SCC File No. 39049

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

BETWEEN:

KAREN ARMSTRONG

Appellant
(Appellant)

– and –

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

Respondents
(Respondents)

and

HEALTHCARE INSURANCE RECIPROCAL OF CANADA and ONTARIO TRIAL LAWYERS' ASSOCIATION

Interveners

FACTUM OF THE INTERVENER, HEALTHCARE INSURANCE RECIPROCAL OF CANADA

(Pursuant to Rules 37 and 42 of the *Rules of the Supreme Court of Canada*, S.O.R./2002-156)

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PART I – OVERVIEW

1. On this appeal, the Court will consider when and how a plaintiff's injury can inform the analysis of whether the defendant met their standard of care. As a line of cases from Ontario has demonstrated, such an undertaking has the potential to undermine the fair adjudication of medical negligence claims. Medical professionals have an obligation of means – not of results. Allowing the outcome to influence the standard of care risks distorting this standard, which ultimately may improperly reverse the burden of proof. This concern is particularly acute in medical negligence cases, the vast majority of which arise from unfortunate, often tragic, outcomes.

2. The Healthcare Insurance Reciprocal of Canada ("HIROC") intervenes to represent the interests of broader stakeholders, including healthcare institutions and non-physician healthcare practitioners.

3. While a strand in the jurisprudence suggests that in certain cases the judge may consider the cause of the injury before considering standard of care, this jurisprudence requires clarification. HIROC submits that it is never appropriate to consider causation before standard of care. However, there are exceptional cases where it may be necessary to use the injury as circumstantial evidence of what occurred at the time to inform whether a breach of the standard of care occurred. HIROC proposes an approach setting out when and how evidence about an injury may be used as circumstantial evidence to inform whether the defendant met their standard care.

PART II – STATEMENT OF ISSUES

4. HIROC makes submissions on three issues:

   a. The sequence and onus of standard of care and causation;

   b. The risk of relying on the outcome to inform standard of care and causation;

   c. An approach to how and when an injury can inform the standard of care inquiry.

PART III – STATEMENT OF ARGUMENT

A. The sequence and onus of standard of care and causation analysis is well-established

5. The context of this appeal requires clearly defining the elements standard of care and causation and their sequence in the negligence analysis.

6. The principle underlying the standard of care analysis is that healthcare providers ought to practice in accordance with the conduct of a prudent and diligent practitioner of the same qualifications in the same circumstances.[1] As this Court has aptly noted, practitioners "have an obligation of means, not an obligation of result."[2] This is because any person receiving treatment is subject to risk no matter what level of care is provided.[3]

7. Causation addresses whether there is a causative link between the breach of the standard of care and the injury such that the defendant should be held liable.[4] This element has two distinct components. The first – factual causation – manifests as the "but for" test and determines whether the injury would have occurred in the absence of the breach of the standard of care.[5] The second – legal causation – examines remoteness or proximate cause, which considers the policy question of whether the defendant ought to be held responsible.[6]

8. The elements of negligence are necessarily sequential.[7] A breach of the standard of care is a prerequisite to causation. The nature of the standard of care and causation inquiries in particular make this clear. The causation inquiry is not intended to answer everything that happened to bring about the injury, but rather, it focuses solely on the fault-based behaviour of the particular defendant.[8] Without first identifying a breach of the standard of care, it is not possible to determine causation, because there is no fault-based act or omission to potentially link to the injury.[9]

9. Accordingly, there are no circumstances where causation can be considered or ruled on prior to determining a breach of the standard of care. This Court has never endorsed such an

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[1] *Ter Neuzen v Korn*, [1995] 3 SCR 674 at para 33 [*Ter Nuzen*].
[2] *St. Jean v Mercier*, 2002 SCC 15 at para 53 [*St. Jean*]. The concept of means versus result has been further discussed by legal scholars. See e.g. Arthur Ripstein, *Private Wrongs* (Cambridge, USA: Harvard University Press, 2016) at 105, 116, 121.

