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MEDICAL PRACTITIONERS and THE LAW

Scope of Qualified Privilege: Summary Judgment Denied in Malice Case

Facts

Mr. B. J. Milne (the "Patient") was injured in an industrial accident in 1995, and made a claim to the Workers' Compensation Board (WCB) for benefits. What followed was a long, unfortunate process where the Patient was ultimately required by the WCB to attend before a medical review panel in 2001. He sued a number of physicians who provided reports to the WCB, including Dr. P. Darlington, alleging, among other things, error, misstatements, and conspiracy. The Patient additionally brought an action against Dr. Darlington in the tort of malice.

Dr. Darlington prepared four reports to the WCB regarding the Patient, dated between June 1998 and April 1999. The first report was extremely thorough and detailed, indicating that the Patient was exhibiting at least partial malingering, in addition to obsessive compulsive personality traits, and containing a number of recommendations. Thereafter, Dr. Darlington wrote a letter to Motor Vehicles indicating that the Patient was addicted to codeine and was an unsafe driver. In June 1998 the Patient asked to meet with Dr. Darlington and, after the meeting, Dr. Darlington provided a brief letter to the WCB disclosing the meeting and advising that he had no reason to modify his opinions.

In September 1998, the Patient wrote a lengthy letter of complaint to the College of Physicians and Surgeons (the "College") in relation to Dr. Darlington. The Patient's list of concerns included accusations of false information and bias. Dr. Darlington responded to the College in October 1998, and sent a third report to the WCB on the same day. Dr. Darlington addressed the College complaint in his WCB report, opined that the Patient was lying and malingering, and provided an updated diagnosis, including "narcissistic and obsessive compulsive traits."

In January 1999, the College responded to the Patient, finding that Dr. Darlington's duty had been fulfilled. Dr. Darlington's final report to the WCB was sent in April 1999, summarizing the College proceedings and reiterating a diagnosis of malingering.

Cause of Action

Dr. Darlington applied for summary dismissal, seeking to have the Patient's action struck on the basis that it disclosed no genuine issue for trial and would assuredly fail. Dr. Darlington swore that his reports were prepared without malice and in an honest belief that they were true.

Decision

The application was dismissed. The Court could not find that there was no genuine issue for trial.

Reasons

Malice

Section 34(4) of the *Workers' Compensation Act*, RSA 2000 c. W-15 provides that a report submitted by a physician to the WCB is privileged and, unless the report was made maliciously, is not admissible in evidence or to be produced in an action or proceeding against the reporting physician. As such, the *Act* awards physicians reporting to the WCB a "qualified privilege" for their reports, which can only be displaced by malice, defined as the intent, without justification or cause, to commit a wrongful act, reckless disregard of the law or a person's legal rights,and improper motive to injur another or to benefit a third party. A careful balance must be struck between respecting the purpose of qualified privilege and monitoring language in reports which can be seen as exceeding the privilege.

Five principles are used to determine whether malice exists to defeat qualified privilege (*Angle* v. *Lapierre*, 2008 ABCA 120):

(1) The defence of qualified privilege is not absolute;

(2) If malice is present, qualified privilege is defeated;

(3) Not all statements will be privileged, particularly where a statement is not appropriate in the context of the circumstances;

(4) A statement will be inappropriate where it is the product of indirect motive or ulterior purpose; and

(5) If the statement arises out of a sense of professional duty, knowledge that the statement might injur another is insufficient, standing alone, to destroy privilege.

While an honest belief in the truth of a statement generally cloaks the statement with privilege (*Davies & Davies Limited* v. *Kott*, [1979] 2 S.C.R. 686), malice is a fact-sensitive issue connected with the context in which it is said to arise.

Summary Judgment

In an application for summary dismissal of a claim, the bar is high, and the courts must be satisfied that there is no genuine issue for trial. Credibility cannot be assessed on an application for summary judgment; that assessment is to be performed by a trial judge. In this application, the Court was called upon to determine whether there was a genuine issue for trial on the question of the applicability of the exemption under s. 34(4) of the *Act*, namely, whether Dr. Darlington acted with malice in making his reports.

In this case there were enough factors, including inconsistencies in the reports, to raise a concern as to the veracity of Dr. Darlington's statement that his reports were prepared without malice. While the original report was thorough, there was virtually no analysis to explain or justify the changes in diagnosis in the last two reports. The final reports made no further recommendations, and appeared to add very little, in the Court's view. The concern of possible malice was not simply dismissed with the sworn statement of Dr. Darlington that he was not malicious when writing the reports, and that issue could not be dealt with on a summary basis. To find otherwise would mean every defamation case could be dismissed by a sworn statement that the alleged defaming party believed what he was saying was honestly true.

Milne v. *Darlington*, 2012 ABQB 518 (Alberta Court of Queen's Bench).

Authored by Anna Zadunayski LLB.

