In *Davis*, and many other malpractice cases, however, doctors and nurses sought to disclaim responsibility. Peter L. Twohig, *Labour in the Laboratory: Medical Laboratory Workers in the Maritimes, 1900–1950* (Montréal and Kingston: McGill-Queen's University Press, 2005), 3.
- 39 Trial transcript, 4, 5.
- 40 Trial transcript, 26.
- 41 "Doctor and Lawyer Have Keen Exchange in Hospital Case," *Truro Daily News* (9 November 1932). Also see "Charges Truro Hospital with Negligence," *Halifax Daily Star* (9 November 1932).
- 42 "Clashes Mark Supreme Court Case at Truro," *Halifax Chronicle* (10 November 1932).
- 43 Trial transcript, 40, 62, 70–3.
- 44 Trial transcript, 41.
- 45 Trial transcript, 42, 44, 49.
- 46 Trial transcript, 68.
- 47 Trial transcript, 69, 70.
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