LAW

Attacking the standard of care

It only works when the standard is fraught with risks so obvious a layperson can see them

BY BILL ROGERS

If a doctor leaves a sponge inside a patient after surgery, and the patient dies as a result, it seems pretty clear the doctor did something wrong. Remarkably, the doctor in this case argued otherwise. He used the defence of "approved practice," also known as "common practice" or "custom," whereby he argued that the procedures he followed were generally approved and used, therefore he should not be found negligent. Unsurprisingly, he lost.

He had performed surgery to remove a child's tonsils and adenoids but was told by the anesthetist, after the operation, that not all the sponges had been taken out. He checked, but found no sponges. The child later died by suffocating on one. The doctor told the court he never took the precaution of using sponges with strings on them and he never had a nurse count the sponges, but neither did anyone else at his hospital. It was "approved practice" to not bother with these precautions. Therefore it was acceptable.

Ruling against him, the Supreme Court of Canada noted that he *could* have used sponges with strings, and he *could* have had a nurse count them—plenty of other doctors in other hospitals did. Therefore, said the court, it does not take an expert to see that he *should* have done these things. The result of not doing them spoke for itself.

This case, called Anderson v. Chasney, was decided in 1949. Since then it has been cited many times in situations where a defendant doctor meets the standard of care, so the plaintiff shifts tactics and attacks the standard of care itself. This is now a well-established strategy. However, it only succeeds in those rare situations where the plaintiff can show that the standard of care is so bad that even the average person off the street would be able to tell. This was a perfect example: Anyone would agree that a standard of care allowing a doctor to shrug off leaving a sponge inside a patient, who later suffocated to death on it, cannot stand.

B.C. case

This approach was attempted recently in a British Columbia case. The plaintiff lost at trial, then appealed on several grounds including that the standard of care should have been attacked and struck down. It began when a 55-year-old patient, who was suffering from cancer of the tongue that had spread to his throat, started vomiting blood and blood clots into the kitchen sink in his home. Firefighters and an ambulance took him to the ER. It was determined that the bleeding had stopped, but the patient would need an embolization to block a blood vessel in his neck. The procedure was scheduled for the next morning. Overnight, however, the bleeding started again, causing a nine-minute hypoxic cardiac arrest. This led to brain injury and eventually death.

The plaintiff, his widow, asserted that the embolization should have been done immediately, rather than waiting until the next morning. The trial judge ruled that waiting until the next morning was a perfectly acceptable medical judgment, and it met the standard of care. So the

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plaintiff switched tactics and argued that this standard of care was too low. The appeal court disagreed, affirming the trial ruling and holding the defendant doctor blameless.

The problem the plaintiff faced was that it is very, very hard to attack a standard of care. As a general rule, where a procedure involves difficult or uncertain questions of medical treatment or complex, scientific or highly technical matters that are beyond the ordinary experience and understanding of the average person, the standard of care will not be found wanting. The only way to accomplish that is when the standard is so "fraught with obvious risks" that anyone would easily be able to see the deficiency.

That was definitely not the case here. Not only were there no "obvious risks" in the standard of care, there was nothing obvious or straightforward about any of it. On the contrary, it was complex, to say the least. For example, the court adopted expert testimony and ruled that, "It was reasonable to schedule the embolization procedure for the following morning, because the patient had a CT angiogram around 6:30 p.m. and it showed a pseudoaneurysm in the right lingual artery and there had been no bleeding since his admission to the hospital emergency room. When the scheduling decision was made, re-bleeding did not appear to be imminent. The patient remained under close observation while awaiting the embolization procedure, and those attending to him knew to look for further bleeding." Imagine telling this to the average person on the street. Would they chuckle and say, "Wow, that approach is so obviously risky, I can't believe anyone would do it!" No.

