S.C.C. File No.: 39049

IN THE SUPREME COURT OF CANADA
(ON APPEAL FROM THE COURT OF APPEAL OF ONTARIO)

B E T W E E N:

KAREN ARMSTRONG

APPELLANT
(Respondent)

and

ROYAL VICTORIA HOSPITAL, DR. COLIN WARD, DR. SCOTT POWELL, DR. JESSIE-JEAN WEAVER and DR. JOSEPH A. ZADRA

RESPONDENT
(Appellant)

and

HEALTHCARE INSURANCE RECIPROCAL OF CANADA and ONTARIO TRIAL LAWYERS' ASSOCIATION

INTERVENERS

FACTUM OF THE RESPONDENT, DR. COLIN WARD

(Pursuant to Rule 42 of the *Rules of the Supreme Court of Canada*)

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PART I - OVERVIEW AND FACTS

OVERVIEW

1. On February 5, 2010, the Respondent, Dr. Colin Ward ("**Dr. Ward**"), carried out a colectomy on the Appellant, Karen Armstrong ("**Ms. Armstrong**") (the "**Surgery**"). The Surgery was uneventful, and routine follow-ups were normal. Ten weeks after the Surgery, it was discovered that Ms. Armstrong had suffered an injury to her ureter, which required her kidney to be removed.

2. Justice Mulligan of the Ontario Superior Court of Justice (the "**Trial Judge**") found that Dr. Ward breached the standard of care and caused the injury to Ms. Armstrong's ureter.

3. The Trial Judge made a series of compounding errors in coming to his decision. He combined the assessment of the standard of care issues with the causation analysis. This was an error.

4. This error caused the Trial Judge to work backwards rather than to first define the standard of care, whether there was a breach, and then relate causation to the breach. He unreasonably accepted the evidence of the Appellant's standard of care expert that any injury would be a breach of the standard of care. The Trial Judge accepted that "no injury" is part of the definition of the standard of care, and consequently the injury resulted in a breach. His analysis of breach and causation was identical.

5. Starting the analysis with causation led the Trial Judge to reason based on hindsight and results, and to impose a standard of perfection on Dr. Ward. These were errors. The correct approach—determining whether the surgeon acted reasonably in the technique employed in carrying out the Surgery; namely, to identify and protect the ureter—was not used to define the standard or to assess breach. Where identity and protection were considered, the Trial Judge found

that Dr. Ward met the standard; however, because the Trial Judge infused his definition of the standard of care with his determination as to what caused the injury, the Trial Judge nonetheless found a breach of the standard.

6. The Court of Appeal for Ontario (the "**Court of Appeal**") correctly reversed the decision. It affirmed established medical negligence law that a trial judge must appropriately define the standard of care and identify a breach. While there may be extremely rare circumstances where the injury itself may be relied on as evidence of a breach of the standard of care, this was not such a case. This was a complex surgical procedure with a known risk of ureteric injury. The Trial Judge's reliance solely on the injury led him to a determination based on results and improper reasoning. The Court of Appeal correctly reversed the decision on this basis.

7. Across this country untold thousands of medical procedures of varying levels of complexity and risk occur every year. Misadventure is inevitable because of the reality that perfection in all cases is unachievable. For this reason, a core principle of professional negligence law is that one cannot reason backwards from an adverse outcome, implicitly assuming that if something went wrong, then someone must be to blame. In substance, the Trial Judge did exactly that, defining the requisite standard of conduct for all practical terms as "not causing an adverse outcome".

8. This appeal should be dismissed.

THE FACTS

9. The Respondent adds the following facts to those set out by the Appellant.

A. THE SURGERY

10. The Surgery was not a straightforward procedure. The Surgery involved Dr. Ward removing Ms. Armstrong's entire colonic structure, including the right, left, and transverse colon.[1]

(i) Anatomy

11. The colon is a U-shaped structure located in the abdomen. It is a very large organ, approximately four to five feet in length. It frames the abdomen. The ureter is a muscular tube that carries urine at a low pressure from the kidney to the bladder. There are two ureters: a left and a right ureter. A ureter is located on each side (left and right) of the colon. There are other structures in the vicinity of colon, including the kidneys and several blood vessels.[2]

(ii) Carrying out the Surgery

12. The Surgery involved:

(a) inserting laparoscopic ports on the left side of the body so the Surgery could be performed on the right side;

(b) mobilizing the right colon by dividing (cutting) the peritoneum and performing blunt dissection (i.e., using a flat instrument to push the colon into the appropriate place);

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[1] Evidence of Dr. Colin Ward, January 12, 2018 ("**Ward Evidence**") at p 14, ll 1-15, Appeal Record of the Appellant, Volume II ("**Appellant Record II**"), Tab 14, p 174.

[2] Reasons of the Trial Judge, indexed as *Armstrong v Royal Victoria Hospital*, 2018 ONSC 2439 at paras 24-27 ("**Trial Decision**"), Appeal Record of the Appellant, Volume I ("**Appellant Record I**"), Tab 1, pp 6-7; Evidence of Dr. Marcus Burnstein, January 11, 2018 ("**Burnstein Evidence**") at p 12, l 3 – p 14, l 13, Appellant Record II, Tab 13, pp 90-92; Evidence of Dr. Laurence Klotz, January 10, 2018 ("**Klotz Evidence**") at p 6, l 14 – p 7, l 19, p 12, l 3-13, Appellant Record II, Tab 12, pp 36-37, 42; Trial Exhibits 3 – Diagram of the Abdomen, Appellant Record II, Tab 17, p 317; Trial Exhibit 3 – Diagram of the Colon, Appellant Record II, Tab 18, p 318.

(c) once the right colon was mobilized, inserting laparoscopic ports into the right side of the abdomen, to perform the remainder of the Surgery on the left side;

(d) prior to mobilizing the remaining colonic structures, identifying the ureter and the blood supply by moving the colon "up towards the ateric [*sic*] abdomen wall" and dissecting medially the mesentery, "tenting" the inferior mesenteric vessels, and visualizing the ureter, seeing it vermiculate, and sweeping it away using blunt dissection;

(e) once the ureter had "disappear[ed] back into the retroperitoneal", opening the LigaSure and mobilizing the left colon with the LigaSure by dividing the colonic mesentery near the bowel, taking "small bites of tissue all the way along" to free up the entire colon to be removed; and,

(f) always "checking and rechecking" where the ureter was when dividing other tissues.[3]

13. When these steps were completed, the colon was removed from the body.

(iii) Laparoscopic and open surgeries

14. The Surgery was performed laparoscopically. Laparoscopic surgery is performed by making small "keyhole" incisions and inserting a laparoscope (a long fibre optic cable system), which allows the surgical team to view the affected area from distance using cameras and screens in the operating room.[4]

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[3] Ward Evidence at p 13, l 25 – p 22, l 11, Appellant Record II, Tab 14, pp 173-182; Evidence of Dr. John Hagen, January 16, 2018 ("**Hagen Evidence**") at p 14, l 5 – p 15, l 13, Appellant Record II, Tab 16, at pp 288-89.

[4] Trial Decision, *supra* at paras 21-23, Appellant Record I, Tab 1, p 6; Ward Evidence at p 12, ll 13-32, Appellant Record II, Tab 14, at p 172.

15. The Surgery could have been performed using the open method. The open method is performed by making a traditional large abdomen midline incision.[5]

16. The surgeon approaches the operation differently in each method. The process of dividing the colonic mesentery and identifying the ureter is different in open versus laparoscopic surgery:

> [in the] laparoscopic approach, you tent up the inferior mesenteric vessels. You make a little window underneath those vessels and in the ten o'clock position, you identify the left ureter and you sweep it away, as described in the operative report, and you can identify it that way from the medial side.
>
> …
>
> When the surgeon is doing laparoscopic surgery, standing on the right side of the patient, right-hand side of the patient and so you're operating towards the left side. When you do open surgery, you're typically standing on the left-hand side of the patient.
>
> …
>
> And so when you do it with the open approach, typically, you divide the attachments of the colon on the lateral side because you're on the left side of the patient and you identify the ureter by the, the lateral approach and so you sweep the colon medially and you can see the ureter laying underneath the mesentery of the colon, yeah.[6]

17. The LigaSure, the device used to divide the colonic mesentery in the Surgery, is not used when a colectomy is performed using the open method.[7]

B. POST-SURGERY ATTENDANCES

18. Following the Surgery, Ms. Armstrong attended upon Dr. Ward on three occasions between February and March 2010. At all appointments, Ms. Armstrong presented with no serious or concerning issues, other than some discomfort.[8]

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[5] Ward Evidence at p 12, ll 13-32, Appellant Record II, Tab 14, at p 172.
[6] Hagen Evidence at p 14 ll 11-32, p 15 l 1, Appellant Record II, Tab 16, at pp 288-89. See also Ward Evidence at p 14 l 30 – p 15 l 23, Appellant Record II, Tab 14, at pp 174-75.
[7] Hagen Evidence at p 15 ll 26-29, Appellant Record II, Tab 16, at p 289.
[8] Trial Decision, *supra* at paras 16, 86, Appellant Record I, Tab 1, pp 4-5, 19.

