Causation in Medical Negligence Cases: A Perspective from British Columbia

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I. Overview

At the end of the day lawsuits are about facts. Proving facts can be a difficult and tiring exercise. Injuries are not limited to what can be causally established on a balance of probabilities. However, imposing liability without evidence reduces justice to a popularity contest. Prudence requires caution before jumping to conclusions that lack a factual or scientific basis.

This paper will explore the limited situations in which the BC courts have relaxed the evidentiary burden of proving causation on a balance of probabilities. This paper consists of six sections:

1. An overview of the general principles governing causation and an explanation as to how reconciling these principles have complicated the law;
2. A description of the “but for” test. This is the legal test most commonly used to determine causation in medical negligence cases;
3. A review of the development of the “robust and pragmatic” approach that courts are often encouraged to apply in certain cases when assessing causation. This section explains why the robust and pragmatic approach does not apply to the majority of medical negligence cases;
4. A review of “loss of chance.” Recovery of damages for “loss of chance” is generally not available to plaintiffs in medical negligence cases involving torts;
5. A review of the “material contribution” concept. “Material contribution” is of limited applicability in medical negligence cases. It cannot be applied when positive evidence has been led by a defendant on the issue of causation. If no evidence can be led on the issue, in exceptional circumstances, the court may create a casual link; and
6. The final section reviews Chambers v. Goertz and explains why, at least in BC, the “material contribution” test is limited to exceptional circumstances.

II. General Principles

Causation is the relationship that must be found to exist between the tortious act of a defendant and the injury to the plaintiff in order to justify compensation of the latter out of the pocket of the former. The plaintiff has the burden of proving, on a balance of probabilities, that the defendant caused or contributed to the injury. Legal theory requires that the plaintiff prove the link between a breach in standard of care, and damages resulting from the breach with certainty. Increasingly, scientific opinions on causal links or relationships are expressed on a continuum of probabilities. This can create a divergence between legal theory and reality. In an attempt to assess causation in cases involving probabilistic causal effects, courts, on occasion, have expanded the “but for” test as an attempt to deal with situations when a causal link is uncertain. However, this expansion has been

1 2009 BCCA 358.
4 McLachlin J., “Negligence Law - Proving the Connection” in Mullany and Linden eds., Torts Tomorrow, A Tribute to John Fleming (Sydney: L.B.C. Information Services, 1998) at 18, summarized the problem in this way:

   Why are the courts now asking questions that for decades, indeed centuries, they did not pose themselves, or if they did, were of no great urgency? I would suggest that it is because too often that traditional “but for,” all or nothing, test denies recovery where our instinctive sense of justice—what is the right result for the situation—tells us the victim should obtain some compensation.
tempered by judicial deference to the principle that the plaintiff has the burden of proving his or her case on a balance of probabilities. The development of the law of causation cannot be understood without a recognition of these two competing principles.

A review of the English and Canadian medical negligence jurisprudence indicates that the courts have been, and likely will continue to be, reluctant to place liability on a medical professional when causation has not been established by the plaintiff on a balance of probabilities. Therefore, one should be cautious of proceeding with a case where causation cannot be factually established on a balance of probabilities.

III. The “But For” Test

The general test for causation is the “but for” test which requires the plaintiff to show that the injury would not occur “but for” the negligence of the defendant. The “but for” test will be applied in circumstances where the plaintiff alleges that the defendant’s tortious act was both necessary and sufficient to cause his or her injuries. The “but for” test requires the plaintiff to establish this causal link on a balance of probabilities. The “but for” test is used in the majority of medical negligence cases in assessing whether there is a causal link between an alleged breach in the standard of care owed to a plaintiff and the damages suffered by the plaintiff.

The importance of the “but for” test and the pivotal role it plays in balancing the general principles summarized above was summarized by Frankel J.A. in Clements (Litigation guardian of) v. Clements:

40 Causation is a fundamental element of liability for negligence. A person who suffers harm is entitled to compensation from those who caused that harm. The but-for test is the method by which factual causation is established. The way the test works is described in Linden and Feldthun, Canadian Tort Law, 8th ed. (Markham, Ont.: LexisNexis Butterworths, 2006) at 116:

[If] the accident would not have occurred but for the defendant’s negligence, this conduct is a cause of the injury. Put another way, if the accident would have occurred just the same, whether or not the defendant acted, this conduct is not a cause of the loss. Thus the act of the defendant must have made a difference. If the conduct had nothing to do with the loss, the actor escapes liability.

41 In Cork v. Kirby MacLean, Ltd., [1952] 2 All E.R. 402 at 407 (C.A.), Lord Denning (as he then was) stated the test as follows:

Subject to the question of remoteness, causation is, I think, a question of fact. If you can say that the damage would not have happened but for a particular fault, then that fault is in fact a cause of the damage; but if you can say that the damage would have happened just the same, fault or no fault, then the fault is not a cause of the damage. It often happens that each of the parties at fault can truly say to the other: “But for your fault, it would not have happened.” In such a case both faults are in fact causes of the damage.

See also: Barker v. Corus (UK) Plc, [2006] UKHL 20.

5 Athey at para. 14; Snell at para. 14.
6 2010 BCCA 581.
42 In *Resurfice Corp.*, the Supreme Court of Canada re-affirmed the but-for test as the primary (i.e., default) test for determining causation. In that case, Chief Justice McLachlin, in stating the general principles that apply to the determination of causation, said:

21 First, the basic test for determining causation remains the “but for” test. This applies to multi-cause injuries. The plaintiff bears the burden of showing that “but for” the negligent act or omission of each defendant, the injury would not have occurred. Having done this, contributory negligence may be apportioned, as permitted by statute.

22 This fundamental rule has never been displaced and remains the primary test for causation in negligence actions. As stated in *Athey v. Leonati*, at para. 14, per Major J., “[t]he general, but not conclusive, test for causation is the ‘but for’ test, which requires the plaintiff to show that the injury would not have occurred but for the negligence of the defendant.” Similarly, as I noted in *Blackwater v. Plint*, [2005] 3 S.C.R. 3, at para. 78, “[t]he rules of causation consider generally whether ‘but for’ the defendant’s acts, the plaintiff’s damages would have been incurred on a balance of probabilities.”

23 The “but for” test recognizes that compensation for negligent conduct should only be made “where a substantial connection between the injury and the defendant’s conduct” is present. *It ensures that a defendant will not be held liable for the plaintiff’s injuries where they “may very well be due to factors unconnected to the defendant and not the fault of anyone”: Snell v. Farrell*, [1990] 2 S.C.R. 311, at p. 327, per Sopinka J.

IV. A “Robust and Pragmatic” Approach to Causation

There are times when a plaintiff due to evidentiary shortcomings is unable to establish the decisive link between his or her injury and the defendant’s proven breach of duty. The courts have expressed concern that, in such circumstances, a rigid application of the “but for” test and of the burden of proof on a balance of probabilities rewards the careless defendant and denies relief to his probable victim. This problem was recognized by the House of Lords in *McGhee v. National Coal Board*.7

A. McGhee v. National Coal Board

*McGhee* involved an employee who developed dermatitis from coal dust at his workplace. However, he could not establish that the provision of washing facilities at the workplace would have prevented him from contracting dermatitis. At trial the National Coal Board was found to have breached the standard of care owed to their employees by not providing washing facilities at the workplace. Mr. McGhee worked for several different employers, none of whom provided appropriate washing facilities. The troubling issue was whether any one employer caused Mr. McGhee’s dermatitis. The matter was considered by the House of Lords who determined that Mr. McGhee had established that the failure of each employer to provide washing facilities materially increased the risk of his injury. The decision seemed to imply that once a plaintiff established a material increase in risk, the burden of proof then shifted to the defendant to disprove the causal link. Lord Wilberforce noted:

First, it is a sound principle that where a person has, by breach of a duty of care, created a risk, and an injury occurs within the area of that risk, the loss should be borne by him unless he shows that it had some other cause. Secondly from an evidential point of view, one may ask, why should a man who is able to show that his employer should have taken certain precautions, because then there is a risk, or an added risk, of injury or disease, have to assume the burden of proving more: namely that it was the addition of the risk, caused by the breach of duty, which caused or materially contributed to the injury? In many cases, of which the present is typical, this is impossible to prove, just because honest medical opinion cannot segregate the causes of an illness between compound causes. And if one asks which of the parties, the workman or the employers, should suffer from this inherent evidential difficulty, the answer as a matter of policy or justice should be that it is the creator of the risk who, ex hypothesi must be taken to have foreseen the possibility of damage, who should bear its consequences.

Lord Wilberforce’s comments have been argued by some counsel as reversing the onus of proof on the issue of causation where the plaintiff is able to establish that the defendant’s breach of duty increased the risk of the injury that occurred. However, the subsequent decision of the House of Lords in *Wilshire v. Essex Area Health Authority* affirmed that this is not the case, and that the plaintiff has the onus of establishing causation on a balance of probabilities remains with the plaintiff.

B. *Wilshire v. Essex Area Health Authority*

In *Wilshire*, a neonate developed an eye condition that was caused either by substandard provision of excessive oxygen to the neonate by employees of the National Health Authority, or occurred due to one of a number of other, non-tortious, factors. The claim against the National Health Authority succeeded in the Court of Appeal based on the causation principles enunciated in *McGhee*. At the Court of Appeal, Sir Nicholas Browne-Wilkinson dissented and distinguished *Wilshire* from *McGhee* on the basis that in *McGhee* there was only one possible cause of the plaintiff’s dermatitis, whereas in this case there were both tortious and non-tortious potential causes. The House of Lords agreed with Sir Browne-Wilkinson and refused to impose liability on the National Health Authority, which had no control over the other potential causes of the infant’s condition. *Wilshire* clarified that, notwithstanding *McGhee*, the burden of proof still lay with the plaintiff. Lord Bridge noted:

> The conclusion that I draw from these passages is that *McGhee v. National Coal Board*, [1973] 1 W.L.R. 1 laid down no principle of law whatsoever. On the contrary, it affirmed the principle that the onus of proving causation lies on the pursuer or plaintiff. Adopting a robust and pragmatic approach to the undisputed primary facts of the case, the majority concluded that it was a legitimate inference of fact that the defenders’ negligence had materially contributed to the pursuer’s injury.

C. *Snell v. Farrell*

The “robust and pragmatic” approach drawn from *McGhee* and *Wilshire* was adopted by the Supreme Court of Canada in *Snell*. In *Snell*, the plaintiff underwent a surgical procedure in which the surgeon admitted that his treatment fell below the requisite standard of care. The plaintiff suffered a stroke and went on to develop blindness. Interestingly, neither the plaintiff’s nor the defendant’s experts could say whether the stroke that triggered the plaintiff’s blindness was caused by the admitted negligence, or whether the plaintiff would have gone blind in any event. In understanding the rationale on the

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8 Ibid., at 6.
10 *Wilshire* at 569.
finding of causation in *Snell* it is important to remember that a court is not permitted to abdicate making a finding of fact on causation\(^\text{11}\) on the basis that neither the plaintiff nor the defendant could establish or disabuse a causal link on a balance of probabilities.\(^\text{12}\) Thus, *Snell* must be understood as an assessment of causation in circumstances where the court was required to make a legal assessment of causation, despite the fact that expert opinion evidence could not establish or disabuse a causal link on a balance of probabilities.

Sopinka J. provided a number of principles to be considered in assessing causation in these circumstances:

- (a) Causation need not be determined with scientific precision\(^\text{13}\);
- (b) Fact-finders are to take a “robust and pragmatic approach” to the facts that the injured person asserts support the conclusion that the misconduct of a defendant is a factual cause of his or her injury\(^\text{14}\);
- (c) Where the relevant facts are particularly within the knowledge of the defendant “very little affirmative evidence will be needed to justify an inference of causation, in the absence of evidence to the contrary”\(^\text{15}\); and
- (d) Factual causation is a question to be answered by the application of “ordinary common sense.”\(^\text{16}\)

The classic statement on causation by Sopinka J., often cited in plaintiff’s arguments and facta addressing causation, is as follows:

> It is not strictly accurate to speak of the burden shifting to the defendant when what is meant is that evidence adduced by the plaintiff may result in an inference being drawn adverse to the defendant. Whether an inference is or is not drawn is a matter of weighing evidence. The defendant runs the risk of an adverse inference in the absence of evidence to the contrary. This is sometimes referred to as imposing on the defendant a provisional or tactical burden.\(^\text{17}\)

*Snell* is a case in which the court, due to evidentiary constraints, had to make a factual finding based on circumstantial evidence. Sopinka J.’s observation that the court may draw an inference of causation when necessary facts lie “particularly within the knowledge of the defendant”\(^\text{18}\) strongly suggest an overlap between what was the “*res ipsa loquitur*” doctrine and the circumstances in which one may apply the *Snell* inference of a causal link. Some authors have developed this concept and suggest that the *Snell* inference is simply an application of the evidentiary rules governing circumstantial evidence.\(^\text{19}\) A close examination of Sopinka J.’s reasons in *Snell* support this proposition. For example, Sopinka J. notes:

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\(^{11}\) A court may abdicate making a finding of fact on standard of care, in which case the claim would be dismissed.

\(^{12}\) See *St-Jean v. Mercier* (2002), 1 S.C.R. 491 at 56.

\(^{13}\) *Snell* at 326 and 328.

\(^{14}\) *Snell* at 330.

\(^{15}\) *Snell* at 329–30.

\(^{16}\) *Snell* at 328.

\(^{17}\) *Snell* at 569.

\(^{18}\) *Snell* at 321 and 328–29.

The legal or ultimate burden remains with the plaintiff, but in the absence of evidence to the contrary adduced by the defendant, an inference of causation may be drawn although positive or scientific proof of causation has not been adduced. If some evidence to the contrary is adduced by the defendant, the trial judge is entitled to take account of Lord Mansfield’s famous precept.20

Lord Mansfield’s precept is that evidence is to be weighed according to the proof which is in the power of one side to have produced and in the power of the other side to have contradicted.21 It is this maxim that underlies the justification provided by Sopinka J. for allowing probable cause to be inferred, notwithstanding the absence of positive evidence of probable cause in medical negligence causes. Sopinka J. summarized the circumstances in which the Snell inference could be relied upon in medical negligence cases as follows:

In many malpractice cases, the facts lie particularly within the knowledge of the defendant. In these circumstances, very little affirmative evidence on the part of the plaintiff will justify the drawing of an inference of causation in the absence of evidence to the contrary.22

D. Evidentiary Rules Governing Circumstantial Evidence

Although the “res ipsa loquitur” doctrine was formally abolished in Canada in Fontaine v. British Columbia, [1998] 1 S.C.R. 424, the doctrine did not disappear; it was simply re-characterized as an evidentiary rule governing the use that could be made of circumstantial evidence. Major J. summarized the evidentiary rule governing circumstantial evidence as follows:

If the plaintiff has no direct or positive evidence which can explain the occurrence and prove that the defendant was negligent, appropriate circumstantial evidence, as defined by the maxim res ipsa loquiter, may be introduced.23

... It would appear that the law would be better served if the maxim [res ipsa loquiter] was treated as expired and no longer used as a separate component action in negligence actions. After all, it was nothing more than an attempt to deal with circumstantial evidence. That evidence is more sensibly dealt with the trier of fact, who should weigh the circumstantial evidence with the direct evidence, if any, to determine whether the plaintiff has established on the balance of probabilities a prima facie case of negligence against the defendant. Once the plaintiff has done so, the defendant must present evidence negating that of the plaintiff or necessarily the plaintiff will succeed.24

The rules of evidence governing the use of circumstantial evidence established by Fontaine define the circumstances in which the Snell inference process may be used. This is reflected by the fact that in circumstances where affirmative evidence has been led by a defendant (on causation), the Snell inference has been found to be inapplicable.25 The reverse is true as well. The plaintiff has the burden

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20 Snell at 330.
21 Blatch v. Archer (1774), 98 ER 969 at 970.
22 Snell at 328-29.
23 Fontaine at para. 25.
24 Fontaine at para. 27.
of proving his case. If evidence existed which could have been led by the plaintiff but was not, the Snell inference cannot be applied.\(^ {26}\) The Snell inference is not well suited to assessing evidentiary gaps that require specialized knowledge. It is better suited to evidentiary gaps were a common sense inference can be meaningfully applied.

E. Application of Circumstantial Evidentiary Rule in Medical Malpractice Cases

In *Moore v. Castlegar & District Hospital*, the plaintiff established that the defendant doctor breached the duty of care owed to the plaintiff by failing to take appropriate spinal x-rays following a motor vehicle accident. At issue was whether the plaintiff’s spinal cord injury occurred in the hospital, or whether the injury occurred at the time of the accident. Both parties led evidence on the issue of causation. The trial judge rejected the plaintiff’s evidence on causation, accepted the defendant’s evidence on causation and dismissed the action. On appeal, the plaintiff contended that the trial judge erred in failing to draw an inference, in the absence of affirmative x-ray evidence,\(^ {27}\) that the defendant’s spinal cord injury occurred after he arrived in the hospital. Hollinrake J.A. determined that, since expert evidence had been led on the causation issue, this was not a circumstance in which the court could rely upon the Snell inference of causation:

> With respect, I think in a case such as this where there is affirmative medical evidence leading to a medical conclusion it is not open to apply “the common sense reasoning urged in Snell v. Farrell.” I take it this is what the trial judge was referring to when she said:
>
> All parties have led evidence on this issue [causation] and it would be inappropriate to resort to an inferential analysis as was argued on the plaintiff’s behalf.

I share that view.\(^ {28}\)

This principle was reaffirmed by our Court of Appeal in *Bigcharles*.\(^ {29}\) In addition, our Supreme Court has interpreted *Moore* as standing for the proposition that the Snell inference approach is limited to situations in which there is no affirmative expert evidence addressing factual causation.\(^ {30}\)

A similar result was obtained in *Bigcharles v. Lomax*.\(^ {31}\) Mr. Bigcharles suffered a spinal injury in a motor vehicle accident, attended at hospital and was later found to have suffered a neurological injury resulting in paraplegia. He had not received an appropriate series of x-rays and the Court had to wrestle with the difficult question whether or not a failure to immobilize Mr. Bigcharles caused or contributed to his ultimate injury. In dissenting reasons, Madam Justice Southin noted at para. 5:

> Because of the nature of the evidence, this case raises what to me is the most elusive concept in the common law—a concept which arises in many branches of the law—“causation.” In the very close case, which this is, that essential ingredient is made not less elusive by being dependent on the doctrine of burden of proof. That doctrine is easy enough to put into words but in every close case its proper application is an

\(^{26}\) See *Sam v. Wilson*, 2007 BCCA 662.

