MEDICAL MALPRACTICE

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Defenses to a Medical Malpractice Claim – Navigating the Minefield

INTRODUCTION

This is part 4 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 (Verdict Issue 165 – Summer 2020)
- **Defenses to a Claim of a Breach of the Standard of Care**
- Causation – Basic Principles
- Causation – Application
- Expert Evidence
- Disclosure of Errors

In our last article, we discussed the standard of care and the need for the plaintiff to prove that the defendant breached the applicable standard in order to succeed in a medical malpractice lawsuit. In this article, we discuss a number of defenses that can be employed in response to a claim of a breach of the standard of care. Plaintiff's counsel must anticipate these defenses and address them head-on, or be prepared to answer them if they arise.

PASSIVE VS. ACTIVE DEFENSES

As discussed in our previous articles, a plaintiff in a medical malpractice action must prove all necessary elements of a claim to succeed: the existence of a duty of care, that a breach of that duty occurred, and that the injury in question was caused by the defendant's breach.

Commonly, a plaintiff will have adduced some evidence on each element of the claim, and a defendant will attempt to discredit the plaintiff's case by introducing competing expert evidence and attacking the plaintiff's claim by techniques such as cross-examination. [1] If a plaintiff has adduced no evidence on one or more essential elements, the defendant can take steps to have the case dismissed (either by bringing a summary trial application or a non-suit motion at the conclusion of the plaintiff's case) as the plaintiff has not made out a prima facie claim. These situations can be classified as "passive" defenses as they involve attacking the plaintiff's claim by undermining one or more necessary elements.[2]

So called "active"[3] defenses to a claim of a breach of the standard of care include:

a) That the defendant followed an approved practice that is generally followed by members of the profession;
b) That the defendant followed one of two accepted schools of thought; and
c) That the defendant exercised his or her clinical judgment and therefore cannot be at fault.

Often, a defendant in a medical malpractice action will rely on one of these active defenses to defend his or her conduct. Each of these active defenses is discussed in more detail below.

APPROVED PRACTICE

The defense of approved practice involves an attempt to prove that the practice or procedure followed was generally approved of and used by members of the defendant's profession at the time in question, and therefore ought not to be considered negligent. [4] For many years, the scope of the defense of approved practice was unclear, with some cases finding that it was conclusive evidence of lack of negligence [5] and others finding that it was only a rebuttable presumption. [6] The Supreme Court of Canada addressed the issue in *ter Neuzen v. Korn*.[7]

Ter Neuzen involved a patient who had contracted HIV through infected sperm used in an artificial insemination (AI) program. The patient claimed that the defendant physician breached the standard of care by failing to be aware of the risk of HIV infection from AI and failing to screen donors for sexually transmitted diseases. The defendant led expert evidence that his practice was in keeping with the practice across Canada, and specifically that his process of recruiting and screening donors was in accordance with national standards. At the time in question, AI was not seriously considered by the general medical community to put anyone at risk of being infected with HIV.

The court confirmed the rule that "[i]t is generally accepted

that when a doctor acts in accordance with a recognized and respectable practice of the profession, he or she will not be found to be negligent." [8] This is because 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, and courts do not ordinarily have the expertise to tell professionals that they are not acting appropriately in their field.

The court, however, made room for certain situations where the standard practice itself may be found to be negligent. Writing for the court, Justice Sopinka stated that "where the standard practice is 'fraught with obvious risks' such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise" [9] or 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," [10] it is open to the court to find the practice, and therefore the defendant, negligent. These two conditions – that the practice is fraught with risk and that this can be easily understood by an ordinary person - rarely appear together and lead to a finding that an accepted practice is negligent. [11]

Anderson v. Chasney [12] was cited in *ter Neuzen* as an example of where the standard practice of the profession was found to be negligent. In that case, a young boy died of suffocation from sponges left inside his nasopharynx following tonsilladenoidectomy surgery. The sponges used during the surgery did not have strings attached so that they could easily be retrieved, even though that product was available. The surgeon presented evidence at trial that it was not his practice, nor the practice of the hospital, to use sponges with strings or to have nurses count the sponges to ensure removal, and the case was dismissed. The Manitoba Court of Appeal reversed the trial decision, finding 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 to determine negligence. The court in *ter Neuzen* cited *Anderson* as an example of a case "where there are obvious existing alternatives which any reasonable person would utilize in order to avoid a risk" [13] and where the failure to adopt such measures could result in the finding of negligence notwithstanding that the defendant followed the prevailing practice.

