MEDICAL MALPRACTICE

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INTRODUCTION

This is part 3 of our 8-part series on the anatomy of a medical negligence claim, within which we review the following topics:

- The Doctor-Patient Relationship and Duty of Care (*Verdict* Issue 163 – Winter 2019)
- Consent (Verdict Issue 164 – Spring 2020)
- **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 STANDARD OF CARE

In a previous article we discussed the first essential criterion in a torts action[1] - the need to establish that a defendant physician owes a duty of care to their patients.[2] There are a number of components of that duty including the duty to attend on their patient, and the duty to diagnose, refer and treat their patient. Once the plaintiff has established that the defendant owed them a duty of care, in order to determine negligence, it is necessary for the court to understand what standard of care is required to discharge these duties. The standard of care is the second essential criterion that a plaintiff must prove to win a medical malpractice lawsuit.

At its heart, the standard of care in a medical malpractice action is no different than in any other torts action. The plainti i must prove that the defendant breached the standard of care. This involves determining what the standard of care is, and if the defendant breached that standard. Courts have acknowledged that these legal principles are plain enough but it is not always easy to apply them to particular circumstances.[3]

WHAT IS THE STANDARD?

The concept of reasonableness pervades the court's determination of the standard of care, as is evidenced by the following statement from *Sylvester v. Crits et al.:* [4]

> "… Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability."

In addition to highlighting that the standard is one of a "reasonable degree of care", this statement also describes that the standard of care expected of a specialist is higher than of non-specialists. There are a number of ways that a physician's practice may call for a higher standard of care. The physician may have formal specialty training and recognition, such as certification as a Fellow of the Royal College of Physicians and Surgeons. Another way a physician's practice could require a higher standard of care is if they restrict their practice to a limited range of conditions – essentially specializing in a focused area of practice.[5]

Although the court in *Sylvester* was specifically dealing with physicians, the expected standard of the "degree of care and skill which could reasonably be expected of normal, prudent practitioner of the same experience and standing" extends to all health care professionals. For example, nurses have a duty to exercise their professional skill and knowledge in accordance with what is expected of a normal, prudent nurse in similar circumstances.[6]

Historically the location of a physician's practice could be considered in the court's determination of the expected standard of care. This was largely on the basis that physicians practicing in remote rural locations should not be held to the same standard as a physician working at larger urban centres. The effect of this locality rule was to lower the standard of care expected of rural physicians. There are a number of components to the standard of care analysis – the limited resources that may be available in a remote community may be directly at play in a case. In *Lush v. Connell*[7] the court acknowledged that the issue to be considered was access to facilities and resources, not geographic location. Although limited access to resources will continue to be a reality for rural health care, the locality rule has been significantly diluted over the years. The promulgation of clinical practice protocols and guidelines intended to highlight best practices in diagnoses, and remote access to specialists for some consults, may have the effect of limiting some of the differences between the practice of medicine in rural and urban settings.

HOW IS THE STANDARD OF CARE DETERMINED?

The standard of care is determined by the trier of fact, and is almost always based on expert opinions. There will inevitably be conflict amongst experts for opposing parties. This does not necessitate the dismissal of the case. In the face of opposing opinions, the court must weigh the conflicting testimony based on factors such as the experience of the expert, the factual foundation on which their opinion is based, and whether or not the expert is conducting themselves as an advocate for a party or is acting in conformity with their duty to assist the court.[8,9]

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Modern health care is becoming more and more complex. Specialty practices in both medicine and nursing are evolving. Nurses are being recognized as independent health care providers, and as members of a health care team in certain settings. Nurses and physicians need to rely on each other to carry out their duties, as decisions made by one may rely on information provided by the other. This has implications for how the court considers what the standard of care is, and for what kind of expert can be qualified to opine on the standard of care.

In *Pinch (Guardian ad litem of) v. Morwood*[10] the plaintiff sought to have a family practice physician qualified to opine on the standard of care expected of a rural emergency room physician and nurse. In addition, the plaintiff sought to have an obstetrician and gynecologist qualified to opine on the standard of care of a general practitioner in a rural emergency department. In addressing the defendant's objection to these specific opinions, the court noted that the family physician had trained nurses in the setting of a rural emergency ward and knew the team effort that was required in these circumstances. Similarly, the obstetrician had received referrals from the emergency ward and would have experienced many patients who had been assessed in the emergency room. In accepting these physicians' qualifications, the court stated that:

> [30] … The real test of qualification is whether the expert's knowledge, skill, or experience is sufficiently reliable to be of assistance to the trier of fact … That is a question of law to be determined in the context of each case. Generalized principles that a specialist cannot opine about the work of a general practitioner or that an opinion cannot be admissible if the expert has not practiced in the locale or in the exact circumstances of the defendant are not determinative of the analysis.