\(^{27}\) Part of the physician’s breach of duty was that appropriate x-rays had not been taken. Had the x-rays been taken there would have been affirmative evidence, one way or the other, with respect to when the spinal cord damage occurred.

\(^{28}\) *Moore* at 105.

\(^{29}\) 2001 BCCA 350 at para. 71.

\(^{30}\) See *Burke-Pietramala* at para. 106; *Miller* at para. 474.

\(^{31}\) 2001 BCCA 350.
intellectual minefield made more dangerous in medical malpractice cases where, if the law is as [defence counsel] asserts, it is all or nothing, by which I mean that no matter how grossly incompetent the physician is, the plaintiff gets nothing unless he can “prove” “causation” or “material contribution” but if he can show a “material contribution” from some act which is on the very borderline of negligence, he may recover an enormous sum of money no matter how tenuous his moral right.

Madam Justice Southin noted:

In my opinion, the only way that a case like this can be fairly decided is upon the judge’s “sense of the moral.”

Her Ladyship further held as follows:

It would not be right by a “formalistic proposition” to deny any recovery to the appellant, but it would equally not be right to hold that he is entitled to recover judgment in the same amount as he would recover from the driver of the other vehicle if that driver had been the sole cause of the collision and the resultant paraplegia.

Southin J.A. would have granted judgment to the plaintiff in the sum of $150,000, an amount which appears to have been intended to reflect either the blameworthiness of the defendant physician’s conduct relative to that of the other tortfeasor or the relative contribution in causal terms of each contributor to the plaintiff’s indivisible injury.

The majority of the Court in *Bigcharles* took a more conventional approach to causation, holding that, because substantial evidence on the issue of causation had been adduced by the defendants, a ruling on the factual evidence was required. That substantial body of evidence had been weighed by the trial judge, who had refused to draw an inference favourable to the plaintiff on causation. Hollinrake J.A. held:

I do not view the principle in *Snell* as being one to permit a trial judge to leap to a conclusion by way of an inference without a full consideration of the evidence during the weighing process. If that process leads to a conclusion that neither party has made out its case on a balance of probabilities where, as here, there is a substantial body of evidence led by the defendants on the issue of causation, it is in my opinion open to the trial judge to decline to draw an inference on this issue.

Further confirmation that the inferential approach is not appropriate in cases where affirmative medical evidence is adduced by the defence on the issue of causation came from the *C.P.M. (Guardian ad litem of) v. Martin* decision.

In *Martin*, a woman gave birth to twins, one of whom was diagnosed with herpes shortly after delivery. She brought an action in negligence against Dr. Martin, a specialist in obstetrics and gynecology, for failing to diagnose her genital herpes. The mother also sued, as guardian ad litem of one of the twins, claiming that the infant contracted herpes in the birth canal during delivery, a result which could have been avoided if Dr. Martin diagnosed her herpes in a timely fashion and recommended birth by caesarean section. Dr. Martin was found negligent at trial for failing to properly test the mother for, and exclude the diagnosis of, herpes. However, the infant plaintiff’s claim was dismissed on the basis that causation had not been proven.

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35 2006 BCCA 333.
There were three possible periods during which herpes could have been acquired by the infant plaintiff in Martin: in utero, during birth, and post-birth in the hospital nursery. Only if the Court could find that herpes was contracted during birth could it hold that Dr. Martin’s negligence in failing to diagnose herpes and recommend birth by caesarean section, which the mother would have accepted, caused the injury.

Each party called expert evidence on the issue of the medical degree of likelihood that the infant plaintiff contracted herpes during delivery. The plaintiff’s expert opined, based on the fact that 90-95% of cases of neonatal herpes infections occur at the time of delivery, it was more likely that the infant plaintiff also contracted herpes during delivery. The defence’s expert did not disagree with the plaintiff’s expert’s statistics, but concluded that specific facts made it more likely that the infant plaintiff’s case fell in the exceptional category of cases in which herpes was contracted in utero or after delivery. The most significant fact favouring this conclusion was that the infant plaintiff’s twin, who was delivered first and was thus exposed to hours of broken membranes and maternal genital secretions, had not contracted the virus.

Having heard both experts’ evidence, the trial judge concluded that there were two equally plausible theories of causation and that the infant plaintiff’s case did not cross the necessary threshold of proof of causation on a balance of probabilities.

On appeal, the infant plaintiff argued that the trial judge erred in failing to apply the robust and pragmatic approach in Snell to the issue of causation. The basis of the infant plaintiff’s argument was that in the absence of “definitive medical proof on a balance of probabilities, it was incumbent on the trial judge to instead apply the Snell approach.” If she had applied Snell, the argument went, the trial judge would have concluded that Dr. Martin’s negligence “materially contributed” to the risk that the infant plaintiff would acquire the virus during birth, amounting to proof of causation. The Court of Appeal disagreed with this argument, noting that the defence led ample evidence that the virus had not been contracted during delivery and that, based on that evidence, the trial judge concluded that the plaintiff failed to establish causation on a balance of probabilities. Snell, in the opinion of the Court of Appeal, did not stand for the proposition that, as the infant plaintiff’s argument implied, a “tie means that the plaintiff succeeds or, to put it another way, that 50% equals 51%.” Further, in distinguishing the Martin case from the Snell case, the Court of Appeal noted:

The defendant in Snell negligently failed to detect and treat a condition that might have led directly to the plaintiff’s blindness in one eye. Dr. Martin did not cause the adult plaintiff to have genital herpes. He did not alter her physical condition. His negligence was his failure to pursue medical investigation that would have resulted in the correct diagnosis. Had he made the correct diagnosis, the risk of either twin contracting herpes during birth would have been lessened by resort to caesarean section, although some risk would have continued. But the question still remained as to whether the infant plaintiff contracted the virus during birth or as a result of one of the other possible causes. The expert evidence was directed to that question. ... The ability of the medical experts in this case to render a subjective opinion as to the likely cause of the infant plaintiff’s exposure to the virus was not obscured by anything done or not done by Dr. Martin.

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36 Ibid., at para. 39.
37 Ibid., at para. 41.
38 Ibid., at para. 39.
39 Ibid., at para. 56.
Another example of a defendant leading “evidence to the contrary” to prevent the drawing of an inference of causation from circumstantial evidence as per Snell is the case of Sam v. Wilson.40

In Sam, the defendant doctor and provincial nurses were found negligent in failing to monitor Mr. Sam while he was taking certain medication with potentially serious side effects. The trial judge held that it could be inferred on the basis of Snell that the defendants’ negligence caused Mr. Sam’s liver failure. On appeal, the trial judge’s finding of causation was overturned.

Mr. Justice Smith, speaking for the majority in Sam, held that because the defendant, Dr. Wilson, led expert evidence that proper monitoring (in accordance with hospital protocols) would not have likely disclosed the abnormally elevated liver enzymes at the time when such disclosure would have altered the outcome for Mr. Sam, there was no support for the finding that Dr. Wilson’s failure to monitor Mr. Sam was a cause of his liver failure. This was, in the opinion of Smith J.A., “evidence to the contrary” to an inference that Dr. Wilson’s negligence caused Mr. Sam’s liver failure.41 Therefore, causation could not be proven on a “but for” test by resorting to a common sense inference on the basis of Snell.

The initial consideration of McGhee and Wilshire in Canada, as reflected in the judgment in Snell, led to a refusal to shift the onus of proof of causation and a reiteration of the “but for” test. However, it also led to confirmation that the onus could be discharged, in appropriate cases, by little positive evidence. An inference of causation would be more readily drawn where the defendant did not call evidence on causation and even more readily drawn in cases where the defendants were uniquely qualified to lead such evidence but failed to do so. After Snell, defendants should consider leading evidence on causation to avoid inviting the court to draw inferences from circumstantial evidence.

Whether the inference is legal or factual has been the result of academic debate. The courts are reluctant to apply the Snell inference where the inference to be drawn is not a factual gap within the knowledge of the defendant but a true knowledge gap in the sense that no one knows whether or not there is a causal link between the tortuous activity and the damage. In the case of the latter, one cannot rely on a common sense approach to arriving at an answer because the causal link consists of nothing more than a guess which is more likely to be wrong than right.42 This was noted by the majority of the BC Court of Appeal in Sam:

[143] Thus, in order to find that Dr. Wilson’s failure to adhere to the TB Protocol caused Mr. Sam’s liver failure, the trial judge would have had to conclude that blood tests in early or mid-March would likely have disclosed abnormally elevated liver enzymes. That was not an inference open to the trial judge to draw, since the inference is not a matter of common sense. Whether and when abnormally elevated liver enzymes would have been present in Mr. Sam’s blood was a question requiring the skill, scientific training, special knowledge, and experience of an expert in the field. It is the type of inference for which judges and juries require the assistance of experts: see R. v. Abbey, 1981 CanLII 510, [1982] 2 S.C.R. 24 at 42 where Dickson J. (as he then was), giving judgment for the court, said,

With respect to matters calling for special knowledge, an expert in the field may draw inferences and state his opinion. An expert’s function is precisely this: to provide the judge and jury with a ready-made inference which the judge and jury, due to the technical nature of the facts, are unable to formulate. “An expert’s opinion is

40  2007 BCCA 622.
41  Ibid., at para. 142.
42  I say more likely to be wrong than right because there is invariably more than one potential cause for an effect.
admissible to furnish the Court with scientific information which is likely to be outside the experience and knowledge of a judge or jury. If on the proven facts a judge or jury can form their own conclusions without help, then the opinion of the expert is unnecessary” (Turner (1974), 60 Crim. App. R. 80 at 83, per Lawton L.J.)

Applying the Snell inference in such a situation reduces causation to a popularity contest where the popular are rewarded and the unpopular punished at the discretion of the court.

F. Conclusions on Inferences of Causation

In BC, the circumstances in which a court may draw an inference of causation are more limited in medical negligence cases than Sopinka J.’s initial wording in Snell might lead one to suspect. The first limitation is that the “but for” test must not be appropriate. If affirmative evidence on causation has been led the “but for” test must be applied. Affirmative evidence can be led by the plaintiff or the defendant. If affirmative evidence could have been led by the plaintiff but was not, the plaintiff has failed to prove his case and the Snell inference should not be applied. The second limitation is that the Snell inference is constrained by the current evidentiary law governing inferences that may be drawn from circumstantial evidence. The Snell inference is not appropriately applied in circumstances where common sense inferences cannot be reliably applied. If the “but for” test cannot be applied and the Snell inference is not appropriate one must then determine if the circumstances are appropriate to apply the “material contribution” test. These circumstances were summarized by the British Columbia Court of Appeal in Clements (Litigation guardian of) v. Clements43 and are dealt with at length later in this paper.

V. Loss of Chance

When a plaintiff must establish a loss on a balance of probabilities, difficulties arise if the tortious conduct of a defendant deprives the plaintiff of a chance of avoiding an injury of less than 50%.44 The idea that a plaintiff may recover for the “lost opportunity,” even if the chance of that opportunity materializing again was less than 50%, was first set out in Chaplin v. Hicks.45

A. Chaplin v. Hicks

In Chaplin, the plaintiff entered into a beauty contest in which 12 winners would be awarded prizes. The plaintiff was selected as one of the 50 finalists for one of the 12 prizes, but the defendant failed to properly notify her and she lost her chance at the prize. The Court concluded that her chances of winning the prize were 12 out of 50, or 24%. Despite the fact that the plaintiff could only prove a possible loss, as opposed to a loss on a balance of probabilities, the Court held that the defendant had breached his contract by failing to use reasonable efforts to notify the plaintiff. The plaintiff was awarded nominal damages of £100. Chaplin established the principle that, at least in contract cases, damages could be awarded for lost chances, even when the chances were well under the traditional “but for” threshold of 50%.

43 2010 BCCA 581 at paras. 48-63.
44 The problem is that damages cannot be proven on a balance of probabilities. If a plaintiff establishes that he or she lost a 10% chance of avoiding a loss, the loss is only a possibility, not a probability, and cannot be established on a balance of probabilities.
45 [1911] 2 K.B. 786.
B.  Seyfert v. Burnaby Hospital Society

One example of the application of the “loss of chance” doctrine is *Seyfert v. Burnaby Hospital Society.* In *Seyfert*, the plaintiff injured his abdomen. The Court found that the treating physician failed to provide him with appropriate treatment and his failure resulted in a delay in obtaining appropriate treatment. The issue at trial was whether the delay in providing the plaintiff with treatment made the plaintiff more susceptible to complications. Relying on *McGhee v. National Coal*, McEachern C.J.S.C., as he then was, held that the negligence had materially contributed to the risk of complications and awarded 25% of the damages representing the “loss of chance” of avoiding the complications and a longer period of convalescence.

C.  Hotson v. East Berkshire Area Health Authority

McEachern C.J.S.C.’s approach was explicitly rejected in England by the House of Lords in *Hotson v. East Berkshire Area Health Authority.* In *Hotson*, a child fell from a tree and received negligent treatment from a doctor. The trial judge found that there was a 75% chance that the child’s eventual loss occurred even with appropriate care, and awarded 25% of the damages on that basis. The House of Lords analyzed the trial judge’s finding and found that the plaintiff had only established a possible loss. Since the plaintiff had failed to prove “but for” causation on the balance of probabilities, the case was dismissed against the physician.

D.  Laferriere v. Lawson

The applicability of the “loss of chance” doctrine in a medical negligence setting was considered by the S.C.C. in *Laferriere v. Lawson.* In *Laferriere*, the defendant physician failed to advise a plaintiff that she had cancer, of which she died in 1978. The issue before the Court was whether the plaintiff, who had not been informed of the diagnosis of cancer, should be compensated for the “loss of chance” of obtaining treatment and possibly avoid her subsequent death. The opinion evidence clearly established that the loss of any benefit of treatment, if it existed at all, was substantially less than 50%. The Supreme Court of Canada clearly rejected the notion of compensation for a “loss of chance” in tort, confining recovery to cases where breach of duty is linked to damages on a balance of probabilities. Gonthier J. rejected the application of the “loss of chance” doctrine in medical negligence cases:

> I do not feel it is appropriate to focus on the degree of probability of success and to compensate accordingly …

... 

It is only in exceptional loss of chance cases that a judge is presented with a situation where the damage can only be understood in probabilistic or statistical terms, and where it is impossible to evaluate sensibly whether or how the chance would have been realised in that particular case. The purest example of such a lost chance is that of the lottery ticket which is not placed in the draw due to the negligence of the seller of the ticket. The judge has no factual context in which to evaluate the likely result other than the realm of pure statistical chance. Effectively,

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49  *Laferriere* at 610.
the pool of factual evidence regarding the various eventualities in the particular case is dry in such cases, and the plaintiff has nothing other than statistics to elaborate the claim in damages.

...

I am not prepared to conclude that particular medical conditions should be treated for purposes of causation as the equivalent of diffuse elements of pure chance, analogous to the nonspecific factors of fate or fortune which influence the outcome of a lottery.50

E. de la Giroday v. Brough

The issue of “loss of chance” was considered by our Court of Appeal in de la Giroday v. Brough.51 In de la Giroday, the plaintiff suffered from necrotizing fasciitis. The condition was not diagnosed initially by the emergency physician and the plaintiff’s diagnosis and treatment were delayed. The expert evidence accepted by the Court was that a possibility existed that the plaintiff would have been diagnosed earlier if he had been referred to a tertiary care facility but the evidence of this did not rise above a possibility. The majority of the BC Court of Appeal held that the action against the defendant physician sounded in both contract and tort, but that the tort action was barred by the “loss of chance” doctrine. The majority concluded—in absence of any specific pleading or evidence—that a contract existed between the plaintiff and the defendant and that every breach of contract entitled the innocent party to at least some damages, even if nominal. In the result, the majority found the contractual “loss of chance” approach could be applied in medical negligence cases. Southin J.A. noted:

For the loss of chance approach to apply in this country in actions of tort would require either a legislative amendment or a decision to that effect of the Supreme Court of Canada. But I see no legal impediment to applying the approach of Dylan L.J. [in Hotson v. East Berkshire Area Health Authority] to an action in contract for breach of the implied obligation to exercise reasonable care and skill.

The result was that the BC Court of Appeal ordered a new trial to decide whether there was a breach of contract and whether, and to what extent, the plaintiff suffered a “loss of chance.” It is important to recognize that this decision was rendered in the context of the old Medical Service Act, R.S.B.C. 1979, c. 255 and the Medical Service Plan Act, R.S.B.C. 1981, c. 18. Southin J.A. emphasized that her decision was only binding on actions arising from the old legislation:

I say that only that the relationship between the patient and physician remain contractual. As to whether it does so now under the replacement statute, the Medicare Protection Act, R.S.B.C. 1996, c. 286, first enacted in 1992, c. 76 of that year, I make no comment.

In Oliver (Public Trustee of) v. Ellison,52 Southin J.A. appears to adopt the position of the majority of the Court of Appeal in de la Giroday. Southin J.A. notes, at para. 35:

I think there may be here some confusion to which I may have materially contributed. The principal question in de la Giroday v. Brough was whether the appellant had a cause of action for Dr. Brough’s breach of duty. We found that he did on the footing that there was a contract between them and that every breach of contract imports damage (para. 34). In other words, damage is not the gist of an

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50 Laferriere at 603-5.
52 2001 BCCA 359.
action for breach of contract. For that reason, the court directed a new trial. It may
be said with some justice that the discussion of “loss of chance” was obiter. It can
also be said that, as counsel for the respondent physician in that case gave no analysis
to the court of the Medical Services Plan, it is now open to the present respondents
to argue that upon its true construction, it is a scheme of the same order as that
which led to the courts in *Hotson v. East Berkshire Area Health Authority*, infra,
proceeding on the footing that the only action which the plaintiff could have
sounded in tort. I agree the point is open.

In coming to its decision in *de la Giroday*, our Court of Appeal noted that *Laferriere* was a civil law
case which did not, in any way, address the implications at common law of contract for medical
services in BC. After *de la Giroday*, the Supreme Court of Canada in *Arndt v. Smith* suggested that
the principles in *Laferriere* should be equally applicable in common law jurisdictions. McLachlin J., as
she then was, went on to say at para. 43:

> This approach accords with the decision of this court in *Laferriere v. Lawson*, [1991] 1 S.C.R. 541 which held (at p. 609) that causation “must be established on the balance of probabilities, taking into account all the evidence: factual, statistical and that which the judge is entitled to presume.” It is consistent with the view there expressed that “statistical evidence may be helpful as indicative but is not
determinative,” and that “where statistical evidence does not indicate causation on the balance of probabilities, causation in law may nonetheless exist where the
evidence in the case supports such finding.” While *Laferriere* arose in the context of the
civil law effect, Gonthier J., speaking for a majority of the court, made extensive
reference to common law jurisdictions, suggesting that the principles discussed may
be equally applicable in other provinces.