To rely on a defense of approved practice, the defendant must compare the treatment or conduct in question to the knowledge that ought to be reasonably possessed at the time, and the court must not judge the defendant too harshly with the benefit of hindsight. [14] Therefore, a procedure that was performed several years ago will not be viewed in light of medical advances or changes in practice that have occurred between the time of treatment and the time of trial, but a doctor who fails to keep up with advances may be found negligent. In *McCormick v. Marcotte*, [15] the plaintiff suffered a broken femur following a motor vehicle accident. He was taken to hospital and seen by the defendant physician. The defendant consulted an orthopedic surgeon who advised a procedure of skin traction followed by insertion of an intramedullary nail. The defendant was not qualified to perform the recommended surgery and performed another procedure that had since fallen into disfavour. The plaintiff suffered an injury which was a known risk of the obsolescent procedure performed, and the defendant was found negligent.

To rely on the approved practice defense, the onus is on the defendant to show that his or her practice conformed to that approved by the profession at the time. Expert evidence is essential to establish the defense, which is open to the plaintiff to rebut.[16]

TWO SCHOOLS OF THOUGHT

The "two schools of thought" defense is closely related to the approved practice defense and provides a scope for disagreement and differing views or approaches among doctors. The rationale for the defense, as stated by the Supreme Court of Canada in *Lapointe v. Hopital Le Gardeur*, [17] is that courts do not have the expertise to choose between two schools of thought which are well-founded medically and seem equally reasonable. A situation involving two schools of thought, however, does not necessarily arise simply because a defendant adduces some evidence contradicting the plaintiff's evidence on the standard of care. Expert evidentiary conflicts occur in almost every case, and just because the evidence is divided does not mean the plaintiff must fail. [18]

The *Maynard v. West Midlands Regional Health Authority* [19] decision of the House of Lords is often cited for the proposition that "in the realm of diagnosis and treatment, negligence is not established by preferring one respectable body of professional opinion to another." [20] This is often argued by defendants to necessitate dismissal of an action where there is disagreement amongst the experts as to whether the defendant breached the standard of care.

Maynard was first considered in Canada in *Brain v. Mador*. [21] At trial, the defendant urologist was found negligent in performing a vasectomy on the plaintiff too soon after the plaintiff had an episode of epididymitis. The defendant, as well as three other highly qualified urologists, gave evidence at trial. Conflicting opinions were expressed by the expert witnesses as to whether a reasonably careful urologist should have operated so soon after the infection.

The defendant appealed on the basis that the trial judge erred in preferring one responsible body of professional opinion over another and relied on the *Maynard* decision. The Court of Appeal noted that *Maynard* goes on to state that "[f]ailure to exercise the ordinary skill of a doctor is necessary" [22] to establish that the defendant breached the standard of care, which is consistent with the test applied in Canada. The court in *Brain* noted that professional opinions expressed have an important bearing on the determination of whether the standard of care has been met, but it is for the trier of fact to weigh the conflicting testimony and ultimately assess the weight to be given to the evidence.

The law on competing schools of thought was thoroughly discussed by the Ontario Superior Court in *Crawford v. Penney*.[23] The case involved a claim for injuries sustained by the plaintiff during her birth. The pregnancy of the plaintiff's mother, Ms. Crawford,

had been managed by Dr. Penney. During the pregnancy, Ms. Crawford experienced rapid weight gain, elevated blood pressure, and she was noted to have protein in her urine. Dr. Penney also managed Ms. Crawford's labour and delivery, which was induced with oxytocin. After the baby's head was delivered at 9:55 pm, shoulder dystocia was encountered. Birth did not occur until 10:10 pm, resulting in 15 minutes of oxygen deprivation to the baby. The trial judge found that the baby suffered hypoxic ischemic encephalopathy caused by shoulder dystocia due to excessive birth weight caused by untreated diabetes in pregnancy, and that the delay during delivery resulted in a period of acute near-total asphyxia.

The trial judge found that Dr. Penney's overall management of the pregnancy involved a failure to properly assess the risk factors associated with the pregnancy as well as an unrealistic view of his own ability to handle its management, including delivery. The judge concluded that he had breached the standard of care notwithstanding expert evidence led on behalf of Dr. Penney that he had acted in accordance with accepted practice.

