TRIAL LAWYERS ASSOCIATION OF BC

Issue 189 • Summer 2026

THE Verdict

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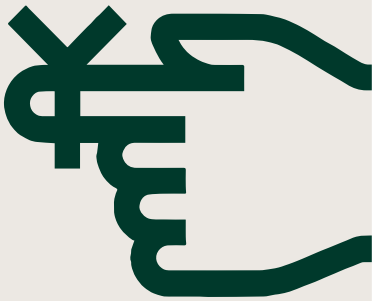

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Together we strive to: promote the rights of individuals, preserve the jury system, improve the professionalism and standards of trial lawyers, enhance access to justice, protect the innocent, promote judicial integrity and independence.

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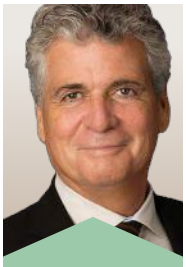

CEO CORNER

BY **DON AVISON KC**
TLABC Chief Executive Officer & Counsel

D.J. (Don) Avison KC joined TLABC as CEO in January 2026. Prior to that, he was the Executive Director and CEO of the Law Society of British Columbia. Don began his legal career as a trial lawyer and has appeared before all levels of court, including the Supreme Court Canada. He has had a varied career that includes being Regional Crown Counsel, the first Director General of the federal Aboriginal Justice Initiative, Deputy Minister of Justice in the Northwest Territories, Deputy Minister of Education/Advanced Education, Crown Corporations and Health in British Columbia, and he was also president of the University Presidents' Council of British Columbia. Don is a Chartered Director with extensive board experience. This includes roles as chair of Emily Carr University of Art + Design, chair of The Centre for Drug Research and Development, vice-chair of the Michael Smith Foundation for Health Research, and as chair of the Regulatory Committee of the Oil and Gas Commission.

As this is my first column for *the Verdict* since my appointment as the CEO of TLABC, I thought it would be appropriate to offer a sense of why I'm here and what I hope to help us achieve over the course of the next several years.

From my perspective, there is much to build on here thanks, in no small measure, to the work our former CEO, Shawn Mitchell, had done, together with our Executive Committee and Board, to position TLABC as a strong and effective voice not only for trial lawyers but, more importantly, for our clients and others who come into contact with the administration of justice in British Columbia.

I also now have the benefit of working with a small — but outstanding — group of colleagues. Chief Operating Officer, Karen St. Aubin, is both exceptional and deeply dedicated to the mission of TLABC, as are Jenny Uechi (publisher of *the Verdict*), Genevieve Tomita, Priscilla Lam and Harshani Ranasinghe.

These are interesting and challenging times. At the time of writing, we await the decision of Chief Justice Skolrood in the *Legal Professions Act* litigation and, thanks to colleagues who have been prepared to step up in advancing a number of interventions before BC courts, we have played a key role in shaping the law here in British Columbia and we will continue to do that.

We will also continue to shine a light on the extent to which new laws are being passed by the Legislative Assembly of British Columbia without the benefit of the disinfecting power of transparency.

> There have simply been too many examples of situations where, as with the *Legal Professions Act* of 2024, debate on complex statutes has been truncated by government's insistence on invoking closure of debate.

With the LPA, closure was triggered after debate on fewer than 30 sections of the 320-section bill. The Legislative Assembly is there for a reason, and the public interest demands that there must be greater latitude for open debate and thoughtful consideration.

I am not — nor have I ever been — a personal injury lawyer. However, as a lawyer with a substantial background in public policy, and as a citizen, I am deeply concerned about how government's "No Fault" insurance program is doing real harm to BC residents injured in motor vehicle accidents through no fault of their own. We will actively engage in the review process that government has announced and will advocate for either repeal or, at minimum, for meaningful improvements. Look for more from us in the coming months on how "No Fault is Not Fair."

You can expect that we will also continue to seek and provide funding levels for Legal Aid. We plan to remind government every single year that they have failed to direct the provincial sales tax on lawyers' billings to Legal Aid as they said they would.

There is a lot of other important work happening here at TLABC. We have recently reprofiled our PAC Fund as the Justice Fund, and will soon be releasing a video promoting the important role this resource can provide.

The TLABC community came together recently earlier in May for the second annual Convention and the Spring Soirée with the presentation of the Awards of Distinction. We celebrated the contributions of Distinguished Jurist David Crossin KC and Distinguished Advocate Agnes Huang. This year, the President's Award went to Gavin Cameron for his tenacious representation of TLABC in the LPA litigation.

Permit me to close with this: I care deeply about the legal profession and the public interest. I am, therefore, honoured to have this opportunity to contribute towards improving the administration of justice here in British Columbia. I look forward to working with all of you on this.

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PRESIDENT'S MESSAGE

BY **REBECCA McCONCHIE**
TLABC President
TLABC Member
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Rebecca McConchie is a criminal lawyer and sole practitioner at McConchie Criminal Law. Rebecca represents clients at trial, on appeal, and in quasi-criminal contexts such as prison law matters. She regularly defends clients before judges and juries on charges ranging from mischief to murder. Rebecca has appeared before all levels of court in BC and at the Supreme Court of Canada. She devotes time in her practice to mentorship, creativity, and thinking about not just what the law is, but what it should be.

The Supreme Court of British Columbia recently released its Annual Report for 2025. The Annual Report details the Court's activities over the past year, covering matters like justice-related projects, policy reforms, changes to the Court's membership, and statistics on different kinds of court proceedings.

It is a more interesting read than one might expect.