19. Approximately ten weeks after the Surgery, Ms. Armstrong attended at the emergency department at the Royal Victoria Hospital and reported complaints of abdominal and left flank pain. Ms. Armstrong had a CT scan, and re-attended upon Dr. Ward. Dr. Ward referred her to a urologist, who identified an obstruction to her left ureter.[9]

20. On October 29, 2010, Dr. Cory Hartsburg, a urologist, performed a nephrectomy (the removal of Ms. Armstrong's left kidney). Dr. Hartsburg noted in his operative report that he "tried to follow the ureter down; however due to her previous colectomy there just seemed to be a lot of adhesions and scarring beyond the proximal third of the ureter and that [*sic*] certainly appeared that the source of the obstruction to the ureter was from scarring from her previous surgery". The operative report makes no mention that the ureter had suffered a thermal injury.[10]

C. THE TRIAL DECISION

21. Damages were settled in advance of trial. The issues at trial were standard of care and causation. The Trial Judge found that Dr. Ward breached the standard of care and that his breach caused Ms. Armstrong's injuries (the "**Trial Decision**").[11]

(i) The framework of the Trial Decision

22. The Trial Judge found that the injury to the ureter was caused by the LigaSure coming within one to two millimetres of the ureter. The Trial Judge reached this conclusion before analyzing the evidence on the standard of care and defining the reasonable standard of care to be utilized by Dr. Ward in performing the Surgery.

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[9] Trial Decision, *supra* at para 16, Appellant Record I, Tab 1, pp 4-5; Medical Records of Karen Armstrong, Appeal Record of the Respondent ("**Respondent Record**"), Tab 1, pp 24, 27, 29, 33.
[10] Trial Decision, *supra* at paras 17-18, Appellant Record I, Tab 1, p 5; Medical Records of Karen Armstrong, Respondent Record, Tab 1, pp 49-50.
[11] Trial Decision, *supra* at paras 4-7, Appellant Record I, Tab 1, p 2.

23. The conclusion on causation informed and infected the Trial Judge's definition of the standard of care, and whether there was a breach.

24. The Trial Judge dedicated his review of the evidence not to the performance of the Surgery, but rather to analysis of the injury. The first sixty-four paragraphs of the Trial Decision primarily focused on determining how the injury occurred based on the nature of the LigaSure and risk of injury. The Trial Judge then identified the issues he perceived were to be considered:

> The issue to be determined by the court can therefore be defined by answers to the following questions:
>
> > (a) Did Dr. Ward breach the standard of care expected of a general surgeon by touching or coming within one to two millimetres of Armstrong's ureter using the LigaSure?
> >
> > (b) Further, if such conduct occurred, did it cause the subsequent damage to Armstrong's ureter?[12]

25. The Trial Judge did not consider or discuss the steps a reasonable prudent surgeon would take in carrying out the Surgery prior to framing the issues in this way. The Trial Judge framed and defined the standard of care before analyzing the evidence on that issue. He relied on his conclusion about how the injury occurred in defining the standard of care expected of Dr. Ward.

(ii) The standard of care

26. The Trial Judge defined the standard of care as follows:

> I am satisfied that the standard of care for a general surgeon is to identify, protect, and avoid direct contact with or close proximity to the ureter when using an energy emitting device like the LigaSure.[13]

27. Close proximity was identified as 1-2 millimetres.[14] Coming within 1-2 millimetres of the ureter was found to be the same as injuring the ureter:

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[12] Trial Decision, *supra* at para 65, Appellant Record I, Tab 1, p 14.
[13] Trial Decision, *supra* at para 81, Appellant Record I, Tab 1, p 18.
[14] Trial Decision, *supra* at paras 81-83, Appellant Record I, Tab 1, pp 18-19.

The expert evidence makes clear that damage to the ureter can be avoided by staying well away from it with medical devices such as the LigaSure.

…

Dr. Burnstein added this caution about the heat generated within the LigaSure's jaws:

> Unfortunately, it's not exclusively within the jaws. There is some spread of thermal energy beyond the jaws in some studies as much as one millimetre, and others as much as two millimetres, but certainly in the range of one to two millimetres of heat beyond what is incorporated within the jaws. So the operator has to be aware of what's around the jaws at the time of firing it because anything in the immediate vicinity of the jaws could also suffer some thermal injury.

…

In his description, Dr. Klotz alluded to an energy dispersion coming from the LigaSure:

> …And there is a dispersion of the energy, for somewhere around one to two millimetres, so when you actually use it, you actually see the tissue right next to it is – starts to bubble a little bit and has some tissue effect.

All four doctors recognized this concept of thermal spread of heat energy emanating from the LigaSure's jaws in their evidence, based on their experience and knowledge of the device. The general understanding can best be summed up by referring to Dr. Burnstein's testimony, stating "[t]he evidence in studies examined this issue have demonstrated that there is thermal spread beyond the jaws in the range of 1-2 mm."

…

At trial, [Dr. Ward] acknowledged that the LigaSure device can cause collateral damage to surrounding structures.

…

There is a risk of injury if the LigaSure touched or came within one or two millimetres of the ureter.[15]

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[15] Trial Decision, *supra* at paras 25, 34, 36-37, 59, 83, Appellant Record I, Tab 1, pp 6, 8-9, 12, 19.

28. The Trial Judge found that Dr. Ward met the standard of care with respect to the identification and protection of the ureter:

> I am satisfied that Dr. Ward took steps during this laparoscoptomy [*sic*] to identify and protect the ureter. He explained those steps and testified that he always kept at least five centimetres away from the ureter. But he acknowledged that the ureter was not always in camera view during this procedure. As to his awareness in 2010 about the spread of thermal energy beyond the jaws of the LigaSure, he answered: "I think so, yes".[16]

29. However, the Trial Judge found that "it would be a breach of the standard of care for a general surgeon to touch the ureter or come within one or two millimetres of it during a routine colectomy on a benign colon".[17]

30. The Trial Judge accepted the opinion of the Appellant's expert, Dr. Marcus Burnstein, in defining the standard of care and whether there was a breach. Dr. Burnstein is a general surgeon who does not perform laparoscopic colectomies or any laparoscopic procedures. Dr. Burnstein does not often use the LigaSure; he stated that it was not a "regular part of [his] toolkit".[18]

31. Dr. Burnstein testified that he would defer to the opinion of the Respondent's standard of care expert, Dr. John Hagen, who performs laparoscopic colectomies, regarding the identification and protection of the ureter in a laparoscopic surgery:

> **He would be in a better position than me to talk about how a laparoscopic surgeon achieves the goals**. He and I would be in the same position with respect to defining the goals of the operation.[19] [emphasis added]

32. Dr. Burnstein's opinion was that the risk of injury to the ureter during the removal of a benign colon should be zero percent. His opinion was that the standard of care for the Surgery is

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[16] Trial Decision, *supra* at para 109, Appellant Record I, Tab 1, p 25.
[17] Trial Decision, *supra* at para 84, Appellant Record I, Tab 1, p 19.
[18] Burnstein Evidence at p 24, ll 1-8, Appellant Record II, Tab 13, p 102.
[19] Burnstein Evidence at p 71 ll 9-16, Appellant Record II, Tab 13, p 149.

to identify and protect the ureter, and that it would be a breach of the standard of care to injure the ureter:

> Q. And then if we assume that the rate of injury to the ureter in total ranges from again, .1 percent to .6 percent, do you have a sense of what the rate of injury in the case of a benign condition like Ms. Armstrong would be?
>
> A. Its my opinion it should be zero. You should be able to remove the normal colon from the normal abdomen without injuring other structures.
>
> ...
>
> Q. And so, doctor, do you have an opinion as to whether Doctor Ward met the standard of care in identifying and protecting Karen Armstrong's ureter during the colectomy surgery?
>
> A. I feel that the standard of care is to identify and protect the ureter and this was not achieved in this case. There are no mitigating factors listed, mass, inflammation - that applied here and that injured ureter in this context is a failure of the standard of care.[20]

33. He testified that, no matter the reasonable steps to identify and protect the ureter, the standard of care requires there to be no injury to the ureter:

> Q. … Number one, injury to the ureter during an elective colectomy if there was no structural abnormality of the colon falls below the standard of care of a general surgeon in Ontario. And you agree that was your opinion expressed in the report?
>
> A. I agree with that, it's my opinion.
>
> …
>
> Q. So in the context of that opinion, coming one to two millimetres from the ureter is really irrelevant because what is relevant is the fact that there was an injury to the ureter, correct? That's what's driving whether there's a breach of the standard of care that an injury was suffered.
>
> A. Yes, if there was no injury there is no breach.
>
> …

[20] Burnstein Evidence at p 23, ll 8-15, p 41, l 25 – p 42, l 2, Appellant Record II, Tab 13, pp 101, 119-20.

