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*May 10, 11, 14, 15, 16
*Oct. 2

ROGER WILSON (*Defendant*) .....APPELLANT;

AND

SWAN SWANSON (*Plaintiff*) .....RESPONDENT.

ON APPEAL FROM THE COURT OF APPEAL FOR BRITISH COLUMBIA

Physicians and surgeons—Degree of skill required of practitioner—Specialist—Surgical operation—Mistaken diagnosis—Matters of judgment.

The defendant, a highly skilled surgeon, performed an operation on the plaintiff, following a tentative diagnosis (made independently by the defendant and others) of cancer. A growth was found in the plaintiff's stomach, and a test made by a pathologist while the plaintiff was still in the operating-room showed that it was probably malignant. The defendant thereupon decided to proceed with the operation rather than postpone it for a further (and more positive) test, which could not be completed in less than 24 hours. Because of his belief that the growth was malignant the defendant removed more of the plaintiff's organs than he would have done if he had known (as was later established) that it was benign.

Held (Kerwin C.J. and Locke J. dissenting): The plaintiff had failed to establish even a *prima facie* case of negligence on the defendant's part, and the action was rightly dismissed by the trial judge.

Per Rand and Nolan JJ.: A surgeon by his ordinary engagement undertakes with the patient that he possesses, and will faithfully exercise, the skill, knowledge and judgment of the average of the special class of technicians to which he belongs. Where the only question involved in one of judgment, the only test can be whether the decision made was the result of the exercise of the surgical intelligence professed, or was such that (apart from exceptional cases) the preponderant opinion of the group would have been against it. The only evidence given on behalf of the plaintiff in the case at bar failed to establish that this test had not been met. In particular, it was not established that any of the preliminary tests suggested in evidence would have been of any assistance in determining the nature of the growth.

Per Abbott J.: The medical man must possess and use that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases, and it is the duty of a specialist such as the defendant, who holds himself out as possessing special skill and knowledge, to have and exercise the degree of skill of an average specialist in his field. In making the decision to proceed with the operation, the defendant exercised his best judgment in what he considered to be the best interest of his patient.

The evidence relating to certain pre-operative tests which, it was claimed, should have been made, was the only evidence which might be considered as *prima facie* evidence of negligence. But it fell short of meeting the test of *prima facie* evidence. The trial judge was right in holding not only that the plaintiff had failed to make out a *prima facie* case of negligence but that there had been no negligence.

*PRESENT: Kerwin C.J. and Rand, Locke, Abbott and Nolan JJ.

APPEAL from the judgment of the Court of Appeal for British Columbia (1), reversing the judgment at trial (2). Appeal allowed, Kerwin C.J. and Locke J. dissenting.

D. McK. Brown, for the appellant.

R. Young, for the respondent.

THE CHIEF JUSTICE (*dissenting*):—For the reasons given by Coady J.A. (1) this appeal should be dismissed with costs.

The judgment of Rand and Nolan JJ. was delivered by

RAND J.:—The defendant in this action is a highly skilled surgeon who is charged with negligence in an operation involving the removal of a stomach ulcer. The negligence is said to have lain in the decision to remove the ulcer as a malignant growth which called for the resection of a larger portion of the stomach, pancreas and spleen than would have been required for the benign growth which it was.

The circumstances under which the decision was made were these. On March 26, 1951 the respondent, at that time 67 years of age, was admitted to a hospital at Lethbridge, Alberta. He complained of pains in the epigastrium or upper central portion of the abdomen, was feverish and weak. He had been troubled with periodic indigestion for many years. In 1926 he had undergone a laparotomy to investigate what he described as an ulcer of the liver, the result of which was the removal of the appendix. In the next year severe pains in the abdominal region were relieved following another laparotomy by the severance of adhesions. In 1944-5-6-7 he suffered attacks of indigestion extending over a week or two accompanied by epigastric fullness and associated with hunger pains which passed away with eating, drinking milk or taking baking soda. Following a prolonged buttermilk diet in 1947 the symptoms of indigestion disappeared only to return in January, 1951, but accompanied by pain of a changed burning character. Before 1951 the pain was not accompanied by loss of weight, but between December, 1950 and March, 1951 he had lost between 15 and 20 pounds. His appetite generally was good and he suffered no nausea or vomiting.