The court also found that, "It was the lingual artery that was bleeding, not the carotid artery. The lingual artery is smaller than the carotid artery, and bleeding from the former is generally less severe than bleeding from the latter. Bleeding from the lingual artery is not sentinel bleeding, which is very ominous and calls for immediate action, because the bleeding was from the tip of the artery rather than from a small tear in the artery wall that may be followed by a larger tear. The patient survived the earlier bleed from the lingual artery at home without medical treatment, so subsequent re-bleeding was not necessarily expected to be catastrophic." Again, imagine saying these words to the average person on the street. Would they burst out laughing and scoff at the blatant recklessness of this standard of care? Would they say it is fraught with obvious risks? No. The average person would not be able to make head or tail of it. Sentinel bleeds, pseudoaneurysms, carotid arteries—this is esoteric stuff. Not like leaving a sponge in someone.

'Obvious risks'

The "fraught with obvious risks" test comes from a Supreme Court of Canada case called ter Neuzen v. Korn, which was a lawsuit against a gynecologist brought by a patient who contracted HIV after being artificially inseminated with infected sperm back in January 1985. A jury had previously come to the verdict that, clearly, the standard of care proposed by the gynecologist was pitifully low—he never warned the patient of the risk of HIV infection, and he didn't test the semen for HIV. Anyone could see this was obviously risky.

Not so fast, said the Supreme Court. The procedure was done January 1985, but the first documented case in the world of HIV transmission through artificial insemination was published in the lay media in July 1985, and in a medical journal in September 1985. None of the obstetric literature mentioned artificial insemination as a mode of transmission of HIV, and no article summarized the disease risks of artificial insemination before 1986. Moreover, as of January 1985 there was *no test available* for the detection of HIV in semen or blood in Canada. Therefore, it made no sense to say the gynecologist's method was "fraught with obvious risks" in that he failed to warn about HIV or test for it. On the contrary, the gynecologist's practice was found to be in keeping with general practices across Canada, and reflected the current state of knowledge. The jury's verdict was set aside.

This accords with common sense. It is very difficult to successfully attack a standard of care, and that is a good thing. Otherwise we would have judges, who typically do not understand the practice of medicine and therefore always require expert witnesses to educate them in malpractice cases, monkeying around with how doctors do their jobs.

"The plaintiff lost at trial, then appealed on several grounds including that the standard of care should have been attacked and struck down."

But in those rare cases where the standard is fraught with obvious risks, it is no excuse for a practitioner to claim he or she was merely conforming to common practice. As the judge ruled in Anderson v. Chasney back in 1949, "Ordinary common sense dictates that when simple methods to avoid danger have been devised, are known, and are available, failing to use these methods, with fatal results, cannot be justified by saying that others also have been following the same old, less-careful practice." A widely used tort law textbook puts it succinctly: "It is obviously not acceptable to injure a patient's body outside the area of treatment, or cause an explosion set off by an admixture of ether vapour and oxygen, or fail to remove a sponge."

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LAW

A sudden illness

The 26-year-old visited the ER the day before she died but the court sided with doctors

BY BILL ROGERS

A 26-year-old patient went to emergency feeling ill. Influenza was suspected, and she was given intravenous saline, Tylenol and Gravol. Three hours later she felt better and went home in a taxi. The next day she came back—and within hours she was dead from complications due to pneumococcal bacterial pneumonia.

An emergency specialist and a fourth-year emergency resident were sued in this tragic Ontario case, on the theory that they ought to have checked for pneumonia when the patient first came in. They should have ordered a chest X-ray and bloodwork. If these steps had been taken, they said, the patient would have lived. The defence, on the other hand, argued that when the patient first arrived it looked like influenza, definitely not pneumonia, so a chest X-ray and bloodwork were not indicated.

The defence prevailed. The doctor and the resident were held blameless. It was not surprising that they did not check for pneumonia, because the patient did not actually *have* pneumonia when she first came in, the court found. It materialized the next day. It then progressed extremely quickly, which was "a very rare event in an otherwise healthy young adult."

When she first came in, there were no pneumonia signs. She was afebrile, with a normal respiratory rate, normal oxygen saturation and a normal respiratory examination. Also, she was non-distressed. She did not complain of chest pain, or shortness of breath or productive cough. (Indeed, she was not observed to cough at all.) She appeared comfortable and was able to carry on a conversation while lying flat on her back in the hospital bed.

