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MEDICAL MALPRACTICE

Foreseeability and Risk of Harm in a Standard of Care Assessment

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THIS IS THE SEVENTH 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

Foreseeability and risk have long played prominent roles in all aspects of medical malpractice litigation. They influence (or can influence) the standard of care in an assessment of negligence, the extent of disclosure required to obtain proper informed consent, whether a reasonable person would accept a proposed procedure if properly informed, factual causation, and legal causation. On February 10, 2026, the Supreme Court of Canada heard the *Hemmings v. Peng case*,[1] in which foreseeability of risk is the key issue. While awaiting the SCC decision, this article explores a few recent medical malpractice cases to show how these concepts have directed outcomes over the years.

STANDARD OF CARE COMMENSURATE TO THE RISK

The law on standard of care in medical malpractice litigation is well established. A medical care provider must meet the standard of a reasonably competent medical care provider of his or her qualifications who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada.[2] The degree of risk to which the patient is subjected as well as the foreseeability of harm are intricately connected with this analysis. This is evident, for example, in how courts assess what medical knowledge defendants ought to have reasonably possessed at the time of the alleged act(s) of negligence. Specifically, courts determine whether the defendants' care was appropriate based on the medical knowledge which was available to them at the time of the events — rather than at a later point when medical knowledge may have improved or evolved.[3] Inherent in this analysis is an acknowledgement that what the medical care providers could foresee regarding

adverse outcomes and harm for their patients dictates the appropriate response or approach to their patient's clinical status.

Generally, following common and accepted practice within a profession will shield a medical care provider from liability.[4] There are circumstances, however, where a 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. When this is the case, liability can be imposed, even when the practice is commonly employed by the profession at issue.[5]

The standard of care does not require perfection on the part of the medical care provider and an adverse outcome alone will not establish negligence.[6] That said, the potential impact of a procedure on the patient will have an effect on the standard of care. As set out in *Ediger v. Johnston,*

> "The standard of care that a physician must provide will take into account all the factors affecting or potentially affecting the life and health of a patient. Thus, the degree of care required is commensurate with the potential danger to the patient. … **In short, the greater the risk, the higher the standard of care.**"[7]

In *Ediger*, the trial judge found that the standard of care did not require a forceps procedure to be done in the operating room with a double setup for emergency c-section if forceps were unsuccessful, but did require that backup for an emergency c-section be "immediately available."[8] The defendant argued that the plaintiff could not prove causation because even if he had arranged for backup to be immediately available by having an anesthetist standing by, he could not have intervened in time to rescue the baby.[9] The Supreme Court of Canada rejected this argument as the proper interpretation of the trial judge's finding that the standard of care required backup to be "immediately available" because it would be unresponsive to the risk in question and potential harm arising from it.[10] If the defendant's argument was accepted, the physician would never be liable for breaching the standard of care where fetal bradycardia results and leads to debilitating injury.[11] Instead, the Supreme Court of Canada concluded that the proper interpretation of the standard of care was that it had to be responsive to the risk and that the defendant had to take reasonable precautions such that the baby could have been delivered without injury upon occurrence of the known risk of the procedure.[12]

EXAMPLES WHERE THE FORESEEABILITY/RISK OF HARM LED TO A SUCCESSFUL CLAIM FOR THE PLAINTIFF

K.B. v. Guhle involved a respiratory illness in a child that evolved into septic shock requiring multiple amputations.[13] This case serves as a good example of how foreseeable harm and degree of risk underlie medical malpractice claims. KB was an 11-month-old infant admitted to hospital on February 19 with an RSV infection (which is a viral infection). She had been experiencing symptoms for two weeks and had a history of respiratory illnesses. Her first physician ordered blood tests, a nose swab and a chest x-ray. He considered (but did not chart) pneumonia and bronchopneumonia. His interpretation of the imaging was that these were not shown. The radiologist report opining that there were findings consistent with bronchopneumonia was not available until much later. Upon admission, KB's care was managed by Dr. Guhle. KB's symptoms worsened on February 21. The on-call physician at the time questioned a secondary infection, noted on the chart that KB should start amoxicillin, a broad-spectrum antibiotic, and directed it be administered orally. The amoxicillin was not administered to KB. Dr. Guhle remained her most responsible physician. KB's chart included symptoms of wheezing, lung crackles, labored breathing, skin color changes and increased fever. Dr. Guhle agreed in evidence at trial that KB's lethargy could be a clinical symptom of progression of a bacterial infection to sepsis but that he heard wheezing in both her lungs which would be consistent with the confirmed RSV infection and inconsistent with a bacterial infection or pneumonia. Dr. Guhle was aware that there was a risk of bacterial infection and sepsis. He ordered a blood test which showed an elevated