(1) (1956), 18 W.W.R. 49 (*sub nom. Swanson v. X*), 2 D.L.R. (2d) 193.
(2) [1955] 3 D.L.R. 171.

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In the examination that followed a G.I. series of x-ray plates was taken which showed a filling defect of the lower third of the stomach and a presumptive diagnosis of cancer was made. As stated by Dr. Johnson of Lethbridge, "We were preparing him for laparotomy and gastric resection if possible" when he decided to return to British Columbia (for other than medical reasons) and there receive attention. The films were furnished him for the use of the British Columbia Cancer Clinic associated with the Vancouver General Hospital.

Following a similar examination in Vancouver a laparotomy was decided upon, again with the provisional diagnosis of cancer, "Cancer seems likely", and on April 23, 1951 the operation was carried out.

There were disclosed numerous adhesions fixing the stomach to the liver, the transverse colon and the pancreas. On the posterior aspect of the stomach a firm annular lesion, adhering to the pancreas, was felt. The stomach was mobilized by a number of transections.

At this point some doubt was entertained of the nature of the tumour and the stomach was opened. A large ulcer was disclosed on the posterior wall involving the depth of the pancreas. There was no gross evidence of malignancy. A section of the ulcer was taken out and subjected to what is called the "frozen" test, on which the pathologist, Dr. Fidler, called to the operating-room, whose eminence is unchallenged, reported that malignancy was probably present. The radical procedure was thereupon carried out. In the course of it and at the suggestion of Dr. Fidler, a further 2 inches of the stomach was removed than Dr. Wilson had thought necessary. The ulcer was 3·5 cm. in largest diameter and would be described as large. The entire spleen was removed, approximately four-fifths of the stomach and between two-thirds and three-quarters of the pancreas. It is conceded that a gastric resection was required; this meant the removal of substantial portions of those three organs as well as a small and unimportant bit of the liver. The issue is on the decision to remove what would have been called for in the presence of carcinoma.

The claim is supported by Dr. Kemp, a general practitioner in Vancouver; he is a certified anaesthetist and from 1920 to 1938 was so employed in the Vancouver General Hospital. For a short time he was with the British Columbia Workmen's Compensation Board since when he has engaged in general practice. He has published a handbook on endocrine glands entitled "Hormones and Vitamins in General Practice". He is not put forward as having special standing or competency in any feature of the medical questions raised and his evidence is a statement of what he would have done prior to and in the course of the operation had the patient been his and what, if during the operation, he had been asked by the surgeon for his opinion, he would have advised.

Dr. Kemp puts himself on two grounds: the first that certain preliminary tests should have been made, which would have been of assistance to the judgment when the stomach was opened; and the second that when the actual condition was revealed, the ulcer, on the assumption that it was benign, which he would make "until it is proved malignant", (although on another occasion he would still "have to be shown there was malignancy or the likelihood of it") should have been removed, the body closed, the "paraffin" test applied, and even perhaps other pathologists called into consultation. If the final judgment was of malignancy, a second operation would then be carried out. These positions will be dealt with in that order.

The alleged aids were several in number. The first was the fluoroscopic report of the radiologist in Lethbridge which was assumed to have been made in writing but which does not appear to have been forwarded to Vancouver. It seems to be implied, for nowhere is it expressly stated, that in some manner not clearly described the movement of the stomach observed on the fluoroscopic screen is, in the presence of carcinoma, of a special nature. That irregularity in the rhythmic motion might indicate the presence of an ulcer or tumour is understandable; the normal muscular action would be interfered with by foreign growth of a radically different structure imbedded in the stomach wall; and if that is what was meant it would indicate only a test for the presence of an ulcer, not one for the detection of carcinoma, and it would become of no significance once the

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laparotomy was done. Nowhere is the significance of the fluoroscopic evidence to the character of the growth precisely stated by Dr. Kemp and I decline on such a matter to draw any inference in conflict with the obvious probability of what lay behind the medical conclusion in Lethbridge. Where the difference between the malign and the benign character of a mass of cells is so difficult to appreciate as the evidence here demonstrates, and no competent opinion is given us that the effect of the former on the stomach's rhythmic action is clearly to be distinguished from that of the latter, a circumstance that would end doubt on the presence of malignancy, there is no ground for giving any weight to the contention made.