**F. No Prima Facie Action in Contract in Medical Negligence Cases?**

The issue as to whether an action lies in medical negligence in contract or tort was further considered
by our Court of Appeal in *Letvad v. Fenwick*. Esson J.A. noted for the Court, in the context of an
application to amend this statement of claim to plead, *inter alia*, breach of contract in the provision of
medical care, the following:

> The remaining question arises from the fact that the amended Statement of Claim
raised for the first time an allegation of a breach of contract against the hospital. The
plea now raised no fresh factual issues. Primarily, it is an acknowledgement of the
view that contract and negligence exist concurrently in circumstances such as are
purpose of raising that plea appears that it might open the way to damages being
assessed on the basis on a loss of chance - an approach which is not available in a
negligence action. It may be doubted that, as a matter of law, such a claim can
succeed.

In *Oliver (Public Trustee of) v. Ellisoni*, the trial judge applied *Laferriere* to dismiss a claim for “loss of
chance” at para. 25:

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54 *de la Giroday* at para. 40.
57 *Letvad v. Fenwick* at para. 45.
At most, the evidence of Ms. Soolsma establishes that by virtue of failing to contact the nursing supervisor, who may have chosen to override Dr. Mitchell, there was the “loss of a chance” that Ms. Oliver’s clinical management may have been altered by Dr. Mitchell. It is clear that an increased possibility of injury as a result of a failure in medical care (otherwise described as a “loss of chance”) is not compensable.\textsuperscript{59}

This decision was appealed, with the plaintiff arguing that the Court of Appeal ought to entertain a claim in contract. The majority disagreed, given that the claim was not advanced in the court below.\textsuperscript{60}

\section*{G. St-Jean v. Mercier}

In \textit{St-Jean v. Mercier},\textsuperscript{61} a case decided under Quebec civil law,\textsuperscript{62} the Supreme Court emphasized that what it said in \textit{Laferriere} was “worth repeating.” In \textit{St-Jean}, the plaintiff sued his orthopedic surgeon for injuries arising out of his treatment following a motor vehicle accident. The lower court found that appropriate medical care, through early immobilization and diminution of the swelling of the spinal cord, offered “chances of recuperation that were more than simple possibilities.” The Supreme Court of Canada noted:

\begin{quote}
... the Court of Appeal basically found the likelihood of an early immobilization leading to recuperation to be somewhere on the spectrum in between the poles of possibility and probability: greater than the realm of what is merely possible but still not enough to meet the threshold of probability. The initial harm of the accident simply outweighed any kind of effect the faulty treatment might have had, to the point where it cannot be said on a probabilistic basis that the faulty treatment had any causal effect. It is worth repeating the traditional principle set out in \textit{Laferriere v. Lawson}, [1991] 1 S.C.R. 541, at pp. 608-609, where I found that causation must be established on a balance of probabilities and that the loss of a mere chance cannot be a compensable harm. (at page 38). Accordingly, the chances of recuperation in this case were not significant enough on a balance of probabilities to establish that the faulty treatment caused the harm suffered.
\end{quote}

\section*{H. Fraser Park South Estate Limited v. Lang Michener Lawrence & Shaw et al}

The rejection of the “loss of chance” doctrine in tort, and its limitation to nominal damages in contract, was affirmed in a majority decision by our Court of Appeal in \textit{Fraser Park South Estate Limited v. Lang Michener Lawrence & Shaw et al.}\textsuperscript{63} In dissent, Southin J.A. would have awarded more than nominal damages based on a breach of contract, but, of significance to causation in alleged medical negligence cases, noted that “loss of chance” is generally not applicable in tort actions:

\begin{quote}
45. It is necessary to struggle with “causation” when the claim sounds in tort, for proof that the lack of reasonable care caused damage is of the essence of the tort of negligence. That causal connection must be proven on a balance of probabilities but in contract the cause of action is complete once the breach is established. See the discussion of this point in my judgment in \textit{de la Giroday v. Brough} (1997), 33 B.C.L.R. (3d) 171 (C.A.), which I shall not repeat here.\textsuperscript{64}
\end{quote}

\begin{itemize}
\item \textsuperscript{59} \textit{Laferriere}.
\item \textsuperscript{60} (2001), 90 B.C.L.R. (3d) 101 (C.A.).
\item \textsuperscript{61} [2002] 1 S.C.R. 491.
\item \textsuperscript{62} The Supreme Court of Canada has consistently indicated that the principles governing medical negligence cases in civil law jurisdictions are, generally, applicable in common law jurisdictions.
\item \textsuperscript{63} (2001), 146 B.C.A.C. 86. This is not a case involving alleged medical negligence.
\item \textsuperscript{64} (2001), 146 B.C.A.C. 86 at para. 45.
\end{itemize}
I. **Other Noteworthy Decisions**

The “loss of chance” doctrine was rejected in the medical negligence context by the Ontario Court of Appeal in *Cottrelle v. Gerrard*. In *Cottrelle*, not only did the Ontario Court of Appeal confirm that recovery on the basis of “loss of chance” is not available to plaintiffs in medical negligence case, but the Court noted that it was bound by the cases of *St-Jean* and *Laferriere*.

Similarly, in the UK, the majority of the House of Lords in *Gregg v. Scott* rejected the introduction of a loss of chance approach. In rejecting the “loss of chance” doctrine, Lord Hoffman noted that a wholesale adoption of possible rather than probable causation as the criterion of liability would be so radical a change in law as to amount to a legislative act:

89. In *Fairchild’s* case [2003] 1 AC 32, 68, Lord Nicholls of Birkenhead said of new departures in the law:

   To be acceptable the law must be coherent. It must be principled.
   The basis on which one case, or one type of case, is distinguished
   from another should be transparent and capable of identification.
   When a decision departs from principles normally applied, the basis
   for doing so must be rational and justifiable if the decision is to
   avoid the reproach that hard cases make bad law.

90. I respectfully agree. And in my opinion, the various control mechanisms
proposed to confine liability for loss of a chance within artificial limits do not pass
this test. But a wholesale adoption of possible rather than probable causation as the
criterion of liability would be so radical a change in our law as to amount to a
legislative act. It would have enormous consequences for insurance companies and
the National Health Service. In company with my noble and learned friends Lord
Phillips of Worth Matravers and Baroness Hale of Richmond, I think that any such
change should be left to Parliament.

*Gregg* was relied upon by Garson J. in *Seatle (Guardian ad litem) v. Purvis* to reject a “loss of chance” argument in an alleged medical negligence action.

*Seatle* was an obstetrical malpractice action where the plaintiff argued that the causation analysis may be abridged or modified in cases where breach of duty materially increases the risk of an adverse outcome. That argument is dealt with at length below. At the conclusion of her reasons for judgment, however, Madam Justice Garson notes that the plaintiff’s analysis is “akin to arguing that she lost her chance of a better outcome” by the general practitioner’s failure to call an obstetrician to attend. Her Ladyship succinctly states:

   To date, the law in Canada or in the United Kingdom does not attach liability to a
defendant upon proof only of the loss of a chance of a better outcome (see *Athey* at

The trial judge’s conclusion on causation in *Seatle* was upheld on appeal. Madam Justice Kirkpatrick, speaking for the Court, held that the plaintiffs only proved that the outcome “might have been better, not that it would have been better” absent medical negligence, which, the trial judge correctly held, was insufficient to meet the requisite standard of proof of causation.

67  2005 BCSC 1567.
68  *Seatle* at note 71, para. 177.
While the courts have expressed considerable sympathy for plaintiffs who have suffered the loss of a chance of a better outcome as a result of medical negligence, the door appears to remain shut to such claims. A similar result was reached in Ontario in *McPherson v. Bernstein*\(^71\) in which a “loss of chance” argument was rejected in a case of delayed diagnosis of breast cancer. In *McPherson*, the Court noted that the “but for” test is applicable in medical malpractice cases.

It is very doubtful whether, in BC, there is any remaining room to argue that a contractual relationship between physicians and patients will support the claim for damages for the loss of a chance. There may be some room for that argument in a health care system that permits access to private care outside the Medical Services Plan but, in principle, *St.-Jean* should apply. There appears to be little appetite in other common law jurisdictions for a contractual analysis. Further, the judgments of Gonthier J. in the civil law cases suggest that what distinguishes medical cases is not that they arise out of a duty of care in negligence, as opposed to a contractual duty of care, but in most cases, at the time of trial, scientific evidence will permit the court to make a finding of fact with respect to whether or not the injury in question could have been avoided by appropriate care.

**J. Conclusions on Loss of Chance**

“Loss of chance” in a medical negligence action is limited to situations when the plaintiff can establish a contractual relationship between himself or herself and the physician, and may result in restricting damages to a nominal amount.

**VI. Material Contribution**

*Athey v. Leonati*\(^72\) represents the Supreme Court of Canada’s next consideration of the “but for” test after *Snell*. In *Athey*, the Court ruled that in some circumstances it is sufficient to prove that it is more likely than not that a defendant “materially contributed” to an injury in order to satisfy a causal link to damages. If indeed *Snell* is limited to factual inferences, *Athey* laid the groundwork upon which legal inferences could be drawn by the court.

**A. Athey v. Leonati**

In *Athey*, the plaintiff had a history of back problems. He was involved in two successive motor vehicle accidents. The defendants in each accident admitted liability. Following the second motor vehicle accident, the plaintiff suffered a disc herniation while stretching in a health club. The plaintiff sued the two defendants who had caused the prior accidents. At trial, the only issue was whether the disc herniation was caused by the injuries sustained in the accidents, or whether they were attributable to the plaintiff’s pre-existing back condition. The trial judge held that, although the accidents were not “the sole cause” of the disc herniation, they played “some causative role,” which was assessed at 25%. The trial judge then awarded the plaintiff 25 percent of the damages to represent the reduced role of the accidents.

The Supreme Court of Canada held that the defendants were liable for all the plaintiff’s damages on the basis that their negligence was proven to have caused or materially contributed to the plaintiff’s injuries. The Supreme Court of Canada noted that a contributing factor was material if it falls outside the *de minimis* range. Once it is established that the defendant’s breach is a “materially contributing cause” of the plaintiff’s injury, the defendant will be fully liable for the plaintiff’s damages caused by his fault. The defendant is not excused from liability merely because other causal factors, for which he


or she is not responsible, helped to produce the plaintiff’s damages. The issue as to when one may use the “material contribution” test to replace the “but for” test is controversial. Athey itself provides little guidance with respect to when the “material contribution” test can be applied; however, it is clear that, no matter whether the “but for” test or the “material contribution” test is used, the plaintiff has the burden of establishing causation on a balance of probabilities. This was affirmed by the Supreme Court of Canada in Blackwater v. Plint.

B. Walker Estate v. York Finch General Hospital

The difficulty in determining when the “material contribution” test should be applied is illustrated by the Supreme Court of Canada decision in Walker Estate v. York Finch General Hospital. In Walker Estate, three plaintiffs contracted AIDS from blood and blood products supplied by the Canadian Red Cross Society before the ability to test for HIV in blood existed. The Red Cross screening procedures included a questionnaire which was given to potential donors. The questionnaire did not ask symptom-specific questions about HIV. Thus, the donors, after filling out the questionnaire, would not have identified themselves as people who might have HIV. The Court determined that the Red Cross Society was negligent in not asking symptom-specific questions about HIV in their questionnaires.

The causation question ultimately turned on whether the infected donor would or would not have donated the tainted blood if he or she had been provided the appropriate questionnaire. The Court decided to approach the question of causation by applying the “material contribution” test. According to the Court, the Red Cross’ negligence in failing to screen donors who were at risk of having HIV was a material contribution, falling outside the de minimis range to the occurrence of the plaintiff’s injury. At para. 88, the Court noted:

In cases of negligent donor screen, it may be difficult or impossible to prove hypothetically what the doctor would have done had he or she been properly screened by the CRCS (the Red Cross). The added element of donor conduct in these cases means that the but for test could operate unfairly, highlighting the possibility of leaving legitimate plaintiffs uncompensated. Thus, a question in cases of negligent donor screen should not be whether the CRCS’ conduct was a necessary condition for the plaintiff’s injuries using the “but for” test but whether the conduct was a sufficient condition. The proper test for causation in cases of negligent donor screen is where the defendant’s negligence “materially contributed” to the occurrence of the injury. In the present case, it is clear that it did. “A contributing factor is material if it falls outside the de minimis range.” (See Athey v. Leonati, [1996] 3 S.C.R. 458 at para. 15). As such the plaintiff retains the burden of proving that the failure of the CRCS to screen donors with tainted blood materially contributed to Walker contracting HIV from tainted blood.

After Walker Estate, it is difficult to understand when the “material contribution” test may be used to establish causation. Until Walker Estate, it appeared that the use of the “material contribution” test was limited to cases of cumulative causation. Application of the “but for” test would have nullified the plaintiff’s claim in Walker Estate; the plaintiff’s contraction of AIDS would only be actionable if the contraction of the disease was caused by a donation that would have been avoided by a proper

76 2005 SCC 58 at para. 78.
screening. The Supreme Court of Canada noted that it was not possible to present any evidence on
that central issue. Therefore, the Court applied the “material contribution” test in order to establish
causation. Paragraph 88 of Walker Estate appears to suggest that the expansion of the “but for” test is
limited to cases involving negligent donor screening. Alternatively, one could argue that the
negligence of the Red Cross caused an increase in risk of the type of harm that developed and that the
causal link was based upon an increase in the risk of harm. This interpretation is compelling because
it is consistent with the subsequent House of Lords decisions of Fairchild and Gregg.

C. St-Jean v. Mercier

The central issue raised by Walker Estate, in the medical negligence context, is whether the
circumstances in which the “material contribution” test could be applied will be expanded to enable
plaintiffs to recover for damages causally linked to conduct on less than a balance of probabilities. The
Supreme Court of Canada clarified that, regardless of Walker Estate, one must still prove causation in
medical negligence cases on a balance of probabilities.

In St-Jean v. Mercier, the plaintiff was hit by an automobile and transported by ambulance to a
hospital. He had open fractures in both legs and was bleeding from the head. He underwent emergent
surgery for his legs, and a subsequent surgery thereafter. After discharge, it was determined that he
had suffered a fracture at the T7 level and went on to develop paraparesis in his legs. The defendant
physician did not fully investigate or treat the injury to the plaintiff’s spine. The trial judge
determined that the care provided by the defendant physician was appropriate and that the lack of
treatment of the spinal fracture was not causally linked to the plaintiff’s paraparesis. The Court of
Appeal reviewed the findings of the trial judge and determined that the defendant physician breached
the standard of care in not making further inquiries into the plaintiff’s spinal fracture. However, the
Court of Appeal concluded that, notwithstanding the faults committed by the physician, the accident
was the legal cause of the plaintiff’s paraparesis, and there was no causal link between the delayed
diagnosis and the plaintiff’s injuries.

At the Supreme Court of Canada, the plaintiff strenuously argued that the circumstances required that
the Court draw an inference of causation against the defendant physician. The plaintiff noted that the
defendant physician created a risk and that the harm subsequently occurred within the ambit of the
risk created such that there should be an inference of causation. In addition, the plaintiff argued that
the defendant’s negligence deprived the plaintiff of some important means of proof and therefore there
should be a reversal of the burden of proof onto the defendant to show that his fault did not cause the
damage. The Supreme Court of Canada rejected both of these arguments, noting:

The Court of Appeal appropriately said that it was insufficient to show that the
defendant created a risk of harm and that the harm subsequently occurred within the
ambit of the risk created. To the extent that such a notion is a separate means of
proof with a less stringent standard to satisfy, Snell, supra, and definitely Laferriere,
supra, should have put an end to such attempts at circumventing the traditional rules
of proof and the balance of probabilities. There may be a misapprehension of what I
said in Laferriere, supra, at page 609:

78 This is problematic because it is difficult to distinguish between what is a loss of chance, and what is an
increase in the risk of harm.

79 2002 SCC 15.

80 Interestingly, there were two trial judges in St-Jean v. Mercier. The original judge was unable to complete
the trial due to illness.

81 These were essentially the same arguments relied upon by the plaintiff in Walker Estate.
In some cases, where a fault presents a clear danger and where such a danger materializes, it may be reasonable to presume a causal link, unless there is a demonstration or indication to the contrary.

This is merely a reiteration of the traditional approach on presumptions and does not create another means of proof in Quebec civil law in the establishment of the causal link. The Court of Appeal correctly interpreted this passage as pertaining to presumptions within the traditional rules of causation.\(^{82}\)

*St-Jean* is important because it indicates that the circumstances when the “material contribution” test are expanded are limited in the medical negligence context. Applying the “material contribution” test to situations involving multiple causative effects is synonymous with allowing recovery for “loss of chance.”\(^{83}\) The Supreme Court of Canada affirmed that causation must be proven using the “but for” test on a balance of probabilities and one cannot adapt the “material contribution” test to circumvent this requirement.

**D. Cottrelle v. Gerrard**

*Cottrelle\(^{84}\)* is a leading case on causation in the medical negligence context. Ms. Cottrelle was a diabetic who was at high-risk for the development of a vascular disease, a risk which was further increased by the fact that she was Aboriginal and a smoker. She developed a sore between her toes and saw her physician, who prescribed a topical cream. No arrangements for a follow-up visit were made, and the physician did not re-examine the plaintiff’s foot until she subsequently visited him five weeks later. Five weeks after that visit, she attended at an emergency department of a hospital where the emergency physician prescribed oral antibiotics. She arranged to see her physician a few days after her emergency department visit. The physician did not examine her foot and referred her to a skin specialist, which was scheduled approximately two months later. Three months after that visit to her physician, the plaintiff’s foot developed gangrene and required amputation.

The plaintiff’s theory of causation was that her physician should have admitted her to hospital for more aggressive treatment and that, had he done so, the infection could have been controlled through antibiotics or the amputation of a toe as opposed to the plaintiff’s leg. The physician’s theory of causation was that, given the serious nature of the infection, more aggressive treatment would not have made any difference. The trial judge determined that the defendant’s failure to provide more aggressive treatment to the plaintiff caused her injuries. The trial judge based her analysis of the causation on the basis that the physician’s lack of action materially contributed to the development of a deeper infection, which materially contributed to the development of gangrene and the resulting need for a below-knee amputation.

