

CANADA / JUDGMENT

Brodeur v. Provincial Health Services Authority

2016 BCSC 968

COURT

Supreme Court of British Columbia

DECIDED

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2016 BCSC 968 Brodeur v. Provincial Health Services Authority

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Brodeur v. Provincial Health Services Authority,

2016 BCSC 968

Date: 20160531

Docket: S118818

Registry: Vancouver

Between:

Tianna Layne Brodeur, an infant by her Litigation

Guardian, Beverly Hicks, and the said Beverly Hicks

Plaintiffs

And

Provincial Health Services Authority operating a public hospital

under the name of British Columbia Women's Hospital and Health Center,

Dr. Delisle, Dr. Freedman, Nurse Marsh and Nurse Jane Doe

Defendants

Before: The Honourable Madam Justice Sharma

Reasons for Judgment

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Place and Date of Trial:

Vancouver, B.C.

September 23, 25, 28-30, 2015

October 1 & 2, 5, 7, 9, 16, 2015

Place and Date of Judgment:

Vancouver, B.C.

May 31, 2016

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I. INTRODUCTION

- [1] Amanda Brodeur gave birth to a baby girl on September 21, 1999. Instead of an occasion filled with joy and happiness, it was a traumatic event which left her daughter with life-long cognitive and physical disabilities. Her daughter, the plaintiff Tianna Brodeur, was delivered by emergency caesarean section because Amanda Brodeur experienced a uterine rupture during her labour. Uterine rupture is a rare complication associated with the type of delivery that was being attempted.
- [2] Tianna Brodeur sues, via her Litigation Guardian Beverly Hicks (her grandmother, Amanda Brodeur's mother), the hospital and some of the nurses and doctors involved in her mother's care during pregnancy and delivery.
- [3] Three doctors had direct care of Ms. Brodeur at different stages of her pregnancy (many documents refer to her having the surname Dionne but for convenience I will use Brodeur). The defendant, Dr. Marie-France Delisle, provided pre-natal care to Ms. Brodeur and admitted her to the hospital, but was not present for the events in question.
- [4] The plaintiffs allege Dr. Delisle did not receive informed consent from Ms. Brodeur for attempting a course of vaginal delivery instead of an elective caesarean section delivery.
- [5] Dr. Khalida Mujaibel was on call and completing her fellowship in maternal-fetal medicine. She performed the caesarean section on Ms. Brodeur. Dr. France Galerneau was the supervising physician on call at the time. Neither of them testified. Both were released from the litigation. The parties agreed that the entire transcript of the examination for discovery of Dr. Mujaibel would constitute evidence at trial. Portions of Dr. Galerneau's discovery evidence were read in.
- [6] The defendant, Dr. Dayna Freedman, was a resident in her fourth year of training for a speciality in obstetrics and gynecology and she assessed Ms. Brodeur during the critical time period. The defendant, Nurse Heidi Marsh, provided nursing care to Ms. Brodeur during the critical moments before the uterine rupture. Nurse Margge Speets was the charge nurse that night, but she was released from this litigation. Some of her discovery evidence was also read in.
- [7] The plaintiffs allege Nurse Marsh and Dr. Freedman failed to meet the standard of care applicable to them during Tianna's birth, and they also allege that negligence was the cause of Tianna's injuries. If it is necessary to distinguish amongst the defendants, I may refer to Dr. Freedman and Dr. Delisle as the "defendant doctors".

- [8] As explained in this decision, I conclude that Dr. Delisle was not negligent and the claim against her is dismissed. However, I find both Dr. Freedman and Nurse Marsh negligent, and I conclude their negligence was the cause of Tianna's injuries.
- [9] The defendant doctors submitted I am obliged to consider apportionment of liability. I agree, but the parties have not had an opportunity to provide submissions on what that apportionment should be. If they cannot agree, they are each at liberty to provide to the Registry no more than 5 pages of written submissions about that issue so long as all of those submissions are delivered no later than June 15, 2016. If that deadline cannot be met, the parties are required to seek an extension from me no later than June 5, 2016 by way of letter.

II. ISSUES

[10] There are four issues in this case:

- a) Did Dr. Delisle receive informed consent from Amanda Brodeur to undergo a trial of vaginal delivery?
- b) Did either Nurse Marsh's or Dr. Freedman's actions during their care of Amanda Brodeur fall below the applicable standard of care?
- c) If the answer to "b" is yes, was that negligence a cause of Tianna Brodeur's injuries?
- d) If the answer to "c" is yes, to what damages is Tianna Brodeur entitled?

III. BACKGROUND MEDICAL FACTS

- [11] Uterine rupture is what happens when the scar from a previous caesarean section opens during a vaginal birth. A healed incision from a caesarean section leaves a fibrous scar and that tissue is weaker than the surrounding uterine tissue. In a normal delivery, as the uterus contracts during labour, the fetus is forced towards the pelvis; it will follow the path of least resistance. With an intact uterus, that path leads to the birth canal. If the birth canal is obstructed for any reason, the fetus gets "stuck" and other interventions may be necessary to successfully deliver the fetus.
- [12] However, where there has been a previous caesarean section, and there is an obstruction, the contractions will force the fetus against the uterine scar. Because the scar tissue is weaker, the scar may thin causing a partial separation (called a dehiscence). This separation causes the mother pain which is continuous and distinct from the pain caused by contractions. If the cervix is already fully dilated when the scar separates and if that separation is small, vaginal delivery may still occur without disrupting the supply of oxygen to the fetus.

- [13] But if the cervix is not fully dilated and the scar completely opens, the fetus is extruded into the abdominal cavity along with amniotic fluid, membranes and placenta. If the placenta is separated from the uterus, the fetus's supply of oxygen, fluid and nutrients ceases, putting the fetus's life in danger. The site of the placental implantation will bleed which endangers the mother's health.
- [14] Upon uterine rupture, the fetal heart rate ("FHR") has an immediate and profound drop. The uterus, now empty, begins to contract, shifting the fetus upward in the maternal abdomen; thus the location of previous detection of the FHR has changed, and the fetus is no longer presenting against the cervix.
- [15] At one time delivering a baby by caesarean section guaranteed that any subsequent delivery would always be by caesarean section. However, beginning in the early 1980's the medical profession embraced a trial of vaginal birth after caesarean section, referred to as "VBAC".
- [16] This was preferred in order to reduce the risks associated with caesarean section deliveries which included possible infection, a prolonged delivery interval, total operative time, blood loss, multiple epidural placement failures, postoperative endometritis and prolonged hospitalization. In general, vaginal birth was viewed as less risky for the mother.
- [17] It was known that VBAC also carried some risk. Uterine rupture is the most significant risk associated with VBAC delivery, and the only response is to conduct an emergency caesarean section. Uterine rupture is a true obstetric emergency which can result in the death of the mother and baby, or, even without death, catastrophic consequences. Because the fetus is deprived of oxygen and the mother could be bleeding, time is of the essence; even seconds make a difference to fetal and maternal survival and outcome. Response time and an awareness of the potential symptoms of uterine rupture are therefore of critical importance.

ISSUE ONE:

IV. DID DR. DELISLE RECEIVE INFORMED CONSENT FROM MS. BRODEUR?

- [18] The plaintiffs allege that Ms. Brodeur was not adequately informed of the risk of uterine rupture associated with VBAC, and if she had been, she would have insisted on proceeding with a caesarean section. Dr. Delisle provided pre-natal care to Ms. Brodeur and says she did inform Ms. Brodeur of the risks.

A. Legal Principles Applicable to Informed Consent

- [19] The parties did not disagree on the applicable legal principles. Those principles recognize that the relationship between a physician and a patient has evolved into a participatory exchange between the parties. Physicians have an obligation to inform a patient of the nature of her condition, as well as the risks and benefits of the proposed treatment and alternatives. The landmark decisions in this area all connect liability with a failure to ensure informed consent based on the tort of negligence: *Hopp v. Lepp*, [1980] 2 S.C.R. 192 and *Reibl v. Hughes*, [1980] 2 S.C.R. 880. Consequently, a determination of the issue of informed

consent requires consideration of the standard elements of negligence: the existence of a duty of care; the failure to meet the requisite standard of care; and a causative connection between that failure and the injuries alleged.

- [20] More specifically, a physician has a duty of care to answer any specific questions asked, and to volunteer, without being asked, information about a patient's treatment options and to disclose any material, special, or unusual risks. The scope of this duty is determined on a case-by-case basis, and is assessed via an application of the standard of care: Hopp at 210.
- [21] In Reibl, the Supreme Court of Canada specifically rejects the professional standard of disclosure, finding that it is not for the physician to decide what should and should not be disclosed to a particular patient. The Court further notes (at 894) that while expert medical evidence is relevant, it is not determinative. Whether the non-disclosure of certain risks undermines informed consent is a matter for the trier of fact. In making an assessment, the trier relies on medical evidence, but also on evidence from the patient and from members of the patient's family (at 895).
- [22] Adequate disclosure requires the disclosure of all material risks, which the Supreme Court of Canada in Hopp (at 208) defines as those which "a reasonable person, in what the physician knows or should know to be the patient's position, would be likely to attach significance to in deciding whether or not to undergo the proposed therapy". In addition, the Court notes that "special and unusual" risks could be those that are probable, but also include those that are mere possibilities if the risk could result in serious consequences (at 209-10).
- [23] The Ontario Court of Appeal comments on what constitutes a material risk in Videto v. Kennedy (1981), 33 O.R. (2d) 497 (C.A.), stating that "[a] risk which is a mere possibility ordinarily does not have to be disclosed, but if its occurrence may result in serious consequences, such as paralysis or even death, then it should be treated as a material risk and should be disclosed" [see also Justice McLachlin's comments in Rawlings v. Lindsay, [1982] B.C.J. No. 209 (S.C.)(at para. 10)].
- [24] Justice Cory comments that the standard of disclosure required by Reibl is such that it would "often be more than that which the medical profession might consider appropriate to divulge": Ciarlariello v. Schacter, [1993] 2 S.C.R. 119 at 133; see also Hollis v. Dow Corning Corp., [1995] 4 S.C.R. 634 per La Forest J. at para. 24. This affirms the importance of recognizing the participatory relationship between patient and physician.
- [25] The standard of disclosure also requires that a physician considers what he or she knows, or should know, about the patient: Reibl at 894. A physician must take reasonable steps to ensure that the patient understands the information presented. The B.C. Court of Appeal finds that failing to take simple steps to confirm the patient's comprehension equates to negligence with respect to informed consent: Smith v. Tweedale, [1995] B.C.J. No. 229 at paras. 6, 10 (C.A.). But as Kelleher J. states in Kern v. Forest, 2010 BCSC 938 at para. 76, a physician is obligated to take reasonable, but not exhaustive, steps to ascertain whether a

patient has understood the discussion of the treatment and risks.

- [26] The standard of care also requires presenting the patient with alternative treatments, including the option of foregoing treatment. In *Van Mol v. Ashmore*, 1999 BCCA 6, Huddart J.A., writing for the majority, notes that while Reibl specifically requires discussion of any material, special, or unusual risks of the proposed treatment, various other cases have considered expanding this requirement to include discussion of alternative treatments as well (at paras. 96-101). She concludes that this is the appropriate standard, and that a patient is entitled to know about all alternatives, and the risks and advantages associated with each (at para. 102).
- [27] A plaintiff must not only prove that informed consent was not obtained, but also that the patient would not have given consent if she had been adequately apprised of the material risks. Causation is not proven if the patient would have made the same decision in any event. Further, it must be established that the material risk that was not adequately disclosed is, in fact, the cause of injury: *Hopp* at 204. The latter issue is not contested in this case.
- [28] In *Reibl*, the Supreme Court of Canada articulates a modified objective test as the test for causation. This requires assessment of what the reasonable person in the plaintiff's particular circumstances would do, on a balance of probabilities (at 928). Despite some problems with consistent application, a majority of the Supreme Court of Canada reaffirms the test in *Arndt v. Smith*, [1997] 2 S.C.R. 539. At para. 9, Justice Cory expounds on the factors to be considered in applying the modified objective test:

Some of the criticisms directed at the *Reibl* test may stem from confusion as to what Laskin C.J. intended in his adoption of a modified objective test. The uncertainty surrounds the basic premise that the test depends upon the actions of a reasonable person in the plaintiff's circumstances. Which aspects of the plaintiff's personal circumstances should be attributed to the reasonable person? There is no doubt that objectively ascertainable circumstances, such as a plaintiff's age, income, marital status, and other factors, should be taken into consideration. However, Laskin C.J. didn't stop there. He went on and stated that "special considerations" affecting the particular patient should be considered, as should any "specific questions" asked of the physician by the patient. In my view this means that the "reasonable person" who sets the standard for the objective test must be taken to possess the patient's reasonable beliefs, fears, desires and expectations. Further, the patient's expectations and concerns will usually be revealed by the questions posed. Certainly, they will indicate the specific concerns of the particular patient at the time consent was given to a proposed course of treatment. The questions, by revealing the patient's concerns, will provide an indication of the patient's state of mind, which can be relevant in considering and applying the modified objective test.

[Emphasis in original.]

- [29] The modified objective test has recently been applied by this court in *Chen v. Ross*, 2014 BCSC 374, aff'd 2015 BCCA 250. Justice Ballance synthesizes the test at para. 307:

The causation test in this context is a modified objective one comprised of a combination of subjective and objective elements. The question is not whether Mr. Chen would have elected to proceed had he been sufficiently informed of the material risks and information relative to the Membrane Surgery. Rather, the test asks whether the reasonable person in Mr. Chen's shoes, being the average prudent person who possesses Mr. Chen's reasonable beliefs, fears, desires, and expectations, would have declined the Membrane Surgery at the particular time had the risk that ultimately came about (i.e. becoming legally blind in his left eye) been fully disclosed: *Arndt v. Smith*, [1997] 2 S.C.R. 539. If the properly informed, reasonable person in Mr. Chen's position would have consented to the Membrane Surgery in any event, Dr. Ross's negligence cannot be said to have been the cause of his injury.

- [30] The only subjective beliefs that the test eliminates from consideration are those idiosyncratic or irrational fears that a patient may possess: *Arndt* at para. 14. Cory J. states that this makes the test fairer than the subjective test advocated for by the minority in that case (at para. 17).

B. The State of Medical Knowledge about VBAC in 1999

- [31] The Society of Obstetricians and Gynecologists of Canada ("SOGC") issued a policy statement regarding VBAC in 1997 which was in effect at the time of Tianna's birth. This policy was adopted word for word by the British Columbia Reproductive Care Program, which was run out of the British Columbia Children's and Women's Health Centre ("BCW"). VBAC was addressed in "Obstetric Guideline 8" (the "Guideline"). All parties agreed the Guideline is important to any determination of the applicable standard of care required of Dr. Freedman and Nurse Marsh, although it is not determinative.
- [32] The Guideline noted the incidence of scar dehiscence "without maternal or fetal consequence" was 0.5%. The risk of uterine rupture with hemorrhaging and fetal compromise or even death was pegged at 0.1%. The Guideline recommended that women with one previous caesarean section (with a transverse low segment scar) undergo a trial of labour, but also stated that "[r]espect for the woman's autonomy, her participation and the participation of her partner in decision making is of paramount importance." The Guideline listed five contraindications for VBAC, but it is not disputed that none applied to Ms. Brodeur.
- [33] The Guideline confirmed that induction of labour with oxytocin raised the risk of scar dehiscence to about 1.8% and uterine rupture to something less than 0.5%. It stated that the safety of prostaglandin gel use "has not been established and further research is needed." The Guideline also stated that if prostaglandin gel is used for a woman undergoing VBAC who has a low segment scar, that woman "must understand the limitation of knowledge in this area."

[34] Both Nurse Marsh and Dr. Freedman agreed they had been instructed to be and were familiar with the Guideline, including Appendix A, which is reproduced in its entirety here:

SIGNS THAT MAY OCCUR WITH A COMPLETE OR PARTIAL UTERINE RUPTURE

- Sudden non-reassuring fetal heart pattern
- Unusual abdominal/uterine pain
- Cessation of contractions or incoordinate uterine activity
- Unexplained vaginal bleeding
- A sudden onset of maternal tachycardia and hypotension
- Excessive fetal movement
- Fetal parts palpated through the abdominal wall
- Presenting part higher than found previously

SIGNS THAT MAY OCCUR WITH IMPENDING UTERINE RUPTURE

- Inadequate labour progress (cervical dilation, fetal descent) despite good contractions
- Incoordinate uterine activity
- Restlessness and anxiety
- Lower abdominal pain between contractions

[35] In 1999, FHR's were classified as either "reassuring" or "non-reassuring" (terms not used now). A reassuring FHR generally meant a baseline rate between 110 to 160 beats per minute (bpm), with variability of between 6 and 25 bpm, acceleration of at least 15 bpm for at least 15 seconds and an absence of decelerations. A non-reassuring FHR generally had a baseline below 110 bpm or above 160 bpm, decreased variability and an absence of accelerations. All medical witnesses acknowledged the importance of continuous electronic FHR monitoring, especially when labour is induced or oxytocin is administered.

[36] The SOGC also issued a memo titled "Advances in Labour and Risk Management" (the "Memo") which accompanied a course in the same topic. Dr. Delisle took this course in May 1999, and taught the course in later years. The Memo stated that the success rate for VBAC (meaning the percentage of women who do deliver vaginally) is in the "60-80% range when patients are properly selected and labour is managed appropriately." The obvious implication was that between 20-40% of women who attempt VBAC ultimately deliver by caesarean section, or with some other intervention, but that was not explicitly stated. The Memo also stated:

Some recent evidence helps predict which women will achieve a vaginal delivery after a trial of labour. The chance of a successful vaginal delivery remains about 70% regardless of what the indication was for the previous caesarean section. However if the indication was dystocia or failure of progress in labour and the patient had reached full dilation with failure of descent of the fetal head, then the chance of achieving a vaginal delivery appears to be reduced to approximately 30%. A trial of labour is not precluded but the likelihood of success is reduced in these patients.

- [37] There is no dispute that in her previous delivery, Ms. Brodeur's caesarean section was ordered because of dystocia; following an extended trial of labour, her cervix was only 3 centimetres dilated.
- [38] With regard to hospital requirements, the Memo noted personnel should be able to recognize the signs and symptoms of uterine rupture which were listed as "non-reassuring fetal monitoring, ease of fetal palpation, cessation of contractions, elevation of presenting part, and scar pain (poor sensitivity and specificity, seldom masked by epidural)."

C. Facts Relating to Informed Consent

- [39] Dr. Delisle completed her fellowship in obstetrics and gynecology in Quebec City. Between 1997 and 2000 she was a fellow in the subspecialty of perinatology at BCW and she provided prenatal care to Ms. Brodeur with regard to Tianna's birth. Dr. Delisle was also involved in the caesarean section birth of Ms. Brodeur's first child. She testified about her memory of events and interactions with Ms. Brodeur during the relevant times.

1. The July 23 Consultation

- [40] At about 24 weeks of her second pregnancy, Ms. Brodeur's family physician referred her to an obstetrician in Abbotsford who in turn consulted Dr. Ballem (an internist at BCW) because of Ms. Brodeur's hypertension. Dr. Ballem recommended adjustments to Ms. Brodeur's blood pressure medication and rest. She also recommended a consultation and follow up visits at BCW with a maternal-fetal specialist; that is how Dr. Delisle came to provide care for Ms. Brodeur.
- [41] Dr. Delisle and Dr. Ballem first met with Ms. Brodeur on July 23, 1999, when Ms. Brodeur was 30 weeks pregnant. Dr. Delisle had a specific recollection about that meeting. She was struck by the fact that at that late stage of pregnancy, Ms. Brodeur held the mistaken belief that once a person has had a caesarean section, they must always deliver that way.
- [42] Dr. Delisle produced the antenatal record for Ms. Brodeur (the "Record"). An antenatal record is a document that contains a summary of important information about the patient during her pregnancy including medical history, features of any previous pregnancy and social factors. Dr. Delisle recorded pertinent information from her patient visits with Ms. Brodeur on the Record. Each box next to the words "VBAC", "C-section", and "birth plan" had all been checked. Dr. Delisle testified that she would only mark those boxes once the topics

and associated risks had been discussed with the patient.

- [43] The Record also documented other concerns about the pregnancy discussed at the time. A primary concern was Ms. Brodeur's severe hypertension and the resulting increased risk of pregnancy-induced hypertension, fetal growth problems, and intrauterine fetal death. Other concerns noted on the Record included Ms. Brodeur's previous caesarean section for failure to progress, her obesity, the need for surveillance and close monitoring of her blood pressure, her resistance to leave work despite it being recommended by the medical team, her reluctance to attend at BCW for prenatal appointments and her preference for delivering in Abbotsford.
- [44] In addition to the information on the Record, Dr. Delisle prepared a consultation report which she dictated on July 29, 1999. The information in that report is consistent with the Record but it also has more detailed information. It noted Ms. Brodeur's resistance to following the recommendation to leave work was because her job was her only "assured income". Dr. Delisle reviewed the situation with Dr. Ballem. The doctors wanted to optimize Ms. Brodeur's compliance and the monitoring of her pregnancy because of the associated risks. In addition to the risks noted on the Record as discussed earlier, the July consultation report stated the doctors discussed the increased risks of her pregnancy for placental abruption, as well as the long-term maternal risk associated with high blood pressure. It also noted that Ms. Brodeur expressed preference for a repeat caesarean section and at that point, the associated "increased risk[s] of hemorrhage, infection and wound dehiscence" related to that procedure were discussed.
- [45] Dr. Delisle was asked to demonstrate in court what her typical risk discussion would involve when explaining the choice between VBAC and repeat caesarean section to a patient. Obviously, this was somewhat artificial given the context. She testified she would have discussed the following points with Ms. Brodeur:
- a) The myth of "once a C-section, always a C-section".
 - b) The benefits of a successful vaginal birth, which included a quicker recovery, initiation and long-term continuation of breastfeeding, and more ability to attend to the demands of a new baby.
 - c) The benefits to the baby in terms of an easier transition from their fetal lives, and a decreased risk of common lung issues.
 - d) The risks of C-section, and the compounding nature of the risks of repeat C-section, where the impact of previous scars and organ movement are somewhat unpredictable, as well as specific risks of infection, extended hospitalization, and complications and delayed healing related to obesity, which would increase recovery and postpartum time. Other C-section risks, exacerbated by obesity, included bleeding requiring transfusions and the risk of blood clots.