The second omission was that of the use of a gastroscope. This is a very small tube apparatus which, lowered into the stomach, enables one to view the inside of that organ. It was suggested that the device permitted, also, a small piece of the ulcer to be snipped off and subjected to pathological testing. But the use of the device for such a purpose was rejected by Dr. Kemp himself and both features were superseded by the laparotomy.

Then it was urged that the hydrochloric acid content of the stomach should have been ascertained. The contention was that the malignant ulcer "usually" brought about a decrease in the quantity of that acid. The authority for this was said to be Professor Boyd, eminent in pathology, but an examination of the 6th edition, 1947, of his work on "Surgical Pathology", at p. 248 discloses this statement: "In early carcinoma free H Cl is often present and it may be demonstrated if the fractional measure is used." Dr. Kemp agreed that in the early stages it is present in 50 per cent. of the cases of carcinoma and it is made quite clear by reference to other authorities that its presence or absence yields no dependable assistance to the determination of the nature of the tumour. If acid in this case had shown normal, malignancy would not have been ruled out.

A similar point was made for a test for lactic acid: its presence suggests the possibility of malignancy and it is not normally found in a fasting stomach; but on the facts before us, no inference drawn from its presence or absence would have been of value.

The presence of occult blood in the stomach fluid was injected into the same views; bleeding is present in both types of tumour but Dr. Kemp stated his understanding to be "that minute bleeding is more common in the malignant ulcers", a statement on its face of no weight.

Another criticism was the absence of a blood count. On this Dr. Kemp observed that: "If one found the presence of a secondary anaemia in the absence of definite bleeding one would say, one would consider that that might point to malignancy." A blood count had been directed in the initial report on the examination in Vancouver. On April 26, two days following the operation, the blood count was reported as 81 per cent. haemoglobin which he agreed was not a significant anaemia.

These items exhibit in a striking manner the character and substance of his suggestions. It was in relation largely to his own physical condition and treatment that he has had medical experience of some of these tests. As a witness, he is in the position of the ordinary practitioner, who, for the purpose of giving evidence, consults work of specialists, as Dr. Kemp had done, and voices the findings or opinions they set forth. For example, in speaking of the location of ulcers, he had expressed the view that the "prepyloric was the most certain location for a malignant ulcer": this proved to be an opinion given him by a local surgeon and he admitted having no view of his own on the question at all. It is a matter of textbook or verbalized knowledge unsupported by habituated professional experience. He has been associated with no case nor was any mentioned in which there was what he claimed should have been the procedure to be followed, a partial resection completed pending a determination of the nature of the ulcer removed, the operation, if malignancy was found, to be renewed. The confident assertions of what he would have advised if his opinion had been asked, or would have done if the patient had been his, rest upon no experience in the application of the ideas so freely but imprecisely dealt with, and they lack that obvious professional caution which is a distinctive mark of a highly qualified specialist.

Dr. Kemp attacked the opinion of Dr. Fidler on the "frozen" test—made during the operation—that there was "probable" linitis plastica. This type of carcinoma was

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declared by him to be a diffused infiltration of the walls of the stomach as distinguished from involvement with an ulcer and he rejected the possibility that such an ulcer as that here could be so classified. On a number of relevant matters, however, he was either uninformed or misinformed. For example, he mistakenly thought Dr. Fidler had never had the gross specimen in his hands; he had overlooked in the doctor's report reference to a thickened mucosa around the ulcer which extended to the pylorus in the region of which the mucosa was much injected. He called Professor Boyd in aid of his view that linitis plastica was slow-growing and when nothing of that sort appeared switched, as his authority, to his early teacher of pathology. He was unfamiliar with different forms of linitis plastica carcinoma. Professor Boyd speaks of two, diffused and local, the latter at the pylorus. Dr. Bockus of the University of Pennsylvania Graduate School of Medicine speaks of varieties of linitis plastica as "the circumscribed and the diffused. The circumscribed type may simulate an ulcer in its gross appearance if surface destruction keeps pace with the growth, producing an actual ulcer defect on the x-ray films"; and "This is a common type of so-called ulcerating carcinoma which simulates benign gastric ulcer roentgeno-graphically."

