[HIGH COURT OF AUSTRALIA.]

PATON AND ANOTHER . . . . . APPELLANTS;
DEFENDANTS,

AND

THOMAS PARKER . . . . . RESPONDENT.
PLAINTIFF,

PATON AND ANOTHER . . . . . APPELLANTS;
DEFENDANTS,

AND

GRACE WINIFRED PARKER . . . . RESPONDENT.
PLAINTIFF,

ON APPEAL FROM THE SUPREME COURT OF NEW SOUTH WALES.

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SYDNEY, *Nov.* 27, 28; *Dec.* 12.

Starke, McTiernan and Williams JJ.

Medical Practitioners—Duties and liabilities—Negligence—Operation—Duty to use reasonable care and skill—Control of operating theatre—Radiator—Open heating element—Anaesthetic—Breaking of bottle containing ether—Fire in theatre—Injury to patient—Practice (N.S.W.)—Joinder of two defendants in action for tort—Whether competent—Nature of wrongful act—Not necessarily separate and independent tort by each defendant—Amendment—Common Law Procedure Act 1899 (*N.S.W.*) (*No.* 21 *of* 1899), *secs.* 49, 260.

In an action against a surgeon and an anaesthetist for negligence whilst performing an operation on a patient, whereby the patient was severely burnt, evidence was led on behalf of the plaintiff that the operation took place in the operating theatre of a hospital; that the theatre was heated by an electric radiator, the heating element of which consisted of wires exposed to the air, which became red hot when the current was switched on; that ether was the anaesthetic used; that while the ether was being administered the bottle containing it fell, or was knocked, to the floor; and that ether fumes went on to the radiator, causing a fire, which burnt the plaintiff's hand. The practice in the hospital was for the theatre sister to

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turn the radiator on or off as she thought fit. Evidence was also led from which a jury could infer that both doctors knew that the radiator was switched on and that ether was inflammable and explosive in the presence of air and oxygen.

Held that as the surgeon was entitled to rely upon the careful administration of the ether by a skilled and competent anaesthetist, and had no reason to anticipate negligence on the part of the anaesthetist or such an untoward event as the dropping of the bottle, the circumstances afforded no evidence of breach of duty on his part; but (*McTiernan* J. dissenting) that the circumstances of the accident, unexplained, afforded evidence fit for submission to a jury of want of care on the part of the anaesthetist.

Held, also, by *Starke* and *Williams* JJ., that the wrongful act charged, being not necessarily a separate and independent tort on the part of each defendant, but being a wrong of which the defendants might have been jointly guilty, no objection could be brought to the action on the ground that claims for damages against the two defendants were joined therein; but that even if the objection were well founded all amendments necessary to do justice could be made under sec. 260 of the *Common Law Procedure Act* 1899 (N.S.W.).

Decision of the Supreme Court of New South Wales (Full Court): *Parker* v. *Paton*, (1941) 41 S.R. (N.S.W.) 237; 58 W.N. (N.S.W.) 189, in part affirmed and in part reversed.

APPEAL from the Supreme Court of New South Wales.

An action was brought in the Supreme Court of New South Wales by Grace Winifred Parker, married woman, against Clive N. Paton and Keith Kirkland, medical practitioners.

By her declaration the plaintiff alleged that the defendants, as medical practitioners and surgeons, undertook to perform a surgical operation upon her at the operating theatre of the Mater Misericordiae Hospital, North Sydney, and that it became and was the duty of the defendants and each of them as such medical practitioners and surgeons to use due and proper skill, diligence and caution in and about performing the operation, the care, control and management of the operating theatre, the preparation, manipulation and control of the heating apparatus in the theatre, and the handling of certain materials and chemicals used by the defendants in the theatre for the purposes of the operation, but the defendants were so negligent in performing the operation and in the control and management of the operating theatre and of the heating apparatus therein and in and about the handling of certain chemicals used by the defendants in the operating theatre for the purposes of the operation that the said chemicals were spilled over the plaintiff and, upon coming into contact with the heating apparatus, exploded

and caught fire, whereby she was seriously burned and otherwise greatly damnified and became permanently incapacitated.

An action against the same defendants was also brought by Thomas Parker, husband of Grace Winifred Parker, for loss of consortium.

The defendants and each of them pleaded, in each action, that they were not nor was either of them guilty as alleged, and also pleaded specific denials to certain of the allegations contained in the respective declarations.

The actions were heard together.

There was evidence which, if accepted by the jury, would establish the following facts :—The female plaintiff had undergone a surgical operation at the Mater Misericordiae Hospital, North Sydney, on 17th June 1936. A further operation, involving the removal of a kidney, was found to be necessary, and at about 3.15 p.m. on 25th June she was taken to the operating theatre of the hospital, in order that the operation might be performed by Dr. Kirkland, one of the defendants. She was then in a very low state of health. The operating theatre was seventeen feet long by fifteen feet six inches wide, and the operating table was in the middle. The only means of heating the room consisted of an electric radiator of the cone type, the heating element of which consisted of wires exposed to the air, which became red hot when the current was turned on. The radiator had been there for a long time. It was situated in a corner of the theatre about six feet from the operating table.