[3] *Hatcher v Black*, [1954] CLY 2289, The Times, 2 July 1954 (Lord Denning).
[4] *Clements v Clements*, 2012 SCC 32 at para 6.
[5] *Ibid* at para 8; *Frazer v Haukioja*, 2010 ONCA 249 at para 39 [*Frazer*].
[6] *Frazer*, *supra* note 5 at para 39; *Saadati v Moorhead*, 2017 SCC 28 at para 20.
[7] *Shantry v Warbeck*, 2015 ONCA 395 at paras 34-35; *Bafaro v Dowd*, 2010 ONCA 188 at para 135 [*Bafaro*]; *Randall v Lakeridge Health Oshawa*, 2010 ONCA 537 at para 35.
[8] Allen M Linden et al, *Canadian Tort Law*, 11th ed (Markham, ON: LexisNexis, 2018) ch 4 at para 4.22.
[9] *McArdle Estate v Cox*, 2003 ABCA 106 at para 25 [*McArdle*].

approach, nor should it. This is distinct from the exceptional cases where it may be necessary to consider whether a plaintiff's injury or how it occurred provides circumstantial evidence relevant to what happened to inform the standard of care analysis, addressed below.

10. Within the established sequence, this Court has clearly stated on several occasions that the burden of proof rests on the plaintiff.[10] This burden of proof is a fundamental component of negligence law and ought not be disturbed.

11. The narrow issue on this appeal regarding non-negligent causes does not call into question the overall burden of proof, which was fully addressed by this Court in *Fontaine*. Where the plaintiff establishes on a balance of probabilities a *prima facie* case, they will succeed unless the defendant can demonstrate an equally likely non-negligent cause.[11] This does not reverse the burden. Reversing the burden where there is no *prima facie* case would in some instances require proof of the impossible as there are cases and entire fields in which the medicine is far from settled or established. While healthcare parties usually have a higher degree of medical and factual knowledge than the plaintiff, these defendants do not have all of the answers and cannot always explain the cause of a plaintiff's outcome.

B. An injury should only be used as circumstantial evidence to inform a breach of the standard of care when necessary and with caution

a. Caution must be exercised: The risk of relying on outcome

11. Considering the outcome during the standard of care analysis runs the very real risk that unfair standards will be imposed on healthcare providers whose very job it is to try to assist people, often in critical and high-risk situations. It is not in the public interest to judge those people by the results of their good faith and reasonable actions.[12] It runs the risk of focusing on the result rather

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[10] *Snell v Farrell*, [1990] 2 SCR 311 at paras 321, 330; *Fontaine v British Columbia (Official Administrator)*, [1998] 1 SCR 424 at paras 23, 27 [*Fontaine*]; *Ediger v Johnston*, 2013 SCC 18 at para 36.

[11] *Fontaine*, *supra* note 10 at paras 24, 27.

[12] T.B. Hugh and S.W.A. Dekker find that decisions arrived at by hindsight bias are likely to be perceived by many medical professionals as a miscarriage of justice, and ultimately impair safe medical practice as they stimulate defensive medicine and alienate clinicians from quality improvement initiatives; Thomas B Hugh & Sidney WA Dekker, "Hindsight bias and outcome

than the means[13] and then looking back at what *could* have avoided that outcome, rather than what was reasonable at the time.