> Q. And if he was four millimetres, found to have been four millimetres from the ureter hypothetically and say there was no injury to the ureter, would that be a breach of the standard of care?
>
> A. No.
>
> Q. So what's important is really your opinion on standard of care is based on the fact that there is an injury to the left ureter here?
>
> A. Yes.[21]

34. Dr. Burnstein testified that his "zero risk" theory was not supported medically (rather, it was his personal opinion) and that he himself warns his colectomy patients of the risk of ureteric injuries.[22] While the Trial Judge accepted that there is a risk of injury to the ureter in a laparoscopic colectomy, he nonetheless agreed with Dr. Burnstein's opinion that an injury is a breach of the standard of care.[23] In substance, he accepted that for the Surgery, the risk of injury is zero percent.

35. Dr. Hagen testified that the standard of care for the Surgery was to identify and protect the ureter. Identification and protection each required specific actions on the part of the surgeon:

> Q. Now, Dr. Hagen, I want you to assume that Dr. Ward, at the time of the laparoscopic colectomy, mobilized the left colon using a combination of cautery and blunt dissection and using the medial approach, Dr. Ward moved the colon upward toward the anterior abdominal wall, something he calls tenting. He then proceeded to identify the ureter visually through the laparoscope and either touched or pushed structures around the ureter to observe it move or vermiculate. Once the ureter is identified visually, using blunt dissection, he moved the retroperitoneal structures, where the ureter is located, away from the colon. Now stopping there, do those steps, are those steps reasonable in the identification and protection of the left ureter?
>
> A. Yes.

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[21] Burnstein Evidence at p 49, ll 11-18, p 51, ll 4-12, p 53, ll 9-18, Appellant Record II, Tab 13, pp 127, 129, 131.

[22] Burnstein Evidence at p 59, l 13 – p 64, l 13, p 65, l 2 to p 66, l 12, 68, ll 29-31, Appellant Record II, Tab 13, pp 137-42, 143-44, 146; Trial Exhibit 11, Case Report- Ureteric Injury due to the Usage of LigaSure, Appellant Record II, Tab 22, p 331; Trial Exhibit 13, Ureteral Injuries External and Iatrogenic, Appellant Record II, Tab 24, p 339.

[23] Trial Decision, *supra* at paras 39, 75, 81, 83-84 Appellant Record I, Tab 1, pp 9, 16, 18-19.

> Q. And do those steps meet the standard of care in the identification and protection of the left ureter from injury during a laparoscopic colectomy?
>
> A. Yes.
>
> Q. I then want you to assume that once the ureter has been identified and pushed away, that Dr. Ward opened the LigaSure package and divided he colonic mesentery with the LigaSure going on the diagram you have there, Exhibit 2, from right to left, circumferentially, staying away from the ureter and near the colon. And Dr. Hagen, does that step I've asked you to assume, to divide the colonic mesentery with the LigaSure, is that a reasonable way of doing it?
>
> A. Yes.
>
> Q. And does that way of dividing the colonic mesentery meet the standard of care?
>
> A. Yes.[24]

36. Dr. Hagen disagreed that an injury to the ureter would breach the standard of care:

> Q. Now, Dr. Burnstein also testified that even if you took reasonable steps to identify and protect the left ureter during a laparoscopic colectomy, but if Dr. Ward had come within one to two millimetres of the ureter with the LigaSure when dividing the colonic mesentery, and injured the ureter, that would be a breach of the standard of care. Do you agree with that?
>
> A. No.
>
> Q. Why not?
>
> A. The key thing about the ureter is identifying the ureter and, and protecting it.[25]

37. Dr. Hagen testified that a ureteric injury is an uncommon but known risk of colectomies. He testified that Dr. Ward met the standard of care in identifying the ureter and protecting it while dividing the colonic mesentery.[26]

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[24] Hagen Evidence at p 12, l 20 – p 13 l 17, Appellant Record II, Tab 16, pp 286-287.
[25] Hagen Evidence at p 15, l 30 – 16, l 7, Appellant Record II, Tab 16, pp 289-290.
[26] Hagen Evidence at p 12, l 13 – p 13, l 25, p 15, l 30 – 16, l 26, Appellant Record II, Tab 16, pp 286-87, 289.

(iii) Breach and causation

38. The Trial Judge considered whether there was a breach of the standard of care and causation, both under the heading "Conclusion on Standard of Care".

39. The Trial Judge considered whether Dr. Ward touched or came within 1-2 millimetres of the ureter during the Surgery. The Trial Judge found that Dr. Ward did not touch the ureter, and then addressed whether Dr. Ward came within 1-2 millimetres of the ureter during the Surgery.[27]

40. The Trial Judge did not conduct a formal causation analysis. He reviewed the law, quoted expert evidence, and then returned to his analysis as to whether the standard of care was breached.[28]

41. The Trial Judge concluded that Dr. Ward came within 1-2 millimetres, which caused Ms. Armstrong's injury, and breached the standard of care:

> I accept Drs. Klotz and Burstein's evidence that Dr. Ward came within one or two millimetres of the ureter, causing damage leading to scar tissue and eventual ureter blockage. Upon surgical investigation several weeks later, this blockage extended eight to ten centimetres along the ureter's centre. This damage led to the ureter's complete shutdown. The ureter was unable to transfer urine from the kidney to the bladder. As a result, Armstrong's kidney had to be removed by a subsequent surgical procedure.
>
> In a colectomy procedure, identification and protection of the ureter is paramount. Using a LigaSure can cause damage by heat transmission if it touches the ureter or comes within one to two millimetres. I am satisfied that on the facts of this case, the plaintiff has established that Dr. Ward breached the standard of care. Further, the breach caused damage to the ureter leading to a stricture of the ureter. This damage required the removal of Armstrong's left kidney.[29]

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[27] Trial Decision, *supra* at paras 85-87, Appellant Record I, Tab 1, p 19.
[28] Trial Decision, *supra* at paras 92-113, Appellant Record I, Tab 1, pp 20-25.
[29] Trial Decision, *supra* at paras 112-113, Appellant Record I, Tab 1, p 25.

(iv) The crux of the Trial Judge's reasons

42. The Trial Judge devoted virtually the entirety of his analysis and reasons as to what caused the injury. He defined the standard of care and determined whether there was a breach relying on his findings as to the injury. Specifically:

(a) the thermal spread of the LigaSure was 1-2 millimetres;

(b) if the ureter was within the range of the thermal spread of the LigaSure, it would be burned;

(c) because there was an injury of the ureter, Dr. Ward must have come within 1-2 millimetres of the ureter during the Surgery;

(d) the standard of care is to not come in close proximity to the ureter. Close proximity is 1-2 millimetres; and,

(e) it is a breach of the standard of care to injure the ureter.[30]

43. The Trial Judge did not identify an act or omission independent from the injury that was a breach of the standard of care. He did not identify any error in the manner that Dr. Ward identified or protected the ureter; in fact, he found that Dr. Ward met the standard in identifying and protecting the ureter.

44. However, the Trial Judge focused on causation and worked backwards in defining the standard of care and assessing a breach. The Trial Judge relied on the opinion of the Appellant's causation expert, Dr. Laurence Klotz, to find that Dr. Ward breached the standard of care. Dr. Klotz opined that Dr. Ward was operating 1-2 millimetres away from the ureter, without touching the ureter, for a full 8-10 centimetres of the ureter (which is 30 centimetres in length), which caused

[30] Trial Decision, *supra* at paras 82, 87-91, 112-113, Appellant Record I, Tab 1, pp 19-20, 25.

an immediate burn to the ureter but that, despite the immediate burn, the stricture on Ms. Armstrong's ureter did not lead to any symptoms for ten weeks.

45. There was substantial evidence in the record demonstrating that the Appellant's causation theory was not credible. Specifically:

(a) the theory, clinical presentation, and timing are inconsistent with the authoritative medical literature, starting with the fact that the theory does not align with human anatomy or the manner in which the Surgery was performed. Dr. Hagen, the most experienced of all experts, testified that it would be *impossible* to damage the ureter for a stretch of 8-10 centimetres while dividing the colonic mesentery. In a laparoscopic colectomy, the mesentery is divided by moving from "west to east" and the ureter runs "north to south";[31]

(b) even if it were anatomically possible, it does not explain Ms. Armstrong's presentation. A ureteric injury is a well-known complication of colon surgery and its symptoms are easily recognized quickly after surgery. None of the expected symptoms (e.g., leakage of urine from the ureter and the formation of urinoma, symptoms of progressive abdominal pain, an elevated white blood cell count, fever in the days after surgery, or possible necrosis) were present in this case;[32]

(c) it was not until the April 23, 2010 visit with Dr. Onlock—approximately ten weeks after the Surgery—that Ms. Armstrong presented with symptoms consistent with ureteric injury, perhaps coming on about eight weeks postoperatively. When

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[31] Hagen Evidence at p 29, l 13 – p 30, l 14, Appellant Record II, Tab 16, at pp 303-04.
[32] Trial Decision, *supra* at paras 103-105, Appellant Record I, Tab 1, pp 23-24; Evidence of Dr. Michael Robinette, January 15, 2018 ("**Robinette Evidence**") at p 16, l 20 – p 17, l 22, p 19, l 25 – p 20, l 9, Appellant Record II, Tab 15, pp 229-30, 232-33.