The other plaintiff, the husband, arrived outside the door of the operating theatre at about 3.30 p.m. The Mother Superior and the matron entered the theatre, and, after this, no-one left it until, about twenty minutes after he arrived, he heard an explosion. A nurse rushed out, and, through the door, he could see another nurse stamping out a fire.

Both Dr. Kirkland and Dr. Paton, the other defendant, who was the anaesthetist, were in the operating theatre when the fire occurred ; and ether was the anaesthetic used. In New South Wales ether is the universal general anaesthetic. In the present case it was administered by placing a wire mask covered with gauze over the patient's face and pouring the ether on to the gauze from a bottle.

A percentage of 1.35 of ether in air makes an explosive mixture ; and it is part of a medical practitioner's training to know that it is dangerous to use ether near a flame. It would be hazardous to pour ether over a gauze mask with an exposed wire radiator switched on only about six feet away. To do so in a room the size of the operating theatre was a very dangerous practice. Even the static

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electricity produced by drawing a blanket over a metal operating table has been known to cause an explosion.

In a public hospital—the Mater Misericordiae Hospital is a public hospital—the surgeon is expected to take the anaesthetist who is on duty. Provided the anaesthetist is carrying out his duties with due care and reasonably, he is independent of the surgeon. But if he is careless he is not. If the surgeon saw a naked radiator on in a theatre where ether was about to be used, he should direct the anaesthetist not to use it, and his order would have to be obeyed, or he should have it switched off before he commenced the operation, and should refuse to operate until this had been done. There was no need to keep such a radiator switched on after the operation had been commenced.

Both the medical practitioners concerned had used the operating theatre for a considerable time before the day in question. The theatre sister used to switch the radiator on or off as she thought fit.

On the occasion in question, flames were seen going towards the operating table, and they caused a serious burn to the plaintiff's hand. This occurred when the surgeon and the nurse were preparing the area of the patient's body which was to be operated upon. When the nurse saw the flames, she took the mask from the patient's face, and stamped out the flames. Dr. Kirkland told the patient's husband that someone dropped a bottle of ether and caught one of the heaters. The fumes caught fire. He had not then started the operation, but had to carry on with it because the patient was so low.

The bottle of ether was, or had been, on a small table placed near the anaesthetist and apparently, it had been knocked therefrom by somebody, but by whom was not shown. The bottle broke and the ether escaped.

Upon the above evidence the trial judge nonsuited both plaintiffs on the grounds (i) that there was no evidence of negligence on the part of either defendant, and (ii) that if there were it would be evidence of individual negligence on the part of either or each, and in such circumstances a verdict could not be given against both or either in an action alleging joint negligence against both.

Upon an application on behalf of the plaintiffs to amend the record by striking out the name of the defendant Kirkland and proceeding only against the defendant Paton, the trial judge held that, assuming that his powers of amendment were wide enough to enable the plaintiffs to proceed against the defendant Paton alone for an independent tort, there was no evidence of negligence against Paton, and refused the application on the ground that

in his Honour's opinion the amendment could produce no useful result.

The Full Court of the Supreme Court set aside the nonsuits and directed that a new trial be had in each action: *Parker* v. *Paton* (1).

From that decision the defendants appealed, by leave, to the High Court.

Further facts appear in the judgments hereunder.

Windeyer K.C. (with him *Asprey*), for the appellants. This action was misconceived as against the appellants or either of them. The respondents' cause of action, if any, was against the hospital authorities. It was the duty of those authorities to do everything necessary and requisite in and about the preparation of the operating theatre. The appellants were entitled to rely on the practice prevailing at the hospital in connection with this matter. The extent of their duty is ascertained by reference to that practice (*Mahon* v. *Osborne* (2)). The practice was for a member of the hospital's nursing staff to switch on or off the radiator in the theatre whenever it became necessary so to do. The appellants are not liable for damage resulting from any dereliction of duty which may have occurred on the part of a member of the hospital's staff. There is not any evidence that either of the appellants knew that the radiator was switched on, or that it was of the open coil type, nor can any inferences to that effect be drawn from the evidence. Even if they had such knowledge, they were entitled to rely upon the members of the hospital's staff to carry out their respective duties fully and properly (*Ingham* v. *Fitzgerald* (3)). A surgeon is responsible for his surgical work, but he is not vicariously responsible for other things that may happen in the operating theatre. Although the bottle of ether was in the theatre for use by the anaesthetist, the presence of other persons in the theatre precludes an inference being drawn that the anaesthetist must have dropped the bottle, or that its fall was in any way attributable to him. The doctrine of *res ipsa loquitur* only applies if it can be shown that the person charged is the only person to whom the matter complained of could be attributed (*Commissioner for Railways* v. *Corben* (4)). The appellants exercised such a degree of care as in the actual circumstances of this case reasonably might be expected from a normally skilful member of the profession (*Mahon* v. *Osborne* (5)). There is

(1) (1941) 41 S.R. (N.S.W.) 237; 58 W.N. 189.
(2) (1939) 2 K.B. 14, at p. 43.
(3) (1936) N.Z.L.R. 905, at pp. 913, 914.
(4) (1938) 39 S.R. (N.S.W.) 55; 56 W.N. 7.
(5) (1939) 2 K.B., at p. 31.