At the Ontario Court of Appeal, plaintiff’s counsel conceded that there was no evidence suggesting that it was more likely than not that had the defendant lived up to the standard of care, the plaintiff’s leg would have been saved. Plaintiff’s counsel argued that the evidence of a possibility, lower than a probability, that the respondent’s leg might have been saved satisfied the “material contribution” test in *Athey*. The Court of Appeal rejected this submission:

> The “but for” test has been relaxed as “unworkable” in cases where, practically speaking, it is impossible to determine the precise cause of the injury. In *Athey*, for

\(^{82}\) *St-Jean* at para. 116.

\(^{83}\) If one were to apply the material contribution test in a delay in diagnosis case one would be able to prove causation; however, if one were to analyze the situation with the “but for” test liability can generally not be proven on a balance of probabilities. Application of the “loss of chance” doctrine would preclude recovery of damages in tort.

example, the Supreme Court affirmed the “material contribution” test as a qualification to the strict “but for” test only when used in cases similar to Bonnington Castings Ltd. v. Wardlaw, supra [[1956] 1 All E.R. 615 (H.L.)], and McGhee v. National Coal Board, supra [[1972] 3 All E.R. 1008 (H.L.)]. The House of Lords decision in Fairchild v. Glenhaven Funeral Services Ltd., [2002] 3 All E.R. 305 (H.L.), also reflects this same tendency to depart from the “but for” standard, but only where the precise cause of the injury is unknown. Bonnington, McGhee, and Fairchild all involved situations where the plaintiff was exposed to a harmful substance from various sources, but could not prove precisely that the substance resulting from the defendant’s tortious conduct caused the loss. In Fairchild, the plaintiffs had been exposed to asbestos while working for various employers for various periods. The plaintiffs developed a fatal disease caused by asbestos, but could not establish which exposure or exposures to asbestos had actually caused the disease. The House of Lords allowed the plaintiffs’ appeals form lower court decisions dismissing their claims and held that they were entitled to recover. The salient feature of Fairchild was that the plaintiffs were definitely injured by the negligence of one of the defendants, and there was no other operative cause or explanation for the injury. As pointed out in Lewis N. Klar, Tort Law, 3rd ed. (Toronto: Thomson, 2003) at 400: “courts will strive to fashion a just solution in this type of case to allow a wronged plaintiff to recover. Courts will not allow wronged plaintiffs to fall between the cracks due to the formal requirements of proving cause.”

In my view, the principle followed in this line of cases does not assist the respondent. In the case at bar, there is no practical uncertainty as to the impact of the appellant’s wrongful conduct upon the plight of the respondent. It was clearly established that the respondent lost her leg because of an infection. The question was whether the appellant could have prevented an outcome that was unquestionably caused by the infection and the respondent’s pre-existing vascular condition. The evidence demonstrated that it is more likely than not that even if the appellant had lived up to the standard of care, the respondent would have lost her leg.

Nor, in my view, is the respondent assisted by the principle established in Snell v. Farrell, supra [[1996] 2 S.C.R. 311, 72 D.L.R. (4th) 289]. Snell involved a situation in which the plaintiff became blind following cataract surgery. The court found the defendant negligent in proceeding with the operation despite retrobulbar bleeding. The expert witnesses who testified were unable to say with certainty what caused the plaintiff’s blindness, but the retrobulbar bleeding was found to be a possible cause. In Snell, Sopinka J. held that the plaintiff did not need to prove with scientific precision that the bleeding was the cause of her blindness, particularly since the facts as to precisely what had occurred during the surgery were within the knowledge of the defendant.

The “robust and pragmatic” approach to proof of causation utilized in Snell v. Farrell does not assist the respondent. In the case at bar, there is no uncertainty over why Darlene Cottrelle suffered the amputation of her leg and this is not a case where the appellant is in a better position to say what happened. Here, the issue is not whether the appellant created a situation that might have caused the respondent’s loss. Instead, the issue is whether the appellant could have prevented the loss of the respondent’s leg in any event. In this case, the experts agree that it is more likely than not that even if the appellant had met the appropriate standard of care, the respondent still would have lost her leg.85

In addition, Cottrelle makes it clear that the majority of delayed diagnosis cases should be analyzed using the doctrine of “loss of chance,” as opposed to using the Athey “material contribution” analysis, and are generally not recoverable. Sharpe J.A. notes:

85 Cottrelle at paras. 24 through 33.
I agree with the appellant’s submission that the case at bar falls within the first category and does not fall into either the second or the third category. Proper treatment might have saved the respondent’s leg, but, according to the medical experts, in view of the severe pre-existing atherosclerosis in her leg, she likely would have lost her leg in any event. The appellant’s negligence was not a necessary cause to bring the case within the second category, nor could the appellant’s negligence alone have been a sufficient cause to bring the case within the third category.

In my view, the respondent established no more than the loss of a less than 50% chance of salvaging her leg had the appellant not been negligent. Unfortunately for the respondent, under the current state of the law, loss of a chance is non-compensable in medical malpractice cases: see Laferriere v. Lawson, supra [1991] 1 S.C.R. 541, 78 D.L.R. (4th) 609; St-Jean v. Mercier, [2002] 1 S.C.R. 491; Hotson v. East Berkshire Area Health Authority, [1987] A.C. 750 (H.L.). The trial judge did not explain the basis for her conclusion that “the loss of chance doctrine is not applicable to this case” [para.72]. In view of the evidence I have reviewed, and in view of the respondent’s concession that there was no evidence to suggest that it was more than likely a better outcome would have followed had the appellant acted with care, the trial judge’s finding reveals either a misapprehension as to the law or a palpable and overriding error on the facts.86

Application for leave to appeal Cottrelle to the Supreme Court of Canada was denied at [2003] S.C.C.A. No. 549.

E. Post St-Jean v. Mercier and Cottrelle Cases

In McClelland v. Zacharias,87 the Court dismissed a medical negligence claim, noting that, “It is not enough to show that earlier treatment ‘might’ have avoided the plaintiff’s present condition,” and cited with approval Cottrelle. The rejection of the expansion of the “material contribution” test was upheld by the BC Court of Appeal in B.M. v. British Columbia (Attorney General).88 The BC Court of Appeal expressly limited the application of the “material contribution” test in B.M. v. British Columbia (Attorney General)89 and Trinetti v. Hunter.90

In Seatle,91 Garson J. relied upon Cottrelle in dismissing a medical negligence claim where the plaintiffs failed to establish causation on a balance of probabilities. The plaintiffs argued that the family physician, found to have been negligent in not calling in the obstetrician for a difficult delivery, caused the injury to the infant because it was more probable than not that the presence of a specialist would have resulted in a quicker delivery and avoidance of the injury. The plaintiffs argued that they had met the “material contribution” test established in Athey v. Leonati by demonstrating a material risk of harm and that the harm, in fact, materialized. The Court described the existing Canadian causation jurisprudence in the following fashion:

I conclude from reviewing these authorities that there are four possible theories of causation available to this plaintiff. At the risk of oversimplification, I would summarize these theories as follows:

86 Cottrelle at paras. 35 and 36.
87 2004 BCSC 1077.
89 2004 BCCA 402.
90 2005 BCCA 549.
91 Seatle at note 71.
1. The plaintiff must prove that “but for” the negligence of the defendant no injury would have occurred. This test should not be applied too rigidly, which means that an inference of causation may be made even in the absence of conclusive, precise, scientific evidence (Snell).

2. Where there are multiple possible causes of an injury, but the plaintiff can prove the defendant’s negligence materially contributed to the injury, liability for the whole loss, subject to claims of contribution, will attach to the defendant (Athey).

3. If the plaintiff can establish that the defendant materially increased the risk of a specific injury, and that specific injury occurs, the court may infer on a sufficient evidentiary basis that the material increase in risk was a contributing cause of the injury such that causation is established (Levitt, Webster). “The evidence is to be applied according to the proof which it was in the power of one side to have produced.” (Snell).

4. The House of Lords has held that there may be a reversal in the burden of proof for causation such that if a plaintiff establishes that the defendant created an area of risk and the injury occurred in that area, the defendant must show that the injury had some other cause in order to escape liability (McGhee). This theory has not been applied in Canada and seems to have been restricted in England to toxic exposure cases.

In response to the plaintiff’s argument that the “but for” test was unworkable in the circumstances and that causation could be established by showing that the defendant’s negligence “materially contributed” to the risk of occurrence of the injury, Madam Justice Garson held that the “material contribution” test requires a plaintiff to prove on a balance of probabilities that the medical error did, along with other causes, materially contribute to the injury, a view which, following Resurfice, is no longer correct. The Court held:

This theory of causation does not relieve the plaintiff of the burden of proving an evidentiary link between the breach of duty and the damage.

Insofar as there was no suggestion in the case that there were multiple causes of the plaintiff's injuries, the “material contribution” test was held to be inapplicable. The Court followed decisions in Ontario and Alberta that have rejected the finding that a “material increase in the risk of harm” satisfies the “material contribution” test, referring to Robinson v. Sydenham District Hospital Corporation and Rhine v. Millan.

On appeal, the plaintiffs argued that the trial judge erred in failing to apply the “material contribution” test set out in Resurfice. Without a detailed discussion of the trial judge’s description of the “material contribution” test itself, the Court of Appeal disagreed with the plaintiffs. As the trial judge held, it was not impossible for the plaintiffs, due to factors outside their control, to prove causation on a “but for” basis. It was within the plaintiffs’ power to have tendered evidence that would have tipped the balance. Causation was not incapable of proof. The plaintiffs had simply failed to provide satisfactory proof on a “but for” basis and were not entitled to rely on the “material contribution” test.

Further, the Court held:

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92 Ibid., at para. 168.
93 Ibid., at para. 171.
95 2000 ABQB 212.
96 Seatle at note 74, para. 68.
There is no scientific gap that requires a departure from the “but for” test. Rather, this was primarily a fact-driven case decided well within established legal principles. While the factual issues were challenging, I see no reversible error in the result.97

The state of the law on causation was carefully considered by the Ontario Court of Appeal in the 2006 decision in Aristorenas v. Comcare Health Services.98 The issue in that case was whether delay in the diagnosis of necrotizing fasciitis caused the plaintiff’s injuries. The trial judge found that that was the case and the defendant physicians brought an appeal. In dissenting reasons for judgment, MacPherson J.A. held that where the “but for” test is unworkable in medical malpractice cases, where scientific proof of causation is simply not attainable, a court is entitled to take a “robust and pragmatic approach” to the fact-finding component of the causation analysis (at para. 29). MacPherson J.A. found that the trial judge had done so and that there was no basis for setting aside the trial judge’s finding on causation. This analysis suggests that the “robust and pragmatic approach” to the fact-finding component of the causation analysis is an alternative to the application of the “but for” test. This view does not appear to be supported by the cases. A court can take a “robust and pragmatic approach” to the evidence and more readily draw inferences of causation in the course of applying the “but for” test. Where the “but for” test is unworkable, the solution to which the courts have turned is not to lower the evidentiary bar, but rather, to pose a different question.

The distinctive nature of the “material contribution” test is described by Rouleau J.A. in the reasons of the majority, concurred in by Rosenberg J.A. Rouleau J.A. found that the case was one that called for the application of a robust and pragmatic approach to causation but held that even taking that approach the plaintiff had not met the “but for” test and that no other test was appropriate. Where the “but for” test is unworkable and where justice requires the application of a different standard, “The plaintiff need show only that the defendant’s conduct materially contributed to the occurrence of the injury (at para. 49).”

The Court noted that the decision in Atrey “Provides little guidance as to where the ‘but for’ test is unworkable and ought to be replaced by the ‘material contribution’ test (para. 52).” After referring to the decision in Cottrelle, the Court held:

Thus, it would seem that the material contribution test is applied to cases that involve multiple inputs that all have harmed the plaintiff. The test is invoked because of logical or structural difficulties in establishing ‘but for’ causation, not because of practical difficulties in establishing that the negligent act was part of the causal chain.

The Court went on to point out that the robust and pragmatic approach to the evidence is not a distinct test for causation. The majority allowed the appeal and set aside the finding that the plaintiff’s injury was caused by the defendant’s negligence.

F. Resurfice v. Hanke

The plaintiff in Resurfice operated an ice-resurfacing machine and was badly burned when hot water overfilled the gasoline tank releasing gasoline and causing an explosion. He sued the manufacturer and the distributor of the machine. He lost at trial, on the basis that neither negligence nor causation had been proven. The trial judge applied the “but for” test to the causation analysis. The Alberta Court of Appeal held that it had been an error to do so and that the “material contribution” test ought to have been applied. The Supreme Court was called upon to clarify the circumstances in which the “material contribution” test should be applied. The Court held:

97 Ibid., at para. 71.
The Court of Appeal erred in suggesting that where there is more than one potential cause of an injury, the “material contribution” test must be used. To accept this conclusion is to do away with the “but for” test altogether, given that there is more than one potential cause in virtually all litigated cases of negligence. If the Court of Appeal’s reasons in this regard are endorsed, the only conclusion that could be drawn is that the default test for cause-in-fact is now the material contribution test. This is inconsistent with the Court’s judgment in Snell v. Farrell ... Athey v. Leonati ... Walker Estate v. York Finch General Hospital ... and Blackwater v. Plint ...

Delivering the judgment for the Court, the Chief Justice reiterated the opinion that the “basic test for determining causation remains the “but for” test and that it "applies to multi-cause injuries." In describing the limited applicability of the “material contribution” test, the Court held:

However, in special circumstances, the law has recognized exceptions to the basic “but for” test and applied a “material contribution” test. Broadly speaking, the cases in which the “material contribution” test is properly applied involved two requirements. First, it must be impossible for the plaintiff to prove that the defendant’s negligence caused the plaintiff’s injury using the “but for” test. The impossibility must be due to factors that are outside of the plaintiff’s control; for example, current limits of scientific knowledge. Second, it must be clear that the defendant breached a duty of care owed to the plaintiff, thereby exposing the plaintiff to an unreasonable risk of injury, and the plaintiff must have suffered that form of injury. In other words, the plaintiff’s injury must fall within the ambit of the risk created by the defendant’s breach. In those exceptional cases where these two requirements are satisfied, liability may be imposed, even though the ‘but for’ test is not satisfied, because it would offend basic notions of fairness and justice to deny liability by applying a “but for” approach.

The decision in Resurfice makes it clear that the “material contribution” test is not simply the application of the “but for” test to cases where there are multiple causes of a loss, each of which, on the evidence, could be said to have materially contributed to the injury. The court appears now to be clearly describing a test which is a departure from the “but for” test and which requires only proof that negligence materially contributed to the risk of an injury. On the other hand, the application of the “material contribution” test appears to be restricted to a very narrow range of cases and, on the basis of the judgments in St-Jean and Laferriere, there is room to argue that the “material contribution” test should rarely, if ever, be applied in medical malpractice cases.

G. Post Resurfice Cases

The British Columbia Court of Appeal considered the Resurfice decision in Jackson v. Kelowna General Hospital. The patient, Jackson, suffered a broken jaw in a bar fight and underwent surgery to repair the fracture on the following day. An anaesthesiologist ordered that a patient-controlled analgesia system be provided to the patient in order to allow him to self-administer morphine. He was to have been regularly monitored thereafter. He later brought an action alleging that he suffered a brain injury as a result of a breach of the standard of care for post-operative monitoring. The trial judge found that the nurses had breached the appropriate standard, but the patient had failed to prove the breach caused his injuries. In fact, the plaintiff led no evidence as to what the nurses would have discovered had they not failed to monitor him during the critical period.

99 Ibid., at para. 19.
100 Ibid., at para. 21.
101 Ibid., at paras. 24-25.
102 2007 BCCA 129.
103 Ibid., at paras. 11-12.
On appeal, it was argued that the standard of proof of causation should be relaxed on policy grounds because the facts lay particularly within the knowledge of the defendants and because factors outside the plaintiff’s control made it difficult to prove causation. The BC Court of Appeal held that Resurfice had articulated the “special circumstances” where the “material contribution” test may be applied and that there was no reason for relaxing the standard of proof of causation in the case on appeal. The Court clarified that the “material contribution” test should only be applied:

... [T]o cases where it is truly impossible to say what caused the injury, such as where two tortious sources caused the injury, as in Cook v. Lewis, [1951] S.C.R. 830, or it is impossible to prove what a particular person in the chain of causation would have done in the absence of the negligence, such as the blood donor cases (Walker Estate v. York Finch General Hospital, [2001] 1.S.C.R. 647).104

Shortly after the Resurfice decision the BC trial court applied the “material contribution” test in another medical malpractice case, Bohun v. Sennewald et al,105 The plaintiff attended at the office of her physician as a result of concerns with respect to a breast lump that she had detected. The patient was examined and followed for a period of time before she was referred to a surgeon. There was an issue at trial with respect to whether or not the surgeon recommended a biopsy and, if he had recommended a biopsy, whether the plaintiff’s cancer would have been promptly diagnosed and treatment would have been started immediately thereafter. The causation issue was whether failure to detect the cancer at that time caused damages. The trial judge found that if there had been prompt diagnosis and removal of the tumour by a surgeon, the plaintiff’s chance of survival would have increased by 20%. The trial judge considered whether this was a “loss of chance” case after concluding that the plaintiff could not meet the “but for” test. Goepel J. held:

[94] ...This is not a “lost chance” case, but a causation case. The case meets the special circumstances that require an application of the material contribution test. In the language of Resurfice, it is impossible for Mrs. Johnson to prove that Dr. Segal’s negligence caused her injury using the “but for” test. The impossibility is due to factors that are outside of her control. While it is known that the cancer metastasised to other parts of Mrs. Johnson’s body prior to the first surgery in January 2002, it is impossible, due to the current limits of scientific knowledge, to know whether that migration took place before or after the June 2001.

[95] Dr. Segal’s negligence caused the delay in diagnosis and treatment. Any delay in the treatment of breast cancer increases the risk. The delay in treatment materially contributed to the fatal outcome Mrs. Johnson now faces. Mrs. Johnson’s injury falls within the ambit of the risk created by Dr. Segal’s negligence when he failed to do a biopsy in June 2001.

The decision in Bohun represented a departure from what should be well-established principles of causation. There were, at the time of the judgment, a number of previous decisions arising out of late diagnosis of cancer in which the diagnosis and prognosis were well-established at the time of trial and the Court had to wrestle with the question of whether the outcome would have been different had the diagnosis been made earlier. In all such cases, the courts determined that the court has a duty to assess the evidence and make a finding, on the scientific evidence available at trial, if such evidence is called (and it was in the Bohun case) with respect to what probably would have happened had there been an earlier diagnosis. In fact, the probabilities were applied by the trial judge in Bohun in assessing damages because he subsequently reduced the plaintiff’s claim to account for the very large contingency that her outcome would have been no different had there been earlier diagnosis. It is submitted that it was contradictory to say that it is impossible to reach any conclusion with respect to what probably would have occurred had there been an earlier diagnosis, while at the same time discounting damages by a specific percentage to account for the probability that the outcome would have been no different.