12. "Hindsight bias" describes how the knowledge of an outcome increases one's perception of the ability to predict that outcome.[14] It has been described as "the greatest obstacle to evaluating the performance of humans in complex systems after bad outcomes."[15] The related "outcome bias", refers to the impact of outcome knowledge on evaluations of care. Both are known to play a significant role in the evaluation of an event in both medical and judicial settings.[16] Clinicians are known to be markedly more critical of identical healthcare when they know a patient has died compared to when a patient survives.[17] It is human nature to be sympathetic to those who have suffered a tragic outcome and it is easy to inadvertently use knowledge learned after the fact to critique care. This can occur despite knowing that sympathy is a poor guide in such matters.[18]

13. Judicial cautions against the dangers of hindsight are common.[19] This Court has stated:

> [C]ourts should be careful not to rely upon the perfect vision afforded by hindsight. In order to evaluate a particular exercise of judgment fairly, the doctor's limited ability to foresee future events when determining a course of conduct must be borne in mind. Otherwise, the doctor will not be assessed according to the norms of the average doctor of reasonable ability in the same circumstances, but rather will be held accountable for mistakes that are apparent only after the fact. [20]

14. The need to protect against hindsight and outcome bias is consistent with this Court's clear repudiation of the former *res ipsa loquitor* principle. For some time, this principle allowed a

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bias in the social construction of medical negligence: A review" (2009) 16 JLLM 846 at 857 [Hugh & Dekker].

[13] *St. Jean*, *supra* note 2 at para 53.
[14] Hugh & Dekker, *supra* note 12 at 848.
[15] Richard I Cook & David D Woods, "Operating at the Sharp End: The Complexity of Human Error" in MS Bognor, ed, *Human Error in Medicine* (Hillsdale NJ: Lawrence Erlbaum Associates, 1994).
[16] Edward Banham-Hall & Sian Stevens, "Hindsight bias critically impacts on clinicians' assessment of care quality in retrospective case note review (2019) 19:1 Clin Med at 16-20.
[17] *Ibid*; see also Megan E Giroux et al, "Hindsight Bias and Law" (2016) 224:3 Zeitschrift für Psychologie 190 at 193.
[18] *Lapointe v Hôpital le Gardeur*, 1 SCR 351 at 36 [*Lapointe*].
[19] *Bafaro, supra* note 7 at paras 26, 30; *Crits v Sylvester*, 1956 CanLII 34 (ON CA) at 14, overturned on appeal on a different issue: [1956] SCR 991; *Roe v Minister of Health*, [1954] EWCA Civ 7 per Lord Denning at p. 139.
[20] *Lapointe*, *supra* note 18 at 16.

summary finding of negligence if the outcome was such that it would not have happened without negligence. This Court firmly rejected the further application of the principle, reiterating that the plaintiff needs to establish the elements of negligence in all cases.[21]

15. A case that demonstrates the dangers of hindsight bias is *Hassen v. Anvari*.[22] The trial judge found "no expert evidence" that the defendant physician breached the standard of care.[23] The trial judge did not articulate the standard of care. Despite this, the trial judge held the defendant liable not on the basis of comparing his means to that of his peers, but on an unfortunate risk materializing.[24]

16. The reality of healthcare is that bad outcomes can occur both in the face of and absent a breach of the standard of care. The Canadian medical negligence regime operates solely on the basis of fault, rather than outcome. This is precisely why the standard of care analysis evaluates the means rather than the result and courts routinely warn against hindsight bias. Doing otherwise risks reversing the burden of proof such that a plaintiff does not have to prove the practitioner did not meet the means of a reasonable practitioner in the circumstances.

b. Existing case law has failed to protect against reliance on hindsight

17. Given the dangers of hindsight and outcome bias, reference to the outcome in the standard of care analysis should only be contemplated if necessary for a fair adjudication of the matter.

18. There is a short line of cases established by the Court of Appeal for Ontario, starting with *Meringolo*[25] and continuing with *Grass*,[26] that have resulted in trial judges broadly considering the injury and even reversing the causation and standard of care analysis.

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[21] *Fontaine*, *supra* note 10 at paras 17-27.
[22] *Hassen v Anvari*, 2001 CarswellOnt 5325 (WL Can) (ON SC), affirmed 2003 CanLII 1005 (ON CA), leave to appeal refused: 2004 CarswellOnt 1768 (WL Can) (SCCA).
[23] *Ibid* at para 11.
[24] The Court of Appeal upheld the decision by finding expert evidence in the record on which a breach of the standard of care could be found, *ibid* at para 19.

