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THE Verdict

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Medical Malpractice

BY **JESSICA KIM**
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Jessica Kim is a lawyer at Pacific Medical Law. She obtained her law degree from the University of Alberta and was called to the bar in 2024. Her practice is focused on representing plaintiffs who have suffered catastrophic injuries as a result of medical malpractice. Prior to practicing law, Jessica obtained a Master of Health Administration from the UBC Faculty of Medicine and engaged in health services research.

Caught on Camera: **The Impact of Photo and Video Evidence in Surgical Negligence Cases**

This is the third 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.

INTRODUCTION

Surgical negligence cases concerning intra-operative negligence are rarely straightforward. The story often begins with a patient who has awakened from surgery to find that they suffered a serious medical complication, but is told that the surgical team did everything right. The operative report does not paint the whole picture. The patient is left confused and frustrated. What happened in the operating room?

The recent Ontario case, *Szeto v. Kives*[1] is an important illustration of how surgical photo evidence can be skillfully utilized to overcome the evidentiary gaps of an operative report written by the defendant and undermine opposing expert opinion.

CHALLENGES OF INTRA-OPERATIVE SURGICAL NEGLIGENCE CASES

Surgical negligence cases are one of the most challenging types of medical malpractice cases for plaintiffs to pursue. The surgical error can be strikingly clear in some cases. News outlets occasionally cover stories about a surgery being performed on the wrong site or patient, the wrong surgical procedure being performed, or surgical items being left behind inside the patient. However, most surgical negligence cases are far from straightforward. Counsel will find that in many cases, the patient or their family have absolutely no understanding of what may have gone wrong for the serious injury or death to have occurred, partly due to limited sources of evidence.

If the patient was under general anesthesia, they would obviously have no clue as to what actually transpired in the operating room behind closed doors. There are no family members or friends present to provide their account of the events during surgery. The only witnesses are the members of the plaintiff's surgical team, who are also the potential defendants. The primary evidence regarding how the surgery was performed will be contained in the operative report written by the defendant surgeon. The operative report will form a part of the patient's medical record, along with other operative records completed by potential defendants. When the medical records paint a seemingly uncomplicated surgery (i.e. no red flags), the investigation will be extremely challenging.

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FACTS OF THE CASE

In the recent Ontario case *Szeto v. Kives*, the plaintiff underwent a robotic-assisted laparoscopic hysterectomy at St. Michael's Hospital, performed by the defendant gynecologist surgeon. The defendant documented in the operative report that she took down or cut a significant quantity of adhesions by the left fallopian tube to the bowel. The defendant also documented that the top of the plaintiff's uterus was inadvertently perforated during the insertion of an instrument called the uterine manipulator. No other complications were documented.

Following the surgery, the defendant went to see the plaintiff in recovery. The defendant was satisfied that the surgery had gone well and informed the plaintiff's sister that it was a "textbook" surgery. There was no mention of any complications. The plaintiff was discharged from the hospital the next morning, although still feeling unwell. In the middle of the night, she developed chest pain and was taken by ambulance to Scarborough General Hospital in critical condition. She underwent lifesaving emergency surgery by Dr. Chiu during which it was discovered that she had a bowel perforation which required a colostomy. The plaintiff suffered permanent injuries and was discharged after months of difficult recovery.

In trial, the experts agreed that the bowel perforation occurred during the surgery conducted by the defendant. Justice Leiper found that the bowel perforation likely occurred while the defendant was cutting the significant quantity of adhesions between the left fallopian tube and the bowel. She acknowledged that another mechanism of injury was possible. However, it ultimately did not matter how the injury occurred because the injury happened during the surgery for which the defendant was responsible. The defence did not dispute that had the defendant discovered the injury intra-operatively and taken steps to repair it, the plaintiff's permanent injuries would likely have been avoided. The parties agreed on damages outside of court.

LEGAL FRAMEWORK

The Supreme Court of Canada in *Armstrong v. Ward* [2] set aside the Ontario Court of Appeal decision in *Armstrong v. Royal Victoria Hospital*,[3] adopting the dissent of Justice van Rensburg. Justice van Rensburg's dissent in *Armstrong v. Royal Victoria Hospital* continues to serve as a roadmap for navigating medical malpractice cases, such as difficult surgical negligence cases that require substantial findings of

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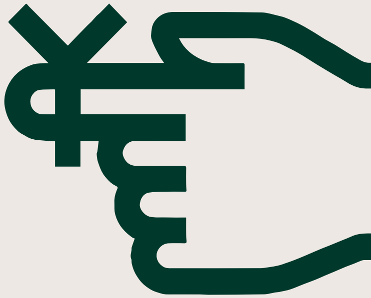