The Annual Report begins with the Report of the Chief Justice and Associate Chief Justice. The Chief Justice and Associate Chief Justice open by addressing public confidence in the justice system. They write that public confidence "is increasingly strained by three interconnected challenges":

1. Misunderstanding of the role of courts and judges in our democratic system, particularly in relation to the legislative and executive branches of government, leading to misplaced criticism when court decisions are unpopular but legally required;

2. Chronic underfunding of the justice system, leading to delays and other barriers to access which undermine efficiency and fairness; and

3. Growing public and political attacks on judicial institutions, coupled with broader democratic backsliding, which threaten respect for the rule of law, the effective functioning of the court, and the independence of the judiciary.

I was struck by how closely the identified challenges align with issues about which TLABC has been raising the alarm.

> TLABC has long advocated for increased funding for the justice system; many (perhaps even most) of the access to justice issues that plague British Columbia's court system have underfunding at their heart.

More recently, TLABC has been forced to repeatedly push back on politicians' misleading criticisms and unfair attacks on members of the judiciary.

I appreciated the forthright manner in which the Court acknowledges these threats to the proper functioning of the justice system. Courts have traditionally been reticent about making public statements to address criticism of courts or the judiciary – but when it comes to democratic backsliding and political attacks, speaking out is absolutely necessary. Otherwise, misinformation will be allowed to flourish in ways that could lead to real, tangible harm to the public. I welcome courts taking steps to adapt to this new, unfortunate reality.

H Teasley, MA(Econ), CPA

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Economic loss comes at the end of your chain of evidence. I distill the germane parts into lost net past earnings, lost future employment capacity, and present value of any future care costs (all perhaps as ranges), perhaps plus lost future domestic capacity (usually per hour per week).

I have regularly given expert, opinion evidence on such matters in the Supreme Court of British Columbia since 1989. I first gave expert evidence on economic losses (in the Superior Court of the State of Washington) in 1972. I first appeared before the BC Human Rights Commission in 2000 and the Tax Court of Canada in 2005. I also welcome clients to my practice in personal-income taxation.

I earned my Bachelor of Science in Electrical Engineering from Purdue University in 1962, served as a US Army EOD or bomb-disposal officer, and earned my Master of Arts in Economics from the University of Oregon in 1968. I qualified as a Certified Management Accountant or CMA in the United States in 1983 and as a Chartered Professional Accountant or CPA in British Columbia in 1986. I exceed the 40 hours per year of continuing professional development that professional accountants require.

I have worked professionally for 49 years as an economic and financial analyst and for nine years as a full-time university teacher (three years teaching accounting at Simon Fraser, six years teaching economics at Western Washington). I dragonboat, I cycle, and I capped half a century of running with second place (not last) in my age group in the last half-marathon my knees allowed, Seattle 2016.

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— • —

In Dueck *v* Mikoula*, the Hon Mr Justice H L Skipp wrote: "It is my opinion that the plaintiff should be profoundly grateful to Mr Teasley, as he was the only organized, credible witness to testify. In short, in my humble opinion, the plaintiff owes whatever success he enjoyed to Mr Teasley." [1996 BCSC 3199, ¶4]*

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ARTICLE

BY **JENNIFER J.L. BRUN KC**

Jennifer is a lawyer and managing director at Harris & Brun Law Corporation. She was appointed a Queen's Counsel in 2021 (now King's Counsel). Her practice focuses on civil litigation and professional regulation. She represents clients before all levels of court and various administrative tribunals in BC. Jennifer's advice is routinely sought in the realms of litigation, investigation, inquiry, discipline, credentialing, privileging, coverage, subrogation, audits, policy wordings and risk management.

Jennifer is a persuasive advocate for her clients, having earned a Bachelor of Science; a Bachelor of Laws; and a Master of Laws specializing in civil litigation and dispute resolution. She also completed a judicial law clerkship at the Supreme Court of BC. Jennifer served as national president of the Young Lawyers – Canadian Bar Association (YL-CBA) in 2012-13 and as Canadian Bar Association – BC Branch president in 2020-21.

Jennifer is a regular contributor and presenter for continuing professional development seminars. Since 2017, Jennifer has co-authored Discovery Practice in BC, a CLEBC practice manual.

BE PREPARED!
The *Health Professions and Occupations Act* is in Effect

CREATION OF THE *HPOA*

In 2018, the Honourable Adrian Dix, then Minister of Health, appointed Mr. Harry Cayton, a leading expert in the field of professional regulation, to undertake an inquiry into what was then called the College of Dental Surgeons of British Columbia. The inquiry examined concerns about the College of Dental Surgeons of BC's governance and operations, and included a review of the *Health Professions Act* and the model of health profession regulation in BC. The Cayton Report was published in December 2018 and suggested approaches to modernize BC's overall health profession regulatory framework. The Hon. Adrian Dix also appointed the Hon. Dr. M.E. Turpel-Lafond to conduct a review of Indigenous-specific racism in the provincial health care system. The report entitled In Plain Sight was published in November 2020, concluding that systemic racism in healthcare requires systemic action to address it. Subsequently, a Steering Committee was struck, guided by three objectives:

- Improve patient safety and public protection;
- Improve efficiency and effectiveness of the regulatory framework; and
- Increase public confidence through transparency and accountability.

The result? The *Health Professions and Occupations Act* [*HPOA*]. On April 1, 2026, the *HPOA* came into effect and the *Health Professions Act*, R.S.B.C. 1996, s. 183 [*HPA*], was repealed.