104 Ibid., at para. 22.
105 2007 BCSC 269.
The trial judge’s conclusion on causation in the Bohun case was reversed by the BC Court of Appeal. The appellant’s fundamental argument, which ultimately succeeded, was that the trial judge erred in principle when he found the surgeon’s delay in treatment caused the harm even though the relative increase in the risk of harm from the delay was only 20%. In other words, the trial judge had found for the defendant on the “but for” test and that should have put an end to his analysis.

The Court of Appeal held that the plaintiff had to prove that it was more probable than not that timely diagnosis and treatment would have prevented her loss—that she would likely have lived longer had the surgeon not been negligent. In other words, she had to establish that the surgeon’s conduct made it more probable than not that the delayed diagnosis of cancer would cause her death to occur earlier than it would have “but for” his negligence. Referring to the English case of Barker v. Corus, where Lord Hoffman stated that it is not enough to show that the defendant’s conduct increased the likelihood of damage and may have caused it, it was necessary to show that the defendant’s conduct did cause the damage in the sense that it would not have otherwise happened. The Court of Appeal concluded that the plaintiff failed to prove causation on a “but for basis.”

Further, because the defence counsel adduced scientific evidence which indicated that the delayed diagnosis increased the risk of harm by 20% only, while clearly not obligated to do so, the defence had, in fact, disproved causation. In these circumstances, it was clearly inappropriate for the trial judge to even consider the “material contribution” test. Even if the defence had not been able to “disprove causation,” the reasoning of the Court of Appeal makes it clear that the Resurfice decision would not provide assistance to the plaintiff because expert evidence on the issue of causation was available and was led at trial. Resurfice, in the opinion of the Court, did not stand for the proposition that mere inability to prove causation on a “but for” basis meant that resort may be had to the less stringent “material contribution” test.

In coming to its conclusion in Bohun, the Court of Appeal relied on its previous decision in B.S.A. Investors Ltd. v. DSB. In B.S.A., the issue was whether the defendant’s negligence caused a fraud to be perpetrated on the plaintiff. Because the question of what the outcome would have been, had the defendant not been negligent, could be answered with certainty only by the fraudster himself, who did not take the stand in his own defence, the Court considered whether it was impossible to prove causation on a “but for” basis, thus permitting resort to the “material contribution” test. Contrary to the opinion of the trial judge, the Court of Appeal concluded that it was not:

With respect, I do not consider this to be one of those “rare cases” where such an inference should have been drawn. The case did not involve principles of causation unknown to modern science; there may have been no direct evidence on point, but the trial judge was still able—and indeed required—to use the available circumstantial evidence in order to decide the point.

The B.S.A. decision makes it quite clear that only in cases where it is truly impossible to prove causation, such as where the limits of scientific knowledge prevent the possibility of proof, can a plaintiff rely on the “material contribution” test. A lack of evidence (B.S.A.) or a lack of favourable evidence (Bohun) does not displace the normal “but for” test of causation.

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106 Bohun v. Segal, 2008 BCCA 23.
108 Bohun v. Segal at note 104, paras. 41 and 52.
109 Ibid, at para. 52.
110 Ibid, at paras. 49-53.
111 2007 BCCA 94.
112 Ibid, at para. 41.
The Alberta Court of Queen’s Bench has also considered the judgment in *Resurfice* in *Tonizzo v. Moysa*.\textsuperscript{113} The plaintiff alleged that the defendant physicians had been negligent in failing to diagnose reflex sympathetic dystrophy. The Court held that the plaintiff could not establish causation of damages. An invitation was made to apply the “material contribution” test in response to which the Court held as follows:

In certain exceptional cases, the “but for” test of causation does not apply. Such cases require that:

(i) it be impossible for the plaintiff to prove that the defendant’s negligence caused the plaintiff’s injury using the “but for” test; and

(ii) it be clear that the defendant breached a duty of care owed to the plaintiff, exposed the plaintiff to an unreasonable risk of injury, and the plaintiff suffered that form of injury: *Resurfice Corp.* at para. 25.

These requirements are not met in this case, as it was not impossible in principle, in the sense in which the Supreme Court of Canada uses the term “impossible” for Mr. Tonizzo to prove that Dr. Moysa’s care caused his injury. Rather, Mr. Tonizzo claim fails simply for lack of evidence of a causal connection. The absence of evidence (as opposed to the impossibility of obtaining evidence) is not a basis to apply this exceptional test of causation).

The Court of Appeal for Ontario also discussed the “material contribution” issue in *Barker v. Montfort Hospital*.\textsuperscript{114} This was an appeal from a decision that the defendant surgeon ought to have attended to assess a patient during a period when her condition was deteriorating and that doing so would have led to earlier diagnosis and surgical treatment. The trial judge found that the patient had suffered loss of a portion of her small intestine as a result of the late diagnosis. There was an appeal from both the finding of a breach of the standard of care and the finding on causation. The causal issue was whether the volvulus which led to strangulation of a portion of the bowel had already developed before the assessment ought to have been done. The majority of the Court found that there was “no expert or other evidence on which the trial judge could base his finding that if the appellant had attended at the hospital late in the evening ... and had decided to operate, the section of bowel would likely not have had to be removed.”\textsuperscript{115}

Significantly, the majority of the Court found that evidence as to causation could have been led. The plaintiff could have addressed causation by proving “when the full volvulus likely formed and assuming that the bowel would have died approximately eight hours later.”\textsuperscript{116}

As a result, when asked to consider the *Resurfice* case, the Court held that the case had no application because “the respondents have not shown that it was impossible to prove that the delay in carrying out the operation caused Mrs. Barker’s injury on a balance of probabilities.”\textsuperscript{117} The evidence that had been led was unfavourable to the plaintiff. The Court of Appeal applied the “but for” test, found the plaintiff’s case wanting and dismissed the claim.

In dissent, Weiler J.A. held that the trial judge was entitled to draw an inference of causation (as suggested in *Snell*), and that the Court of Appeal should treat that inference with deference. Further, however, Weiler J.A. observed that the appellant himself submitted that it was impossible for the

\textsuperscript{113} 2007 ABQB 245.
\textsuperscript{114} 2007 ONCA 282.
\textsuperscript{115} *Ibid.*, at para. 35.
\textsuperscript{117} *Ibid.*, at para. 53.
respondent to prove that “but for” the delay in operating she would not be suffering from “short-bowel syndrome.” Weiler J.A. rejected that submission, finding that causation could be proven with the aid of a “robust and pragmatic” approach. Had she accepted the submission that causation could not possibly be proven, she would have applied Resurfice, found that the injury which materialized was “within the ambit of the risk created by the appellant’s negligence” and found that the appellant had proven causation of damages.

In the Sam decision, the majority, having found that the “but for” test of causation could not be satisfied by the common sense inference from Snell in light of expert evidence to the contrary led by the defence, considered the applicability of the “material contribution” test. Smith J.A., speaking for the majority and relying on the English decision in Fairchild v. Glenhaven Funeral Services Ltd., restated his conclusion in B.M. v. B.C. (A.G.) that this was not a test of causation at all, but rather a rule based on policy:

[165] The majority in Fairchild imposed liability on the basis of policy. Lord Bingham’s speech is representative of this view. After acknowledging that it may properly be said to be unjust to impose liability on a party who has not been shown to have caused the damage, he said:

[33] [...] On the other hand, there is a strong policy argument in favour of compensating those who have suffered grave harm, at the expense of their employers who owed them a duty to protect them against that very harm and failed to do so, when the harm can only have been caused by breach of that duty and when science does not permit the victim accurately to attribute, as between several employers, the precise responsibility for the harm suffered.

[166] In imposing liability as a matter of law, the majority expressly rejected the notion that the basis of the finding was a factual or legal inference of causation. Again, I refer to Lord Bingham, who said:

[35] For reasons given above, I cannot accept the view [...] that the decision in McGhee’s case was based on the drawing of a factual inference. Nor, in my opinion, was the decision based on the drawing of a legal inference. Whether, in certain limited and specific circumstances, a legal inference is drawn or a different legal approach is taken to the proof of causation, may not make very much practical difference. But Lord Wilberforce, in one of the passages of his opinion in McGhee’s case ... wisely deprecated resort to fictions and it seems to me preferable, in the interests of transparency, that the courts’ response to the special problem presented by cases such as these should be stated explicitly. I prefer to recognize that the ordinary approach to proof of causation is varied than to resort to drawing of legal inference inconsistent with proven facts.

Following these comments, Smith J.A. concluded the “material contribution” test did not apply. The trial judge erred in inferring causation on a “but for” basis, the appeal was allowed and the claim dismissed.

118 Ibid., at para. 101.
119 Ibid., at paras. 103-4.
120 [2002] UKHL 22.
121 Sam v. Wilson, supra, note 32, para. 109, citing from B.M. v. B.C. (A.G.), ibid., at para. 165.
H. Conclusions on Material Contribution

The “material contribution” test should only be applied when the “but for” test is unworkable and, in the medical negligence context, should generally only be applied in circumstances where the plaintiff’s injury is caused by the cumulative effect of two or more factors, at least one of which is tortious. The “material contribution” test requires proof, on a balance of probabilities, that the tortious act was a factor, above the “de minimus,” in causing the plaintiff’s injury. The “material contribution” test is generally not applicable to situations involving a delay in diagnosis or treatment; these situations are more appropriately analyzed using the “loss of chance” analysis.

VII. Chambers v. Goertz—“But for” ... Very Little

Resurface has had very little impact on the law of causation in medical malpractice cases. The special circumstances in which the “material contribution” test can be applied are, and must be, limited. “Special circumstances” is simply shorthand for inference of legal causation. It is limited to circumstances when proof of causation lies outside the realm of scientific knowledge. The connection between the wrongful act and the harm is almost exclusively based upon some form of temporal connection. In such circumstances one cannot make a factual inference. Scientific knowledge can provide no reliable guidance. One is left with a popularity contest.

In Chambers v. Goertz, Mr. Justice Smith concluded that the application of the “material contribution” test is not based on a finding of fact, but assesses liability as a matter of law:

[17] In the passages from Resurface Corp. v. Hanke, to which Mr. Ahmad refers, Chief Justice McLachlin, writing for the Court, used the phrase in connection with cases in which it is impossible for the plaintiff to prove a causal link between the breach of duty and the harm, such as where the explanation of the causal link is beyond the limits of current scientific knowledge (Fairchild v. Glenhaven Funeral Services Ltd., [2002] UKHL 22, [2002] 3 All E.R. 305; Barker v. Corus (UK) Plc., [2006] UKHL 20, [2006] 2 A.C. 576—cases in which the defendants’ breach of duty materially increased the risk of harm but it was not possible to prove a causal connection to the harm itself; where it is impossible to prove which of two simultaneous acts by two negligent actors caused the loss (Cook v. Lewis, 1951 CanLII 26 (S.C.C.), [1951] S.C.R. 830, [1952] 1 D.L.R. 1); and where it may be impossible to prove what a third party, whose conduct was a “but for” cause of the loss, would have done absent the defendant’s careless conduct (Walker Estate v. York Finch General Hospital, 2001 SCC 23 (CanLII), [2001] 1 S.C.R. 647, 198 D.L.R. (4th) 193). As this Court noted in Sam v. Wilson, 2007 BCCA 622 (CanLII), 2001 SCC 23,78 B.C.L.R. (4th) 199 at para. 109, 249 B.C.A.C. 228, this use of “material contribution” does not signify a test of causation at all; rather it is a policy-driven rule of law designed to permit plaintiffs to recover in such cases despite their failure to prove causation. In such cases, plaintiffs are permitted to “jump the evidentiary gap”: see “Lords a’leaping evidentiary gaps,” (2002) Torts Law Journal 276, and “Cause-in-Fact and the Scope of Liability for Consequences,” (2003) 119 L.Q.R. 388, both by Professor Jane Stapleton. That is because to deny liability “would offend basic notions of fairness and justice.” [emphasis added]

Although the Supreme Court of Canada has endorsed the process of assessing liability without factual proof of causation, the circumstances in which this departure from fundamental evidentiary principles can be invoked are extremely limited.

122 Ibid.
In *Clements* our Court of Appeal, noting with approval the conclusions of Professor Knutsen, limited the circumstances in which one could depart from the “but for” test as follows:

63 In summary, having regard to the over-arching policy that the material-contribution test is available only when a denial of liability under the but-for test would offend basic notions of fairness and justice, I agree with the following statement made by Professor Knutsen in setting out his conclusions (at 187):

- g) The “but for” test rarely fails, and currently only in situations involving circular causation and dependency causation:
  1) Circular causation involves factual situations where it is impossible for the plaintiff to prove which one of two or more possible tortious causes are the cause of the plaintiff’s harm;
  2) Dependency causation involves factual situations where it is impossible for the plaintiff to prove if a third party would have taken some action in the face of a defendant’s negligence and such third party’s action would have facilitated harm to the plaintiff;

- h) If the “but for” test fails, the plaintiff must meet two pre-conditions to utilize the “material contribution” test for causation:
  1) It must be impossible for the plaintiff to prove causation (either due to circular or dependency causation); and,
  2) The plaintiff must be able to prove that the defendant breached the standard of care, exposed the plaintiff to an unreasonable risk of injury, and the plaintiff must have suffered that type of injury.

64 What does this mean for the present case? It means that once the trial judge determined that Mrs. Clements had failed to establish that the motorcycle would not have capsized but for Mr. Clements’s negligence, he should have found that causation had not been proven. This is not a case involving either circular or dependency causation. Rather, it is a case like many others in which, given the current state of knowledge, it is not possible to prove whether the negligent actions of a defendant caused harm. I do not consider it either unfair or unjust, or, to use the words of Professor Knutsen (at 172), “just plain wrong” not to fix Mr. Clements with liability when Mrs. Clements has been unable to show factually that his negligence was a cause of her damages.

There is one final case worth mentioning, likely as a footnote, *Steinebach v. Fraser Health Authority*. In *Steinebach*, Mr. Justice Pitfield noted:

133 Having regard for all of the evidence, I find as a fact that if Dr. O’Brien had appropriately assessed Ms. Steinebach and the fetus at 2250 hours on March 30, and if Nurse Hermogenes had reported her observations to Dr. O’Brien any time between 0455 and 0500 hours as she should have done, Mirella would have been delivered before 0517 hours and before the onset of harm occasioned by the abruption. The “but for” test has been satisfied. Should that not be the case because it is not possible to know what those persons in the labour and delivery chain would have done had Dr. O’Brien conducted an appropriate assessment of Ms. Steinebach and the risks to the fetus at 2250 hours, then the circumstances warrant application of the “material contribution” test to which the Supreme Court of Canada referred in *Snell v. Farrell* and *Resurfice Corp. v. Hanke*, supra.

This statement does not appear to be consistent with *Clements*; an appeal from *Steinebach* has already been argued; we are awaiting the reasons.

123 2010 BCSC 832.
COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: Ediger v. Johnston,
2011 BCCA 253

Date: 20110530
Docket: CA037058

Between:

Cassidy Alexis Ediger,
an infant by her Guardian Ad Litem, Carolyn Grace Ediger

Respondent/ Appellant on Cross Appeal (Plaintiff)

And

William G. Johnston

Appellant/ Respondent on Cross Appeal (Defendant)

And

Fraser Health Authority, Lisa B. Jeppesen,
Jane Doe 1 and Jane Doe 2

Defendants

Before: The Honourable Madam Justice Saunders
The Honourable Madam Justice D. Smith
The Honourable Mr. Justice Groberman

On appeal from: Supreme Court of British Columbia, March 24, 2009

Counsel for the Appellant:
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A. Howell

Place and Date of Hearing:
Vancouver, British Columbia
October 20 and 21, 2010

Place and Date of Judgment:
Vancouver, British Columbia
May 30, 2011
Written Reasons by:
The Honourable Madam Justice D. Smith

Concurred in by:
The Honourable Madam Justice Saunders
The Honourable Mr. Justice Groberman
Reasons for Judgment of the Honourable Madam Justice D. Smith:

A. Overview

[1] This appeal focuses on the issue of causation in a damages action for medical negligence during the delivery of the infant respondent. Cassidy Ediger, now 13, was born on January 24, 1998, in a compromised state. She suffered an acute and severe hypoxia-ischemic encephalopathy (damage to the central nervous system caused by inadequate oxygen) about 20 minutes before her birth. The injury was caused by the compression of the umbilical cord. The effect of the cord compression was to cut off the exchange of blood and oxygen from the placenta to her brain. The asphyxia in turn caused a sharp deceleration in the fetal heart rate from a normal range of between 120 and 160 beats per minute (bpm) to a critical level of 60 bpm (fetal bradycardia). The fetal bradycardia persisted until Cassidy was delivered by Caesarean section. Upon delivery, she was non-responsive and severely brain damaged. Her injuries are catastrophic and irreversible; they have significantly shortened her life expectancy.

[2] The respondent, Carolyn Ediger, who is Cassidy’s mother and guardian ad litem, commenced the within negligence action against the appellant obstetrician Dr. William Johnston. In the action, she sought damages for Cassidy’s pain and suffering, loss of enjoyment of life, loss of amenities of life, loss of income earning capacity, economic loss, and cost of care, all both past and future. Dr. Johnston denied liability.

[3] The focus of the respondent’s submissions at trial was that the appellant had breached the standard of care of an obstetrician practicing in a community hospital at the time of Cassidy’s birth, by attempting a mid-level rotational forceps delivery without a “double set-up”. A “double set-up” would require the procedure to be undertaken in a high risk delivery suite or operating room with a dedicated surgical team, including an anaesthetist, standing by (scrubbed and ready for surgery) in the event the procedure was unsuccessful and an emergency Caesarean section became necessary.
[4] In the alternative, the respondent claimed that the appellant had breached a lower standard of care by undertaking the procedure without a dedicated surgical team being “immediately available” at the hospital. The “immediately available” standard of care would permit a mid-level forceps delivery to be performed in a regular labour room with a back-up surgical team immediately available at the hospital in the event that an emergency Caesarean section was required.

