COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: *Focken v. Miller,* 2024 BCCA 74

Date: 20240301
Docket: CA48734

Between:

Teisha Leanne Focken

Appellant
(Plaintiff)

And

Dr. Mark Jonathan Miller and Dr. Andrew Kurt Best

Respondents
(Defendants)

Before: The Honourable Mr. Justice Harris
The Honourable Mr. Justice Willcock
The Honourable Mr. Justice Hunter

On appeal from: An order of the Supreme Court of British Columbia, dated December 6, 2022 (*Focken v. Fraser Health Authority*, 2022 BCSC 2124, Vancouver Docket S197211).

Counsel for the Appellant:	D.O. Shane
Counsel for the Respondents:	J.A. Morris B. Desparts
Place and Date of Hearing:	Vancouver, British Columbia December 15, 2023
Place and Date of Judgment:	Vancouver, British Columbia March 1, 2024

Written Reasons by:
The Honourable Mr. Justice Willcock

Concurred in by:
The Honourable Mr. Justice Harris
The Honourable Mr. Justice Hunter

Summary:

This is an appeal from an order dismissing a medical negligence action which arose from the death of the appellant's husband. The respondents, Drs. Miller and Best, were involved in the patient's care. At trial, the appellant asserted the respondents breached the required standard of care and, specifically, that an embolization procedure should have been performed immediately upon the patient's admission to hospital, instead of being scheduled for 8:00 a.m. the next day. The trial judge dismissed the action, concluding that Dr. Best, in consultation with Dr. Miller, had exercised reasonable clinical judgment in scheduling the embolization procedure. The appellant says the trial judge made two errors of law with respect to standard of care and two further palpable and overriding errors.

Held: Appeal dismissed. First, contrary to the appellant's assertion, the trial judge considered the degree of foreseeable risk to the patient when assessing the appropriate standard of care. Second, the trial judge did not fail to grapple with the appellant's argument that the course of treatment chosen was so fraught with obvious risks that it was negligent. In any event, that argument is unsupportable on the facts. Third, the trial judge made no error in listing the experts whose opinions were favorable with respect to whether Drs. Miller and Best had met the standard of care. In any event, the error alleged would not be "overriding". Fourth, the trial judge did not err in placing weight on the evidence of Dr. Best with respect to the higher complication rates associated with after hours procedures.

Reasons for Judgment of the Honourable Mr. Justice Willcock:

Introduction

[1] At approximately 3:00 a.m. on December 20, 2018, while hospitalized at Royal Columbian Hospital, Bradley Focken, a 55-year old architect, experienced bleeding in his throat that obstructed his airway leading to hypoxic cardiac arrest lasting appropriately nine minutes. He was intubated and placed on life support but suffered a significant hypoxic ischemic brain injury. He passed away in the intensive care unit on January 10, 2019.

[2] Teisha Focken, his widow and the appellant on this appeal, asserted at trial that the attending physicians breached the standard of care they owed to Mr. Focken and their negligence caused his death. She alleged his condition on admission to the hospital, at around 1:30 p.m. on the afternoon of December 19, 2018, called for the performance of an embolization procedure on an "emergent" (i.e., immediate) basis, and had that been done Mr. Focken would have survived.

[3] The trial judge, for reasons indexed at 2022 BCSC 2124, concluded that none of the medical professionals who treated Mr. Focken breached the standard of care expected of them and dismissed the claim.

[4] He found that, although admitted with a prior bleed, Mr. Focken was stable soon after arriving at the hospital and had no active bleeding until 3:00 a.m. on the morning of December 20, 2018. That being the case, the decision to perform an embolization on an "urgent" (i.e., within 24 hours) basis at 8:00 a.m. on December 20, 2018, rather than on an emergent basis, did not breach the standard of care expected of the attending physicians and nurses.

[5] That conclusion was founded upon the judge's acceptance of the expert opinion evidence of the defence witnesses, Drs. Man, Irvine, Legiehn and Best, and his conclusion that limited weight could be placed upon the opinion evidence adduced on behalf of Ms. Focken, that of an otolaryngologist, Dr. Gillis. Dr. Gillis' opinion was considered to be unhelpful because he made an assumption unsupported by the evidence, that Mr. Focken's pre-existing cancer was in remission, and because he was unaware of much of the significant evidence, including Mr. Focken's stable and continuously monitored vital signs during the critical period.

[6] Dr. Gillis had not been provided with Mr. Focken's November 27, 2018 chest X-ray; he did not know Mr. Focken had a CT scan of his neck done on November 29, 2018, which showed necrosis; and he was not aware of a December 14, 2018 PET scan performed on Mr. Focken, which suggested residual cancerous disease. In addition, at the time he wrote his report, Dr. Gillis did not know that Mr. Focken had his vital signs continuously monitored throughout the afternoon and evening of December 19, 2018, and that these vital signs were stable; or that a CT angiogram, performed on the afternoon of December 19, 2018, revealed that Mr. Focken had bled from the right lingual artery but was no longer bleeding at the time of the angiogram.