KB's chart included symptoms of wheezing, lung crackles, labored breathing, skin color changes and increased fever.

complete blood count, an abnormal neutrophil count and a white blood cell count that had increased since the previous blood test. He was reassured, however, by the fact that the white blood cell count remained in the normal range, even if it had increased. By the morning of February 22, KB was in respiratory failure. By that time, it was too late to intervene to avoid her permanent injuries. All medical experts agreed that by then, KB was suffering a bacterial infection that caused her to develop sepsis and multi-organ dysfunction which, despite treatment on February 22, led to ongoing limb ischemia and resulted in multiple amputations.

The Court was clear that the injury itself does not set the standard of care and the distressing result should not be given undue weight.[14] Instead, whether an act or omission was negligent was to be assessed by considering whether a reasonable person should have anticipated that what happened might be a natural result of that act or omission.[15] The Court also considered the "worst first principle," the idea that the differential diagnosis process ought to eliminate the most serious, rather than the most probable diagnoses first, and that failure to do so is a breach of the standard of care.[16] The admitting doctor's evidence was that his practice was to address the most common or most likely diagnosis first. The Court found that this practice conflicts with the law and that the principle that possibilities with a higher risk of mortality must be addressed first is clearly established in both law and medicine.[17] Furthermore, the Court held that "common sense dictates that when a life-threatening condition has been brought to the attention of a physician, they cannot ignore precautions in the face of those signs, symptoms, and information."[18]

THE COURT ALSO CONSIDERED THE "WORST FIRST PRINCIPLE," THE IDEA THAT THE DIFFERENTIAL DIAGNOSIS PROCESS OUGHT TO ELIMINATE THE MOST SERIOUS, RATHER THAN THE MOST PROBABLE DIAGNOSES FIRST, AND THAT FAILURE TO DO SO IS A BREACH OF THE STANDARD OF CARE.

By the afternoon of February 21, the Court found that KB was showing symptoms of bacterial infection and she was not getting better as expected from an RSV infection alone. The Court found that it was increasingly difficult to rule out a bacterial infection and the blood test results should have raised alarm for Dr. Guhle. The Court found that Dr. Guhle should have taken further steps, recognizing the increased risk that KB had a bacterial infection at that time; these steps included starting antibiotics while other follow-up testing was done. By failing to do so, Dr. Guhle breached the standard of care.

The on-call physician was found to have breached the standard of care after KB's symptoms worsened and he determined that a bacterial infection was much more likely to be present and charted a "suggestion" of IV antibiotics but failed to communicate to Dr. Guhle directly, did not perform further assessments, did not order testing, and did not order the antibiotics he suggested in his charting. The Court found that a potentially serious complication and risk to KB's health was clearly identified to him and he breached the standard of care by failing to take sufficient steps to respond to such risks.

The *Ewashko v. Hugo* case also serves as an example of a case where the role of risk and foreseeability in the assessment of the standard of care led to a decision in favour of the plaintiff.[19] Ms. Ewashko was admitted to hospital in the

early stages of labour. Her baby was in breech position, and at the time, the hospital did not perform vaginal breech deliveries, which meant that caesarean section was her only option if she was to deliver there. An attempted rotation of the fetus was not possible due to the onset of labour. Fetal heart rate monitoring was commenced at 4:10am. Between 4:13 am and 4:19 am, there was a marked deceleration of the fetal heart rate which classified the fetal heart rate tracing as "abnormal", requiring "prompt" delivery according to the Society of Obstetricians and Gynecologists of Canada. Ms. Ewashko was assessed by Dr. Groenewald between approximately 4:30am and 4:35am. He concluded that an urgent caesarean section was required. He required the presence of Dr. Hugo, an obstetrician with the requisite training to perform the caesarean section. Dr. Hugo was on call at home and had to come to the hospital. Before calling Dr. Hugo, Dr. Groenewald was called away to attend to another patient having a heart attack. He contacted Dr. Hugo at 5:08 am, after dealing with the heart attack patient. Dr. Hugo attended to the hospital and examined Ms. Ewashko around 5:25-5:30 am. The operating room team was called after the examination and arrived at 5:45 am. While the operating room team was setting up the operating room, and before the birth at 6:08 am, Baby Ewashko suffered a significant heart rate deceleration which deprived him of oxygen and caused a permanent brain injury. The litigation revolved around the timing of the caesarean section and whether negligent delays caused Baby Ewashko's injuries.