PURPOSE OF THE *HPOA*

- The *HPOA* aims to improve public protection and safety in the health system, by:

- Establishing the Health Professions and Occupations Regulatory Oversight Office (HPOROO) to ensure regulatory colleges are focused on patient safety and the public interest;

- Enhancing a commitment to cultural safety and humility, through requiring colleges to offer Indigenous support workers for Indigenous peoples going through the discipline process;

- Creating an independent disciplinary hearing process that provides support services and support workers for people going through the process;

- Including all instances of disciplinary actions and summary protection orders against a health professional on the public registry following the disciplinary hearing process; and

- Moving to fully appointed college boards, whose board members are selected based on merit and competency.

The new complaints process under the *HPOA* offers robust protection to complainants, to encourage victims who have been hurt or wronged by a health professional to come forward. For example, the *HPOA* offers identity protection measures throughout the complaint process to people who have experienced discrimination, sexual abuse, or sexual misconduct by a health professional; provides access to support workers and support services such as counselling for people who have experienced sexual abuse, sexual misconduct or discrimination while receiving health care from a regulated health-care provider; creates a legal duty to report for professionals when they see other professionals committing an act of discrimination under the legislation; and enables trauma-informed practices to inform disciplinary hearing proceedings, such as physical barriers during hearing processes, and written cross-examinations.

As of April 1, 2026, six current regulatory colleges will be governed by the *HPOA*: College of Physicians and Surgeons of BC (CPSBC), BC College of Nurses and Midwives (BCCNM), BC College of Oral Health Professionals (BCCOHP), College of Pharmacists of BC (CPBC), College of Complementary Health Professionals of BC (CCHPBC), and College of Health and Care Professionals of BC (CHCPBC). The core regulations under the *HPOA* (the *Regulated Health Practitioners Regulation* and the *Health Professions and Occupations Regulation*) apply to all regulated health professions, while profession-specific regulations are systematically grouped by college.

Of note, the repealed *HPA* had 56 sections under five parts, whereas the *HPOA* has 645 sections under 12 parts.

GUIDING PRINCIPLES AND DUTIES OF LICENCEES

One of the primary guiding principles of the *HPOA* is to protect the public from harm and discrimination. If a conflict arises in balancing the interests of the public and the interests of a regulated health practitioner, the conflict must be resolved in favour of the public (s. 14(4)).

Under the *HPOA*, licencees must be fit to practice (s. 69); must practice ethically (s. 70); must not commit an act of misconduct (s. 71); must act in accordance with protecting the public from harm and discrimination, taking anti-discrimination measures, and being respectful of patient privacy (s. 72(1)); and must comply with all practice standards of types of services, informed consent, patient confidentiality, recordkeeping, and reporting (s. 72(2) and (3)). Further, licensees must make a regulatory report if they have reasonable grounds to believe another licensee is not fit to practice and the continued practice by the licencee presents a significant risk of harm to the public (s. 85); or if they have reasonable grounds to believe that the other licensee has committed an act of sexual misconduct, sexual abuse or discrimination (s. 86). Additionally, employees have a duty to report a regulated health professional if there is a suspected significant risk to the public or if there is an instance of sexual misconduct, sexual abuse, or discrimination.

COMPLAINTS, INVESTIGATIONS AND DISCIPLINE

Under the *HPOA*, the registrar can make their own complaint or receive a complaint (ss. 119–120). Either way, the registrar must gather information and records, including the respondent's disciplinary record and capacity summary (if any), and provide to the Investigation Committee ("IC") along with recommendations (if any) (ss. 121 and 123). Further, the registrar can request a summary protection order from the IC, if of the opinion that the allegations made against the respondent, if admitted or proven, are such that there may be a significant risk of harm to any person (s. 122(1)). The registrar also has the power to make a summary dismissal order unless the complaint alleges that the respondent lacks capacity or has committed an act of sexual abuse (s. 122(3)).

If a respondent's capacity is in question, the IC must direct the registrar to order that the respondent undergo a capacity evaluation/competence assessment and divide the investigation for the purposes of the evaluation (*i.e.*, capacity officer is in charge of the capacity evaluation) (ss. 128 and 132). Investigators have a positive duty to proceed in

a timely manner (s. 129). They may make production orders and have significant powers without court order (s. 131). For example, investigators have the authority to conduct a site visit, inspection of site/equipment/records (including copying personal/confidential information), recording of practice of licencee, *et cetera*.

At the conclusion of their investigation, the investigator must submit a final report to the IC regarding the investigation of the complaint (s. 134). The IC must assess whether it has reasonable grounds to believe that the respondent lacks competence or has committed an act of misconduct (s. 134). In so doing, the IC must consider the context in which the respondent's conduct occurred (s. 135) and the perspectives of those involved and the influence of those perspectives on their actions (s. 135).

If an IC has reasonable grounds to believe that a respondent lacks competence or has committed an act of misconduct, the registrar must: dispose of the complaint by making one or more disciplinary orders under section 157 *[restorative processes]*, 158 *[disposition with respondent's consent – disciplinary orders that either do or do not affect practice authority]* or 159 *[disposition without respondent's consent – disciplinary orders that do not affect practice authority]*; or request the director of discipline to issue a citation and propose to the director the content of the citation with respect to the allegations made against the respondent. If a registrar requests the director of discipline to issue a citation, the registrar has an ongoing duty to provide the director with all pertinent information (s. 137). If the IC and a respondent reach an agreement before the citation is published, the director of discipline must be given the proposal and reasons for same, and be asked to approve the proposed orders and cancel the citation (s. 139). The director of discipline may decline to approve the proposed orders, and instead, issue the citation and proceed with the discipline hearing.