Delayed Diagnosis: Discoverability Occurs Only When Material Facts Are Known

Facts

In October 2002, Shauna Thompson (the "Patient") was seen by her family physician, Dr. Joanne Fry. Dr. Fry advised the Patient of the importance of breast self-examination in order to detect suspicious breast lumps. About a year later, in August 2003, the Patient saw Dr. Fry again and disclosed a family history of breast cancer. Dr. Fry again emphasized the importance of breast self-examination but, despite the concerning family history, did not feel that breast mammography was required or appropriate, likely because of the Patient's young age. Upon examination, the Patient's breasts were found to be normal.

The Patient later found a lump in her breast and, in January 2004, went to see Dr. Yogi Sehgal. Upon examination, he confirmed a 1 cm mass in the Patient's right breast. However, he did not order any further testing, either a

mammorgram, CT scan or biopsy. The Patient was diagnosed with a benign right breast lump, and was referred to Dr. James Sherstan, who she saw in February 2004. He performed a fine needle aspiration biopsy, but deferred mammography. His operative note indicated that, in his opinion, he was dealing with fibrocystic disease, not breast cancer. Unfortunately, the pathology report indicated that the fine needle biopsy specimen was deficient, and was inadequate to permit a diagnosis to be made. Dr. Sehgal concluded that the Patient did not have breast cancer, even though the biopsy was inadequate. There was no follow-up.

In April 2004, the Patient was concerned about the increasing size of the lump in her breast, and had an ultrasound test, which disclosed a solid 1.3 cm mass. The radiologist who interpreted that result suggested a clinical indication for a further biopsy. Again, there was no follow-up.

The lump continued to increase in size, and the Patient saw Dr. Sehgal in April 2005. He confirmed her concern, noted a family history of breast cancer, and documented a 1.5 cm breast mass. Despite this, he did not order any further diagnostics. Finally, in May 2006, the Patient requested that the mass be removed because of her family history. Nothing was done. Eight months later, in January 2007, another ultrasound showed the mass to be nearly 3 cms, more than double the size it had been previously. An additional lobulated mass was noted in the Patient's right axilla; typically regarded as highly suspicious for malignancy.

In February 2007, the Patient revisited Dr. Sherstan, given the findings. He extracted a mass from her right breast, which pathology confirmed to be a "Grade 1, 5 cm infiltrating ductal carcinoma of the right breast." Six months later, in August 2007, the Patient underwent a double mastectomy and axillary node dissection in Thunder Bay, Ontario. Following surgery, the Patient learned that she had Stage III cancer, and that there was a statistical likelihood that the cancer would return.

In October 2009, the Patient learned that the cancer had returned and that it had metastasized. On December 24, 2009, the Patient commenced an action for medical malpractice against three of her physicians (the "Physicians") on the basis of delayed diagnosis and negligence in the performance of a deficient breast biopsy. She is 35 years old and dying of terminal breast cancer.

Cause of Action

The Physicians brought an application for summary judgment, asking the Court to dismiss the Patient's claim under Rule 20 of the *Rules of Civil Procedure* on the basis that the limitation period had expired.

Decision

The application was dismissed. The Court opined that this was not a case where summary judgment could or should be granted. The Physicians failed to meet the high standard imposed upon them to show that there was no genuine issue for trial.

Reasons

Summary Judgment

Rule 20(4) requires that summary judgment be granted where there is no genuine issue for trial. The determining factor on this type of application is whether a fair and just determination of the claim can be achieved through summary judgment, bearing in mind that the purpose of the rule is not to eliminate trials, just trials that are unnecessary. If such a determination cannot be made, the matter must proceed to trial.

In some cases, it is more appropriate to use the summary judgment rule, for example, where a claim is clearly without merit, of where the interests of justice do not require that the matter be adjudicated at trial. For other cases however, disposition by way of summary judgment is not suitable.

Limitation Period

The Physicians alleged that the Patient had not brought her action in time, and that it should be summarily dismissed. Whether or not the Patient's claim was statute barred fell to be determined under section 4 of the *Limitations Act, 2002*. That provision precludes an action from being commenced after two years from the day on which the claim was discovered. Discoverability is defined as the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known that a cause of action existed.

The Physicians argued that the limitation period began to run in 2007, when the Patient first received her cancer diagnosis. The Court did not agree. In the Court's view, the Patient did not bring her action until 2009 because after her 2007 mastectomy, the cancer went into remission and the Patient was thought to be cancer free. In 2007, the Patient had no damage, and thus had no cause of action. Her claim arose when the cancer returned in 2009, and she was told that her condition was terminal.

The Court commented that, in this case, the failure of the Physicians to properly treat the Patient, and their delay in diagnosing her condition contributed to the severity or degree of advancement of her condition, and thus to the existence and extent of her damage or injury. That damage was only discoverable when all of the material facts became known to the Patient. It was too simplistic, in the Court's view, to suggest that all of the elements necessary to commence a cause of action were known to the Patient in 2007, because the extent of the damage or injury was not known at that time.