Dr. Kemp was not aware that, in addition to polypoid, ulcerated, ulcer-like carcinomas with diffused infiltration into the neighbouring wall of the stomach, and extensively diffused carcinomas with a more or less uniform thickening of the whole or part of the stomach wall, there was a mixed type in which various combinations of the four types are found. He disclaimed any suggestion that Dr. Fidler was not justified in his opinion that the ulcer was probably malignant; but still he would not agree with the diagnosis for the reason that the picture described by Dr. Fidler "could have been one of inflammation". If such an inference were possible, that it would not have been drawn by either Dr. Fidler or Dr. Wilson needs no comment. He added that the difference between the scirrhous or infiltrating tissue produced by inflammation and new growth or carcinoma tissue is "very, very difficult to distinguish under a microscope".

I have dealt with his evidence in some detail because it is the foundation of the argument before us. I can only describe the opinions which it embodies as a collection of elementary views on the diagnosis of cancer by one who is a virtual stranger to the exercise of such a medical and surgical judgment. Dr. Kemp nowhere intimates that surgeons of the rank of Dr. Wilson would, in the circumstances here, have followed the course he outlined or that any considerable number of them would not have done what Dr. Wilson did. The latter admittedly executed the surgery with consummate technique, and admittedly acted in all according to his best judgment formed deliberately. Admittedly Dr. Fidler stands at the highest level of pathologists. If under the microscope—which reaches nearest to certainty in detecting malignancy—the interpretation could be erroneous, what significance could tests have which can give the same result in either type of tumour? On the basis of what appears in the case, I should say none whatever.

Dr. Palmer was accepted by Dr. Kemp as of outstanding competency. He focused in its real dimensions the question that faced Dr. Wilson. The alternatives were to postpone the larger excision and run the risk of postoperative complications—which actually followed—and the serious possibility of aggravating the activity of a malignancy, or to act on his own and Dr. Fidler's best judgment. The removal of the larger sections of the organs, while important, was not a vital circumstance. The respondent made a good recovery and as Dr. Palmer put it, the difference between impairment to the bodily health of the effects of the admittedly necessary resection and that carried out can be disregarded where there is good cause for it. Such a cause was faced in the avoidance of action that might have had fatal results to the respondent.

In the presence of such a delicate balance of factors, the surgeon is placed in a situation of extreme difficulty; whatever is done runs many hazards from causes which may only be guessed at; what standard does the law require of him in meeting it? What the surgeon by his ordinary engagement undertakes with the patient is that he possesses the skill, knowledge and judgment of the generality or average of the special group or class of technicians to which he belongs and will faithfully exercise them. In a given situation some

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

There is here only the question of judgment; what of that? The test can be no more than this: was the decision the result of the exercise of the surgical intelligence professed? Or was what was done such that, disregarding it may be the exceptional case or individual, in all the circumstances, at least the preponderant opinion of the group would have been against it? If a substantial opinion confirms it, there is no breach or failure. No attempt has been made to show that the operation as completed was not within those limits. The only express evidence we have is that of Dr. Palmer who approved it; but there is the approval by action of Dr. Fidler as well as of Dr. Wilson himself. Dr. Kemp did not—and properly—pretend to suggest the mode of meeting the situation of anyone but himself.

An error in judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge. Although universally-accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.

In *Rann v. Twitchell* (1), the following language is used:—

> He is not to be judged by the result, nor is he to be held liable for an error of judgment. His negligence is to be determined by reference to the pertinent facts existing at the time of his examination and treatment, of which he knew, or in the exercise of due care, should have known. It may consist in a failure to apply the proper remedy upon a correct determination of existing physical conditions, or it may precede that and result from a failure properly to inform himself of these conditions. If the latter, then it must appear that he had a reasonable opportunity for examination and that the true physical conditions were so apparent that

(1) (1909), 82 Vt. 79 at 84.

they could have been ascertained by the exercise of the required degree of care and skill. For, if a determination of these physical facts resolves itself into a question of judgment merely, he cannot be held liable for his error.

