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The Intersections of Family and Estate Litigation

PART II

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CONTENTS

Articles

Featured

Columns & Miscellaneous

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MEDICAL MALPRACTICE ▸

BY **ANDREA DONALDSON**
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Andrea Donaldson is an associate lawyer at Pacific Medical Law. She obtained her law degree from the University of British Columbia and was called to the BC bar in 2016. Her practice involves representing severely injured plaintiffs who have suffered as a result of medical negligence. Before joining Pacific Medical Law as an articling student in 2015, Andrea worked at a civil litigation firm, gaining experience representing individuals injured in motor vehicle accidents and occupier's liability claims.

Surgical Negligence

This is the second article in our series aimed at providing a detailed examination of the challenges and pitfalls in different types of medical negligence lawsuits and approaches to overcoming them. Each article will focus on specific injuries and will highlight the obstacles a plaintiff faces in bringing their case to a successful conclusion. By comparing cases involving similar injuries, we aim to illustrate how the plaintiff succeeded, and when they did not, strategies that may have been available to improve their chance of success.

The 2021 Supreme Court of Canada decision in *Armstrong v. Ward,* 2021 SCC 1, has implications for medical malpractice claims across the country. The decision, which clarified the law on causation, should make proving this aspect of a negligence claim easier for the plaintiff than if the Ontario Court of Appeal decision was left to stand, which could be read as holding that as long as the defendant physician "tried" to meet the standard of care, there could be no finding of negligence.

However, there are still many pitfalls in surgical negligence cases that plaintiffs must avoid in order to succeed. In this article, we begin by examining the *Armstrong* decision and its effect on the law. We then look to a number of surgical negligence cases where the plaintiff was not successful for various reasons, and then question if anything can be gleaned from *Armstrong* that may have affected the outcome of those cases.

Armstrong v. Ward

In *Armstrong*, the Supreme Court of Canada set aside the decision of the Ontario Court of Appeal in a medical malpractice action, restoring the trial judgement which found the defendant physician liable for the plaintiff's injuries.

The case centered around the plaintiff Ms. Armstrong's colectomy surgery performed by Dr. Ward. Although the surgery appeared to be uneventful, Ms. Armstrong began to experience increasing problems from mild abdominal pain and a pulling sensation to significant left flank pain postoperatively. Further investigation showed that Ms. Armstrong's left ureter (a tube that carries urine from the kidney to the bladder) was blocked. The blockage led to significant damage to her left kidney which ultimately had to be removed.

The plaintiff's theory of the case was that Dr. Ward caused the damage to the ureter using a cauterizing device known as a LigaSure by improperly bringing it within two millimeters of the ureter.

Both the plaintiff and defense experts agreed at trial that the thermal energy from the LigaSure can spread beyond the jaws of the device and can damage tissue within two millimeters. All of the experts stressed the importance of identifying and protecting the ureter during laparoscopic colectomy surgery, with the plaintiff's expert indicating that if a surgeon takes the necessary steps to identify and protect the ureter, the injury would simply not occur in an anatomically normal colon.

The trial judge described the standard of care this way:

> I am satisfied that the standard of care for a general surgeon is to identify, protect, and avoid direct contact with or close proximity to the ureter when using an energy emitting device like the LigaSure.
>
> Based on the experts' testimony, "close proximity" means within one to two millimeters of the ureter...[1]

Injuries from a LigaSure in colectomy surgery are rare, and most cases involve anatomical risk factors, which were not present in Ms. Armstrong's case. Dr. Ward admitted that it would have been a breach to use the LigaSure within 2mm of the ureter, but doubted that he had done so. He did not adduce any evidence that staying two millimeters away from the ureter would not be accomplished if the surgeon used reasonable care.

The trial judge found that Dr. Ward took some, but not *all necessary* steps, to protect the ureter and he was not sufficiently diligent in checking and rechecking where he was, and inadvertently came too close to the ureter. The judge ultimately found that Dr. Ward was negligent and caused Ms. Armstrong's injury, by either burning the ureter directly or bringing the LigaSure too close to the ureter, which then healed and created the blockage.