Shauna Thompson v. *Dr. Yogi Sehgal*, 2012 ONSC 3258 (Ontario Superior Court of Justice).

Authored by Anna Zadunayski, LLB.

MEDICAL PROFESSIONALS and THE LAW

Prescribing Practices: Appeal Court Upholds Penalty Decision

Editor's Note: The Memorandum of Judgment in this case was issued by the Alberta Court of Appeal on May 17, 2012. On May 31, 2012, the College of Physicians and Surgeons of Alberta issued a media release announcing that the appellant, Dr. Wachtler, would stand suspended beginning June 1, 2012 and ending November 30, 2012. Dr. Wachtler was directed to pay the College $82,654.94 no later than November 1, 2012; his practice permit would stand suspended until costs were paid in full.

Facts

Dr. O. Wachtler was found guilty of unbecoming conduct by the Council of the College of Physicians and Surgeons of Alberta (the "Council") in August 2007. The Council found that he had been improperly prescribing drugs and sanctioned him accordingly. Dr. Wachtler appealed that order, and his suspension and cost orders were stayed pending determination of the appeal. In the interim, Dr. Wachtler undertook not to prescribe restricted drugs.

In October 2008, following a rotine monitoring process, a Notice to Practitioner was issued from the College advising that Dr. Wachtler was being investigated for further unbecoming conduct. The College conducted a hearing and found that Dr. Wachtler had continued to prescribe restricted drugs, and failed to undertake a prescribing course stemming from the 2007 investigation. The Council suspended Dr. Wachtler's licence for six months, required an audit of his prescribing practices, and directed payment of 75% of costs of the investigation and appearances, failing which his practice permit and licence would be suspended until the costs were paid in full.

Cause of Action

Dr. Wachtler appealed the order of the Council finding him guilty of unbecoming conduct, arguing that the Council failed to give adequate reasons, relied upon hearsay, and imposed an excessive penalty.

Decision

In the Court's view, there was no basis to vary the penalty decision. As the penalty fell within the range of reasonable outcomes, the appeal was dismissed.

Reasons

Insufficient Reasons

Dr. Wachtler submitted that the reasons for decision given by the Council were insufficient. The sufficiency of reasons must be considered in the context of the more general analysis of the reasonableness of the decision (*Newfoundland and Labrador Nurses' Union* v. *Newfoundland and Labrador (Treasury Board)*, 2011 SCC 62). The question is whether the reasons reveal how and why a decision was made, and whether the decision is transparent, logical, and within the range of possible legal outcomes in the circumstances. In this case, the Court found the reasons and findings of the Council to be clear and supported by the evidence.

Hearsay

Dr. Wachtler objected to the admission into evidence of Alberta Blue Cross records on the basis that they were hearsay, that they could have been erroneous or misleading, and that their admission was so prejudicial as to result in a denial of natural justice. The Court disagreed, holding that copies of specific prescriptions, etc. had sufficient indicia of reliability and were of probative value. The evidence clearly supported a conclusion that Dr. Wachtler was continuing to prescribe restricted drugs. Testimony of profressional colleagues supported the same conclusion.

Penalty

The Court found no basis to vary the penalty decision. A six month suspension, a requirement of audit and peer review, together with the costs order were reasonable and made in accordance with the purposes of the *Medical Profession Act*.

Wachtler v. *College of Physicians and Surgeons of Alberta*, 2012 ABCA 145 (Alberta Court of Appeal).

Authored by Anna Zadunayski LLB.

Third Party Reports: Physician Cautioned to Maintain Objectivity

Facts

V.G. (the "Patient") was diagnosed with Hepatitis C in 1997, and with non-Hodgkin's lymphoma in 1999. Thereafter, the Patient began receiving long-term disability benefits through Manulife Financial ("Manulife"). Dr. E.F. (the "Physician") is a family physician with an active clinical practice in emergency medicine, who also acts as a part-time consultant to Manulife. At Manulife's request, the Physician reviewed the Patient's file and supplied an opinion regarding diagnosis, and severity of the conditions, including restrictions and limitations. The Physician never examined the Patient, whose benefits were terminated by Manulife in 2004.

The Patient discovered that Manulife had retained the Physician to provide an opinion regarding eligibility for benefits, and believed that the decision to deny benefits was based on that opinion. Manulife subsequently reinstated the benefits, however, the Patient made a complaint to the College of Physicians and Surgeons of Ontario (the "College") regarding the Physician's conduct. The complaint alleged:

(1) The Physician was not qualified to provide an opinion in the Patient's case and, in so doing, he was practicing medicine beyond his scope;

(2) The Physician provided an opinion without examining the Patient; and

(3) In providing the opinion, the Physician was motivated by financial gain, without regard for the health consequences of the Patient.

The College investigated the complaint, and decided to take no further action.