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a distinction between operative skill and administrative skill; hospital authorities are responsible only in respect of a breach of the latter (*Hillyer* v. *Governors of St. Bartholomew's Hospital* (1)). A plaintiff cannot sue defendants jointly in seeking to establish several torts; he cannot in the same declaration charge a joint tort and a several tort. If in the declaration a joint tort be alleged against two or more persons there is a failure of proof if the plaintiff merely proves several torts against one or more of such defendants. Evidence of individual negligence is not evidence of joint negligence, that is, of a joint tort as framed in the declaration. The appellants have been sued as joint tortfeasors, but the evidence shows that, if anything, they are independent tortfeasors; thus the respondents are endeavouring to have two separate causes of action dealt with in one action (*Bailey* v. *Willis* (2)). Separate causes of action are not allowed to be joined with joint causes of action. A case commenced and conducted to prove joint causes of action cannot be converted into a single cause of action against separate persons (*Sadler* v. *Great Western Railway Co.* (3); *Thompson* v. *London County Council* (4); *Bell* v. *Thompson* (5); *Frankenburg* v. *Great Horseless Carriage Co.* (6))—See also *Payne* v. *British Time Recorder Co. Ltd.* (7). A declaration charging a joint tort cannot be satisfied by proving a several tort. The gist of the action in *Govett* v. *Radnidge* (8) was the misfeasance, which, in its nature, was several. A judge has no discretionary power enabling him to permit a declaration to be amended in such a way as to allege a several tort in lieu of a joint tort. Such an amendment does not come within the scope of sec. 260 (2) of the *Common Law Procedure Act* 1899 (N.S.W.). The nonsuits were rightly granted and should be upheld.

O'Sullivan (with him *O'Toole*), for the respondents. In an action brought against two or more defendants who are alleged to be joint tortfeasors in respect of a single cause of action, the jury may acquit one or other of such defendants whom it finds to be not guilty, and award damages against the other or others whom it finds to be guilty (*Bell* v. *Thompson* (9); *Govett* v. *Radnidge* (8); *Bastard* v. *Hancock* (10); *Hardyman* v. *Whitaker* (11); *Cooper* v. *South* (12)). The old common-law system of pleading prevails in New South Wales.

(1) (1909) 2 K.B. 820.
(2) (1930) 30 S.R. (N.S.W.) 131; 47 W.N. 23.
(3) (1896) A.C. 450.
(4) (1899) 1 Q.B. 840.
(5) (1934) 34 S.R. (N.S.W.) 431; 51 W.N. 138.
(6) (1900) 1 Q.B. 504, at p. 512.
(7) (1921) 2 K.B. 1, at pp. 14, 15.
(8) (1802) 3 East. 62 [102 E.R. 520].
(9) (1934) 34 S.R. (N.S.W.), at p. 435.
(10) (1695) Carth. 361 [90 E.R. 810].
(11) (1748) 2 East. 573n [102 E.R. 489].
(12) (1813) 4 Taunt. 802 [128 E.R. 547].

It is not disputed that even though they result in one damnum independent torts must be independently charged (*The Koursk* (1)). But here the appellants jointly did the respondents harm by their joint concerted acts. In any event, the necessary amendments would have been permitted under sec. 260 of the *Common Law Procedure Act* 1899. It is submitted that the High Court will not lightly interfere with or upset a judgment of the Full Court of a State on a question of pleading practice in that State. There was evidence from which the jury reasonably could have inferred a want of care on the part of the appellants or either of them in the particular circumstances; therefore the nonsuits were wrong and the cases should have been allowed to go to the jury. The appellants must have known the danger of using ether near a naked light. It was their duty to ensure that the radiator was switched off. The question whether or not the appellants or either of them had knowledge that the radiator was switched on was essentially a question for the jury and not for the judge (*Harratt* v. *Wise* (2); *Ward* v. *Roy W. Sandford Ltd.* (3); *Marshall* v. *Owners of S.S. Wild Rose* (4); *Commissioner of Railways* v. *Leahy* (5); *Brown* v. *Great Western Railway Co.* (6); *Parfitt* v. *Lawless* (7)). The facts proved would have enabled the jury to draw the rational conclusion that the radiator was not only switched on, but, also, that that fact must have been known to the appellants or either of them (*Williams* v. *Commissioner for Road Transport and Tramways* (*N.S.W.*) (8); *Davis* v. *Bunn* (9); *Roeder* v. *Commissioner for Railways* (*N.S.W.*) (10); *Grant* v. *Australian Knitting Mills Ltd.* (11); *Carr* v. *Baker* (12); *Jones* v. *Great Western Railway Co.* (13)). The appellants failed to take sufficient care to ensure proper control of the ether while the radiator was switched on. Negligence lay in having the radiator switched on during the process of anaesthetizing. "Hospital practice" was dealt with in *Perionowsky* v. *Freeman* (14). There is an imperious duty to take care cast upon every person when handling articles dangerous in themselves (*Jefferson* v. *Derbyshire Farmers Ltd.* (15)). Each of the appellants, *a fortiori* the appellant Paton, was under that duty of care. The question