treating this new development, Ms. Armstrong's total renal function was measured. Her obstructed left kidney was contributing only 30% (and her right kidney was contributing 70%). This indicates that an obstruction had existed for several weeks but was undetected, likely because of scar tissue continuing to build, as opposed to a thermal injury at the time of Surgery;[33]

(d) Dr. Hartsburg's operative report made no mention that Ms. Armstrong's ureter had suffered a thermal injury, and instead noted that the scarring occurred "actually quite some time after the surgery". Dr. Hartsburg's operative note also highlighted a significant degree of adhesions and scarring following the nephrectomy and, again, no reference to a thermal injury;[34] and,

(e) there is a material inconsistency between Dr. Burnstein's evidence and Dr. Klotz's evidence. Dr. Burnstein testified in cross-examination that if Dr. Ward was four millimetres away from the ureter (as opposed to 1-2 millimetres), he could not have injured the ureter (i.e., there would be no scar tissue build-up in the surrounding tissues). Dr. Klotz testified that scar tissue could have been formed in the surrounding tissue to the ureter.[35]

46. The Trial Judge relied on the comments from Drs. Burnstein and Klotz that it would be the "end of the LigaSure" and that it would be "an entity that haunts my practice" if injuries occurred beyond 1-2 millimetres.[36] This was not based on any scientific assessment or particular experience.

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[33] Trial Decision, *supra* at para 16, Appellant Record I, Tab 1, p 4; Robinette Evidence at p 24, l 12 – p 25, l 17, Appellant Record II, Tab 15, pp 237-38.
[34] Trial Decision, *supra* at para 18, Appellant Record I, Tab 1, p 5; Medical Records of Karen Armstrong, Respondent Record, Tab 1, pp 49-50.
[35] Burnstein Evidence at p 51, l 4 – p 52, l 30, Appellant Record II, Tab 13, pp 129-30; Klotz Evidence at p 35, l 15 - p 38, l 21, Appellant Record II, Tab 12, pp 65-68.
[36] Trial Decision, *supra* at paras 107-108, 111, Appellant Record I, Tab 1, pp 24-25.

It was an anecdotal comment from, in Dr. Burstein's case, a physician who does not often use the LigaSure.

47. The Trial Judge further relied on the fact that Dr. Ward could not always see the ureter during the Surgery.[37] He relied on Dr. Klotz's testimony that surgery must always be performed under direct view:

> Q. When you say that it is always done under direct vision, Dr. Klotz, why is that?
>
> A. There is a safety issue. So, surgery in general needs to be done under direct vision. So a skilled surgeon learns to resist the temptation to do dissection not under direct vision, because you can get into trouble. So I would say, certainly in urologic surgery, you must see what you are doing all the time.[38]

48. The Trial Judge appears to have misunderstood Dr. Klotz's testimony. Dr. Klotz discussed the need to dissect tissue with the LigaSure under direct view—i.e., the tissue being divided must be in view of the camera. This took place. In laparoscopic surgery however, not all surrounding structures will always be in view of the camera, including the ureter. As part of the protection of the ureter, the laparoscopic surgeon pushes the ureter away, out of view, using blunt dissection. In other words, the surgeon has only successfully protected the ureter when it *is not* in direct view.[39]

49. The Trial Judge defined the standard of care based on uninformed comments by the Appellant's experts. The Trial Judge made a causation finding that was identical to the definition of the standard of care, notwithstanding the fact that it was inconsistent with the weight of the evidence. He did both having turned his mind only to what caused the injury, and not to what process the surgeon needed to follow in carrying out the Surgery. This was a chain of reasoning

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[37] Trial Decision, *supra* at paras 55, 109, Appellant Record I, Tab 1, pp 12, 25.
[38] Klotz Evidence at p 16, ll 3-9, Appellant Record II, Tab 12, p 46.
[39] Hagen Evidence at p 12, l 20 – p 13, l 17, Appellant Record II, Tab 16, pp 286-287; Ward Evidence at p 17, ll 5-10, p 20, l 26 – p 21, l 2 Appellant Record II, Tab 14, pp 177, 180-181.

that led the Trial Judge away from the process he should have adopted, which was: to identify the standard of care based on the reasonable steps required in carrying out the Surgery; to ask whether the Surgery was performed in that manner; and then, only if some error is identified, to examine what happened and assess whether the outcome was attributable to the error.

D. THE ONTARIO COURT OF APPEAL

50. Dr. Ward appealed the Trial Decision. The Court of Appeal released its decision on December 10, 2019.[40] Justices Paciocco and Juriansz authored the majority decision. Justice van Rensburg dissented.

(i) The majority decision

51. The Court of Appeal allowed Dr. Ward's appeal, holding that the Trial Judge erred in his articulation and analysis of the standard of care:

> … I agree with Dr. Ward that the trial judge erred in defining the standard of care that Dr. Ward had to meet, improperly establishing a standard of perfection. In simple terms, the trial judge effectively concluded that if Dr. Ward injured Ms. Armstrong's ureter with the cauterization tool he was employing, he would be liable. Instead, the trial judge should have determined whether Dr. Ward performed the operation in the manner that a reasonably prudent surgeon would have.
>
> On that correct measure, the trial judge's own finding was that during the surgery, Dr. Ward took the steps he described to identify and protect the ureter. These were essentially the same steps that Ms. Armstrong's own expert surgeon conceded a reasonably prudent surgeon would use. Given this finding, the trial judge should have dismissed Ms. Armstrong's action.[41]

52. The majority stated that the Trial Judge found that Dr. Ward met the standard of care as to identifying and protecting the ureter—it was only the injury that led to the breach. Therefore, on a

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[40] Reasons of the Ontario Court of Appeal, indexed as *Armstrong v Royal Victoria Hospital*, 2019 ONCA 963 ("**Appeal Decision**"), Appellant Record I, Tab 3, p 30.
[41] Appeal Decision, *supra* at paras 3-4, Appellant Record I, Tab 3, p 31.

proper articulation of the standard of care (i.e., taking reasonable steps to identify and protect the ureter), on the Trial Judge's own findings of fact, Dr. Ward must have met the standard:

> As I will explain in more detail below, the trial judge found that Dr. Ward took steps to identify and protect the ureter. Dr. Ward was found to have failed to meet the standard of care because he came within one to two millimetres of the ureter with the LigaSure. The factual finding that he did so was made because it is only within this one to two millimetre distance that the LigaSure is capable of causing the thermal injury that Ms. Armstrong was found to have sustained. The controversial component of the standard of care that the trial judge imposed was therefore his finding that a normal, prudent surgeon would avoid direct contact or close proximity (within two millimetres) between the ureter and the LigaSure.[42]

53. The majority accepted that the Trial Judge erred by defining the standard of care as a goal rather than analyzing the reasonable means to be employed to achieve the goal:

> Dr. Ward contends that it is improper and perilous to articulate and apply the standard of care in this fashion. Avoiding contact or proximity to the ureter with the LigaSure is a goal that a prudent surgeon aims to attain. Defining the standard of care by stating the goal tells us nothing about how a prudent surgeon would go about achieving that goal, which is the pertinent inquiry.
>
> Moreover, where the goal used to define the standard of care is, in essence, avoiding the injury, as it is here, the standard being imposed is strict or absolute liability since liability follows with every injury. This is not a proper measure of liability in a negligence case.
>
> Stating the standard of care in this way also invites circular reasoning and collapses the causation inquiry: Did the failure to meet the standard of care cause the injury? It did, because causing the injury is a failure to meet the standard of care.
>
> For these reasons, it is generally an error of law to use outcomes or goals as the standard of care. … Negligence standards of care are to be measured by the behaviour that a relevant prudent person would undertake, rather than the results that prudent person would seek to attain or avoid.[43]

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[42] Appeal Decision, *supra* at para 38, Appellant Record I, Tab 3, pp 42-43.

[43] Appeal Decision, *supra* at para 39-42, 44, Appellant Record I, Tab 3, pp 42-44, citing *Fullowka v Pinkerton's of Canada Ltd*, 2010 SCC 5 [***Pinkerton's***]; *St Jean v Mercier*, 2002 SCC 15 [***St Jean***].

54. Justice Paciocco declined to discuss other grounds of appeal in detail beyond the standard of care, on the basis that a reversible error had been made on that issue. Briefly in *obiter*, however, Justice Paciocco discussed certain causation issues, including when factual causation can be considered as part of the breach of the standard of care analysis. This sideline, however, did not form part of the *ratio* of the majority's decision.[44]

(ii) The dissenting opinion

55. Justice van Rensburg based her dissent largely on deference owed to the Trial Judge. She disagreed that the law regarding the standard of care was applied incorrectly by the Trial Judge and stated that it was open to the Trial Judge to make the findings of fact that he made. Justice van Rensburg did not disagree with the established principles defining the standard of care; only how those principles were applied and to what extent the evidence supported the Appellant's position. Justice van Rensburg would have dismissed the appeal, finding no error by the Trial Judge.[45]

PART II - RESPONDENT'S POSITION ON THE APPELLANT'S QUESTIONS

56. The appropriate questions on appeal are not as set out by the Appellant. There are four questions on this appeal, all of which relate to the Trial Judge's assessment of the standard of care:

(a) did the Trial Judge err in defining the standard of care;

(b) did the Trial Judge err in finding a breach of the standard of care;

(c) did the Trial Judge err by failing to address non-negligent causes of the Appellant's injury; and,

(d) did the Court of Appeal apply the correct standard of review?