- e) The significance of an existing caesarean section scar, and its characterization as a weak point that could potentially split open, resulting in a uterine rupture. If this was to happen, Dr. Delisle said it would be a "catastrophe", and she described the resulting emergency during which both the mother and the baby's lives would be at risk.
 - f) The likelihood of a uterine rupture was about 0.8 to 1 percent, and it would result in an emergency caesarean section. In such a circumstance, the baby can suffer severe damage, and be handicapped in terms of both motor and mental function.
 - g) Despite this risk, national guidelines concluded that VBAC was preferable based on the success rate and the ability to avoid the risks of repeat caesarean section.
- [46] After that discussion, Dr. Delisle testified she would have asked the patient if she had any questions and would have recommended that the patient, and in this case, her partner, go home to think about their options and inform the doctors of their choice on the next visit. She emphasized that unlike her testimony in court, the conversation would have been dynamic with the patient able to ask questions throughout.
- [47] Ms. Brodeur recalled meeting with Dr. Delisle several times prior to being admitted to hospital, but, not surprisingly, she was unable to distinguish what happened at each visit. She remembered the content of their conversations globally. But Ms. Brodeur testified that she was never given the option of having a caesarean section, and that Dr. Delisle was very adamant about pursuing VBAC. Ms. Brodeur said that her main concern at each patient visit was requesting a caesarean section, and that each visit began with that request. She testified that she wanted to deliver by caesarean section because she did not want to have to go through the pain of labour, only to have the baby delivered by caesarean section as she did with her first pregnancy. She said medical staff dismissed the request each time, telling her that there was no reason for her not to deliver naturally.
- [48] Mr. Brodeur accompanied Ms. Brodeur at her patient visits. His testimony was much the same as his wife's. He also testified that caesarean section was never presented as an option. He attended every visit at BCW with her and testified that on each visit he and Ms. Brodeur expressed their preference for repeat caesarean section. He had several relatives who had had caesarean sections in the past, and he understood that the rule was "once a C-section, always a C-section". Each time they were told that the rule no longer stood, and there was no reason not to attempt VBAC.
- [49] Dr. Delisle testified that after the initial conversation on July 23, to her knowledge, neither Ms. Brodeur nor her husband expressed a desire to deliver by repeat caesarean section. Likewise, she said they did not express a preference for caesarean section after admission to hospital, and there is no documentation of such a request. Dr. Delisle denied that she insisted that Ms. Brodeur attempt a trial of labour and maintained that she offered a choice to Ms. Brodeur.

- [50] Ms. Brodeur testified about her understanding of the risks associated with caesarean section. She had the impression that the possibility of infection was the physician's main concern. Likewise, Mr. Brodeur does not recall a discussion of risks related to obesity and he testified that the only risk associated with another caesarean section discussed with them was the high risk of infection.
- [51] Ms. Brodeur and Mr. Brodeur both testified that no risks associated with vaginal delivery were ever discussed. They said they had never heard the term "ruptured uterus" and had never heard of a uterine scar opening. Ms. Brodeur testified she did not recall being told to take time to think about her options, and that they would be discussed again at a later date. She denied that Dr. Delisle told her that her baby could be injured, disabled, or handicapped with a vaginal delivery, and testified that Dr. Delisle did not use words such as "handicapped" or "brain damaged". Although Ms. Brodeur acknowledged that she does not recall all of the details of her visits with Dr. Delisle, she is sure that these topics were never addressed. Mr. Brodeur testified that although they were not aware of any risks associated with VBAC, their preference was still for caesarean section because Ms. Brodeur's attempt at vaginal delivery with her first pregnancy had been such an ordeal and resulted in a caesarean section being performed in any event.
- [52] Ms. Brodeur's mother (Ms. Hicks) attended an examination for discovery and excerpts from that were read into the record. Ms. Hicks stated that she believed Ms. Brodeur had been told of the different risks associated with both VBAC and caesarean section, and that the physicians thought, considering Ms. Brodeur's weight and hypertension, that VBAC was the better option. Ms. Brodeur denied telling her mother this.
- [53] Dr. Delisle testified that it would be "impossible" for her to fail to mention the risk of uterine rupture associated with VBAC, because it is the only significant risk related to that procedure. When comparing the two options, there would be nothing to say with respect to VBAC if uterine rupture was not discussed. She was very confident that she would have used words like "catastrophe" and "handicapped" in the context of the risk discussion.
- [54] When presented with the Record and specifically pointed to the concerns written by Dr. Delisle, Ms. Brodeur did recall hypertension and pregnancy-induced hypertension being discussed, but did not recall mention of increased risk of fetal growth problems or intrauterine death. Ms. Brodeur also then recalled that obesity was discussed as a risk.

2. The August 20 Consultation

- [55] At Ms. Brodeur's next visit, on August 20, 1999, Drs. Ballem and Delisle recommended to Ms. Brodeur that she be hospitalized immediately in order to monitor her blood pressure. The physicians attempted to impress upon Ms. Brodeur the seriousness of her situation. Ms. Brodeur insisted on continuing to work, so Dr. Delisle contacted Ms. Brodeur's family doctor in Abbotsford in an effort to arrange additional follow up. Dr. Delisle testified that she had a vivid recollection of this visit, because it was unusual that a patient, after having such serious concerns presented to her, would reject the medical team's recommendations and

insist on continuing to work.

[56] Ms. Brodeur recalled the physicians' recommendation that she stop working and go on bedrest, and acknowledged that she did not accept this advice. She testified that she could not afford to stop working, and that her job was not stressful. Ms. Brodeur admitted that with respect to these conversations about her stopping work, she was able to assert herself, negotiate with physicians, and maintain a situation that suited her.

[57] Dr. Delisle testified that the choice between VBAC and caesarean section was not the central topic of discussion during the August 20 visit, and she had no specific recollection of it coming up; the physicians were primarily concerned with convincing Ms. Brodeur to be admitted to hospital.

3. September Consultations

[58] Ms. Brodeur attended at BCW again on September 3 and September 17, 1999. The decision was made at the September 17 appointment to induce labour based on Ms. Brodeur's hypertension, limited feeling of fetal movement, and difficulty with compliance respecting medication and fetal monitoring. Induction represented a change in the birth plan so Dr. Delisle testified she had the second of two informed consent discussions. This discussion was intended to review the earlier conversation, and consider the other developments that had taken place in the meantime, including putting the risks and benefits of VBAC and caesarean section within the context of induced labour. She testified she would have explained that induction does not preclude VBAC, and that she would have confirmed whether the patient was still agreeable to that procedure. The Record is consistent with Dr. Delisle's testimony on these points. Ms. Brodeur stated again that she did not recall the risks of VBAC ever being discussed.

4. Admission and Induction

[59] Ms. Brodeur was admitted to hospital for induction of labour on September 20, 1999. She was examined and the final birth plan was discussed. Mr. Brodeur testified that even at the time of being admitted to hospital, they asked about the possibility of a caesarean section instead of VBAC. He stated that everyone provided the same answer: there was no reason not to attempt vaginal delivery.

[60] Dr. Delisle testified that Ms. Brodeur indicated no reluctance about induction. If she had, Dr. Delisle stated she would not have proceeded with gel insertion, and she would have brought her supervisor to discuss the situation with Ms. Brodeur and to provide a second opinion.

[61] Dr. Delisle stopped in several times throughout the day to monitor Ms. Brodeur's progress. At approximately 5:00 p.m. she handed over all of the information relevant to Ms. Brodeur to the incoming physician, and reviewed the situation. Dr. Delisle was not present at the hospital during the emergency caesarean section and the events leading up to it.

[62] Ms. Brodeur had limited memory of what occurred following her admission to hospital. She remembered being in considerable discomfort and experiencing pain that did not subside with her contractions. She remembered a nurse checking some things and making a phone call, being assessed by a doctor, and then being wheeled to the operating room.

5. The Impact of Induction on the Risk of Uterine Rupture

[63] Dr. Delisle testified that in 1999 there was no contraindication for the use of prostaglandin when inducing labour in VBAC patients. Her understanding was consistent with what was contained in the Guideline and the Memo, and although there was some indication in those that the use of oxytocin may increase the risk of uterine rupture, both oxytocin and Foley catheters were approved of and regularly used when inducing labour in VBAC patients.

[64] As noted above, Dr. Delisle testified that she did specifically review the risks of induction in her second risk discussion with Ms. Brodeur. In her assessment, the fact that Ms. Brodeur experienced no complications from her first caesarean section did not affect the risk assessment of a subsequent surgery. Ms. Brodeur was not being informed of the baseline risk of caesarean section, but the risk of repeat caesarean section coupled with her obesity, hypertension, and possible gestational diabetes. Under cross-examination, Dr. Delisle acknowledged that the risks associated with emergency caesarean section were greater than with a planned, repeat caesarean section, although she stated that increase was not necessarily significant.

D. Expert Evidence about Informed Consent

[65] Two doctors provided expert evidence on the standard of care with regard to informed consent for VBAC deliveries that would have been applicable in 1999: Dr. Oppenheimer and Dr. Doersam.

[66] Dr. Oppenheimer is an obstetrician and gynecologist and is also a maternal-fetal medicine specialist. He prepared a report dated November 24, 2014. He was asked whether the care provided by Dr. Delisle was in keeping with what would be expected of an average and prudent fellow in maternal-fetal medicine with specific attention to several different questions.

[67] I summarize from his report the most relevant opinions about the first informed consent discussion. In his opinion, Dr. Delisle's discussion of risks was appropriate for 1999:

- a) Dr. Oppenheimer discussed the impact Ms. Brodeur's previous caesarean section, hypertension, gestational diabetes and the fetal size had on the decision to proceed with VBAC. In his view, none of those factors were contraindications for VBAC and it was appropriate to recommend VBAC to Ms. Brodeur.

- b) With regard to the impact of Ms. Brodeur's obesity, he opined that it would not "commonly have been discussed as a risk factor [for VBAC] in 1999". But the available data in 1999 suggested an increased risk of complications with caesarean section delivery given Ms. Brodeur's obesity. In his opinion "Dr. Delisle's explanation that vaginal birth would probably be associated with less morbidity than a repeat caesarean section, was a fair reflection of the understanding of the risks at that time."
- c) With regard to a patient in similar circumstances to Ms. Brodeur, Dr. Oppenheimer stated there was no "absolute standard" with regard to obtaining consent for VBAC in 1999, but in his view the risk of uterine rupture and possibility of a caesarean section would be discussed.
- [68] Dr. Oppenheimer also commented on the state of knowledge regarding the use of prostaglandin gel in the induction of labour for VBAC patients. While Williams, the leading text on obstetrics at that time, made no mention of concerns regarding induction for VBAC patients, the Guideline stated "[t]he safety of prostaglandin gel has not been established and further research is needed. the woman must understand the limitation of knowledge in this area." Dr. Oppenheimer questioned whether there were sufficient studies in 1999 to suggest an increased risk. He also noted that prior to 1999, "the product monograph for [prostaglandin] gel cited previous [caesarean] as a contraindication for its use" but that despite this, many physicians used it "off label". Health Canada identified this contraindication in 1995, but Dr. Oppenheimer opined this did not have an impact on the profession. He then reviewed literature available at the time and concluded that "[t]he general perception in 1999 was that prostaglandin induction of labour in VBAC was not associated with a significant increase in risk [of] rupture."
- [69] In his opinion induction with prostaglandin gel and oxytocin was considered appropriate in 1999 for VBAC patients. Dr. Oppenheimer noted both the Guideline and the Memo allowed for induction "with close patient monitoring". The Guideline did state that while the use of gel appeared to be safe "there are occasional reports of uterine rupture." It was his opinion that the increased risk associated with oxytocin and prostaglandin induction would not have been specifically addressed in 1999.
- [70] Dr. Doersam is a specialist in obstetrics and gynecology. He prepared three reports dated June 5, 2015, one of which addressed the issue of informed consent. Dr. Doersam's opinions assumed that Dr. Delisle was aware in 1999 that the possibility of successful vaginal delivery during VBAC was reduced when the reason for the prior caesarean section was a failure to progress. Dr. Doersam was asked to opine on two possibilities. First, that it was Dr. Delisle's practice in 1999 to inform VBAC patients about the percentage risk of uterine rupture and that she would have used the words "damage", "handicap" or "brain damage". Second, that the risk of uterine rupture was not mentioned.
- [71] The summary of the most relevant of Dr. Doersam's opinions with regard to Dr. Delisle's first informed consent discussion included:

- a) If the court finds Dr. Delisle did discuss the risk of uterine rupture, his opinion was that she "did not adequately portray the lifetime of disability and dependence" that could result. He noted that based on the assumption Dr. Delisle quoted the risk of rupture at 0.8 to 1%, "she did not supply a similar numerical estimate of the risk of major maternal complication of a planned repeat Caesarean delivery." He noted that Dr. Delisle stated the goal was to avoid a second operation, but that she "did not provide any substantial support for her contention that a planned repeat operation was more hazardous than a trial of labour, either in numerical or in descriptive terms." This resulted in an unbalanced view of the relative risks of the two modes of delivery. He concluded this failed to meet the standard of care.
 - b) Dr. Doersam opined that Dr. Delisle should have outlined factors that distinguished Ms. Brodeur's personal circumstances from those of the average patient, which he listed as a much larger baby, "a pelvis lined with more fat than at her previous failed labour", an unripe cervix, a presenting part above the pelvic inlet, the limited ability to conduct fetal monitoring because of obesity and the "contraindication of rupturing membranes to apply internal electronic monitoring". In his view this meant Dr. Delisle failed to provide Ms. Brodeur with individualized risk estimation.
 - c) Dr. Doersam said that Dr. Delisle's stated goal (to avoid surgery) was not responsive to Ms. Brodeur's wishes and this fell below the standard of care.
 - d) In Dr. Doersam's opinion, Ms. Brodeur was a poor candidate for VBAC and the failure to explain that to her fell below the standard of care. Dr. Doersam's conclusion was based on his assessment that Ms. Brodeur's chances of success of delivering vaginally were low for the reasons discussed above at paragraph "b". But he also relied on his own assessment of the failure to progress with the first pregnancy, noting that Dr. Delisle ought to have known that "[a]ny soft tissue dystocia" Ms. Brodeur had in 1998 would be "replicated or exceed[ed]" since Ms. Brodeur weighed more than she did during the first pregnancy. In his view this would have led an "average obstetrician to deduce that the risk of uterine scar separation was elevated" above the average.
- [72] With regard to the standard of care for disclosure of risks associated with induction in VBAC, he opined that any obstetrician of average competence in 1999 would have advised against the use of induction by prostaglandin gel given Ms. Brodeur's "low probability of successful VBAC, a greater than average risk of uterine rupture and markedly limited monitoring capability." He also faulted Dr. Delisle for not stating there was an "unknown risk" attached to prostaglandin. In his opinion, once the prostaglandin gel "failed to achieve cervical change", administering oxytocin was ill advised given the factors mentioned above with regard to her being a poor candidate and the elevated risk of rupture.

E. Analysis

1. What risks regarding VBAC did the Standard of Care require to be disclosed?

- [73] There is no dispute that VBAC procedure carried a statistically small, but sufficiently serious risk so as to be considered a material risk. Although the prevalent medical practice at the time was to encourage VBAC, it was incumbent upon physicians to discuss all material risks and alternatives. I find that the standard of care in 1999 clearly required patients to be informed of the specific risk of uterine rupture and its potential consequences when VBAC was discussed as a possibility. The parties do not disagree; their dispute centres on the sufficiency of the information given to Ms. Brodeur regarding the risks of VBAC and subsequent emergency caesarean section, as well as VBAC with induction.
- [74] Dr. Doersam opined that Dr. Delisle's description of the risks associated with VBAC was deficient because she failed to individualize her analysis and discussion of risks to Ms. Brodeur's personal situation; as described earlier in my summary of his opinion, Dr. Doersam noted the significant factors which ought to have informed that discussion. However, there was no evidence those factors were mentioned in any authoritative literature or applicable policies or guidelines as being contraindications for VBAC. Accordingly, there is no medical-based evidence to support Dr. Doersam's opinion on this point, and therefore I do not find it reliable.
- [75] In Dr. Doersam's opinion, the discussion about the risks of uterine rupture as contrasted to a repeat caesarean section was not further attenuated by a comparison of the risks of a planned repeat caesarean section, and a caesarean section required because of a failure of the labour to progress. Dr. Delisle acknowledged there could be a difference, but not one significant enough to discuss. On top of that, Dr. Doersam said Ms. Brodeur's obesity ought to have played a more significant role in the assessment and discussion of risks.
- [76] Although there is an initial logical appeal to Dr. Doersam's analysis, I do not find it alters the standard of care required at the time. The Memo discussed a decreased rate of success for vaginal birth when a previous caesarean section delivery was necessary because of a failure to progress with a fully dilated cervix. Ms. Brodeur did not fit that description because she never achieved full dilation with her first delivery. Furthermore, there was no evidence presented at trial that it was known in 1999 that there was a significant difference amongst the risks of an non-urgent caesarean section after failed attempt at VBAC, a planned caesarean section, and an urgent caesarean section after failed VBAC. Therefore, I disagree with Dr. Doersam that a discussion that failed to include those risks was inadequate.
- [77] Ms. Brodeur's obesity was clearly a complicating factor in what happened, but other than Dr. Doersam's statement, there was no evidence that in 1999 obesity was a contraindication to VBAC. In fact, Dr. Oppenheimer noted that in 1999 obesity tended to be associated only with increased surgical risks. In my view, the evidence established that the risks from obesity were related to the quality of care and monitoring that could be provided. This is not the type of medical risk that must be disclosed in order to meet the standard of care for informed consent.

- [78] With regard to induction and VBAC, Dr. Oppenheimer concluded that it was not necessary in 1999 to discuss the relationship between induction and an increase in uterine rupture. Dr. Doersam does not address whether the possibility of an increased risk of uterine rupture should have been part of any informed consent discussion; rather he concludes that given Ms. Brodeur's circumstances, induction ought not to have been recommended at all. Basically, Dr. Doersam criticizes the decision to induce. An error in diagnosis or treatment does not necessarily lead to negligence: *Scrimgeour v. Singer*, [1988] B.C.J. No. 31 at para. 11.
- [79] The difficulty is that I find Dr. Doersam's views to be based, to a large degree, on his experience in the United States, which is not applicable to my determination of what the standard of care in British Columbia was at the time. I find more compelling Dr. Oppenheimer's evidence (which is most consistent with the medical literature), that it was after 1999 that the medical profession began recognizing an increased risk of uterine rupture associated with induction.
- [80] More generally, Dr. Doersam's analysis is not limited to the applicable standard of care for informed consent; he wades into an analysis about the decision to recommend VBAC, and induction. I am not convinced the opinions he expressed about those are relevant to the issue before me. Even if they are, however, I am cognizant of the court's recognition that hindsight may play too great a role when judging care given by medical professionals : *Crouch (Guardian ad litem of) v. B.C. Women's Hospital & Health Centre*, 2001 BCSC 995 at para. 32 and *Smith (Guardian ad litem of) v. Grace*, 2004 BCSC 395 at paras. 5-6. In my view, Dr. Doersam intermingled his analysis of the standard of care for informed consent with his opinion about treatment decisions. I find this approach does suffer from a degree of hindsight analysis which further diminishes the reliability of his opinions.
- [81] I conclude that in 1999 it was not known that induction in VBAC significantly increased the risk of uterine rupture such that it was a material risk that had to be disclosed to patients. Thus, the standard of care in 1999 required a physician to disclose the risk of uterine rupture and its potential consequences, but not to discuss the then unknown risks associated with induction.
2. Did Dr. Delisle's risk discussions meet the standard of care?
- [82] The parties' positions are diametrically opposed as to what Dr. Delisle said to Ms. Brodeur about the second pregnancy. The plaintiffs allege that Dr. Delisle never mentioned the possibility of uterine rupture, or the consequent effect this might have on their child. In the alternative, they submit if I were to find the risk discussion did take place, their position is that it was not presented in an understandable manner. They say that based on Dr. Delisle's testimony describing what such a conversation would entail, the information was presented rapidly, with a pronounced accent, and not in a way as to obviously compare and contrast the two options available to Ms. Brodeur.

- [83] Dr. Delisle, on the other hand, testified that there was a detailed conversation about the risks of both VBAC and repeat elective caesarean section. She submits that as uterine rupture is the only serious risk associated with VBAC, any conversation of the risks would necessarily have included a discussion of this particular possibility. Her position is that Ms. Brodeur gave no indication that she failed to understand the conversation about risks.
- [84] The plaintiffs submit that Dr. Delisle did not understand the difference between what she actually said to Ms. Brodeur, versus what she believed she would have told her based on her usual practice. I do not agree Dr. Delisle was confused about this. She was able to identify instances when she had a specific recollection of a conversation and she could identify why it stood out for her. I also find it significant that Dr. Delisle's consultation report is consistent with the antenatal report in terms of the information conveyed. In my view, these factors enhance her credibility and reliability.
- [85] Moreover, it is acceptable to accept evidence about one's usual practice to be evidence of what happened. In *Belknap v. Meakes*, [1989] B.C.J. No. 2187, 1 C.C.L.T. (2d) 192 (C.A.), the Court of Appeal held that "[i]f a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that surely is evidence and possibly convincing evidence that he did it in that way on the day in question."
- [86] I dismiss the plaintiffs' suggestion that Dr. Delisle had a "pronounced accent". She has a francophone accent, but I find as a fact this did not make her difficult to understand; nor do I agree with the plaintiffs that she spoke in an overly rapid fashion. Neither Ms. Brodeur nor Mr. Brodeur testified that they found Dr. Delisle difficult to understand and certainly did not mention difficulty with her accent or the rapidity of her speech.
- [87] On the other hand, while I find that both Mr. and Ms. Brodeur are credible witnesses, I have concerns about the reliability of their evidence. In particular, Ms. Brodeur admitted she did not have a recollection of any specific conversation and tended to blur the information from all of her appointments together. Furthermore, in her testimony in chief she stated she was only told about one risk related to repeat caesarean section (infection) but she agreed in cross-examination that she was told about other risks.
- [88] I also find it significant that Ms. Hicks remembers being told by Ms. Brodeur about the reason why VBAC was recommended. Ms. Brodeur's denial of this follows from her denial that those risks were discussed with Dr. Delisle. Given that I have found Dr. Delisle did identify those risks, I find Ms. Brodeur's statement that she never told her mother that advice has minimal reliability.
- [89] It is also difficult to accept a witness who is adamant about what was not said when they admittedly have a poor recollection generally of the relevant conversations. While Mr. Brodeur claimed to have better recollection, I do not think that was demonstrated by his testimony. Also, it was clear during his testimony that his emotions about these events are still strong, and in my view, that diminishes the reliability of his evidence.