On appeal, Dr. Ward argued that the trial judge adopted a "results-oriented" approach to the standard of care. Dr. Ward argued that the trial judge concluded he was negligent simply because he failed to achieve the "goal" of avoiding injury to Ms. Armstrong's ureter, or alternatively that, after concluding that Dr. Ward had taken "steps" to identify and protect the ureter, it necessarily followed that he was not negligent. Dr. Ward also argued that the trial judge failed to consider the possibility that he had accidentally, and without negligence, came too close to Ms. Armstrong's ureter.

The majority of the Ontario Court of Appeal agreed with Dr. Ward and found that the trial judge erred in defining the standard of care that Dr. Ward had to meet and improperly established a "standard of perfection." Key to the majority's analysis was that the trial judge measured Dr. Ward's liability according to the *goal* of a prudent surgeon (not to touch or come within two millimeters of the ureter) rather than the *means or steps* a prudent surgeon would use to attain that goal. The majority accepted Dr. Ward's argument that defining the standard of care by stating the goal says nothing about how a prudent surgeon would go about achieving that goal, which is the pertinent inquiry.

Justice van Rensburg wrote a dissenting opinion for the Court of Appeal. She concluded that trial judge's decision was fully supported by the evidence. The trial judge ultimately accepted the plaintiff's theory of the case that a thermal injury resulted from the defendant's use of the LigaSure within two millimeters of the ureter. By contrast, Dr. Ward's evidence was that he stayed 5-15 cm away from the ureter. His experts offered different opinions as to how the injury could have occurred at this distance, which the trial judge did not accept.

In Justice van Rensburg's analysis, to determine whether Dr. Ward used the LigaSure within two millimeters of the ureter, the trial judge first had to determine how the injury happened. The trial judge explained why he rejected the defendant's experts' proposed alternative explanations of the injury and explained why he accepted the evidence of Ms. Armstrong's expert: that the ureter was injured by thermal spread from the LigaSure. It then followed that Dr. Ward had, in fact, used the device within two millimeters of the ureter, contrary to his own evidence. No non-negligent accidental scenarios were put to any of the experts at trial, and Justice van Rensburg further explained that a trial judge is not obliged to consider potential non-negligent causes where there is no evidentiary foundation to do so.

Presumably, a defendant could testify that they tried to meet the standard of care but were not successful and that would be sufficient to meet the standard of care – a defense to almost any claim of negligence, making succeeding in such cases near impossible for plaintiffs.

One of the serious problems with the Court of Appeal's decision was that it could be read as holding that as long as the defendant physician was *trying* to do his or her best, there could be no finding of negligence:

> "...However, the trial judge did not confine his standard of care to knowing, intentional, and unnecessary deployment, whether intentional or accidental, breaches of the standard of care. Avoiding accidental deployment within two millimeters of the ureter cannot be fairly described as a step that prudent surgeons would take. Instead, it is a goal or result that is to be pursued. Put otherwise, trying to maintain a safe distance is a step one takes; successfully achieving this is a goal."[2]

The case was then argued at the Supreme Court of Canada. The SCC allowed the appeal for the dissenting reasons of Justice van Rensburg.

The decision has important implications for plaintiffs in medical malpractice actions. The judgement confirms that the plaintiff does not have to explain why all non-negligent causes of the injury can be ruled out if the defense does not raise these at trial. Further, had the majority of the Court of Appeal's decision been up-

held, it could be read to say that taking some of the steps required to meet the standard of care versus *all necessary steps* would be sufficient to meet the standard of care. Presumably, a defendant could testify that they *tried* to meet the standard of care but were not successful and that would be sufficient to meet the standard of care – a defense to almost any claim of negligence, making succeeding in such cases near impossible for plaintiffs.

Lastly, the SCC's ruling confirms that it is not always necessary to address standard of care prior to causation – at times, court will need to determine what happened in order to resolve whether the standard of care has been breached. Determining causation prior to the standard of care does not necessarily mean that the trier of fact adopted a "results-oriented approach" which necessitated a finding of negligence.