This was approved in *Green v. Stone* (1). In *DuBois v. Decker* (2), a qualification is introduced:—

> We are aware that he claimed to have waited ten days before operating, for the purpose of seeing whether the foot could not be saved, and that a physician and surgeon will not be held liable for mere errors in judgment. But his judgment must be founded upon his intelligence. He engages to bring to the treatment of his patient care, skill and knowledge, and he should have known the probable consequences that would follow from the crushing of the bones and tissues of the foot.

In *M'Clallen v. Adams* (3), Shaw C.J. deals with this feature:—

> The performance of this operation being within the scope of the plaintiff's authority, if in his judgment necessary or expedient, and that it was so, is to be presumed from the fact, it was not necessary for him to prove to the satisfaction of the jury, that it was necessary and proper, under the circumstances. . . .

In 1853 the Superior Court of New Hampshire in *Leighton v. Sargent* (4), following the general principles on the professional undertaking enunciated by Tindal C.J. in *Lanphier v. Phipos* (5), and in the many other English authorities cited, observed, on the matter of judgment:—

> To charge a physician or surgeon with damages, on the ground of unskilful or negligent treatment of his patient's case, it is never enough to show that he has not treated his patient in that mode, nor used those measures, which in the opinion of others, even medical men, the case required; because such evidence tends to prove errors of judgment, for which the defendant is not responsible, as much as the want of reasonable care and skill, for which he may be responsible.

These statements articulate what is in fact the actual or mutually understood though unexpressed undertaking of the specialist in surgery and they are cited because they deal specifically with the element involved here, judgment.

In reaching this conclusion I have not overlooked the difficulty on occasion of obtaining critical opinions in such matters from those qualified to give them. But throughout this unfortunate episode, Dr. Wilson was most candid and every facility was furnished to the respondent to make the most searching enquiry into the facts. Dr. Wilson was subjected to an exhaustive examination for discovery, many

(1) (1934), 119 Conn. 300 at 304.
(2) (1891), 130 N.Y. 325 at 330.
(3) (1837), 36 Mass. 333 at 335.
(4) (1853), 27 N.H.R. 460 at 474.
(5) (1838), 8 C. & P. 475, 173 E.R. 581.

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portions of which were put in evidence. Dr. Rose of Lethbridge was examined *de bene esse* and the respondent had the benefit of that before trial. Dr. Wilson as soon as the final report of the pathologist was received, himself conveyed to the respondent, then still in the hospital, its finding.

It is these circumstances and the fullness in which the case is before us that overbear the view expressed in the Court of Appeal that such an error called for a thorough explanation which—because no evidence was adduced by the defence—it did not receive. The onus was on the plaintiff to establish negligence; the entire facts are before us; nothing could have been added except opinions. There was no obligation on Dr. Wilson personally to support the means he took: a sensitive person might very well prefer to leave his conduct to the judgment of others. That he expressed his own opinion on discovery can be assumed and whatever was considered helpful to the respondent was read against him.

I would, therefore, allow the appeal and restore the judgment at trial with costs in both courts.

LOCKE J. (*dissenting*):—My consideration of the evidence in this matter leads me to the same conclusion as that reached by the learned judges of the Court of Appeal (1). I respectfully agree with the reasons for judgment delivered by Mr. Justice Coady.

I would dismiss this appeal with costs.

ABBOTT J.:—This is an appeal from a judgment of the Court of Appeal for British Columbia (1) reversing the judgment of the Supreme Court of British Columbia (2), which had dismissed respondent's action in which he had sued appellant for alleged medical malpractice.

The respondent, who had had stomach trouble off and on for some years, in March 1951 (prior to which date this stomach trouble appears to have become aggravated), went to a medical clinic in Lethbridge, Alberta, of which one member was a Dr. Johnson. He was placed in Galt Hospital in Lethbridge where he was examined by Dr. Johnson and remained under observation for 16 days, until April 11,

(1) (1956), 18 W.W.R. 49, 2 D.L.R. (2d) 193. (2) [1955] 3 D.L.R. 171.

