MEDICAL MALPRACTICE

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PACIFIC MEDICAL LAW

INTRODUCTION

At their core, medical malpractice lawsuits are tort actions. The basic elements are the same as in any other tort action - duty, breach of the duty, causation, injury – just like we learned in law school. What makes medical malpractice lawsuits different? The complexity of the medical underpinnings and the health care system itself, the uncertain response any patient can have to a medical intervention, the patient's role as an active participant in his or her health care, and the vigorous defence of these actions all conspire to make this area of law unique and challenging.

In this 8-part series we'll consider the anatomy of a medical malpractice lawsuit, with a particular focus on the nuances that set these cases apart from others. The following topics will be reviewed:

- **The Doctor-Patient Relationship and Duty of Care**
- Consent
- Standard of Care
- Defences to a Claim of a Breach of the Standard of Care
- Causation – Basic Principles
- Causation – Application
- Expert Evidence
- Disclosure of Errors

THE DOCTOR-PATIENT RELATIONSHIP AND DUTY OF CARE – HOW WIDE SHOULD THE NET BE CAST?

1. To succeed in an action for medical negligence, a plaintiff must prove four essential elements:
2. The defendant owed the plaintiff a duty of care;
3. The defendant breached the standard of care;
4. The plaintiff suffered an injury or loss; and
5. The defendant's conduct was the actual and legal cause of the plaintiff's injury.

One of the first issues plaintiff's counsel must consider before commencing a medical malpractice action is which health care provider owed their client a duty of care. A duty of care can include specific duties such as: "the duty to assess; the duty to diagnose; the duty to communicate; and the duty to refer".[1] If a duty of care cannot be established, a medical negligence action cannot succeed. A doctor's duty of care to his or her patient arises from the nature of the doctor-patient relationship.

Originally, the medical profession was a "common calling" like that of barbering or inn-keeping. Certain expectations were placed on those who professed such a calling, including a legal duty to use proper care and skill. Therefore, the doctor's duty to his or her patient arose from the doctor's status as a member of the medical profession.[2] Later, with the development of contract law, this original basis of liability was replaced by a contractual one: the patient's request for treatment constituted the offer and the acceptance was the doctor's commencement of care.[3]

In the past two centuries, most actions against doctors have been based in negligence, with the doctor's conduct being judged by tort principles. Now, it is clear that a duty of care exists independently of any contract between patient and doctor. "For example, there is a duty to use reasonable skill, care, and judgment when a doctor attends on an unconscious patient who cannot be said to have voluntarily submitted to care."[4] Similarly, a doctor has a duty to respect a patient's refusal of treatment, even if they cannot communicate this at the time of the doctor assuming care.[5]

The doctor-patient relationship has long been recognized as one of the traditional categories of fiduciary relationship, a relationship in which one party (the patient) places special trust, confidence, and reliance in, and is influenced by, another (the doctor) who has a fiduciary duty to act for the benefit of the patient. The fiduciary nature of the doctor-patient relationship has been described by the Supreme Court of Canada as "the most fundamental characteristic of the doctor-patient relationship", which has trust, not self-interest, at its core.[6]

WHEN DOES THE DUTY OF CARE ARISE?

The duty of care arising from the doctor-patient relationship is not limited to doctors, but applies to all health care professionals (nurses, dentists, chiropractors, physiotherapists, massage therapists, psychologists, etc.). Typically, where a doctor has

participated in the care of a patient, a duty of care arises. This includes telephone consultations, and situations where a specialist reviews the patient's imaging or blood or tissue samples, but never actually meets the patient (such as a radiologist, lab technician, or pathologist).[7]

The number of health care professionals that may have participated in the care of a plaintiff has implications for naming defendants when commencing an action. Take, for example, a claim for a delayed diagnosis of cancer. The plaintiff may have a claim against his or her family doctor if the doctor did not follow up with a test result as required. Consider, however, all of the other health care professionals that were involved in the care of this patient. Was the imaging misread by the radiologist? Was the sample properly analyzed by the lab technician? Are there other support staff involved in providing the services whose names never appear in the records?