After receiving a request to issue a citation, the director of discipline must review the information produced and decide whether to issue the citation as proposed or at all (ss. 161–162). They must issue the citation unless they are satisfied there is: insufficient evidence; significant and unmitigable unfairness to the respondent if a hearing proceeds because a complainant's anonymity or the protection of a person's identity under an identity protection order unduly prevents the respondent from making a reasonable defence; significant issues of procedural fairness or timeliness; not in the public interest; or double jeopardy (s. 162). If a citation is not issued, the matter is either dismissed or remitted back to the IC for disposition (s. 168). If a citation is issued, it must include: the respondent's name; the allegations made against the respondent; the date after which proposals may no longer be made under section 139 *[if proposal for disciplinary order]*; the date, time and, if applicable, location of the discipline hearing and information respecting the hearing process; and the advice that the hearing is authorized to proceed despite the respondent's absence, if the respondent does not attend the hearing, and there is proof that the citation was served in accordance with the regulations.

If a discipline hearing proceeds, the discipline panel must consist of three panel members, including at least one licensee who is licensed to practice the same designated health profession as the respondent, and one representative of the public (s. 169). The discipline panel must consider the education, training, experience and other qualifications needed to assess the allegations made against the respondent (s. 170). Colleges and respondents may be represented by counsel (s. 174). The proceeding is recorded (s. 177) and evidence is admissible as per s. 40 of the *Administrative Tribunals Act*. The discipline panel must_make an order following the hearing (ss. 190–192).

A respondent, a regulatory college, or a complainant may make an application for a review of an order made by a discipline panel (s. 194). The director of discipline can dismiss the application or confirm, vary, rescind or terminate the order that is under review. Further, they can refer the matter back to the IC with or without directions, or can substitute a new order. The regulatory college that is a party to a discipline hearing is responsible for the enforcement of disciplinary orders made against the respondent by the discipline panel or the director of discipline (s. 197).

HEALTH PROFESSIONS REVIEW BOARD ("HPRB") AND HEALTH PROFESSIONS AND OCCUPATIONS REGULATORY OVERSIGHT OFFICE ("HPOROO")

Under the *HPOA*, the current HPRB is continued (ss. 307–324). The HPRB will maintain its current jurisdiction over licensing decision reviews, complaint disposition reviews requested by the complainant, and timeliness reviews requested by the complainant or respondent.

Under the *HPOA*, the HPOROO is a new office led by a superintendent. The HPOROO has five responsibilities (s. 435):

1. Make recommendations to the Minister for regulatory college board appointments using a merit-based process and ensuring a diversity of perspectives.

2. Perform designation assessments at the direction of the Minister or on their own initiative.

3. Oversee the regulatory colleges through audits, investigations, and systemic reviews.

4. Receive complaints about the performance or conduct of the regulatory colleges and make recommendations where regulatory colleges are deficient.

5. The Discipline Tribunal, led by the Director of Discipline, conducts independent hearings and decides disciplinary actions for licensees following an investigation process by a regulatory college (ss. 443-451).

Under the *HPA*, each regulatory body had its own discipline committee. Under the *HPOA*, there is a single Discipline Tribunal led by the Director of Discipline.

Section 512 of the *HPOA* relates to judicial review opportunities and applies to the director of discipline, a discipline panel and the Health Professions Review Board. It states they have exclusive jurisdiction to inquire into, hear and determine all those matters and questions of fact, law and discretion arising or required to be determined by the person or body under this Act, and to make any order authorized to be made by the person or body under this Act.

A decision or order on a matter with respect to which the person or body has exclusive jurisdiction is final and conclusive and not open to question or review in any court. Sections 57 (60-day time limit) and 58 (standard of review when privative clause) of the *Administrative Tribunals Act* apply to a judicial review of a decision or order referred to here (*i.e.*, a court can only interfere if a decision is patently unreasonable (if finding of fact or law, or exercise of discretion is appealed) or the tribunal acted unfairly).

TRANSITIONAL PROVISIONS

All investigations in process immediately before the coming into force of the *HPOA* are deemed a transitioned investigation and must be continued in accordance with the *HPOA* (s. 542). If a transitioned citation has been issued but the discipline committee has not yet begun a hearing with respect to the citation, the registrar must transfer the citation to the director of discipline and include with the citation all information and records. The *HPOA* applies as if the citation had been issued by the director of discipline. Only if a discipline hearing has taken place or is taking place on April 1, 2026, will the former *HPA* apply (s. 543).

ANTI-INDIGENOUS RACISM AND OTHER FORMS OF DISCRIMINATION

The *HPOA* aligns with the *UN Declaration on the Rights of Indigenous Peoples* (UNDRIP) pursuant to the *Declaration on the Rights of Indigenous Peoples Act* (Declaration Act) (s. 14). It is also informed by the 2020 report, *In Plain Sight*, which addresses Indigenous specific racism and discrimination in BC healthcare systems. To this end, discrimination is a legislated form of professional misconduct under the *HPOA* as defined in the *Human Rights Code* to include Indigenous identity and race (s. 9). Further, the *HPOA* recognizes Indigenous practices, including restorative processes for resolving disputes, and includes them as options for disposition/order (s. 268).

SEXUAL MISCONDUCT AND SEXUAL ABUSE

The *HPA* simply stated that "professional misconduct" included sexual misconduct, without defining same. Consent of the person who experienced the misconduct or abuse was required under the *HPA* to initiate the investigation. That is not the case under the *HPOA*.

The *HPOA* provides enhanced clarity on what constitutes sexual misconduct and sexual abuse (s. 8). It requires employers to report staff sexual misconduct/abuse to the appropriate regulatory college. Pursuant to the *HPOA*, a regulatory college is not able to dispose of a complaint about sexual abuse without consulting the Director of Discipline.

