


MEDICAL MALPRACTICE

BY BRENDA OSMOND & PAUL McGIVERN
PACIFIC MEDICAL LAW

ESTABLISHING OR CHALLENGING THE STANDARD OF CARE IN THE MEDICAL MALPRACTICE CONTEXT

In order to succeed in a medical malpractice case, a plaintiff must prove, usually through expert evidence that: the defendant health care professional owed the plaintiff a duty of care; the defendant breached the standard of care; the plaintiff suffered an injury or loss; and that the negligence identified was the cause of the injury or loss. (E.I. Picard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada* (Toronto: Thompson Canadian Limited, 2007) [*Picard*].

The standard of care expected of a physician is the use of "that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases" *Wilson v. Swanson,* 1956 CanLII 1 (SCC), [1956] S.C.R. 804 at 811-812, 5 D.L.R. (2d) 113. The standard of care, which is usually defined as "accepted practice", sets the bar by which a health care professional's actions will be measured in a medical malpractice case.

This article will review the law with respect to the standard of care and will provide some tips for counsel regarding how to establish or challenge an existing standard of care.

ESTABLISHING THE STANDARD OF CARE

As noted in *Hoy v. Medtronic*, 2004 BCSC 440, determining the standard of care is a matter of mixed fact and law and is fluid, not rigid. But how do you go about characterizing the standard of care in a specific case?

One of the first steps is to look for relevant documents such as policies, guidelines or standards adopted by regulatory authorities or medical associations. These documents can be helpful in determining what the existing standard is, but are often not definitive. In *Ediger v. Johnson*, 2009 BCSC 386, Holmes, J. found that the guidelines published by the Society of Obstetricians and Gynaecologists of Canada and by the BC Reproductive Care Program set the parameters for the determination of the standard of care. In *Kern v. Forest*, 2010 BCSC 938 (CanLII) [*Kern*], the use of guidelines was found to be completely unhelpful. In *Kern* the plaintiff was treated by the defendant chiropractors and alleged negligence causing serious injury. The plaintiff called a chiropractor to give expert evidence. The expert relied on Canadian guidelines for chiropractic practice as setting out the standard of care for the profession and opined that the defendants had not met that standard of care. The Court rejected that view for two reasons. The guidelines themselves included a general disclaimer that they were not intended to replace clinical judgment and were not standards of care. The Court noted that although policies and guidelines provided assistance to the Court, considerable weight had to be given to the evidence of experts who comment on and interpret those policies and guidelines. This lead to the Court's second concern: the plaintiff's expert had extremely limited general practice experience, while the defence expert had over 20 years' experience in general practice. The Court accepted the evidence of the more experienced defence expert and found the chiropractor was not negligent.

Another example of the need to support guidelines with expert evidence is *Maher v. Sutton*, 2013 BCSC 1808 (CanLII). Here the plaintiff alleged that eye surgery should not have been performed on him and relied on the evidence of an ophthalmologist practising in New York State, as well as protocol and procedure manuals and Canadian guidelines. The Court found that since no expert evidence was led to support the conclusion that the guidelines had been adopted by ophthalmologists in BC as the accepted practice, the documents could not be considered to have set the standard. Generally speaking, the use of US based experts to set the standard of care to be met in BC should be avoided.

FACTORS INFLUENCING THE STANDARD OF CARE

The standard of care is normally a function of two factors: the foreseeability and the degree of risk inherent in a procedure. As noted in *Picard*:

> "The standard of care is influenced by the foreseeable risk. As the degree of risk involved in a certain treatment or procedure increases, so rises the standard of care expected of the doctor.

In *McArdle, Estate v. Cox*, 2003 ABCA 106 (CanLII) [*McArdle*], the deceased had undergone a reversal of a stomach-stapling procedure. Two weeks later she died of a stroke related to a massive infection in her abdomen due to leakage through perforations in the wall of the stomach caused by the reversal surgery. The trial judge established the standard of care by "thoroughly reviewing the circumstances of the case … and the interaction between the [surgeon] and the patient. He analysed the risks involved in the surgery, especially that of a perforation." The Court of Appeal noted that the standard of care needed to be applied within the context of the injury and the forces relevant to its occurrence. Noting that the degree of risk in a procedure is one of the relevant circumstances to be considered, the court said:

> [27] The degree of foreseeable risk involved in a procedure or treatment is not only an appropriate, but indeed an essential determinant of the appropriate standard of care. The standard of care is influenced by the *foreseeable* risk. As the degree of risk increases, so does the standard of care of the doctor.