Even if a physician does not assume care, a duty of care may arise if they have an ethical obligation to render assistance. In *Egedebo v. Windermere District Hospital Assn.*,[8] the plaintiff was brought to the emergency department suffering from lack of feeling in his legs and a burning feeling in his chest. The ER doctor was busy with an operation and unable to treat the plaintiff until two hours after his arrival in hospital. During this time, another doctor was in hospital and made aware of the plaintiff's condition, but he stated that he was "not on call" and felt that the plaintiff should wait and be seen by the ER doctor. Unfortunately, the plaintiff developed permanent triplegia due to a ruptured vascular malformation in his spinal cord before being seen by the ER doctor. The court concluded that the available doctor had a duty of care to the plaintiff based on his ethical obligation to assist when he knew, or ought to have known, that no other doctor was available.

Egedebo makes it clear that a doctor cannot avoid owing a duty of care to a patient by declining to see the patient. Consider, however, the case of *Morrison v. Hicks*[9] in which the court did not find that the defendant doctor who declined to provide care owed a duty of care to the plaintiff in a similar situation. In *Morrison*, the plaintiff, who was severely injured in a motor vehicle accident, was under the care of the ER doctor. The plaintiff's mother, concerned about the care her son was receiving and a potential injury to his neck, happened to see his family doctor in the emergency room and asked him to see her son. The doctor explained that he could not see her son right away, that the ER doctor was looking after him, and that he would assume care once the plaintiff was admitted to a ward. After the plaintiff was transferred to intensive care, he was found to be quadriplegic. The plaintiff brought an action against the ER doctor and his family doctor, among others. On the issue of whether a duty of care arose with respect to the plaintiff's family doctor, the court found that he did not owe the plaintiff a duty of care at the relevant times, as he did not undertake to provide care until the plaintiff was admitted to a ward. Although very similar factually, *Morrison* can be distinguished from *Egedebo* on the basis that another doctor had already assumed care, so that the subsequent doctor was not obligated to render assistance.

As the cases above illustrate, the existence of a duty of care is not always obvious. A thorough understanding of when a duty of care arises is essential to ensure that potential defendants are not missed when drafting pleadings, potentially undermining the plaintiff's claim.

SPECIAL CIRCUMSTANCES

The courts have considered whether a physician owes a duty of care – and the extent of that duty - in a number of special circumstances, each of which are examined below.

Does a doctor owe a duty of care to an unborn baby?

A long line of authority exists that states that if a doctor or nurse is negligent in the prenatal care or delivery of a baby, resulting in the baby suffering an injury, the doctor or nurse will be found liable. The principle is that doctors and nurses owe a duty of care to the unborn baby not to cause harm, with the cause of action crystalizing when the baby is born alive.[10] If the baby is not born alive (for example, in a situation involving an abortion), no duty of care arises. If the baby is born alive with injuries due to prenatal or perinatal care, or botched abortion, there is a duty to that baby once it is born.[11]

Doubt was cast on the principle that there is a duty of care owed to an unborn baby in the case of *Paxton v. Ramji*.[12] In that case, a woman was prescribed Accutane, an acne medication known to cause birth defects, and she became pregnant shortly after starting the medication. The child was born with severe disabilities as a result of the mother taking the medication around the time of conception, and allegations of negligence were made against the doctor for failing to warn the woman that she should take additional precautions to ensure that she did not become pregnant. At trial, the judge found that the doctor owed a duty of care to the unconceived baby, but that he met the standard of care. The Ontario Court of Appeal dismissed the child's claim on the basis that the doctor owed no duty of care to an unconceived baby, as this would inevitably conflict with the doctor's duty of care to the woman. This is somewhat in contrast to the analysis in the line of authority mentioned above which clearly establishes that a doctor owes a duty of care to a baby subsequently born alive. These cases make no finding of a conflict in caring for the woman and her unborn baby, with the duty to the baby crystalizing when born alive.

At numerous points in the *Paxton* judgment, the Court of Appeal casts the issue as whether a doctor owes a duty to a future

child who is "conceived or not yet conceived" at the time of the negligent act.[13] As a result, defence counsel attempted to rely on *Paxton* for the proposition that health care professionals do not owe a duty to an existing unborn baby subsequently born alive. This proposition was subsequently rejected by the courts.[14] The law is that doctors, nurses, and other health care professionals owe a duty of care to a baby subsequently born alive, and *Paxton* should only be read as applying to the specific facts of the case (that is, to a baby not yet conceived).[15]

Does a doctor owe a duty of care during an IME?