PUBLICATION OF COMPLAINTS AND DISCIPLINE

Under the *HPOA*, the registrar must update the registry to include disciplinary orders and summary protection orders (s. 249). If a summary protection order or disciplinary order is made that limits, suspends, or revokes the respondent's practice authority, the registrar must give notice to the licencee's employer (ss. 253–254). The registrar or IC may disclose that a regulatory complaint has been received, that a citation has been issued (if served), and that a regulatory complaint or citation has been dismissed (s. 255). The registrar must publish a copy of each summary protection order, disciplinary order and, if applicable, request for citation, and the reasons for the orders and the request (s. 256). Further, regulatory colleges will now be able to acknowledge that they have received a complaint or disposed of a complaint, in order to respond to public sources like the media.

SUMMARY

The *HPOA* sets out clear and comprehensive duties for licensees, which were previously articulated only in bylaws, or in practice and ethical standards, or which existed simply as general legal principles.

Under the *HPA*, regulatory colleges received complaints, conducted investigations, determined disciplinary actions, and enforced discipline through disciplinary orders. Under the *HPOA*, regulatory colleges will:

- continue to receive complaints, conduct investigations, and issue limited types of disciplinary action for administrative matters (*i.e.*, failing to respond to requests from the college);
- retain the ability to resolve less serious issues by making agreements with health professionals (*i.e.*, issuing a warning, requiring the health professional to agree not to repeat the conduct, or agreeing to take additional training among other actions – these are still defined as disciplinary orders) and
- enforce the disciplinary orders decided by the Discipline Panel.

The *HPOA* establishes a new Discipline Tribunal, housed within the HPOROO, which will conduct hearings and determine discipline for health professionals who have been investigated by their regulatory college following a complaint. The Discipline Tribunal is led by the Director of Discipline, who will not be involved in hearings but will oversee the Tribunal as a whole and will conduct reviews of decisions upon application. Independent discipline panels appointed by the Director will consist of a professional of the same profession subject to discipline, a member of the public, and a specialist in the area of concern. The Discipline Tribunal will determine the disciplinary action against a professional who has been found to have committed misconduct.

Only time will tell whether the *HPOA* has achieved its stated objectives. In the meantime, practitioners must review the lengthy *HPOA*, associated regulations, and each college's new bylaws prior to April 1, 2026, to be positioned to provide current and relevant advice to their health practitioner clients.

MEDICAL MALPRACTICE

Foreseeability and Risk of Harm in a Standard of Care Assessment

BY **LINDSAY MCGIVERN**
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THIS IS THE SEVENTH ARTICLE OF OUR SERIES DISCUSSING PRACTICAL AND EVIDENTIARY ISSUES IN MEDICAL MALPRACTICE. EACH ARTICLE WILL EXAMINE RECENT MEDICAL MALPRACTICE CASE LAW AND FOCUS ON THE PRACTICAL AND EVIDENTIARY ISSUES WITHIN THEM. THE GOAL IS TO PROVIDE SOME USEFUL INSIGHT INTO THE OBSTACLES THAT OCCURRED IN HOPES THAT FUTURE CASES CAN ADAPT AND DEVELOP NEW WAYS TO OVERCOME THESE CHALLENGES.

INTRODUCTION

Foreseeability and risk have long played prominent roles in all aspects of medical malpractice litigation. They influence (or can influence) the standard of care in an assessment of negligence, the extent of disclosure required to obtain proper informed consent, whether a reasonable person would accept a proposed procedure if properly informed, factual causation, and legal causation. On February 10, 2026, the Supreme Court of Canada heard the *Hemmings v. Peng case*,[1] in which foreseeability of risk is the key issue. While awaiting the SCC decision, this article explores a few recent medical malpractice cases to show how these concepts have directed outcomes over the years.

STANDARD OF CARE COMMENSURATE TO THE RISK

The law on standard of care in medical malpractice litigation is well established. A medical care provider must meet the standard of a reasonably competent medical care provider of his or her qualifications who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada.[2] The degree of risk to which the patient is subjected as well as the foreseeability of harm are intricately connected with this analysis. This is evident, for example, in how courts assess what medical knowledge defendants ought to have reasonably possessed at the time of the alleged act(s) of negligence. Specifically, courts determine whether the defendants' care was appropriate based on the medical knowledge which was available to them at the time of the events — rather than at a later point when medical knowledge may have improved or evolved.[3] Inherent in this analysis is an acknowledgement that what the medical care providers could foresee regarding

adverse outcomes and harm for their patients dictates the appropriate response or approach to their patient's clinical status.

Generally, following common and accepted practice within a profession will shield a medical care provider from liability.[4] There are circumstances, however, where a practice is *fraught with obvious risks* such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise. When this is the case, liability can be imposed, even when the practice is commonly employed by the profession at issue.[5]

The standard of care does not require perfection on the part of the medical care provider and an adverse outcome alone will not establish negligence.[6] That said, the potential impact of a procedure on the patient will have an effect on the standard of care. As set out in *Ediger v. Johnston,*

> "The standard of care that a physician must provide will take into account all the factors affecting or potentially affecting the life and health of a patient. Thus, the degree of care required is commensurate with the potential danger to the patient. … **In short, the greater the risk, the higher the standard of care.**"[7]