Professional standards or clinical guidelines can be of assistance to the court in determining what the standard of care is in a particular instance, but a breach of a standard or guideline does not necessarily lead to a finding of a breach of the standard of care. In order for standards or guidelines to be compelling, evidence must be led that the standards or guidelines have been adopted by the profession. Some guidelines will include "permissive" wording that will bolster a defendant's claim that the guidelines should not be considered conclusive evidence of the standard. For example, in *Kern v Forest*[11] the court noted that clinical guidelines for a chiropractor included a general disclaimer at the beginning of the publication that clearly describe the guidelines as a non-binding document:

> "… These guidelines are not intended to replace a clinician's clinical judgment or to establish the only appropriate approach for all patients. They are intended to be flexible. They are not standards of care. Adherence to them is voluntary. … alternative practices are possible and may be preferable under certain clinical conditions. ..."

The court in *Ediger*[12] also noted that a breach of a recommended professional guideline does not in and of itself constitute a failure to meet the applicable standard of care:

> [59] … As … guidelines are practical tools to assist practitioners in the delivery of services; they are not a substitute for a determination, on all the evidence, of the applicable standard of care

If plaintiff's counsel intends to rely on standards or guidelines as evidence of the standard of care, it is critical to have a thorough understanding of not only the content of the standard or guideline, but also the role they play in the practice of a reasonably competent practitioner.

In determining the standard of care, specific features of the risk of the procedure or treatment in question must be considered, particularly the foreseeability of risk and the inherent degree of

risk. In *McArdle, Estate v. Cox*[13], the court described the effect as follows:

> [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. …

The concept that an increasing degree of risk necessitates a higher standard of care was further developed in *Ediger*, an obstetrical case.[14] Here, the degree of risk associated with the mid-forceps delivery procedure was at the heart of the trial judge's interpretation of the meaning of the immediate availability of access to a caesarean section. 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 risks of the procedure In this case the recognized risk was that of persisting fetal bradycardia leading to severe brain damage that could occur during an attempted mid-level forceps delivery. The standard of care had to be understood in light of that recognized risk, and needed to be responsive to that risk.[15]

IS THERE A ROLE FOR COMMON SENSE IN ESTABLISHING THE STANDARD OF CARE?

Is it always necessary for the plaintiff to provide expert opinion regarding the standard of care? The Supreme Court of Canada has clarified that if a matter can be easily understood by a layperson with no expertise in the medical profession, and where the common practice itself is so "fraught with obvious risks" that the practice can be found to be negligent, it is open to the trier of fact to determine the applicable standard of care, even though it might not align with the standard practice within the profession.[16] In describing what has come to be known as the "ter Neuzen exception" the Court summarized this principle:

> [43] Thus, it is apparent that conformity with standard practice in a profession does not necessarily insulate a doctor from negligence where the standard practice itself is negligent. The question that remains is under what circumstances will a professional standard practice be judged negligent? It seems that it is only where the practice does not conform with basic care which is easily understood by the ordinary person who has no particular expertise in the practices of the profession. … (W)here the common practice is fraught with danger, a judge or a jury may find that the practice is itself negligent.

In *Goodwin v. Olupona*[17], despite no evidence being led on the issue, a jury found that a hospital breached the standard of care by failing to provide appropriately trained and supervised nursing staff, and in failing to provide adequate equipment and resources in its labour and delivery facility. The hospital appealed this finding, on the grounds that the jury's verdict was unreasonable and unsupported by the evidence. In finding that the jury's verdict was, in fact, reasonable and supported by the evidence, the court noted that:

> [34] Identifying these fundamental obligations – that a hospital must provide staff and facilities capable of meeting the basic needs of patients – is well within the "ken of the average juror". These responsibilities form the very foundation of a hospital's duties to its patients.

Another variation in how a court attempted to determine the standard of care can be found in *Rowlands v. Wright*.[18] Here, the court considered the technique used by a surgeon in removing a patient's gallbladder – during the surgery he mistakenly cut the patient's common bile duct. The trial judge found that the surgeon used the proper technique, nonetheless, he concluded that the defendant breached the standard of care. The trial judge came to that conclusion by relying on his "common sense" to find that the current surgical techniques were inadequate. The appeal court set the judgement aside stating:

> [21] Although common sense no doubt has a role to play in assessing medical negligence, it plays a limited role "where a procedure involves difficult or uncertain question of medical treatment or complex, scientific or highly technical matters that are beyond the ordinary experience and understanding of judge or jury." … . In such cases, it will not generally be open to the trier of fact to find a standard medical practice negligent, subject to an exception where "a standard practice fails to adopt obvious and reasonable precautions which are readily apparent to the ordinary finder of fact": Ter Neuzen, at para. 51.