(1) (1924) P. 140.
(2) (1829) 9 B. & C. 712, at p. 717 [109 E.R. 264, at p. 266].
(3) (1919) 19 S.R. (N.S.W.) 172, at p. 185.
(4) (1910) A.C. 486.
(5) (1904) 2 C.L.R. 54, at p. 60.
(6) (1885) 1 T.L.R. 614.
(7) (1872) 2 P. & D. 462, at p. 472.
(8) (1933) 50 C.L.R. 258, at p. 264.
(9) (1936) 56 C.L.R. 246, at pp. 255, 260.
(10) (1938) 60 C.L.R. 305, at p. 334.
(11) (1936) A.C. 85, at p. 101.
(12) (1936) 36 S.R. (N.S.W.) 301, at pp. 306, 307.
(13) (1930) 47 T.L.R. 39, at p. 41.
(14) (1866) 4 F. & F. 977, at pp. 980-982 [176 E.R. 873, at pp. 874, 875].
(15) (1921) 2 K.B. 281, at p. 289.

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whether a surgeon is liable for the negligence of another person was dealt with in *Mahon* v. *Osborne* (1). In *Ingram* v. *Fitzgerald* (2) it was admitted that the surgeon was not personally liable; there it was only a question of vicarious liability for the acts of the nurse concerned. Similarly, *Hillyer* v. *Governors of St. Bartholomew's Hospital* (3) does not assist the court: the question there involved was whether the hospital was liable for the alleged negligence of the surgeons. A different system of heating was installed in the theatre immediately after the injury had been sustained by the female respondent.

Windeyer K.C., in reply. The trial judge was entitled to nonsuit the respondents, and the nonsuits should not be set aside on appeal. The appellants are not liable for the acts or omissions of members of the hospital staff (*Perionowsky* v. *Freeman* (4)). Neither of the appellants was under the duty of ensuring that whenever necessary the radiator was switched on or off. According to the practice prevailing this was the duty of other persons (*Mahon* v. *Osborne* (1)). Upon the evidence the state of knowledge of either of the appellants in the matter of whether the radiator was switched on or off can only be conjectured.

Cur. adv. vult.

Dec. 12. The following written judgments were delivered :—

STARKE J. Consolidated appeals from a judgment of the Supreme Court of New South Wales setting aside a nonsuit and directing a new trial between the parties.

Action was brought by Mrs. Grace Winifred Parker against the appellants here, who are medical practitioners, for negligence whilst performing an operation upon her, whereby she was seriously burned and otherwise injured. Another action was by her husband for loss of consortium. It appears that the respondent Mrs. Parker entered the Mater Misericordiae Hospital for a serious operation, namely, the removal of a kidney. The hospital is one to which the *Public Hospitals Act* 1929-1937 (N.S.W.) applies, but it is not carried on, I apprehend, by any public authority. The establishment consists of the hospital, operating theatres and appliances, and a staff including sisters, nurses, and so forth.

The appellant Kirkland is a visiting surgeon and the appellant Paton an anaesthetist at the hospital. There is no evidence that

(1) (1939) 2 K.B. 14.
(2) (1936) N.Z.L.R. 905.
(3) (1909) 2 K.B. 820.
(4) (1866) 4 F. & F. 977 [176 E.R. 873].

they are employed by the hospital authorities, but their services are available at the hospital. The respondent Mrs. Parker was taken by the nursing staff to the operating theatre in due course. It was heated by an electric radiator of the cone type, the heating element consisting of wires exposed to the air, which became red hot when the current was turned on. The respondent Mrs. Parker was placed under an anaesthetic by the appellant Dr. Paton. He administered it by placing a wire mask covered with gauze over Mrs. Parker's face and pouring ether over the gauze from a small bottle. Ether is very inflammable and, mixed with air or oxygen, is explosive. The radiator was not turned off whilst the ether was being poured over the gauze.