Surgical Negligence Pitfalls

The leading case which defines the standard of care for a skilled surgeon is *Wilson v. Swanson*, [1956] S.C.R. 804, 1956 CanLII 1 (SCC), at 811-812:

> ...What the surgeon by his ordinary engagement undertakes with the patient is that he possesses the skill, knowledge and judgment of the generality or average of the special group or class of technicians to which he belongs and will faithfully exercise them. In a given situation some may differ from others in that exercise, depending on the significance they attribute to the different factors in the light of their own experience. The dynamics of the human body of each individual are themselves individual and there are lines of doubt and uncertainty at which a clear course of action may be precluded.

As the above quote illustrates, many factors come into play in surgical negligence cases, such as a physician's clinical judgement, surgical technique and individual patient considerations. Surgical negligence cases are rarely as straight-forward as a surgery performed on a wrong body part, or instruments left inside a patient. Indeed, there are many challenges for plaintiffs particular to these types of cases: that the injury was a known risk of the surgery, a contention from the defendant that avoiding injury in the situation would require a standard of perfection, or in an informed consent case, that the plaintiff would have consented anyways if they had been properly informed of the risks. Also, since plaintiffs in surgical negligence cases often have an injury which necessitated the surgery in the first place, they are open to allegations that their injuries were the result of pre-existing complications or are otherwise unrelated to the surgical injury.

Known Risk of Surgery

A common defense in surgical cases is that the injury suffered by the plaintiff was a known risk of the procedure, which could and did occur in the absence of any negligence on the part of the defendant.

In *Johnston v. Hader,* 2009 ABQB 424, the plaintiff suffered from debilitating epileptic seizures. She underwent selective amygdalohippocamectomy ("SAH") surgery in an effort to eliminate those seizures by removing part of her amygdala and hippocampus. During the surgery, the retractor used to provide access to the part of the brain being operated on (known as a Greenberg retractor), moved at least a centimeter into the brain from its original position. The plaintiff experienced right-side paralysis post-operatively as a result, but her seizures were eliminated. The plaintiff alleged that retractor blade was pushed or misplaced, possibly because landmarks in the brain were ignored or misidentified. The defendants countered that the blade was initially positioned correctly but subsequently the blade moved into the brain stem, probably as the result of a bump. Unlike in *Armstrong*, non-negligent scenarios for the injury were raised by the defendants which the court was entitled to accept. The defendants' experts testified that it was very unusual for the blade to move one centimeter beyond its initial placement accidentally, but that it was possible for this to occur even if all care and due attention was taken.

The court concluded that the defendants met the standard of care and the injury that occurred was a risk of the particularly surgery performed. The court preferred the evidence of the defendants' experts where there was disagreement, noting that the defense experts were more experienced neurosurgeons and more experienced with the Greenberg retractor. The plaintiff's expert's involvement in SAH procedures had decreased over the years due to involvement in research and other types of neurosurgical procedures, and at the time of the trial he no longer used the Greenberg retractor.

Johnson illustrates the importance of choosing the right experts for a surgical negligence case, as well as assuring that the plaintiff is able to adduce evidence to counter any non-negligent causes of injury raised by the defense.

Defendant is Not to Be Judged by the Result of the Surgery

Plaintiffs in surgical negligence cases must be alert to a defense that the plaintiffs' experts are holding the defendant to a standard of excellence by focusing on the result of the surgery.

In *Carlsen v. Southerland*, 2006 BCCA 214, the defendant physician appealed from trial judgment which found him negligent in his performance of disc surgery on the plaintiff. During a discectomy for L4-L5 disc herniation, the defendant's instruments went past the annulus fibrosis and inadvertently cut the iliac artery and

common iliac vein. The defendant noticed bright red blood in disc space but when it soon stopped he assumed nothing was wrong. He closed surgical incision and sent plaintiff to post-anesthetic recovery. Shortly thereafter, plaintiff's heart rate rose and she complained of left leg pain and abdominal tenderness, which was found to be due to the artery being cut and blood flowing freely into her abdominal cavity. The plaintiff underwent urgent vascular repair requiring 13 units of blood. She gradually improved over the next year but was left with agonizing leg pain due to a lesion on her spine as a result of the injury to the artery.

The trial judge inferred from the fact that the iliac artery and common iliac vein were cut that the defendant was *prima facie* negligent. Having found so, he concluded on the principles enunciated in *Fontaine v. British Columbia,* [1998] 1 SCR 424, that defendant was required to present evidence negating negligence.