The trial judge held that both physicians fell below the standard of care, causing 50 minutes of unnecessary delay without which Baby Ewashko's brain injury would have been avoided. The most likely cause of the first fetal heart rate deceleration (that the physicians wanted to rule out) was cord compression. The depth of the deceleration raised concerns as to whether the fetus was able to oxygenate his brain. At the time of his assessment of Ms. Ewashko, Dr. Groenewald thought this baby needed to be delivered as soon as possible. He knew that the deceleration had resolved but recognized that whatever caused the prolonged deceleration then may recur at any time. The first step towards delivery was to contact Dr. Hugo. Dr. Groenewald argued that it was reasonable to delay that call until after he dealt with a life-threatening emergency for another patient, given that concerning features of Ms. Ewashko's fetal heart rate tracing had resolved, and she and her fetus were stable. He argued, that decision was a defensible exercise of his clinical judgment. The Court disagreed, and held that the applicable standard of care was that Dr. Groenewald contact

Dr. Hugo, as soon as reasonably possible to advise him of the need for his prompt attendance at the hospital and the core reasons: Ms. Ewashko's arrival at the hospital in early labour, the baby in breech position and an abnormal fetal heart rate pattern.

The Court held that Dr. Groenewald did not call as soon as reasonably possible and thereby breached the standard of care. Both his heart attack patient and Ms. Ewashko needed urgent care and Dr. Groenewald was required to either make an immediate one-minute call to Dr. Hugo directly or ask a nurse to call while he attended to his other patient. A key component of this judgment was the finding that Ms. Ewashko had not "stabilized" in the sense that all steps towards initiating the caesarean section could be put on hold until the other emergency had been cleared. While the fetal heart rate was no longer abnormal, cord compression was the likely cause of the deceleration and there was a recognized risk of recurrence of such compression or other cause, with no way of knowing when a further incident might occur, for how long, and with what severity. Dr. Groenewald was not entitled to view the clinical situation as if that deceleration had not occurred. Foreseeability and risk of harm played an important role in the court's reasoning. The Court viewed Ms. Ewashko's situation as "akin to an earthquake having occurred, citizens in the earthquake zone needing assistance to be rescued, and the risk of another material tremor hanging over the situation."[20] The situation is "stable" in the sense that there is no earthquake currently occurring. It is not certain that another tremor will occur, but it is also not certain that another tremor will not occur.

Dr. Hugo's liability attached to his "judgment call" to attend to the hospital, examine Ms. Ewashko and get her consent to a caesarean section before he called the operating room team. The Court held that the applicable standard of care

was to immediately mobilize the operating room team, direct that Ms. Ewashko be prepped for surgery and then depart his home for the hospital. Part of this analysis was the foreseeability of the need for caesarean section. The Court accepted the expert evidence that there was nothing to weigh in favour of deferring the call to the team until after Dr. Hugo had assessed Ms. Ewashko. Dr. Hugo knew that rotation of the fetus was not an option due to her ongoing labour. He knew that the breech presentation prevented vaginal delivery at that hospital. Caesarean section was the only option for Ms. Ewashko. Although Dr. Hugo wanted to assess the fetal heart rate tracing for himself, the clinical situation was that there was prolonged deceleration of the fetal heart rate which required an urgent delivery, as assessed by Dr. Groenewald, a physician that Dr. Hugo had confidence in. The Court found that although Ms. Ewashko's consent would be required, there was no material possibility that she would decline in this situation to warrant waiting for the consent prior to mobilizing the operating room team. The only downside of calling them in and finding that Ms. Ewashko declined the caesarean section, was having the team unnecessarily attend the hospital from home. In contrast, if Ms. Ewashko had consented but the team had not yet been called, the downside would be wasting valuable time with an urgent operation. The Court noted that the first downside is relatively inconsequential compared to the second.