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fact due to inconsistent evidence. The court in *Szeto v. Kives* followed the approach adopted in *Armstrong v. Ward* and found that it was appropriate to first determine what happened during the surgery before turning to the question of whether the standard of care was breached.[4]

In *St-Jean v. Mercier*, the Supreme Court of Canada emphasized that "professionals have an obligation of means, not an obligation of result."[5] The courts should be careful to not use hindsight bias, and to avoid finding that the defendant necessarily breached the standard of care simply because the plaintiff suffered an injury. This is particularly relevant in surgical negligence cases. In *Szeto v. Kives*, Justice Leiper affirmed that it is important to keep the question of standard of care distinct from causation in order to avoid this very mistake. However, Justice Leiper also found that the risk of hindsight bias was low in this case because the plaintiff did not submit that the fact of the bowel perforation necessarily meant that the defendant was negligent.[6] The plaintiff acknowledged at the outset that bowel perforation was a known risk of the surgery and that she gave informed consent to undergo the surgery.

ISSUE AT TRIAL

The issue at trial was whether the defendant was liable in negligence for failing to carefully examine the bowel and detect the injury during surgery, such that it could be repaired in a timely manner to avoid permanent injury to the plaintiff. The experts agreed that the standard of care for the defendant was to carefully inspect the area where adhesions were dissected for potential damage to the bowel, prior to completing the surgery. The experts also agreed that a significant bowel perforation of 1–2 cm in size would have been visible, had the defendant met the standard of care by carefully inspecting the areas of dissection. Consequently, it was necessary for the court to make a factual finding on the size of the bowel perforation. The plaintiff's position was that the perforation was already 1–2 cm during the surgery, and thus visible had the defendant inspected the bowel. The defendant's position was that the injury was a mere "nick" which likely widened to 1–2 cm post-operatively. The size of the perforation was a highly contentious issue that was central to the theories advanced by both parties.

CORROBORATING PHOTO EVIDENCE

The first documentation of the size of the bowel perforation was by Dr. Chiu, who conducted the emergency repair surgery. In his operative summary, Dr. Chiu noted that the bowel perforation was quite large and about 2 cm in diameter. The section of the bowel with the perforation was removed during surgery and sent to the pathology lab for examination. In support of the defence theory that a small cut grew over time to potentially 1–2 cm, the defendant tendered at trial the pathology report. The report described the pathologist's finding that the perforation measured "1 cm in maximum dimension."

At trial, the plaintiff tendered photographs of the portion of bowel removed from the plaintiff, taken by a member of Dr. Chiu's surgical team. One of the photographs had a ruler laid alongside the specimen affording fairly objective visual proof about the size of the injury.

Justice Leiper found that the photo evidence of the bowel perforation was consistent with Dr. Chiu's operative summary and the plaintiff expert's opinion on the clinical course. The plaintiff's expert additionally testified that the specimen sent to the pathology lab would have been preserved in formalin, which causes specimens to shrink in size by up to 50%. The expert opinion supported the argument that the specimen had likely shrunken by the time of the pathologist's examination approximately two weeks later, which offered an explanation of the findings consistent with the plaintiff's version of the events. Based on the consistent and corroborating evidence, Justice Leiper found that the bowel perforation was more likely than not already between 1-2 cm in size during the initial surgery, and that it would have been visible upon inspection and capable of repair had it been detected by the defendant intra-operatively.

Even if photos or video recordings existed at one point, there is always a risk that they are disposed of later or are lost, especially when the records are requested years after the surgery. The result is that patients are afforded limited sources of evidence and will need to rely mostly on written documentation contained in medical records and witness testimony to paint their story.

INCONSISTENCIES IN DEFENCE EVIDENCE

As a part of her findings of fact, Justice Leiper turned to what steps the defendant took to "check her work" prior to completing the surgery. The defendant testified at trial that she inspected the site of the adhesions prior to completing the surgery. Justice Leiper rejected the defendant's evidence, finding that it is inconsistent with (1) the defendant's operative note, (2) the defendant's usual practice, and (3) the defendant's discovery evidence.[7] The defendant failed to document an inspection of the bowel, despite making notes on the significant quantity of adhesions in that area and how she took down those adhesions. She also did not document a positive finding that no injuries were sustained during the procedure based on the alleged inspection.