[25] *Meringolo (Committee of) v Oshawa General Hospital*¸ 1991 CarswellOnt 1078 (WL Can) (ON CA), leave to appeal refused: [1991] SCCA No 155 (QL) [*Meringolo*].
[26] *Grass (Litigation Guardian of) v Women's College Hospital*, 2001 CanLII 8526 (ON CA), leave to appeal refused: [2001] SCCA No 372 (WL Can) [*Grass*].

19. This development in the case law is prejudicial to the fair adjudication of professional negligence cases. First, the cases have not defined when and how it is appropriate to consider the injury when evaluating the standard of care. Second, they have not been explicitly alive to the risks of hindsight bias. Finally, they have introduced confusion into the negligence analysis, with some judges purporting to determine causation prior to standard of care, and others allowing the injury to influence more than just a factual determination of what happened.

20. *Meringolo*[27] is the first of this line of cases that opened the door to considering a plaintiff's injury in the standard of care analysis. The primary plaintiff underwent a bronchoscopy under general anesthetic. Near the end of the procedure, the plaintiff suffered a cardiac arrest and ultimately sustained severe brain damage. The plaintiffs' theory of the case was that Mr. Meringolo was inadequately ventilated during the procedure leading to hypoxia and cardiac arrest. The defendants' theory of the case was that the plaintiff was adequately ventilated and instead suffered a pulmonary embolism. The Court of Appeal concluded that there needed to be a determination of how the patient sustained brain damage in order to know whether adequate ventilation was provided to determine whether the standard of care had been met.

21. The courts in *Grass* were also faced with a factual discrepancy – this time, whether the defendant obstetrician appropriately applied traction when using forceps or whether there was repeated use of excessive force and traction such that the standard of care was breached. The trial judge accepted the defendant's evidence and found no breach of the standard of care. The Court of Appeal relied on *Meringolo* to overturn the trial judge's decision and sent it back for a new trial, finding that a determination of what happened was required to address whether the standard of care was met.

22. Neither of these decisions provide guidance to lower courts as to when or how the outcome should be used in determining whether the standard of care was met. Neither warn against the dangers of hindsight bias or the risks of allowing the injury to play a larger role than simply determining what happened at the time of the alleged negligence. The result has been conflicting jurisprudence both within Ontario[28] and across the country.[29]

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[27] *Meringolo, supra* note 25.
[28] *Bafaro, supra* note 7.
[29] *McArdle*, *supra* note 9.

23. The *Meringolo* and *Grass* line has been distinguished or criticized in many cases[30] and adopted by several others.[31] In those where it has been relied upon, it has generally been summarily adopted with no analysis or consideration of the risks.[32] Application of the principle has been noted to be in the trial judge's discretion, with no defined limits to when it can be used.[33] In the *Dear* case, the trial judge determined it was necessary to decide whether the defendant caused or contributed to the plaintiff's injury prior to addressing negligence.[34] In *Wereszczakowski*, the court similarly purported to analyze what led to the plaintiff's premature termination of her pregnancy, which had no bearing on the alleged breach of the standard of care of failing to draw blood sugar.[35] These cases go much farther than *Meringolo* or *Grass* purported to go and enter the impermissible realm of reordering the elements of negligence.[36]

C. HIROC proposes a principled approach to when and how an injury can inform the standard of care inquiry

24. HIROC recommends a principled approach that (1) provides guidance as to the narrow circumstances when it is appropriate to consider the injury; and (2) sets basic guiding principles for courts to consider to avoid the risk of hindsight bias.

a. The narrow circumstances warranting consideration of the injury

25. Given the significant risks that hindsight bias poses, courts should always make explicit efforts to decide whether a breach of the standard occurred without considering the injury. This is