[7] The appellant appeals the dismissal of her action against the respondents Dr. Mark Miller, an otolaryngologist, and Dr. Andrew Best, an interventional radiologist. She contends the judge erred in law by:

a) failing to analyze the standard of care with reference to the degree of foreseeable risk to Mr. Focken; and

b) failing to analyze the standard of care with reference to whether the decision to wait until the morning of December 20, 2018, to perform the embolization, was so fraught with obvious risk that it was negligent.

[8] She contends the judge made a palpable and overriding error by:

a) finding that one of the respondents' expert witnesses, Dr. Irvine, was of the opinion that Dr. Miller and Dr. Best did not breach the applicable standard of care when he did not express that opinion; and

b) relying on the anecdotal and opinion evidence of Dr. Best as to the higher complication rates associated with after hours medical procedures.

[9] The appellant does not appeal the dismissal of her action against Dr. Diana Stancu. Her appeal of the dismissal of the action against the Fraser Health Authority, the operator of the hospital, has been dismissed as abandoned as a consequence of her failure to post security for costs of that appeal.

[10] For the following reasons, I would dismiss the remaining appeal.

Background

Medical History

[11] A CT scan performed on May 9, 2018, revealed that Mr. Focken had tongue cancer at the base and back of his tongue. The cancer had spread to his hyoid bone, located in the throat, and to lymph nodes on both sides of his neck.

[12] Mr. Focken underwent radiation treatment and chemotherapy from June 19, 2018, to August 3, 2018. The radiation treatment increased the risk of rupture of, and bleeding from, blood vessels. After radiation treatment, Mr. Focken developed problems swallowing and required a feeding tube.

[13] On November 16, 2018, he suffered from a throat infection secondary to necrosis, which is tissue death. On November 29, 2018, CT imaging showed necrosis and that the center of the cancerous tumour was contaminated or infected.

[14] Early in the afternoon of December 19, 2018, a pseudoaneurysm (a localized pooling of blood resulting from injury to a blood vessel with the appearance of an aneurysm) of his right lingual artery ruptured and began to bleed. The course of events on December 19–20, 2018, was summarized by the trial judge as follows:

> [1] On December 19, 2018, Bradley Focken vomited blood and thick blood clots into the kitchen sink in his home. Firefighters and an ambulance took him to Royal Columbian Hospital ("RCH") in New Westminster, BC where Dr. Brendan Wood, the attending Emergency Room physician, examined Mr. Focken. Dr. Wood did not note any ongoing bleeding during the examination but he admitted Mr. Focken. Dr. Mark Miller, an otolaryngologist at RCH, examined Mr. Focken and determined that he required an embolization to block a blood vessel in his neck that caused the earlier bleeding. By telephone, Dr. Miller consulted with Dr. Andrew Best, an interventional radiologist at RCH, who would perform the embolization procedure. They concluded that Mr. Focken needed to have this procedure done urgently, within 24 hours, but that his condition was not emergent such that he required this procedure immediately. They scheduled the procedure for 8 a.m. on December 20, 2018.
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> [2] At approximately 3 a.m. on December 20, 2018, while hospitalized at RCH, Mr. Focken suffered another significant bleed in his neck. The impact was catastrophic. His brain did not receive oxygen for approximately ten minutes. He was intubated and placed on life support but he sustained significant brain damage. Mr. Focken died on January 10, 2019.

[15] The issues at trial were whether Mr. Focken was actively bleeding prior to 3:00 a.m. on December 20, 2018 (a fact that had to be weighed when determining how urgently he required surgery), and whether the decision to perform the embolization at 8:00 a.m. on December 20, 2018, instead of doing it immediately on December 19, 2018, breached the standard of care expected of the physicians and/or the nurses.

[16] After an extensive review of the evidence, the judge found that Mr. Focken was stable soon after arriving at the hospital and had no active bleeding until 3:00 a.m. on the morning of December 20, 2018: at para. 51. No issue is taken here with that finding of fact.

[17] The remaining question was, therefore, addressed on the footing that the care provided to Mr. Focken by the defendants had to meet the standard applicable when the relative urgency of intervention is being assessed in circumstances where a bleed from a pseudoaneurysm of the right lingual artery has stopped and the patient has been stable under observation for hours.

[18] The judge, at paras. 9–51 and 73–79 of his reasons, described the evidence with respect to the care of Mr. Focken and observations of the medical staff as follows:

a) Dr. Wood, an emergency room physician, examined Mr. Focken upon his admission on December 19, 2018. He ordered a CT angiogram, electrocardiogram, and pain medication. He recorded that:

    i) there was clotted blood in Mr. Focken's oropharynx;

    ii) the bleeding was secondary to a lingual artery pseudoaneurysm;

    iii) he consulted with Dr. Miller, an otolaryngologist at the hospital, and they decided that an interventional radiation procedure would be required; and

    iv) a hospitalist would take over Mr. Focken's care overnight.

b) At 2:35 p.m. on December 19, 2018, Mr. Focken underwent the CT angiogram. Dr. Best, an interventional radiologist at the hospital, read the results and noted a pseudoaneurysm in the lingual artery and a necrotic mass at this location. He did not see any leakage of blood into the surrounding tissue, suggesting no active bleeding.