The respondents proved in evidence as part of their cases a statement by the appellant Kirkland that someone dropped the bottle of ether, the fumes of which went onto the heater, caught fire, and burned Mrs. Parker's hand. The theatre sister stated that she saw the flames around Mrs. Parker and stamped them out and afterwards saw some broken glass on the floor and the burn on Mrs. Parker's hand. It was part of her duty to prepare the theatre for the operation and she could turn the radiator on or off as she thought fit. The appellant Kirkland was in the theatre whilst ether was being administered, but had not started to operate when it caught fire. But he nevertheless went on and completed the operation because of the low and critical condition of Mrs. Parker.

In the circumstances stated, it is clear that both the appellants came under a relationship of duty towards Mrs. Parker. They accepted the responsibility of and undertook an operation upon Mrs. Parker and were bound to use the care, caution, and prudence of reasonable men, including the skill of ordinary competent practitioners if special competence was necessary to ensure safety. And it is a question of fact in the circumstances of each case whether due care, caution, prudence and skill was in fact exercised.

No lack of professional skill is disclosed by the evidence in the present case, but it is said that the appellants were negligent in conducting an operation in conditions which they knew or ought to have known to be dangerous to the safety of Mrs. Parker. They, however, insist that they were not responsible for the arrangement or management of the operating theatre or for turning the radiator on or off, which was the duty of the hospital or the nursing staff. It is true enough that the operating surgeon was in charge of the operation and could give directions to the anaesthetist and to the nursing staff, but they were not his servants or agents, nor were the medical officers the servants or agents of each other, though no

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doubt they would be responsible for the acts or omissions of others which they severally ordered or directed. The medical officers, however, cannot relieve or excuse themselves from the performance of their duty to exercise due care and caution because the hospital or the nursing staff or some of them failed to perform their duties with due care and caution.

The question remains whether the medical officers used the care, caution and prudence of reasonable men, including the skill of ordinary competent practitioners, necessary to ensure the safety of Mrs. Parker. Ether was the anaesthetic used for the operation. The anaesthetist knew this, and it was open to the jury to conclude that the surgeon was aware of the fact, both from its common use in Sydney for the purpose of surgical operations and from its evaporation during administration. Further, it was open to the jury to conclude that both medical officers knew that ether was inflammable and explosive in the presence of air and oxygen. It was common knowledge of the profession. Again, it was said that the medical officers must have seen the lighted radiator, or at all events that a jury might so conclude, for the radiator was alight and in a position in which anyone in the room could see it.

All these findings were, I think, open to the jury on the evidence as it was left on the application for a nonsuit. Still, in my opinion, that does not involve the surgeon, Dr. Kirkland, in any responsibility for the burning of Mrs. Parker's hand. The surgeon was entitled to rely upon the careful administration of the ether by a skilled and competent anaesthetist. No fact was proved which suggests that he ought reasonably to have anticipated negligence, whether wilful or accidental, on the part of the anaesthetist. No verdict of negligence against the surgeon in such circumstances would be reasonable, and it could not be supported if it were given. Indeed, the proximate cause of the injury in the present case was not in the administration of the ether but in the dropping of the bottle on the floor, which broke it and allowed the ether to escape. Such an untoward event was not one which the surgeon ought reasonably to have anticipated, nor would any jury be justified in making any finding to that effect. It may be that a surgeon should intervene if he knows that the anaesthetist or anyone else is endangering the safety of a patient in his charge, but there is no evidence in the present case fit for submission to a jury that the surgeon had any such knowledge or that he should reasonably have anticipated any act or omission which resulted in injury to Mrs. Parker.

The case of the anaesthetist, Dr. Paton, rests upon other considerations. He administered the ether, and in the course of that

administration Mrs. Parker was seriously burned. There was evidence led on behalf of Mrs. Parker, as already stated, that the bottle of ether was dropped upon the floor, broke, and allowed the ether to escape, which caught fire and injured her. A suggestion was made in argument that one of the nurses must have accidentally knocked the bottle from the anaesthetist's table, which stood near-by. No evidence was given which supports the suggestion. Mrs. Parker was seriously burned whilst the ether was being administered by and under the control of the anaesthetist. An accident such as happened does not ordinarily occur if those in control of the anaesthetic use proper care. Unexplained, these facts constitute some evidence of want of care on the part of the anaesthetist fit for submission to the jury. It is for the anaesthetist to relieve himself of responsibility and to satisfy the jury that the injury to Mrs. Parker happened without his fault.