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[44] Appeal Decision, *supra* at paras 32, 59-65, Appellant Record I, Tab 3, pp 40, 51-53.
[45] Appeal Decision, *supra* at paras 71, 86-88 (dissent), Appellant Record I, Tab 3, pp 55-56, 60-61.

PART III - STATEMENT OF ARGUMENT

THE TRIAL JUDGE ERRED IN DEFINING THE STANDARD OF CARE

57. The Trial Judge made the following interrelated errors in defining the standard of care:

(a) he erred by combining the standard of care assessment with the causation analysis; and,

(b) in so doing, he utilized a results-based assessment of the standard of care, imposing a standard of perfection on Dr. Ward.

A. THE CAUSATION ANALYSIS MUST BE DISTINCT FROM THE STANDARD OF CARE ASSESSMENT

58. This Court has established the elements of the negligence analysis. They are sequential and separate.[46] The plaintiff must demonstrate that:

(a) the defendant owed a duty of care;

(b) the defendant's behaviour breached the standard of care;

(c) the plaintiff sustained damage (i.e., an injury); and,

(d) the damage was caused, in fact and in law, by the defendant's breach.[47]

59. It is an error to conduct a negligence analysis out of order, and in particular to place causation ahead of the standard of care:

> It is a critical fault to reorder negligence analysis by placing the causation before that of the standard of care. How can a judge decide whether, but for the defendant's substandard action, the plaintiff would not have been injured, if the characterization and application of the standard of care decision depends on the causation decision? The suggestion that causation be analysed before standard of care truly is putting the cart before the horse.[48] [emphasis original]

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[46] *Shantry v Warbeck*, 2015 ONCA 395 at paras 34-35.
[47] *Mustapha v Culligan of Canada Ltd*, 2008 SCC 27 at para 3.
[48] *McCardle v Cox*, 2003 ABCA 106 at para 25.

60. The Ontario Court of Appeal affirmed the need for separate and distinct assessments of causation and breach in *Bafaro v. Dowd*, where Justice Laskin held:

> **…Ms. Bafaro's submission wrongly conflates the issues of standard of care and causation, or at least asks the court to determine factual causation before determining whether the standard of care was breached**. Ms. Bafaro seeks to use the *Snell* approach to causation to find that a burn injury caused the fistula, and then to use this finding to demonstrate that Dr. Willard breached the standard of care because he did not detect the burn during the exploratory laparotomy. This submission intermingles standard of care and causation. **Yet, the two issues are quite separate. Moreover, the question whether the standard of care was breached should be decided before the question of factual causation. In other words, the issue of factual causation arises after the trier of fact has found that the defendant breached the standard of care**.[49] [emphasis added]

61. On rare occasions, the factual circumstances of the injury may be relevant to whether there was a breach of the standard of care.[50] Even where this is permitted, a trial judge cannot use these findings to *define* the standard of care.

62. The Trial Judge incorrectly worked from the injury backwards in coming to a determination of the definition of the standard of care. There was no independent analysis.

63. The Trial Judge used the causation opinion of Dr. Klotz to inform his analysis of the definition and breach of the standard. The Trial Judge stated that the standard of care will be breached where the LigaSure directly touches the ureter or where it comes within 1-2 millimetres of it. Dr. Klotz testified that an injury to the ureter would occur where it was directly touched or

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[49] *Bafaro v Dowd*, 2010 ONCA 188 at para 35.

[50] Appeal Decision, *supra* at para 62-64, Appellant Record I, Tab 3, pp 52-53, citing *Meringolo (Committee of) v Oshawa General Hospital* (1991), 46 OAC 260 (CA), Book of Authorities of the Respondent, Tab 7 ("**BOA**") and *Grass v Women's College Hospital* (2001), 200 DLR (4th) 242 (Ont CA).

the LigaSure came within 1-2 millimetres of it.[51] This might well be the case, but it has nothing to do with the definition of the standard of care.

64. The Trial Judge did not conclude on his determination of breach until after the causation assessment. Indeed, the entire causation analysis is subsumed under the heading "Conclusion on Standard of Care". In his conclusion on standard of care, the Trial Judge recited his conclusion on causation. The Trial Judge held that because an injury occurred, the standard was breached.[52]

65. Defining standards of care involves asking what reasonable professionals, as a matter of practice, actually do when they perform comparable procedures. There was no evidence available to the Trial Judge supporting the selection of this observation by a causation expert, and then elevating that observation into standard of care evidence by accepting it as defining the standard.

B. AVOIDING INJURY CANNOT BE THE STANDARD OF CARE

66. Avoiding an injury cannot be part of the standard of care. To hold as such would violate the rules against results-based reasoning and hindsight, and it would adopt a standard of perfection. For decades, courts have admonished such practices throughout negligence law. The Trial Judge used hindsight and results-based reasoning and imposed a standard of perfection in defining the standard of care. The Court of Appeal correctly identified these errors.

(i) The standard of care cannot be based on hindsight, results-based reasoning, or a standard of perfection

67. When deciding whether a medical practitioner has breached the standard of care, medical practitioners cannot be judged based on the result itself. Trial judges must avoid the "retrospectoscope" in defining the standard of care and in conducting breach analyses.[53] A

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[51] Trial Decision, *supra* at paras 85-91, Appellant Record I, Tab 1, pp 19-20.
[52] Trial Decision, *supra* at paras 81-113, Appellant Record I, Tab 1, pp 18-25.
[53] *Epstein v Salvation Army Scarborough Grace General Hospital* (1999), 124 OAC 233 at paras 43-44 (CA); *Wilson v Swanson*, [1956] SCR 804 at 812-813 [***Wilson***].

plaintiff's case that advocates a results-based, retrospective approach to the standard of care and attempts to work backwards from the result of the surgery to prove negligence is incorrect in law, as "*post hoc, ergo propter hoc* has no place in our law".[54]

68. In adopting the Ontario Court of Appeal's 1956 decision in *Crits v Sylvester*, this Court accepted Lord Denning's reasoning in the 1954 English Court of Appeal decision *Roe v Minister of Health et al*, in which he stated:

> It is so easy to be wise after the event and to condemn as negligence that which was only a misadventure. We ought always to be on our guard against it, especially in cases against hospitals and doctors.[55]

69. In the 2002 decision of *St Jean v Mercier*, this Court emphasized the importance of avoiding an approach based on an injury in surgical cases, holding that trial judges must also distinguish negligence and a breach of the standard of care from surgical misadventure:

> To ask, as the principal question in the general inquiry, whether a specific positive act or an instance of omission constitutes a fault is to collapse the inquiry and may confuse the issue. What must be asked is whether that act or omission would be acceptable behaviour for a reasonably prudent and diligent [surgeon] in the same circumstances. The erroneous approach runs the risk of focusing on the result rather than the means. [Surgeons] have an obligation of means, not an obligation of result.[56] [emphasis original]

70. Trial judges regularly include the caution against a retrospective analysis in their reasons.[57]

71. Similarly, Canadian law does not hold medical practitioners to a standard of perfection. This standard has long been expressly discouraged. As no medical practitioner ensures that he or she will achieve a perfect result, it is an error of law to hold a physician to too high a standard.

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[54] *Bafaro v Dowd*, [2008] OJ No 3474 at para 26, 30 (Sup Ct).
[55] *Roe v Minister of Health et al*, [1954] 2 All ER 131 at 137 [***Roe***], BOA, Tab 8, cited in *Crits v Sylvester*, [1956] OR 132 at para 15 (CA) [***Crits* CA**], BOA, Tab 2, aff'd [1956] SCR 99.
[56] *St Jean, supra* at para 53.
[57] See e.g. *Keith v Abraham*, 2011 ONSC 2 at para 213.