The trial

During the course of the trial, the patient's lawyers highlighted several things that might be seen as smoking guns, or at least as evidence of negligence, but the court was not persuaded by any of them. For example, the patient's lawyers asserted that, far from having no signs of respiratory problems, when she first came to emergency she was suffering from "congestion." It said so right on the intake form.

Rejecting this assertion, the court found that although she was never observed to cough, the patient did *complain* of a cough when she first arrived, so the triage nurse chose the "cough/congestion" selection from the Canadian Emergency Department Information System (CEDIS) Presenting Complaint List. However, the court noted, there is no option on the CEDIS form for "cough" alone, so the nurse had no other choice.

There was no notation of "phlegm" or "sputum" or "productive cough" in the hospital records, the court observed. The patient's expert witness "incorrectly assumed that the patient was congested, and he based this solely on the triage nurse's entry "cough/congestion" showing on the CEDIS form. He had not understood that this was a pre-populated menu selection and that it did not reflect an actual reported complaint." The expert agreed that congestion was not noted anywhere else in the medical records, and there was no note that the patient complained of a productive cough that day. Furthermore, the court accepted the resident's testimony that the patient did not, at any point, tell him she had congestion.

The patient's lawyers also made much of the fact that the resident did not chart the respiratory exam he did when the

patient first came in. Did he actually do one? If so, did he do a proper one? Their expert witness testified, ominously, that "the poorer the record, the poorer the care given."

Actually, no, said the court. True, the resident committed a "technical breach" of the standard of care by failing to chart the results of his physical respiratory examination. (In fact, he re-wrote the results of the cardiovascular examination on the chart, through inadvertence.) "This breach is of no consequence," the court ruled, noting that, "There is no evidence that anyone relied on the resident's chart notations such that his failure to record the results of his physical respiratory examination caused any issues or problems in her care or treatment."

Plus, the court found that the resident had indeed performed a physical respiratory examination by having the patient sit up, auscultating the front and back of her chest with a stethoscope, and getting her to take deep breaths in and out while listening for adventitious breath sounds like crackles or wheezes. The examination revealed "bilateral air entry, no adventitious sounds and no cough."

Differential diagnoses

The patient's lawyers also found fault with the fact that the charts did not set out all the differential diagnoses that came into play. This strategy was not successful. "I do not accept the plaintiffs' contention that an emergency department physician is required to document every differential diagnosis that they consider on a patient's hospital chart," the court ruled. "None of the expert witnesses testified that that was the standard. It is impossible for an emergency department physician to document everything they discuss with a patient. It is the most relevant parts of a patient's assessment that need to be documented, in a concise and precise manner. Documenting every differential diagnosis that an emergency department physician ends up eliminating when assessing a patient would not be practical, useful or necessary."

There was also the fact that the emergency doctor never charted any of her own observations or assessments.

"I do not accept the plaintiffs' contention that an ED physician is required to document every differential diagnosis that they consider on a patient's chart."

"I do not find that this falls below the applicable standard," the court ruled, accepting the uncontroverted evidence of the defence expert that it is "very, very rare" for attending physicians to document their own notes, because they usually listen and talk to the residents, and there is typically no added value to documenting the attending staff physician's assessment, as it is usually the same as the resident's.

The court went on to speculate about what would have happened if the pneumonia had in fact been checked for earlier. Would the outcome have been any different? This is part of the well-settled principle that even if a physician is negligent, no damages will be payable if the negligence did not *actually cause harm*. Obviously, not checking for pneumonia was not negligence here, because there were no signs of it, and the patient did not actually have it, at first. However, the court went through the speculation anyway, as they always do, just to cover all bases.