But it was sought to maintain the nonsuit granted at the trial upon a technical rule of procedure. The *Common Law Procedure Act* 1899 (N.S.W.) provides in sec. 49 that causes of action of whatever kind, provided that they are by and against the same parties and in the same rights, may be joined in the same suit. Accordingly, claims for damages against two or more defendants in respect of their several liabilities for separate torts cannot be combined in one action: Cf. *Sadler* v. *Great Western Railway Co.* (1); *Thompson* v. *London County Council* (2). In the present case, the declaration is introduced by the statement that it was the duty of the defendants and each of them to use due care, but the wrongful act declared upon is the negligence of the defendants. The charge against the defendants is, according to the argument, as joint tort-feasors (*The Koursk* (3)); but it was said that the charge could not in law, in the present case, be joint, or could only be sustained against them, upon the evidence, as independent wrongdoers. The old law is thus stated in *Chitty* on *Pleading*, 7th ed. (1843), vol. 1, p. 97: —"If several persons be made defendants jointly, where the tort *could not* in point of law be joint, they may demur, and if a verdict be taken against all, the judgment may be arrested or reversed on a writ of error. . . . In other cases, where in point of fact and of law several persons *might have been jointly guilty of the same offence*, the joinder of more persons than were liable in a personal or mixed action in *form ex delicto*, constitutes no objection to a partial recovery, and one of them may be acquitted, and a verdict taken against the others." All parties engaged in a common wrongful act are liable

(1) (1896) A.C. 450.
(2) (1899) 1 Q.B. 840.
(3) (1924) P. 140.

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jointly and severally (*Bretherton* v. *Wood* (1); *Govett* v. *Radnidge* (2); *Bell* v. *Thompson* (3); *Sudholz* v. *Withers Pty. Ltd. and Tramway Board* (4); *Mendoza* v. *Mayor &c. of Melbourne* (5)). And this, I gather, was the view taken in this case by the learned Chief Justice of the Supreme Court. The wrongful act charged in the present case was not necessarily a separate and independent tort on the part of each defendant, but one in respect of which they might have been jointly guilty. Accordingly the argument based upon the rule of procedure in force in New South Wales fails. But if it were well founded, the powers conferred by the *Common Law Procedure Act* 1899 (N.S.W.), sec. 260, enable the Supreme Court to make all amendments necessary to do justice.

The nonsuit in favour of the surgeon Dr. Kirkland should be restored, and the order for a new trial, in his case, should be set aside.

McTIERNAN J. The principal question to be decided is whether there is any evidence upon which the jury could reasonably find that the outbreak of fire in which Mrs. Parker's right hand was burned occurred in consequence of the failure of Dr. Kirkland and Dr. Paton or either of them to attain that standard of care which the law required in the circumstances in which the surgical operation upon her was done. In order to decide this question it is necessary to inquire what was the nature and scope of the duty of care which, taking due account of all the circumstances, each of them, Dr. Kirkland as the surgeon and Dr. Paton as the anaesthetist, owed to Mrs. Parker. The negligence to be proved is negligence which is correlative to that duty.

The duty to which each of the appellants became subject arose out of the performance of his undertaking to Mrs. Parker to perform his allotted part in the operation in the operating theatre of the Mater Misericordiae Hospital, a public hospital, under the arrangements made by members of the hospital staff for the performance of the operation and with the assistance of the members of the staff present in the operating theatre. Each of the appellants was bound to exercise in the performance of his part of the operation the skill and care of an ordinarily good and careful practitioner. No fault is found with the manner in which Dr. Kirkland performed the surgical work involved in the removal of the patient's kidney (the operation that was to be done when her right hand was burned) or

(1) (1821) 3 Brod. & B. 54 [129 E.R. 1203].
(2) (1802) 3 East. 62 [102 E.R. 520].
(3) (1934) 34 S.R. (N.S.W.) 431; 51 W.N. 138.
(4) (1918) V.L.R. 375.
(5) (1897) 22 V.L.R. 611.

with the manner in which Dr. Paton administered the anaesthetic for the purposes of the operation. But it would be an unduly narrow view to take of the scope of the duty of care which both appellants owed to their patient, to say that the duty of care was strictly confined to the careful and skilful performance of the tasks to be done on the operating table. The patient having entrusted herself to their care, each of them had the duty to exercise such care as was reasonable in the circumstances to protect her from any dangers arising in the operating theatre. But it was their paramount duty to concentrate their attention on their strictly surgical work. It was that primarily which they undertook to Mrs. Parker to perform. And it would be unreasonable to impose upon them a duty which would require them to divert their attention away from their surgical work (I include in that the administration of the anaesthetic) to matters within the province of the members of the hospital staff assisting at the operating and which it was reasonable to leave to them.

The case made against Dr. Kirkland and Dr. Paton is based on the evidence that it is dangerous to liberate ether in a room where there is a naked light. The negligence charged is that this danger was created by giving Mrs. Parker ether as an anaesthetic while an electric radiator with an exposed cone, which was the apparatus used to warm the operating theatre, was alight in the operating theatre. There is evidence from which the jury might infer that Dr. Kirkland and Dr. Paton saw the radiator in the operating theatre and were aware that it was alight before the administration of any ether began. There was evidence that it was the practice in this operating theatre for the theatre sister to turn the radiator on or off as she thought fit, and that the two doctors had been accustomed to work in this operating theatre. In my opinion it was reasonable for both doctors to rely upon the theatre sister to turn off the radiator if it was dangerous to be on when Dr. Paton began to administer the anaesthetic, or to remove the radiator from the danger zone. The jury could not reasonably find on the evidence that it was brought home to the mind of either practitioner that the theatre sister did not take either course. That is the fact of which the jury needed to be convinced before convicting either of them of negligence.