1951. The respondent was x-rayed and fluoroscoped, and this examination revealed that he had a large filling defect on the rear wall of the stomach. He was told that he most likely had stomach cancer and an exploratory operation was recommended.

The respondent, either because he was unwilling to accept this diagnosis as definitive or because he preferred to have further treatment and advice in British Columbia where his home was, came to Vancouver with the x-ray films taken in Galt Hospital and a letter from Dr. Johnson to the British Columbia Cancer Institute. He visited the cancer institute on April 13, 1951, delivered the x-ray films and Dr. Johnson's letter, and was examined by Dr. Crawford and another doctor of that institute. So far as the record discloses, the respondent did not bring with him any report of the Lethbridge radiologist who had made the x-ray examination. That same day he was also examined by Dr. Wilson, the appellant, in Dr. Crawford's presence. As a result of his own examination, a consideration of the x-rays, Dr. Johnson's letter, and the report of Dr. Crawford's examination, Dr. Wilson diagnosed probable cancer of the stomach and recommended an exploratory operation and the removal of the growth, if it was operable.

Some 10 days elapsed before respondent entered the Vancouver General Hospital where a room had been reserved for him by appellant. On entering the hospital he was also examined by an interne, Dr. Lambert, who diagnosed probable stomach cancer.

No further x-ray examination was made after respondent's arrival at Vancouver nor do any other special blood-tests or tests concerning the stomach area appear to have been made prior to the operation.

The operation took place on April 24, 1951, and after opening the abdomen and mobilizing the stomach, the surgeon could feel the lesion on the rear wall of the stomach, confirmed that it was a large one which it was necessary to remove and that it was attached to the pancreas. Up to this point he still considered the lesion was probably cancerous and decided it would be necessary to open the stomach and view the lesion itself. This was done. At this stage in the operation, after viewing the lesion, the

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surgeon entertained some doubt as to whether it might be benign rather than cancerous; he therefore sent for the hospital's chief pathologist Dr. Fidler, and after removing a small portion of the lesion, a lymph-node and adjoining tissue, gave it to the pathologist for a pathological test known as a frozen section. This test, although admittedly not conclusive, can be completed in 15 to 20 minutes. It should be mentioned here, that it is in evidence that a conclusive test could not be made in less than some 24 hours. The pathologist reported that in his opinion the lesion was probably malign, of a type known as linitis plastica. Appellant then removed a major part of the stomach, including all of the lesion, and handed it to the pathologist who, on examination, reiterated his opinion that it was probably malignant and suggested that a somewhat larger portion of the stomach be removed, which was done.

If the lesion were malignant, it is conceded, appellant was bound to remove the adjoining portion of the pancreas and the spleen, which in fact he did. On the other hand, if the lesion were benign, all that needed to be taken out was the infected portion of the stomach. Faced with these alternatives, the appellant decided to proceed with the removal of those portions of the organs necessary to ensure a complete eradication of the cancer, if such in fact existed. A final test of the infected organs by what is known as the paraffin wax method (which admittedly could not have been done under 24 hours) disclosed that the lesion was not malignant.

The patient suffered post-operative complications but ultimately made a good recovery and was discharged from hospital on May 31, 1951. It was admitted on behalf of appellant at the trial that as a result of the operation and the removal of a portion of the pancreas respondent had developed mild diabetes. Respondent, who was 67 years of age at the time of the operation in April 1951, testified at the trial, which was held some four years later in March 1955. He died prior to the hearing of the appeal to this Court.

The only significant medical evidence led by respondent consisted of a portion of appellant's examination for discovery and the evidence of a Dr. Palmer and a Dr. Kemp. In addition to this, medical records of the Vancouver General

Hospital, a copy of a letter from Dr. Johnson of Lethbridge, and a copy of Dr. Crawford's report were filed by respondent as exhibits.

The appellant elected to call no evidence and took the position that the respondent had failed to establish a *prima facie* case of negligence. This contention was upheld by the trial judge but has been reversed by the Court of Appeal.