c) At approximately 6:37 p.m., Dr. Miller examined Mr. Focken and performed a nasal pharyngeal endoscopy. He identified no active bleeding.

d) Dr. Miller then consulted with Dr. Best by telephone. He provided Dr. Best with some background regarding Mr. Focken's throat cancer and noted that he had been bleeding from his throat earlier in the day. At the time of their discussion, Mr. Focken was stable and had no signs of bleeding clinically, on the CT angiogram, or on endoscopic examination. The two physicians agreed that embolization was necessary. They agreed that Mr. Focken would have an urgent embolization at 8:00 a.m. on December 20, 2018.

e) At 8:40 p.m. on December 19, 2018, Mr. Focken was moved from the trauma bay to an acute care bed. He remained on continuous cardiac monitoring. His vital signs remained stable.

f) Three nurses sequentially cared for Mr. Focken. They regularly assessed his vital signs and overall condition. Mr. Focken's blood pressure was recorded 16 times in the twelve hours between 1:00 p.m. on December 19, 2018, and 1:00 a.m. on December 20, 2018. It was stable throughout this period. His pulse and respiratory rate were measured 15 times during this period and they were also stable. Mr. Focken's vital signs remained stable until he began to bleed again at 3:00 a.m. on December 20, 2018.

g) At approximately 11:45 p.m., Dr. Stancu, the hospitalist on duty, examined Mr. Focken and noted that he was stable, alert, oriented and not in distress. She did not find any blood in Mr. Focken's mouth and did not see any bleeding. She consulted with Dr. Miller and told him that Mr. Focken had no ongoing bleeding. She consulted with Dr. Best with respect to preparation for the embolization procedure the following morning.

h) Dr. Stancu reassessed Mr. Focken at 1:00 a.m. on December 20, 2018. She noted that his vital signs remained stable and he was not bleeding. Dr. Stancu and the attending nurses knew Mr. Focken was at risk of bleeding and she

and the nurses monitored for this. She instructed the nurses to call her immediately if Mr. Focken started bleeding.

i) Dr. Stancu received such a call at 3:00 a.m., and saw Mr. Focken less than a minute after receiving the call. She ordered two units of blood and that he be moved to the trauma room. Her notes record her observation that he lost over 500 millilitres of blood.

Expert opinion evidence

[19] The trial judge determined he could place little reliance upon the evidence of Dr. Thomas Gillis, an otolaryngologist and the author of a February 25, 2022 expert report filed by the appellant. As I noted above, Dr. Gillis had incorrectly assumed that Mr. Focken's cancer had resolved. He was also unaware of both the necrosis diagnosis, and Mr. Focken's stable and continuously monitored vital signs on December 19, 2018. Dr. Gillis described Mr. Focken's first bleed as a "sentinel bleed"—an initial bleed that warns of a more catastrophic bleed that could occur at any time. He was of the opinion that Mr. Focken should have had an angiogram with intent to embolize any bleeding sites identified, and that the embolization procedure should have been done immediately.

[20] The judge preferred the opinion evidence of Dr. Christopher Man (with respect to the standard of care to be expected of an otolaryngologist); Dr. Leo Wong (with respect to the claim against the hospitalist); and Dr. Gerald Legiehn (with respect to the standard expected of an interventional and diagnostic radiologist).

[21] Dr. Man, in an expert report dated February 20, 2022, expressed the opinion that the question of how many hours of waiting was safe before Mr. Focken's embolization procedure was a matter of clinical judgment. In his opinion, it was reasonable on December 19, 2018, for Drs. Miller and Best to schedule the embolization procedure for the following morning, because Mr. Focken had a CT angiogram around 6:30 p.m. and it showed a pseudoaneurysm in the right lingual artery and there had been no bleeding since his admission to the hospital emergency room at about 2:00 pm. When the scheduling decision was made,

re-bleeding did not appear to be imminent. Mr. Focken remained under close observation while awaiting the embolization procedure, and those attending to him knew to look for further bleeding. Dr. Man considered it to be appropriate for an otolaryngologist to defer to an interventional radiologist on the timing of the embolization procedure.

[22] It was Dr. Man's opinion that it was Mr. Focken's lingual artery that was bleeding, not his carotid artery. The lingual artery is smaller than the carotid artery, and bleeding from the former is generally less severe than bleeding from the latter. Bleeding from the lingual artery is not sentinel bleeding, because the bleeding is from the tip of the artery rather than from a small tear in the artery wall that may be followed by a larger tear. Mr. Focken survived the earlier bleed from the lingual artery at home without medical treatment, so subsequent re-bleeding was not necessarily expected to be catastrophic.