[5] Dr. Johnston advocated a third standard of care at trial. He submitted that the “thirty-minute rule”, which had been the prevailing standard at community hospitals such as the one in which Cassidy was born, should continue to be followed. The thirty-minute rule requires a back-up surgical team to be available within 30 minutes of being called. It does not require the team to be present at the hospital before a mid-level forceps delivery is attempted.

[6] The respondent also claimed that the appellant had breached the standard of care by failing to advise Mrs. Ediger of the risks associated with the procedure and the alternatives to it, and in failing to obtain her informed consent.

[7] The trial judge found Dr. Johnston had breached the standard of care that required a surgical team to be “immediately available” before the procedure was undertaken and by failing to obtain the respondent’s informed consent to the procedure. She found that a mid-level forceps delivery was a high risk procedure and that, before attempting the procedure, Dr. Johnston should have advised Mrs. Ediger of its benefits and risks (albeit statistically low), along with the benefits and risks of any alternative procedure, including a Caesarean section. In the result, she found the appellant liable for Cassidy’s injuries and made awards for non-pecuniary and pecuniary damages. See Ediger v. Johnston, 2009 BCSC 386.

[8] Dr. Johnston appeals the finding of liability on the issue of causation only. He also appeals some of the awards of damages, as does the respondent in the cross-appeal. However, for the reasons that follow, I find it unnecessary to address the appeal and cross-appeal on the awards of damages.
B. **Factual Background**

[9] This was Mrs. Ediger's first pregnancy. Early in the pregnancy, Dr. Jeppesen (now Dr. LeGresley), Mrs. Ediger's family physician, referred Mrs. Ediger to Dr. Johnston for a concern unrelated to the injuries sustained during birth. Dr. Johnston saw Mrs. Ediger again at 36 weeks and diagnosed her with oligohydramnios (low volume of amniotic fluid), intrauterine growth retardation and mild gestational diabetes. An ultrasound indicated the fetus was small, although non-stress tests were reassuring. Dr. Johnston considered Mrs. Ediger's pregnancy to be high risk and decided to induce the pregnancy, before term, at 38 weeks.

[10] On January 23, 1998, Mrs. Ediger was admitted into Chilliwack General Hospital and was started on the induction process. She was discharged home, and returned to the hospital that evening at 2000 hours. (The time references in these reasons are taken from the attending nurses' specialized notes on labour and delivery (the partogram) and the nurses' focus notes, except as stated otherwise. The trial judge found that the time and sequence of events, as recorded in the partogram and focus notes, were inconsistent with one another and not made contemporaneously during the critical period. She therefore decided not to rely on the accuracy of those records on the issues of the time and sequence of events. Instead, she found that the best record of the chronology during the critical period came from the fetal monitoring strip because it contemporaneously recorded the time and changes in the fetal heart beat.)

[11] Dr. Johnston artificially ruptured Mrs. Ediger's membranes. The amniotic fluid was clear (normal) and there was no evidence of fetal hypoxia. Mrs. Ediger entered the first stage of labour. By morning, her contractions were strong in duration and intensity, and she was in considerable pain. By 1200 on January 24, however, she remained in the first stage of labour and her progress had stalled. The baby's head was only at spines -2 (where it had been the evening before) and she was very fatigued.
[12] Mrs. Ediger entered into the second stage of labour at 1300 with full dilation of the cervix. By 1430 she had been pushing for about one-and-a-half hours but had not made any significant progress. Dr. LeGresley called for Dr. Johnston who arrived at 1430.

[13] Dr. Johnston determined that the baby’s head was in a left occipital transverse position (sideways) in “deep arrest” and fully engaged at spines 0. He noted that “the fetal heart rate was fairly normal with some slight variable decelerations with contractions”. He was concerned that, given its small size, the baby’s reserves might run out. Based on his clinical assessment, he elected to proceed with a mid-level forceps delivery, which would rotate the baby’s head from its sideways position into the anterior-posterior position (face down) for delivery through the birth canal. His practice was to use the Kielland forceps for that procedure because of its thinness and flexibility.

[14] Mrs. Ediger was in the regular labour room when Dr. Johnston began the forceps procedure at 1430. A high risk delivery room was available on the same floor. Dr. Johnston did not anticipate that anything would go wrong with the procedure and therefore did not inform Mrs. Ediger of the potential, albeit statistically-low, risks associated with the procedure. Those included vaginal lacerations to the mother, trauma to the baby’s head, and fetal bradycardia if the baby could not tolerate the procedure. Nor did he advise Mrs. Ediger of the option of and risks associated with having a Caesarean section. They included bleeding and infection from surgery, damage to internal organs, and blood clots in the legs and lungs (all to the mother), and injury to the baby. Consequently, Dr. Johnston did not inquire into the immediate availability of an anaesthetist and operating room staff before undertaking the procedure.

[15] After giving Mrs. Ediger a pudendal block, Dr. Johnston inserted the anterior blade. He noted in his consultation report:

The anterior blade was wandered into position without too much difficulty. I was not, however, able to apply the posterior blade. The posterior blade was then removed, the anterior blade removed and the patient informed she
would need a Caesarean section. It was then noted that the fetal heart was down at 60 and stayed at 60.

[16] Dr. LeGresley’s recollection of the attempted forceps delivery was slightly different. She specifically recalled that Dr. Johnston had applied both blades of the Kielland forceps to the baby’s head because he had advised her that he was not happy with the placement of the second blade. It was at that point, she said, that Dr. Johnston abandoned the procedure, elected to proceed with a Caesarean section and left the labour room to make the necessary arrangements.

[17] The issue of whether the appellant applied one or both of the Kielland blades was of some import at trial because of the respondent’s theory about how the cord compression likely occurred. Drs. Farquharson and Shone, obstetricians called by the respondent, testified that in their opinion the application of or removal of the forceps likely elevated the baby’s head from its engaged position against the pelvic wall thereby creating a space into which the cord slipped and became compressed. The compression of the cord would then have been “assisted” by Mrs. Ediger’s contractions.

[18] Dr. Johnston testified that he was unable to place the second blade and therefore abandoned the procedure without attempting to rotate the baby’s head. He also testified that the application of the Kielland blades would only have rotated the baby’s head laterally and would not have elevated it or created a space into which the cord could have slipped.

[19] The trial judge accepted Dr. LeGresley’s evidence on this issue and found that Dr. Johnston had applied both blades to the baby’s head.

[20] Dr. Johnston left the labour room at 1450 to make arrangements for a Caesarean section. At that time, the fetal monitoring strip continued to exhibit a normal variability. He walked across the hallway to the nursing station where he contacted the on-call anaesthetist to assist in what he anticipated would be a non-emergency Caesarean section. Dr. Boldt advised him that he was occupied with an emergency life and death surgery in another operating room and anticipated he would be unavailable for another hour. He suggested that Dr. Johnston contact
Dr. Lim, the next on-call anaesthetist. Dr. Lim was off site and subject to the “thirty-minute rule”.

[21] During Dr. Johnston’s absence, Dr. LeGresley first heard and then saw the fetal heart rate on the monitoring strip drop to 60 bpm from its previous variability of between 120 and 160 bpm. Dr. LeGresley testified that Dr. Johnston was gone “a couple of minutes” and that it was during that interval that she heard the fetal heart monitor drop to 60 bpm. After 20 to 30 seconds she confirmed that the bradycardia was sustained and called out to Dr. Johnston that Mrs. Ediger needed an emergency Caesarean.

[22] Dr. Solimano was a neonatologist who testified for the respondent. He said that the fetal monitoring strip was the “best window” in which to identify the timing of the sudden interruption of the placental blood flow to the baby that caused the profound asphyxia because it provided a contemporaneous recording of the fetal heart rate. From his examination of the strip, he determined that the onset of fetal bradycardia occurred at 1451.40.

[23] The strip displayed a lot of artefact, which made it difficult to confirm whether it was recording the fetal heat rate or the mother’s heart rate. Accordingly, when Dr. Johnston responded to Dr. LeGresley’s call and returned to the labour room at 1453, he attached a fetal scalp clip to the baby’s head and left it there for about two minutes in order to verify the true fetal heart rate. All the medical experts agreed that this course of action was reasonable. At 1455, Dr. Johnston confirmed persistent bradycardia and contacted Dr. Boldt again, who was still occupied in the operating room on the floor below, to advise him that Mrs. Ediger needed an emergency Caesarean section.

[24] The trial judge found that after sustained bradycardia was confirmed, “everyone [was] rushing to prepare for a Caesarean section” (para. 111). After being prepared for transfer, at 1500 Mrs. Ediger was transferred to the high risk delivery suite where she was prepped and draped for surgery. Dr. Boldt arrived at 1506 and rapidly anaesthetized Mrs. Ediger within two minutes. At 1508 Dr. Johnston made his first incision and by 1511 Cassidy was delivered.
[25] Dr. Lim, the next on-call anaesthetist who had been contacted when Dr. Johnston initially determined that Mrs. Ediger required a non-emergency Caesarean section, arrived well within the “thirty-minute rule” but after Dr. Boldt had already anaesthetized Mrs. Ediger. Dr. Lim then took over for Dr. Boldt.

[26] Cassidy was delivered almost 20 minutes after the onset of bradycardia. She was born “flat”, and with the umbilical cord around her neck and shoulders; there was no redundant cord remaining in the mother. There was no evidence that the cord compression had been caused by placental abruption (the placenta separating from the pelvic wall), cord prolapse (the cord proceeding in advance of the presenting part of the baby’s head in the birth canal), or a short cord (under 30 cm). The cord in this case was 35 cm; a long cord can measure up to 50 cm.

[27] Cassidy also had bruising on the right side of her face. Dr. Pendleton, an obstetrician called by the appellant, testified that the bruising was not synonymous with traction on the forceps but could have been caused by their application.

C. The Trial Judge’s Reasons for Judgment

[28] The trial judge framed the liability issues, based on “the parties’ positions and the evidence”, as follows:

1. whether Dr. Johnston breached the applicable standard of care

   (a) in attempting the mid-forceps procedure without a double set-up, or if he did not,

   (b) in doing so without first checking that an anaesthetist was reasonably available to provide back-up support if necessary;

2. if he breached the standard of care in either of the ways outlined above, whether the mid-forceps attempt caused the bradycardia that, in turn, caused Cassidy’s injuries;

3. whether Dr. Johnston proceeded without Mrs. Ediger’s informed consent to the mid-forceps attempt and thus caused the bradycardia that, in turn, caused Cassidy’s injuries;
4. whether the law entitles Cassidy, who was a fetus at the time, to bring her claims, particularly her claim based on lack of her mother’s informed consent.

[29] The trial judge began her analysis by noting that the burden of proof was on the respondent to establish that Dr. Johnston’s attempted forceps delivery was more likely than not the cause-in-fact of the respondent’s injuries, citing Prosser and Keeton on *The Law of Torts*, 5th ed. (St. Paul, Minn.: West Publishing Co., 1984) at 269:

> On the issue of the fact of causation, as on other issues essential to the cause of action for negligence, the plaintiff, in general, has the burden of proof. The plaintiff must introduce evidence, which affords a reasonable basis for the conclusion that it is more likely than not the conduct of the defendant was the cause in fact of the result. A mere possibility of such causation is not enough; and when the matter remains one of pure speculation or conjecture, or probabilities are at best evenly balanced, it becomes the duty of the court to direct a verdict for the defendant.

i. **The duty of care**

[30] The issue of Dr. Johnston’s duty of care to the fetus arose after the evidence and parties’ submissions had been tendered, and judgment was reserved, as a consequence of the decision in *Paxton v. Ramji*, 2008 ONCA 697, 72 O.R. (3d) 401. The trial judge permitted the parties to provide further written submissions on the duty of care issue that was raised by the publication of this decision after submissions had been completed.

[31] *Paxton* dealt with the issue of whether an appellant physician owed a duty of care to his patient’s fetus. The Court concluded he did not, which then cast some doubt over the established jurisprudence, including *Cherry v. Borsman* (1992), 70 B.C.L.R. (2d) 273 (C.A.) from this jurisdiction, that a doctor owes a duty of care to a fetus upon its live birth.

[32] In *Paxton* the Court found that a doctor prescribing drugs to a woman who was not pregnant did not owe a duty of care to his patient’s yet to be conceived children. This determination, it was argued, extended to a fetus. However, in *Liebig v. Guelph General Hospital*, 2010 ONCA 450, the Ontario Court of Appeal narrowed
the application of *Paxton* to the facts of that case and strongly endorsed the 
established principle in most jurisdictions that “an infant, once born alive, may sue 
for damages sustained as a result of the negligence of health care providers during 
labour and delivery” (para. 1) (Emphasis added).

[33] *Cherry* continues to be binding in this jurisdiction and provides an 
authoritative basis for finding that the appellant owed a duty of care to the infant 
respondent, upon her birth. Such a duty of care gave the infant respondent the legal 
status to sue the appellant in tort for any injuries that he caused to her as a fetus 
before her birth as a result of his failure to meet the requisite standard of care during 
her delivery.

ii. **The standard of care**

[34] Dr. Johnston does not take issue with the trial judge’s finding that he 
breached the standard of care that required him to have an anaesthetist 
“immediately available” before attempting the mid-level forceps delivery, and in 
failing to obtain Mrs. Ediger’s informed consent to the procedure. However, in order 
to provide context for a discussion of the causation issue I find it necessary to review 
the trial judge’s findings on the standard of care issue.

[35] The central focus of the evidence and submissions at trial was on whether the 
appellant had breached the “double set-up” before attempting the mid-level forceps 
delivery. However, the trial judge found the standard of care to be the “immediately 
available” rather than the “double set-up” for an obstetrician performing a mid-level 
forceps delivery at the time of Cassidy’s birth. The “immediately available” standard 
of care was based on the guidelines for forceps deliveries published by the Society 
of Obstetricians and Gynaecologists of Canada (the “SOGC”) and the British 
Columbia Reproductive Care Program. It permitted a mid-level forceps delivery to be 
performed in a regular labour room without a back-up surgical team having to be 
present.
The trial judge also found that Dr. Johnston had breached the standard of care that required him to have obtained Mrs. Ediger’s informed consent to the mid-level forceps delivery before he attempted the procedure. An informed consent required Mrs. Ediger to be advised of the risks attendant with the procedure and of the alternatives to the procedure, including the option of having a Caesarean section.

The trial judge then turned to the issue of causation.

iii. Causation

The trial judge began her analysis of this issue by noting that the “plaintiff cannot succeed unless she establishes that Dr. Johnston’s failure to meet the standard of care caused Cassidy’s injuries”. She identified the issues as two-fold: First, whether Dr. Johnston’s attempted forceps delivery caused the cord compression, which in turn caused the fetal bradycardia; and second, whether the cord compression (and thus the bradycardia) would not have occurred but for Dr. Johnston’s failure to have a anaesthetist “immediately available” before undertaking the procedure.

The trial judge also identified the inquiry into whether Dr. Johnston’s failure to meet the standard of care by obtaining Mrs. Ediger’s informed consent to the procedure as two-fold: whether Dr. Johnston appropriately disclosed the material risks, and if he did not, whether the lack of informed consent caused Cassidy’s injuries.

1. Did the appellant’s attempted forceps delivery cause the cord compression?

The medical experts agreed that cord compression had likely caused the fetal bradycardia which led to the acute hypoxia-ischemic injury. The threshold issue was whether Dr. Johnston’s attempted forceps delivery had caused the cord compression.
(a) **Evidence relating to the onset of the bradycardia**

[41] The medical experts who testified on this issue agreed that the onset of fetal bradycardia would occur within seconds of cord compression, whatever its cause: Dr. Liston, for the appellant, estimated that fetal bradycardia would occur within, at most, 10 seconds after the onset of cord compression; Dr. Shone and Dr. Solimano, for the respondent, said, respectively, that it would occur within seconds of and “almost immediately” after the cord is compressed.

[42] Therefore, the contemporaneous application and/or removal of the forceps with the onset of bradycardia was a critical finding to the respondent’s theory of causation. This was summarized in the respondent’s written submissions to the trial judge as follows:

The issue here is whether the bradycardia occurred around the time of the application of the forceps, or whether there was a gap of several minutes after the removal of the second blade before it occurred. The Defendant relies upon the evidence of Drs. Johnston and LeGresley (formerly Jeppesen) to suggest the gap. It is respectfully submitted that their evidence, insofar as it conflicts with the contemporaneous record of events made by the nursing staff, should be rejected.

[43] The respondent’s contention was that the fetal heart rate fell to 60 bpm immediately after the forceps were removed. This was consistent with the theory that the forceps created a space into which the cord slipped thereby causing the resultant bradycardia. In support of the timing of that event, the respondent relied on the nurses’ notes.

[44] Neither Dr. Farquharson nor Dr. Shone, for the respondent, offered an opinion on the timing of the onset of bradycardia in relation to the removal of the forceps. However, Dr. Solimano, for the respondent, noted that based on the fetal monitoring strip, the fetal heart rate started to steadily decline midpoint between 1451 and 1452 (1451.40 to be exact), and continued to decline for a further minute until it plateaued at 60 bpm. In his opinion, persistent bradycardia began at 1452.
Dr. Solimano was also of the view that the likely mechanism for Cassidy’s injuries was cord compression or cord prolapse associated with the application of forceps following which the baby’s fetal heart rate decreased and remained at around 60 bpm. He formed his opinion based on an assumption that Dr. Johnston’s statements in his consultation report were made contemporaneously with the events he recorded. Those statements included that “[a]t that time, as the forceps was applied her fetal heart rate decreased and remained around 60 bpm”. Dr. Solimano opined that while the timing of the asphyxia could be determined by the fetal monitoring strip, which indicated that it began between 1451-1452, the effect of the asphyxia on brain injury follows an accelerating and not linear curve:

The effect of a single, constant near-total profound asphyxia event on brain injury is not linear but follows an accelerating curve, such that each 5 minutes of the event are unlikely to contribute to the eventual poor outcome. Thus, in a situation like the one described it is reasonable to expect the last 5 minutes would have contributed in the order of 35 to 40% of the final outcome.

In his addendum, he clarified this paragraph and demonstrated through the use of graphs how, realistically, 40-45% of Cassidy’s injuries could have been prevented had she been delivered five minutes earlier.

The appellant’s submission at trial, based on his evidence and the evidence of Dr. LeGresley, was that the fetal heart rate fell to 60 bpm one to two minutes after he had left the labour room. Dr. LeGresley testified that the fetal heart rate dropped to 60 bpm “a couple of minutes” after Dr. Johnston left the labour room, that she waited 20 to 30 seconds to see if it persisted, and then she called out to Dr. Johnston that Mrs. Ediger required a “stat” Caesarean section.