The BCCA found that the trial judge's conclusion that "the simple precaution that Dr. Southerland should have taken was to ensure that he not let his instruments penetrate past the annulus fibrosus"[3] indicated he improperly focused only on the result of the surgery and not on the precise manner in which the defendant failed to meet the appropriate standard of care. The BCCA held that "determining negligence by focusing solely on the result of the medical treatment rather than the manner in which it was performed is improper and amounts to imposing a standard of excellence"[4] that was impossible to rebut, and ordered a new trial.[5] As *Armstrong* shows, it is important for the plaintiff in surgical negligence cases to adduce evidence that had standard of care been met, the injury could not have happened.

Informed Consent

Informed consent often comes into play in cases involving elective surgery. In *Kooijman v. Bradshaw*, 2016 BCSC 2316, Ms. Kooijman alleged that defendant pathologists wrongly diagnosed her as having cancer in her lymph nodes for which she underwent left modified radical neck dissection surgery, during which her spinal accessory nerve (SAN) was damaged resulting in debilitating health issues. The plaintiff alleged that had the defendants properly diagnosed the lymph nodes as "suspicious" rather than positive for malignancy, she would have undergone alternative procedures, such as a biopsy, as opposed to the surgery performed. The defendants alleged that that plaintiff would have undergone surgery anyways, or if she did opt for a biopsy, the risk of damage to the SAN was equally likely.

The court applied the modified objective test of what a reasonable patient would have done in the circumstances, and concluded that Ms. Kooijman would have proceeded with the surgery in any event due to several factors, including that the surgeon would have recommended the surgery even if the diagnosis was suspicious, as well as Ms. Kooijman's concern about her family history of cancer and her own history of cancer.

Informed consent cases are always challenging, and usually require a plaintiff prove that their particular circumstances make them unlikely to accept a doctor's recommendation, or that their circumstances made them particularly adverse to the risks of the procedure.

Impact of Pre-Existing Issues

It is essential in any medical malpractice case that the plaintiff is able to tie the negligent act to the resultant injury and the plaintiff's ultimate outcome. This is especially true in surgical cases where the plaintiff may have been experiencing issues which necessitated the surgery in the first place.

In *Keech v. Chang*, 2009 CanLII 18293, the defendant anesthetist was found to have negligently pierced Ms. Keech's spinal cord while administering a combined spinal-epidural anesthetic in preparation for hip replacement surgery. The plaintiff alleged that this negligence caused permanent neurological deficits, depression, anxiety and sleep deprivation, which resulted in a loss of income and future care costs. Midway through the trial, the defendant admitted she pierced the spinal cord resulting in a lesion which caused Ms. Keech some permanent numbness, but argued that this injury was slight and did not cause any of the other injuries for which Ms. Keech was seeking damages.

The court found that the spinal lesion caused permanent paresthesia in the plaintiff's genital region, resulting in bowel urgency and rare episodes of incontinence. However, the court found that the plaintiff's low back and leg pain was largely identical to the back and leg problems she had been complaining about for years before the surgery, and any alleged sleeplessness due to pain was also therefore not causally linked to lesion. The court also determined that Ms. Keech had significant pre-existing psychiatric problems and that the lesion did not cause any additional depression or anxiety beyond this. The court awarded the plaintiff $85,000 in general damages but held that she had not established any income loss or future care costs as a result of the spinal lesion.

As the above cases establish, there are many challenges and pitfalls specific to surgical negligence cases. If the Ontario Court of Appeal decision in *Armstrong* was left to stand, proving negligence in such cases would be extremely difficult for plaintiffs as the defendant would only have to prove that they tried to meet the standard of care, and took some steps to do so. Thankfully, this decision was overturned by the Supreme Court of Canada. It is hopeful that this decision assists plaintiffs in the uphill battle they already face in such claims.

1 *Armstrong v. Royal Victoria Hospital*, 2018 ONSC 2439 at paras. 81-82.
2 *Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963 at para. 48.
3 *Carlsen* at 37
4 *Carlsen* at 13
5 The plaintiff was successful following a new trial in this matter: *Carlsen v. Southerland*, 2008 BCSC 1772