- [90] The plaintiffs say I should place little weight on Dr. Delisle's demonstration of risk conversations at trial because it had inconsistencies with the same demonstration she gave during her examination for discovery. At her discovery, however, it was clear Dr. Delisle was giving an abbreviated version of the discussion given the awkwardness of the situation. The plaintiffs also say Dr. Delisle was unclear about when conversations took place: on a summary of events written after Tianna's birth, Dr. Delisle appears to have identified the date of the second discussion about risks to be different than the date given in her testimony. I accept Dr. Delisle's testimony that she was focussing on what happened and not on specific dates. In other words, this was simply an error. I do not find the inconsistencies identified by the plaintiff to have an appreciable impact on the reliability of her evidence.
- [91] I find it highly unlikely that Mr. and Ms. Brodeur started every visit with hospital staff by requesting a repeat caesarean section. Dr. Delisle noted in her July 29 consultation report that Ms. Brodeur had a preference for a caesarean section; there is no reason why she would not continue to document that request if it was said to her again, especially if it was consistently brought up as claimed by the plaintiffs.
- [92] In order for me to accept the plaintiffs' position that Dr. Delisle failed to mention the risk of uterine rupture at any appointment, I would have to find Dr. Delisle lacks credibility because she was firm in her testimony that it was "impossible" for her not to have spoken about that risk. I would also have to find that she falsified the antenatal report in two places, and that her consultation report was partly fictional. I would also have to reject Ms. Hick's testimony that Ms. Brodeur explained to her the associated risks. I find none of these possibilities to be compelling. I find Dr. Delisle to be credible and reliable.
- [93] Moreover, it is difficult to accept that Ms. Brodeur would not have been successful in insisting on having a caesarean section if that was truly what she wanted at that time. Although I accept that she felt she could not stop working for financial reasons even though that was the medical advice. I find at least part of her refusal was her belief in her own well-being. She did not convey any sense of stress or worry attached to her determination that she had to continue working, despite the great risk this posed to her baby and herself. This is consistent with her simply believing she would be fine. In her testimony, she stated her belief that her job was not that stressful and that she could manage the risks by introducing enough rest breaks. This is consistent with her refusal being tied to her own opinion about her health, which demonstrates a confidence in disagreeing with medical advice.
- [94] I find Ms. Brodeur clearly had the confidence to refuse medical recommendations. I note that the plaintiffs suggest her confidence in rejecting medical advice enhances the credibility of the claim that she was not told about the risks of VBAC. While that has some logic, weighing all the evidence presented, I find on a balance of probabilities that Dr. Delisle did adequately inform Ms. Brodeur of the risks.

3. Conclusion on Informed Consent Issue

[95] Based on the foregoing, I conclude that Dr. Delisle did provide adequate and sufficient information to Ms. Brodeur regarding the specific incidence and consequent risks of uterine rupture from VBAC on two occasions. She therefore met the standard of care with regard to informed consent. Accordingly, I do not need to analyze causation.

ISSUE TWO:

V. THE STANDARD OF CARE FOR PROVIDING MEDICAL CARE TO VBAC PATIENTS

[96] The defendants did not dispute they owed Ms. Brodeur a duty of care, or that the uterine rupture injured Tianna. There is also little disagreement on the legal principles to be followed when determining the standard of care. The parties do dispute the standards of care applicable in this case, and whether Nurse Marsh and Dr. Freedman met those standards.

A. Legal Principles

[97] The standard of care for medical malpractice has been settled for many years. A leading case from the Supreme Court of Canada outlines the basic principles with regard to the standard of care owed by a physician to her patient. In *Wilson v. Swanson*, [1956] S.C.R. 804 at 811-12 Justice Rand stated:

What the surgeon by his ordinary engagement undertakes with the patient is that he possesses the skill, knowledge and judgment of the generality or average of the special group or class of technicians to which he belongs and will faithfully exercise them. In a given situation some may differ from others in their exercise, depending on the significance they attribute to the different factors in the light of their own experience.

There is here only the question of judgment; what of that? The test can be no more than this: was the decision the result of the exercise of the surgical intelligence professed? Or was what was done such that, disregarding it may be the exceptional case or individual, in all the circumstances, at least the preponderant opinion of the group would have been against it? If a substantial opinion confirms it, there is no breach or failure.

An error in judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge. Although universally-accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgement has long been recognized as satisfying the professional obligation.

- [98] Nurses are bound by a similar standard of care. Nurse Marsh had a duty to exercise her professional skill and knowledge to make appropriate assessments and accurately communicate those to the doctors. The standard is determined with reference to what is reasonably expected of a prudent and careful nurse in similar circumstances: *Durnin et al. v. Victoria Hospital*, 2012 ONSC 320 at para. 18.
- [99] Nurses do not diagnose, but they are responsible for bringing to the doctor's attention any signs or symptoms of a potentially developing problem so that it can be diagnosed and addressed before it becomes a crisis: *Tekano (Guardian ad litem of) v. Lions Gate Hospital*, [1999] B.C.J. No. 1763, 90 A.C.W.S. (3d) 150 at paras. 109-10. This has been described as nurses being the "eyes and ears" of the physicians.
- [100] Although not determinative, a treating doctor's expectations are "highly relevant and probative in determining whether the nurses' standard of care has been met", especially in the context of obstetric care where "the physicians and nurses work together as a close team": *Guerineau v. Seger*, 2001 BCSC 291 at para. 59. The importance of this team approach is described by Justice Cunningham in *Granger v. Ottawa General Hospital*, [1996] O.J. No. 2129 at paras. 32-34, 97 and *Bauer v. Seager et al.*, 2000 MBQB 113 at para. 43.
- [101] A specialist is held to a higher standard, as explained in *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at para 33:
- In the case of a specialist, such as a gynaecologist and obstetrician, the doctor's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field. A specialist, such as the respondent, who holds himself out as possessing a special degree of skill and knowledge, must exercise the degree of skill of an average specialist in his field.
- [102] A resident's standard of care is addressed by the Supreme Court of Canada in *Vancouver General Hospital v. Fraser*, [1952] 2 S.C.R. 36 at 46:
- [the resident] must use the undertaken degree of skill, and that cannot be less than the ordinary skill of a junior doctor in appreciation of the indications and symptoms of injury before him, as well as an appreciation of his own limitations and of the necessity for caution in anything he does.
- [103] The appreciation of one's own limitations reflects another aspect of the duty of care: there is an obligation to call for help in an obstetric emergency: *Skeels (Estate of) v. Iwashkiw*, 2006 ABQB 335 at paras. 182-83:
- [182] There is a key thread flowing through the obstetrical opinion of Dr. Steinberg, Dr. Birch and Dr. Iglesias and was acknowledged by both Dr. Iwashkiw and Ms. Tutt as being an important first step. What is that step? The step is to call for help.
- [183] *Williams Obstetrics*, makes it the first item in the recommended emergency intervention checklist, as does the Hope study.

[Emphasis in original.]

[104] The law does not require perfection, and medical practitioners are not meant to be insurers. Mere errors of judgment in diagnosis or treatment are not necessarily negligent: *Scrimgeour v. Singer* at para. 11. On the other hand, just because the error involves an exercise of judgment will not preclude the possibility of a finding of negligence. The determinative factor is whether the doctor exercises the knowledge, skill and judgment of the careful and prudent doctor in the same circumstances: *Whitehouse v. Jordan*, [1981] 1 ALL E.R. 267 at 281 (H.L.).

[105] It is important to assess the impugned actions in light of the state of scientific knowledge at the time, and that requires expert evidence: *ter Neuzen v. Korn* at paras. 38, 44. Where the state of knowledge is in flux, or where a reputable body of medical opinion supports more than one course of action, adherence to one over another is not sufficient to prove negligence: *Belknap v. Meakes* at 220; *Brimacombe v. Mathews*, 2001 BCCA 206. Seaton J.A. in *Belknap* (at 220) relies on Lord Scarman's reasons in *Maynard v. West Midlands Regional Health Authority*, [1985] 1 All E.R. 635:

In *Maynard v. West Midlands Regional Health Authority*, [citations omitted] the House of Lords dealt with a case in which the evidence of the medical experts disagreed as to the wisdom of the steps taken by the defendants. Lord Scarman, with whom all of the Lordships agreed, said (at p. 638 [W.L.R.]):

I do not think that the words of Lord President Clyde in *Hunter v. Hanley*, 1955 S.L.T. 213, 217 can be bettered:

"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care "

[106] It is also important to judge a professional's actions according to what was known by the medical professional at the precise time of her actions. This is explained in *Child v. Vancouver General Hospital et al.*, [1970] S.C.R. 477 at 493:

I think it desirable to stress the fact that the question of liability in the present case is to be determined in light of the circumstances as they existed immediately before Miss Tennesy left the room to go for her coffee break. After an accident it is all too easy to approach the question of fault in light of the event which has happened,

[107] The standard of care must also be sensitive to the degree of risk. Where a doctor has, or ought to have, knowledge of a particular risk, that standard of care is greater. Justice Holmes explains this in *Ediger v. Johnston*, 2009 BCSC 386 at para. 49, *aff'd* 2013 SCC 18:

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 the patient. Thus, the degree of care required is commensurate with the potential danger to the patient: *Badger v. Surkan* (1970), 16 D.L.R. (3d) 146 (Sask. Q.B.) at 153, *aff'd* [1973] 1 W.W.R. 302 (C.A.). In short, the greater the risk, the higher the standard of care: see *Picard & Robertson*, at 237.

[108] A main issue in this case is whether medical staff ought to have recognized and responded sooner to the signs and symptoms of uterine rupture than they did. To answer this, I must integrate the discussion earlier in these reasons about the state of medical knowledge into the legal analysis. In doing so, it is important to analyze the practitioners' actions "in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence" and not, "with the benefit of hindsight, judg[ing] too harshly doctors who act in accordance with prevailing standards of professional knowledge": *ter Neuzen v. Korn* at para. 34. I am also mindful that the tragic outcome in this case must not drive the analysis. As Justice Satanove notes in *Smith et al. v. Grace et al.*, 2004 BCSC 395 at para. 5, "just because a baby is born with brain damage, it does not mean that the medical professionals involved in [the baby's] birth were negligent."

[109] Keeping those concepts in mind, I turn to the facts relevant to the claims in negligence.

B. Facts Relevant to the Standard of Care for VBAC Patients

[110] Nurse Marsh started her career as a surgical nurse before taking training at BCIT to receive her perinatal nurse's certificate. This included further courses in both low and high risk pregnancies. She was hired by BCW and following a six to eight week orientation in place of a practicum, and less than a year on the low risk side of the labour unit, she was transferred to the high risk unit where Tianna was born.

[111] When she started her shift with Ms. Brodeur, Nurse Marsh was aware of the factors that made Ms. Brodeur a high risk patient, which included hypertension, gestational diabetes, non-compliance with doctor's treatment recommendations to address those conditions, a risk of preeclampsia seizure and the fact that she weighed over 300 pounds. Nurse Marsh was aware of the specific risk of uterine rupture attached to VBAC and that timely intervention was critical. Because of this, she understood that monitoring the strength of contractions and FHR were very important for VBAC patients.

[112] Nurse Marsh felt there were inadequate parameters in place to monitor Ms. Brodeur. She knew the reliability of the electronic monitoring of the FHR and contractions would be compromised because of Ms. Brodeur's obesity, but she also knew the obesity made manual palpations of contractions challenging. This was because the girth of the abdomen makes it very difficult to sense the uterine contractions. If Ms. Brodeur was supine, the fatty tissue over the abdomen would have fallen to the side somewhat, allowing closer access to the uterus. But a supine position was not a safe position as it could interfere with blood flow to the fetus.

- [113] Dr. Freedman had a poor recollection of what practices and protocols were in place in 1999 as distinct from those that exist today, because she has been practicing as an obstetrician and gynecologist since 2001. Nevertheless, she agreed that in 1999 she knew the potential signs of a possible rupture included a drop in the FHR, abdominal pain and a change in the contraction pattern.
- [114] Dr. Freedman's evidence about what happened during Tianna's birth was drawn from what she believed she would have done on the basis of reviewing documents, including medical records, because she had little recollection of the events surrounding Tianna's birth. She did have two clear memories about Tianna's birth: (i) performing the vaginal exam on Ms. Brodeur, realizing the fetus had not descended into the birth canal meaning something was wrong, and wondering where the other team members were; and (ii) witnessing the caesarean section and seeing that the baby had been expelled into the abdominal cavity.
- [115] She did not, however, remember what she was told when she first walked into Ms. Brodeur's room. She believed she would have looked at the electronic monitoring information. She testified that she "must have been" concerned by what she saw although during her discovery, her evidence was slightly different. At discovery she agreed that between 21:40 and the time she arrived in the room, the data was "very concerning" and possibly indicative of fetal compromise. The significance of this evidence is discussed later in these reasons.

1. The Partogram and the Strip

- [116] The partogram is a record of data, observations and actions completed by nurses caring for a labour patient. It is the nurse's responsibility to complete the partogram contemporaneous with events. One side of the partogram has charts and tables designed to record at specific times the baseline FHR, cervical dilation and station, details about contractions including frequency, strength and duration, any medications administered, details about urine analysis and information about the mother's blood pressure, pulse, temperature and respiration rate. On the other side of the partogram, nurses write a narrative of observations and actions.
- [117] The fetal monitoring strip was also entered into evidence. This is the strip of graph paper upon which information from the electronic fetal monitor is recorded (the "strip"). Monitoring of the FHR is done by an ultrasound transducer that is placed on the mother's abdomen with a belt and it provides a graphic display as well as an auditory output. Another monitor, the tocodynamometer (the "TOCO"), provides graphic information about the duration and frequency of uterine contractions, but it cannot measure the strength of those contractions. Information from both monitors is drawn on the strip by needles as the paper is fed through the machine at a rate of 2 cm (represented by two squares on the graph) per minute. The time is stamped on the strip at ten minute intervals, but there is also a sequential five digit number stamped every five minutes on the graph. In addition to the electronic record, nurses typically write down important events on the strip itself while it is

recording.

- [118] Because for the most part the information on the partogram was recorded contemporaneously, it is, in my view, reliable evidence of what happened and when it happened in relation to the events in question. Similarly, the nurses' notations on the strip are reliable.
- [119] The strip provides important data, although that data was subject to interpretation. In particular, experts disagreed on whether the FHR was reassuring at different points, and how the pattern of contractions should have been characterized. The accuracy of the data on the strip was dependent upon the correct placement of the monitors, and anything else that might have interfered with the ability of the TOCO or heart monitor to have picked up a signal. It was acknowledged that Ms. Brodeur's obesity may have impacted the accuracy of the TOCO recording. This means the accuracy of the electronic record on the strip may not be absolute, thus diminishing that evidence's reliability.

2. The Timeline

- [120] I have constructed the timeline below based on information from several sources. Entries that begin with a time contain only information which I have deciphered from the partogram, and is a word for word reproduction if in quotation marks. I have also drawn on data from the strip. The testimony of witnesses who attended to Ms. Brodeur, where helpful and relevant, is interspersed amongst these other facts. I also include comments based on my review of the documents.
- [121] Unless specifically identified, the events on the time line constitute my findings of fact about what happened:
- a) 18:30 - Ms. Brodeur was nauseated and vomiting. Medication ordered to treat.
 - b) 19:10 - Ms. Brodeur was sitting upright, uncomfortable with contractions and retching. There was difficulty picking up the FHR on the electronic monitor. She was receiving oxytocin at 9 mu/minute. Dr. Freedman and Dr. Mujaibel assessed Ms. Brodeur. Dr. Freedman did a vaginal exam but could not reach the cervix, meaning the fetus was still high in the pelvis.
 - c) 19:40 - The anesthetist, Dr. Kamani, arrived and prepared Ms. Brodeur for the epidural while she was sitting upright.
 - d) 20:00 - Contractions were 4-5 per 10 minutes, 45-60 seconds in length and of fair strength. This is the last notation on the chart portion of the partogram about the contractions. Subsequent references are drawn from the narrative on the reverse of the partogram.
 - e) 20:01 - Dr. Kamani administered an epidural to Ms. Brodeur without difficulty.
 - f) 20:15 - The baseline FHR was 145-150 bpm with decreased variability, and contractions were 4-5 every 10 minutes. Ms. Brodeur was comfortable and resting.

- g) 21:05 - Dr. Mujaibel did a vaginal exam. The cervix was dilated 1 cm and 2 cm long.
- h) There is uncertainty about whether Dr. Mujaibel authorized an increase in oxytocin at this point. The partogram has a note consistent with that: "continue [up arrow drawn] oxytocin". At her examination for discovery however Dr. Mujaibel stated she does not remember ordering an increase. Based on the fact she did not record making that order at that time, and the context of the questioning which assumed there was coupling of contractions at that point, her evidence became more firm that she would not have ordered an increase. But earlier in her evidence she confirmed she was not concerned about the contraction pattern at that point. The significance, if any, of this lack of clarity will be addressed later in this decision.
- i) 21:20 - (this is the first entry by Nurse Marsh) Nurse Marsh assessed the contractions as irregular and coupling. Oxytocin was increased to 11 mu/minute from 10 mu/minute. Ms. Brodeur was "slightly uncomfortable" and sensory levels indicated uneven effectiveness of the epidural.
- j) Nurse Marsh testified that because the cervix was only dilated to 1 cm, she concluded Ms. Brodeur was not in active labour. She regarded the FHR to be reassuring. She increased the oxytocin to encourage Ms. Brodeur into active labour. With regard to the incoordinate uterine activity and coupling of contractions, Nurse Marsh did not conclude that was an indication one way or another of a change in the strength of contractions - she simply could not say.
- k) 21:30 - Ms. Brodeur was more uncomfortable and having to breathe through contractions. Dr. Kamani attended again and was not concerned; he concluded the epidural was effective. He suggested the pain may be due to a distended bladder. He recommended emptying Ms. Brodeur's bladder. The baseline FHR was 150 bpm.
- l) 21:35 - A Foley catheter was inserted to drain the bladder.
- m) 21:45 - Ms. Brodeur complained of "constant left lower uterine pain" and she was "wretching [sic] from pain".
- n) The partogram records that the FHR had variable decelerations to 120 with recovery to 140 or 150 bpm but there is a dispute which I address later about the correct characterization of the FHR at this point.
- o) In response to the vomiting, Nurse Marsh lowered the head of the bed. She wanted to position Ms. Brodeur into the recovery position (lying on her left side). Because she viewed the FHR as reassuring at this point, she did not believe she needed to act urgently on the report of pain. She testified once she had the vomiting managed she would have informed the doctor of the pain.

- p) Under cross-examination, Nurse Marsh did not agree that the FHR between 21:45 and 21:54 represented a non-reassuring heart beat because even if the strip does not record the FHR, there is an audible component to the monitor and she could hear the rate and considered it reassuring until 21:54 when she called for help.
- q) 21:54 - the FHR was 60 bpm and help was called.
- r) Nurse Marsh auscultated the FHR at 60 bpm and called for the charge nurse and Dr. Freedman. She knew this was an emergency and activated the call bell. She was unsure if she knew in 1999 whether the resident could call a caesarean section but she relied on the doctor to understand what to do.
- s) 21:56 (this note was written by Nurse Marsh on September 25, 1999) - oxytocin was shut off and Dr. Freedman and Nurse Speets were in the room to help.
- t) A notation on the strip by Nurse Speets shows the oxytocin was shut off just after 21:57.
- u) Nurse Marsh told Dr. Freedman that the FHR was 60 bpm and about the new, continuous pain and the vomiting. She recalled showing Dr. Freedman the strip at numerical marker 08260 (just before 21:56). According to Nurse Marsh, Dr. Freedman replied that it would not have been possible to detect FHR of 60 bpm because of the patient's obesity. Nurse Marsh testified she felt Dr. Freedman did not believe her.
- v) Nurse Marsh was very upset that Dr. Freedman insisted on doing her own assessment of the FHR because Nurse Marsh felt the situation was urgent.
- w) 21:58 (this note was written by Nurse Marsh on September 25, 1999) - the fetal monitor shut off as Dr. Freedman was checking FHR with ultrasound. The timing of these events is disputed as discussed below.
- x) Notations on the strip suggest Dr. Freedman performed a vaginal exam at 22:01, and an ultrasound at 22:06. Ms. Brodeur was moved to the operating room at 22:08.
- y) Nurse Marsh wrote on the strip that an ultrasound check was being done and the fetal monitoring shutoff but no time is written beside either note. Instead, there is an arrow pointing to the left (implying earlier in time). That is followed (in order from left to right) by the following notes: "VE 2201" "ultrasound 2206" and "OR 2208". There is another, larger arrow beside "VE 2201" that points as far back as about 21:57:30 (the big arrow). I discuss that arrow later in these reasons. The interpretation of these notes on the timing of events is disputed and discussed later in this decision.
- z) Turning off the electronic monitoring resulted in the section of the strip between 21:50 and 22:00, which under normal circumstances would represent a 10 minute period, represented 14 minutes.

aa) At some point after 21:58 and before 22:06, Dr. Freedman called and spoke on the phone with Dr. Mujaibel. Dr. Freedman said she could not find the FHR. Dr. Mujaibel started hyperventilating and told Dr. Freedman that it was most likely uterine rupture. She ran to Ms. Brodeur's room.

bb) Dr. Mujaibel was in the room by 20:06 but no one has a clear recollection of the exact time she arrived. Dr. Mujaibel "really ran" to get there. It was "definitely" obvious to her when she walked into Ms. Brodeur's room that they were dealing with a uterine rupture. She did not even look at the chart; she looked at Ms. Brodeur and made the decision to perform the caesarean section on the basis of the constant pain Ms. Brodeur was in. Dr. Mujaibel was aware that Ms. Brodeur had an epidural which would not mask pain from a ruptured uterus. She quickly did a vaginal examination which confirmed her diagnosis.

cc) According to Dr. Mujaibel, Dr. Freedman was doing an ultrasound when she arrived. This timing in relation to other events is disputed.

3. Did Dr. Freedman perform the vaginal exam before or after the first ultrasound?

[122] The plaintiffs submit I should find that Dr. Freedman conducted the vaginal exam before she did the first ultrasound exam, but she waited until that first ultrasound was done before calling Dr. Mujaibel. The plaintiffs say I should find the fact that the big arrow next to the "VE 2201" notation points back on the strip to a place before the words "ultra sound check", is an indication that the vaginal exam was done before the ultrasound (see subparagraph "y" above).

[123] The complicating factor is the period of time (about four minutes) when the electronic monitoring was turned off. It is plausible that Nurse Marsh's arrow is misleading and she simply did not notice the end point of the arrow landed before the first notation of the ultrasound. This is logical because if one counts forward from 21:50, the "VE 2201" note is at the right time had the strip been continuously running. It is possible that when she wrote "ultrasound 22:06", she noticed the fact that events that occurred at 22:01 and 22:06 were too close together on the strip. She drew the arrow, estimating as best she could where 22:01 might be on the strip, not realizing it landed before the ultrasound note. I also take into account that by this point, Nurse Marsh felt Dr. Freedman had not believed her that Ms. Brodeur was in an emergency situation. The stress and tension in the room would have been high. In my view, these are logical, reasonable and common sense explanations that were possible.

[124] The only testimony that supported the plaintiffs' theory was Nurse Marsh's honest, but equivocal statement when confronted with the arrow in cross examination, that she "guess[ed] by my arrow, yes, [the vaginal exam] might have been done just before the ultrasound check." I do not find that sufficient to outweigh all the other evidence that suggests the vaginal exam was done after the first ultrasound exam (as noted in the timeline above, among other places). Therefore, I find that Dr. Freedman performed the first ultrasound exam before the vaginal exam.