Reasonable surgeons may exercise different judgments; the surgeon is merely required to make decisions within the exercise of his or her surgical intelligence.[58]

72. In the 1975 English Court of Appeal decision *Greaves & Co (Contractors) Ltd v Baynham Meikle & Partners*, Lord Denning highlighted that the law in medical negligence cases does not offer a standard of perfection or the promise of a cure. The law provides only that the professional will use reasonable care and skill.[59]

73. In the British Columbia Court of Appeal decision of *Carlsen v Southerland*, the Court overturned the trial judge's decision on this basis:

> …**by imposing a standard of excellence that amounted to perfection, the trial judge set a standard that was impossible to rebut.** Indeed, as can be seen from para 37 of the trial judge's reasons, he concluded that "the simple precaution that Dr. Southerland should have taken was to ensure that he not let his instruments penetrate past the annulus fibrosus." **In this respect, the trial judge improperly focused only on the result of the surgery, and not on the precise manner in which Dr. Southerland failed to meet the appropriate standard of care. In the result, he held Dr. Southerland to a standard that amounted to a guarantee**.[60] [emphasis added]

74. This Court affirmed the prohibition against standards of perfection in negligence in the non-medical case of *Fullowka v Pinkertons of Canada Ltd*, relied on by the Court of Appeal. This Court explained that the trial judge erred in his definition of the standard of care by establishing a standard that was an absolute duty (perfection):

> With respect to the law, my view is that the trial judge erred by failing to articulate the standard of care to which Pinkerton's was to be held. Although the trial judge acknowledged that Pinkerton's was not an insurer of the mine's safety (para. 752), he nonetheless found that it had failed to ensure that the entrances were properly guarded

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[58] *Wilson, supra* at 812.
[59] *Greaves & Co (Contractors) Ltd v Baynham Meikle & Partners*, [1975] 3 All ER 99 at 103-104 (Eng CA), BOA, Tab 3.
[60] *Carlsen v Southerland*, 2006 BCCA 214 at para 15 [***Carlsen***].

> to avoid incursions (para. 764). This statement is problematic in two respects. To the extent that the trial judge required Pinkerton's to ensure there was no clandestine access to the mine, he imposed an absolute duty, not a duty of reasonable care.[61]

75. Trial courts regularly avoid standards of perfection on this basis.[62]

76. The policy principles for avoiding hindsight and standards of perfection are clear. A retrospective analysis is contrary to the way medicine is practiced:

> Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience; and experience often teaches in a hard way. Something goes wrong and shows up a weakness, and then it is put right.[63]

77. A standard of perfection is "impossible to rebut".[64] As Lord Denning stated in *Roe*, it would be a disservice to the community to hold medical practitioners accountable for anything that could go wrong:

> … But we should be doing a disservice to the community at large if we were to impose liability on hospitals and doctors for everything that happens to go wrong. **Doctors would be lead to think more of their own safety than of the good of their patients. Initiative would be stifled and confidence shaken. A proper sense of proportion requires us to have regard to the conditions in which hospitals and doctors have to work**. We must insist on due care for the patient at every point, but we must not condemn as negligence that which is only a misadventure.[65] [emphasis added]

78. This Court's deliberate language in *St Jean* is instructive: in defining the standard of care, one must identify whether an "act or omission" would be acceptable behaviour for a reasonably prudent and diligent surgeon. If that "act or omission" was not reasonable, the surgeon may fall

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[61] *Pinkerton's*, *supra* at para 80.
[62] See e.g. *Kooijman v Bradshaw*, 2016 BCSC 2316 at para 184.
[63] *Roe*, *supra* at 137, BOA, Tab 8; see also *Kehler v Myles* (1986), 74 AR 259 at para 134 (QB), aff'd 1988 ABCA 350, leave to appeal to SCC refused, 21364 (6 April 1989).
[64] *Carlsen*, *supra* at para 15.
[65] *Roe*, *supra* at 139, BOA, Tab 8, cited in *Crits* (CA), *supra* at para 16, BOA, Tab 2.

below the standard of care; however, the breach is based on an "act or omission" by the surgeon, not the outcome of the procedure or the fact of an injury.

(ii) This policy is consistent throughout professional liability law

79. The rules against the hindsight, results-based reasoning, and avoiding a standard of perfection are universal principles throughout professional negligence law.

80. In the 1838 Court of Common Pleas decision, *Lanphier v Phipos*, Chief Justice Tindal stated the following:

> Every person who enters into a learned profession undertakes to bring to the exercise of it a reasonable degree of care and skill. **He does not undertake, if he is an attorney, that at all events you shall gain your cause, nor does a surgeon undertake that he will perform a cure; nor does he undertake to use the highest possible degree of skill.** There may be persons who have higher education and greater advantages than he has, but he undertakes to bring a fair, reasonable, and competent degree of skill . . . [66] [emphasis added]

81. For lawyers, the standard of care is one of "reasonable care, skill and knowledge".[67] As Justice Doherty wrote in the 2005 Ontario Court of Appeal decision, *Folland v Reardon*, so long as the lawyer has met this standard, "his or her duty to the client is discharged, even if the decision proves to be disastrous".[68] Avoiding hindsight is crucial:

> In accepting the reasonably competent lawyer standard, I do not detract from the often repeated caution against characterizing errors in judgment as negligence. Lawyers make many decisions in the course of a lawsuit. Those decisions require the exercise of judgment. **Inevitably, some of those decisions, when viewed with the benefit of hindsight, will be seen as unwise**. The reasonable lawyer standard does not call for an assessment of the sagacity of the decision made by the lawyer. The standard demands that the lawyer bring to the exercise of his or her judgment the effort,

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[66] *Lanphier v Phipos* (1838), 173 ER 581, 8 C&P 475 at 478 (Ct CP), BOA, Tab 6.
[67] *Central Trust Co v Rafuse*, [1986] 2 SCR 147 at para 58.
[68] *Folland v Reardon* (2005), 249 DLR (4th) 167 at para 44 (Ont CA) [***Folland***].

> knowledge and insight of the reasonably competent lawyer.[69] [emphasis added]

82. For auditors, the standard of care similarly avoids perfection and hindsight—and has for decades. In the English Court of Appeal decision of 1895, *re London and General Bank (No. 2)*, Lord Linley wrote:

> An auditor, however, is not bound to do more than exercise reasonable care and skill in making inquiries and investigations. He is not an insurer; he does not guarantee that the books do correctly shew the true position of the company's affairs; he does not even guarantee that his balance-sheet is accurate according to the books of the company. If he did, he would be responsible for error on his part, even if he were himself deceived without any want of reasonable care on his part, say, by the fraudulent concealment of a book from him. His obligation is not so onerous as this. Such I take to be the duty of the auditor: he must be honest—i.e., he must not certify what he does not believe to be true, and he must take reasonable care and skill before he believes what he certifies to be true.[70]

83. For engineers and architects, the principles are identical. In the Honourable Beverly M. McLachlin and Arthur Grant's treatise, *The Canadian Law of Architecture and Engineering*, the authors draw a distinction between negligent conduct and errors of judgment. They note that where an engineer has met the standard of care, "the fact that the work proves unsatisfactory in some way will not render them liable for breach of contract or negligence".[71]

84. In the 1990 Ontario Court of Appeal decision, *Larche v Ontario*, Justice Krever held "the defendant architects met a reasonable standard in the construction and design of the railing," avoiding hindsight and a perfection standard:

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[69] *Folland*, *supra* at para 44.
[70] *In re London and General Bank (No 2)*, [1895] 2 Ch 673 at 683 (CA), BOA, Tab 5, cited by this Court in *Guardian Insurance Co of Canada v Sharp*, 940 CarswellQue 36 at paras 12, 16, [1941] 2 DLR 417 at 430-431 (SCC), BOA, Tab 4.
[71] Beverly M McLachlin & Arthur M Grant, *The Canadian Law of Architecture and Engineering*, 3rd ed (Toronto: LexisNexis, 2020*)* at 133, BOA, Tab 1.

> It may be true, as the appellant argues, that it would have been simple and easy to design a barrier to the roof of the stores building which would have prevented a patient such as the plaintiff from climbing onto the roof in search of a frisbee, but this argument misses the point. In the circumstances, the trial judge held that what was designed was reasonable and represented the discharge of the architects' duty to design a barrier which "met an acceptable security standard in the particular location it was constructed at this type of psychiatric facility".[72]

(iii) The Trial Judge did not follow the above law and erred in defining the standard of care

85. In addition to conflating his causation findings into his definition of the standard of care, the Trial Judge erred in defining the standard of care by:

(a) working from the injury backwards; and,

(b) creating a standard of care based on absolutes, results, and perfection.

86. The Trial Judge first determined that the injury to the ureter was caused by coming within 1-2 millimetres of the ureter with the LigaSure. He then defined the standard of care in terms that reflected what he had found: “to identify and protect the ureter and to avoid close proximity (1-2 millimetres) or direct contact with the ureter”. In other words, the Trial Judge established that the standard of care was to identify, protect, and to *not injure* the ureter.

87. Injuring the ureter, in any circumstance, would be a breach of the standard—consistent with the opinion of Dr. Burnstein.

88. An act or omission independent from the injury is necessary to establish a breach of the standard of care. Establishing as part of the standard of care the requirement to “stay at least 1-2 millimetres away from the ureter” is identical to finding “do not injure the ureter” or “an injury is a breach”. There is no difference.

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[72] *Larche v Ontario* (1990), 75 DLR (4th) 377 at para 8 (Ont CA).

89. In defining the standard of care based on the avoidance of injury, the Trial Judge created a standard of perfection. The Trial Judge established the same "absolute duty" that this Court prohibited in *Pinkertons*.

90. The Trial Judge unfortunately missed the point. Instead of considering whether Dr. Ward acted as a reasonably prudent surgeon he focused on the fact of an injury. Adopting this standard of care—where an injury is an automatic breach—led the Trial Judge to engage in an injury-centred and results-based analysis, rather than focusing on whether the ureter was appropriately identified and protected. The Trial Judge provided no analysis of the real question to be addressed—whether Dr. Ward took the steps of a reasonable practitioner in the same circumstances—and instead focused solely on the injury.