[23] Because the trial judge's reliance upon the opinion evidence of Dr. Irvine is controversial, I reproduce in its entirety all of the judge's references to that evidence:

> [49] [referring to the suctioning of fluid from Mr. Focken's mouth during his hospitalization] … I accept the evidence of Dr. Irvine that the suctioning device could not have reached the source of the bleeding and therefore would not have provoked the onset of further bleeding.
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> …
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> [64] Mr. Focken underwent radiation treatment and chemotherapy from June 19, 2018 to August 3, 2018. According to Dr. Irvine, the radiation treatment undergone by Mr. Focken weakens his blood vessel walls. … increasing the risk of rupture and bleeding.
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> …
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> [72] Dr. Irvine opined that, it is likely that Mr. Focken had persistence or recurrence of his cancer at the time of his lingual artery rupture on December 19, 2018. This is because he exhibited throat pain and halitosis, both of which indicate cancer recurrence or tissue necrosis due to radiation damage.
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> …
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> [95] Dr. Irvine is also an otolaryngologist, an ear, nose and throat specialist. He provided an expert report dated June 6, 2021. In this report, he identified the original location of the bleeding as being from the pseudoaneurysm of Mr. Focken's right lingual artery as identified on the CT angiogram performed on December 19, 2018.

> [96] He confirmed that there was no active bleeding at the time the CT angiogram was taken. He explained that a pseudoaneurysm is a weakness in the wall of a blood vessel due to some form of injury. In Mr. Focken's case, the pseudoaneurysm was exposed inside his throat and this area would not be visible on physical examination through his mouth, even with the use of a tongue depressor.
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> [97] Dr. Irvine further noted that Mr. Focken's cancer and/or the effects of the radiation treatment were responsible for the tissue necrosis at the base of his tongue and the injury to the lingual artery. He also concluded that Mr. Focken's pain symptoms and the foul odour emanating from his mouth were most likely due to the recurrence or persistence of cancer.
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> [98] Dr. Irvine explained that embolization is the procedure performed by a radiologist that involves inserting a catheter into the right femoral artery. The catheter is then advanced into the carotid artery. Contrast dyes are injected resulting in the visualization of the carotid artery and its branches under X-ray imaging. The lingual artery and the pseudoaneurysm were identified through this technique. Coiled wires would then be deployed through the catheter into the lingual artery in order to occlude the blood flow and prevent further bleeding.
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> [99] Dr. Irvine found that it was unlikely that Mr. Focken would have been able to bring the tip of the suction catheter within close proximity or direct contact with the pseudoaneurysm. Furthermore, he noted that the back of the tongue is a highly sensitive area and contact in this area normally provokes a strong gag reflex. Mr. Focken had considerable pain in his throat which would have further limited his ability to insert the suction device very far into his mouth, especially if he was performing the suctioning himself.
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> …
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> [108] I accept the opinions of Drs. Man, Irvine, and Legiehn that Dr. Miller and Dr. Best did not fail to meet the standard of care expected of physicians in similar circumstances and they followed the accepted standard practice of their peers.

[24] Dr. Gerald Legiehn, an interventional and diagnostic radiologist, agreed with Dr. Best's interpretation of the December 19, 2018 CT angiogram: that it demonstrated a small pseudoaneurysm arising from the mid-right lingual artery lying in close proximity to the mucosal surface of the throat. It was his opinion that the absence of ongoing clinical bleeding, and the absence of evidence of extravasation or bleeding on the CT angiogram, along with the endoscopic evaluation, all suggested that immediate, or "emergent", embolization was not required. The standard of care required that embolization be performed urgently (within 24 hours), though not emergently (immediately).

Analysis

Failing to weigh the degree of foreseeable risk

[25] The appellant submits the judge erred in law "in not assessing standard of care with consideration to the degree of foreseeable risk" to Mr. Focken. She argues:

> 51. The experts all agreed that the bleeding could resume at any time, and if it did, could be devastating for the deceased.
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> 52. However, when analyzing standard of care, the learned trial judge did not turn his mind to this level of significant risk to the deceased. In failing to do so he erred in not considering "…*an essential determinant of the appropriate standard of care*…".
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> 53. The learned trial judge discussed the law pertaining to standard of care in paragraphs 52-62 of the trial judgment. Nowhere in that analysis does the trial judge touch on, or acknowledge, the **essential** consideration of the degree of foreseeable risk to the deceased, or the potential danger he was in.
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> 54. Further, in his exoneration of Dr. Miller and Dr. Best at paragraphs 105-112, the learned trial judge does not touch on, or give any consideration to, the foreseeable risk to the deceased, or the danger he was in, which risk and danger was abundantly clear from the evidence presented at trial. At a minimum, the trial judge should have, in concluding that the respondents had met standard of care, addressed the essentially uncontroverted evidence that Dr. Miller and Dr. Best both knew that the deceased could resume bleeding at any time, and that if he did, such bleeding could result in significant complications to the deceased. The analysis of standard of care had to take into account this foreseeable risk to the deceased (a risk which did, in fact, materialize). No such analysis was done.
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> [Emphasis in original.]