C. Expert Evidence about The Standard Of Care for Nursing Care

[125] Chris Rokosh is a registered nurse in Alberta who provided opinion evidence on behalf of the plaintiffs. She provided a report dated June 19, 2015 and an addendum dated July 30, 2015 that responded to Ms. King's and Dr. Farquharson's reports. Ms. Rokosh's opinions focussed on nursing care between 21:20 and 22:08. She concluded Nurse Marsh's conduct did not meet the standard of care in the following ways:

- a) Nurse Marsh felt the situation was unsafe because she believed Ms. Brodeur had too many risks and was not being adequately monitored. Nurse Marsh should have contacted the attending physician to report on the unsafe situation, or refused to provide care until the situation was improved.
- b) At 21:20, Nurse Marsh increased the rate of oxytocin to 11mu/min which heightened the existing risk to Ms. Brodeur and the fetus. Nurse Marsh should have decreased or discontinued oxytocin, provided resuscitative measures and requested a physician assess the situation.
- c) At 21:30, Ms. Rokosh said the contraction pattern changed from coupling to minimal uterine activity and Ms. Brodeur was complaining of increased pain. Ms. Rokosh was asked to assume two things about that uterine pattern: (i) Nurse Marsh was not aware that a decrease in uterine contractions is consistent with potential uterine rupture; and (ii) Nurse Marsh concluded the change in uterine activity represented a problem with the fetal tracing. Ms. Rokosh said that lack of knowledge about the relationship between decreased uterine activity and uterine rupture fell below the standard of care. She also concluded that Nurse Marsh should have treated the change in uterine contraction more seriously by discontinuing the oxytocin until she was assured there was reliable fetal monitoring, which may have also required other interventions.
- d) Once Dr. Kamani reported the epidural was effective and the bladder had been drained, Nurse Marsh ought to have recognized the constant pain Ms. Brodeur reported at 21:45 was a sign of possible uterine rupture. She should have stopped oxytocin, taken resuscitative measures and asked for the obstetrician to attend immediately.
- e) Nurse Marsh should not have taken the time to deal with the vomiting at 21:45 without first, or simultaneously, seeking assistance by pressing the call bell. She also criticized Nurse Marsh for the measures she took to deal with the vomiting, but I agree with the defendants that her conclusion was based on a misapprehension about the position of the bed at the time; I therefore disregard her opinion on that point.

[126] Angela King is a registered nurse in Ontario who testified on behalf of Nurse Marsh. She provided a report dated June 14, 2015. Ms. King concluded that Nurse Marsh's actions met the applicable standards in the following manner:

- a) The administration of oxytocin was according to physician orders and vital signs were monitored.
- b) Because "Ms. [Brodeur] was monitored continuously with the electronic fetal monitor", that was documented every 15 minutes and those actions were in compliance with hospital policy, the Guideline and physician orders.
- c) Uterine contractions were adequately monitored by assessing (and presumably recording, although she did not specifically mention that) the frequency, duration and intensity of the contractions.
- d) At 21:45, Ms. Brodeur's pain and vomiting were appropriately managed by her being positioned to left lateral.
- e) When Nurse Marsh assessed the FHR at 60 bpm at 21:54, she called Dr. Freedman and the charge nurse, which was in compliance with hospital policies.

[127] Nurse Marsh submitted that Ms. King's current clinical experience made her evidence more reliable than Ms. Rokosh, who has not been involved in clinical practice for many years. I do not find that to be as significant a factor relating to the reliability of their evidence as proposed by Nurse Marsh. Both nurses presented evidence and analysis about the nursing standards that were applicable in 1999, a point in time when they were both involved in clinical practice.

[128] Moreover, it could be said that daily contact with clinicians unconsciously influences an expert to more easily justify dubitable clinical behaviour, whereas someone removed from the practice may have a more objective viewpoint. In any event, I find neither maxim applies in this case. In my view, both nurses were qualified to give the opinions they did.

[129] However, I agree with Nurse Marsh that Ms. Rokosh's report contains an error that does diminish the weight I can place on some of her opinions. Ms. Rokosh was asked to assume Nurse Marsh did not trust the information obtained by the electronic fetal monitoring with regard to the contraction pattern at 21:30. In Ms. Rokosh's opinion, the uterine activity was minimal at that point. Ms. Rokosh said in view of Nurse Marsh's suspicion, she should have discontinued oxytocin until more reliable monitoring could be established. Ms. Rokosh suggested Nurse Marsh should have requested the insertion of an intrauterine pressure catheter (IUPC).

[130] But Ms. King pointed out that such intervention was not possible at 21:30 because Ms. Brodeur's cervix was only dilated at 1 cm and her membranes had not ruptured. Rather than admit the error, in her rebuttal report Ms. Rokosh commented that the request for an IUPC ought to have been made before induction. This placed blame on Nurse Marsh for a decision not only beyond her authority, but well outside the short period of time she was caring for the patient. I find this reduces the weight I place on some of Ms. Rokosh's opinions.

- [131] I have another concern with Ms. Rokosh's report. Ms. Rokosh identified several occasions when, in her opinion, Nurse Marsh ought to have discontinued the current treatment and sought assistance from the physician. The only time Ms. Rokosh does not fault Nurse Marsh is when she called Dr. Kamani and Dr. Freedman.
- [132] I find the tenor of her opinions and her report is akin to asking Nurse Marsh to exercise little nursing skill or judgment and, in effect, delegate the care of her patient to the physicians. In my view, her report relied too heavily on detailed scrutiny of individual decisions that amounted to almost a search for error instead of a contextual examination of Nurse Marsh's care for Ms. Brodeur during the relevant time period. For those reasons, I approach her evidence with caution.
- [133] But I also have concerns about Ms. King's report. The structure of Ms. King's report is to identify discrete policies and comment on whether Nurse Marsh's actions fell within parameters identified. Obviously those policies and guidelines are relevant to the standard of care, but they are not determinative: *Ediger v. Johnston* at para. 59; *Downey v. St. Paul's Hospital*, 2007 BCSC 478 at para. 88. I find her lack of analysis troubling.
- [134] Ms. King opined that the standard of care for induced labour required the continuous electronic fetal monitoring of contractions was to be documented every 15 minutes. Ms. King concluded the standard of care was met, in large part, because the monitoring and documentation were done. She failed to point out, however, that there was no documentation of Ms. Brodeur's contractions on the partogram after 21:00. This oversight and lack of explanation is concerning.
- [135] I found Ms. King's opinion about Nurse Marsh's response to Ms. Brodeur's reports of pain to be unhelpful. She simply noted that Ms. Brodeur's "discomforts of labour were managed in accordance with the standard of care and as per [hospital policy] and physician orders." But the allegation of negligence is not about the management of Ms. Brodeur's pain. The allegation is that medical staff failed to recognize it as a symptom of uterine rupture.
- [136] Ms. King concluded the standard of care was met because Nurse Marsh appropriately called the physician once the FHR was 60 bpm at 21:54. Her report lacks an analysis of whether the constellation of facts that Nurse Marsh faced required her to suspect uterine rupture, or at least seek physician help earlier than 21:54. Given all these factors, Ms. King's opinions are of minimal assistance to the issues I must decide.
- [137] Dr. Doersam also provided an opinion about Nurse Marsh's actions. One of his reports, dated June 5, 2015, addressed Nurse Marsh's actions during Tianna's delivery. Dr. Doersam concluded Nurse Marsh did not meet the standard of care in several respects, the most relevant of which are summarized below:

- a) He was asked to assume that Nurse Marsh concluded there were inadequate monitoring parameters in place for Ms. Brodeur and she felt she could not safely provide care. In his view, by failing to call for additional help as soon as she began caring for Ms. Brodeur, she failed to meet the standard of care.
- b) Once the anesthetist pronounced the epidural to be effective and the bladder was empty, the escalation in Ms. Brodeur's pain was a "hallmark symptom of uterine rupture". The change in pain at 21:45 combined with the characteristics of the FHR created an urgent situation and Nurse Marsh ought to have taken action on an assumption of a possible uterine rupture.
- c) Nurse Marsh should have manually palpated for contractions. She either did not do so, or failed to record that she did; both were deficient in Dr. Doersam's view. She should not have attempted to reposition an obese patient on her own when she already had evidence that something was seriously amiss.
- d) Nurse Marsh should have called a more senior physician rather than Dr. Freedman.
- e) At four points during Dr. Freedman's assessment, Nurse Marsh should have initiated a stat call to the supervising physician: (1) at Dr. Freedman's initial failure to accept Nurse Marsh's assessment that the FHR was 60 bpm; (2) at Dr. Freedman's request to bring in the ultrasound machine; (3) when Dr. Freedman failed to locate the FHR upon the first ultrasound exam; and (4) when Dr. Freedman started to conduct a second ultrasound.

[138] Nurse Marsh pointed out that Ms. Rokosh's opinion differed from Dr. Doersam's on certain facts, including whether the FHR was reassuring and what the character of contractions was at different points of time. She submits because of this discrepancy the plaintiffs' own evidence falls short of establishing on a balance of probabilities that Nurse Marsh failed to meet the standard of care based on the "two schools of thought" doctrine.

[139] In *Fairley v. Waterman et al.*, 2002 BCSC 10, Justice Wong describes this doctrine by noting (at para. 42) that the "law is clear that an error in clinical judgment cannot be seen as negligence when there are two separate schools of thought." He continues by stating that "adherence to one of those schools is not negligence, even if, in retrospect, adherence to that school of thought is erroneous." This principle is drawn from *Maynard v. West Midlands Regional Health Authority*, as quoted by Seaton J.A. in *Belknap v. Meakes* at 220. In *Maynard* at 639, Lord Scarman stated that "in the realm of diagnosis and treatment, negligence is not established by preferring one respectable body of professional opinion to another." The gravamen of these principles is that the exercise of clinical judgment is based on a number of factors and reasonable practitioners acting reasonably may exercise their clinical judgment differently.

[140] The interpretation of data on the strip and how to respond to it does implicate clinical judgment. I do not agree, however, that the differences between Ms. Rokosh and Dr. Doersam rise to the level of different "schools of thought". It is more accurate to say they disagreed on facts. I address the implications of these differences later in these reasons.

[141] Nurse Marsh and the doctor defendants also submit I should not rely on Dr. Doersam's evidence about nursing care because he is "far removed from nursing". He no longer has exposure to obstetric nursing staff or obstetric practice on a daily basis. They also point out he has not been a practicing obstetrician since 2008. Dr. Doersam was engaged in obstetrical practice at the relevant time for the events in this case. In my view, these points go more towards his qualification to offer an opinion, which was not challenged. I do not discount his reliability on this basis.

[142] However, I do consider the fact that Dr. Doersam lacks certification in maternal-fetal medicine to be relevant to the weight I place on his opinion. A subspecialty in maternal-fetal medicine requires two years training in addition to the four years of obstetrics and gynecology training. It primarily deals with high-risk pregnancy and overlaps into areas of genetics, prenatal diagnosis, ultrasound, fetal treatment and adverse maternal conditions. I also note a significant amount of his clinical experience was outside of Canada, a point that he referred to when discussing the history of the medical profession's attitude towards VBAC deliveries. For those reasons, I conclude that his opinions must be approached with some caution.

[143] I qualified Dr. Farquharson as an expert to give opinion evidence in obstetrics and maternal-fetal medicine. He has over 30 years of practice in obstetrics and gynecology and he provided evidence on behalf of all defendants. He prepared a report dated June 24, 2015 which addressed the standard of prenatal and intrapartum care received by Ms. Brodeur.

[144] Dr. Farquharson's opinion with respect to nursing care is wholly contained in the following paragraph:

The very first warning of any difficulties began at 21:45 with the onset of pain and vomiting. Nursing action at that time was appropriate. The patient was turned to her left side so as not to aspirate and at 21:54 when the fetal heart rate was discovered to be bradycardic at 60 beats per minute call for help went out which was answered promptly by both Dr. Freedman and Dr. Mujaibel. By the time of Dr. Mujaibel's arrival the persistent bradycardia made the likely diagnosis of uterine rupture and called for urgent caesarean section to take place which was subsequently handled in as rapid a fashion as possible given the difficult circumstances. Literature reviews of the subject often refer to abnormalities in fetal heart rate in association with persistent pain over the lower uterine segment where the old scar was to be the most consistent patterns of presentation

[145] The defendants claim Dr. Farquharson's opinion was never challenged on cross-examination. They say only broad general propositions were put to him but those were not linked back to the facts in this case and his conclusion that the nursing and medical staff met the standard of care was "not touched". I do not agree that is an accurate description of the cross-examination.

- [146] I have concerns about Dr. Farquharson's expert report. Despite his eminent qualifications, the opinions in his report are primarily conclusions that are not accompanied by thorough or helpful analysis. The portion of Dr. Farquharson's report devoted to his opinion on the standard of prenatal and intrapartum care is two and a half pages long, but about a page and a half of that is a recitation of the history of Ms. Brodeur's prenatal condition and the events on September 21, 1999. Accordingly, over half of the "opinion" section in his report is not opinion at all but a reiteration of events.
- [147] It may be his conclusions are sound, but his explanations are cursory. Relying heavily on his report would amount to Dr. Farquharson usurping the role of the court. An expert's role is to assist the court, not overtake the fact-finding function.
- [148] More importantly, Dr. Farquharson's opinion was in two places based on facts not in evidence. During cross-examination, Dr. Farquharson was asked about the significance of Ms. Brodeur's report of pain at 21:45. He seemed to attach little or no significance to the difference between the description of pain at 21:30 ("more uncomfortable through contractions having to breathe through") and 21:45 ("[patient] complaining of constant left lower uterine pain; [patient] retching from pain") [emphasis added]. Not only was the character of the pain different, so was its intensity. Nurse Marsh agreed that she recognized the pain at 21:45 to be "new". In my view, he minimized the significance of the pain report based on an erroneous assumption that the pain was not new and apparently attributing the pain to a "patchy epidural". Because his opinion was based on an assumption not in the evidence, I do not rely on his opinion about Nurse Marsh's reaction to the report of pain at 21:45.
- [149] Dr. Farquharson also proceeded on a misunderstanding of the facts about the FHR. Dr. Farquharson said he assumed Nurse Marsh called for help at 21:54 because "she had heard a deceleration prior to that and then lost the fetal heart." He also noted that there were gaps in the FHR. Within those parameters, the "lost FHR" to him was most likely not due to a true "lost" FHR but difficulty in recording it because of Ms. Brodeur's obesity.
- [150] Nurse Marsh was clear that she called for help because she auscultated the FHR at 60 bpm, not because she "lost" the FHR. I accept her testimony. Dr. Farquharson's opinion about the response to the drop in the FHR at 21:54 is not reliable because it is not based on the facts of this case and I disregard it.
- [151] Lastly, I found Dr. Farquharson's evidence on one point was inconsistent. Dr. Farquharson testified that a drop to 60 bpm was not a bradycardia unless it lasted for ten minutes; it should have been seen only as a deceleration. This conflicts with his report where he opined that at 21:54 "the fetal heart rate was discovered to be bradycardic at 60 beats per minute" [emphasis added]. He also writes Dr. Freedman's second ultrasound "confirmed the [FHR] persisting in a bradycardia at 60 beats per minute" [emphasis added]. This inconsistency reduces the reliability of his opinion.

[152] In my view, the declaratory nature of Dr. Farquharson's opinions combined with the dissonance between his assumptions and the facts diminish to a very significant degree, the weight I place on his evidence.

D. Expert Evidence about The Standard Of Care For Physician Care

[153] Both Dr. Doersam and Dr. Farquharson provided opinion evidence regarding Dr. Freedman's actions. My concerns regarding Dr. Farquharson's report regarding Nurse Marsh's actions apply equally to his opinions about Dr. Freedman. Dr. Farquharson concluded that when the FHR was discovered to be 60 bpm, the call for help went out and Dr. Mujaibel's diagnosis of likely uterine rupture was in "as rapid a fashion as possible given the difficult circumstances." He also commented that the "[i]ntrapartum care ... appeared entirely appropriate and well documented." These are declaratory opinions. He failed to comment on whether Dr. Freedman ought to have attempted two ultrasound exams to find the FHR notwithstanding Nurse Marsh auscultated the rate to be 60 bpm. His opinion is of little assistance to me for these reasons.

[154] Dr. Doersam's opinion about Dr. Freedman is encapsulated in the penultimate paragraph of his June 5, 2015 report:

In summary, Dr. Freedman was presented with a patient known to be at elevated risk of uterine rupture during a VBAC labour, whose clinical condition had deteriorated abruptly, whose fetal status had deteriorated sharply and whose fetus was no longer located where it had been. Dr. Freedman chose to consume immeasurably valuable minutes in laboriously proving a bradycardia that was already known and was consistent with other obvious maternal and fetal signs of uterine rupture. In doing so, she delayed taking any useful action in a desperate emergency situation for which the only solution was a stat Caesarean section.

[155] I note that when Dr. Freedman entered Ms. Brodeur's room, there was no indication Dr. Freedman could have relied upon to indicate that the fetus was no longer located where it had been. That only became clear when Dr. Freedman conducted the vaginal exam.

[156] Dr. Doersam's opinion depends upon his theory that "no condition in clinical obstetrics mimics the signs and symptoms of uterine rupture." For him, this meant that every VBAC patient must be viewed with a "high index of suspicion of uterine scar separation" and that response is required at the "first sign consistent with scar separation." In his opinion, medical personnel needed to act within the time frame required to extract the fetus unharmed with the appearance of any of the following clinical features of uterine rupture: alteration of the FHR, new maternal abdominal pain, especially non-periodic pain, and change in either the location of the FHR or the fetal presenting part.

[157] Dr. Doersam then identified four ways in which he concluded Dr. Freedman failed to meet the standard of care:

- a) Dr. Freedman should have immediately recognized when she walked into the room that "Ms. [Brodeur's] pain .. was altered in both pattern and severity" meaning there was a "the high probability" of uterine rupture. If Dr. Freedman did not realize that the patient's constant pain was a "red flag" for uterine rupture, then the state of her knowledge fell below standard of care.
 - b) Once advised of bradycardia in a labouring VBAC patient, any reasonably competent physician would "recognize that uterine rupture was the probable cause" and would notify the physician responsible.
 - c) Dr. Freedman's insistence on attempting to confirm Nurse Marsh's report of bradycardia from 21:56 to 22:06 was an inappropriate delay; she should have immediately called Dr. Mujaibel or Dr. Galerneau. In his testimony, however, he qualified this opinion by saying he does not fault her for performing the ultrasound, but said that ought to have occurred after the call for help, or at least at the same time.
 - d) Lastly, with regard to each of the above scenarios, Dr. Freedman ought to have immediately started the process for transferring Ms. Brodeur to the operating room.
- [158] Dr. Oppenheimer also provided expert evidence with regard to Dr. Freedman's actions. He prepared two reports: one, dated November 24, 2014, contained his opinion about Dr. Freedman's actions; the second is dated July 28, 2015 and is a rebuttal report to Dr. Doersam's report.
- [159] Dr. Oppenheimer concluded that Dr. Freedman should not be faulted for failing to recognize signs of a possible uterine rupture before she called Dr. Mujaibel. The following four premises underlie his conclusion:
- a) He opined that the change in variability of the fetal heart rate was not significant "compared to the prior tracing, and the variable decelerations seen prior to the loss of recording [were] not concerning for a patient in labour and have a rapid recovery";
 - b) When Dr. Freedman arrived in the room, the FHR tracing was "no longer reliably recording";
 - c) The diagnosis of persistent FHR bradycardia, both by the FHR transducer and with the ultrasound machine, was more challenging because of Ms. Brodeur's obesity;
 - d) In his view, "[e]ven in a VBAC patient, while uterine rupture must be considered, these other causes [to bradycardia] are . . . more frequent and are usually amenable to interventions" that would not require a stat caesarean section. The other causes he referenced are belt misplacement, descent of the fetus from rapid progress of labour, and sudden onset of prolonged bradycardia from uterine hyper stimulation or cord compression.

- [160] Based on his description of other more likely causes, Dr. Oppenheimer concluded that expecting Dr. Freedman to have suspected uterine rupture based on a "phone call" (presumably Nurse Marsh's call for help at 21:54) was unreasonable. In his view, "training staff to institute immediate action in the face of potential warning signs of rupture was not the standard of care in 1999."
- [161] Dr. Oppenheimer also concluded that it was reasonable for Dr. Freedman to utilize the ultrasound to verify Nurse Marsh's report of FHR at 60 bpm for three reasons: (i) Ms. Brodeur was obese making signal detection difficult; (ii) her position had recently been changed because of her vomiting; and (iii) "uterine rupture was the least likely cause of the loss of signal in labour." However, Dr. Oppenheimer added this qualification: "[h]ad the fetal bradycardia been clearly recorded, confirmation [by Dr. Freedman] would not have been necessary."

E. Did the standard of care require a "Worst First" approach?

- [162] The most fundamental difference between the parties' expert evidence and their positions in this case is the proper medical approach to possible signs of uterine rupture. The plaintiffs say medical care must be delivered on the basis of "the worst first" assumption. They say to maximize patient safety, medical staff must first rule out the most dangerous complications before accepting a benign explanation for any symptoms observed. They say this is particularly important in high risk VBAC patients because the window of time for intervention to avoid catastrophe is so small.
- [163] It is not appropriate for me to make a finding -- in general -- about the wisdom of a diagnostic approach. But the evidence and case law about this approach is relevant to my determination about standard of care. Ultimately, I must determine with specific reference to the facts in evidence, what the standard of care required of Dr. Freedman and Nurse Marsh in 1999 with regard to Ms. Brodeur's care.
- [164] In terms of the expert evidence on "worst first", Dr. Doersam agreed with this maxim. He testified that doctors should assume the worst outcome and act without hesitation to the point where it is ruled out or appropriately treated. He would say a doctor is not obliged to "prove uterine rupture" before responding on the assumption that is what is happening.
- [165] Dr. Farquharson was outspoken in his criticism of the worst first principle. He stated "worst first seems terribly flawed to me." He testified that most physicians work on the basis of probable causes. In his view, the very rare possibility of uterine rupture had to be weighed against unnecessarily operating on a patient because surgery also brings risks. This was explained in the following exchange from his cross-examination (T, Day 11, p. 15, l. 25-42) :

Q: You agree with me that if it is -- if this -- if the drop in the fetal heart rate was the first sign -- let's assume it was -- the first sign of a uterine rupture, then you have a very narrow window within which to deal with the problem or the baby is going to be brain damaged or the baby is going to die, and the mother may very well die at the same time; right?

A: To answer that question properly would require review of the fetal heart records. When I carefully reviewed these records there were several variable decelerations noted well in advance of this patient's eventual problem, so that functionally, if I would have raced her to the operating room on the basis of seeing variable decelerations, I would have been inappropriately operating on a patient whose attendant risks of surgery were huge.

[166] I explain earlier in this decision why I do not rely on some of Dr. Farquharson's opinions in his report. I also place little weight to his testimony on this issue.