EXAMPLES WHERE RISK OF HARM WAS INSUFFICIENT TO GROUND A CLAIM

In *Focken v. Miller*, the extent of the risk to the patient was found to be insufficient to establish liability for failure to respond more diligently to that risk.[21] Mr. Focken attended the hospital in the afternoon with bleeding from a pseudoaneurysm in his neck. He was vomiting blood and thick clots. At the hospital he was assessed by an otolaryngologist who determined that he required an embolization to block a blood vessel in his neck that caused the earlier bleeding. Together with an interventional radiologist, the otolaryngologist concluded that the procedure needed to be done urgently, within 24 hours, but that it could wait until 8am the following morning. At the time of that decision, Mr. Focken's vital signs were stable with no active bleeding. Before the procedure was completed, however, Mr. Focken had another significant bleed in his throat that blocked his airway leading to hypoxic cardiac arrest and ultimately, death.

The plaintiff's expert described the first bleed as a "sentinel bleed" that warns of a more catastrophic bleed that could occur at any time and requiring immediate treatment. The trial judge preferred the evidence of the defence experts who opined that the embolization could wait because re-bleeding did not appear imminent, he was under close observation and the artery that bled initially was one that leads to less severe bleeding (i.e. not a "sentinel bleed"). Their opinion was that Mr. Focken survived the first bleed at home without medical treatment, so subsequent re-bleeding was not necessarily expected to be catastrophic.

On appeal, the plaintiff argued that the trial judge erred in law "in not assessing standard of care with consideration to the degree of foreseeable risk" to Mr. Focken.[22] The Court of Appeal held that expert assessment of the degree of foreseeable risk is essential to the description of applicable professional standards and thus, to the expression of an expert opinion as to the expected standard of care. Judges are therefore entitled to accept expert opinion evidence which has already weighed that degree of foreseeable risk without doing an independent analysis of risk separate from the weighing of the expert evidence. In this case, the foreseeable risk was dictated in part, by where the bleed had likely occurred, which vessel was affected and whether it was likely to progress to a significant tear in the vessel, which would then impact the severity of risk posed by a potential second bleed. The risk to the patient could not be determined without expert assistance. The judge weighed the expert evidence and accepted that of the defendants over the plaintiffs, in part due to information missing from or erroneously assumed in the plaintiff's expert report. The Court of Appeal held that in doing so, the trial judge appropriately considered the degree of foreseeable risk to the patient when assessing the standard of care.

Both Courts also held that the medical practice of waiting until the morning for the embolization procedure was not one that was so fraught with obvious risk as to be negligent. The medical questions at issue were too complex to fall into that exception. Both Courts observed that in cases where a claim that standard practice is so fraught with obvious risk as to be negligent, "the common thread… is a focus on practical, systems-based, or common-sense considerations rather than substantive medical issues."[23] The Court of Appeal noted that such cases often involved issues of communication or adequacy of follow up arrangements.

CONCLUSION

As demonstrated in the above cases, foreseeability of harm and risk to the patient are inextricably integrated into the determination of the standard of care applicable to medical care providers, including whether that standard of care has been breached. These concepts play other roles in medical malpractice litigation which are broad, and in certain cases, remain to be considered. The pending judgment by the Supreme Court of Canada in the Hemmings v. Peng case will likely provide helpful parameters on how to assess foreseeability of risk and legal causation in medical malpractice cases.

1. 2022 ONSC 2674, 2024 ONCA 318
2. *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674, 127 D.L.R. (4th) 577 at para 33.
3. *Ibid*, at para 34.
4. *Ibid*, at paras 38-40.
5. *Ibid*, at para 41.
6. *Ibid*, at para 19.
7. *Ediger (Guardian ad litem of) v. Johnston*, 2009 BCSC 386 at para 49.
8. *Ibid*.
9. *Ibid*.
10. *Ediger (Guardian ad litem of) v. Johnston*, 2013 SCC 18 at para 44 [Ediger (SCC)].
11. *Ibid*.
12. *Ibid*, at para 45.
13. 2025 ABKB 472
14. *Ibid*, at para 17.
15. *Ibid*, at para 18.
16. *Ibid*, at para 28.
17. *Ibid*, at para 258.
18. *Ibid*, at para 31.
19. *Ewashko v. Hugo*, 2025 ABKB 295
20. *Ibid*, at para 128.
21. 2024 BCCA 74
22. *Ibid*, at para 25
23. *Ibid*, at para 57.