[26] In support of the proposition that the court must engage in the process of weighing the risk when determining the standard of care, the appellant relies heavily upon the judgment of the Supreme Court of Canada in *Armstrong v. Ward*, 2021 SCC 1, adopting the dissenting reasons of van Rensburg J.A. in the Court of Appeal for Ontario (see *Armstrong v. Royal Victoria Hospital*, 2019 ONCA 963 [*Armstrong C.A.*]). She also relies upon *McCardle (Estate of) v. Cox*, 2003 ABCA 106 at para. 27; *Badger v. Surkan* (1970), 16 D.L.R. (3d) 146 at 153, 1970 CanLII 667 (Sask. Q.B.), aff'd (1972), 32 D.L.R. (3d) 216, 1972 CanLII 804 (Sask. C.A.); and commentary in Gerald B. Robertson & Ellen I. Picard, *Legal*

Liability of Doctors and Hospitals in Canada, 5th ed. (Toronto: Thomson Reuters, 2017) at 305.

[27] The authorities to which the appellant refers in this regard are not controversial. They stand for the proposition that as the degree of risk involved in a certain procedure or treatment increases, so rises the standard of care expected of the doctor. In her text and in her judgments, Justice Picard has described the proposition. In *McCardle Estate* she wrote:

> [27] The degree of foreseeable risk involved in a procedure or treatment is not only an appropriate, but indeed an essential determinant of the appropriate standard of care. The standard of care is influenced by the *foreseeable* risk. As the degree of risk increases, so does the standard of care of the doctor. This principle was succinctly stated many years ago in *Badger v. Surkan* (1970), 16 D.L.R. (3d) 146 at 153 (Sask. Q.B.), affirmed (1972), 32 D.L.R. (3d) 216 (Sask. C.A.): "The degree of care required by law is care commensurate with the potential danger". Chief Justice Cardozo (as he then was), a famous American jurist and future U.S. Supreme Court justice, said it in words known to every student of tort law: "The risk reasonably to be perceived defines the duty to be obeyed". (*Palsgraf v. Long Island Railway Co.*, 162 N.E. 99 at 100 (N.Y. 1928), 248 N.Y. 339; see Picard, *supra*, at 197.)
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> [Emphasis in original.]

[28] It is surprising to me that *Badger* is often cited as authority for this proposition. In my view, it is not a seminal or precedent-setting case. It is one of many where the courts have applied the rule described in *Palsgraf*.

[29] Nor are the comments of van Rensburg J.A. on the standard of care analysis in *Armstrong C.A*. controversial or novel. She says:

> [87] In any case where standard of care is at issue, the court must determine what is reasonably required to be done (or avoided) by the defendant in order to meet the standard of care: *Berger v. Willowdale A.M.C.* (1983), 41 O.R. (2d) 89 (C.A.), at p. 95, citing *Blyth v. The Company of Proprietors of the Birmingham Waterworks* (1856), 156 E.R. 1047, at p. 1049. In a medical malpractice case, the court must determine what a reasonable physician would have done (or not done) in order to meet the standard of care: *Kennedy v. Jackiewicz*, 2004 CarswellOnt 4914 (Ont. C.A.), at para. 20, leave to appeal refused: 2005 CarswellOnt 1669 (S.C.C.). The degree of foreseeable risk affects the determination of the standard of care: *McArdle Estate v. Cox*, 2003 ABCA 106, 327 A.R. 129, at para. 27.

[30] The point of disagreement with the majority in *Armstrong C.A.* was whether there was sufficient evidence in support of the standard of care imposed by the trial judge. The majority were of the view the trial judge had imposed a standard of perfection and faulted the defendant surgeon for failing to achieve the *goal* of the surgery in question, rather than taking appropriate *means* to achieve that goal. Justice van Rensburg held: there was agreement that the standard of care required a general surgeon to identify, protect and stay away from the site of the injury while using the surgical device; maintaining appropriate distance from the injury site was *consistently described* as a "step" that should be taken in the surgery and not the "goal" of the operation; and to the extent there was any disagreement amongst the experts, it was only in the refusal of two experts to admit that if the defendant had come too close to the site of injury, he had breached the standard of care.

[31] The trial judge in the case at bar applied well-settled principles when considering how to describe the standard of care, referring to often-cited medical cases: *Wilson v. Swanson*, [1956] S.C.R. 804 at 811–812, 1956 CanLII 1; *Crits v. Sylvester*, [1956] O.R 32 at 143, 1956 CanLII 34 (C.A.), aff'd [1956] S.C.R. 991, 1956 CanLII 29; *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at paras. 33–34, 1995 CanLII 72; and this Court's decision in *Carlsen v. Southerland*, 2006 BCCA 214. In my view, the proposition referred to by Picard J.A. in *McCardle Estate* is implicitly recognized in all these cases.

[32] I would not accede to the argument that the judge erred by failing to weigh the degree of foreseeable risk of harm to the patient, Mr. Focken, against the cost of measures to avoid the risk.

[33] It is clearly necessary for a judge to engage in that weighing exercise in those cases where the court is capable of describing an applicable standard of care without the assistance of experts. However, a distinct assessment of the risk by the judge is not necessary (or perhaps appropriate) where the specific question in issue is what steps are necessary to address the risk of injury or death associated with an untreated medical condition. In such cases, expert assessment of the degree of

foreseeable risk is essential to the description of applicable professional standards and, thus, to the expression of an expert opinion as to the expected standard of care. In relying on the assistance of such expert evidence to describe the standard of care in these cases, a judge is therefore relying on evidence which has already weighed the degree of foreseeable risk and is implicitly adopting that assessment.

