TRIAL LAWYERS ASSOCIATION OF BC

Issue 183 • Winter 2024

THE Verdict

The Weaponization of Family Law Litigation

PLUS

How Modern Social Science Demands We Rethink Hearing from Children

PM 40027828

OUR MISSION: TO SUPPORT AND PROMOTE THE RIGHTS OF INDIVIDUALS IN BRITISH COLUMBIA

CONTENTS

Featured

Columns

Articles

Columns + Miscellaneous

DIGITAL EDITION
tlabc.org

@BCTrialLawyers
@tla_bc
@tlabc
Trial Lawyers Association of British Columbia

Medical Malpractice

BY **LINDSAY MCGIVERN**
TLABC Member

Lindsay McGivern is a lawyer and director of Pacific Medical Law, representing plaintiffs injured by medical malpractice. Since joining Pacific Medical Law, the primary focus of Lindsay's practice has been representing infants who were injured at birth or within the first month of life. Lindsay obtained her law degree from Dalhousie University in 2014 and was called to the Bar in 2015. Lindsay articled at a civil litigation defence firm before moving to Pacific Medical Law. Working on both sides of civil litigation has allowed her to have a broader perspective and given her a better understanding of the different approaches taken by plaintiff's and defence counsel. Lindsay is also an adjunct professor at the UBC Allard School of Law where she teaches the Medical Negligence course.

The Impact of Contemporaneous Medical Records on Credibility Disputes

This is the first article of our series discussing practical and evidentiary issues in medical malpractice. Each article will examine recent medical malpractice case law and focus on the practical and evidentiary issues within them. The goal is to provide some useful insight into the obstacles that occurred in hopes that future cases can adapt and develop new ways to overcome these challenges.

In medical malpractice cases, where cases may come to trial long after the incident in question and the defendants may have seen hundreds of patients in the interim, witnesses' memories can often be hazy. In these cases other sources of evidence, including the medical chart and a medical provider's standard practice, can be critical pieces of evidence. Ensuring that the plaintiff's theory of the case incorporates, is consistent with or explains any departures from these sources of evidence is vital to the success of the case.

FACTS OF THE CASE

This article examines the case of *A.G. (Litigation guardian of) v. Rivera*,[1] a case that involves a premature infant who failed to receive medications intended to reduce the risks and injuries of premature delivery and suffered several medical complications as a result. A.G.'s mother Li Qu, attended hospital on November 30, 2014. Her baby was 25 weeks and 1 day gestational age. Ms. Qu attended hospital with concerns about vaginal bleeding and was assessed. Dr. Rivera did a test to confirm that her membranes had not ruptured, and ordered an ultrasound. The ultrasound reported that her cervix was shorter than expected, a concerning sign indicative of a risk of preterm labour. Ms. Qu was less concerned about a report of shortened cervix as she had been told she had the same issues during her first pregnancy and carried that baby to full term. Ms. Qu reported some irregular cramping in the previous days that had since resolved. There was significant debate at trial about the remainder of that visit.

There was also some confusion with the dating of Ms. Qu's pregnancy. Ms. Qu and the defendants were under the impression that the gestational age of her baby was 23 weeks and four days, although was in fact over a week more developed. The mistake's relevance related to the exponentially increasing risks to a fetus for each additional week of prematurity. Survival rates are only 20 percent for babies at 23 weeks but increase to 80 by 25 weeks. These realities affect treatment recommendations. The decision always rests with the mother, after being fully informed by her physician, but at earlier gestations some practitioners discourage attempts of resuscitation with a focus on palliative care whereas at 25 weeks, most practitioners would recommend full resuscitation of the infant. Regardless of the correct gestational age, the experts agreed Ms. Qu should have been given full information about the risks, likelihood of survival, potential complications of prematurity and the right to choose between full resuscitation measures to keep him alive or something less than full resuscitation (down to potentially no resuscitation and only palliative care). If full resuscitation was being planned, betamethasone (a steroid) could be given to improve his lung function/maturation. In the absence of steroids, the plaintiff developed necrotizing enterocolitis, a life-threatening condition that was treated by removing part of his bowel, with lifelong consequences.