The appellant’s medical experts were of the view that the theory of cord compression advanced by the respondent’s experts was impossible, first, because Dr. Johnston had stated he did not apply the second forceps or attempt the manipulation (which the trial judge rejected), and second, because there was no redundant cord left in the mother. They said that cord compression during a mid-level forceps was exceedingly rare (some had never experienced it), however, it could occur as a result of a tightening of the cord, or a spasm or kink in the cord,
which can develop for any number of reasons including the movement of the baby as the baby descends into the birth canal. In many cases, they said, the cause of cord compression is unknown.

[49] All of the medical experts agreed that there were other possible explanations for the cord compression that caused the bradycardia. Dr. Shone acknowledged that a “kink” in the cord or a nuchal cord (one that is wrapped around the baby’s neck) were also potential causes of cord compression. The other possible explanations included a short cord and cord prolapse, although both of these causes were rejected by the experts. Dr. Pendleton opined that “[m]any times we simply do not know what causes bradycardia although cord occlusion is a recognized cause. This may occur spontaneously with a cord around the neck and shoulder.”

(b) The trial judge’s findings of fact

[50] The trial judge had the difficult task of reconciling the discrepancies in the evidence as to the timing and sequence of the events, including the onset of bradycardia. The importance of the trial judge’s findings on the timing and sequence of the events before and after the onset of the bradycardia necessitates a thorough account of her analysis of the evidence on this issue:

[106] According to the evidence of Dr. Johnston and Dr. LeGresley, who was assisting him, it was only after the forceps attempt had failed and Dr. Johnston had left the room to arrange for a Caesarean section that the bradycardia began, perhaps as much as two minutes after the conclusion of the forceps attempt.

[107] Dr. LeGresley had a more specific recollection than Dr. Johnston. She testified that Dr. Johnston told her he was not happy with the placement of the posterior, or second, blade, and that they would have to proceed to a Caesarean section, and he left the room to make the necessary arrangements. At that point, the monitor sounded a drop in the fetal heart rate. After verifying, over the next twenty to thirty seconds, that the drop was a sustained one, Dr. LeGresley put her head around the curtain at Mrs. Ediger’s bed, and told Dr. Johnston that the Caesarean section needed to be “stat”, or on an emergency basis. Dr. LeGresley testified that Dr. Johnston was at that time using a telephone at a nursing station, directly across the hallway from the delivery room. Dr. LeGresley estimated that a couple of minutes had elapsed from the time Dr. Johnston had left the delivery room.
Dr. Johnston remembered not being able to apply the second blade, but testified that his memory of the events afterwards was less strong. He had some memory of being on the telephone, near the nursing station, when Dr. LeGresley came out of the delivery room to tell him that there was a bradycardia, but he candidly offered that this recollection was not crisp, and that he could not be sure it was accurate.

I did not take Dr. Johnston, in acknowledging a weak memory in this area, to concede that the sequence of events may have been as the Edigers described. Indeed, in his cross-examination concerning the SOGC Guideline concerning fetal distress as an indication for the use of forceps, he emphasized that there was, here, no fetal distress until at least one minute after removal of the second forceps blade. I took Dr. Johnston as acknowledging a weak recollection of details concerning when and how he learned of the persistent bradycardia, but maintaining his position that the bradycardia occurred after the conclusion of the forceps attempt.

The Edigers' version of the sequence of events finds some support in a nursing note on a partogram that records Dr. Johnston inserting forceps at 1450 hours, and, at 1451, the following, (revised to convert the abbreviations to the versions counsel used):

1451 FH [fetal heart rate] [down to] 68 for [minute(s)]. Second blade removed.

On its face, the note suggests that the drop in the heart rate coincided with the forceps procedure. However, in doing so it also suggests a sequence by which only after a bradycardia lasting a minute or minutes did Dr. Johnston remove the second blade. None of the other evidence suggests that Dr. Johnston waited as long as a minute from the onset of the bradycardia before removing the forceps; by all of the evidence, the bradycardia created an emergency that had everyone rushing to prepare for a Caesarean section.

Moreover, the combination of the sequence and times noted in the partogram are inconsistent with those noted in the applicable “focus notes”, also made by nursing staff, which indicate that the forceps were applied at 1453.

There was no evidence about the maker(s) or the making of these particular notes. However, the evidence as a whole indicated that nurses’ notes cannot always be made at the time of the events they record for numerous reasons, including that nurses must give priority over record-keeping to the medical care of patients, especially in emergencies. The partogram note on which the plaintiff relies related to a crisis which, by all accounts, required urgent action by all the medical and nursing staff at hand. In those circumstances, it is unlikely that the note was made at the time, and its content must be considered in that light.

After rejecting Dr. Johnston’s and the Edigers’ evidence on this issue, the trial judge turned to Dr. LeGresley’s evidence:

Dr. LeGresley was not seriously challenged in her evidence in this area. The only offered bases for inaccuracy in her evidence were distortion
as a result of discussions with others and the lapse of time, and the fact that she was initially a defendant in this action.

[122] However, Dr. LeGresley’s discussions with others were relatively few. She discussed the events in a debriefing with Dr. Johnston, as they tried to ascertain the cause of the bradycardia. Dr. LeGresley also told her husband about the events shortly after they occurred, because of their emotional toll. She did not otherwise review the circumstances of the birth until she was served with a subpoena in late 2003.

[123] The circumstances of the birth were evidently traumatic and significant for Dr. LeGresley; they must have made a lasting impression. The sequence of those events was important to Dr. LeGresley’s professional role in relation to the labour and delivery, at the time the events occurred and afterwards. It is not likely something which Dr. LeGresley has overlooked or forgotten, and I find no basis on which to conclude that her evidence of that sequence is unreliable.

[52] The trial judge concluded that the most reliable evidence on the timing and sequence of events, including the onset of the bradycardia came from Dr. LeGresley, and adopted her testimony as an accurate statement of what had occurred:

[124] On all the evidence, I conclude that Dr. LeGresley’s evidence provides the most specific and reliable account of the events, and that the bradycardia began shortly after Dr. Johnston had abandoned the forceps attempt, and had left Mrs. Ediger in order to arrange for a Caesarean section. Since Dr. LeGresley estimated that she called Dr. Johnston to tell him that an emergency Caesarean section was required within about two minutes of his leaving the delivery room, the bradycardia -- which Dr. LeGresley took about 30 seconds to check was not transient -- must have begun within at most one and two minutes of Dr. Johnston abandoning the forceps attempt.

[53] The trial judge’s finding that the onset of bradycardia occurred “within at most one to two minutes”, implicitly rejected the timing of the event based on the nurses’ notes. This was a significant finding that worked against the respondent’s theory of causation.

[54] The trial judge then turned to the evidence (or lack thereof) of how the cord compression occurred. This issue was also difficult to determine because it was based on opinions about what had likely occurred in utero where no direct observations could be made.
The trial judge reviewed the opinions of Dr. Farquharson and Dr. Shone, for the respondent, summarizing:

Dr. Shone explained the mechanics of potential cord compression in a rotational mid-forceps procedure. He testified that the baby’s head may move when the first blade is swung or wandered over the baby’s face to the other side of its head. Also, with the second blade applied, the head must be manoeuvred, usually by twisting it out of the position in which it is lodged; that process creates space around the baby’s head, and the cord may become trapped around the side of the head or under the forceps blades.

Dr. Farquharson explained similarly that, for a rotational mid-forceps procedure, a minor elevation or displacement of the baby’s head from its position firmly fixed against the pelvis is necessary before the head can be rotated. He testified that if the umbilical cord is, for example, alongside the baby’s cheeks or neck at the time of the minor elevation or displacement of the head, the cord may slip down into the space created, and the next labour contraction will compress the cord against the pelvis, causing umbilical obstruction.

Dr. Shone’s evidence that the baby’s head may move when the first blade is moved across the face did not explain how that process would create space in which the umbilical cord could become trapped and compressed. It was suggested that the umbilical cord was thinner than most, and therefore may more easily have become trapped in a space inadequate to accommodate an umbilical cord of normal thickness. However, the post-birth measurement of Cassidy’s umbilical cord was in some doubt, because of various factors at play.

Furthermore, Dr. Johnston and other witnesses testified very differently from Drs. Farquharson and Shone about the potential for forceps rotation to create a space into which the umbilical cord may move and become compressed. Dr. Johnston testified, for example, that any displacement of the head is upwards, and not in a direction in which the cord will drop, and any space created by the procedure is minimal, insufficient to accommodate the relatively thick cord.

The evidence thus does not establish with precision the mechanical process by which the umbilical cord was compressed so as to cause the persistent bradycardia. Two further factors should be mentioned.

First, some of the medical experts discussed or mentioned the effect of labour contractions, which occur periodically and may cause adjustment of the relative positioning within the birth canal. Thus, a displacement may not cause cord compression at the time, but a labour contraction afterwards may cause further movement that forces the cord into the space created earlier.

Second, underlying much of the evidence in this area was the acknowledgement -- express or tacit -- of most of the medical witnesses that in general almost nothing is impossible in childbirth.

[Emphasis added.]
Based on this evidence, the trial judge was unable to determine the precise mechanism that caused the cord compression and therefore was unable to answer the question of whether Dr. Johnston’s attempted forceps delivery caused the cord compression. She concluded, however, that Dr. Johnston’s actions had caused Cassidy’s injuries because of the close proximity in time between his attempt of the procedure and the onset of the fetal bradycardia:

Although the mechanics of a causal relationship between the mid-forceps procedure and the cord compression that caused the bradycardia are not established, that such a relationship existed is, I conclude, more likely than it is not. That is because of the close proximity in time of the forceps attempt and the bradycardia; the known risks of cord compression during forceps procedures, coupled with the inability of medical science to always explain the mechanics; and the physical effects and distortions of labour contractions during labour on relative positioning within the uterus, and therefore on the timing of steps in the mechanical sequence leading to cord compression. No other explanation, than that the mid-forceps attempt caused the cord compression, arises from the evidence. The only reasonable inference from all the evidence is that the mid-forceps attempt likely caused the cord compression that in turn caused the bradycardia.

The plaintiff has therefore proven on the balance of probabilities that the cord compression that caused the bradycardia would not have occurred without the forceps attempt.

2. Did the appellant’s breach of the “immediately available” standard of care cause Cassidy’s injuries?

Having found that the cord compression and attendant bradycardia were caused by the forceps attempt, the trial judge turned to the second causation issue of whether Dr. Johnston’s breach of the “immediately available” standard of care caused Cassidy’s injuries:

In the circumstances, she [the plaintiff] must also establish that the cord compression (and thus the bradycardia) would not have occurred without Dr. Johnston’s negligence, in failing to ensure that adequate back-up was available.

In the result, back-up was provided and Cassidy was delivered within about eighteen minutes. This was probably the best possible outcome in the circumstances Dr. Johnston created when he proceeded with the attempt while Dr. Boldt was tied up with another life and death situation. However, minutes mattered, and with the passage of time Cassidy’s bradycardia had done its damage. Had back-up been available even five to ten minutes more quickly, most -- possibly even all -- of Cassidy’s injuries could have been avoided. Dr. Alfonso Solimano, specialist in neonatology, testified that,
according to undisputed clinical opinion, injury begins in most cases at ten minutes from the onset of bradycardia; with delivery within ten minutes, chances are very high that the baby will be uninjured.

[139] The plaintiff has thus proven that but for Dr. Johnston’s negligence she would not have suffered her injuries. She meets the well-established “but for” standard set described in *Snell v. Farrell*, [1990] 2 S.C.R. 311, 72 D.L.R. (4th) 289. It is therefore unnecessary to consider Mr. McGivern’s [for the plaintiff] interesting submission that she may base her case on the arguably less demanding standard described in *Resurfice Corp. v. Hanke*, 2007 SCC 7, [2007] 1 S.C.R. 333, by proving that Dr. Johnston’s negligence made a material contribution to the harm she sustained.

3. *Did the appellant’s failure to obtain Mrs. Ediger’s informed consent cause Cassidy’s injuries?*

[58] In regard to Dr. Johnston’s second breach of the standard of care, the trial judge found that Mrs. Ediger was not advised of the risks associated with the procedure and her informed consent not obtained. Dr. Johnston does not appeal that finding. The only issue he raises on appeal is the trial judge’s finding that, but for his failure to obtain Mrs. Ediger’s informed consent, Cassidy’s injuries would not have occurred.

[59] In determining whether Dr. Johnston’s failure to obtain Mrs. Ediger’s informed consent would have resulted in Mrs. Ediger declining the procedure and electing a Caesarean section, the trial judge again found that she was unable, on the evidence, to answer this question:

[169] ... It is difficult, therefore, to determine whether, or to what extent, Dr. Johnston’s considerable experience and success with mid-forceps deliveries would have affected the response to an explanation of the risks, benefits, and alternatives of a reasonable person in Mrs. Ediger’s position.

[60] However, the trial judge found it unnecessary to answer this question because the test to be applied was the modified objective test established in *Arndt v. Smith*, [1997] 2 S.C.R. 539. That test required her to determine only whether a reasonable patient in Mrs. Ediger’s circumstances would have wanted to be informed of the risks associated with the procedure and, having been informed of those risks, would have chosen to wait on the procedure until an anaesthetist was available (paras. 170-173). See also *Ciarlariello v. Schacter*, [1993] 2 S.C.R. 119
and *Reibl v. Hughes*, [1980] 2 S.C.R. 880. Based on that test, the trial judge concluded:

[172] As I discussed earlier, there was no urgency requiring immediate delivery. In the circumstances as they were, I have no doubt that Mrs. Ediger, and a reasonable patient in her position, despite her fatigue and pain, would have chosen to at least delay the mid-forceps procedure -- even if not to opt for Caesarean section -- until Dr. Boldt or another anaesthetist would likely be available to step in quickly if necessary. That almost certainly no such back-up was available, was necessary information relating to her assessment of the material risks associated with the procedures open to her. I find that the information would have made a difference to her, and the reasonable person’s decision.

[173] The causal link between Dr. Johnston’s failure to obtain Mrs. Ediger’s informed consent and Cassidy’s injuries is therefore established.

[61] Having found that Mrs. Ediger would have “chosen to at least delay the mid-forceps procedure -- even if not to opt for Caesarean section -- until Dr. Boldt or another anaesthetist would likely be available to step in quickly if necessary”, the trial judge concluded, similar to her earlier reasoning, that the causal link was established between Dr. Johnston’s failure to obtain Mrs. Ediger’s informed consent and Cassidy’s injuries.

D. **Discussion**

[62] The appellant contends that the trial judge erred in finding: (i) that his actions in the attempted forceps delivery caused the cord compression and attendant fetal bradycardia (relating to the issue of factual causation); and (ii) that, but for his failure to comply with the “immediately available” standard of care and in failing to obtain Mrs. Ediger’s informed consent to the procedure, Cassidy’s injuries could have been prevented or diminished (relating to the issue of legal causation).

i. **Standard of review**

[63] Causation is a question of fact which attracts a deferential standard of review. Absent palpable and overriding error, deference must be given to the trial judge’s finding on this issue.
In Bystedt (Guardian ad litem of) v. Hay, 2004 BCCA 124, 24 B.C.L.R. (4th) 205, Madam Justice Rowles, for the majority, summarized the standard of review to be applied on the issue of causation where the trial judge found a breach of the standard of care of appropriate medical treatment to the plaintiff:


[19] [Housen v. Nikolaisen, 2002 SCC 33, [2002] S.C.R. 235] also emphasized that where there is evidence to support a conclusion, a difference of opinion over the weight to be assigned to the evidence does not provide a proper foundation for an appellate court to interfere[.]

Justice Rowles also referred to Van de Perre v. Edwards, 2001 SCC 60, [2001] 2 S.C.R. 1014, where the Supreme Court of Canada outlined the approach to appellate review at para. 15:

... [T]he approach to appellate review requires an indication of a material error. If there is an indication that the trial judge did not consider relevant factors or evidence, this might indicate that he did not properly weigh all of the factors. In such a case, an appellant court may review the evidence proffered at trial to determine if the trial judge ignored or misdirected himself with respect to relevant evidence.

Therefore, in order to succeed on this issue the appellant must demonstrate that the trial judge made a material error in her factual conclusions on causation.

ii. The law of causation

Causation in negligence is determined by the “but for” test. The test requires the plaintiff to prove, on a balance of probabilities, that “the injury would not have occurred but for the negligence of the defendant”: Athey v. Leonati, [1996] 3 S.C.R. 458 at para. 15.

There are two aspects to the causation inquiry. The first requires the plaintiff to identify the specific acts of negligence by the defendant that caused the specific
harm to the plaintiff. This is sometimes referred to as the cause-in-fact (i.e., factual causation) of the plaintiff’s injuries and requires a substantial connection between the defendant’s negligent act and the harm to the plaintiff. The second aspect of the inquiry requires the plaintiff to establish the proximate cause between the defendant’s negligent conduct and the plaintiff’s loss or harm. This is sometimes referred to as the cause-in-law (i.e., legal causation) and requires the loss or harm caused by the negligent conduct to fall “within the range of that for which it is just to make the defendant responsible” (W.V.H. Rogers, Winfield and Jolowicz on Tort, 17th ed. (London: Sweet & Maxwell, 2006) at 6-1. And see: L.N. Klar, Tort Law, 4th ed. (Toronto: Thomson Carswell, 2008) at 428-429). Legal causation defines the limits of a defendant’s liability.

[69] The interplay between factual and legal causation is described in Winfield and Jolowicz on Tort at 6-3:

... “Causation in Fact”, is concerned with a question which arises (at least in theory) in every case, that is to say, whether the defendant’s act (or omission) should be excluded from the events which contributed to the occurrence of the claimant’s loss. If it is so excluded, that is the end of the case, for if there is no connection between the defendant’s act and the loss there is no reason for a private law system of liability to operate with regard to him. ... If we conclude that it was, we move on to consider whether it was a sufficiently legally effective cause among the complex of other causes (and there may be many) to justify imposing tort liability on the defendant.

[70] Thus, if the plaintiff cannot establish factual causation that ends the inquiry: without cause-in-fact, there can be no cause-in-law.

[71] The “but for” test has given rise to two theories of causation. The strict theory of causation requires that the defendant’s negligent act must fall “within the risk” (in Winfield and Jolowicz on Tort it is described as “within the range”) or be the “real causa causans” of the plaintiff’s harm or loss. In other words, the loss or harm “must result from the type of risk to which plaintiffs expose themselves, not from a totally different hazard”: Allen M. Linden in Canadian Tort Law, 8th ed. (LexisNexis Butterworths, 2006) at 490.
The source of the less stringent theory of causation was *McGhee v. National Coal Board*, [1923] All E.R. 1008, 1 W.L.R. 1 (H.L.). In that case, the Court found that causation was established if the defendant’s negligent act merely created a risk of harm or a “mere causa sine qua non” without which the plaintiff would not have suffered his or her loss or harm. In other words, the plaintiff was only required to prove that his or her injuries fell within the ambit of the risk of harm created by the defendant’s negligent act.