[34] On these facts, a trial judge would be incapable of assessing the risk of harm to the patient without the assistance of expert witnesses. The complexity of the exercise is demonstrated by the conflict between the experts with respect to whether Mr. Focken had a “sentinel bleed” on the afternoon of December 19, 2018. That question apparently turns upon where the bleed likely occurred, what vessel was affected and whether the bleed was likely to progress to a significant tear of the wall of the vessel.

[35] The severity of risk posed by a potential second bleed, similarly, could not be described by a jurist without expert assistance. As I have noted, there was evidence that a bleed from the tip of the lingual artery, the bleeding vessel, was considered to be dangerous but less immediately life-threatening than a bleed from a major artery, such as the carotid.

[36] All of the expert opinion evidence in this case was intended to permit the judge to determine how significant the risk facing Mr. Focken was, and, in light of that assessment, what care was mandated. The questions were inseparable. It was for that reason that the controversy with respect to whether Mr. Focken had continued bleeding prior to the catastrophic bleed early in the morning of December 20, 2018, had to be resolved before turning to the question whether Mr. Focken was appropriately managed. The standard of care issue was, ultimately, how urgently surgery was required, given that there was no ongoing bleeding and the patient was hemodynamically stable. The clinical question faced by the physicians was: how should Mr. Focken have been treated, given the threat this condition posed?

[37] The exercise of medical judgment in assessing the risk to Mr. Focken, and then determining the appropriate course of treatment is carefully addressed by the experts in this case.

[38] In his first expert report, dated February 20, 2022, Dr. Man described the hospital triage process, and expressly considered cases where there is severe bleeding or an acute airway obstruction to be among those requiring “immediate/ within one hour” care. He addressed the question “how many hours of waiting was safe for Mr. Focken”, and described that as a matter of clinical judgment.

[39] In his second report, dated March 30, 2022, in reply to Dr. Gillis’ opinion, Dr. Man considered the evidence with respect to the immediacy and severity of the risk posed by Mr. Focken’s untreated condition when addressing appropriate care. He noted that ongoing bleeding would eventually create a life-threatening situation and that bleeding in the throat would be a threat to the airway.

[40] As I alluded to above, in Dr. Man’s opinion, the bleed in the early afternoon of December 19, 2018, was not a “sentinel bleed”. In his second report, Dr. Man wrote:

> 84. The concept of sentinel bleeding is a minor bleeding preceding catastrophic bleeding, as in cerebral aneurysm. … In carotid artery blowout, where the side wall of the vessel is about to rupture, it may be preceded by a small tear of the wall, followed by a big tear. The concept of sentinel bleeding does not apply to bleeding from the lingual artery. The bleeding is from the tip of the artery, not from the side wall. The amount of bleeding would the same as before, and not more severe, because the lingual artery would not suddenly become larger in size than before.

[41] He specifically addressed the risk of bleeding from the lingual artery as follows:

> 23. In the case of Mr. Focken, the bleeding was found to be arising from the right lingual artery, one the eight branches arising from the external carotid artery. Each of these branches is much smaller than the external carotid artery. Bleeding from one of these blood vessels is not as life-threatening as bleeding from the external carotid artery itself. Bleeding from the lingual artery is not necessarily catastrophic.
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> [Emphasis added.]

[42] Later in his report Dr. Man added:

> 82. The bleeding vessel was found to be the lingual artery, as opposed to one of the carotid arteries (i.e.: the common carotid, the internal carotid or the external carotid artery).
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> 83. Bleeding from the lingual artery is expected to be much less severe than from the carotid arteries. If the bleeding was from one of the carotid arteries, re-bleeding would likely be catastrophic. Immediate endovascular treatment (stenting or embolization) should be done, even if there was no bleeding.
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> [Emphasis added.]

[43] Nevertheless, he was of the view that the risk of resumed bleeding was significant and noted that the hospital staff knew that bleeding could create a life-threatening situation when providing care to Mr. Focken.

[44] Dr. Legiehn expressed an opinion on the risks that had to be weighed by the treating physicians in deciding on a course of treatment. In his first report, dated February 21, 2022, he expressed the view that among the most important variables in determining whether a patient proceeds onto emergent (immediate intervention) management is the *relative threat* to the airway and to general hemodynamic stability.

[45] In his second opinion, dated March 28, 2022, he wrote:

> 7. … [O]ne should be cautioned that although the mere presence of ongoing bleeding in such a situation could potentially put the airway at risk of obstruction clot and rapidly devolve into potentially devastating consequences including hypoxia, stroke and/or death, the rate and volume of the bleed as well as the clinical status of the patient would still need to factored into clinical management and patient preparation before rushing headlong to the angiography suite for a potential embolization procedure.

