

CANADA / JUDGMENT

Severn v. Bokelman

2018 BCSC 1100

COURT

Supreme Court of British Columbia

DECIDED

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2018 BCSC 1100 *Severn v. Bokelman* IN THE SUPREME COURT OF BRITISH COLUMBIA Citation: *Severn v. Bokelman*, 2018 BCSC 1100 Date: 20180703 Docket: S165881 Registry: New Westminster Between: Mr. Craig Severn Plaintiff And Dr. John F. Bokelman, Dr. Ashit Bardhan, Ridge Meadows Hospital Defendants Before: The Honourable Madam Justice B.J. Brown Reasons for Judgment Counsel for Plaintiff: S.P. Grey Counsel for Dr. John Bokelman and Dr. Ashit Bardhan: M.G. Thomas Counsel for Ridge Meadow Hospital: D.J. Bell Place and Date of Hearing: New Westminster, B.C. April 20, 2018 Place and Date of Judgment: New Westminster, B.C. July 3, 2018

Introduction

- [1] This matter comes before me as a summary trial application. There is only one issue that I am to determine and that is: "would a reasonable patient, in the position of Mr. Severn, fully apprised of the risks associated with an epidural, have proceeded with that treatment option?" If the plaintiff cannot satisfy me that a reasonable person in his position would not have proceeded with an epidural then the action must be dismissed.
- [2] The parties agree that this issue is appropriate for determination on a summary trial basis.

Background

- [3] In September 2012, the plaintiff's doctor, Dr. Greg Kotylak recommended that the plaintiff undergo major abdominal surgery; a sigmoid resection to treat persistent diverticulitis. The plaintiff had several pre-existing conditions which made him a higher risk for surgery. These conditions included: raised cholesterol; increased fasting glucose; previous cardiovascular events with left sided palsy; stroke; and heavy smoking. Because of his conditions, Mr. Severn required a pre-anaesthetic consultation. The consultation was performed by Dr. Bokelman at Ridge Meadows Hospital on November 1, 2012.
- [4] During the consultation, Dr. Bokelman recommended a combined general/epidural anaesthetic for the planned surgery. The epidural would assist with pain control during and after the surgery. The alternative treatment option was general anaesthetic with a PCA (patient controlled analgesic) after the surgery.

- [5] Mr. Severn was concerned about an epidural. He did not want one because he thought the insertion of the needle would be too painful. This belief was based on a previous experience he had with a similar injection. Dr. Bokelman advised the plaintiff that his concern about pain could be appropriately managed with the judicious use of anaesthetic during the insertion. He was told by Dr. Bokelman that the procedure could be stopped if it was too painful. The plaintiff agreed to proceed with the epidural.
- [6] There is a dispute as to whether Dr. Bokelman warned the plaintiff of the risk of neurological damage at the time of the pre-anaesthetic consultation.
- [7] On the day of the surgery (November 5, 2012), the plaintiff met with Dr. Bardhan who was the anaesthesiologist assisting with the surgery. He confirmed with the plaintiff that he was scheduled to have an epidural. Mr. Severn looked uneasy. Dr. Bardhan asked him if he had any concerns. The plaintiff told him that he had a previous experience with a similar injection and found the insertion of the needle to be very painful.
- [8] Dr. Bardhan told the plaintiff that he provides a lot of numbing medication to reduce the pain of insertion. He also told the plaintiff that he could stop the insertion at any time. He told the plaintiff that he did not have to have the epidural but given his clinical situation it would be better if he proceeded with the insertion of the epidural. The plaintiff agreed to proceed with the epidural.
- [9] In the statement of claim, the plaintiff pleads that as a result of the epidural he has suffered permanent nerve damage and is now effectively a paraplegic. Position of the Parties The Applicants
- [10] The applicants (the defendants Dr. Bokelman and Dr. Bardhan) argue that the matter is suitable for determination on summary trial. They submit that the determination of this specific issue will resolve the litigation faster, promote the orderly use of court time and reduce the costs to both parties and the court.
- [11] The applicants argue that the plaintiff must prove two elements:
1. Informed consent was not obtained; and
 2. A reasonable person in the position of the plaintiff would not have given consent if he had been adequately apprised of all material risks. It is only this second aspect that is at issue before me.
- [12] The applicants argue that assessing this liability issue without incurring the time and expense of assessing damages is appropriate. It will not require the court to make any findings of credibility. They submit potential savings in court time and expense would be considerable.
- [13] The applicants note that onus is on the plaintiff to prove that a reasonable person in his position would not have proceeded with the epidural had they been advised of the risks. This requires the court to consider what the reasonable patient in the circumstances of the