Speculation

The court ruled that even if the pneumonia had been checked for earlier, it would not have mattered. The court accepted expert testimony that even if a blood test had been done on the patient's first visit to emergency, it "would not likely have shown the profound neutropenia encountered the next day" and, furthermore, "a moderately or mildly elevated abnormal white blood cell count would not have been helpful in discriminating between the underlying viral infection and the early onset of pneumococcal pneumonia." As for a chest X-ray, this too would likely not have detected pneumococcal pneumonia because, even after the onset of clinical signs of that disease—of which, again, there were none on the patient's first visit—a chest X-ray can remain negative for a few hours and "the infectious process of pneumococcal pneumonia can or will *precede* the radiologic changes" that an X-ray would reveal.

Moreover, even if the pneumonia had been detected earlier than it was, the patient would have died anyway, the court ruled. The infectious process here was "exceedingly and highly unusually rapid," and it was so bad that "multiple antibiotics and aggressive intervention did not save her, and could not save her."

The expert also testified that it was "extremely unlikely" the patient was suffering from undetected pneumococcal pneumonia when she first came in, because if that had been the case, she would have become symptomatic shortly after her departure from emergency, not 24 hours later. Plus, it would have been "extremely unlikely" for a patient to have pneumococcal pneumonia and also have a normal respiratory rate, and a normal oxygen saturation and not be distressed. Bottom line: She did not have it when she first came in, but it hit her suddenly the next day.

Why did it kill her? It is not possible to say for sure, but the expert suggested that the patient possibly had an unknown immunodeficiency, such as a complement deficiency, which had not previously affected her. He said, "There are numerous congenital immunodeficiencies that do not show any signs of disease or of compromise until a patient comes in with that first overwhelming infection."

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LAW

Backwoods medicine

Appeal court ruled that applying a lower standard based on the doctor's rural location was an error of law

Rural doctors used to be held to a lower standard. It was not because they were bumbling bumpkins. Rather, it was because they typically had far fewer resources, and could not easily communicate with their colleagues. A recent case from the Manitoba Court of Appeal reminds us that those days are long gone. Rural practitioners are held to the same standard as everyone else.

The defendant doctor in this case was a general surgeon doing orthopedics in a small town. He performed an open reduction and internal fixation on a patient's calcaneus (i.e., heel bone), which had been severely fractured in a motor vehicle accident. The procedure included inserting a metal plate and some screws. He also provided post-operative care, including debridement of the surgical wound.

Unfortunately, the patient continued to be symptomatic, for the next 10 years, until she went to another surgeon. He removed some bone and moved the errant tendons—which he described as being "grossly out of place"—back into their correct position.

The patient sued the first doctor, claiming that her delayed recovery and resulting damages were caused by his negligent failure to position her tendons where they were supposed to be. She claimed this led to infection and arthritis.

The trial judge rejected her claim. He ruled that none of the allegations of negligence had been proven, and her problems were purely the result of the car accident.

The patient appealed, on the basis that the trial judge had applied the lower standard of "a general surgeon in a *rural* community-based hospital practicing in orthopedics."

She won the appeal. Applying lower standards to doctors simply because they are "rural" might have been OK long ago, the appeal court ruled, but nowadays it is a clear error of law. There is no longer any forgiveness for physicians just because they work in the boondocks. A new trial was ordered, which has yet to take place.

The idea that rural physicians should be held to a lower standard is known historically as the "locality rule." It is no longer good law, except for one remaining vestige: If you can show that, because of geographic location, adequate facilities, equipment or staff were not available, then a court can take this into account. Apart from that, though, healthcare providers are judged by the expected standard of knowledge irrespective of where they practice, and standards are set at a national level. Put another way, while equipment or the ready availability of resources or staff may vary from community to community, standards of knowledge should not.

The locality rule

The locality rule has been under judicial

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attack for a very, very long time. In an Ontario case called Town v. Archer, the judge criticized it as being out of step with "improvements in modern communications, medical education, and the uniformity of examinations for doctors in Canada." This was in 1902.

He went on to say that "all the physicians practising in a given locality might be equally ignorant and behind the times. Therefore, regard must be had to the present advanced state of the profession, and to the easy means of communication with, and access to, the large centres of education and science."