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[30] *Liuni (Litigation Guardian of) v Peters*, 2001 CanLII 5153 (ON CA) [*Liuni*]; *Locke v Smith*, 2002 CanLII 44964 (ON CA); *McArdle*, *supra* note 9; *Matthews Estate v Hamilton Civic Hospitals (Hamilton General Division)*, 2008 CanLII 52312 (ON SC); *MacGregor v Potts*, 2009 CanLII 44720 (ON SC); *Andersen v St. Jude Medical Inc.*, 2012 ONSC 3660 [*Andersen*]; *Shantry v Thompson*, 2015 ONCA 395.

[31] *Dear v Davidson (c.o.b. Dr. R.G. Davidson, Inc.)*, 2001 BCSC 1574 [*Dear*]; *Dybongco-Rimando Estate v Lee*, 1999 CarswellOnt 4283 (WL Can) (ON SC) [*Dybongco*]; *Wereszczakowski v Swales Estate*, 2002 CarswellOnt 1856 (WL Can) (ON SC) [*Wereszczakowski*]; *Crawford v Penney*, 2003 CanLII 32636 (ON SC) [*Crawford*]; *Jenkins v Knickle*, 2003 PESCTD 49 [*Jenkins*].

[32] *Dybongco*, *supra* note 31; *Wereszczakowski*, *supra* note 31; *Crawford*, *supra* note 31; *Jenkins*, *supra* note 31.

[33] *Andersen*, *supra* note 30 at para 54.

[34] *Dear*, *supra* note 31 at para 30.

[35] *Wereszczakowski*, *supra* note 31 at para 30.

[36] It is likely that confusion surrounding whether courts have the discretion to consider causation at this stage commenced with *Meringolo*'s unclear reliance on *Snell* to ground its analysis.

possible in most cases.

26. However, there are some cases where it is impossible to determine what happened at the time of the alleged negligence without considering circumstantial evidence from the injury. This will occur either (a) when there is no evidence about what occurred or (b) conflicting evidence such that the court needs to look at additional evidence to resolve the conflict. In such cases, courts can rely on the injury to make factual findings about what happened. To do so, there needs to be a factual dispute or uncertainty about material facts relevant to the determination of a breach of the standard of care. This should not simply be done because causation is in dispute, as it may still be possible to resolve whether a breach of the standard of care occurred without looking at the injury.

27. For example, in *Grass*, it was open to the court to find that it needed further evidence to resolve the conflicting evidence regarding the frequency and force of forceps use to be able to rule on whether the standard of care was breached.[37]

b. Three basic principles to ensure fair adjudication of standard of care

28. Courts that consider relying on the injury as circumstantial evidence of a breach of the standard of care ought to be guided by these three principles to minimize the risk of injecting hindsight bias into their negligence analysis.

29. ***Principle #1: The injury is irrelevant to defining the requisite standard of care***. While courts have often collapsed the discussion of the standard of care analysis into one inquiry, it is fundamentally comprised of two distinct considerations: (1) what was the standard of care for the practitioner; and (2) did the practitioner meet that standard of care?[38] Describing the standard of care is an essential step to allow comparison to the defendant's means.[39]

30. Neither the outcome nor a factual determination of what happened at the time of the alleged negligence are relevant to defining the standard of care. The standard of care is based on expert evidence of what the reasonable practitioner would have done in a similar situation.[40] Therefore,

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[37] *Grass, supra* note 26 at para 16.
[38] *Grey Condominium Corp. No 27 v Blue Mountain Resorts Ltd.,* 2008 ONCA 384 at paras 39-40; *Skinner v Matheson*, 2017 ABQB 342 at para 44.
[39] It is a legal error to fail to articulate the standard of care to which the defendant is to be held; *Fullowka v Royal Oak Ventures Inc.*, 2010 SCC 5 at para 80.
[40] *Ter Neuzen*, *supra* note 1 at paras 33-55.

what the particular defendant did does not inform the first step in the standard of care analysis. To consider the outcome at this stage would invite hindsight bias and would be highly prejudicial.