plaintiff would have done in the same situation. The trier of fact must take into consideration any particular concerns of the patient and any special considerations affecting the particular patient in determining whether the patient would have refused treatment if given all the information about possible risks: see *Reible v. Hughes*, [1980] 2 S.C.R. 880 [Reible], at para. 25.

- [14] The applicants submit that a reasonable patient in the circumstances of Mr. Severn would have opted to undergo the epidural on November 5, 2012. This is so because proceeding without an epidural posed a significantly higher risk of serious, critical or fatal complications in comparison to proceeding with the epidural. The Plaintiff
- [15] Mr. Severn says that he made it abundantly clear to Dr. Bokelman that he did not want an epidural. He says that Dr. Bokelman in effect browbeat him into going ahead with an epidural in addition to the general anaesthetic.
- [16] He agreed that the issue of whether a reasonable person in the position of the plaintiff would have consented to having an epidural with knowledge of all risks associated with the procedure can be determined on the summary judgment application.
- [17] Mr. Severn argues that someone in his position who:
1. did not want to have an epidural;
 2. had experienced pain related to an epidural-like procedure before;
 3. was undergoing a similar abdominal surgery; and
 4. had been properly advised of all of the risks associated with the epidural; would not have proceeded with the epidural. Discussion
- [18] The issue before me is a narrow one--whether a patient in a similar position to Mr. Severn, having been apprised of the risks of an epidural, would have proceeded with one anyway. I am able to determine this issue on the evidence before me. It is does not turn on conflicting affidavit evidence.
- [19] To be successful, Mr. Severn must prove that a reasonable person his position would not have given consent if he had been adequately apprised of the material risks.
- [20] In *Reible*, the Supreme Court of Canada said the following with respect to the objective test for determining what the Court should consider when addressing this issue:
- [25] the objective standard would have to be geared to what the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery or foregoing it were made known to him. Far from making the patient's own testimony irrelevant, it is essential to his case that he put his own position forward.

- [26] The adoption of an objective standard does not mean that the issue of causation is completely in the hands of the surgeon. Merely because medical evidence establishes the reasonableness of a recommended operation does not mean that a reasonable person in the patient's position would necessarily agree to it, if proper disclosure had been made of the risks attendant upon it, balanced by those against it. The patient's particular situation and the degree to which the risks of surgery or no surgery are balanced would reduce the force, on an objective appraisal, of the surgeon's recommendation. Admittedly, if the risk of foregoing the surgery would be considerably graver to a patient than the risks attendant upon it, the objective standard would favour exoneration of the surgeon who has not made the required disclosure. Since liability rests only in negligence, in a failure to disclose material risks, the issue of causation would be in the patient's hands on a subjective test, and would, if his evidence was accepted, result inevitably in liability unless, of course, there was a finding that there was no breach of the duty of disclosure. In my view, therefore, the objective standard is the preferable one on the issue of causation.
- [27] In saying that the test is based on the decision that a reasonable person in the patient's position would have made, I should make it clear that the patient's particular concerns must also be reasonably based; otherwise, there would be more subjectivity than would be warranted under an objective test.
- [21] In *Arndt v. Smith*, [1997] 2 S.C.R. 539, the Court elaborated on this modified objective test and said at para. 9:
- [9] "[S]pecial 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.
- [22] The applicants have provided me with an opinion dated May 3, 2017, from Dr. Pantel, a specialist in anaesthesiology. He opines as follows:
1. Potential advantages of using a combined general anesthesia/epidural technique;
 - a. An epidural provides excellent analgesia in the post-operative period
 - b. An epidural positively contributes to recovery by facilitating mobilization and recovery of gut function
 - c. An epidural can reduce pulmonary, cardiovascular, thromboembolic, gastrointestinal and other complications occurring after abdominal surgery
 - d. An epidural allows the anesthesiologist to use lower doses of general anesthetic agents intraoperatively, facilitating recovery
 - e. Use of an epidural reduces the acute stress response to surgery