In *McArdle,* the Court points out that the risk is an "impor-

tant but sometimes silent player" and that the risk analysis is so central to the characterization of the standard of care that it is usually the main theme in the reasons of a trial judge and is not usually dealt with as a discrete topic. This emphasizes the need for plaintiff's counsel to ensure that experts consider the specific characteristics of the plaintiff when forming an opinion, and ensure that those characteristics inform their views on the "accepted practice".

The concept of the foreseeability of risk was also at play in *Ediger*. Here the defendant physician attempted a mid-level forceps delivery of a baby but abandoned the procedure when he was unable to place the forceps satisfactorily. Shortly after that the infant's heart slowed and the infant was deprived of oxygen for 18 minutes until she could be delivered by C-section. The infant suffered a severe brain injury. At issue was the meaning of Guideline 21 of the Society of Obstetricians and Gynecologists, which identified a mid-forceps delivery as one of three procedures that required the "immediate availability" of Caesarean section back-up. The degree of risk and the foreseeability of the risk informed the judge's analysis of what "immediate availability" meant. The undisputed expert evidence was that brain injury to a fetus begins in most cases at ten minutes from the onset of bradycardia. The trial judge interpreted the meaning "immediately available" in light of the recognized risk that bradycardia lasting for ten minutes or more would cause severe injury to the baby.

The Supreme Court of Canada upheld the trial judge's finding that the standard of care required the defendant to take reasonable precautions that were responsive to the recognized risk of bradycardia and the severe injury that would result if the bradycardia lasted for more than ten minutes.

The concept that the standard of care must be responsive to the risk provides an opportunity, in the right factual circumstances and with the right expert evidence, to have the standard of care interpreted favourably for the plaintiff. The Supreme Court of Canada has stated that standard of care need not prevent every injury at any expense – but as *Ediger* illustrates, a careful analysis of both the foreseeability of the risk and the degree of risk can lead to a finding that essentially "raises the bar."

IS THE STANDARD PRACTICE ADEQUATE?

If an analysis of the foreseeability of the risk and the degree of risk still does not raise the bar on the standard of care enough for the plaintiff to succeed, is it possible that the standard of care is simply not adequate to address the potential risks, and that the court should substitute its opinion over that of experts in the field? Some authors suggest that the courts do have a role to play in advancing professional standards:

> "The courts on behalf of the public have a critical role to play in reviewing, monitoring and precipitating change in professional standards. […] [H]olding compliance with approved practice to be negligence may be the only route to move some members of a profession to a new, better course […] The courts are the appropriate organ for the adjustment of this balance, and should not abdicate their responsibility to adjudicate upon the negligence in any profession." (*Picard*, page 359)

Anderson v. Chasney, [1949] 4 D.L.R. 71 (Man. C.A.), aff'd [1950] 4 D.L.R. 223 (S.C.C.), is an early example of when the Court found that a physician's usual practice, even though followed by physicians in his hospital and other hospitals, did not provide a defence to a "faulty" practice. In *Anderson*, a doctor performed surgery on a child's throat using sponges that did not have tape or string attached to ensure that none were left in the child's throat. A sponge was left in the throat and the child died of suffocation. The defendant's position was that it was not his practice to use sponges with tape or string, or to have a sponge count done. The Manitoba Court of Appeal noted that the fact that a sponge was left in a potentially dangerous position is one which "the ordinary man is competent to consider in arriving at a decision as to whether or not there was negligence."

The idea that a generally accepted practice could be found to be negligent was developed further in *ter Neuzen v. Korn*, 1995 CanLII 72 (SCC) [*ter Neuzen*]. In *ter Neuzen* a patient contracted HIV from infected sperm used in an artificial insemination program. The patient alleged that the defendant doctor was negligent in not knowing the risk of HIV infection from artificial insemination and in failing to screen donors for sexually transmitted diseases. The Court confirmed the general rule that compliance with "a recognized and respectable practice of the profession" is persuasive evidence of the absence of negligence on the basis that the medical profession as a whole is "assumed to have adopted procedures which are in the best interests of patients and are not inherently negligent." Nonetheless, the Court made room for "certain situations where the standard practice itself may be found to be negligent"– this has come to be known by some as the "*ter Neuzen* exception". In order for a standard practice to be found negligent it must be "fraught with obvious risks" such that anyone is capable of finding it negligent, without needing to judge matters requiring diagnostic or clinical expertise. A review of the cases demonstrates that these two conditions – that the practice be "fraught with obvious risks" AND within the realm of the ordinary person without diagnostic or clinical expertise – rarely appear in concert and rarely lead to a finding that an accepted practice is in itself negligent.