There is evidence that the radiator was standing on the floor about six feet from the operating table. A witness who gave evidence that it was hazardous to use ether in an operating theatre in which an electric radiator is alight added that the risk of explosion or fire depended upon the proportion of ether to air in the room. But there was other evidence that it was very dangerous to give ether as an

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anaesthetic at all in the circumstances. However, the fire, which unfortunately burnt the patient, did not occur until a bottle of ether fell onto the bare terrazo floor of the operating theatre and broke. If the jury could reasonably draw the inference that this mishap was the cause of the fire rather than the omission to put out the radiator, there is clearly no evidence to connect Dr. Kirkland with the outbreak of the fire. There is no evidence how the bottle of ether happened to fall. The bottle of ether was provided for the use of Dr. Paton by the hospital. It was within the province of the nurses as well as of Dr. Paton to handle the bottle. There is no positive evidence that he caused the bottle to fall or that he did not take reasonable care to prevent the bottle from falling. There is no ground for a presumption that he did cause it to fall or did not take such care.

In my opinion there is no evidence upon which the jury could reasonably find that either Dr. Kirkland or Dr. Paton was guilty of any breach of duty to Mrs. Parker resulting in the occurrence of the fire which burned her.

The appeal should be allowed and the nonsuit restored.

WILLIAMS J. The respondents, who are husband and wife, brought two actions against the appellants in the Supreme Court of New South Wales at common law. By her declaration the female respondent alleged that the appellants, who are duly qualified medical practitioners, undertook to perform a surgical operation upon her, but were negligent in performing the operation, and in the care, control and management of the operating theatre, and in and about the preparation, manipulation and control of the heating apparatus therein, and in and about the handling of the chemicals which they used in the operating theatre for the purposes of the operation, whereby certain of the materials and chemicals were spilt over the plaintiff and came into contact with the heating apparatus and exploded and caught fire, whereby the plaintiff was seriously burnt and otherwise hurt and injured. The male plaintiff sued for the damages which he suffered by the loss of the comfort and services of his wife and for expenses incurred for medical and nursing attention for her.

The actions were heard together, and at the close of the plaintiffs' case the learned trial judge nonsuited them both on the ground that there was no evidence of any negligence on the part of either defendant. Both plaintiffs appealed to the Full Court of New South Wales, which ordered new trials of both actions against both defendants. The defendants have, by leave, appealed to this court against the order of the Supreme Court.

From the plaintiffs' case it appears that the Mater Misericordiae Hospital is a public hospital situated at North Sydney. It contains two operating theatres, the dimensions of the principal theatre being seventeen feet long by fifteen feet six inches wide. This theatre is approached in the first place through outer folding doors. There is then an ante-room or corridor, from which further doors lead into the theatre itself. On 17th June 1936 it was warmed by a radiator, the heating element of which consisted of horizontal wires fixed on an iron frame which became red hot when the radiator was switched on, the dimensions of the wires being about fifteen inches by four inches and those of the entire radiator about two feet or two feet three inches by eighteen inches. The plug to which the cord of the radiator was attached was in the left-hand corner at the entrance to the theatre. On the afternoon of that day the female plaintiff was being anaesthetized by Dr. Paton on the operating table situated in the centre of this theatre, and the surgeon Dr. Kirkland was engaged in draping the area around her left kidney which he was about to remove. The anaesthetic was being administered by dropping ether out of a glass bottle from time to time onto gauze stretched on a wire frame placed over the patient's face. Dr. Paton was sitting at the side of the operating table near the patient's head. He had a table alongside him for the use of the anaesthetist, on which the bottle was placed when he was not using it to drop the ether onto the mask. At this stage somebody knocked the bottle onto the floor. The fumes of the ether mixed with the air and formed a combustible mixture, which was exploded by the heating element in the radiator, which was situated about six feet from the operating table and turned on. The explosion caused a fire on the floor which spread to the bottom of the table and severely burned the patient's right hand, which was hanging down over the side. There is no evidence as to who switched the radiator on or as to how long it had been switched on at the time of the accident. In addition to the surgeon and anaesthetist there were present Dr. Garde, the medical superintendent of the hospital, apparently as an onlooker, and five sisters or nurses employed by the hospital. There was some evidence from which the jury could infer that the surgeon and anaesthetist had been there for about half an hour. They had both taken part on several occasions in previous operations in the theatre. The radiator was the sole means of warming the theatre, and the only evidence as to its use was that the theatre sister used to turn it on or off as she thought fit. Ether is very inflammable and explosive. Approximately speaking, as low a mixture as 1.35 per cent of ether will explode if mixed with ninety-eight per cent of air. There was evidence