- f. Studies have shown a higher level of patient satisfaction with combined GA/epidural techniques
2. Risk factors, considerations and potential complications of using an epidural technique, in general:
 - a. Difficult Insertion or failure to properly place the epidural in the correct location
 - i. Anatomic factors (eg scoliosis, obesity)
 - b. Epidural dislodgement or failure after insertion
 - c. Pain on insertion of the epidural
 - i. Localized pain at the insertion site ii. Paresthesia (nerve pain after contacting a nerve during insertion)
 - d. Positioning factors
 - i. Sitting vs. lateral position for insertion
 - e. Requirement for sedation or analgesia during placement
 - f. Bleeding during placement or removal of the epidural
 - i. Localized bleeding at the insertion site ii. Spinal hematoma causing pain or neurological damage iii. Risk factors for excessive bleeding (eg anticoagulants or blood clotting disorders)
 - g. Infection
 - i. Localized infection (eg cellulitis) at or near the insertion site ii. Systemic blood-borne infections (eg bacteremia)
 - h. Adverse drug reactions or allergies to local anesthetic agents
 - i. Potential for drug administration errors
 - j. Difficult removal or knotting of the epidural catheter
 - k. Potential for accidental dural puncture or CSF leak
 - i. Immediate: on placement of the epidural ii. Delayed: while the catheter is indwelling iii. Difficulty in managing a dural puncture headache if it does occur
 - l. Potential for Neurological Damage
 - i. Pre-existing nerve disease (eg Multiple Sclerosis) ii. Pre-existing known spinal cord pathology (eg spina bifida, syringomyelia, spinal tumours, arachnoid cysts, etc) iii. Potential for physical damage to nerves at the site of insertion iv. Toxic reactions to local anesthetic agents or the components of the drug solutions
 - m. Surgical Requirements

- i. Ability to assess lower limb neurological function post op ii. Interference with the surgical site iii. Hospital policy and post-op nursing requirements
- n. Previous experience with epidural or spinal anesthesia
- o. Patient preference and consent
- 3. Anesthesia protocols known as Enhanced Recovery After Surgery (ERAS) have recently been introduced in many hospitals, including at Lions Gate Hospital (LGH) in 2016. The ERAS protocol at LGH is attached as Appendix D, with references to the epidural highlighted. The ERAS Protocols emphasize that the preferred technique for open abdominal surgery is a combined thoracic epidural with general anesthesia. Many anesthesiologists have been following the principles of ERAS, even if they have not been formally adopted at their hospital.
- 4. For major abdominal surgery, the patient will require a GA (General Anesthetic) no matter which technique is chosen, In general, my decision to recommend a combined GA/epidural technique is based on an assessment of the potential benefits vs risks (outlined above) in each individual patient.