One case where the *ter Neuzen* exception was followed was *Ivanitz v. Van Heerden,* 1996 CanLII 2559 (BC SC) [*Ivanitz*]. In *Ivanitz* the plaintiff was using a hammer on a car's transmission shaft when he was struck by two pieces of metal, one to his lip, the other to his right eye. In the emergency room of the local hospital, the examining physician did not order an x-ray. The plaintiff led no expert evidence on this point, and the two defence experts said no x-ray was needed, but on different facts than those found by the judge. The judge, in determining that the standard of care required an x-ray of the eye, stated it was "not only sound from a professional medical perspective but make good common sense. There is no risk to the patient who undergoes an X-ray. There is a real risk to a patient who says he has been

hammering metal on metal and reports metal in an eye from one fragment […]". Citing Professor Fleming as quoted in *ter Neuzen*,the Court noted:

> […] [N]egligence in diagnosis and treatment […] cannot ordinarily be established without the aid of expert testimony or in the teeth of conformity with accepted medical practice. However there is no categorical rule. Thus an accepted practice is open to censure […] in matters not involving diagnostic or clinical skills, on which an ordinary person may presume to pass judgment sensibly […].

The judge went on to state that given his analysis of the risk of doing an x-ray versus not doing an x-ray, there could "be no doubt about the need for an x-ray."

Although the courts have purported to follow the *ter Neuzen* exception on occasion, there are far more examples of cases in which the courts refused to apply the exception. Two examples are presented below.

In *Larson v. Lucky et al*, 2005 BCSC 829 (CanLII) [*Larson*] the plaintiff asked the Court to follow the reasoning in *Ivanitz* and find that common sense dictated that an x-ray was necessary. In *Larson*, the plaintiff alleged that the physician failed to diagnose a fractured finger. The Court declined to decide whether or not an x-ray was needed, because, in the Court's view, that was not the proper basis on which to frame the standard of care question. The correct question was whether the defendant should have suspected that the finger might be fractured, and if she did not, did that failure fall below the standard of care. The Court found that ordinary common sense could not answer this question and expert evidence was required.

Emmonds v. Makarewicz, 1999 CanLII 6639 (BC SC), rev'd 2000 BCCA 573 (CanLII) is another case in which the plaintiff asked the court to find that the existing standard of care should be found to be inadequate, despite the expert evidence supporting the existing standard of care. Here the plaintiff had laparoscopic gall bladder surgery. During the surgery gallstones were spilled in the abdomen causing pain and suffering in the five years between the original surgery and the follow-up surgery to remove the stones. The expert evidence at trial was that it was common practice for surgeons not to make aggressive efforts to remove stones and not to advise patients that spilled stones were left in the abdomen, even though it could cause harm. Despite that, the trial judge found the surgeon negligent because the standard practice in 1991 was "fraught with obvious risk, such that anyone is capable of finding it negligent." In overturning this finding the BC Court of Appeal noted that the second condition of the *ter Neuzen* exception, that the impugned practice must be within the realm of the ordinary person without diagnostic or clinical expertise to find it negligent, had not been met. There was a body of expert evidence adduced at trial on the question of the prevailing practice in relation to leaving spilled stones behind in the abdomen, making this an area that a court was not competent to judge.

CONCLUSION

These cases highlight the need to fully understand the expert evidence related to the standard of care. Plaintiff's counsel must ask not only what the standard of practice is, but what are the underlying reasons for the standard? What are the risks that the standard is aimed at addressing? How serious are those risks? Will that standard of practice be effective in addressing those risks? What reasonable precautions can be taken to avoid the risk? In other words, at the end of the day, it must be determined if the standard of practice is in fact "responsive to the risks."

PRACTICE TIPS WHEN CONSIDERING THE STANDARD OF CARE

- Look for policies, guidelines, standards in the area, and seek expert opinion to show they have been adopted into practice
- Challenge your experts on the risks: are the accepted practices adequate to avoid the risks or are there other reasonable precautions that could be taken?
- Understand not only what the "accepted practice" is, but why it exists
- Ask what the risks of any given procedure are, and what steps are in place to address the risks.
- Identify if there are any features unique to the plaintiff that change the degree of risk or the foreseeability of the risk V