In *Ediger*, the trial judge found that the standard of care did not require a forceps procedure to be done in the operating room with a double setup for emergency c-section if forceps were unsuccessful, but did require that backup for an emergency c-section be "immediately available."[8] The defendant argued that the plaintiff could not prove causation because even if he had arranged for backup to be immediately available by having an anesthetist standing by, he could not have intervened in time to rescue the baby.[9] The Supreme Court of Canada rejected this argument as the proper interpretation of the trial judge's finding that the standard of care required backup to be "immediately available" because it would be unresponsive to the risk in question and potential harm arising from it.[10] If the defendant's argument was accepted, the physician would never be liable for breaching the standard of care where fetal bradycardia results and leads to debilitating injury.[11] Instead, the Supreme Court of Canada concluded that the proper interpretation of the standard of care was that it had to be responsive to the risk and that the defendant had to take reasonable precautions such that the baby could have been delivered without injury upon occurrence of the known risk of the procedure.[12]

EXAMPLES WHERE THE FORESEEABILITY/RISK OF HARM LED TO A SUCCESSFUL CLAIM FOR THE PLAINTIFF

K.B. v. Guhle involved a respiratory illness in a child that evolved into septic shock requiring multiple amputations.[13] This case serves as a good example of how foreseeable harm and degree of risk underlie medical malpractice claims. KB was an 11-month-old infant admitted to hospital on February 19 with an RSV infection (which is a viral infection). She had been experiencing symptoms for two weeks and had a history of respiratory illnesses. Her first physician ordered blood tests, a nose swab and a chest x-ray. He considered (but did not chart) pneumonia and bronchopneumonia. His interpretation of the imaging was that these were not shown. The radiologist report opining that there were findings consistent with bronchopneumonia was not available until much later. Upon admission, KB's care was managed by Dr. Guhle. KB's symptoms worsened on February 21. The on-call physician at the time questioned a secondary infection, noted on the chart that KB should start amoxicillin, a broad-spectrum antibiotic, and directed it be administered orally. The amoxicillin was not administered to KB. Dr. Guhle remained her most responsible physician. KB's chart included symptoms of wheezing, lung crackles, labored breathing, skin color changes and increased fever. Dr. Guhle agreed in evidence at trial that KB's lethargy could be a clinical symptom of progression of a bacterial infection to sepsis but that he heard wheezing in both her lungs which would be consistent with the confirmed RSV infection and inconsistent with a bacterial infection or pneumonia. Dr. Guhle was aware that there was a risk of bacterial infection and sepsis. He ordered a blood test which showed an elevated

KB's chart included symptoms of wheezing, lung crackles, labored breathing, skin color changes and increased fever.

complete blood count, an abnormal neutrophil count and a white blood cell count that had increased since the previous blood test. He was reassured, however, by the fact that the white blood cell count remained in the normal range, even if it had increased. By the morning of February 22, KB was in respiratory failure. By that time, it was too late to intervene to avoid her permanent injuries. All medical experts agreed that by then, KB was suffering a bacterial infection that caused her to develop sepsis and multi-organ dysfunction which, despite treatment on February 22, led to ongoing limb ischemia and resulted in multiple amputations.

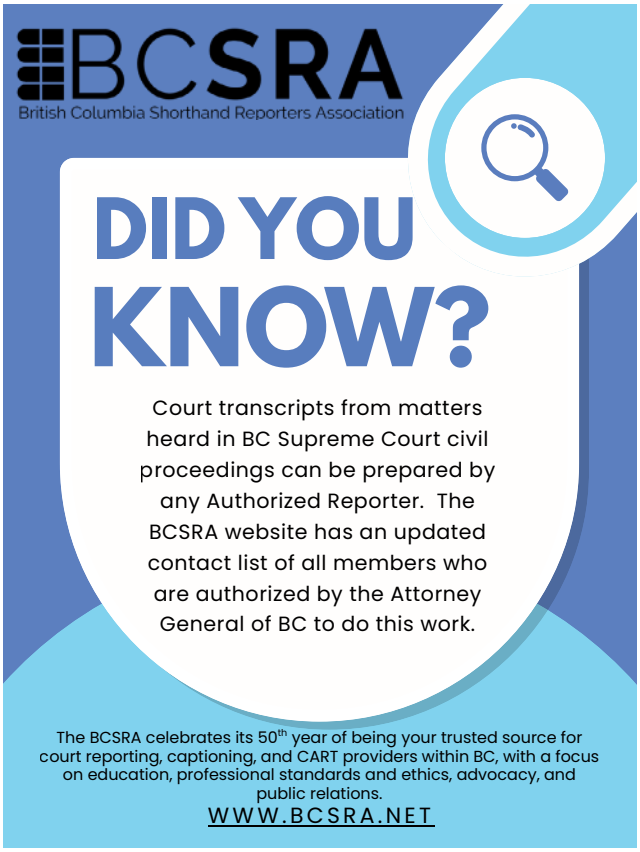
The Court was clear that the injury itself does not set the standard of care and the distressing result should not be given undue weight.[14] Instead, whether an act or omission was negligent was to be assessed by considering whether a reasonable person should have anticipated that what happened might be a natural result of that act or omission.[15] The Court also considered the "worst first principle," the idea that the differential diagnosis process ought to eliminate the most serious, rather than the most probable diagnoses first, and that failure to do so is a breach of the standard of care.[16] The admitting doctor's evidence was that his practice was to address the most common or most likely diagnosis first. The Court found that this practice conflicts with the law and that the principle that possibilities with a higher risk of mortality must be addressed first is clearly established in both law and medicine.[17] Furthermore, the Court held that "common sense dictates that when a life-threatening condition has been brought to the attention of a physician, they cannot ignore precautions in the face of those signs, symptoms, and information."[18]

THE COURT ALSO CONSIDERED THE "WORST FIRST PRINCIPLE," THE IDEA THAT THE DIFFERENTIAL DIAGNOSIS PROCESS OUGHT TO ELIMINATE THE MOST SERIOUS, RATHER THAN THE MOST PROBABLE DIAGNOSES FIRST, AND THAT FAILURE TO DO SO IS A BREACH OF THE STANDARD OF CARE.