[23] He quotes the risks of complications of epidural anaesthesia for Mr. Severn as:

- 5. With respect to the relative risks and the potential consequences of proceeding with epidural placement and without epidural placement, in this particular patient:
 - a. Mr. Severn was known not to have a healthy cardiovascular system. He was a long-standing smoker with a tendency to diabetes and high cholesterol. He had already had a minor stroke. I would consider this patient a higher than normal risk for complications post-op.
 - b. I would have been very uncomfortable proceeding without an epidural and providing only general anesthesia for the planned surgery. It would not have been the surgery itself that concerned me, but the first 24-48 hours post-op when the risk of complications is highest.
 - c. Mr. Severn was a patient who was already sensitized to pain and would almost certainly require higher than normal doses of narcotics post-op if no epidural was used, Without an epidural, and thus receiving increased doses of narcotics he would be expected to have many or all of the following effects and possible resulting complications. Each one of these possible complications may result in significant or critical illness, and in combination they can be fatal:
 - i. Increased nausea and vomiting with potential disruption of incisions and suture lines ii. Slower GI tract recovery and greater degrees of ileus, leading to poorer bowel healing, possible infection and/or suture disruption iii. Increased fluid requirements, leading to bowel edema and poorer healing iv. Slower mobilization, possibly leading to an increased chance of blood clots, deep vein thrombosis and pulmonary embolism

- v. Decreased cough and respiratory depression, possibly leading to pneumonia and hypoxemia (low oxygen levels)
 - vi. Longer use of post-op narcotics, possibly leading to narcotic dependency and addiction issues
 - vii. Urinary retention, leading to prolonged catheter use and possible bladder/kidney infection
 - viii. Poorer nutritional intake, possibly leading to malnutrition, poor wound healing and infections
- d. All of the effects and potential complications listed above are significantly less likely to occur with a combination epidural/GA technique
- e. Overall, I would say that proceeding without the epidural would have a significantly higher risk of serious, critical or fatal complications than proceeding using a combination epidural/GA technique.
- e. I typically do not quote the risk of rare complications or death from anesthesia, but if the discussion goes in this direction then I typically discuss the common complications of epidural anesthesia as:
- i. 1:4 chances of a backache at the site of the epidural insertion. If the patient has pre-existing backache or disk disease then I tell them that there is a possibility that needle insertion into the spine could exacerbate their underlying condition, however, I explain that the epidural is posterior and does not go near the discs (which are located on the anterior aspect of the spine)
 - ii. 1:200 chance of an inadvertent dural puncture with the possibility of a Post-Dural Puncture Headache (PDPH)
 - iii. 1:10,000 chance of a major or severe complication resulting in permanent injury or death.
- [24] In my view, a reasonable person in the position of Mr. Severn, provided with the information above, would have proceeded with the epidural in combination with a general anaesthetic, rather than a general anaesthetic followed by PCA. I accept Dr. Pantel's opinion that proceeding without the epidural would have a significantly higher risk of serious, critical or fatal complications.
- [25] As Dr. Pantel noted in his opinion, Mr. Severn was known to have issues with his cardiovascular system. As such, he was at a higher than normal risk for complications postoperatively. He would almost certainly have required higher than normal doses of narcotics postoperatively if no epidural was used. He also could have expected to have many of the negative effects and possible resulting complications with increased doses of narcotic which could result in critical illness, addiction or fatality. All of those potential complications were significantly less likely to occur with a combination of epidural and general anaesthetic.

- [26] I note that the only concern expressed by Mr. Severn regarding the epidural was with respect to the pain that he had experienced before in a similar procedure. As both Dr. Bokelman and Dr. Bardhan have stated in their affidavits, they addressed this concern, advising Mr. Severn that they would guard against the pain by local anaesthetic where the epidural was to be inserted and if it were too painful, they could stop. That is what happened. Mr. Severn then proceeded with the epidural.
- [27] I conclude that a reasonable person in Mr. Severn's position, advised of a 1 in 10,000 chance of a major or severe complication resulting in permanent injury or death from the epidural, and of the risks of proceeding without an epidural, would have proceeded with an epidural. The fact that Mr. Severn may have suffered the rare risk that the epidural involved, does not negate the likelihood that a properly advised patient, weighing the pros and cons of each treatment option, would have proceeded with the epidural.
- [28] As such, the action against doctors Bokelman and Bardhan is dismissed pursuant to R. 9-7 of the Supreme Court Civil Rules.
- [29] The applicants are entitled to costs. "B.J. Brown J."

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