Although there are examples where the court has found liability in the absence of, or contrary to, expert opinion, these cases are few and far between. Plaintiff's counsel would be ill-advised to assume that a "*ter Neuzen*" exception would be found to apply. Robust supportive expert opinion continues to be a fundamental component of identifying the standard of care and proving a breach of the standard of care.

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THE COURT'S ROLE IN ADVANCING THE STANDARD OF CARE

Although the objective of a torts action is to put the plaintiff in the position they would have been in but for the negligence, some authors have suggested that the courts 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."[19]

Anderson v Chasney[20] is an example of the court taking such action. In *Anderson* a 5-year-old boy had surgery to remove his tonsils. Shortly after the surgery he stopped breathing and died of suffocation. During the procedure the surgeon had inserted sponges into his nasopharynx. The nurses were not asked to count the sponges to make sure they were removed at the end of the procedure, and the sponges used did not have strings attached so they could easily be retrieved, even though that product was available. At trial, the court found the surgeon not liable, as no evidence had been led that using sponges with strings was ordinary or good practice, or that having nurses count sponges was practical. The appeal court found that the surgeon took an unnecessary risk by failing to use one of the two methods available. In the court's view, these precautions were within the understanding of the trier of fact and were sufficient for the determination of negligence. A finding such as this has the potential to advance practice in the interest of public safety.

WHAT COMES FIRST – STANDARD OF CARE OR CAUSATION?

Given that the third essential element of a torts action, causation, requires the plaintiff to prove a link between the breach of the standard of care and the injury suffered by the plaintiff, it stands to reason the liability analysis should unfold in a prescribed order.[21] It will not be possible to know if the breach caused the injury, if the breach hasn't been decided first. The court in *Chasczewski v. 528089 Ontario Inc.*[22] described two reasons for this ordering of the analysis:

> [15] First, without a finding that the defendant has breached the standard of care, the question of causation becomes moot. Second, … it is the defendant's particular substandard act or omission that must be shown to have caused the harm; therefore, it is necessary to identify that act or omission to determine what, if any, connection it has to the harm at issue. In other words, causation can only be assessed in the context of a breach of the standard of care.

DEFENCES TO A CLAIM OF BREACH OF THE STANDARD OF CARE

This article has reviewed the various approaches a plaintiff may take in order to prove a breach of the standard of care in medical malpractice cases. There are a number of defences available to a defendant, and plaintiff's counsel must anticipate those defences and be prepared to address them head-on, or answer them should they arise. Those defences will be canvassed in the next article in this series. V

1. Donaldson, Andrea, *The Doctor-Patient Relationship and Duty of Care – How WideShould the Net be Cast?*, The Verdict, Issue 163, Winter 2019.
2. Note that although we will often refer to physicians, in general these principles apply to all health care professions.
3. *Sylvester v. Crits et al.*, 1956 CanLII 34 (ON CA)
4. *Ibid.*
5. Robertson and Picard. *Legal Liability of Doctors and Hospitals in Canada*. 2017Thomson Reuters Canada Limited, citing *McKeachie v. Alvarez,* [1970] B.C.J. No. 491.
6. *Brodeur v. Provincial Health Services Authority,* 2016 BCSC 968 (CanLII).
7. *Lush v. Connell,* 2012 BCCA 203 (CanLII) at 77.
8. *Crawford v. Penney,* 2003 CanLII 32636 (ON SC) at 248.
9. For example, *Hewlett v. Henderson,* 2006 BCSC 300 (CanLII) at 60 – 65.
10. *Pinch (Guardian ad litem of) v. Morwood*, 2016 BCSC 75 (CanLII).
11. *Kern v Forest*, 2010 BCSC 938 at 162.
12. *Ediger (Guardian ad litem of) v. Johnston,* 2009 BCSC 386 at 59.
13. *McArdle, Estate v. Cox,* 2003 ABCA 106 (CanLII).
14. *Supra* note 12.
15. *Ediger v. Johnston*, 2013 SCC 18 (CanLII).
16. *ter Neuzen v. Korn,* 1995 CanLII 72 (SCC).
17. *Goodwin v. Olupona,* 2013 ONCA 259 at 33.
18. *Rowlands v. Wright*, 2009 ONCA 492 (CanLII), at 20, 21.
19. *Supra* note 5 at 457.
20. *Anderson v. Chasney*, 1949 CanLII 236 (MB CA).
21. *Supra* note 5 at 353
22. *Chasczewski v. 528089 Ontario Inc,* 2012 ONCA 97 (CanLII).