By the afternoon of February 21, the Court found that KB was showing symptoms of bacterial infection and she was not getting better as expected from an RSV infection alone. The Court found that it was increasingly difficult to rule out a bacterial infection and the blood test results should have raised alarm for Dr. Guhle. The Court found that Dr. Guhle should have taken further steps, recognizing the increased risk that KB had a bacterial infection at that time; these steps included starting antibiotics while other follow-up testing was done. By failing to do so, Dr. Guhle breached the standard of care.

The on-call physician was found to have breached the standard of care after KB's symptoms worsened and he determined that a bacterial infection was much more likely to be present and charted a "suggestion" of IV antibiotics but failed to communicate to Dr. Guhle directly, did not perform further assessments, did not order testing, and did not order the antibiotics he suggested in his charting. The Court found that a potentially serious complication and risk to KB's health was clearly identified to him and he breached the standard of care by failing to take sufficient steps to respond to such risks.

The *Ewashko v. Hugo* case also serves as an example of a case where the role of risk and foreseeability in the assessment of the standard of care led to a decision in favour of the plaintiff.[19] Ms. Ewashko was admitted to hospital in the



early stages of labour. Her baby was in breech position, and at the time, the hospital did not perform vaginal breech deliveries, which meant that caesarean section was her only option if she was to deliver there. An attempted rotation of the fetus was not possible due to the onset of labour. Fetal heart rate monitoring was commenced at 4:10am. Between 4:13 am and 4:19 am, there was a marked deceleration of the fetal heart rate which classified the fetal heart rate tracing as "abnormal", requiring "prompt" delivery according to the Society of Obstetricians and Gynecologists of Canada. Ms. Ewashko was assessed by Dr. Groenewald between approximately 4:30am and 4:35am. He concluded that an urgent caesarean section was required. He required the presence of Dr. Hugo, an obstetrician with the requisite training to perform the caesarean section. Dr. Hugo was on call at home and had to come to the hospital. Before calling Dr. Hugo, Dr. Groenewald was called away to attend to another patient having a heart attack. He contacted Dr. Hugo at 5:08 am, after dealing with the heart attack patient. Dr. Hugo attended to the hospital and examined Ms. Ewashko around 5:25-5:30 am. The operating room team was called after the examination and arrived at 5:45 am. While the operating room team was setting up the operating room, and before the birth at 6:08 am, Baby Ewashko suffered a significant heart rate deceleration which deprived him of oxygen and caused a permanent brain injury. The litigation revolved around the timing of the caesarean section and whether negligent delays caused Baby Ewashko's injuries.

The trial judge held that both physicians fell below the standard of care, causing 50 minutes of unnecessary delay without which Baby Ewashko's brain injury would have been avoided. The most likely cause of the first fetal heart rate deceleration (that the physicians wanted to rule out) was cord compression. The depth of the deceleration raised concerns as to whether the fetus was able to oxygenate his brain. At the time of his assessment of Ms. Ewashko, Dr. Groenewald thought this baby needed to be delivered as soon as possible. He knew that the deceleration had resolved but recognized that whatever caused the prolonged deceleration then may recur at any time. The first step towards delivery was to contact Dr. Hugo. Dr. Groenewald argued that it was reasonable to delay that call until after he dealt with a life-threatening emergency for another patient, given that concerning features of Ms. Ewashko's fetal heart rate tracing had resolved, and she and her fetus were stable. He argued, that decision was a defensible exercise of his clinical judgment. The Court disagreed, and held that the applicable standard of care was that Dr. Groenewald contact

Dr. Hugo, as soon as reasonably possible to advise him of the need for his prompt attendance at the hospital and the core reasons: Ms. Ewashko's arrival at the hospital in early labour, the baby in breech position and an abnormal fetal heart rate pattern.

The Court held that Dr. Groenewald did not call as soon as reasonably possible and thereby breached the standard of care. Both his heart attack patient and Ms. Ewashko needed urgent care and Dr. Groenewald was required to either make an immediate one-minute call to Dr. Hugo directly or ask a nurse to call while he attended to his other patient. A key component of this judgment was the finding that Ms. Ewashko had not "stabilized" in the sense that all steps towards initiating the caesarean section could be put on hold until the other emergency had been cleared. While the fetal heart rate was no longer abnormal, cord compression was the likely cause of the deceleration and there was a recognized risk of recurrence of such compression or other cause, with no way of knowing when a further incident might occur, for how long, and with what severity. Dr. Groenewald was not entitled to view the clinical situation as if that deceleration had not occurred. Foreseeability and risk of harm played an important role in the court's reasoning. The Court viewed Ms. Ewashko's situation as "akin to an earthquake having occurred, citizens in the earthquake zone needing assistance to be rescued, and the risk of another material tremor hanging over the situation."[20] The situation is "stable" in the sense that there is no earthquake currently occurring. It is not certain that another tremor will occur, but it is also not certain that another tremor will not occur.