The trial judge found that expert evidence is subject to the same process of being weighed and assessed against all the other evidence as evidence from lay witnesses is, and that expert evidence that the defendants acted in accordance with the standard of care does not necessitate dismissal of the action. The court's function is to evaluate conflicting testimony, including expert testimony, and determine the facts he or she accepts by proof or inference. Expert evidence must be weighed in accordance with such findings of fact and in accordance with consideration of the reliability of such opinion evidence. The court found that there is no necessary dismissal of a medical negligence claim simply because honest and competent experts disagree over a doctor's diagnosis and treatment. [24]

Unfortunately, there are a number of BC decisions that suggest that as long as the defendant adduces some evidence to the contrary, then they have established competing schools of thought and the plaintiff's claim must fail. *Brimacombe v. Mathews* [25] involved an infant who had suffered a hypoxic ischemic injury during labour and delivery. The trial judge found the defendant, Dr. Mathews, negligent for failing to apply traction to hasten the birth of the infant plaintiff during a breech vaginal delivery. The BC Court of Appeal did not agree, finding that the decision to apply traction or not represented two competing schools of thought among the plaintiff and defense experts, and ordered a new trial on this and other grounds.

Fairley v. Waterman [26] involved the interpretation of fetal heart monitoring strips and what needed to be done in response. The primary issue in the case was whether there were earlier signs of compromise, or at least sufficient uncertainty about the baby's condition, that required the defendant to intervene earlier than he did. The court found that the plaintiff had, at best, established that there are two schools of thought in respect of the interpretation of the fetal heart monitoring strips and the required action, and dismissed the plaintiff's claim:

> In circumstances where there are two competing and acceptable schools of thought the law is quite clear that adherence to either school (i.e. non-intervention versus intervention) is an acceptable standard of care, and a simple clinical misjudgment cannot amount to negligence.[27]

More recently, *O'Connor v. Wambera* [28] was a case involving a teenage girl who suffered a hemorrhagic stroke due to an undiagnosed arterio venous malformation ("AVM"). She brought a claim against her pediatric neurologist, alleging that she was negligent in failing to order brain imaging which would have diagnosed the AVM. The court accepted that the opinions of the defendant's experts, who opined that her differential diagnosis and follow up was appropriate, "represented one accepted school of thought as to the standard of care," [29] and therefore concluded that the defendant had met the requisite standard.

The case of *Kita v. Braig* [30] offers a genuine example of a defendant adhering to one of two acceptable schools of thought. The plaintiff, Mr. Kita, suffered from chronic sinusitis, and when no conservative treatment was successful, he underwent an antrostomy – the making of an opening between the sinus and the nose. One of the known risks of antrostomy is a hemorrhage. If hemorrhage does occur, packing or cautery is performed. If these fail to control the hemorrhage, the next step is to perform surgery to stop the flow of blood to the site of the hemorrhage.

In Mr. Kita's case, the antrostomy resulted in significant hemorrhaging which was not alleviated by packing or cautery. The defendant Dr. Braig, an otolaryngologist, recommended ligating the carotid artery to stop the flow of blood to the site of the hemorrhage, which Mr. Kita accepted. Dr. Braig ligated the carotid artery approximately 1.5 cm above the carotid bulb, leaving a stump of the artery. Following the procedure, Mr. Kita suffered a stroke.

At trial, the court accepted Mr. Kita's contention that the most probable source of the embolus causing the stroke originated in the stump of his external carotid artery following the ligation. Mr. Kita's expert neurosurgical evidence was that the carotid artery should have been ligated flush to the bulb, and had that been done, the stroke would not have occurred. Conversely, Dr. Braig adduced expert evidence supporting his method as that which was commonly practiced within the otolaryngology community.

The BC Supreme Court found that the conflicting medical evidence as to the appropriate standard of care originated partly from the different objectives of the specialties of neurosurgery and otolaryngology. The otolaryngology community performed the external carotid ligation procedure with the goal of restricting the supply of blood to the source of the hemorrhage. The neurosurgical community performed the procedure to inhibit clot formation in a compromised vascular system. Both specialties were unaware of the standards of the other and, in particular, the practice of ligating flush to minimize risk of clot formation. The court dismissed the plaintiff's claim, finding that the defendant acted reasonably and complied with a respectable school of thought as to how to best perform the procedure.

A court may find that divergent medical opinions amongst experts do not reflect opposing schools of thought, but different points on a continuum of a single school of thought or reasonable practice. [31] In many cases, the trial judge will prefer the evidence of one expert over the other in determining what the standard of care is, rather than accepting the evidence of both sides as reflective of equally reasonable but different standards of care.