[167] The plaintiffs say adhering to the "worst first" doctrine does not result in a reckless rush to surgery as described above by Dr. Farquharson because there is always a "pause" in the operating room. The evidence was that a pause is when the surgeon steps back to re-evaluate the situation to ensure the surgery is necessary, while the preparations for surgery continue. The plaintiffs also point out that in this case, the surgery proceeded in the absence of a firm "diagnosis" of uterine rupture. Dr. Farquharson disagreed. He said there can be no "diagnosis" of uterine rupture until the surgery is underway. Although this could be seen merely as a quarrel over semantics, it aptly demonstrates how important it is to be precise about the evidence. In my view Dr. Farquharson has exaggerated the implications of "worst first" in a way not consistent with the plaintiffs' theory, or the other evidence. On that basis, I find Dr. Doersam's opinion to be more helpful than Dr. Farquharson's.

[168] There was other evidence pertinent to the "worst first" theory. In her testimony, Nurse Marsh explicitly disagreed with the worst first principle because in her mind, a non-reassuring FHR was a necessary symptom of uterine rupture; without it, there was no cause to suspect uterine rupture. Thus, even though she recognized the contraction pattern as incoordinate and the pain at 21:45 as "new", because she assessed the FHR as reassuring, she did not think the situation was urgent. This focus on a single symptom of possible uterine rupture is inconsistent with the Guideline and the Memo. Therefore, her rejection of "worst first" is unpersuasive.

[169] Both Nurse Marsh and Dr. Freedman were aware that Ms. Brodeur's labour was high risk for a number of additional reasons unrelated to the risk of uterine rupture. They also testified that Ms. Brodeur's obesity made assessing the FHR and contractions more challenging. Careful and constant monitoring were explicitly required in the Guideline. The evidence is clear that fetal monitoring was compromised at the time of Ms. Brodeur's "new" pain. Regardless of whether the report of pain itself signalled a possible emergency, the combination of factors heightened the degree of caution the staff ought to have used in assessing her condition. I find that required a response from the medical team that did not occur. In that way, it is not determinative to the issues I have to decide whether the medical team accepted the "worst first" approach.

- [170] Nevertheless, there is case law that is consistent with the plaintiffs' position. In *Paniccia Estate v. Toal*, 2011 ABQB 326, the court held that "[c]hoosing a diagnostic process based on probability rather than severity is fundamentally flawed and negligent": at para. 40. The court continues: "[f]ailing to consider the worst first principle and then failing to carry out appropriate tests to confirm or eliminate the worst of the potential diagnoses is not a mere error of judgment but, rather, a breach in the standard of care."
- [171] That case did not involve the type of urgently emerging crisis as in the facts before me. The deceased's stomach cancer was misdiagnosed as gastritis for over one and a half years, and by the time the appropriate diagnosis was made, it was too late for adequate treatment. Justice Shelley found (at para. 106) that the standard of care had been breached when the treating physician concluded there was no possibility of cancer, despite a radiologist's report to the contrary, and when he failed to advise the deceased of the possibility of cancer, and, in fact, misinformed the deceased, despite specifically being asked whether cancer was a possibility.
- [172] But in *Guerineau v. Seger*, Justice Boyd adopts the same approach in a case with the identical clinical condition before me: a woman attempting VBAC who suffered a uterine rupture. The child in that case was born in 1998, so the state of medical knowledge would have been the same. While the defendants correctly point out the particular facts in that case are different, the issues for the court were the same. The plaintiffs in that case alleged "the nursing staff ought to have recognized either that the mother was demonstrating the signs of a potential uterine rupture or, at the least, ought to have recognized that something unusual was occurring and thus contact [the doctor or obstetrician]" (at para. 3).
- [173] Justice Boyd concludes negligent conduct continued throughout a time period of almost two hours. One finding central to her conclusion of negligence is the nurses' misinterpretation of the fetal heart strip. The nurses argued this was a matter of differing clinical judgment and not indicative of negligence. Justice Boyd disagreed, noting at para. 84:

While it may be that various nurses would have differing interpretations of the strip and might have attributed the decreased variability and poor pick-up to the earlier narcotics administered and the mother's restlessness and distress - it behooved [the nurse] to follow up the matter and pursue continued fetal monitoring in an effort to obtain clear reassuring evidence of the fetus' wellbeing, thus ruling out any danger to the mother and baby. In effect both nurses short-circuited the process of differential diagnosis, immediately accepting the simplest explanation of the decreased variability (i.e. narcotics) without clearly ruling out the perhaps less likely, but much more dangerous possibility of uterine rupture. I find that the nurses' failure to pursue this matter and their discontinuance of the fetal monitoring amounts to negligence.

- [174] The defendants seek to distinguish this case because of the factual differences: the medical staff did not respond to the complaint of unusual pain for 40 minutes, a nurse failed to recognize the FHR as non-reassuring, and a nurse erroneously called the family physician for consultation rather than an obstetrician.

- [175] I do not agree the case can be easily distinguished. Justice Boyd's description of what the nurses ought to have done is not based on those factual differences. She notes that at the onset of unusual pain, one of the nurses admitted the strip reflected reduced variability, but that nurse discounted the changes in FHR by assuming it was a side-effect of pain medication. The pain itself was also assumed to have been caused by the administration of the prostaglandin gel. In other words, the nurses assigned benign causes to what the trial judge found to be a symptom that ought to have signaled them to call for assistance (unusual pain).
- [176] In *Strachan v. Reynolds et al.*, 2004 BCSC 915, Justice Hood also faced a claim in negligence for VBAC delivery in 1999 that resulted in caesarean section because of uterine rupture. He agreed with the plaintiffs' position that unusual abdominal pain, particularly occurring between contractions, "must be taken as a sign of womb separation unless and until the physician is able to exclude a developing uterine rupture as the cause of the pain" (at para. 466).
- [177] Justice Hood addresses the significance of fetal heart strips. It was acknowledged that the experts did not necessarily differ to a great degree on the interpretation of the strips. The question was whether the strips should be viewed independently, or in the context of "a VBAC patient experiencing severe constant abdominal pain" (at para. 473). Justice Hood preferred the second, contextual approach advocated by the plaintiffs' experts.
- [178] He further noted that the location of the pain is irrelevant; it is the constancy of abdominal pain that must be taken as a sign of womb separation until the physician is able to exclude it (at para. 466). He agreed with the plaintiffs' expert that once the nurse became concerned about the complaint of constant pain, a medical emergency arose (para. 494). Justice Hood specifically commented on the approach advocated in this case by Drs. Oppenheimer and Farquharson at para. 540:

This appears to be another distinguishing feature of the position taken by the defence experts to the effect that there are a number of benign causes of abdominal pain, and they should be considered when the patient is medically assessed. Again, it ignores the time element. The fact that there are many causes for abdominal pain in pregnancy, should bring no comfort to the defence. That patient was a VBAC patient. The patient was experiencing constant abdominal pain for over 40 minutes. Constant abdominal pain is a known sign of uterine rupture. The circumstances required Dr. Reynolds to deal with the situation immediately by bringing in a specialist, an obstetrician. It would be pointless, and very dangerous, to start considering benign causes. The causes are irrelevant unless in the short timeframe available for any kind of medical assessment, it is found that one of the benign causes is in fact the cause, thus excluding developing uterine rupture as the cause.

- [179] Unusual abdominal pain was also identified as a sign that may signal uterine rupture or dehiscence in *Strachan* (at para. 466).

[180] Nurse Marsh submits a better case for guidance is *Tekano (Guardian ad litem of) v. Lions Gate Hospital*. In that case, the plaintiff presented at the hospital in the early stages of labour and the nurse's review of her prenatal record described a normal pregnancy. The trial judge dismissed the claims, finding that earlier signs were not predictive of prolonged bradycardia, and that to expect otherwise would have amounted to creating a standard of perfection (at paras. 112-13). Justice Macauley summarized his findings at para. 103:

Although [the baby] was small for his age at the time of his birth, nothing occurred during the pregnancy that ought to have alerted Dr. Clark to anticipate anything other than a normal vaginal delivery. After Mrs. Tekano went into early labour, and while she was being assessed and monitored at the hospital, the FHR decelerated on several occasions and did not consistently recover to baseline with good variability in spite of appropriate nursing interventions. When it was apparent that nursing interventions were not resolving the difficulties, Nurse Burniston called Dr. Clark and communicated the seriousness of the situation adequately. Dr. Clark then responded appropriately by going immediately to the hospital and assessing the patient. She then arranged an obstetrical consultation and placed an operating room on standby for a likely caesarean section. There was no need for an urgent, or stat caesarean section, until the unpredictable deep and continuing bradycardia at 2306 hours.

[181] That case is distinguishable on its facts. Unlike Ms. Tekano, Ms. Brodeur was a high risk patient attempting VBAC, which all experts in this case agreed required vigilant monitoring. Ms. Tekano was not identified as a high risk patient in her prenatal care, and did not demonstrate any high risk factors when she attended at the hospital. Whether a patient is high risk has a direct impact on the standard of care, especially with regard to monitoring and vigilance for potential signs of urgent situations.

[182] The clinical conditions in *Strachan* and *Guerineau* were very similar to the facts in this case, and in both those cases, the trial judge found the standard of care for the medical staff was to respond to the unusual pain as a symptom of uterine rupture unless it could be ruled out.

[183] Because the applicable standard of care is a question of fact, none of these cases are binding on me, but the similarity in the clinical situations means I cannot ignore them either. In my view, they provide relevant and helpful guidance on what was the norm in medical practice for VBAC patients in 1999. However, I must conduct my analysis based on the evidence in this case. It is against that backdrop that I assess whether the defendants were negligent.

VI. DID NURSE MARSH MEET THE STANDARD OF CARE?

[184] I analyze this issue in the categories addressed by the experts.

A. Response to Report of Pain

- [185] Both Dr. Doersam and Ms. Rokosh were of the opinion that once Dr. Kamani reported the epidural was effective and the bladder was drained, Nurse Marsh ought to have viewed the increased pain Ms. Brodeur indicated at 21:45 as a sign of possible uterine rupture and treated it as urgent. They opined failing to do so fell below the standard of care.
- [186] I am mindful that I have expressed reservations on the weight I can place on Ms. Rokosh's opinion regarding Nurse Marsh's actions, and that I have some reservations with regard to Dr. Doersam. But I have also concluded that I cannot rely on Dr. Farquharson's opinion on this point, and Ms. King's opinions were not helpful. That leaves me with some, albeit slight, expert evidence consistent with a conclusion that Nurse Marsh failed to meet the standard of nursing care.
- [187] However, Dr. Mujaibel's evidence was consistent with the plaintiffs' theory of the case. She was not an expert, but as a physician involved in the actions being scrutinized, her evidence carries significant weight. In her view, by 21:45 the pain was constant and everyone should have recognized that it was a situation of a uterine rupture, and Ms. Brodeur needed to be transferred to surgery right away. It is tempting to view her evidence with skepticism based on it being "in hindsight". But there was no dispute about her actions. Regardless of her testimony about what she thought at the time, she immediately called for a caesarean section when she entered Ms. Brodeur's room. In my view, that provides strong support for the plaintiffs' position.
- [188] The defendants point to Dr. Oppenheimer's opinion. He was asked to comment whether Ms. Brodeur was taken to the operating room in a timely manner and in that context, his opinion is relevant to the determination of whether unusual pain required a more rapid response by the medical team.
- [189] He referred to two studies, but only one was relevant to the issue of pain as a signal of possible uterine rupture. That study only included six cases of uterine rupture leading to complete extrusion into the abdomen. Based on an analysis of only 23 cases, the authors of that study concluded that "abdominal pain was a poor indicator of uterine rupture" because it was only reported in four patients and there was no association of it with extrusion of the fetus. Based partly on that, Dr. Oppenheimer concludes that "[c]onstant pain is not diagnostic of uterine rupture." He concluded that the speed of the response of the team was "within the expected range, based on my personal experience and peer review of similar cases, as well as the literature."
- [190] That study is clearly inadequate to provide guidance since it involved only 23 subjects. Even if the sample size was larger, there was inadequate information provided to me about the study, and I am surprised that any expert would draw any definitive opinion based on it.

- [191] The defendants also point to the leading text valid at the time [Williams Obstetrics, Cunningham et al., 20th ed (New York: Appleton & Lange, 1996)] which stated that "less than 10% of women with scar separation experience pain and bleeding, and fetal heart rate decelerations are the most likely sign of such an event". To the extent they rely on that to suggest "pain" is not a reliable signal of uterine rupture, that is, with respect, not an inevitable conclusion from that statement. The logic is faulty. The fact that 90% of women who had scar separation did not have pain, does not mean that when pain is present, it is not a possible sign. Moreover, given the potentially catastrophic consequences of a uterine rupture, why is 10% not enough to be considered a possible sign? Also, it is unclear if, in that study, scar separation is restricted to uterine rupture or also included cases of uterine thinning. It is also unclear if the statement would be the same if it was restricted to "pain" instead of "pain and bleeding".
- [192] Moreover, the Guideline specifically identifies unusual abdominal pain as a signal of possible rupture or scar separation. The Guideline does not purport to prioritize any of the symptoms in the manner by which Nurse Marsh found FHR to be most important.
- [193] I also note that the plaintiffs did not suggest the pain at 21:45 was diagnostic in the way Dr. Oppenheimer has interpreted. The plaintiffs' position is that the pain at 21:45 ought to have been treated as a symptom of the potential of uterine rupture. They say that required Nurse Marsh to urgently call for assistance, which she did not do. I did not understand the plaintiffs to suggest no other checks needed to be made to confirm the suspicion, but that the team needed to act quickly with a high degree of suspicion.
- [194] For all those reasons, I am not persuaded by Dr. Oppenheimer's opinion. I find the evidence supports on a balance of probabilities that in 1999, the unusual report of pain between contractions in a VBAC situation was a signal of potential uterine rupture that required an urgent response.
- [195] Ms. Brodeur was a high risk patient that Nurse Marsh acknowledged was challenging to monitor because of her obesity. For nine minutes Nurse Marsh was aware that Ms. Brodeur had unexplained, constant pain between contractions. Her obesity made it difficult for Nurse Marsh to reposition her when she was vomiting and the repositioning compromised the accuracy of the electronic fetal monitoring. I accept that she felt her auscultation of the FHR was sufficient information, but faced with the challenge of trying to reposition Ms. Brodeur, which compromised the reliability of the fetal monitoring, it was incumbent upon Nurse Marsh to call for assistance and report the pain immediately. Failing to do so fell below the standard of care.

B. Reaction to the Electronic Fetal Monitoring

[196] The plaintiffs allege that Nurse Marsh ought to have been suspicious of potential uterine rupture prior to 21:45. This position rests on the assumption that the FHR and uterine activity were either not adequately monitored, or showed signs consistent with potential uterine rupture before 21:45.

[197] Nurse Marsh points out that the interpretation of a fetal heart monitoring strip is fraught with difficulty. Clearly, it is subjective. In *Lotocky v. Markle*, 2006 BCSC 1295, Justice Macaulay similarly faced differing interpretations of FHR at critical time. At paras. 105-06 he stated:

The real question, of course, is whether the plaintiffs demonstrated that the nurse's interpretation of the August 18 NST as reassuring fell below the standard of a reasonably competent nurse in those circumstances. In effect, the plaintiffs say that no reasonably competent nurse could have interpreted the test result as reassuring.

In my view, the plaintiffs' own expert evidence does not support this conclusion, particularly when I consider the differences in the various interpretations of the August 18 NST insofar as amplitude, cycles, decelerations and accelerations are concerned. In reviewing this evidence, I am satisfied that the Kubli scoring system provides a convenient and useful, but not an exact, means of recording the examiner's interpretation of the strip. Nurse Tier scored amplitude the same as Nurse Callander. Nurse Callander scored cycles at 1-2. Nurses Tier and Burke scored them at 1; Dr. Farmer scored them at 2. Nurse Burke scored accelerations at 1, exactly the same as Nurse Callander. .

[198] I agree that with regard to interpreting the strip, it would not be enough for the plaintiffs to show another nurse would have interpreted it differently. I also keep in mind that the standard of care cannot require perfection and must not amount to "hindsight analysis".

[199] The strip was put into evidence and many witnesses commented on it. To evaluate the opinions and testimony presented, I had to scrutinize a small section of that strip. In my view, it would be improper to base my conclusions about the standard of care solely on such a detailed analysis of one piece of evidence covering a short period of time. That type of focus on a few details inevitably leads to improper hindsight analysis into what was a dynamic situation.

[200] The only witness that classified the FHR prior to 21:45 as non-reassuring was Ms. Rokosh. I have already noted that I have concerns with the reliability of her evidence. Even if I did not, however, the other problem is her opinion contradicts Dr. Doersam's on the same issue. He identified the loss of fetal heart signal at 21:47 to be the signal that required a response, not the earlier tracing. During cross-examination by counsel for Nurse Marsh, he did not disavow the opinion in his draft report that "the tracing from 2015 until 2147 hours is nearly continuous throughout and the pattern is reassuring".

- [201] I agree with Nurse Marsh's position (mentioned earlier in this decision) that the conflict within the plaintiffs' expert evidence is highly problematic (although on a slightly different basis than suggested by Nurse Marsh).
- [202] I add that Nurse Marsh testified that in her view a non-reassuring FHR was the most reliable signal of possible uterine rupture, and at no time before 21:54 did she perceive the FHR to be non-reassuring. Her evidence is based on her auscultation of the FHR, rather than a post-incident examination of the strip. I found her to be a credible witness and on this point, her testimony is reliable. For all those reasons, I do not find that prior to 21:45 the FHR was non-reassuring.
- [203] The plaintiffs also say that Nurse Marsh ought to have viewed the contraction activity with more suspicion. This is based on both Dr. Doersam and Ms. Rokosh's opinion. Dr. Doersam opined that if Nurse Marsh was not "keeping her hand" on Ms. Brodeur's abdomen she failed to meet the standard of care because she had no accurate knowledge of the contraction pattern. The electronic monitoring was acknowledged by most to be less reliable because of Ms. Brodeur's girth, but as pointed out by Nurse Marsh, unless the patient was put in an unsafe position (lying on her back), manual palpations were not likely to be any more reliable. There was no evidence to dispute this.
- [204] Ms. Rokosh's opinion is that Nurse Marsh ought not to have increased oxytocin once she assessed the uterine contraction pattern to be incoordinate and coupling (at 21:20). This requires me to first determine the significance, if any, of an evidentiary issue referred to early in this decision: Did Dr. Mujaibel authorize an increase to the oxytocin at 21:05? Dr. Mujaibel's evidence at discovery is that she does not remember ordering an increase when she examined Ms. Brodeur at 21:05.
- [205] The original physician's order to administer oxytocin included directions on the rate of increase (p. 94 of Ms. Brodeur's chart). This was consistent with BCW Policy 225 - "Induction/Augmentation of Labour using Oxytocin or Prostaglandin" at clause 3.5 which stated that oxytocin is commenced at 1 or 2 mU/min. and increased by 1-2 mU/min at 30 to 60 minute intervals. Clause 1.13 of the policy confirmed that only if oxytocin dosage was to go beyond 20mU/min was a medical assessment and physician's order required. The policy also stated at clause 3.8 that oxytocin should be discontinued in certain circumstances, including prolonged fetal heart rate deceleration or severe variable decelerations (more than 60 bpm, longer than 60 sec, to less than 60 bpm). Neither of those conditions existed.
- [206] I find Nurse Marsh's actions were consistent with the standing physician order on the administration of oxytocin. She did not require a medical assessment or order to increase the infusion rate to 11 mU/min. Complying with the attending doctor's orders in the absence of "clear and obvious evidences of neglect or incompetence" cannot amount to negligence: *Serre et al. v. de Tilly et al.* (1975) 58 D.L.R. (3d) 362 at 367 (Ont. H.C.); *Lotocky* at para. 24; *Tekano* at para. 110. Accordingly, I reject Nurse Rokosh's opinion.

[207] Based on the preceding analysis, I do not find the evidence supports a finding that prior to 21:45 the FHR was non-reassuring, or the pattern of uterine contractions was suggestive of a possible sign of uterine rupture. Therefore, Nurse Marsh's actions prior to 21:45 met the standard of care.

C. Accepting Ms. Brodeur into her Care

[208] Ms. Rokosh's suggestion that Nurse Marsh had options before "accepting" the care of Ms. Brodeur because of her admitted lack of experience is unrealistic. I find a similar flaw in Dr. Doersam's opinion where he states:

Nurse Marsh was called upon to deliver specialized bedside nursing care to a high-risk obstetrical patient. In Nurse Marsh's mind, the patient was not a suitable candidate for the process she was undergoing and nursing staff did not have adequate monitoring parameters in place for [Nurse Marsh] to perform safe nursing practice on [Ms. Brodeur]. Nurse Marsh nonetheless undertook single-handedly the care of a patient for whom she felt she could not safely provide care. As a nursing professional relatively new to high-risk obstetrics, working in a specialized hospital with many more experienced nursing staff on hand, Nurse Marsh's failure to call for additional help as she first undertook [Ms. Brodeur's] care in my opinion did not meet the standard of professional nursing care expected of her.

[209] Apart from the obvious employment implications as well as the effective functioning of the unit in which she worked, Nurse Marsh testified eloquently that failing to provide care for Ms. Brodeur would have been unethical and not in keeping with her responsibilities as a nurse. I agree. I do not find Nurse Marsh negligent for not refusing to care for Ms. Brodeur.

D. Calling Dr. Freedman

[210] The plaintiffs allege Nurse Marsh should have called immediately for Dr. Mujaibel or Dr. Galerneau, rather than Dr. Freedman. As a resident in 1999, Dr. Freedman did not have authority to decide if an emergency caesarean section was necessary; she was required to inform Dr. Mujaibel of any situation that raised the possibility of that complication. Dr. Mujaibel was authorized to decide if an emergency caesarean section was needed and perform that surgery, but she was obliged to inform Dr. Galerneau. Dr. Freedman did acknowledge one of her responsibilities would be to organize for surgery so that it could be done as quickly as possible if that was ordered by whoever did have that authority.

[211] Ms. Rokosh and Dr. Doersam said Nurse Marsh failed to meet the standard of care by calling the charge nurse and Dr. Freedman instead of Dr. Mujaibel because she should have known this was an emergency. Dr. Mujaibel's evidence is consistent with that because during her discovery, she stated that she understood that at any sign of uterine rupture the nurse ought to have called her rather than the resident.

- [212] Nurse Marsh's actions were consistent with BCW's policy CU020- Non-Urgent/Urgent/ Emergency Situation: Obtaining Medical attendance/Assistance for women and newborns. Clause 1.0 of that states that "[i]n an emergency situation, the RN/delegate consults the most immediately available Physician including resident." While the policy cannot be definitive, I find it to be a significant factor supporting Nurse Marsh's actions.
- [213] More importantly, nurses do not diagnose. Her responsibility as the "eyes and ears" of the physician in charge was to ensure assistance was called to respond to the urgent situation. To fault her for not disobeying hospital policy by going over the head of Dr. Freedman would impose on her the duty to know both that Dr. Freedman could not call the caesarean section, but also that it was probable that a caesarean section was needed. In my view, that would make Nurse Marsh responsible for diagnosis which is beyond a nurse's responsibility.
- [214] These reasons also explain why I disagree with Dr. Doersam that Nurse Marsh should have started the process for moving Ms. Brodeur to the operating room. To do so would have required a diagnosis that a caesarean section was probable, and that was not her role.
- [215] I find Nurse Marsh did not fail to meet the standard of care by calling the charge nurse and Dr. Freedman instead of Dr. Mujaibel or Dr. Galerneau when she realized the situation was urgent.