(iv) The Court of Appeal correctly identified the Trial Judge's errors

91. The definition of the standard of care was devoid of the central requirement of any standard of care: reasonableness. The Court of Appeal correctly identified this.[73] In so doing, the Court of Appeal described the Trial Judge's errors as focusing on the goals, rather than the means to achieve these goals.

92. This language is not reflective of a new principle. It is a synthetization of and shorthand for the principles of medical practitioners being held to a standard of reasonableness, not of perfection. Non-injury cannot form the standard of care. The Court of Appeal's articulation of this principle is nearly identical to this Court's determination on the same issue in *St Jean*: "[Surgeons] have an obligation of means, not an obligation of result".[74]

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[73] Appeal Decision, *supra* at paras 3, 51-55, Appellant Record I, Tab 3, pp 31, 48-50.
[74] *St Jean*, *supra* at para 53.

93. While the Appellant attempts to distinguish this case from *Pinkerton's*, the case is instructive on this point.

94. This Court found that the trial judge did not explain what specifically Pinkerton's, the security provider of the mine at issue, was required to do to meet the standard of care. The trial judge found that Pinkerton's had failed to ensure that the entrances were properly guarded to avoid incursions (i.e., it failed in its goal/desire outcome) and it therefore fell below the standard of care.[75] He did not explain what reasonable steps Pinkerton's was expected to take in order to do so (e.g., number of security guards per shift, requirements for electronic surveillance, etc.).

95. The Trial Judge made the same error in this case: the Trial Judge defined the standard as avoiding injury, rather than the steps a reasonable surgeon must take to avoid injury.

96. The Appellant relies on the dissenting opinion in which Justice van Rensburg states that "coming within 1-2 millimetres" is a step on its own. This ignores the factual finding that coming within 1-2 millimetres *is* the injury. It would be the equivalent of the trial judge in *Pinkerton's* saying the "step" was not allowing people onto the premises. It is not reasonable, instructive, or permitted at law.

97. The Appellant submits that "virtually every aspect of surgery could be characterized as either" a step or a goal. With respect, this is incorrect. A step is something that the surgeon must do in order to meet the standard of care. A goal is the desired outcome. In the context of avoiding injury to the ureter in colon surgery, the steps are identifying and protecting the ureter; the goal is not injuring the ureter when conducting the procedure.

98. This distinction is seen in other negligence actions:

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[75] *Pinkerton's, supra* at para 80.

(a) in the *Pinkerton's* example, steps would be ensuring staff are adequately trained and that an appropriate number of staff are present throughout the day. The goal would be avoiding unauthorized access to the mines; and,

(b) in the solicitor's negligence examples above, the steps would be adequately conducting the relevant legal research, adequately preparing witnesses, and reasonably assessing the likelihood of success at trial in providing advice to the client. The goal is success at, or "not losing", the trial.

99. The Appellant argues that the Court of Appeal's decision has turned the standard of care of a surgeon into "trying" to meet the standard of care.[76] With respect, this is incorrect. What the Court of Appeal is articulating is the requirement that the standard of care be one of reasonableness, not an absolute guarantee. If a surgeon, a security company, or a solicitor, takes reasonable steps to achieve the desired outcome or goal, the surgeon, security company, or solicitor will meet the standard of care.

100. The Appellant argues that "[m]ore importantly, nobody suggested that there was any circumstance in which maintaining an appropriate distance might not be possible, or that protecting the ureter was somehow out of the surgeon's control".[77] Respectfully, this is incorrect. As described above, Dr. Hagen was clear that accidents happen and that an injury is not a breach.[78] This is consistent with the law and with the actual performance of the Surgery.

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[76] Factum of the Appellant ("**Appellant Factum**") at para 61.
[77] Appellant Factum, *supra* at para 76.
[78] Hagen Evidence at p 36, ll 10-25, Appellant Record II, Tab 16, p 310.

THE TRIAL JUDGE ERRED IN FINDING A BREACH OF THE STANDARD OF CARE

101. The Appellant failed to discharge her burden to identify an act or omission independent from the injury that would breach the standard of care. As a result, the Trial Judge erred in finding a breach based only on the injury.

102. As set out above, a plaintiff in a medical negligence action must establish an act or omission by the defendant independent from the injury that would breach the standard of care. An injury alone will not be sufficient to establish a breach of the standard of care.

103. The Appellant's submissions support that there is always a factual finding of an act or omission separate from the injury in finding a breach of the standard of care:

(a) in *Cooper v Flood*, the standard of care was breached when the trocars, the instrument used in the procedure, were not placed in the correct location throughout the procedure;[79] and,

(b) in *Hassen v Anvari*, the defendant had breached the standard of care by inserting the trocar either too far, or with too much speed or pressure, slightly off-angle or off-direction, or a combination of any of those.[80]

104. The Appellant led no evidence of an act or omission independent from the injury. The Appellant's standard of care evidence was led through Dr. Burnstein. Dr. Burnstein, who does not often use the LigaSure or perform laparoscopic surgery, testified that other than the injury Dr. Ward met the standard of care:

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[79] *Cooper v Flood*, 2015 ABQB 567 at paras 148, 163; *Cooper v Flood*, 2016 ABCA 365 at paras 4-5.
[80] *Hassen v Anvari*, [2003] OJ No 3543 at paras 14, 23 (CA), leave to appeal to SCC dismissed, 30044 (29 April 2004).

> Q. And you'll agree with me that these steps I've suggested to you as I anticipate Doctor Ward will testify are steps that reasonably identify the left ureter in a left sided colectomy.
>
> A. Yes.
>
> Q. And meet the standard of care in the identification of the left ureter.
>
> A. Yes.
>
> Q. And they are steps that are reasonable in the division of the colonic mesentery using a LigaSure during a colectomy.
>
> A. I agree.
>
> Q. And those steps also meet the standard of care.
>
> A. I do agree with that.
>
> Q. And they are therefore reasonable steps to take to both identify and protect against injury to the ureter.
>
> A. Yes.
>
> Q. And if those steps would be taken by a general surgeon such as Doctor Ward that general surgeon would be meeting the standard of care.
>
> A. Yes.[81]

105. Dr. Hagen, an experienced and well-respected laparoscopic surgeon, testified that Dr. Ward met the standard of care and that ureteric injury is a recognized complication of the Surgery. He disagreed that an injury would be a breach of the standard. His opinion was un-touched in cross-examination.

106. The Trial Judge made no factual findings of an error by Dr. Ward in performing the Surgery, in the process he undertook, or at all. In fact, the Trial Judge found that Dr. Ward met the standard of care with respect to the identification and protection of the ureter:

> I am satisfied that Dr. Ward took steps during this laparoscoptomy [*sic*] to identify and protect the ureter.[82]

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[81] Burnstein Evidence at p 78, ll 7-29, Appellant Record II, Tab 13, at p 156.
[82] Trial Decision, *supra* at para 109, Appellant Record I, Tab 1, p 25.

107. But the Trial Judge accepted Dr. Burnstein's definition of the standard of care and breach.[83] Dr. Burnstein was unequivocal that any injury was a breach of the standard of care. As a result, the Trial Judge found a breach of the standard of care based *only on the fact of an injury* and no other act or omission, despite his finding that Dr. Ward met the standard of care in identifying and protecting the ureter.

108. By a correct definition of the standard of care, the Trial Judge's own findings were that Dr. Ward met the standard. As set out above, the majority of the Court of Appeal recognized this error:

> On that correct measure, the trial judge's own finding was that during the surgery, Dr. Ward took the steps he described to identify and protect the ureter. These were essentially the same steps that Ms. Armstrong's own expert surgeon conceded a reasonably prudent surgeon would use. Given this finding, the trial judge should have dismissed Ms. Armstrong's action.[84]

109. The Trial Judge's error is not excused because an expert defined the standard of care in a manner that cannot be supported at law. While the dissenting opinion suggests that it was open to the Trial Judge to accept Dr. Burnstein's theory, it was not open for him to do so where this leads to such an error. That is what occurred here.

110. The Appellant argues that there are cases where an injury can be the breach of the standard of care, and the rules with respect to perfection and hindsight do not apply in such cases.[85] In reality, there may be circumstances where an injury may be a breach of the standard of care, but this would be an exceptional category of cases, where it is patently obvious that only negligence could have caused the injury.[86] The Court of Appeal recognized that this action is not such a case.[87]

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[83] Trial Decision, *supra* at paras 81-84, Appellant Record I, Tab 1, pp 18-19.
[84] Appeal Decision, *supra* at para 4, Appellant Record I, Tab 3, p 31.
[85] Appellant Factum, *supra* at paras 111-117.
[86] Appeal Decision, *supra* at para 46, Appellant Record I, Tab 3, p 45.
[87] Appeal Decision, *supra* at para 46, Appellant Record I, Tab 3, p 45.