[46] He also reiterated the view that the relative threat to the airway was among the most important variables in deciding where a case fits on “a clinical gradient or continuum in determining the level of acuity to intervene upon any bleeding site”.

[47] The assessment of risk, both the likelihood of bleeding and its anticipated severity, clearly served as the basis of the opinions of Dr. Man and Dr. Legiehn. The judge weighed and accepted their opinion evidence, and implicitly adopted their

descriptions of the risk posed by waiting until the next morning to perform the embolization.

[48] The judge's principal task in this case was to determine whether the defendant medical professionals correctly assessed the risk and acted appropriately in light of that assessment. He expressly noted at paras. 87–88 of his reasons, referring to Dr. Man's evidence, that all of the medical practitioners attending to Mr. Focken were aware of the risk that a resumption of bleeding could create a life-threatening situation.

[49] In my opinion, the trial judge clearly considered the degree of foreseeable risk to the patient when assessing the appropriate standard of care in this case. He could not have done otherwise. On this note, it seems to me that a passage from the judgment of Fuld J. in *Perlmutter v. Beth David Hospital*, 123 N.E.2d 792 (N.Y. 1954), cited by Sopinka J. in *ter Neuzen* (at para. 93), is particularly apt:

> The art of healing frequently calls for a balancing of risks and dangers to a patient. Consequently, if injury results from the course adopted, where no negligence or fault is present, liability should not be imposed upon the institution or agency actually seeking to save or otherwise assist the patient.

Failing to analyze the standard of care with reference to obvious risks

[50] The appellant contends the trial judge should have, but did not, address her argument that, notwithstanding whether Dr. Miller and Dr. Best had followed "accepted protocol", the course of treatment chosen in this case was so fraught with obvious risks that it was negligent.

[51] This argument was an appeal to the judge to set a standard of care for the treatment of bleeding of the lingual artery without relying upon the opinion evidence of medical experts. In my view, that argument is appropriately addressed at para. 59

of the reasons for judgment, where the judge cites with approval the following passage from the judgment in *ter Neuzen*:

> [38] […] As L'Heureux-Dube J. stated in *Lapointe* [*v. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351, 1992 CanLII 119], in the context of the *Quebec Civil Code* (at pp. 363-64):
>
> > Given the number of available methods of treatment from which medical professionals must at times choose, and the distinction between error and fault, a doctor will not be found liable if the diagnosis and treatment given to a patient correspond to those recognized by medical science at the time, even in the face of competing theories. As expressed more eloquently by André Nadeau in "La responsabilité médicale" (1946), 6 R. *du B.* 153 at p. 155:
> >
> > [TRANSLATION] The courts do not have jurisdiction to settle scientific disputes or to choose among divergent opinions of physicians on certain subjects. They may only make a finding of fault where a violation of universally accepted rules of medicine has occurred. The courts should not involve themselves in controversial questions of assessment having to do with diagnosis or the treatment of preference.
>
> [Emphasis added by Sopinka J.]

[52] The exceptions from this general rule are described in *ter Neuzen* at para. 40, where Sopinka J. quotes with approval the following passage from p. 110 of Professor Fleming's text, *The Law of Torts*, 7th ed. (Sydney: Law Book Co., 1987):

> Common practice plays its most conspicuous role in medical negligence actions. Conscious at once of the layman's ignorance of medical science and apprehensive of the impact of jury bias on a peculiarly vulnerable profession, courts have resorted to the safeguard of insisting that negligence in diagnosis and treatment (including disclosure of risks) cannot ordinarily be established without the aid of expert testimony or in the teeth of conformity with accepted medical practice. However there is no categorical rule. Thus an accepted practice is open to censure by a jury (nor expert testimony required) at any rate in matters not involving diagnostic or clinical skills, on which an ordinary person may presume to pass judgment sensibly, like omission to inform the patient of risks, failure to remove a sponge, an explosion set-off by an admixture of ether vapour and oxygen or injury to a patient's body outside the area of treatment.
>
> [Emphasis added and footnotes omitted by Sopinka J.]

[53] The trial judge was clearly aware of and followed the leading cases that warned him against involving himself in controversial questions of assessment having to do with diagnosis or treatment. That jurisprudence was an answer to the

suggestion that the accepted standard practice described by the experts in this case was “so fraught with obvious risks that it was negligent”.

[54] The appellant invites us to address this as a case where “the matter at issue is easily understood by a layperson with no expertise in the medical profession, and where the common practice itself is so ‘fraught with obvious risks’ that the practice can be found to be negligent”.

[55] The principal case upon which she relies for support, *ter Neuzen*, is, in fact, an object lesson with respect to the perils of doing so. In that case, there was evidence that a physician’s artificial insemination practice was in keeping with general practices across Canada. The trial judge instructed the jury that it was open to find the defendant physician negligent on the basis that he failed to comply with the standard medical practice at that time, or, alternatively, on the basis that the approved practice itself was negligent. The jury verdict in favour of the patient was set aside on appeal. Both this Court and the Supreme Court of Canada held that it was for the trial judge to determine as a question of law whether the impugned standard could itself be considered to be negligent and the judge had erred in leaving that question with the jury.