CLINICAL JUDGMENT

The Supreme Court of Canada has repeatedly held that medical practitioners are not to be held liable for errors of clinical judgment that are distinguishable from professional fault. [32]

A poor outcome does not mean that any negligence occurred as a doctor is not expected to be a guarantor of success, and cannot be held liable for an exercise of clinical judgment even if his or her judgment is wrong.

In *Brimacombe*, discussed above, the BC Court of Appeal found that the trial judge's finding of negligence against the defendant could not stand as the judge had equated the failure to apply traction to expedite delivery of the infant plaintiff with carelessness, whereas on appeal, the court found that this was more accurately described as an error of judgment that could not attract liability. Citing the Supreme Court of Canada in *Wilson v. Swanson*, [33] the Court of Appeal noted that "an error in judgment has long been distinguished from an act of unskillfulness or carelessness… the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation." [34]

However, just because an error involved the exercise of judgment does not completely shield a doctor from liability. As stated by the House of Lords in *Whitehouse v. Jordan* [35]:

> Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not… it depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself as having, and acting with ordinary care, then it is negligent. If, on the other hand, it is an error that a man, acting with ordinary care, might have made, then it is not negligence.[36]

In most cases, the success of a clinical judgment defense hinges on whether or not the defendant obtained all necessary information, or availed him or herself of all necessary resources before exercising his or her judgment.

In *Williams v. Bowler,* [37] the plaintiff, Ms. Williams, had long-standing headaches and abdominal pain, as well as psychological difficulties and prescription drug abuse. She attended the hospital on multiple occasions and with different complaints and requests for pain control medication, leading doctors to question whether she was drug seeking.

On March 16, 1993, Ms. Williams was seen by Dr. Bowler for headaches following a bar room brawl the previous week in which she hit her head on a cement pillar. Over the next few days, Ms. Williams made repeated visits to the hospital emergency department with more severe headaches associated with other symptoms, including nausea, vomiting, blurry vision, and a "wild looking" presentation atypical of her usual neatly groomed appearance. On March 22, she was admitted for treatment of migraine and dehydration. A lumbar puncture three days later revealed the presence of red blood cells which could be due to viral meningitis, self-limiting subarachnoid hemorrhage, or a 30% chance of a life threatening condition such as a leaking or ruptured aneurysm. On March 31, she was discharged from hospital with a diagnosis of viral meningitis and subarachnoid hemorrhage due to head injury in the bar brawl. On April 19, she suffered a rupture of brain aneurysm, leading to permanent brain injury.

The issue before the court was whether it was a breach of the standard of care for Dr. Bowler to have failed to include leaking or ruptured aneurysm in his differential diagnosis and make an urgent referral to a neurologist. Had this occurred, appropriate investigation would have revealed the aneurysm and it would have been surgically treated in time to prevent the rupture and brain injury.

The defense asserted that Ms. Williams' injury was the unfortunate result of the exercise of Dr. Bowler's clinical judgment, and in the context of Ms. Williams' complicated history, he exercised his clinical judgment reasonably with respect to the interpretation of the lumbar puncture results and could not be found negligent. The court did not agree, and concluded that in interpreting the lumbar puncture result, Dr. Bowler entered unchartered waters, and the standard of care required him to seek the input of a neurologist or neurosurgeon, and found that he was negligent for failing to do so.

Crawford, discussed above, involved an allegation that the defendant had a duty to refer Ms. Crawford to a specialist to manage her pregnancy in light of her cumulative risk factors. The trial judge agreed that the duty to refer involves a matter of judgment, but that does not mean that a court cannot examine the grounds upon which the judgment is exercised:

> The proper exercise of judgment by a physician is one that is made after his/her weighing, assessing and evaluating such information as may be available. What "may" be available includes the results of tests or consultations that should have been carried out. In other words, the information upon which a judgment or decision is reached must be as complete as is reasonably available and possible in the circumstances. [38]

Negligence may be found where a doctor, exercising his or her clinical judgment, has failed to obtain all clinically significant information via tests and examinations. In *Wade v. Nayernouri*,[39] a patient presented to the emergency department with severe headache, nausea, dizziness, numbness, and photophobia, and was diagnosed by the defendant physician as suffering from migraine headaches. The patient was, in fact, in the early stages of subarachnoid hemorrhage and died several days later. The court found that the erroneous diagnosis alone did not determine the defendant's liability, but found that the defendant was negligent for failing to make use of all diagnostic resources, including referring the patient to a specialist, before coming to his conclusion and discharging the patient.