Dissatisfied, the Patient requested that the Health Professions Appeal and Review Board (the "Board") review the decision. The Patient forwarded to the Board several documents that he had discovered were missing from the record and had not been considered by the College, and complained that the Physician had knowingly misled College investigators in the case.

> "... all physicians have a duty to be as objective as possible in their review and presentation of medical evidence ... physicians are under a duty to prepare complete, accurate and objective reports, wherein the basis of the professional opinion is apparent."

The Board directed the College to reconsider the complaint, and to take into account the missing documents that were not provided to the College during the original investigation. Particularly troubling was a statement the Physician had made that "family physicians are advocates on behalf of their own patients," raising a question as to his objectivity. The College reconsidered its decision in accordance with the Board's direction, and decided to strongly counsel the Physician to be objective and unbiased in the preparation of third party reports.

Cause of Action

The Physician objected to the counsel and requested that the Board review the College's decision.

Decision

Pursuant to s. 35(1) of the *Health Professions Procedural Code*, Schedule 2 to the *Regulated Health Professions Act, 1991*, the Board confirmed the College's decision to strongly counsel the Physician to be objective and unbiased in the preparation of third party reports.

Reasons

Professional Integrity

In conducting a review of a College decision, the Board may make recommendations, but cannot require the College to do things outside of its jurisdiction, such as making findings of misconduct or incompetence.

In this case, the crux of the Physician's objection to the College's decision to counsel him was that it impugned his professional integrity. The Physician argued that the decision to issue a counsel was unreasonable, in that it was made without regard to the totality of the medical information upon which his third party reports were based.

The Board opined that the Physician was missing the point of the review. The College's task upon reconsideration was not aimed at the specific findings of the Physician, but on the perception of the reliability of those findings in light of his stated views.

College Policy on Third Party Reports

The College Policy on Third Party Reports states that all physicians have a

duty to be as objective as possible in their review and presentation of medical evidence, and that physicians are under a duty to prepare complete, accurate and objective reports, wherein the basis of the professional opinion is apparent.

In this case, the College was concerned with the possibility that the Physician's conclusions regarding the Patient were influenced by his stated characterization of information received from treating family physicians. Information supplied by the Patient's familiy doctor and oncologist indicated support of the disability claim largely because of fatigue and complications from treatment. Conversely, the Physician's reports to Manulife suggested that there was insufficient objective evidence of disability in the medical record.

While it is not unreasonable to suggest that family physicians *are* advocates for their patients, the College was troubled that the Physician might possibly dismiss information from treating family physicians due to perceived advocacy rather than on an objective review of the available medical evidence.

EF v. *VG*, 2012 CanLII 26800 (Ontario Health Professions Appeal and Review Board).

Authored by Anna Zadunayski LLB.

MEDICAL PATIENTS

Public Interest Standing Granted in Maternal-Child Rights Case

Facts

The Alouette Correctional Centre for Women (ACCW) opened in 2004 as the provincial medium security correctional facility for female offenders in British Columbia. The ACCW population includes a high number of women with fractured family backgrounds, including aboriginal women with a history of state apprehension. A significant number of women at ACCW are mothers.

After opening, ACCW developed the Mother-Baby Program (the "Program") that accomodated women giving birth while incarcerated, and allowed infants to remain with their mothers. The Program was cancelled in 2008, with no similar programs in the B.C. provincial correctional system. The only similar program in B.C. is the federal Mother-Child Program, offered at the Fraser Valley Institution in Abbotsford.

In September 2008, Patricia Block was arrested and charged with possession of cocaine for the purposes of trafficking, and she was remanded to ACCW. She pled guilty to the charge and, at the time of sentencing, was approximately 4.5 months pregnant. Due to the cancellation of the Mother-Baby Program, Ms. Block requested a longer, two-year federal sentence in order to have the opportunities of the Mother-Child Program and remain with her baby. The request was denied due to the short length of her sentence and anticipated parole. Her newborn daughter was removed from her care shortly after birth. Since 2008, numerous other birthing women, both aboriginal and non-aboriginal, in the provincial corrections system have had a similar experience.

A number of individuals impacted by the Program closure (the "Plaintiffs") commenced an action seeking to establish the constitutional right of mothers and infants to remain together while mothers are incarcerated in the provincial corrections system. The Statement of Claim alleged that the cancellation of the Program infringed the rights of both mothers and infants under ss. 7, 12 and 15 of the *Charter of Rights and Freedoms*. Specifically, the claim alleges that the Program cancellation:

(1) Seriously interfered with the psychological integrity of both babies and mothers;

(2) Deprived infants of the health benefits of breastfeeding;

(3) Deprived infants of the opportunity for bonding with their mothers;

(4) Contributed to maternal stress and depression;

(5) Forced women to choose longer sentences in the federal system as the only possible way to remain with their newborns; and

(6) Disproportionately affected and systematically discriminated against aboriginal women and babies.