SEE PAGE 38 _

_ FROM PAGE 35

PRACTICAL AND EVIDENTIARY ISSUES

The main subject of debate in this case was whether Dr. Rivera and Ms. Qu discussed the possibility of preterm birth and the available treatment options. Ms. Qu testified that no such discussion took place; Dr. Rivera told her she was at risk of miscarriage, but nothing about the likelihood that her child might survive or about potential treatment options. Dr. Rivera's recollection of the conversation was very different. She testified that she explained to Ms. Qu her risk of premature delivery because of her shortened cervix and what that would mean for a baby of 23 weeks and five days gestation. Dr. Rivera's evidence was that she attempted to engage Ms. Qu in a conversation about whether she "would wish everything to be done" in terms of full resuscitation and if she wanted to receive betamethasone. She recalled that this conversation stalled because Ms. Qu was upset at the possibility of premature delivery and unconvinced that the short cervix would be a problem (it wasn't in her previous delivery). Dr. Rivera testified that Ms. Qu would not engage in the conversation and insisted on going home. Dr. Rivera felt the discharge home reasonable in the circumstances since Ms. Qu was stable, but "negotiated" a follow up ultrasound in two days. Dr. Rivera testified that hoped for a more fulsome discussion about premature delivery and options at the follow up once Ms. Qu had an opportunity to digest the situation.

WITNESS CREDIBILITY

To a certain extent, the judicial fact-finding process is the same in medical malpractice as in any other case. A judge must consider the credibility of each witness: "the witness's sincerity, that is, his or her willingness to speak the truth as the witness believes it to be."[2] In addition, the judge must consider the reliability of each witness: the accuracy of the witness's evidence which "involves considerations of the witness's ability to accurately observe, recall and recount the events in issue."[3] In making this assessment, judges consider the following factors:[4]

a) The ability and opportunity of the witness to observe events;

b) The firmness of their memory;

c) Their ability to resist the influence of interest to modify their recollection;

d) Whether their evidence harmonizes with independent evidence that has been accepted;

e) Whether the witness changes their evidence during cross-examination (or between examination for discovery and trial) or is otherwise inconsistent in their recollection;

f) Whether their evidence seems generally unreasonable, impossible or unlikely;

g) Whether the witness has a motive to lie; and

h) The demeanour of the witness generally.

In medical malpractice cases, however, the assessment is often focused less on the memories of the parties and more on the available documentation. The extent to which the party's recollections harmonize with the other independent evidence is often critical.

DISCOVERY RULE FOR MINORS AND MEMORY ISSUES

The reality of medical malpractice cases involving children is that most of these lawsuits are not brought, and certainly not before the court, until many years after the incident at issue. In A.G.'s case, it was nine years. In other cases, when litigation is not commenced until close to the end of the individual's limitation period, it can be more than two decades as the limitation period does not run while a plaintiff is a minor. Such temporal distance will inevitably cloud and blur the memory. In addition, the defendants are usually medical providers who have seen dozens of patients by the end of the week, potentially by the end of the day, when they saw the patient. Recalling specific details of every patient interaction would be virtually impossible. This is especially true in the context of a missed diagnosis where the medical provider discharged the patient thinking it was a routine visit and didn't learn about the catastrophic consequences until being served with a lawsuit many years down the road.

DEFENDANT'S STANDARD PRACTICE

The plaintiff attempted to attack Dr. Rivera's testimony by arguing that it was quite detailed regarding all that she did in her interactions with Ms. Qu and she could not possibly remember such detail of a routine encounter nine years later. This argument was overcome by pointing to her "standard practice." In recognition of the realities of the imbalance of memory between the provider and the patient in medical cases, the courts have accepted that it is permissible to put significant weight on a physician's testimony about what their "standard practice" is with respect to patient assessments:

> It is well-established that the court may consider evidence of a medical practitioner's common or usual practice, and even give it significant weight. The usefulness and admissibility of such evidence was expressed in *Belknap v. Meakes*, 1989 CanLII 5268, 64 D.L.R. (4th) 452 (B.C.C.A.) as follows:
>
> [39] If a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that surely is evidence and possibly convincing evidence that he did it in that way on the day in question.[5]

Accordingly, the court was willing to accept Dr. Rivera's detailed evidence based on a combination of memory and her standard practice when assessing and caring for patients.

PLAINTIFF'S MEDICAL RECORDS AND DOCTOR NOTES

In the medical context, the reality is that a medical chart is (or is supposed to be) recorded contemporaneously to document the details of the patient encounter. This documentation will include the reported complaint, the patient's medical history as understood by the medical provider, any observations made during the assessment, lab results, test results, the differential diagnosis of potential explanations for the patient's symptoms, the medical provider's plan and any treatment provided. It often includes notes about discussions that occurred and any discharge instructions given. Medical providers have a legal and ethical obligation to create and maintain these records. The intention of the medical chart to provide sufficient details to allow a subsequent medical provider to understand what was discussed, assessed and treated in the previous visit.