The rural community in that case was Port Perry, Ont., which in 1902 was "only two hours travel" from Toronto, a throbbing megalopolis of "a quarter of a million people," boasting "three medical colleges and numerous hospitals." No doubt this judge would have marvelled at things like the internet, telemedicine and artificial intelligence.

Communications and access to information have of course improved greatly since 1902, so there is even less reason to differentiate between localities. Moreover, as legal scholars have argued, any principle that permits an inferior brand of medicine for rural patients is undesirable, and indeed, repugnant.

A 2003 case

Another nail in the locality rule's coffin was hammered in by a 2003 birth trauma case called Crawford v. Penney, where the judge ruled that "a rural physician practicing his/her profession is under the same obligation as is a physician with a similar practice in an urban setting to keep up with developments in areas of medicine pertinent to their practices."

This judge also cited a case where a rural doctor was held liable for negligence after he performed an "obsolete" type of operation on a patient because he was unable to do the one recommended by a specialist.

The demise of the locality rule raises an interesting corollary: Rural doctors may now have a *more* onerous job than their urban counterparts, because they must be particularly vigilant to risk factors that might crop up due to the lack of availability of immediate help. The need to refer patients to specialists may be greater in a rural setting than in an urban one.

Regarding the Manitoba case, it is difficult to understand exactly how the trial judge's erroneous use of the locality rule worked any mischief. It was not as if he ruled that the defendant doctor botched the operation horribly, but that's OK because it was done in a pastoral setting.

No, the trial judge found that the patient simply did not prove her various allegations of negligence, which included claims that the doctor did not properly reduce the calcaneus, with the result that the tendons were not placed back where they should be; the doctor did not perform the surgery at the "appropriate" time, that is, at least seven days after the initial fracture, to allow swelling to subside, or within 24 hours post-injury before swelling occurs; the doctor removed the sutures and staples from the incision too soon; and the doctor failed to prevent infection.

The trial judge also noted that "the defendant doctor's testimony, although at times expressed with unnecessary bravado, was consistent. He has performed hundreds of calcaneal repair surgeries over his lengthy career; the hospital granted him privileges to perform calcaneal repair surgery, and The College of Physicians and Surgeons of Manitoba continues to allow him to perform orthopedics today, 15 years post-incident."

True, said the trial judge, the patient's condition was "less than ideal" following surgery. However, "her complaints are directly attributable to the motor vehicle accident and the resulting injuries, not the doctor's repair of her calcaneus. There is nothing in the medical record to indicate her outcome was anything other than anticipated in these types of injuries, especially with the strain she placed on her foot and ankle when she resumed her activities of daily living."

What seems to have offended the appeal court was that the erroneous application of the locality rule somehow affected the trial judge's assessment of the expert evidence, and influenced him to prefer the defence's experts over the patient's.

It is not entirely clear how this occurred, though. Indeed, it appears there were other factors at play, factors which had nothing whatsoever to do with the locality rule. For example, the trial judge found that the findings of the patient's experts "were clouded by errors and omissions raised during cross-examination." Obviously, an expert making errors and omissions is a separate issue from whether the defendant doctor's procedure was performed in the countryside.

10 years post-surgery

Furthermore, said the trial judge, the patient's experts "looked at what occurred through the lens of 10 years post-surgery. In this period there were advances in surgical technique which did not exist when the defendant doctor performed the calcaneal repair in 2006." Once again, this has nothing at all to do with rural medicine issues.

As often happens in malpractice cases, the trial judge expressed sympathy for the patient, noting that her vigorous efforts to return to full activity after her injury were admirable. "She pushed herself to return to work and did so within seven months of her surgery. She was also able to continue her personal activities. She was an active participant in her recovery. She followed treatment recommendations, she was diligent in addressing those recommendations, and she advocated for her own well-being. The court cannot fault her in any way. She was an innocent victim of an all too common T-bone accident at uncontrolled intersections in rural Manitoba."

Presumably, the patient's counsel was hoping the appeal court would substitute a different ruling, in the patient's favour, rather than ordering a new trial. But this was not in the cards. Therefore, after doing the original trial, plus the appeal, it will no doubt require great fortitude to start all over again.

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