The relief sought included declaratory relief under s. 24(1) of the *Charter*, that the cancellation of the Mother-Baby Program was unconstitutional. The impugned law was s.38(2) of the *Correction Act Regulation*, B.C. Reg 191/2007, setting out jurisdiction regarding programs for inmates. There are no reported Canadian cases considering the constitutional rights of mothers and babies to remain together during incarceration and the obligations of the corrections system to accommodate and respect such rights.

The Minister of Public Safety and the Attorney General of British Columbia (the "Defendants"), among others, took the position that the Plaintiffs

lacked a direct interest in the cancellation of the Program and had failed to disclose a reasonable claim under the *Charter*.

Cause of Action

The Plaintiffs applied to the Court for public interest standing to advance their claim(s), and to add affected infants into the action.

Decision

The application was granted. The Court granted the Plaintiffs public interest standing to advance their constitutional claim(s).

Reasons

Public Interest Standing

The test for public interest standing to bring a constitutional challenge is a 3-part test (*Canadian Council of Churches* v. *Canada (Minister of Employment and Immigration)*, [1992] 1 S.C.R. 236):

(1) Is there a serious issue raised as to the constitutional validity of the legislation in question?

(2) Is the plaintiff directly affected, or does the plaintiff have a genuine interest in the validity of the legislation?

(3) Is there another reasonable and effective way to bring the issue forward?

In this case, it was clear to the Court that the action presents a serious issue to be tried, given the issues raised in the pleadings. The Plaintiffs had a genuine interest in the litigation, given their lived experiences. The crux of the application became the third question, namely, whether there was another reasonable and effective way to bring the issue(s) forward.

The purpose of granting public interest status is to prevent the immunization of legislation or public acts from any challenge, particularly where it is improbable that a private litigant will bring a challenge forward. While a class of persons could be identified who were directly affected by the cancellation of the Program, the question was not whether there was a more appropriate individual to initiate the challenge, but whether such a person would do so. The vulnerable status of such persons is an important element in the analysis. As such, the Court concluded that this was an appropriate case to exercise discretion to grant public interest standing to enable the adjudication of the action as pleaded.

Inglis v. *British Columbia (Minister of Public Safety)*, 2012 BCSC 1023 (Supreme Court of British Columbia).

Authored by Anna Zadunayski LLB.

Ending the Physician-Patient Relationship: Family Doctor Follows Protocol

Facts

M.L.B. (the "Patient") had a history of mental health concerns and a longstanding movement disorder requiring the use of a wheelchair and a catheter. In 2007, she began working at a call centre in Kingston, Ontario. In time, she began to have troubles at work, due to pain and her need for frequent breaks. In 2009, the Patient had a suprapubic catheter inserted, and her ongoing treatment was supervised by a urologist.

The Patient experienced problems and pain associated with the catheter and, in May 2009, she attended at the emergency department of a hospital due to her concerns. Thereafter, she continued under the care of L.A.B. ("Dr. B."), a family physician. Dr. B. agreed to provide a note for the Patient's employer so that the Patient's needs could be accomodated. He also made a series of referrals for the Patient regarding daily cleaning care and pain control.

In response to the Patient's concerns about workplace stress, Dr. B. provided a note to her employer stating, "… she will be unable to attend at the workplace for medical reasons for the foreseeable future." Thereafter, Dr. B. completed an Attending Physician Form to support the Patient's absence from work. In August 2009, the Patient received a letter from the disability management firm for her employer, stating that her continued absence from work was not supported. Dr. B. wrote a letter on the Patient's behalf, indicating a diagnosis of adjustment disorder with fixed mood features supported by symptoms of severe subjective anxiety, difficulty concentrating, social isolation, tendency toward conflict, insomnia, rumination and episodic suicidal ideation.

During an appointment in September 2009, the Patient openly disagreed with the contents of Dr. B.'s letter, indicating that it "made her look bad, as someone undesireable to the company." Dr. B. responded that the Patient could take the letter or leave it, but that it constituted his medical opinion at the time. The appointment ended with Dr. B. questioning whether it made sense to continue the doctor-patient relationship. The Patient resigned from her job, and thereafter received a letter from Dr. B. indicating that he was no longer able to act as her family physician.

The Patient made a complaint to the College of Physicians and Surgeons of Ontario regarding Dr. B.'s care and conduct. Among other things, the Patient complained that Dr. B.:

(1) Failed to provide appropriate care;

(2) Inappropriately characterised her as having episodic suicidal ideation when she believed she was emotionally frustrated but not mentally ill;

(3) Acted in an unprofessional manner; and

(4) Terminated her as a patient inappropriately.

The College investigated the complaint, and decided to take no further action.

Cause of Action

Dissatisfied with the response from the College, the Patient brought the matter to the Health Professions Appeal and Review Board (the "Board").