E. Conclusion on Nurse Marsh's Conduct

- [216] In my view, Nurse Marsh failed to meet the standard of care by not immediately reporting to the physician at 21:45 Ms. Brodeur's report of constant pain between contractions. I do not find any other actions by Nurse Marsh fell below the standard of care.

VII. DID DR. FREEDMAN MEET THE STANDARD OF CARE?

- [217] The plaintiffs allege several actions by Dr. Freedman failed to meet the standard of care. I have concluded that Dr. Freedman was negligent for not immediately calling Dr. Mujaibel or Dr. Galerneau when Nurse Marsh advised her that the FHR had dropped to 60 bpm. I find her equally negligent for not responding in an urgent manner when she was advised of Ms. Brodeur's constant pain between contractions.

A. At what point did Dr. Freedman call Dr. Mujaibel?

- [218] Dr. Freedman testified that she called Dr. Mujaibel after completing the first ultra sound exam. The plaintiffs submit Dr. Freedman did not call Dr. Mujaibel until she was doing or had done the vaginal exam. Why does this matter? The plaintiffs submit Dr. Freedman's failure to immediately call for Dr. Mujaibel when she walked in the room fell below the standard of care (discussed below); a finding that she waited until after performing the vaginal exam would compound the impact of that failure. It may also have some probative value on the issue of causation.

- [219] The plaintiffs point to Dr. Mujaibel's evidence that during the telephone call she had with Dr. Freedman, Dr. Mujaibel realized it was uterine rupture and told Dr. Freedman that. Their theory is that it is more likely Dr. Mujaibel came to the conclusion of a potential uterine rupture not just on the basis of the ultrasound results, but also because the baby was not presenting against the cervix. Dr. Freedman pointed out Dr. Mujaibel made no mention of the vaginal exam in her discovery evidence, but in my view that is not necessarily inconsistent with her having been told about it at the time. There is no evidence on that from her one way or another.
- [220] Dr. Freedman testified that she had a clear memory of wondering where everyone was while performing the vaginal exam; her position is that this is inconsistent with the suggestion that she called Dr. Mujaibel after that exam. The plaintiffs submit that it is equally likely that her thinking "where is everyone" arose upon her realization that this was an emergency situation; they say that did not happen until she did the vaginal exam because she did not believe Nurse Marsh's report of the FHR being 60 bpm.
- [221] I have no direct evidence as to when Dr. Mujaibel was called, but she did testify that Dr. Freedman was performing the second ultrasound when she arrived; I find her evidence on that point credible and reliable. I find that she arrived just before 22:06. The plaintiffs' theory is that Dr. Freedman called Dr. Mujaibel either simultaneous with, or just after vaginal exam so at 22:01.
- [222] Dr. Mujaibel's discovery evidence is that she "really ran" to get to the room after speaking with Dr. Freedman because at the time, the room she would have been in was "away" from the labour room. Dr. Mujaibel was not busy with other patients and, given the urgency with which Dr. Mujaibel responded, I find that the phone call would not have lasted very long, perhaps a minute.
- [223] On the plaintiffs' theory, that meant Dr. Mujaibel would have left between 22:02 or 22:03, arriving at 22:06 which is consistent with the partogram and strip.
- [224] Based on Dr. Freedman's theory that she spoke with Dr. Mujaibel after the first ultra sound (which was no later than 21:58), and adding a minute or two, that means Dr. Mujaibel would have left between 21:59 and 22:00. On that theory, Dr. Mujaibel would have taken between 6 to 8 minutes to get into the room; I do not find that to be as consistent with Dr. Mujaibel's evidence that she "really ran" as the plaintiff's timing.
- [225] But my conclusion is not dependant on determining the precise time of events; rather, I am assessing what sequence of events most probably occurred given the information there is about timing. On that measure, I find the plaintiffs' theory is more probable.
- [226] Other evidence is also more consistent with the plaintiff's timing. During her testimony in chief, Dr. Freedman was asked if "there [were] circumstances in 1999 where you'd come into the room and even before you start your assessment ask the attending to come?" She answered as follows:

A. I don't recall any situation that it happened to me personally, but there could be a clinical situation where you would walk in and ask the attending, but my feeling about a situation would be that if that was the case and it was an acute emergency, it would have been a call to everybody that would have come out at the same time.

Q. Meaning a calling to --

A. To the entire team: myself, the staff, anybody else who was on call.

[emphasis added]

[227] It was put to Dr. Freedman that she under-estimated the severity of Ms. Brodeur's condition on the assumption that the nurse would have called Dr. Mujaibel if it was a true emergency. Dr. Freedman testified that she could not remember if that would have even been part of her thinking at that time.

[228] In my view, her testimony in chief provides the answer as to what was most probably her thinking at the time. I find that Dr. Freedman did underplay the urgency of the situation when she was called on the assumption that Dr. Mujaibel would have been called if it was an urgent situation. I find this also accounts in part for why she did not believe Nurse Marsh's report of a 60 bpm FHR.

[229] I am not satisfied that Dr. Freedman's recollection (wondering where everyone was) is enough to override the evidence that demonstrated the probability that she called Dr. Mujaibel during or after the vaginal exam. I do not suggest she is not credible. The recollection she has is an emotional one not a clinical one and less likely to be reliable as to timing. Based on all of the preceding evidence, I find on a balance of probabilities that Dr. Freedman called Dr. Mujaibel while performing or shortly after having performed the vaginal exam.

B. Should Dr. Freedman have called Dr. Mujaibel upon receiving Nurse Marsh's report of Ms. Brodeur's condition?

[230] The plaintiffs' position is that Dr. Freedman's insistence on verifying the FHR after Nurse Marsh reported she auscultated it at 60 bpm fell below the standard of care and that she should have immediately called for Dr. Mujaibel.

[231] Dr. Freedman's evidence on why she insisted on conducting an ultrasound was somewhat inconsistent. While stating her training required her to "verify" information received from the nurse, she also admitted that she relied on nursing staff to advise her of any signs of a possible uterine rupture. She agreed during cross-examination that if she had been told the FHR had dropped to 60 bpm, she needed to rule out the possibility of uterine rupture as quickly as possible, because uterine rupture has the potential to be life-threatening for both the mother and baby. She also confirmed a few times that she relied on nursing staff as the "eyes and ears" to monitor for signs and symptoms of possible uterine rupture. Yet, she maintained she was "required" to verify the information from the nurse.

- [232] I find Nurse Marsh's testimony about what was said in these moments to be credible and more reliable than Dr. Freedman's. I find that Nurse Marsh reported to Dr. Freedman that the FHR was at 60 bpm, and Ms. Brodeur was enduring constant pain and vomiting, but that Dr. Freedman did not believe her. In my view, although Dr. Freedman testified she was attempting to "verify" Nurse Marsh's information, she was effectively disregarding it. She failed to act on it. This is not consistent with the team approach to providing obstetric care to a high-risk patient.
- [233] Dr. Oppenheimer concluded that Dr. Freedman was justified in using the ultrasound to verify the FHR, but importantly he added a qualification to his opinion that confirmation was unnecessary if the bradycardia had been clearly recorded. In my view, Nurse Marsh telling Dr. Freedman that she auscultated the FHR at 60 bpm was such a clear report and ought to have been relied upon by Dr. Freedman.
- [234] It is also important to note that Dr. Oppenheimer's opinion does not take into account the report of unusual pain at 21:45, which I have found Nurse Marsh relayed to Dr. Freedman as soon as the latter entered the room. Accordingly, Dr. Freedman was not faced with a single symptom of possible uterine rupture; there were two -- the bradycardia and unusual abdominal pain. The facts therefore are different from what Dr. Oppenheimer relied upon in giving his opinion and that reduces the weight I attach to it.
- [235] I have concerns about the significance Dr. Oppenheimer attaches to Ms. Brodeur's obesity with regard to the standard of care. If obesity made monitoring of Ms. Brodeur's FHR less reliable, presumably that was true throughout her labour and not just at the report of bradycardia. In that way, I find two of the four factors upon which he based his opinion (see above para. 159) are somewhat inconsistent.
- [236] I find the evidence was clear and the experts agreed that careful monitoring for VBAC patients is crucial to provide adequate care. They also agreed Ms. Brodeur's obesity possibly reduced the accuracy of the electronic monitoring. The evidence also establishes that her obesity demanded increased suspicion and vigilance, not less. That ought to have made staff more suspicious of potential problems, rather than the opposite.
- [237] Instead, the defendants' experts point to her obesity to support the assumption that the monitoring was not reliable, and that it was reasonable to assume abnormalities had a benign cause. But upon her admission to hospital, everyone was aware monitoring was more difficult with Ms. Brodeur because of her personal characteristics, which included obesity. In my view, the medical staff failed to integrate that clinical fact into how they approached her care. Dr. Freedman relied upon Ms. Brodeur's obesity to disregard Nurse Marsh's report of the FHR. Ms. Brodeur's obesity cannot be a reason to explain away a failure to respond quickly to possible signs of an emergency situation.
- [238] In my view, that is essentially what Dr. Oppenheimer's opinion did. Her obesity should have informed the standard of care under which medical staff operated by increasing the vigilance and index of suspicion they would have about potential problems, especially

uterine rupture. I find Dr. Oppenheimer's opinion is premised on an opposite approach. He found it acceptable for staff to assume symptoms were the result of inaccurate or unreliable monitoring because of Ms. Brodeur's obesity. For that reason, I place less weight on Dr. Oppenheimer's opinion with regard to whether Dr. Freedman was justified in conducting the ultrasound.

[239] I find Dr. Doersam's opinion on this point to be reasonable and most consistent with the evidence. In his opinion, doing the ultrasound to verify the FHR was acceptable so long as help had already been called. This is also supported by Dr. Mujaibel's evidence:

Q. Did you have a conversation with Dr. Freedman after the Caesarean section to talk about what had happened?

A. Yes.

Q. At that time did you ask her why she was wasting time with doing an ultrasound rather than

A. I think she wanted to make her own assessment at that time, but I said it was clear; the fact that she had severe bradycardia, and she being at her level of registrar or a chief resident or whatever, she should have called me or called Dr. Galerneau to come to the labour room immediately because, okay, it's not the simple bradycardia with a simple patient. This is a high-risk patient with all the factors which going with the possibility of uterine rupture all raising up, okay.

Q. Right.

A. But she said that, "Khalida, I have to make my own judgment." I respect her opinion but I said, "Still, you have to call me because this is a maternal-fetal medicine patient and I should make the decision, not you." That's it.

[240] For all those reasons, I find that Dr. Freedman failed to meet the standard of care by not calling for Dr. Mujaibel upon learning from Nurse Marsh that she had auscultated the FHR at 60 and Ms. Brodeur had constant pain between contractions.

C. Conclusions on Dr. Freedman's Standard of Care

[241] I conclude Dr. Freedman failed to meet the standard of care by failing to immediately recognize the report of unusual pain as a possible sign of uterine rupture, and by not immediately calling Dr. Mujaibel and/or Dr. Galerneau. I also conclude disregarding Nurse Marsh's report of FHR 60 bpm fell below the standard of care.

VIII. CAUSATION

- [242] Dr. John Van Aerde provided an expert report on behalf of the plaintiffs related to causation. He is a neonatologist and clinical professor of pediatrics for the University of Alberta and the University of British Columbia. He has achieved the highest level of Neonatal Intensive Care (classified as level III/IV) for infants with the most complex problems. He has a PhD in medical sciences. He has extensive and impressive clinical experience in neonatal intensive care, including being involved in the development and implementation of policies, guidelines and quality of care to reach or exceed standard of care for newborn infants.
- [243] Dr. Van Aerde produced a report dated June 12, 2015 that was admitted into evidence; he was not called for cross-examination so his opinions were not contested. I accept his evidence as reliable and credible.
- [244] Dr. Van Aerde's report was based on his review of the literature and relevant medical studies. That literature confirms that there are "three periods of progressive brain damage during an asphyxia lasting approximately 25-30 minutes." If resuscitation is started within the first 10-15 minutes of the onset of asphyxia, human brain function is most likely not negatively impacted. The second period (from 10-15 to 25-30 minutes of asphyxia) is itself divided into two smaller but overlapping periods. At the 20 minute mark, and close to it is when damage to the thalami and basal ganglia occurs which results in choreoathetoid cerebral palsy. The closer the period of asphyxia gets to the 25-30 minute mark, the more likely the cortex will be damaged causing quadriplegic cerebral palsy and cognitive impairment.
- [245] Dr. Van Aerde confirmed that Tianna has choreoathetoid (also termed athetoid or dyskinesic) cerebral palsy. The condition is the result of static and non-progressive, bilateral brain lesions to the thalami and basal ganglia. That diagnosis was confirmed by a number of brain scans including one taken when Tianna was 12.
- [246] In addition, according to Dr. Van Aerde, Tianna fulfills all criteria identified by the American Academy of Pediatrics & the American College of Obstetricians and Gynecologists to link "the acute perinatal event with the neonatal encephalopathy (HIE) after birth with her current choreoathetoid cerebral palsy."
- [247] After reviewing the literature and the background facts, Dr. Van Aerde opined that "Tianna's brain damage occurred mostly between the 10-15 minute mark and 20-25 minute mark after the onset of the acute and total or near-total asphyxia." He continued:

The clinical history and the findings of the brain images obtained at 3 days, [2 ¾] years and 12 years of age indicate that the asphyxia lasted up to 20-25 minutes. According to classic studies and publications, for the first 10-15 minutes, the brain would have been normal; if a stat caesarean section had been called immediately at that time, the delivery would have happened at a time when the brain was still normal and the child would have been normal today.

Given that the stat caesarean section was executed in the respectable time of 10 minutes with an additional 2 minutes from decision to incision, the child would have had a much higher probability than not to have a normal brain with normal function if the infant had been delivered within 10 and probably within 15 minutes after the onset of the bradycardia.

[248] Dr. Van Aerde's opinion is unassailable and I accept it.

[249] Dr. Kenneth Poskitt is a radiologist. He reviewed three head scans taken of Tianna at ages 3 days (CT scan), 2 ¾ years (MR) and at about 12 years (MR). Dr. Poskitt's February 17, 2015 report was entered into evidence without objection and he was not called for cross-examination. In his report he finds all three scans are consistent with Tianna having suffered an acute profound asphyxia at or very near to the time of her birth. I also accept and rely on his opinion.

A. Legal Principles

[250] The parties agree on the governing legal test for causation that was established in, among others, *Clements v. Clements*, 2012 SCC 32 at paras. 9-12; *Snell v. Farrell*, [1990] 2 S.C.R. 311 at 330; and *Athey v. Leonati*, [1996] 3 S.C.R. 458 at paras. 16-17. The plaintiffs have the burden to prove on a balance of probabilities that "but for" the negligence of the defendants the injury would not have occurred. Causation does not need to be proven with scientific precision. It is a question of fact which relies on practicality and common sense.

B. Analysis

[251] In my view, the uncontested evidence of Drs. Van Aerde and Poskitt are sufficient to meet the plaintiffs' burden. Dr. Van Aerde's report is entirely consistent with the evidence presented at trial. His evidence was not challenged and, as I have noted above, I find it reliable and credible. His ultimate opinion is that Tianna would have had "a much higher probability than not to have a normal brain with normal function if [she] had been delivered within 10 and probably within 15 minutes after the onset of the bradycardia." Dr. Poskitt's opinion confirms that the asphyxia suffered at birth is the cause of her cerebral palsy.

[252] The defendants submit that the facts in the case do not support a conclusion of causation based on the evidence of what happened after the onset of bradycardia. They reconstruct time lines to support their position.

[253] As I note above, it not appropriate to make definitive conclusions based on exact calculations of time. Common sense dictates that all clocks in a hospital are not perfectly synchronized. It is possible that medical staff refer to their own watches which might not be synchronized with each other, nor with hospital clocks. Common sense also dictates that in times of stress nurses and doctors may not be able to be completely accurate in writing down the time of certain events, especially in an urgent situation when it might be necessary to make a note a short time after an event. It is also true, that courts need to be

careful when accepting people's estimation of times, especially during stressful or traumatic events. I was given no evidence upon which I could discount these common sense propositions. An analysis of timing is helpful, but I approach with caution any analysis that seeks to draw definitive conclusions about causation, based on suppositions of what might have happened.

1. Timing in Relation to Nurse Marsh's Actions

- [254] Tianna was born at 22:20. We know that Ms. Brodeur was moved from her room towards the operating room at 22:08. As discussed above, I found that Dr. Mujaibel entered the room at about 22:06 because her testimony was that Dr. Freedman was doing an ultrasound exam as she arrived.
- [255] Accordingly, Tianna was born within 14 minutes of Dr. Mujaibel making the call for an emergency caesarean section. She was clear that as soon as she walked in the room she made the decision to call the caesarean section based on how much pain Ms. Brodeur was in. The fact that she did a vaginal examination to confirm her diagnosis does not increase this timeline as asserted by the defendants. The evidence was that the nurses would have started the process of unplugging the equipment in order to move Ms. Brodeur to the operating room while Dr. Mujaibel was conducting a quick vaginal exam to confirm her suspicion of uterine rupture.
- [256] The defendants submit I cannot assume Dr. Freedman would have come right away if Nurse Marsh had called at 21:45. I disagree. There is neither any evidence before me nor any basis upon which a reasonable inference can be drawn that had Nurse Marsh made the appropriately urgent call at 21:45, Dr. Freedman would not have arrived as quickly as she did when the call went out at 21:54.
- [257] The partogram indicates that help was called at 21:54 and that Dr. Freedman was in the room at 21:56 to help. Looking at the strip, there is a notation that Dr. Freedman was in the room at 21:55. In any event, I find it reasonable to assume that Dr. Freedman would have arrived no later than 21:47 if Nurse Marsh had called for assistance at 21:45.
- [258] At 21:47, the strip starts to show variability in the FHR. This may be because Nurse Marsh was repositioning Ms. Brodeur. However, with another person in the room, it is more probable than not that a more accurate assessment of Ms. Brodeur's condition would have occurred.
- [259] As discussed above, the standard of care for a high-risk VBAC patient required Dr. Freedman to have a high degree of suspicion based on the report of unusual pain at 21:45. This means when she arrived, she ought to have done two things: (1) immediately called Dr. Mujaibel and/or Dr. Galerneau, and (2) investigate if she could rule out the suspicion of uterine rupture. Even if I assume that took two minutes (Dr. Freedman testified a vaginal exam could be done very quickly), Dr. Mujaibel would have been called at the latest at 21:49.

- [260] Dr. Mujaibel indicated she was running because she understood uterine rupture was a possibility. According to her testimony, Dr. Freedman told her she could not find the FHR. Based on the model above, it is not probable that Dr. Freedman would have made that same report [that she could not find the FHR] at 21:49. But Dr. Mujaibel was clear that the report of unusual pain was enough for an urgent call to be made. Nevertheless, I will assume she might not have rushed in the same manner, but taken a bit longer. Assuming she took five minutes to arrive, that puts her arrival at 21:54.
- [261] At 21:54, the fetal heart rate dropped to 60 bpm. I find that Dr. Mujaibel would have reacted to that, and made the call for an immediate caesarean section. This is consistent with her evidence that she based her decision to call a caesarean section upon seeing the amount of pain Ms. Brodeur was in when she walked in the room. The bradycardia would simply have made Dr. Mujaibel more confident in her decision. This means the surgery would have been done and Tianna delivered at 22:08. That is 12 minutes sooner than she was delivered.
- [262] Dr. Van Aerde's opinion was that the brain could have been normal for the first 10 and probably up to 15 minutes after the fetal heart rate dropped. The evidence as discussed above puts Tianna's birth within that time frame, and in my view, this analysis is sufficient to establish the facts upon which Dr. Van Aerde's opinion is based. I conclude the plaintiffs have established on a balance of probabilities that "but for" Nurse Marsh's negligent conduct, Tianna would not have suffered injury.
- [263] Nurse Marsh also put forward a timeline analysis to submit that the plaintiffs have not proven causation. I agree with the plaintiffs that most of this analysis fails to be persuasive because it is based on evidence that is not before me, or it requires me to speculate. I do not find any of the inferences Nurse Marsh has asked me to draw to be reasonable based on the facts I have found.

2. Timing in Relation to Dr. Freedman's Actions

- [264] Counsel for Dr. Freedman submitted that the evidence in this case is such that the plaintiffs' succeeding on the standard of causation is virtually impossible. They say an analysis of the timeline suggests Dr. Freedman's negligence would have saved at most, two minutes in the surgery. I do not find that analysis persuasive. Furthermore, the analysis above defeats that submission.
- [265] Counsel for Dr. Freedman assumed that time needs to be added for Dr. Mujaibel to have done her own assessment of the patient. However that is not in keeping with the evidence because she testified that she made the call for the caesarean section immediately and did the vaginal exam after, in order to verify that diagnosis. There is no evidence that the vaginal exam she conducted delayed going to surgery because I have inferred, as is consistent with the evidence, that the nurses would have started the preparations for moving the patient while she was doing the exam.

[266] The defendant constructed a timeline starting at 21:54. I agree with the plaintiffs' written summations in response to that:

Had Dr. Freedman acted in accordance with the standard of care expected of her, meaning had she acted more promptly to the clear signs and symptoms of uterine rupture which were presented to her, the evidence indicates that Dr. Galerneau or Dr. Mujaibel would have been called within a minute of her arrival (i.e. - by 21:56 hrs) The stat caesarean section would have been called at that time and delivery would have been effected within 12 minutes. Even if that took us slightly over the 22:09 "deadline" [from Dr. Van Aerde's report], there is no doubt that the delays caused by the negligence of Dr. Freedman contributed to the injury suffered by [Tianna] and, on that basis, she is liable for all the damages associated with this indivisible injury.

C. Conclusion

[267] For all those reasons, I find that the plaintiffs have established on a balance of probabilities that, but for the negligence, Tianna would not have suffered her injury.

IX. DAMAGES

[268] The parties agreed that if I concluded any of the defendants were negligent, the following represent appropriate awards, and I so order:

- a) non-pecuniary damages in the amount of \$363,200;
- b) damages for income loss in the amount of \$1,000,000;
- c) damages for loss of interdependency in the amount of \$221,638; and
- d) damages for speech language pathology in the amount of \$125,000.

[269] The parties also agreed that the amount of the Ontario Hospital Insurance Plan claim is \$7,817.57, and the amount claimed pursuant to the Health Care Costs Recovery Act, S.B.C. 2008, c. 27 is \$54,577.07. I make those awards.

[270] The items in dispute are damages for the cost of future care and both the entitlement and quantum of special damages.