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that it would be hazardous to drop ether onto a mask in the manner already mentioned if there was a heated metal coil six feet away from the operating table, and that if the bottle was broken "nothing could save a fire." In a public hospital the surgeon has to accept the services of the anaesthetist on duty and of the staff provided by the hospital. There is a legal duty on the hospital authorities to exercise reasonable care to provide a suitable theatre and equipment, including the warming apparatus, and to select as members of the staff persons who are competent either as surgeons, anaesthetists or nurses (*Lindsey County Council* v. *Marshall* (1); *Hillyer* v. *Governors of St. Bartholomew's Hospital* (2); *Lavelle* v. *Glasgow Royal Infirmary* (3); *Reidford* v. *Aberdeen Magistrates* (4)). It was the duty of Dr. Kirkland to carry out a difficult surgical operation on a woman in a low state of health, and of Dr. Paton to administer the necessary quantity of ether to render and keep her in an unconscious state before and during the operation, and to safeguard her against the risks inherent in the inhalation of an anaesthetic by a patient in such a condition. These tasks were successfully performed. Both doctors were entitled to assume, in the absence of notice to the contrary, that the theatre was in a suitable condition to enable them to carry out their work, that the anaesthetic in the bottle was ether, that the instruments, gowns, sheets, robes, &c., were properly sterilized; and, generally, that the preparations were such that all they would have to do would be to concentrate upon the performance of their respective parts of the operation. It follows, therefore, that they could only be liable for the accident if there was evidence from which the jury could reasonably infer that they knew or ought to have known that the radiator was of the type that contained an open heating element, that it was dangerous to use ether while such a radiator was switched on, and that the theatre sister had failed in her duty to switch it off. I agree that the evidence that both doctors had been in a small theatre for half an hour before the accident, that they both knew the theatre well, that the operation was being performed in the winter, and that the theatre would have to be heated to protect the patient, would be sufficient, in the absence of any explanation, to enable the jury to draw the inference that they both knew or ought to have known the means for warming the theatre was a radiator of the type already described and that it was switched on. Moreover, there is evidence that it was Dr. Kirkland's duty to know that it was hazardous for Dr. Paton to drop the ether onto the gauze out of a small bottle under such

(1) (1937) A.C. 97, at pp. 108, 119, 123, 124.
(2) (1909) 2 K.B. 820.
(3) (1932) S.C. 245, at pp. 251, 252.
(4) (1933) S.C. 276, at p. 281.

conditions. But even if it was his duty to have this knowledge, there is no evidence that the patient's hand was burnt because of his failure to guard against this danger, the effective cause of the accident being the breaking of the bottle when it fell onto the floor. In my opinion, therefore, the learned trial judge was right when he granted the nonsuits to Dr. Kirkland, so that the appeal should succeed in his case.

It remains to consider the position of Dr. Paton. The bottle of ether was in his charge. There is no explanation of how it came to be knocked off his table onto the floor. As there is evidence from which the jury could infer he knew the type of radiator, and that it was switched on, it was his duty to know that there was a danger of explosion if the small percentage of ether already mentioned became mixed with the air. Even if he was entitled to believe that he could drop the ether onto the mask without danger with the radiator on, he ought to have known, if the plaintiffs' evidence is correct, that, if the glass bottle dropped onto the floor and broke, an outbreak of fire was practically certain. If, therefore, he knew the radiator was switched on, he had a duty to take reasonable precautions to see that the patient was safe against explosion and fire, not only in respect of the ether dropped on the gauze but also in the event of the bottle falling on the floor. On the procedural point I agree with the judgment of my brother *Starke*, so that it follows, in my opinion, that the Full Court of New South Wales was right in ordering new trials in his case and that his appeal fails.

Appeal allowed in case of Dr. Kirkland; dismissed in case of Dr. Paton. 1. Set aside the nonsuit in the case of Dr. Paton. 2. Also set aside any order for costs on first trial. 3. Set aside the order of the Full Court dated 26th June 1941. *4. Restore nonsuit in the case of Dr. Kirkland. 5. Direct new trial in the case of Dr. Paton. 6. Order respondents to pay Dr. Kirkland his costs of appeal in this court and in the Supreme Court except so far as the same were increased by joinder with Dr. Paton in such appeals. 7. Reserve costs of first trial, including the costs of Dr. Kirkland on the first trial, to the Supreme Court of New South Wales or any justice thereof. 8. Remit action to the Supreme Court of New South Wales, there to be dealt with in conformity with this judgment.*

Solicitors for the appellants, *Stephen, Jaques & Stephen.*
Solicitor for the respondents, *Colin Biggers.*

J. B.