CONCLUSION

In this article, we examined a number of defenses open to medical professionals when facing a negligence claim. These defenses show that even though a plaintiff has obtained expert evidence critical of the defendant's care, this will not necessarily result in a finding of fault. The analyses of the courts as to how these defenses apply to a physician's conduct help to illustrate why so few medical malpractice cases that go to court are decided in favor of the plaintiff. The statistics from the Canadian Medical Protective Association (CMPA) are telling in this regard.

> The latest statistics indicate that out of the total number of legal cases resolved by the CMPA in 2018, only 1% resulted in a legal judgment in favour of the plaintiff. [40]

Adherence to an approved practice is *prima facie* evidence that the defendant met the standard of care, but it is still possible for the court to find that this approved practice itself is fraught with obvious risk and therefore find that both the practice and the defendant are negligent. As discussed, this involves the court finding that the standard of practice is so unsafe that a layperson would be capable of finding negligence. These situations are exceedingly rare. Similarly, even if the plaintiff had adduced evidence that the defendant breached the standard of care, if the defendant can show that he or she adhered to one accepted school of thought supported by members of his or her profession, the plaintiff's claim will not succeed. The defense of clinical judgment is difficult for a plaintiff to overcome, as much of a medical treatment involves the exercise of clinical judgment. To succeed against a clinical judgment defense, it will usually be necessary for a plaintiff to show that the defendant failed to take into consideration all necessary facts or resources.

In all cases, it is for the court to weigh all the evidence and determine the standard of care applicable in the circumstances of the particular case and then determine whether that standard was met or not. The applicable standard of care is determined by the trier of fact having regard for all of the evidence led on behalf of the plaintiff and the defendant. V

1. Gerald B. Robertson & Ellen I. Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th ed (Toronto: Thomson Reuters, 2017) at 450 [*Robertson*].
2. *Ibid*.
3. *Ibid*.
4. *Ibid* at 451.
5. see *McDaniel v. Vancouver General Hospital*, [1934] 4 DLR 593.
6. see *Anderson v. Chasney*, [1949] 4 DLR 71 (Man. CA) aff'd [1950] 4 D.L.R. 233 (SCC) [*Anderson*].
7. 1995 CanLII 72 (SCC) [*ter Neuzen*].
8. *Ibid* at para 38.
9. *Ter Neuzen*, supra note 7 at para 41.
10. *Ibid* at para 43.
11. See *Ivanitz v. Van Heerden*, 1996 CanLII 2559 (BCSC) for an example of "one of those occasions where a lay person could pass judgment." (para 35)
12. *Anderson, supra* note 6.
13. *Ter Neuzen, supra* note 7 at para 44.
14. *Ibid* at para 34.
15. [1972] SCR 18, 20 DLR (3d) 345.
16. *Robertson, supra* note 1 at 459.
17. [1992] 1 SCR 351 [*Lapointe*].
18. *Layden v. Cope*, 1984 ABCA 306 at paras 2-3.
19. [1984] 1 W.L.R. 635 (H.L.), [*Maynard*].
20. *Ibid* at 639.
21. [1985] O.J. no. 119.
22. *Maynard, supra* note 19 at 639.
23. [2003] OJ No 89 (SCJ), aff'd [2004] OJ No 3669 (Ont CA) [*Crawford*].
24. *Ibid* at para 248.
25. 2001 BCCA 206.
26. 2002 BCSC 10.
27. *Ibid* at para 11.
28. 2018 BCSC 886.
29. *Ibid* at para 120.
30. 1991 CanLII 442 (BCSC), aff'd 1992 CanLII 1421 (BCCA).
31. *Stubbins v. Johnson*, 1995 CanLII 598 (BCSC). In this case, the court found the divergent expert opinions represented "different points on a continuum of a single school of thought as to the level of caution and delay required in the circumstances." (at para 82)
32. *Lapointe*, supra note 17 at 720.
33. *Wilson v. Swanson*, [1956] SCR 804
34. *Ibid*.
35. [1981] 1 All E.R. 267 (H.L.)
36. *Ibid* at 281.
37. 2005 CanLII 27526 (ON SC).
38. *Crawford, supra* note 22, at para 229.
39. [1978] O.J. No. 413.
40. 2018 CMPA Annual Report, https://www.cmpa-acpm.ca/static-assets/pdf/about/annual-report/2018/19_com_2018_annualreport-e.pdf.