The Surgery involved a complicated procedure requiring various steps, including the identification and protection of the ureter.

ADDRESSING NON-NEGLIGENT CAUSES IS AN ISSUE OF BURDEN

111. The majority of the Court of Appeal stated in *obiter* that if a trial judge is willing to proceed on the basis that only negligence could have caused the injury, he or she must consider and rule out non-negligent causes.[88]

112. The Appellant submits that the majority's statement requires a trial judge to consider factors *outside* the trial process and that it creates "negative implications" for the law.[89] With respect, this is incorrect. The majority held that a trial judge will need to consider and rule out non-negligent causes where a plaintiff proceeds on the theory that only negligence could have caused the injury because this is what is required for a plaintiff to meet his or her burden on that theory.

113. An injury alone will not prove negligence, absent exceptional circumstances. To succeed on a theory that the injury alone proves negligence, a plaintiff will need to demonstrate that her case falls within these exceptional circumstances. This will involve leading evidence that only negligence could have caused the injury. As a practical matter, this will necessarily include evidence ruling out non-negligent causes, which the trial judge will consider. This does not require or include the consideration of facts outside of the trial process. The majority's statement requires the opposite: evidence to prove that the plaintiff's case falls within the exceptional category must be led at trial such that a trial judge can consider it.

114. Put simply, the majority is stating that if a plaintiff intends to lead a case where only negligence could have caused the injury, she must *lead that case*. This will include evidence of

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[88] Appeal Decision, *supra* at para 56, Appellant Record I, Tab 3, at p 50.
[89] Appellant Factum, *supra* at paras 82-91.

non-negligent causes to be considered by the trial judge. It may be that in this theoretical category of cases the defendant would be required to lead affirmative evidence to support her theory of the case as well. This may also be evidence of a non-negligent cause for the trial judge to consider. In all cases, the evidence considered by the trial judge would be adduced at trial.

115. This case would not fall within the exceptional category of cases. As the majority stated, it involved a complex surgical procedure with multiple steps. All experts agreed that identification and protection of the ureter were essential steps to the procedure. Identification and protection each required specific actions by the surgeon.

116. Even if this case did fall within the exceptional category of cases, the plaintiff did not lead evidence that would discharge her burden on that theory. The Trial Judge did not consider and rule out non-negligent causes because none were provided by the Appellant. The Trial Judge accepted the Appellant's evidence on the standard of care and causation despite there being no evidence of how only negligence could have caused the injury. As the Appellant identified, "it was never suggested to any witness that there might be a non-negligent reason – such as the surgeon's dexterity or movement of the anatomy – for a surgeon to use the LigaSure within 2mm of the ureter".[90] If the Trial Judge was to make a circumstantial inference of negligence because the LigaSure came too close to the ureter, more evidence would have been needed than an expert's comments that coming too close to the ureter is negligent.

117. Accordingly, the "negative implications" argued by the Appellant are not realistic consequences of the majority's statement. In fact, the majority's statement can be best summarized as a reaffirmation of how trial judges should treat *res ipsa loquitor*. As this Court stated in *Fontaine v British Columbia (Official Administrator)*, the maxim should be treated as expired:

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[90] Appellant Factum, *supra* at para 84.

> It would appear that the law would be better served if the maxim was treated as expired and no longer used as a separate component in negligence actions. After all, it was nothing more than an attempt to deal with circumstantial evidence. That evidence is more sensibly dealt with by the trier of fact, who should weigh the circumstantial evidence with the direct evidence, if any, to determine whether the plaintiff has established on a 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.[91]

118. The majority's statement is consistent with this principle and imposes no more of a burden or duty on a plaintiff than is already present.

THE COURT OF APPEAL APPLIED THE CORRECT STANDARD OF REVIEW

119. The Court of Appeal applied the correct standard of review in this case. It is not contentious that the appellate standard of review for questions of law is correctness.[92] The appellate standard of review for questions of mixed fact and law is palpable and overriding error.[93]

120. The Court of Appeal applied these standards, as appropriate, throughout its analysis. In overturning the Trial Decision, the Court of Appeal identified an error of law in the Trial Judge's definition of the standard of care and reviewed this error on a standard of correctness.

PART IV - SUBMISSIONS WITH RESPECT TO COSTS

121. The Respondent asks that he be awarded costs.

PART V - ORDER SOUGHT

122. The Respondent requests that the Court of Appeal's decision reversing the Trial Decision is upheld and that the action is dismissed.

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[91] *Fontaine v British Columbia (Official Administrator)*, [1998] 1 SCR 424 at para 27.
[92] *Housen v Nikolaisen*, 2002 SCC 33 at paras 8-9 [***Housen***].
[93] *Housen*, *supra* at paras 26-37.

PART VI - SUBMISSIONS ON CONFIDENTIALITY

123. The Respondent has no submissions with respect to confidentiality.

ALL OF WHICH IS RESPECTFULLY SUBMITTED, THIS 9TH DAY OF NOVEMBER, 2020

for:
Mark Veneziano

for:
Jaan E. Lilles

for:
Sean Lewis

Counsel for the Respondent, Dr. Colin Ward

PART VII - LIST OF AUTHORITIES

No.	Authority	Paragraphs Cited	Hyperlink
Case Law			
1.	*Armstrong v Royal Victoria Hospital*, 2018 ONSC 2439	11, 14, 18-21, 24, 26-29, 34, 39-42, 45-47, 61, 63, 106, 107	CanLII
2.	*Armstrong v Royal Victoria Hospital*, 2019 ONCA 963	50-55, 61, 91, 108, 110, 111,	CanLII
3.	*Bafaro v Dowd*, [2008] OJ No 3474 (Sup Ct)	67	CanLII
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5.	*Carlsen v Southerland*, 2006 BCCA 214	73, 77	CanLII
6.	*Central Trust Co v Rafuse*, [1986] 2 SCR 147	81	CanLII
7.	*Cooper v Flood*, 2015 ABQB 567	103	CanLII
8.	*Cooper v Flood*, 2016 ABCA 365	103	CanLII
9.	*Crits v Sylvester* (1956), 1 DLR (2d) 502 (Ont CA)	68, 77	Tab 2 BOA
10.	*Crits v Sylvester*, [1956] SCR 991	68	CanLII
11.	*Epstein v Salvation Army Scarborough Grace General Hospital* (1999), 124 OAC 233 (CA)	67	CanLII
12.	*Folland v Reardon* (2005), 249 DLR (4th) 167 (Ont CA)	81	CanLII
13.	*Fontaine v British Columbia (Official Administrator)*, [1998] 1 SCR 424	117	CanLII
14.	*Fullowka v Pinkerton's of Canada Ltd*, 2010 SCC 5	53, 74, 93, 94, 96, 98,	CanLII
15.	*Grass v Women's College Hospital* (2001), 200 DLR (4th) 242 (CA).	61	CanLII
16.	*Greaves & Co (Contractors) Ltd v Baynham Meikle & Partners*, [1975] 3 All ER 99 (Eng CA)	72	Tab 3 BOA

17.	*Guardian Insurance Co of Canada v Sharp*, [1941] SCR 164, 2 DLR 417	82	CanLII Full English version Tab 4 BOA
18.	*Hassen v Anvari*, [2003] OJ No 3543 (CA), leave to appeal to SCC dismissed, 30044 (29 April 2004)	103	CanLII
19.	*Housen v Nikolaisen*, 2002 SCC 33	119	CanLII
20.	*In re London and General Bank (No 2)*, [1895] 2 Ch 673 (CA)	82	Tab 5 BOA
21.	*Kehler v Myles* (1986), 74 AR 259 (QB)	76	CanLII
22.	*Kehler v Myles*, 1988 ABCA 350, leave to appeal to SCC refused, 21364 (6 April 1989)	76	CanLII
23.	*Keith v Abraham*, 2011 ONSC 2	70	CanLII
24.	*Kooijman v Bradshaw*, 2016 BCSC 2316	75	CanLII
25.	*Lanphier v Phipos* (1838), 173 ER 581, 8 C&P 475 (Ct CP)	80	Tab 6 BOA
26.	*Larche v Ontario* (1990), 75 DLR (4th) 377 (Ont CA).	84	CanLII
27.	*McCardle v Cox*, 2003 ABCA 106	59	CanLII
28.	*Meringolo (Committee of) v Oshawa General Hospital* (1991), 46 OAC 260 (CA)	61	Tab 7 BOA
29.	*Mustapha v Culligan of Canada Ltd*, 2008 SCC 27	58	CanLII
30.	*Roe v Minister of Health et al*, [1954] 2 All ER 131	68, 76, 77	Tab 8 BOA
31.	*Shantry v Warbeck*, 2015 ONCA 395	58	CanLII
32.	*St Jean v Mercier*, 2002 SCC 15	53, 69, 78, 92	CanLII
33.	*Wilson v Swanson*, [1956] SCR 804	67, 71	CanLII
Secondary sources			
1.	Beverly M McLaughlin & Arthur M Grant, *The Canadian Law of Architecture and Engineering*, 3rd ed (Toronto: LexisNexis, 2020)	83	Tab 1 BOA