In almost every medical malpractice case, this chart becomes the foundation of the factual evidence and a witness's evidence is expected to harmonize with the chart. It is a legal document that can be admissible in court under section 42 of the *Evidence Act*[6] as an exception to the hearsay rule, provided the notes being admitted are original entries, made contemporaneously by a person who had a duty to make the entry, had personal knowledge of information being documented and had no reason to misrepresent the information. This will usually encapsulate the vast majority of a plaintiff's medical chart from the visit(s) in question. In the absence of evidence to the contrary, courts have found that contemporaneous chart entries are business records admissible as *prima facie* proof of the facts stated within them.[7]

In this case, the medical chart included Dr. Rivera's handwritten notes including the words "23w5" and "previable." She also charted the options of inpatient or outpatient bedrest with a note that the patient preferred outpatient, and a repeat ultrasound in two days. She also wrote "consider steroids in two days if further shortened cervix." The plaintiff argued that "previable" supported Ms. Qu's recollection of events with a discussion about miscarriage rather than preterm birth. That is, if Dr. Rivera thought the fetus was not viable, there would be no reason to discuss resuscitation or treatment options. Ms. Qu also argued that the reference to steroids (betamethasone) was for future consideration which supported her position that the discussion about steroids did not occur during the visit at issue. Unfortunately for the plaintiff, the medical chart also included the following typed note from Dr. Rivera's dictation later that afternoon:

> **Impression and Plan**
>
> Li presents with _____ bleeding and short cervix at 23 weeks and 5 days gestation. We discussed the potential for severe preterm delivery given the short cervix, however she has a good prognosis given her previous term delivery. She was offered the option for inpatient observation, but declined. She is recommended to have a repeat transvaginal ultrasound in 2 days' time for review the cervical length. She is to return to hospital with any recurrence of cramping, pain or bleeding. We discussed the option for betamethasone administration should we perceive a risk of delivery within the next week. Her cervix is short, and she is currently previable. She did not wish to address this type of concern today. She became quite emotional when we discussed this earlier. This can be reassessed in 2 days' time with repeat ultrasound.

The defendant argued, successfully, that this dictated chart note accorded fully with Dr. Rivera's version of the discussion and supported her assertion that she offered betamethasone and it was declined. This argument was further supported by a text message sent by Dr. Rivera to Ms. Qu's regular obstetrician stating "[n]o steroids today, pt couldn't handle the thought of possible preterm delivery."

STANDARD OF CARE

The factual finding that Dr. Rivera had attempted to discuss the possibility of premature delivery and the treatment options with Ms. Qu led to another evidentiary issue in this case. The defendants served expert reports opining that Dr. Rivera met the standard of care by making this attempt and that she was not required to administer betamethasone if Ms. Qu didn't consent. The plaintiff had served an expert report that assumed no steroids were offered because of the presumed gestational age. They had no expert evidence on the applicable standard of care in a scenario where the physician attempted to discuss possibility of prematurity and the patient was unwilling or unable to engage in the conversation. The burden was on the plaintiff to prove a breach of the standard of care and, absent exceptional circumstances, negligence cannot be proven in the absence of expert evidence.[8]

CAUSATION

Whether betamethasone administration on November 30, 2014 would have avoided the plaintiff's injuries was another very complicated issue. The plaintiff's primary lasting injury from his premature birth resulted from his bowel resection for necrotizing enterocolitis. Necrotizing enterocolitis is a known complication of prematurity. Betamethasone is known to improve lung function in preterm babies. The plaintiff's position was that betamethasone's positive impact on the baby's lungs would improve oxygenation to the rest of his body and have a domino effect on his other organs. That is, the results of this global improvement in his health would have prevented the necrotizing enterocolitis.

Causation was not addressed in the judgment because of the conclusion that Dr. Rivera had met the standard of care. These highly complex analyses of causation in medical malpractice cases are a frequent source of failure and often the most difficult part of advocacy in this legal field. The practical and evidentiary issues related to causation will be addressed in future articles in this series.

CONCLUSION

This case serves as a reminder that the plaintiff's medical chart is often the foundation of any medical malpractice case. In any case, counsel should spend considerable time thoroughly examining the medical chart along with appropriate medical experts to identify practical and evidentiary issues that must be addressed and review and discrepancies between the information contained medical records and your client's recollection of the events. Given the weight afforded to contemporaneous medical records, counsel should look to obtain any available evidence which would suggest that the plaintiff's version of events should be preferred over the written records. The failure to consider potential, and sometimes obvious arguments to be raised by the opposing party can result in challenges, including potentially a complete dismissal of the claim. ■

1 2024 BCSC 242

2 *R. v. Morrissey* (1995), 22 O.R. (3d) 514 at 526, 1995 CanLII 3498 (C.A.)

3 *Ibid.*

4 *Bradshaw v. Stenner*, 2010 BCSC 1398 at para. 186, aff'd 2012 BCCA 296

5 *Gilmore v. Love*, 2023 BCSC 1380 at para 62

6 RSBC 1996, c 124

7 *Gilmore, supra* at para 54-55

8 *Basil v. Interior Health Authority*, 2012 BCSC 1158 at para 35, 37-39