Decision

The Board reviewed the matter, and confirmed the decision of the College to take no further action.

Reasons

Powers of the Board

Under s. 33(1) of the *Health Professions Procedural Code*, being Schedule 2 to the *Regulated Health Professions Act, 1991*, the mandate of the Board in a complaint review is to consider the process and decision of the College. The Board will consider either the adequacy of the investigation, the reasonableness of the decision, or both.

Adequacy of the Investigation

An adequate investigation need not be exhaustive, rather, essential information must be obtained relevant to making an informed decision regarding issues raised by the complaint. In this case, the College obtained communications from the Patient, a response from Dr. B., records from the Patient's employer, and her medical records. Additionally, the Patient submitted a number of unauthorised audio recordings from medical appointments with Dr. B.

The Patient submitted that the College investigation was inadequate because the College did not listen to the audio recordings from a number of doctor's appointments. The Patient acknowledged that the recordings were obtained without consent. Nevertheless, after reviewing the audio recordings, the Board opined that the content of the recordings would not have changed the College's decision. In the end, the Board found that the College obtained the essential information relevant to making an informed decision regarding the issues raised by the complaint.

> "... breakdown of trust and respect between the physician and patient is a situation where a physician may decide to end the physician-patient relationship, as trust and respect are the foundation of that relationship."

Reasonableness of the Decision

In considering reasonableness, the question for the Board was not whether it would have reached the same decision as the College, but whether the decision was reasonably supported by the information such that it could withstand a somewhat probing examination. Did the College decision fall within a range of possible, acceptable outcomes that were defensible in respect of the facts and the law?

Appropriate Care and Professionalism

One of the Patient's primary complaints was that Dr. B. had mischaracterised her mental health status by noting "episodic suicidal ideation" in the letter to her employer. In considering the Patient's complaints, the College had the Patient's full medical chart. On review, the Board noted that medical records from other health professionals indicated that the Patient had a lengthy history of psychiatric illness from childhood, and had been hospitalized several times for long periods due to mental illness. Suicidal ideation was well supported in the record. As such, the Board found that Dr. B. did not provide inaccurate information, and the College's decision not to take further action fell within a range of acceptable outcomes based on the information in the record.

Ending the Physician-Patient Relationship

The College's Policy #3-08 *Ending the Physician-Patient Relationship* lists "breakdown of trust and respect between the physician and patient" as a situation where a physician may decide to end the physician-patient relationship, as trust and respect are the foundation of the relationship and, without them, the physician is no longer able to provide quality care to the patient.

In this case, Dr. B. followed the recommended protocol by sending a letter to the Patient outlining the reasons for the discharge and suggestions for securing alternate care. The Board noted that when a physician terminates a physician-patient relationship, the provision of necessary interim medical services should be ensured, which Dr. B. had done by way of professional referrals. The Board affirmed the decision of the College not to take further action as being resonable in the circumstances.

MLB v. *LAB*, 2012 CanLII 46002 (Ontario Health Professionals Appeal and Review Board).

Authored by Anna Zadunayski LLB.

MEDICAL ADMINISTRATION

Necrotizing Faciitis: Action Against Health Authority Summarily Dismissed

Facts

In June 2008, Mr. Zachery Basil (the "Patient") attended at the East Kootenay Regional Hospital complaining of pain and an injury to his left foot. He was assessed and triaged, was given an x-ray, medical tape to support his big toe, prescribed an air cast brace, and discharged without any laboratory tests. The Patient was seen as an outpatient and was not admitted to the Hospital.

The following evening, the Patient's condition and pain had worsened, and his niece contacted the Creston Valley Hospital by telephone. She was told that, since it was after hours, there was no physician directly on site, and that the Patient could be seen the next day. She was further told to elevate the Patient's leg and to monitor his condition.

The Patient died two days later, as a result of a streptococcus A infection leading to necritizing fasciitis, or "flesh eating disease." His estate brought an action in negligence against the Hospitals, alleging a failure to investigate and diagnose, and a breach of the standard of care. No physicians were named in the action.

Cause of Action

The Hospitals applied for summary dismissal of the action, as failing to show a cause of action and as being outside of the limitation period.

Decision

The application was granted, and the action was dismissed.

Reasons

Scope of Responsibility

The Hospitals denied all negligence, arguing that hospitals are not responsible for ordering medical diagnostic tests, including laboratory tests, diagnosing medical conditions or making medical decisions. Such decisions are made by physicians who are independent contractors, and not persons for whom hospitals are generally vicariously liable. It has long been established that hospitals are not responsible for the negligence of non-employed medical staff (*Yepremian et al*. v. *Scarborough General Hospital et al*., (1980) 110 DLR (3d) 513). None of the particulars of negligence outlined in the claim, including the failure to undertake a diagnostic investigation, failure to conduct tests of blood and urine, and failure to prescribe medication, were within the scope of responsibility of the Hospitals or employees for whom the Hospitals were responsible. Given that the claims were founded on issues of medical diagnosis and treatment and no medical professionals were named in the action, liability could not attach to the Hospitals.