A plaintiff may undergo an independent medical examination in the context of personal injury litigation, life insurance application, or employment. The doctor's duty in these situations is limited. The doctor does not have a duty to provide medical care or treatment and there is no duty to act in the plaintiff's best interests in terms of the opinion that doctor provides (e.g. for the purpose of insurance, disability benefits, or litigation), but is required to "take reasonable steps to ensure that the patient understands the nature and extent" of that responsibility to the third party.[16]

If the doctor causes injury to the patient during the assessment, the doctor can be liable as the duty not to cause harm to the patient still exists.[17] In *Branco v. Sunnybrook & Women's College Health Sciences Centre*,[18] the plaintiff, who was receiving disability benefits, was directed by his employer to attend the defendant hospital for an IME to assess whether he was physically capable of performing the job he was then employed at in light of his complaints of neck and chest pain. The doctor who conducted the IME reported to the plaintiff's employer that the plaintiff was suffering from mechanical back pain and associated symptoms. He considered the plaintiff to have a favorable prognosis for returning to work and recommended he receive physical therapy, an MRI of the spine and consultation with a neurosurgeon. The plaintiff alleged that the doctor failed to take into account his symptoms and did not have enough medical information before him to conclude that he could return to work. He also alleged that the physical activities performed during the IME caused him pain and suffering. The court concluded that "the primary duty owed by the doctor was to the plaintiff's employer and the only duty owed to the plaintiff was to do no harm to him in the course of conducting the IME"[19] and concluded that the doctor did not, in fact, harm the plaintiff.

Does a doctor owe a duty of care at the scene of an accident?

In situations where doctors or other medical professionals provide emergency assistance to a person at the scene of an accident and the care is provided voluntarily and gratuitously, they are protected by statute. In BC, the *Good Samaritan Act*[20] is aimed at encouraging medical professionals to provide emergency assistance, and precludes a finding of liability unless the aid provided was grossly negligent.[21]

Does a doctor owe a duty of care to a third party?

The issue of whether a doctor owes a duty of care to a third party often arises in the context of a duty to warn someone, other than the doctor's patient, of a risk of harm. The landmark case is *Tarasoff v. Regents of the University of California*,[22] in which a psychiatric patient disclosed his intention to kill his former girlfriend. The patient carried out his plan, and the psychiatrist was found liable for failing to warn the girlfriend. The Supreme Court of California held that it did not matter that Ms. Tarasoff was not a patient of the psychiatrist, as "once a therapist does in fact determine, or under applicable professional standards reasonably should have determined, that a patient poses a serious danger of violence to others, he bears a duty to exercise reasonable care to protect the foreseeable victim of that danger."[23] The court noted that, as a general rule, one person does not have a duty to control the conduct of another, nor a duty to warn those who may be endangered by such conduct, unless the defendant bears some special relationship to the dangerous person or to the potential victim. The court found that in the present case, the relationship of a doctor to a patient was sufficient to support a duty to exercise reasonable care for the benefit of third parties.

Tarasoff has only been considered in one Canadian case, that of *Wenden v. Trikha*,[24] which "involved a voluntary psychiatric patient who absconded from hospital, ran a red light and injured another motorist. The motorist sued the hospital and the attending psychiatrist, as well as the patient, and the court discussed the *Tarasoff* decision at some length." For a doctor to have a duty to warn a third party, the court stated that "two conditions must be satisfied. First, the relationship between the doctor and the patient must be such as to impose a duty on the" doctor to control the conduct of the patient. "Secondly, sufficient "proximity" must exist between the doctor and the third-party in danger." Ultimately, the court concluded that although the psychiatrist and hospital owed a duty of care to the plaintiff in the circumstances, neither could have foreseen that the patient would escape and drive dangerously, and dismissed the claim against them.

Duty of Care in Novel Situations

In considering whether a duty of care applies to a doctor or any health care professional in a novel situation, the test, based on the House of Lords case of *Anns v. Merton London Borough Council*, [25] and adopted by the Supreme Court of Canada in *Cooper v. Hobart,*[26] is whether:

there is a sufficiently proximate relationship, and whether it is reasonably foreseeable that negligence by the doctor may cause harm to the other party; and there are residual policy considerations that may negate the imposition of a duty of care.[27]

"The first stage encompasses whether there is a *prima facie* duty of care by analyzing reasonable foreseeability and whether there is a sufficiently close and direct relationship of proximity, including policy considerations that affect the relationship. The second stage considers whether, despite finding a *prima facie* duty of care, there are residual policy reasons to reject a duty of care."[28]