31. Accordingly, the court should articulate the specific standard of care that the defendant is being held to relevant to the allegations, without considering the injury. In *Grass*, this would have included what kind of frequency and force of forceps use is justified by the standard of care.

32. ***Principle #2: The factual uncertainty should be explicitly and narrowly defined.*** To ensure there is no confusion about how the injury can be considered and there is no inadvertent use of the information gained that prejudices a defendant or reverses the burden of proof, the court should explicitly set out the narrow issue on which they are seeking further circumstantial evidence. Once the requisite standard of care is defined, the court should be able to tell whether any necessary information is lacking to determine whether a breach occurred. In *Grass* for example, this would be what frequency and degree of force was used with the forceps. This should be explicitly stated to ensure that the information gleaned from the injury is only used for that specific purpose and does not inadvertently influence the standard of care inquiry.

33. This also protects against courts using the outcome to determine negligence outright, as the majority in *Armstrong* suggested may be possible in some hypothetical cases.[41] The Court of Appeal stated that in some cases, such as amputation of the wrong limb, a breach of the standard of care may be defined by the outcome. However, HIROC submits there is no reason to depart from the usual framework in these cases. While such examples often lead to liability, it is not because of the injury *per se*, but because the means in place to prevent such injuries are so well established that if followed, it is unlikely the outcome would occur. It is always necessary for a plaintiff to establish that the means followed by the practitioner did not meet the standard of care.

34. Once the court has narrowly set the question to be answered and reviewed the injury for any relevant circumstantial evidence on that issue, it can then decide if the injury provides any circumstantial evidence to answer the factual uncertainty about what happened at the time. If it resolves the uncertainty, the court can go on to decide whether the facts as determined constitute a breach of the standard of care as compared to the standard of care already determined. If it does not resolve the uncertainty, then the plaintiff has failed to meet its burden of proof and no breach

[41] *Armstrong v Royal Victoria Hospital*, 2019 ONCA 963 at para 46.

of the standard of care can be found. The outcome itself does not establish *prima facie* negligence.

35. ***Principle #3: The causation analysis is distinct.*** As has been seen in the existing case law, confusion can arise over the use of the term "causation" when considering whether the injury provides any circumstantial evidence of what happened. Courts need to be clear that the analysis of the causation element of negligence remains distinct and considering the injury at this stage is not an opportunity to consider factual or legal causation prior to determining the standard of care.

36. While in plain language, "what happened" can be framed as a form of causation, courts should refrain from using the term "causation" to avoid conflation with the later steps of factual and legal causation. It should be narrowly defined as considering whether the injury provides circumstantial evidence of what happened.[42]

37. When the court makes a decision on standard of care and moves to causation, the causation inquiry should not be a recitation of the factual findings in relation to what happened. There is an important distinction between what happened and whether the breach caused the outcome (factually and legally). A court that conflates the two will have collapsed the inquiry in such a way that a fair trial outcome is not possible. In *Grass* for example, the inquiry into the injury may have shown that the force used with the forceps was so strong that it fell below the standard of care. Now, at the causation stage, the court addresses whether the strong use of the forceps caused the child's cerebral palsy – an issue not yet determined.

38. The above three principles will help to ensure a fair determination of negligence with minimal risks of prejudice arising from hindsight bias. These principles fit well within the already established negligence framework and settled burden of proof on a plaintiff.

PART IV – SUBMISSIONS ON COSTS & PART V ORDER

39. HIROC does not seek costs and asks that no order as to costs be made against it. HIROC takes no position on the outcome of this appeal.

PART VI – SUBMISSIONS ON PUBLICATION

N/A

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[42] *Kennedy v Jackiewicz*, 2003 CanLII 19994 (ON SC) at para 6; affirmed 2004 CanLII 43635 (ON CA).