While proof of causation in medical malpractice cases can be challenging, in *Snell v. Farrell*, [1990] 2 S.C.R. 311 the Supreme Court of Canada rejected the less stringent approach from *McGhee* and adopted the strict theory of causation. For the Court, Mr. Justice Sopinka reasoned as follows:

... Is the requirement that the plaintiff prove that the defendant’s tortious conduct caused or contributed to the plaintiff’s injury too onerous? Is some lesser relationship sufficient to justify compensation? I have examined the alternatives arising out of the *McGhee* case. They were that the plaintiff simply prove that the defendant created a risk that the injury which occurred would occur. Or, what amounts to the same thing, that the defendant has the burden of disproving causation. If I were convinced that defendants who have a substantial connection to the injury were escaping liability because plaintiffs cannot prove causation under currently applied principles, I would not hesitate to adopt one of these alternatives. In my opinion, however, properly applied, the principles relating to causation are adequate to the task. Adoption of either of the proposed alternatives would have the effect of compensating plaintiffs where a substantial connection between the injury and the defendant’s conduct is absent.

In *Snell*, the plaintiff lost her eyesight after cataract surgery. An anaesthetizing injection caused bleeding behind the plaintiff’s eye. The ophthalmologist surgeon was found negligent in failing to detect the bleed during the surgery and discontinue the operation. There were two possible causes for the resulting atrophy to the optic nerve: the undetected bleed during the surgery or natural causes. Neither of the medical experts at trial could state with any certainty which of these events caused the injury to the optic nerve and consequential loss of the plaintiff’s eyesight.

The trial judge ruled out natural causes. He held that the defendant doctor’s negligence had increased the risk of damage to the plaintiff’s eye, and that the loss
of the plaintiff’s eyesight fell within the scope of that risk (which utilized the now rejected test in *McGhee*). The decision was upheld on appeal. On further appeal to the Supreme Court, the decision was upheld, although the *McGhee* reasoning was rejected. Instead, the Court concluded that where the defendant was in a better position to observe and interpret what occurred, and it was impossible for anyone else to detect the precise cause of the injury, the plaintiff could rely on a common sense inference that the bleed during the surgery caused the injury.

[76] The Supreme Court of Canada confirmed its adoption of the strict theory of causation in *St-Jean v. Mercier*, 2002 SCC 15, [2002] 1 S.C.R. 491. On the issue of the scope of the risk of harm necessary to find causation, the Court stated:

[116] The Court of Appeal appropriately said that it is insufficient to show that the defendant created a risk of harm and that the harm subsequently occurred within the ambit of the risk created. To the extent that such a notion is a separate means of proof with a less stringent standard to satisfy, *Snell, supra*, and definitely [*Laferriere v. Lawson*, [1991] 1 S.C.R. 541] should have put an end to such attempts at circumventing the traditional rules of proof on the balance of probabilities.

[77] More recently, in *Resurfice Corp. v. Hanke*, 2007 SCC 7, [2007] 1 S.C.R. 333, Chief Justice McLachlin, for the Court, explained the requirement of a substantial connection between the defendant’s negligent conduct and the plaintiff’s injuries in order to meet the burden of the “but for” test:

[23] The “but for” test recognizes that compensation for negligent conduct should only be made “where a substantial connection between the injury and the defendant’s conduct” is present. It ensures that a defendant will not be held liable for the plaintiff’s injuries where they “may very well be due to factors unconnected to the defendant and not the fault of anyone”: *Snell v. Farrell*, at p. 327, *per* Sopinka J. [Emphasis added.]

impossible to determine which of the negligent acts of two or more defendants created an unreasonable risk of the type of injury that the plaintiff experienced (para. 27) or where the “but for” chain of causation is broken by the inability of the plaintiff to prove what a person in the causal chain would have done had the defendant not committed the negligent act or omission (para. 28).

[79] In Athey, the Court observed that “the courts have recognized that causation is established where the defendant’s negligence ‘materially contributed’ to the occurrence of the injury” (para. 15). However, the phrase “material contribution” in this statement from Athey is not synonymous with the “material contribution test” referred to in Resurface. The distinction between the two was explained by Mr. Justice Smith, for the majority, in Sam v. Wilson, 2007 BCCA 622:

[109] “Material contribution”, as that phrase was used in Athey v. Leonati, is synonymous with “substantial connection”, as that phrase was used by McLachlin C.J.C. above in Resurface Corp. v. Hanke. This causal yardstick should not be confused with the “material contribution test”. As McLachlin C.J.C. explained in Resurface Corp. v. Hanke, at paras 24-29, the “material contribution test” applies as an exception to the “but for” test of causation when it is impossible for the plaintiff to prove that the defendant’s negligent conduct caused the plaintiff’s injury using the “but for” test, where it is clear that the defendant breached a duty of care owed the plaintiff thereby exposing the plaintiff to an unreasonable risk of injury, and where the plaintiff’s injury falls within the ambit of the risk.

[80] In this particular case, the material contribution test was not applicable because it was not impossible for the respondent to prove that the appellant’s negligent conduct caused Cassidy’s injuries. The “but for” test of causation required the respondent to establish, on a balance of probabilities, a substantial connection between the risk of harm caused by the appellant’s negligent acts (the breach of the “immediately available” standard of care and/or failure to obtain Mrs. Ediger’s informed consent) and the resulting injuries to the respondent. In other words, in order to succeed, the respondent had to demonstrate that Cassidy’s injuries fell within the type of risk to which Mrs. Ediger was exposed, i.e., the forceps procedure, and that the appellant’s negligent conduct was the cause-in-fact or a “real causa causans” of Cassidy’s injuries.
iii. Did the respondent establish the cause-in-fact link between the negligent conduct and the harm to Cassidy?

[81] The trial judge began her analysis with the threshold issue of whether the appellant’s attempted forceps delivery caused the cord compression that created the bradycardia, which in turn resulted in the harm to Cassidy. This was a threshold issue in the causation inquiry for establishing that a substantial connection existed between the appellant’s negligent conduct and the harm to Cassidy. On this issue, the trial judge reasoned that although the precise mechanics of how the attempted forceps procedure caused the cord compression remained unknown (in other words was not established on the evidence), the temporal connection between the procedure and the onset of the fetal bradycardia was sufficient to reasonably infer that a causal connection existed between the two events (para. 135).

[82] However, the trial judge’s finding, that the appellant’s attempted forceps delivery caused the cord compression and bradycardia, is not supported by her findings of fact on the timing and sequence of events and is inconsistent with the undisputed medical evidence. In my view, this is not a case where an inference of causation could be drawn.

1. The common sense inference of causation

[83] The “robust and pragmatic” approach to the analysis of evidence adopted in Snell, which permits an inference of causation to be drawn in certain circumstances, is not applicable where evidence to the contrary on a plaintiff’s theory of causation is tendered. As Sopinka J., for the Court, stated:

[33] The legal or ultimate burden remains with the plaintiff, but in the absence of evidence to the contrary adduced by the defendant, an inference of causation may be drawn although positive or scientific proof of causation has not been adduced. If some evidence to the contrary is adduced by the defendant, the trial judge is entitled to take account of Lord Mansfield’s famous precept. This is, I believe, what Lord Bridge had in mind in Wilsher when he referred to a “robust and pragmatic approach to the ... facts” (p. 569). [Emphasis added.]
[84] This court confirmed in Moore v. Castlegar & District Hospital (1998), 49 B.C.L.R. (3d) 100 (C.A.) that "where both parties have led expert evidence on the issues of causation, it is not open to this court to apply the 'common sense' reasoning urged in Snell" (para. 11).

[85] In this case, the appellant led evidence to the contrary. While some potential causes for the cord compression were ruled out by the medical experts (including cord prolapse, placental abruption, and a short cord) there was also evidence that cord compression could occur from a "kink" in the cord or a nuchal cord, or in some instances for unknown reasons. The fact that the precise mechanism of how the cord compression occurred could not be determined did not lessen the burden of proof on the respondent or the trial judge’s task of having to weigh the evidence on causation in the context of her other findings of fact. The inference of causation from Snell was not available to be drawn. The trial judge had to determine whether the evidence established that, on a balance of probabilities, the appellant’s attempted forceps delivery was the cause of the cord compression.

2. Did the appellant’s attempted forceps delivery factually cause the bradycardia?

[86] The undisputed evidence was that fetal bradycardia would occur within seconds of cord compression. Therefore, if Dr. Johnston’s attempted forceps delivery had caused the cord compression, fetal bradycardia would have occurred almost contemporaneously with the forceps procedure. If, however, there was a gap in time between the abandonment of the forceps procedure and the onset of the fetal bradycardia, then the fetal bradycardia was likely caused by an event other than the attempted forceps delivery. This evidence on the timing of the onset of bradycardia was critical to the respondent’s theory of causation.

[87] In finding a causal connection between the attempted forceps delivery and Cassidy’s injuries based only on the close proximity in time between the two events, the trial judge appears to have overlooked her finding of fact in para. 124 of her reasons (see para. 52 above) that, based on Dr. LeGresley’s evidence, which she
accepted as reliable, the bradycardia began “within at most one and two minutes” after Dr. Johnston had abandoned the procedure and left the labour room to schedule a non-emergency Caesarean section. This was a critical finding of fact that had to be addressed by the trial judge in view of the consensus of opinion from the medical experts that cord compression would have caused an immediate (within seconds), sudden and dramatic decrease in the fetal heart rate.

[88] The trial judge’s conclusion, that the appellant’s attempted forceps delivery was the cause of the cord compression and thus the fetal bradycardia, is not supported by the evidence or her findings of fact based on the evidence, and consequently amounts to palpable and overriding error.

3. Did the respondent establish factual causation between the appellant’s negligent conduct and Cassidy’s injuries?

[89] The trial judge then turned to the second issue in the causation inquiry, namely whether the respondent had established that, but for the appellant’s negligent conduct in failing to ensure an adequate back-up was available, Cassidy’s injuries would not have occurred (para. 137). On this issue, she found that had back-up been available five to ten minutes earlier most, and possibly all, of Cassidy’s injuries could have been prevented (para. 138). The appellant does not dispute this finding. The trial judge then concluded that, based on Dr. Solimano’s evidence that persistent bradycardia will cause irreversible brain damage after ten minutes, the respondent had proven the “but for” test. However, it is unclear what evidence she relied upon to support that determination as there was no evidentiary basis and consequently no finding of fact that if a back-up team had been immediately available Cassidy could have been delivered five to ten minutes sooner and all or some of her injuries could have been prevented or diminished.

[90] That omission is not surprising given that no questions were directed to the medical experts or evidence adduced to support the theory that an “immediately available” surgical team could have delivered Cassidy within the first ten minutes of the onset of bradycardia. Rather, the focus at trial was how a “double set-up” could
have prevented all of Cassidy’s injuries. The consequences of a finding that the “immediately available” standard of care was applicable were never expressly addressed by the evidence. There was no evidence led and therefore no findings of fact made to support a determination that but for the appellant’s breaches of the standard of care, that is having a back-up surgical team “immediately available” and/or having obtained the respondent’s informed consent, Cassidy could have been delivered before any irreversible brain injury occurred.

[91] Before this court, the respondent submitted that the record could sustain a finding that, but for the appellant’s negligent conduct, Cassidy would not have suffered the injuries that she did. The appellant contended that the trial judge’s findings that “minutes mattered” based on the appellant’s breach of the “immediately available” standard of care had no evidentiary basis, and that even if the forceps procedure had caused the cord compression and bradycardia there was no evidentiary underpinning to support the respondent’s position that the appellant’s breaches of the standard of care had caused Cassidy’s injuries.

[92] A similar issue arose in Aristorenas v. Comcare Health Services (2006), 83 O.R. (3d) 282 (C.A.). At trial, the appellant doctor was found negligent in his post-natal treatment of the respondent patient who contracted necrotizing fasciitis three days after her release from the hospital. The appellant appealed only the issue of causation: whether the doctor’s negligence, which led to the delay in the respondent’s treatment, caused the necrotizing fasciitis. The Court concluded that the evidence did not support such a finding and the action was dismissed. In rejecting an application of the “robust and pragmatic” approach to drawing an inference of causation, Mr. Justice Rouleau, for the majority, concluded:

[73] When evaluating this evidence, the following difficulty becomes apparent. Even if you assume that there is a link between the delay in the treatment of an infection and contracting necrotizing fasciitis, no witness considered or gave evidence as to what effect the three-day delay in performing the first debridement had in this case.

... 

[80] I return to what Sharpe J.A. said at para. 25 of [Cotrelle v. Gerrard (2003), 67 O.R. (3d) 737 (C.A.), which in my view is fatal to the plaintiff’s position: “if, on a balance of probabilities, the plaintiff fails to prove that the
unfavourable outcome would have been avoided with prompt diagnosis and
treatment then the plaintiff’s claim must fail. It is not sufficient to prove that
adequate diagnosis and treatment would have a chance of avoiding the
unfavourable outcome unless that chance surpasses the threshold of more
likely than not. [Emphasis added.]

[93] In this case, no evidence was led nor findings of fact made regarding what
delay, if any, could have been avoided if the appellant had had a surgical team
“immediately available” or obtained Mrs. Ediger’s informed consent. Specifically, the
medical experts were never asked if Cassidy could have been delivered any faster
under the “immediately available” standard of care than she was delivered in the
existing circumstances where “everyone [was] rushing to prepare for a Caesarean
section”. Nor were they asked that had Dr. Johnston obtained Mrs. Ediger’s informed
consent to the procedure it would have made any difference to the outcome.

[94] In my view the reasoning in *Aristorenas* and *Cotelle v. Gerrard* (2003), 67
O.R. (3d) 737 (C.A.) is applicable in these circumstances. Absent evidence to
support a finding of fact that, but for Dr. Johnston’s breaches of the standard of care,
Cassidy would have been delivered earlier than she was and all or part of her
injuries would have been prevented or diminished factual causation on the “but for”
test was not established.

iv. The alternative causation argument – legal causation

[95] At trial, the respondent advanced an alternative argument on causation. The
trial judge found it unnecessary to deal with this argument but described it as
follows:

[140] ... [It is] the plaintiff’s position that the mechanism of the cord
compression may be regarded as irrelevant in this context because --
regardless of its cause -- the compression would have been relieved, and
Cassidy’s injuries avoided, if adequate back-up had been available, as the
standard of care required, when Dr. Johnston attempted the forceps delivery
with which the bradycardia coincided. That position relies on what -- if the
cord compression were unrelated to the forceps attempt -- would have been a
fortuitous temporal coincidence between an unexplained bradycardia and Dr.
Johnston’s failure to meet the standard of care concerning a medical
procedure unrelated to the bradycardia, and, in my view, would offer a less
direct route to causation. [Emphasis added.]
The essence of this submission is that Dr. Johnston should be held liable for Cassidy's injuries because his admitted negligence in failing to meet the “immediately available” standard of care and in failing to obtain Mrs. Ediger’s informed consent before attempting the forceps procedure was sufficient to establish legal causation for Cassidy's injuries.

However, legal causation between the appellant’s negligent conduct and Cassidy’s injuries requires a substantial connection between the two events. Cassidy's injuries must have been “within the risk” or “within the range” of harm that would arise from Dr. Johnston’s failure to have a surgical team immediately available or to have obtained Mrs. Ediger’s informed consent to the forceps procedure. Professor Linden’s statement that injury “must result from the type of risk to which plaintiffs expose themselves, not from a totally different hazard” (see para. 71 above) is apposite in these circumstances.

The respondent had to establish that the appellant’s attempted forceps procedure caused the bradycardia in order to establish legal causation. This finding was a vital link in the chain of causation. If Dr. Johnston’s attempted procedure did not cause the bradycardia, then Cassidy’s injuries were caused by something outside the risk of harm to which Mrs. Ediger was exposed by the procedure and therefore was not substantially connected to Cassidy’s injuries.

Although the risk of fetal bradycardia occurring during the forceps procedure existed, it was a risk that exists in every delivery. While the bradycardia was a risk to which Mrs. Ediger was exposed by the procedure, the evidence and the trial judge’s findings of fact on the timing of the onset of the bradycardia establish that the cause-in-fact of the bradycardia was unrelated to the forceps procedure. As the proximity between the cord compression and attendant bradycardia was not sufficiently close (i.e., within seconds) to establish that the bradycardia was caused by the forceps procedure, Cassidy’s injuries cannot be said to have occurred “within the risk” to which Mrs. Ediger was exposed by the procedure.
The trial judge’s finding that the appellant’s breach of the standard of care caused Cassidy’s injuries was made in the context of a finding that Dr. Johnston’s attempted forceps delivery caused the cord compression and in turn the fetal bradycardia. It was in that context that the trial judge found the harm to Cassidy was substantially connected to the appellant’s breach of the standard of care, and it was that connection which led to the trial judge’s conclusion that “minutes mattered”.

Absent the finding that Dr. Johnston’s actions factually caused the cord compression and consequential bradycardia, it was not, in my view, open for the respondent to argue that, but for the appellant’s breaches of the standard of care, the harm to Cassidy would not have occurred. It was the complications that could have arisen out of an attempted forceps delivery that was the identified risk of harm and required Dr. Johnston’s compliance with the “immediately available” standard of care, and it was those complications about which Dr. Johnston failed to inform Mrs. Ediger. In short, there was no substantial connection (ie., a lack of proximity) between the attempted forceps procedure and Dr. Johnston’s negligent conduct and therefore legal causation could not be established.

E. Conclusion

Medical negligence cases, particularly those involving the delivery a child, can be challenging in many respects. One can only feel sympathy for the tragic consequences that Cassidy has suffered from the injuries she sustained in birth, and for the demanding responsibilities that her parents lovingly provide in meeting her daily challenges. However, the burden of proof in any tort action remains with the party who advances the claim. In my view, that burden was not met on the evidence in this case.
Absent a causal connection between Dr. Johnston’s attempted forceps delivery and the cord compression with its attendant fetal bradycardia, the respondent’s action cannot succeed. In these circumstances, I am of the view that the appeal must be allowed and the action dismissed.

“The Honourable Madam Justice D. Smith”

I AGREE:

“The Honourable Madam Justice Saunders”

I AGREE:

“The Honourable Mr. Justice Groberman”