Summary Dismissal

In deciding whether a case is appropriate for summary judgment, full consideration must be given to all of the evidence, including whether the evidence is sufficient for adjudication. On application, the Court must be able to find the facts necessary to decide the issues of fact and law and must be of the opinion that it would be just to decide the issues on the application, rather than at trial.

In this case, the burden was on the plaintiffs to prove that a breach of the Hospitals' duties caused a loss. It was not sufficient to make generalized allegations, and to take no steps to establish those allegations. Given that no claim in negligence could be maintained against the Hospitals, and given the delays in the action contrary to the *Limitation Act*, the Court held that it was not in the interests of justice to allow the action to proceed to trial.

Basil v. *Interior Health Authority*, 2012 BCSC 1158 (British Columbia Supreme Court).

Authored by Anna Zadunayski LLB.

We welcome back Anna Zadunayski as Author and Editor of our Medico-Legal Reporter

Anna Zadunayski LLB, MSc(c) is a Calgary-based bioethicist, litigation and research lawyer, and writer.

She is the Clinical Ethicist at Alberta Children's Hospital and Foothills Medical Centre in Calgary, where she supports patients, families and healthcare teams facing challenging medical decisions.

Anna has a particular interest in perinatal law and maternal-child health ethics.

OTHER INTERESTING CASES

When Individual Citizens Take Matters Into Their Own Hands: Two Cases

Public Safety Risk: Emotional Distress is No Defence

Facts

In March 2011, David and Amie Weber were expecting their second child. Due to pregnancy complications, their baby was to be delivered by a planned caesarean section on March 25, 2011, in Brandon, Manitoba. On March 21, 2011, the Weber family was driving home from Winnipeg when Amie began experiencing contractions and bleeding. They did not have a cell phone and therefore could not call for assistance. David Weber knew from a previous conversation with their physician that smaller centres such as Portage la Prairie did not have facilities to perform a caesarean section, so he decided to rush to Brandon.

Mr. Weber was pulled over for speeding by an RCMP officer outside of Portage la Prairie. He requested assistance and an escort, but was presented with a $964.75 speeding ticket for travelling 172 km/hour in a 100 km/hour zone, and was told to attend a nearby hospital to arrange for an ambulance to Brandon. Instead, he continued west on Highway 1, and was pulled over again and presented with a second ticket for speeding. The RCMP officer on this occasion arranged for an ambulance to Brandon, where Amie Weber gave birth later that day.

In Provincial Court, Mr. Weber pled guilty to one count of speeding. The second ticket was quashed due to a deficiency, namely, the face of the ticket failed to disclose an offence. On sentencing, the first ticket was reduced to $400.00. The Justice of the Peace (the "JP") expressed concern that Mr. Weber:

(1) Decided to proceed without obtaining professional help;

(2) Failed to follow the advice of the first officer to attend hospital in Portage la Prairie; and

(3) Was a danger to others on the highway while travelling at an excessive speed.

Further, had Mr. Weber arranged for an ambulance, transport would have been much safer for all.

Thereafter, Mr. Weber's driver's licence was suspended by the Registrar of Motor Vehicles (the "Registrar"), likely due to excessive speed.

Cause of Action

Mr. Weber appealed the sentence, given the exceptional circumstances. He maintained that his actions were motivated by the belief that his wife and unborn child were at risk.

Decision

The appeal was dismissed. While the Court agreed that some reduction of the set fine was appropriate given all of the factors, the Court was not prepared to interfere with the discretion of the sentencing JP.

Reasons

Standard of Review

Absent an error in principle or failure to consider a relevant factor, an appellate court should only intervene to vary a sentence where it is demonstrably unfit (*R.* v. *M.* (C.A.), [1996] 1 S.C.R. 500 at 90). This deferential standard of review has profound functional justifications. Not only does a sentencing judge have the advantage of directly assessing submission to all parties, but will normally preside in close proximity to the community which bears the consequences of the crime. As such, a sentencing judge will have a strong sense of sentencing goals that are "just and appropriate" for the protection of that community. The discretion of a sentencing judge should thus not be interfered with lightly.

In this case, the sentencing JP clearly listened to the compelling explanation given by Mr. Weber at the hearing, as well as reading into the record a letter written by their physician. The JP considered that Mr. Weber was "emotionally distraught" with his mind fixed on the health of his wife and unborn child, and assessed a fine that was some $564.75 less than the set fine at the speed of 172 km/hour. The driver's licence suspension was levied by the Registrar after conviction, outside of the purview and control of the sentencing JP. As such, the Court held that the sentencing JP considered all of the relevant factors and made no error in principle. The Court was not prepared to interfere with the discretion of the JP.

R. v. *Weber*, 2012 MBQB 162 (Manitoba Court of Queen's Bench).

Authored by Anna Zadunayski LLB.