Dr. Hugo's liability attached to his "judgment call" to attend to the hospital, examine Ms. Ewashko and get her consent to a caesarean section before he called the operating room team. The Court held that the applicable standard of care

was to immediately mobilize the operating room team, direct that Ms. Ewashko be prepped for surgery and then depart his home for the hospital. Part of this analysis was the foreseeability of the need for caesarean section. The Court accepted the expert evidence that there was nothing to weigh in favour of deferring the call to the team until after Dr. Hugo had assessed Ms. Ewashko. Dr. Hugo knew that rotation of the fetus was not an option due to her ongoing labour. He knew that the breech presentation prevented vaginal delivery at that hospital. Caesarean section was the only option for Ms. Ewashko. Although Dr. Hugo wanted to assess the fetal heart rate tracing for himself, the clinical situation was that there was prolonged deceleration of the fetal heart rate which required an urgent delivery, as assessed by Dr. Groenewald, a physician that Dr. Hugo had confidence in. The Court found that although Ms. Ewashko's consent would be required, there was no material possibility that she would decline in this situation to warrant waiting for the consent prior to mobilizing the operating room team. The only downside of calling them in and finding that Ms. Ewashko declined the caesarean section, was having the team unnecessarily attend the hospital from home. In contrast, if Ms. Ewashko had consented but the team had not yet been called, the downside would be wasting valuable time with an urgent operation. The Court noted that the first downside is relatively inconsequential compared to the second.

EXAMPLES WHERE RISK OF HARM WAS INSUFFICIENT TO GROUND A CLAIM

In *Focken v. Miller*, the extent of the risk to the patient was found to be insufficient to establish liability for failure to respond more diligently to that risk.[21] Mr. Focken attended the hospital in the afternoon with bleeding from a pseudoaneurysm in his neck. He was vomiting blood and thick clots. At the hospital he was assessed by an otolaryngologist who determined that he required an embolization to block a blood vessel in his neck that caused the earlier bleeding. Together with an interventional radiologist, the otolaryngologist concluded that the procedure needed to be done urgently, within 24 hours, but that it could wait until 8am the following morning. At the time of that decision, Mr. Focken's vital signs were stable with no active bleeding. Before the procedure was completed, however, Mr. Focken had another significant bleed in his throat that blocked his airway leading to hypoxic cardiac arrest and ultimately, death.

The plaintiff's expert described the first bleed as a "sentinel bleed" that warns of a more catastrophic bleed that could occur at any time and requiring immediate treatment. The trial judge preferred the evidence of the defence experts who opined that the embolization could wait because re-bleeding did not appear imminent, he was under close observation and the artery that bled initially was one that leads to less severe bleeding (i.e. not a "sentinel bleed"). Their opinion was that Mr. Focken survived the first bleed at home without medical treatment, so subsequent re-bleeding was not necessarily expected to be catastrophic.

On appeal, the plaintiff argued that the trial judge erred in law "in not assessing standard of care with consideration to the degree of foreseeable risk" to Mr. Focken.[22] The Court of Appeal held that expert assessment of the degree of foreseeable risk is essential to the description of applicable professional standards and thus, to the expression of an expert opinion as to the expected standard of care. Judges are therefore entitled to accept expert opinion evidence which has already weighed that degree of foreseeable risk without doing an independent analysis of risk separate from the weighing of the expert evidence. In this case, the foreseeable risk was dictated in part, by where the bleed had likely occurred, which vessel was affected and whether it was likely to progress to a significant tear in the vessel, which would then impact the severity of risk posed by a potential second bleed. The risk to the patient could not be determined without expert assistance. The judge weighed the expert evidence and accepted that of the defendants over the plaintiffs, in part due to information missing from or erroneously assumed in the plaintiff's expert report. The Court of Appeal held that in doing so, the trial judge appropriately considered the degree of foreseeable risk to the patient when assessing the standard of care.

Both Courts also held that the medical practice of waiting until the morning for the embolization procedure was not one that was so fraught with obvious risk as to be negligent. The medical questions at issue were too complex to fall into that exception. Both Courts observed that in cases where a claim that standard practice is so fraught with obvious risk as to be negligent, "the common thread… is a focus on practical, systems-based, or common-sense considerations rather than substantive medical issues."[23] The Court of Appeal noted that such cases often involved issues of communication or adequacy of follow up arrangements.

CONCLUSION

As demonstrated in the above cases, foreseeability of harm and risk to the patient are inextricably integrated into the determination of the standard of care applicable to medical care providers, including whether that standard of care has been breached. These concepts play other roles in medical malpractice litigation which are broad, and in certain cases, remain to be considered. The pending judgment by the Supreme Court of Canada in the Hemmings v. Peng case will likely provide helpful parameters on how to assess foreseeability of risk and legal causation in medical malpractice cases.

1. 2022 ONSC 2674, 2024 ONCA 318
2. *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674, 127 D.L.R. (4th) 577 at para 33.
3. *Ibid*, at para 34.
4. *Ibid*, at paras 38-40.
5. *Ibid*, at para 41.
6. *Ibid*, at para 19.
7. *Ediger (Guardian ad litem of) v. Johnston*, 2009 BCSC 386 at para 49.
8. *Ibid*.
9. *Ibid*.
10. *Ediger (Guardian ad litem of) v. Johnston*, 2013 SCC 18 at para 44 [Ediger (SCC)].
11. *Ibid*.
12. *Ibid*, at para 45.
13. 2025 ABKB 472
14. *Ibid*, at para 17.
15. *Ibid*, at para 18.
16. *Ibid*, at para 28.
17. *Ibid*, at para 258.
18. *Ibid*, at para 31.
19. *Ewashko v. Hugo*, 2025 ABKB 295
20. *Ibid*, at para 128.
21. 2024 BCCA 74
22. *Ibid*, at para 25
23. *Ibid*, at para 57.

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