Defendants often cannot recall what they did or what happened years ago, and may refer to their standard or usual practice as evidence that they would have acted in the same way on the day in question. It is well-established that the court may consider such evidence and even give it significant weight.[8] In this case, Justice Leiper found that the standard procedure or usual practice which informed the defendant's recollection of the events did not include an inspection of the bowel. The defendant's usual practice, described as a check for "good hemostasis," did not include checking the bowel area in every patient. The significant quantity of adhesions in the bowel area was unique to the plaintiff in this case.

Lastly, the defendant's evidence at discovery that she did not inspect where she took down the adhesions, was inconsistent with her evidence in chief at trial that she did look at that area. In cross-examination, she agreed that her discovery evidence was accurate and true. Additionally, the defendant's discovery evidence, given three years after the surgery was that she did not have a recollection of the specific steps that she took during surgery. However, at trial, nine years after surgery, the defendant provided a detailed description of the adhesions that she had made no note of in the operative report. Justice Leiper found that the defendant's discovery evidence only three years after surgery was more reliable compared to the testimonial evidence at trial, given nine years after surgery.[9] Justice Leiper was cautious about accepting the defendant's testimony in trial. After further consideration, the court found that the defendant breached the standard of care, and that breach caused the plaintiff's injuries.

BENEFITS OF PHOTO AND VIDEO EVIDENCE

When available, photo and video evidence can be used to quickly dismiss an inaccurate theory of events by providing more objective, verifiable evidence of what happened. A witness's account of the events from years ago can be limited by inaccurate memory recall. Documentation in the patient's chart could be a result of subjective observation and interpretation of the events at the time. Like MRI imaging and electronic fetal heart rate strips, surgical photos and videos can be offered to medical-legal experts for an independent opinion, which may reveal details that are critical to advancing the case. Photos and videos also contain metadata which can serve as time-stamped proof against fabrication of the timeline.

According to the Practice Standard of the Board of the College of Physicians and Surgeons of British Columbia (CPSBC),[10] the current position of the CPSBC on photographic, video and audio recording of patients is as follows:

> Medical and surgical procedures involving patients may be recorded for a variety of purposes. The recording may be

> made as part of the patient's care to assist in the assessment, investigation, and treatment, in which case the recording forms part of the patient's medical record and must be treated as such.... Alternatively, the recording may be made for a secondary purpose such as teaching, training, or research resulting in the need for additional safeguards. The collection of personal information for these purposes is authorized under section 11(a) of the Personal Information Protection Act (PIPA). In all of these circumstances, the informed consent of the patient must always be obtained.

In reality, patients continue to face barriers in obtaining photos or video recordings of their own surgery. Canadian hospitals and many surgeons do not routinely video record surgeries for any reason, so surgical video recordings rarely form a part of the patient's medical record.[11] In *Szeto v. Kives*, the robotic laparoscopy technology used by the defendant permitted her to record the surgery. However, it was not the defendant's practice at the time to record her surgeries and the footage was unavailable to the plaintiff to be tendered as evidence in trial. Even if photos or video recordings existed at one point, there is always a risk that they are disposed of later or are lost, especially when the records are requested years after the surgery. The result is that patients are afforded limited sources of evidence and will need to rely mostly on written documentation contained in medical records and witness testimony to paint their story.

CONCLUSION

With the lack of routine video recording of surgeries, intra-operative surgical negligence cases will continue to be an evidentiary challenge. *Szeto v. Kives* offers a roadmap on overcoming gaps in the medical record by building a coherent theory corroborated by visual evidence and expert opinion. When investigating a case, counsel should take extra care in verifying the existence of photo or video evidence (e.g. OR Black Box) and preserving any critical evidence to be tendered at trial.

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1. *[Szeto] v. Kives*, 2024 ONSC 7258 *[Szeto]*.
2. *Armstrong v. Ward*, 2021 SCC 1.
3. *Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963.
4. *Szeto, supra* note 1 at para 28.
5. *St-Jean v. Mercier*, 2002 SCC 15, [2002] 1 SCR 491 at para 53.
6. *Szeto, supra* note 1 at para 27.
7. *Ibid* at para 101.
8. *Gilmore v. Love*, 2023 BCSC 1380 at para 62.
9. *Szeto, supra* note 1 at paras 116-117.
10. College of Physicians and Surgeons of British Columbia, "Practice Standard: Photographic, Video and Audio Recording of Patients" (7 October 2024), online: <https://www.cpsbc.ca/files/pdf/PSG-Photographic-Video-Audio-Recording.pdf>.
11. Alison Motluk, "Cameras in the OR: educational asset or legal liability?" (2019) 191:36 CMAJ E1012.