In *Paxton,* discussed above, the court chose to analyze the doctor's relationship to a baby not-yet conceived as a novel situ-

ation. The court sought to determine whether the doctor and a "future child" are in a "close and direct relationship" that ought to impose a duty of care on the doctor to the future child. The court found that a finding of a "duty of care to a future child of a female patient, the doctor could be put in an impossible conflict of interest between the best interests of the future child and the best interests of the patient" such that a duty should not be imposed.[29] This is an interesting conclusion, considering that a duty to an existing unborn baby subsequently born alive, has long been accepted. *Paxton* can be distinguished, however, on the basis that the duty in question was from a doctor to an unconceived fetus. Although it was not necessary to conduct the second stage of the *Anns* test, the Court concluded that even if a relationship o.f sufficient proximity had been found, residual policy considerations would weigh against the imposition of such a duty as this would affect the doctor's existing legal obligation to his or her patient, and recognized that the proposed duty would have implications for society as a whole, impacting the medical and legal right of a woman to abort a fetus, for example.[30] Some commentators have critiqued the court's reasoning in this judgment.[31]

CONCLUSION

A duty of care arises whenever there is a relationship between a patient and health care provider. As the cases discussed above illustrate, however, the existence of a duty of care is not always obvious, and determining whether there is a duty of care is largely a fact-driven analysis.

The importance of carefully analyzing the duties owed to a patient cannot be overstated. A detailed review of all of the plaintiff's health care providers and the plaintiff's relationship to each of them is necessary to ensure a potentially important defendant is not left out, thereby running the risk of undermining the plaintiff's claim.

1. *Briante v. Vancouver Island Health Authority*, 2014 BCSC 1511 at para 265, rev'd in part on appeal.
2. Gerald B. Robertson & Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th ed (Toronto: Thomson Reuters, 2017) at 1.
3. *Ibid* at 2.
4. *Ibid*.
5. See *Malette v. Shulman*, 67 D.L.R. (4th) 321 (Ont. C.A.), [1990] O.J. No 450.
6. *Norberg v. Wynrib*, [1992] 2 S.C.R 226 at para 63.
7. See *Benhaim v. St-Germain*, 2016 SCC 48, [2016] 2 S.C.R. 352.
8. [1991] B.C.J. No. 2381 (S.C.), affirmed (1993). 78 BCLR (2d) 63 (C.A.).
9. 49 C.C.L.T. 167, [1989] BCJ No. 1169.
10. *Duval v. Seguin* (1972), 26 D.L.R. (3d) 418 (Ont. H.C.), affirmed (1973), 1 O.R. (2d) 482 (C.A.).
11. *Cherry (Guardian ad Litem of) v. Borsman*, 94 D.L.R. (4th) 487, [1992] B.C.J. No. 1687. If a therapeutic abortion, for example, is carried out negligently, resulting in the birth of a baby but with no injury to the child, the mother has a claim for wrongful birth, which includes non-pecuniary damages, some damages for loss of income, but no damages for raising a healthy but unwanted child (see *Roe v. Dabbs*, 2014 BCSC 957). The child does not have a claim for wrongful life whether they are born healthy or not (see *Bovingdon v. Hergott*, 2008 ONCA 2).
12. 2008 ONCA 697, [2008] O.J. No. 3964 [*Paxton*].
13. *Ibid* at para 76.
14. *Steinebach v. Fraser Health Authority*, 2010 BCSC 832 at para 44; *Cojocaru (Guardian Ad Litem) v. British Columbia Women's Hospital*, 2009 BCSC 494 para 223-224; *Ediger v. Johnston*, 2009 BCSC 386 at para 213.
15. *Liebig v. Guelph General Hospital*, 2010 ONCA 450, 321 D.L.R. (4th) 378.
16. Canadian Medical Association, *Code of Ethics* (2004), s. 36.
17. *Branco v. Sunnybrook & Women's College Health Sciences Centre,* 133 A.C.W.S. (3d) 421, [2003] OJ No. 3287.
18. *Ibid*.
19. *Ibid* at para 13.
20. *Good Samaritan Act*, [RSBC 1996] Chapter 172.
21. *Ibid* at s 1.
22. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (Cal. 1976)
23. *Ibid* at 25.
24. [1991] A.R. 81, [1991] A.J. No. 612
25. [1978] A.C. 728, [1977] 2 All E.R. 492 (H.L.)
26. 2001 SCC 79, [2001] 3 S.C.R. 537.
27. *Ibid* at para 30.
28. *Paxton, supra* note 12 at para 32.
29. *Ibid* at para 66.
30. *Ibid* at para 79.
31. Erin Nelson, "Prenatal Harm and the Duty of Care" (2016) 53 Alta. L. Rev. 933.