A. Legal Principles Relating to Cost of Future Care

[271] *Andrews v. Grand & Toy Alberta Ltd*, [1978] 2 S.C.R. 229 remains a leading case about cost of future care damages. More recent cases also describe the applicable legal test, including *Krangle (Guardian ad litem of) v. Brisco*, 2002 SCC 9 at paras. 21-22, *O'Connell v. Yung*, 2012 BCCA 57 at para. 55, and *Joinson v. Heran*, 2011 BCSC 727 at para. 420. The Court of Appeal repeats the test in *Tsalamandris v. McLeod*, 2012 BCCA 239 at paras. 62-63:

The test for assessing future care costs is well-settled: the test is whether the costs are reasonable and whether the items are medically necessary: *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33 at page 78; affirmed (1987), 49 B.C.L.R. (2d) 99 (C.A.):

3. The primary emphasis in assessing damages for a serious injury is provision of adequate future care. The award for future care is based on what is reasonably necessary to promote the mental and physical health of the plaintiff.

McLachlin J., as she then was, then went on to state what has become the frequently cited formulation of the "test" for future care awards at page 84:

The test for determining the appropriate award under the heading of cost of future care, it may be inferred, is an objective one based on medical evidence.

These authorities establish (1) that there must be a medical justification for claims for cost of future care; and (2) that the claims must be reasonable.

[272] The Supreme Court of Canada emphasizes that the plaintiff must be given the "full measure" of her loss but that the award should not transform the injury into a windfall: *Ratych v. Bloomer*, [1990] 1 S.C.R. 940 at 962. As an aid to determining the appropriate amount, Justice Dickson states the court must ask whether a right minded person would consider the expenditure to be a squandering of money: *Thornton v. School Dist. No. 57 (Prince George) et al.*, [1978] 2 S.C.R. 267 at 280-81.

[273] In *Harrington v. Sangha*, 2011 BCSC 1035 at para. 151, the court discusses the distinction between medical justification and medical necessity, noting the plaintiff need only prove the former to succeed:

The distinction between medical justification and medical necessity is that the former requires only some evidence that the expense claimed is directly related to the disability arising out of the accident, and is incurred with a view toward ameliorating its impact. The latter test, necessity, would require the court to impose some standard other than reasonableness by asking not whether the expense is a reasonable one, but rather, whether there is any way in which it might be avoided. The latter test is inappropriate. It would impose upon the victim of an accident to be content with a state of affairs other than that which he or she would have occupied had they not been injured.

[274] While expert evidence is necessary to establish the costs of future care, it need not be from a physician. The court must be satisfied, however, that an evidentiary link exists between a physician's assessment of pain or disability and the recommended treatment and care: *Gregory v. Insurance Corporation of British Columbia*, 2011 BCCA 144 at para. 39.

[275] Lastly, it is well settled law that in determining future events, the evidentiary burden is whether the plaintiff can prove there is a "real and substantial" possibility the costs will be incurred, rather than a balance of probabilities: *Athey v. Leonati* at para. 27.

B. Tianna's Early Years

- [276] Tianna's older sister, Ms. Breanne Brodeur (to avoid confusion with references to her mother, I will refer to her as Breanne and I intend no disrespect in doing so), their father, Mr. Brodeur, and Ms. Brodeur all testified, describing Tianna and what it is like to spend time with and care for her.
- [277] Tianna spent her first month after birth hospitalized. From birth, she needed to be fed through a tube. Her father became familiar with operating the tube and was responsible for feeding her during the night once she was discharged from the hospital. Each feeding required about 15 or 20 minutes because a pump had to be operated since she had not developed a gag reflex.
- [278] At about six months of age she received a G-tube which delivered nourishment directly to her stomach. Mr. Brodeur recounts how, despite this, they would always try to see if Tianna could take a bottle and at most she would take a very small amount: only about one or two teaspoons. He said that at about 15 months of age, Tianna spontaneously was able to drink an entire bottle without incident. He said it was as if a switch had been turned on. Up until that point, he estimates that he was getting at most two or three consecutive hours of sleep each night because of the frequency and length of feedings Tianna required.
- [279] Tianna was between 3 and 3 ½ years old when she began speaking with short and simple sentences. She did not start walking until about 4 ½ years old. Tianna was not toilet trained until about age 5 or 6. In kindergarten and grade one, Tianna had a teaching assistant assigned exclusively to her to assist with toileting, homework and even carrying her backpack. After grade one, the teaching assistant had other students, so Tianna no longer received one-to-one care.
- [280] Breanne recalled often being called out of class during elementary school to help calm Tianna. Tianna did not enjoy school and would sometimes have fits which could only be addressed by her sister sitting with her. In other respects, Breanne described her sister as having a fun and energetic personality. She said that Tianna talks a lot and they are close, spending a great deal of time together.
- [281] Ms. Hicks provided much needed respite but in early 2010, Ms. Hicks moved back to Thunder Bay. Both parents testified that they depended on Ms. Hicks to assist with Tianna's care, and therefore they felt it was necessary for Ms. Brodeur and her daughters to relocate to Thunder Bay. By this time, Mr. and Ms. Brodeur had separated and he remained in Vancouver to work. He was planning on moving to Thunder Bay, but not until he could sell the family home.
- [282] Breanne testified that after the move to Thunder Bay, before Mr. Brodeur arrived, Tianna was experiencing more fits at home and at school; this was a very stressful time for Tianna. According to Breanne, Tianna never fully adjusted to living without her father. Tianna has always been very close to him and Breanne described her as a "daddy's girl". As a result, Mr.

Brodeur moved to Thunder Bay sooner than he planned, having to pay a penalty on the mortgage. He found a house in Thunder Bay that is about a seven minute walk away from Ms. Brodeur's house.

- [283] Tianna's parents both agreed that they have shared in her care over the years and that Breanne and Ms. Hicks have also contributed to Tianna's upbringing. Because of Ms. Brodeur's illness, Breanne has provided the majority of Tianna's care with respect to daily tasks for a number of years.

C. Tianna's Current Functioning

- [284] Tianna has always lived with her family. Currently, she lives with her mother during the week and with her father on the weekends. No party contested the fact that Tianna cannot live alone. She is not capable of any kind of planning and tends to live day-by-day, making decisions on the spur of the moment. She does not respond well to any change in her circumstances. Her family members testified that she is rarely left home alone because they are worried about her safety.
- [285] Breanne assists Tianna's getting ready for school, especially during those times when their mother is ill and unable to do so. Breanne helps her wake up and assists with dressing. Tianna lacks the fine motor skills that would allow her to fasten buttons or clasps (such as on a bra).
- [286] Tianna can shower on her own, but has to be reminded to clean up after herself after a shower. She needs constant reminders to take care of her hygiene including brushing her hair and brushing her teeth. Mr. Brodeur commented that even when Tianna has been told to take a shower and does so, she will sometimes forget to wash her hair and she will have to go back to do that. He is concerned about Tianna's difficulty with her hygiene as she becomes older and needs greater privacy. In addition to needing assistance with these things because of her physical limitations, it takes Tianna a longer time to get ready than normal.
- [287] While she can make her own simple breakfast and lunch, Tianna does need to be reminded to clean up. She can do laundry but has difficulty separating different colours.
- [288] Fortunately Tianna's difficulty with tasks requiring fine motor skills does not impede her ability to use a computer. Everyone agrees that Tianna has excellent computer skills, can type easily and enjoys being on the computer. She also loves music and often listens to her iPod.
- [289] The two girls are in the same school and Breanne sees her sister every day. Breanne testified that Tianna may get lost and has difficulty remembering where her classes are at school. This makes the start of each school year especially stressful because Tianna has to get used to a new routine.

- [290] Tianna does not make friends her own age at school, but does develop close relationships with some of her teachers, and she is particularly close with the school counsellor, Ms. Honeysett. Ms. Honeysett testified and described her observations and impressions of Tianna's behaviour. According to her, Tianna gets agitated and frustrated very often, and can easily dissolve into tears. Tianna has had difficulties with personal hygiene to the extent Ms. Honeysett has had to intervene and ask Ms. Brodeur to bring clean clothes to school for Tianna. Tianna does not interact with her peers and gravitates towards adults. In Ms. Honeysett's view, Tianna succeeds best when clear expectations and parameters are set for her, and she has a relationship with the teacher. Even then, she needs constant reminders. Ms. Honeysett testified that even after two years, Tianna has to be reminded that she cannot simply walk into Ms. Honeysett's office without knocking first.
- [291] In terms of her academic achievements, Ms. Honeysett explained that it is expected Tianna will graduate in June 2017 with a high school diploma from a special stream, which is a program designed for students with cognitive deficits. The school attempts to integrate the students from that stream into the main stream but special instruction is provided for some subjects to accommodate those students' different needs. The expectation for graduation from this stream is that the student will achieve about one half of the credits compared to students in the regular stream. Tianna has already achieved that goal. Although these special streams do allow students to stay in school up to age 21, Ms. Honeysett has not seen many students who have stayed that long.
- [292] The girls took the bus to school together, although Tianna leaves the house earlier than Breanne because it takes her longer to walk to the bus stop. Breanne watches from the window because she worries whether Tianna checks for traffic when crossing the road.
- [293] Tianna's balance is compromised. At school she has a key to the elevator so she does not have to use the stairs, but the evidence was that she does not use it often. Mr. Brodeur and Breanne commented that Tianna usually only goes up or down stairs while holding railings on both sides. She has sometimes tripped but fortunately has not injured herself. She stumbles or trips easily because of her disability, even when walking on a level surface.
- [294] Tianna enjoys swimming, but Breanne does not feel she is able to be in the pool by herself, especially in the deep end. Therefore Breanne always accompanies Tianna to the swimming pool which fortunately is close to their home. For a time the girls were in Girl Guides, but as Breanne is older she moved on to a different group, and Tianna did not continue because she could not be with her sister. Breanne tries to encourage Tianna to use a gym during the time of year when the pool is closed, but she has not had much success at doing so.

- [295] Tianna also has certain unique movements. When she gets excited or anxious she will flap her arms quickly, often for very long periods of time. On some occasions she will rub her legs constantly. Mr. Brodeur and Breanne also commented that when Tianna is upset, she has a tendency to grab and throw things; Mr. Brodeur said Tianna has gone through a lot of laptops, phones and other electronic equipment because of this. Ms. Brodeur testified that Tianna continues to have tantrums, especially when she does not get her own way.
- [296] In terms of her cognitive abilities, Breanne testified that Tianna has difficulty with homework and other tasks. She has difficulty remembering what she needs to do or whose job it is. Tianna also has some challenges speaking clearly. Breanne finds that she has to interpret Tianna's speech even at school because people have difficulty understanding what Tianna is saying.
- [297] Tianna's family have not ever sought out any kind of behavioural management counselling for Tianna despite an incident that could be viewed as very troubling. When Tianna was having difficulty adjusting to a new school year, Breanne witnessed Tianna making motions as if she was cutting herself with a razor. Fortunately she had been unable to remove the plastic cover, or perhaps was simply unaware of it. That was the only incident where she has tried to hurt herself.
- [298] The plaintiffs point to another troubling incident. Breanne testified that the family originally planned on leaving Tianna with her grandmother in Thunder Bay during the trial. They changed their mind, and Tianna came with the family, but her behaviour has caused significant concern. Apparently Tianna overheard a discussion about surveillance of her in relation to this litigation. Breanne said that Tianna became extremely upset and paranoid, believing that she is being constantly monitored. She has been "freaking out" and saying that people are possessed by demons; she had hallucinations, and had been screaming, pushing and saying extreme things like wanting to kill somebody because they killed her family. Breanne testified Tianna had been admitted into the psychiatric ward of BC Children's Hospital.
- [299] Breanne's testimony was the only evidence about this extreme behaviour, even though her mother and father testified after her. The description of Tianna's behaviour is a marked departure from all other descriptions of her emotional or cognitive challenges. Experiencing hallucinations and being paranoid about demons and surreptitious monitoring, appears to fall on a completely different plane from the deficiencies noted in Tianna's judgment or planning skills. They may be indicative of serious psychiatric issues.
- [300] Although I have no reason to doubt Breanne's credibility, I am cautious about this evidence for three reasons. First, it is behaviour that even Breanne admitted must be related to the experience of being away from home in what must be a strange and unfamiliar atmosphere, at a time when, understandably, the people around her may be feeling some stress from the litigation. Given the description of Tianna's difficulty with changes in routine, it would be surprising if the change in location did not manifest in her behaviour

in some way. Although extreme, that suggests it is an isolated event. Secondly, although Breanne's description was quite vivid ("hallucinations", "demons", "freaking out"), it is difficult to put those comments in context when there are no other descriptions. I accept that Tianna exhibited behaviour confirming emotional upheaval and upset by travelling to Vancouver, but I am not convinced this particular testimony has any relevance beyond that. Third, as indicated above, despite Tianna's cognitive and intellectual challenges, the family has never sought out counselling for Tianna related to psychological or mental health issues. Without having that exposure, it is possible that Breanna's descriptions do not match how a psychological counsellor or professional would describe the behaviour. For all those reasons, I find it very difficult to rely on this evidence.

D. The Family's Wishes for Tianna's Future

- [301] There is no dispute that the levels of Tianna's developmental and cognitive abilities make her vulnerable. Her family testified they are very concerned that she could be taken advantage of and, in particular, as she is now a teenager, that she could be mistreated sexually. These are valid concerns which must be taken into account with respect to any award of future care damages.
- [302] Both parents testified that they want Tianna to live with them until they are no longer able to care for her, at which time they agreed and understood Tianna would live with Breanne. Breanne confirmed that she would always have Tianna in her life and any of her own future plans regarding a family or career, would take into account what is best for Tianna. She would expect any future life partner to accept Breanne's desire to care for Tianna.
- [303] Mr. and Ms. Brodeur testified that they do not want Tianna to live in a group home, particularly because they worry about her vulnerability living with strangers, although there was discovery evidence that contradicted this testimony. But all family members also agree that Tianna is in need of friends and is often lonely.

E. Evidence about Care Available

- [304] I heard testimony from four witnesses with regard to what living and care options are available for adults with disabilities in Ontario, and specifically Thunder Bay: Susan Fraser, Michael Manula, Lisa Foster and Rick Menassa.
- [305] Ms. Fraser is the area director for Bayshore Home Health in Thunder Bay. She has worked in different roles for the company for 16 years, but has been area director for the last 10. Bayshore is the largest home care provider in Canada and is externally audited every three years for its compliance with international standards.
- [306] Ms. Fraser described Bayshore's services as client-focused. In-home assessments are done once a year to assess clients' needs. In Thunder Bay, Bayshore serves between 800-900 clients. They have 125 front-line support workers which includes registered nurses, licensed practitioner nurses, personal support workers (PSW), development support

workers (DSW) and home support workers (HSW). These categories of workers have different skills which dictate the types of clients to whom they can provide care. DSW are specifically trained to work with people with development disabilities; PSW and HSW do not have this specialized training. DSW can also find or plan recreational and social activities which are designed to help clients progress. Ms. Fraser noted that Thunder Bay currently suffers a shortage of support workers.

- [307] Mr. Manula has been the executive director of the Lutheran Community Care Centre since August 1983. That organization provides social services at the community level. He described what has emerged as the new model of government-funded support for people with disabilities. The Lutheran Community Care Centre is a central access point for government funded services for Northern Ontario and has been since July 2011. It provides information about government services and funding, and confirmation of eligibility. Services are provided by agencies that enter into service contracts with the provincial government. The government remains responsible for setting the quality of services to be provided, but does not provide care directly. The eligibility criteria are also set by legislation.
- [308] People are now assessed individually and receive funding depending on their level of need. They are provided with a "passport", and they decide how to utilize it for the type of support care they receive. Passport funding ranges from \$2,000 to \$35,000 per year.
- [309] Applicants are interviewed to assess what type and level of support is needed. Clients do have input into the assessment. The interview is conducted by trained assessors and is comprehensive, taking three or four hours to complete. Eligibility for services is based on the thresholds set by legislation for cognitive abilities and adaptive functioning.
- [310] While care is available upon turning the age of 18, individuals are able to start the application process at age 16. Mr. Manula acknowledged there is a waiting list for services, although clients can be on a number of different waiting lists at the same time. Also, clients' positions on the wait list are determined by the level of support needed, and not by the date they applied. He confirmed there is no means-testing to be eligible.
- [311] Ms. Foster has been executive director of Community Living in Thunder Bay since July 2013. She has been a front line support worker in group homes for 15 years and is currently undertaking DSW training. Community Living currently oversees 26 group homes in Thunder Bay, but consistent with Mr. Manula's testimony, Community Living's philosophy is shifting from group living towards community supports. Thus, if a group home is closed, it is not replaced.

[312] Ms. Foster stated that Community Living is unable to guarantee that the occupants of any group home would be exclusively female, nor are residents able to choose their own roommates. In general, she was critical of the quality of care provided in group homes and recounted certain "horror stories" of inadequate care. I am concerned that her testimony may have gone beyond providing facts and observations and may have been tainted by a bias against group home living, and I therefore approach it with caution.

[313] Lastly, I also heard testimony from Mr. Menassa who has been the president for four years of iCare Home Health Care. This organization is located in Oakville but offers servicers throughout the province of Ontario. It is in the process of being accredited. Given the lack of current accreditation, and the fact that iCare has never provided services to clients that live in Thunder Bay, I do not rely on his evidence in terms of assessing future cost of care.

F. Expert Evidence

[314] As noted above, the parties have agreed on the quantum for certain items. Because of that I will not summarize or describe the expert evidence which supports those items.

[315] The following expert evidence was tendered by the plaintiffs:

- a) Dr. Jacqueline Purtzki is a specialist in pediatric and adult physical medicine and rehabilitation and she provided an expert report dated June 4, 2015. She was not cross-examined on her report.
- b) Dr. Michael Joschko has a Ph.D. in psychology and is a registered psychologist specializing in clinical psychology and neuropsychology. He provided a report dated May 4, 2015, a supplemental report dated May 19, 2015 and a responding report dated July 24, 2015. He did not testify.
- c) A "Home Accessibility Report" dated June 16, 2015 was prepared by David Wallace. He is Vice-President of "Adapt-Able Design Group". His report was accepted into evidence and he was not required to testify.
- d) Karyn Drewnowsky is a registered physiotherapist and Certified "Life Care Planner". She submitted a "Life Care Plan" for Tianna dated June 13, 2015. She also prepared a report dated July 29, 2015 which responded to one of the defendants' expert's reports. She testified and was cross-examined.
- e) Marla Rosenfeld is an occupational therapist. She completed a functional assessment of Tianna on March 16, 2015 and her report dated June 9, 2015 was accepted into evidence. She too was cross-examined.
- f) Darren Benning is an economist and he provided three reports; he did not testify.

[316] The following expert evidence was submitted on behalf of the defendants:

- a) Scott Puddicombe prepared a report reviewing the Home Accessibility Report of Mr. Wallace dated July 22, 2015, and an updated report dated August 6, 2015. He did not testify.
 - b) Dr. Jo-Anne Finegan has a Ph.D. in psychology and is a clinical psychologist. She prepared a report dated January 14, 2015 and a supplementary report dated July 20, 2015. She was cross-examined.
 - c) Sandra Vellone is a certified rehabilitation counsellor. She prepared a report dated June 19, 2015 based on an in-home interview and assessment she conducted of Tianna on October 27, 2014. She also prepared a letter dated July 28, 2015 which responded to Ms. Drewnowsky's report. She testified.
 - d) Douglas Hildebrand is an economist who prepared a report dated September 15, 2015. He did not testify.
- [317] The defendants submit I ought to place little or no weight on Ms. Rosenfeld's evidence because her opinions were not consistent with the plaintiffs' medical experts (Dr. Purtzki and Dr. Joschko) or testimony from Tianna's family members.
- [318] I agree I must approach Ms. Rosenfeld's evidence with caution. In particular, in her report, she opined that Tianna would need daytime supervision but she testified that Tianna needs 24 hour "awake" care. This is a dramatic change in her opinion from her written report, and I was not satisfied that she explained what led her to change her opinion. Moreover, the family's evidence did not support a finding that Tianna requires overnight awake care; there was no suggestion that any family member stays awake all night while living with Tianna. In my view, this recommendation is unfounded.
- [319] The defendants also say that Ms. Rosenfeld put little thought into her plan because it was based not on an analysis of what was required to address Tianna's situation, but merely on a gross number of hours needing a support worker. In that way, her opinions were not tailored to the evidence at trial. The defendants also point to Ms. Rosenfeld's statement in her report that Tianna experienced an "increased frequency" in falls and that she "repeatedly" fell in the bathtub. Those observations did not appear in her notes, nor were they supported by the family member's testimony. Given these examples, I do not have confidence that Ms. Rosenfeld's opinions are reliable and I reduce the weight I attach to her evidence.
- [320] The defendants also point to things in Ms. Drewnowsky's evidence that they say establishes she was acting as an advocate. I am not persuaded that she overstepped her role as an expert, but I agree her opinions did sometimes come close to advocate for the plaintiffs. I approach her evidence with some caution.
- [321] The plaintiffs did not suggest any overarching concerns with the defendants' experts and I found their evidence to be relevant and reliable.

G. Cost of Future Care

[322] Rather than summarize the expert's evidence at length, I prefer to first identify those facts relevant to assessing the cost of future care on which the parties agreed, or which I find have been established on a balance of probabilities based on both expert and lay witness evidence.

- a) Tianna's life expectancy is 72.5 years.
- b) Tianna will never be able to live independently. She is vulnerable to being taken advantage of financially, emotionally and physically, including sexually.
- c) Tianna will never be competitively employed.
- d) Tianna cannot manage her own finances except for small purchases.
- e) She will always need help with some aspects of her daily, personal care including getting dressed, grooming, personal hygiene and eating habits.
- f) She will need some type of physical therapy to address issues with her fine and gross motor skills.
- g) She is able to perform some basic housekeeping chores such as making light meals for herself and doing some laundry. She does not need help manoeuvring in her own home except for grab bars in the tub and relying on rails while on stairs.
- h) With regard to her cognitive capacity, she has a mild intellectual disability but she is functionally literate. She is computer literate.
- i) With regard to psychological adjustment, Tianna has difficulty with emotional and behavioural self-regulation; she is disinhibited and impulsive and responds very poorly to stress and adversity. She easily becomes overwhelmed.
- j) Her adaptive functioning is poor as a result of both her poor psychomotor skills and intellectual deficits.
- k) She has only basic social communication skills and has difficulty with complex social communication that will probably lead to frustration and anxiety as she gets older. These difficulties may increase over time.
- l) She would benefit from increased socialization and recreational activities, but they must be introduced gradually in a way that she can handle. She is not capable of initiating this or finding out what is available.
- m) She will never be competent to drive and would not be safe taking public transit unaccompanied.