Defence of Necessity: Balancing Harms in a Medical Crisis

Facts

On January 28th, 2010, Mr. Jeffrey Davis and his wife were at home in a rural area on the outskirts of Thunder Bay, Ontario. They had supper and retired for the evening. Mr. Davis had consumed four alcoholic beverages, and did not intend to leave his residence or drive that evening.

Shortly after midnight, Mr. Davis's wife (the "Patient") suffered a fall and fractured her leg. As she was in considerable pain and quite distraught, Mr. Davis called an ambulance, which arrived within 30 minutes. The attendants loaded the Patient into the ambulance and left for Thunder Bay Regional Health Sciences Centre (the "Hospital"), approximately 10 miles from the residence. Along the way, the Patient was in extreme pain and lost consciousness. She awakened at the Hospital, but was in no condition to provide information regarding her complex medical history or to give instructions about her healthcare. She eventually had surgery to repair the fracture.

Given the circumstances, Mr. Davis believed that he had no alternative but to follow the ambulance in his own vehicle. The ambulance attendants did not offer him a ride, nor did he ask for one. En route, Mr. Davis was stopped by an Ontario Provincial Police Constable for a traffic violation near the Thunder Bay Expressway. Mr. Davis explained that he was in a hurry, following an ambulance transporting his wife to the Hospital. The Constable noted an odour of alcohol. Mr. Davis said that he had consumed alcohol that evening, and complied with a demand to provide a breath sample. Mr. Davis failed the screen, was arrested, cautioned, and taken to the police station for processing. He was cooperative, and thereafter was taken by the police to the Hospital to see his wife.

Mr. Davis was charged with operating a motor vehicle with a blood alcohol concentration in excess of the legal limit.

Cause of Action

Mr. Davis pleaded the defence of necessity, and the matter went to trial.

Decision

The Court concluded that there was no air of reality to the defence of necessity in this case. Mr. Davis was convicted of impaired driving.

Reasons

Defence of Necessity

The only issue before the Court was whether the defence of necessity applied. There are three elements to the defence (*R.* v. *Latimer*, [2001] 1 SCR 3):

(1) There is a requirement of imminent peril or danger; harm must be unavoidable and near;

(2) The accused must have no reasonable alternative to the action he undertakes, requiring a realistic appreciation of the available alternatives; and

(3) There must be proportionality between the harm inflicted and the harm avoided.

The legal test for the first two elements is a modified objective standard, taking into account the situation and circumstances. The proportionality requirement is to be considered using an objective standard. If there is an 'air of reality' to the defence of necessity, the onus is on the Crown to prove its case beyond a reasonable doubt.

Imminent Peril

The first requirement is imminent peril or danger. In this case, the Patient had a serious leg injury and was in excruciating pain. Once the ambulance arrived, trained professionals took charge of the Patient's care and transported her to the Hospital. The Court noted that Mr. Davis remained understandably concerned for his wife's wellbeing, however the situation did not rise to the level of imminent peril or danger. The Court might have viewed the case differently in the extreme circumstance where Mr. Davis could not have contacted professional help.

No Reasonable Alternative

The second requirement is that Mr. Davis had no reasonable alternative but to drive to the Hospital himself. The Court noted that Mr. Davis had available alternatives, including:

(1) Asking to ride in the ambulance;

(2) Calling a taxi;

(3) Seeking the help of a neighbour; or

(4) Calling a friend or relative.

The Court further noted that, while the alternatives would have taken more time, Mr. Davis could have telephoned the Hospital to advise of any concerns, particularly regarding his wife's medical history and medications. Instead, the Court opined that Mr. Davis acted on instinct motivated by compassion and concern for his wife's health, rather than considering alternatives.

Proportionality: Balancing Harms

The third requirement is proportionality: the harm inflicted (impaired driving) must not be greater than the harm avoided (attending at the Hospital quickly). Regarding this requirement, the Court noted a significant public interest in preventing drinking and driving; the risks associated with the crime are well-known and very real, including property damage, bodily harm and death. Using an objective standard, the Court held that the public risk of impaired driving outweighed Mr. Davis's individual need to attend at the Hospital quickly, given that the Patient was in the care of trained medical professionals.

R. v. Davis, 2012 ONCJ 434 (Ontario Court of Justice).

Authored by Anna Zadunayski LLB.

Implications & Applications

The preceeding two cases highlight the potential pitfalls of taking matters into one's own hands and failing to seek appropriate professional assistance. Both cases also raise the question of the role of emergency responders, such as police or ambulance attendants, in supporting citizens who are emotionally distressed, and may need support in basic communication and decision-making. While the courts are likely to be sympathetic to individuals facing an emergent medical crisis, real or perceived, the cases illustrate that the public safety risks of reckless or illegal individual action remain of paramount concern to the courts, and will not go unaddressed.

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