ALL OF WHICH IS RESPECTFULLY SUBMITTED this 11th day of December, 2020.

Per: _____
Anna Marrison

PART VII – AUTHORITIES

Caselaw:

No.	Authority	Paragraph Reference
1.	*Andersen v. St. Jude Medical Inc.*, 2012 ONSC 3660	23
2.	*Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963	33
3.	*Bafaro v. Dowd*, 2010 ONCA 188	8, 13, 22
4.	*Clements v. Clements*, 2012 SCC 32	7
5.	*Crawford v. Penney*, 2003 CanLII 32636 (ON SC)	23
6.	*Crits v. Sylvester*, 1956 CanLII 34 (ON CA) at 14, overturned on appeal on a different issue: [1956] SCR 991	13
7.	*Dear v. Davidson (c.o.b. Dr. R.G. Davidson, Inc.)*, 2001 BCSC 1574	23
8.	*Dybongco-Rimando Estate v. Lee*, 1999 CarswellOnt 4283 (WL Can) (ON SC)	23
9.	*Ediger v. Johnston*, 2013 SCC 18	10
10.	*Fontaine v. British Columbia (Official Administrator)*, [1998] 1 SCR 424	10, 11, 14
11.	*Frazer v. Haukioja*, 2010 ONCA 249	7
12.	*Fullowka v. Royal Oak Ventures Inc.*, 2010 SCC 5	29
13.	*Grass (Litigation Guardian of) v. Women's College Hospital*, 2001 CanLII 8526 (ON CA), leave to appeal refused: [2001] SCCA No 372 (WL Can)	18, 21, 23, 27, 31, 32, 37
14.	*Grey Condominium Corp. No. 27 v. Blue Mountain Resorts Ltd.*, 2008 ONCA 384	29
15.	*Hassen v. Anvari*, 2001 CarswellOnt 5325 (WL Can) (ON SC), affirmed 2003 CanLII 1005 (ON CA), leave to appeal refused: 2004 CarswellOnt 1768 (WL Can) (SCCA)	15

No.	Authority	Paragraph Reference
16.	*Hatcher v. Black*, [1954] CLY 2289, The Times, 2 July 1954 (Lord Denning)	6
17.	*Jenkins v. Knickle*, 2003 PESCTD 49	23
18.	*Kennedy v. Jackiewicz*, [2003] O.J. No. 1854 at para 6; affirmed [2004] O.J. No. 4816	36
19.	*Lapointe v. Hôpital le Gardeur*, 1 SCR 351	12, 13
20.	*Liuni (Litigation Guardian of) v. Peters*, 2001 CanLII 5153 (ON CA)	23
21.	*Locke v. Smith*, 2002 CanLII 44964 (ON CA)	23
22.	*MacGregor v. Potts*, 2009 CanLII 44720 (ON SC)	23
23.	*Matthews Estate v. Hamilton Civic Hospitals (Hamilton General Division)*, 2008 CanLII 52312 (ON SC)	23
24.	*McArdle Estate v. Cox*, 2003 ABCA 106	8, 21, 23
25.	*Meringolo (Committee of) v. Oshawa General Hospital*¸ 1991 CarswellOnt 1078 (WL Can) (ON CA), leave to appeal refused: [1991] SCCA No 155 (QL)	18, 20, 21, 23
26.	*Randall v. Lakeridge Health Oshawa*, 2010 ONCA 537	8
27.	*Roe v. Minister of Health*, [1954] EWCA Civ 7	13
28.	*Saadati v. Moorhead*, 2017 SCC 28	7
29.	*Shantry v Thompson*, 2015 ONCA 395	23
30.	*Shantry v. Warbeck*, 2015 ONCA 395	8
31.	*Skinner v. Matheson*, 2017 ABQB 342	29
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