In my opinion this appeal turns upon the question as to whether in the circumstances of this case the evidence of Dr. Kemp established a *prima facie* case of negligence against appellant. The learned trial judge held that it did not and while indicating that he felt both Dr. Palmer and Dr. Kemp were honest and endeavouring to help the Court to the best of their ability, stated that where the evidence of Dr. Kemp differed from that of Dr. Palmer, he preferred to accept the evidence of the latter. Aside from any question of credibility, where medical opinion evidence is involved, in my view the trial judge who heard the evidence was in a particularly favourable position to assess what weight should be given to such evidence.

The test of reasonable care applies in medical malpractice cases as in other cases of alleged negligence. As has been said in the United States, the medical man must possess and use that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases, and it is the duty of a specialist such as appellant, who holds himself out as possessing special skill and knowledge, to have and exercise the degree of skill of an average specialist in his field: see Meredith, Malpractice. Liability of Doctors and Hospitals, 1956, at p. 62, and the authorities there referred to.

As I have said, appellant, before making his diagnosis of probable stomach cancer, had the benefit of a similar diagnosis made by Dr. Johnson after two weeks' observation of respondent in the hospital, an examination of the x-ray films taken in Lethbridge which clearly showed a large filling defect in the stomach, his own physical examination of the patient and the results of the examination made by Dr. Crawford. In the course of the exploratory operation, when appellant had some doubt as to whether or not the lesion was malignant, he obtained the

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opinion of a pathologist of recognized competence. He then made an admittedly difficult decision but the sort of decision which every surgeon must be called upon to make from time to time. In making that decision I am satisfied he exercised his best judgment in what he considered to be the best interest of his patient.

A great deal of the medical evidence was read to us at the hearing and I have again read all this evidence with care. I shall not attempt to review it in detail but I am satisfied that the only portion of Dr. Kemp's evidence which might be considered as *prima facie* evidence of negligence on the part of appellant is that portion relating to certain pre-operative tests which Dr. Kemp claimed he would have made. Dr. Kemp, who was the last witness to testify, stated that had the patient been his patient, before making a clinical diagnosis as to the probable character of the stomach lesion, he would have had certain tests made, including a test of the gastric juices and a blood count and that in addition he would have had fresh x-rays taken and a report from a radiologist. All that this proves, of course, is that Dr. Kemp would have made these additional tests, or had them made, not that other doctors would consider it necessary to do so. On cross-examination Dr. Kemp agreed that any conclusion which might be drawn from such tests could only be tentative and that to establish a conclusive diagnosis in the case of a suspected stomach cancer an exploratory operation must be undertaken and a pathological examination made of the suspected lesion. There is no evidence that either the medical history of the patient, or the result of the tests referred to by Dr. Kemp, would be of any assistance to the pathologist in his examination of the suspected tissue. The surgeon on receiving a report from the pathologist of probable cancer, as was the case here, would still have to decide what he should do.

As to Dr. Kemp's special qualifications, he testified that for many years he had practised as an anaesthetist. After the last war he was for some time with the Workmen's Compensation Board of British Columbia and since leaving that board has been engaged in general practice. He has never practised as a surgeon, is not a pathologist, and stated in cross-examination that he had never at any time suggested he was an authority on gastric disorders.

Prima facie evidence has been defined as "Evidence, which, not being inconsistent with the falsity of the hypothesis, nevertheless raises such a degree of probability in its favour that it must prevail if it be accredited unless it be rebutted or the contrary proved": *Kirk v. Kirkland et al.* (1), affirmed *sub nom Johnson v. Kirk* (2).

In my opinion the evidence to which I have referred, given by a medical man of Dr. Kemp's limited experience and qualifications, falls far short of meeting such a test.

The learned trial judge found not only that the respondent had failed to make out a *prima facie* case of negligence but affirmatively that there was in fact no negligence. I respectfully share that view.

I would therefore allow the appeal with costs throughout and restore the judgment of the learned trial judge.

Appeal allowed with costs.

Solicitor for the plaintiff, respondent: R. Young, Vancouver.

Solicitor for the defendant, appellant: L. St. M. Du Moulin, Vancouver.