- n) It would be beneficial for her to remain living with or very close to her family, so long as that does not impair her ability to get support to gradually improve her level of independence, socialization and community engagement.
- [323] The expert evidence was divergent on some important facts that impact the level of care Tianna will need. The most significant difference is the plaintiffs' submission that Tianna cannot be left unsupervised at any time, including overnight. This is based on Ms. Rosenfeld's testimony, whose evidence I approach with caution as discussed earlier in this decision, and Dr. Purtzki's report. But the plaintiffs' position is not supported by Dr. Joschko's evidence. In his first report, he opined that it is unlikely "from a neuropsychological perspective that Tianna will need full time, one-to-one supervision" and that she can safely be left on her own. In a subsequent report, however, he answered "no" to the following two questions: 1. "Is it safe for Tianna to be unsupervised during the day?", and 2. "Is it safe for Tianna to be unsupervised during the night?" He does not explain how he reconciles his answer to the first question with his opinion in his original report. In my view, the two statements are congruent if we assume that supervision does not mean "one on one", vigilant supervision, but the assurance that a responsible adult is available to monitor Tianna. This fits with the fact that Dr. Joschko emphasized the importance of making sure doors and windows are locked for night time supervision.
- [324] As to Dr. Purtzki's opinion, I agree with Dr. Mason's interpretation that she simply assumed that level of care was necessary rather than conducting her own analysis. Even if she had, however, I find Dr. Mason's opinion that Tianna "requires a supervised and assisted environment, but not one-to-one care" to be compelling. This is the only conclusion that is consistent with the rest of the evidence. There was no suggestion that a family member stays awake all night to supervise Tianna. I conclude the recommendation for 24 hour awake care is unreasonable and unfounded.
- [325] There was also a disagreement about Tianna's executive functioning. Dr. Joschko concluded that Tianna exhibits poor motivation which is not reflective of noncompliance or disinterest, but simply that she has "difficulty getting started". Dr. Purtzki's findings were consistent with this observation. But Dr. Finegan questioned whether Tianna's low motivation and effort are related to her injury. She said those types of symptoms ought to have been seen early on, whereas Tianna's school history was not consistent with that conclusion. Dr. Finegan also concluded that Tianna did not put her best effort into some of the tests administered by Dr. Finegan.
- [326] I am not satisfied that Dr. Finegan's single observation of poor engagement can be determinative that Tianna's brain injury is not responsible for deficits in initiative and motivation. There is evidence from other experts and lay witnesses to support a finding that Tianna genuinely has difficulty with the initiation of tasks and staying focussed. Also Dr. Finegan's assumption about Tianna's functioning is based on report cards which do not present a complete picture of Tianna's functioning.

- [327] I also do not rely on Dr. Finegan's statement that "[l]ittle is known about the executive functions" of people with cerebral palsy. She suggested that studies were inconclusive with respect to the impact of that condition on memory, communication and visual perception and functioning. Both Dr. Purtzki and Dr. Joschko opined specifically on Tianna's characteristics rather than referring generally to studies of people with cerebral palsy. Dr. Finegan's statements about executive functioning are not opinions based on Tianna's circumstances and I do not rely on them. I find that Tianna does have executive function deficits related to her injury that should be recognized in any award for cost of future care.
- [328] The parties also disagree about whether Tianna needs counselling. Dr. Joschko opined Tianna "may have more difficulty than the average person in coping with unpredictable future adversity, although serious problems requiring professional support are not an inevitable outcome and cannot be predicted with certainty." In his opinion, Tianna demonstrates "poor psychological resilience". This accords with the evidence at trial about how difficult it was for Tianna to adjust to new living arrangements and a new school. While that conclusion was not controversial, the parties disagreed on the mode of addressing it. Dr. Joschko also said Tianna was "mildly depressed" and that her self-esteem and social skills could be improved by psychotherapy.
- [329] I do not find there is sufficient evidence to demonstrate Tianna has psychological or mental health problems causatively linked to her birth injuries. Mental health disorders cannot be casually diagnosed and unlike her other physical and cognitive characteristics, there was not a consistent history supporting Dr. Joschko's opinion.
- [330] I agree with Dr. Finegan who made the obvious point that "psychotherapy is unhelpful in those with limited insight, poor self-awareness, and weak capacity for abstraction and generalisation." Her opinion accords with common sense. She also stated that in her experience, "self-esteem and social skills cannot be addressed in a vacuum, or in the abstract", but need "real life interventions" by engaging in recreational and social groups. In her view, once Tianna's social contacts increase, her mood and self-esteem will naturally improve. I find Tianna does not have a psychological or mental health condition. In my view, the evidence falls short of demonstrating counselling sessions can be reasonably justified for Tianna.
- [331] Dr. Purtzki concluded that Tianna met the criteria for "secondary" or acquired Attention Deficit and Hyperactivity Disorder, and on that basis she recommended a trial of medication to treat that condition. Dr. Purtzki is a physiatrist. I am not satisfied her opinion is sufficient evidence to conclude Tianna has ADHA and requires medications. Nor is there any evidence to support a conclusion that if she has ADHD it is sufficiently related to the injuries she sustained at birth to require compensation.
1. What model of care is most appropriate for Tianna?

- [332] The parties disagree whether I should base an award for future care premised on group home or shared living, or living with her family with community supports.
- [333] In my view, group home living is not a viable option. I am not satisfied a suitable group home would be available for Tianna when she would be ready for that life change given the evidence that government-funded care for people with disabilities in Ontario is shifting away from the philosophy of group care. Ms. Vellone recommended this option primarily to increase the socialization and community engagement for Tianna. All experts agreed that is an important goal for Tianna. However, I am satisfied those concerns can be addressed in other ways. Furthermore, given Tianna's vulnerabilities and cognitive deficits, there is a legitimate concern whether a group home would be safe for Tianna.
- [334] I also place importance on the fact that Tianna's family want her to live with them. Breanne testified that she plans to have a family, but that any potential partner will have to accept that Tianna will be integrated into their life. Breanne is still very young and it is not unreasonable to think that view may be modified to some degree in the future, but I am satisfied that Tianna's family will remain closely involved in Tianna's care and life.
- [335] I also agree with the plaintiffs that the evidence does not support the option of Tianna living with roommates with similar care needs or interests from age 21. Although Dr. Finegan recommended that arrangement, I note that Ms. Foster and Mr. Manula testified that in their experience, today's youth prefer to live with their families, or at least in a family setting. Another consideration is that even if it could be established that there is a real possibility Tianna would, for a period of time, live with other developmentally delayed adults, it is not clear there would be a reduction in her care costs; in fact, they would likely increase.
- [336] The goal of assessing an amount for future care is to make sure the plaintiffs will have the means to provide a living environment for Tianna that approximates as close as possible what she would have enjoyed but for the injuries she suffered at birth. I agree with the defendants that it is likely Tianna will live with her family with support. But I do not think it is realistic to assume that arrangement will be in place for the entirety of Tianna's life. It is common for elderly people to live in care homes and given the challenges Tianna will continue to have, I find it is reasonable to assume in her later years, Tianna will be placed in a care facility. The evidence was unclear about the viability and availability of elderly care homes for people with disabilities so it is possible she would need support if she were to live in that environment.
- [337] Taking all these factors into account, Mr. Justice Sigurdson's comments in *Kahlon v. Vancouver Coast Health Authority*, 2009 BCSC 922 at para. 385 are apposite. He noted that "the reality is that the care that will be provided for [the plaintiff] will be an amalgam of all of the options that were discussed in the evidence." I find that some combination of living with her family, with attendant care and elderly care home is the most likely scenario.

- [338] The plaintiffs seek \$400,000 for accessible housing based on an assumption that she would buy her own home, but would need extensive renovations to accommodate her disabilities. They concede it is reasonable to assume she would have bought her own house but for the accident so that the purchase price is not compensable. They claim an amount they say represents only renovations. The amount is also based on recommendations that she requires separate rooms for exercise and homework and accommodations in the kitchen. None of these are medically justified. The only home renovations that are supported by medical evidence are the grab bars in the tub or shower and hand rails for stairs.
- [339] Furthermore, I agree with the defendants' position that the case law does not permit awarding funds to buy the plaintiff a capital asset because of the possibility that amounts to over-compensation (*Greenhalgh v. Douro-Dummer (Township)*, [2009] O.J. No. 5438 (S.C.)) or enrichment that is not justified (*Fullerton (Guardian ad litem of) v. Delair et al.*, 2005 BCSC 204). It is important to keep in mind that compensation is for "the pecuniary loss aspect of the cost of future care" and not "the non-pecuniary goal of providing solace": *Aberdeen v. Township of Langley, Zanatta, Cassels*, 2007 BCSC 993 at para. 120.
- [340] In light of that, the defendants submit that a contingency amount for renovations in the amount of \$50,000 is reasonable; I agree.
2. Should the cost of future care be reduced to account for government funding?
- [341] The parties disagree on whether a contingency should be applied to any award for cost of future care on the basis that there will be government funding available for people with developmental disabilities. The plaintiffs submit that the court should not take into account government-funded programs because there is no guarantee they will exist in future, or not be cut back.
- [342] The plaintiffs point to the evidence there are significant wait lists for government funded support and services in Ontario and only limited funding is available. They also suggest that the supports are discretionary in nature, and the limited pool of funds available is insufficient to provide all necessary supports. They submit that the law does not require plaintiffs to "make do" with government subsidized care and only receive compensation that falls outside of the "system": *Cojocar v. British Columbia Women's Hospital*, 2009 BCSC 494. That is true but the defendants are not suggesting government funding would replace compensation, only that there should be an adjustment for that contingency.
- [343] The plaintiffs rely on *Fullerton (Guardian ad litem of) v. Delair*, 2006 BCCA 339 in which the Court of Appeal found that no deduction to compensation could be made for a government service entitled, "At Home Program". The defendants say the case is distinguishable and I agree. The "At Home Program" considered in *Fullerton* had a proviso that funding could be eliminated or reduced if damages were awarded. There was no evidence that this is a feature of the current Ontario scheme.

- [344] The defendants point to the principle that damages must be assessed once and for all at the time of trial, and adjustments are appropriate for the contingency that the future will differ from the evidence: Krangle at para. 21. The defendants rely on *Ediger v. Johnston*. The court held it was appropriate to take into account that the plaintiff may live in a group home environment (provided by Community Living BC) and applied a contingency to recognize that "a reasonable method of cost-sharing will arise in the future, and the portion of the award reflecting the cost of [the injured infants'] future attendant care" should be reduced (at para. 261). In *Forde v. Inland Health Authority*, 2010 BCSC 91, the court held government benefits must be taken into account if they are available regardless of tort compensation. This assures there is no double recovery. The defendants also submit the evidence demonstrates a substantial possibility that Tianna will be eligible for Passport funding.
- [345] I agree with the defendants' position. Based on the evidence I have heard, I am persuaded that whatever criteria is legislated, Tianna would be eligible given the undisputed evidence that she cannot live alone and will need support for the rest of her life. Mr. Manula testified that current funding ranges from about \$2,000 to \$35,000 per year and there is no means-testing. The defendants submit Tianna is likely to receive something above the minimum.
- [346] Accordingly, I conclude a contingency must be applied to reduce the amount awarded for cost of future care to account for the likelihood Tianna will receive government benefits. The defendants did not make submissions on the amount of the contingency or the method of calculating or applying it, which leaves the court in a difficult position. Based on the only evidence available to me (Mr. Manula's description of the range of funds available) I find that it is reasonable to reduce the award for attendant care by an amount of approximately \$10,000 per year based on the likelihood that Brianna will receive government benefits whether through direct financial payments or access to programs.

H. Damages Awarded

- [347] With the preceding comments in mind, I turn to the specific heads of damages claimed. I am mindful that my determination must be based on the evidence at trial but with regard to quantifying future losses, I am not obliged to "[assign] percentage probabilities to estimates of the likelihood of certain events and take the step of expressly discounting the award by a percentage amount to reflect contingencies": *Tsalamandris v. McLeod*, 2012 BCCA 239 at 53.
- [348] Therefore, I explain the formula I considered in determining quantum but that explanation is not necessarily accompanied by precise calculations. As to determining the present value for future losses, no party suggested I could not rely on the expert evidence of Mr. Benning or Mr. Hildebrand; nor did any party provide oral submissions on the reliability of their evidence. I have consulted both reports, particularly the multiplier tables, and used multipliers that are roughly an average of their figures to calculate the present value of some of the future care costs.

1. Attendant Care

- [349] I find Tianna will need attendant care for the rest of her life but as noted above, I reject the plaintiffs' position that she needs 24 hour care. I find the plaintiffs' experts' recommendations are excessive not only in the amount of hours, but also the level of care.
- [350] In terms of the level of care, I acknowledge that Ms. Rosenfeld recommended the award for attendant care include the cost of rehabilitation support workers (RSW). That recommendation is not justified by the medical evidence. The plaintiffs' expert, Dr. Joschko, opined that Tianna will be capable of some level of independence and that obviates the justification for RSW. I rely on the opinions of Ms. Vellone and Ms. Drewnowsky that DSW will be able to provide adequate support if guided by professionals such as an occupational therapist.
- [351] Overall, I prefer that aspect of Ms. Vellone's model which recommended an amount for some hours of DSW care and near-daily PSW support during the week until Tianna is 21. Because I am not persuaded that there is a real and substantial possibility that Tianna will enter into a shared living arrangement at age 21, I conclude the award should be based on supported care for most of the rest of Tianna's life. Ms. Vellone conceded that she failed to account for the higher wages that will have to be paid for statutory holidays and that should be added. Ms. Vellone did not appear to calculate PSW time for when Tianna lives with her father. In my view, this is necessary because it may no longer be appropriate for Mr. Brodeur to be assisting Tianna with dressing, grooming or hygiene. Ms. Vellone then calculated PSW hours per week.
- [352] In awarding compensation for attendant care, I take into account a number of contingencies that I find were proven likely on the evidence. The most significant contingency is the likelihood that in her senior years, Tianna will need to live in a care home but perhaps with attendant care. The evidence was clear that type of care would be more expensive than Tianna living with her family with attendant care. I also do not find it likely that Tianna will remain in school until age 21 so the award is based on attendant care starting immediately.
- [353] In terms of negative contingencies, I find it reasonable to take into account that while Tianna lives with her family, there will be times (perhaps over Christmas holidays) that support workers may not be hired for the same amount of time because the family wants to enjoy time together with less disruption. I also find it reasonable to acknowledge that Tianna, like any person, will want some "downtime" such as she currently has when in her room listening to music or being on her computer. These factors support a downward adjustment.

[354] I award \$3,000,000 for attendant care. I am satisfied that this award will, to the greatest extent possible, place Tianna in the same position as if she had not been injured. The amount is based on approximately 10 hours for DSW and 25 hours of PSW per week. In addition to the contingencies, I have added an amount to recognize extra pay for statutory holidays and a contingency for family respite each year. That total was reduced for government care as discussed above, and present value tables were consulted.

2. Physical and Psychological Therapies

[355] Because of my concerns with some of the plaintiffs' expert evidence (as discussed earlier), I prefer the evidence of Dr. Mason with regard to Tianna's physical capabilities. He diagnosed Tianna with "bilateral, spastic, ataxic cerebral palsy" and "mild bilateral plantar flexion contractures secondary to the spastic component of the cerebral palsy". His opinion was that she has an increased risk of musculoskeletal problems in her foot and ankle and joint problems in her knees. He also opined she is at an increased risk for falls.

[356] He recommended some physiotherapy assessment in conjunction with someone to assist with exercise, but also to account for her risk of future falls. He did not recommend a full physiotherapy program throughout her life because his opinion was that her functioning had plateaued. I am also mindful that Tianna will receive trained attendant care and (as will be discussed later in this decision), funds for recreation and occupational therapy and there could be significant overlap and double recovery if too much is awarded for physiotherapy. I award \$20,000 for this item.

[357] Based on that medical evidence, I am also satisfied the evidence supports an award for occupational therapy because Tianna is unable to perform certain tasks for herself related to her personal and environmental care (dressing, grooming, planning etc.). Ms. Vellone estimated an initial block of some hours to set up a program and then an annual award for the rest of Tianna's life. She said that DSW more than likely will be able to follow instructions, but I find that is not a replacement for occupational therapy. Consulting an occupational therapist will provide valuable oversight into how DSW work with Tianna. I award \$35,000 for this amount which approximates the present value of six hours a year and additional hours every five years to handle life changes, plus travel costs.

[358] All experts agreed Tianna needs some type of behavioural management. I have concluded the medical evidence does not justify an award for psychological or psychiatric counselling. Dr. Finegan's evidence was that the type of behavioural management Tianna will require can be provided by DSW's who are trained for that type of care, but she also recommended very specific counselling to address Tianna's tantrums. I find it reasonable to make a specific limited award for that purpose. I award \$10,000 for this item.

3. Case Management

[359] I am satisfied the medical evidence justifies an award for these services because of Tianna's executive function and cognitive deficiencies. Ms. Vellone calculated a need for 60 hours a year for one year and then bi-monthly visits for the rest of Tianna's life. That is excessive given that I find it likely Tianna's family will be closely involved in her care. I award \$50,000 for this item. This is based on approximately 12 hours a year and 100 extra hours spread over her lifetime to accommodate the extra help she may need with major life changes.

4. In Trust Claim

[360] The defendants submit the evidence to support the quantification of this claim is scant. In *Bystedt v. Hay*, 2001 BCSC 1735, Madam Justice Smith reviews relevant case law and summarizes the factors to consider when awarding an "in trust" claim. The plaintiffs rely on *Cojocar* (appealed on a different ground) for the principle that precise mathematical calculations are not required. Instead, it is important to provide quantification based on an estimate of extra hours of time.

[361] The plaintiffs calculated the number of hours of extra care family members provided to Tianna from birth to age 16. The defendants suggested a lower number and used the amount of \$15 per hour. The plaintiffs' estimation of the number of hours better accords with the evidence and is reasonable, but the rate they applied was too high. I award \$200,000 for the in-trust claim based on approximately the plaintiffs' hours and a per hour rate between the parties' estimates.

5. Miscellaneous Items

[362] I award \$4,169 which is the present value of the cost of contraception until Tianna turns age 50. I also award \$9,946 for the special deodorant Tianna needs. As noted above, I order \$50,000 for home renovations.

[363] Tianna does not currently wear orthotics and the defendants urged me not to make an award on that basis. I do not agree. In my view it is most likely she is not wearing orthotics presently at least in part because she has not received sufficient prompting to do so. I also find there is a medical justification for orthotics given her demonstrated challenges with balance and walking and Dr. Mason's opinions. It is likely that her physical need for orthotics will increase with her age.

[364] The plaintiffs' calculation for this item was based on two pairs replaced every two years for the rest of her life which I find to be unreasonable. I reduce that amount by two-thirds to account for the fact that she is not currently wearing them and the replacement interval is wholly dependent upon how often Tianna wears them. I award \$9,000.

[365] All experts agree Tianna would benefit from increased recreational activities, but those may need to be specialized to her needs. The plaintiffs seek costs based on a specific facility membership and activity. I prefer Ms. Vellone's approach which is to provide an annual sum that can be spent on whatever activity Tianna and her caregivers decide is best. However, I also find it most likely that had the injury not occurred, Tianna's family would

have spent some money on leisure or recreation as that is a common, every day expense. There is also a real and substantial possibility some of the recreational opportunities she will access will be government funded. An award is appropriate, but I reduce the annual amount assessed by Ms. Vellone. I award \$16,500 for recreation over her lifetime (this takes into account the present value calculations).

- [366] Tianna will not be able to drive and on that basis, the plaintiffs claim an amount for taxi trips. Many people do not drive or do not own vehicles and therefore they pay for transit. It is not reasonable to base an award on the total amount of transportation it is anticipated Tianna would need on an annual basis. It is more likely than not that she would have incurred transportation costs without the injury. I do find it reasonable to recognize the extra number of medical and professional appointments she will need to attend over her lifetime and make an award for that. I award \$10,000 for this item.
- [367] The plaintiffs seek an award for housekeeping services. Ms. Drewnowsky estimated a need for 12 hours a week for the rest of her life (meant to address cleaning and light meal preparation). I am not persuaded this item is justified based on the evidence. Tianna is capable of making herself light meals and doing some chores to contribute to the upkeep of her dwelling. Any amounts beyond that duplicate what would naturally be provided by a family member or facility in which she would live; I therefore find the expense would be duplicative and I award no amount for it.

6. Special Damages

- [368] The defendants emphasize that no receipts were provided for the amounts claimed apart from the amount Mr. Brodeur had to pay to cancel his mortgage early and move to Thunder Bay. In *Camp Development Corporation v. South Coast British Columbia Transportation Authority*, 2011 BCSC 355, Mr. Justice Cullen explains the rationale for the need to specifically plead special damages (at para. 8), but I do not read that passage as precluding recovery just because no receipts are provided; what is required is to particularize the claim.
- [369] The plaintiffs say Tianna's family does not have receipts for most special damage claims because the money was spent before the litigation was contemplated by the family, and when it was commenced they were unaware of what items could be reimbursed. The plaintiffs particularize a claim for \$33,027.80, of which the defendants say only \$15,000 is reasonable, which approximates the interest charges Mr. Brodeur paid, and an amount for extra trips to, and parking at the hospital.
- [370] An amount for extra diapers and wipes would have been reasonable to claim because it took Tianna longer to be toilet trained. But I was presented with no evidence to explain the amount claimed; even some evidence about the current cost of this item would have been helpful. Without any evidence, I do not make that award.

[371] I also do not find expenses related to the family's move to Thunder Bay to be appropriate. I understand why Ms. Brodeur and her daughters would choose to move to Thunder Bay to be closer to Ms. Hicks, but there is no evidence that Ms. Hicks' move to Thunder Bay was in any way related to Tianna's injuries.

[372] I do agree, however, that Mr. Brodeur having to hasten his move and pay a penalty on his mortgage was caused by Tianna's unique circumstances. The evidence was clear she was having difficulty coping living without her father. In my view, \$15,000 is appropriate award for special damages.

X. SUMMARY OF DAMAGES

[373] I order the following:

By Consent:

Non pecuniary damages

\$363,200.00

Damages for income loss

\$1,000,000.00

Damages for loss of interdependency

\$221,638.00

Speech language pathology

\$125,000.00

TOTAL

\$1,709,838.00

Cost of Future Care:

Attendant Care

\$3,000,000.00

Physiotherapy

\$20,000.00

Occupational Therapy

\$35,000.00

Behavioural Management

\$10,000.00

Case Management

\$50,000.00

Miscellaneous Items

Medication - \$4,169

Deodorant - \$9,946

Home Renovation - \$50,000

Orthotics - \$9,000

Recreation - \$16,500

Transportation - \$10,000

\$99,615.00

TOTAL

\$3,214,615.00

In Trust Award

\$200,000.00

Special Damages

\$15,000.00

OHIP

\$7,817.57

Health Care Costs Recovery Act

\$54,577.07

TOTAL DAMAGES

\$5,201,847.64

XI. REMAINING ISSUES

[374] Should the parties be unable to agree on the issue of apportionment, they may provide to me via the Registry no more than five pages each on the issue. All submissions must be received no later June 15, 2016.

[375] If the parties cannot agree on costs, they may contact the registry within 30 days of this judgment being released to arrange a time convenient to counsel and the court for a brief hearing. In the alternative, the parties may provide written submissions in which case I expect them to compose a fair schedule amongst themselves for the exchange of submissions so long as the last submission is received by me via the Registry no later than September 30, 2016.

"Sharma J."

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Prepared on 26 October 2026 · Esheria