[56] In the course of his analysis in *ter Neuzen*, Sopinka J. discussed where it is appropriate to rely upon *Anderson v. Chasney*, [1949] 4 D.L.R. 71, 1949 CanLII 236 (Man. C.A.), aff'd [1950] 4 D.L.R. 223, 1950 CanLII 336 (S.C.C.), as authority for the proposition that expert evidence is not always necessary to set the standard of care in medical cases. Discussing the concurring judgment of Coyne J.A. in *Anderson*, he held:

> [49] … Coyne J.A. emphasized that the case involved no difficult or uncertain questions of medical or surgical treatment nor any matters of a scientific or highly technical character. It was simply a matter of whether obvious and simple precautions, easily understood by ordinary individuals, were required to be taken. Coyne J.A. remarked (at pp. 86-87):
>
> > *Ordinary common sense dictates that when simple methods to avoid danger have been devised, are known, and are available, non-user, with fatal results, cannot be justified by saying that others also have been following the same old, less-careful practice; and that when such*

> *methods are readily comprehensible by the ordinary person, by whom, also, the need to use them or not is easily apprehended, it is quite within the competence of Court or jury, quite as much as of experts to deal with the issues; and that the existence of a practice which neglects them, even if the practice were general, cannot protect the defendant surgeon.* [Emphasis added by Sopinka J.]
>
> 50 In brief reasons, the Supreme Court of Canada affirmed the reasons of McPherson C.J.M. The Court left open the issue of when it is appropriate for a judge or jury to find a standard medical practice to be unacceptable in terms of taking reasonable care.
>
> 51 I conclude from the foregoing that, as a general rule, where a procedure involves difficult or uncertain questions of medical treatment or complex, scientific or highly technical matters that are beyond the ordinary experience and understanding of a judge or jury, it will not be open to find a standard medical practice negligent. On the other hand, as an exception to the general rule, if a standard practice fails to adopt obvious and reasonable precautions which are readily apparent to the ordinary finder of fact, then it is no excuse for a practitioner to claim that he or she was merely conforming to such a negligent common practice.
>
> [Emphasis added.]

[57] Among the cases the appellant draws to our attention as instances where standard practices have been considered to be negligent, in addition to *Anderson*, is the recent judgment in *Buckingham v. Hobza*, 2023 BCSC 399. After reviewing a number of cases in which judges have found physicians to be negligent in the absence of expert opinion evidence (including many of the cases relied upon by the appellant here), Schultes J. observed: “The common thread in these findings, it appears to me, is a focus on practical, systems-based, or common-sense considerations, rather than on substantive medical issues”: at para. 220. I agree with that characterization of the cases. Many involve simple issues such as the quality of communication or observation or the adequacy of arrangements for follow up.

[58] In my view, the medical questions in this case are far more complex than those falling within the exception to the rule described by Sopinka J. in *ter Neuzen*. They are, in fact, more complex than the medical question in issue in *ter Neuzen*.

[59] I would not accede to the suggestion that the trial judge failed to consider the appellant’s argument. Further, and in any event, the argument is unsupportable on the facts of this case.

Misapprehension of Dr. Irvine's evidence

[60] As noted above, the trial judge (at para. 108 of his reasons) accepted the opinion of Dr. Irvine (among others) that Dr. Miller and Dr. Best did not fail to meet the standard of care expected of physicians in similar circumstances, and that they followed the accepted standard practice of their peers.

[61] The appellant says it was a misapprehension for the trial judge to think Dr. Irvine had expressed an opinion on the adequacy of the care provided to Mr. Focken by the defendant physicians. She contends that is a palpable and overriding error. The error is palpable because it is demonstrably incorrect, no opinion on care having been provided by Dr. Irvine. It is overriding because the judge dismissed the case on the strength of the opinions of the defence witnesses.

[62] In his expert report, Dr. Irvine addresses 17 requests made and questions posed by counsel, which were principally directed to causation issues. Question 12 was: "Dr. Miller apparently determined that the source of the bleeding could not be addressed by surgery. Can you explain, if you agree, why surgery was not an option?". Dr. Irvine responded to that question as follows:

> The paper referenced above by James Cohen, et al,[1] describes the difficulty with open surgical management of a carotid blowout. Following radiotherapy, the neck tissues are scarred and firm, making dissection and identification of structures difficult and dangerous. There are several important nerve and vascular structures in close proximity to the lingual artery. This paper makes note of other published papers describing a 40% risk of mortality and a 60% risk of major neurological complications from open surgical repair. It was for these reasons that Dr. Miller determined that an open surgical approach through the neck was not appropriate in this circumstance, and I agree with that determination. The location of the pseudo aneurysm in the tongue base would have been difficult or impossible to access through the mouth, making cauterization or suturing of the aneurysm also difficult or impossible.
>
> [Emphasis added.]

[63] On cross-examination, Dr. Irvine expressed the opinion that Dr. Best correctly interpreted a CT scan.

[1] James Cohen & Ionel Rad, "Contemporary management of carotid blowout", (2004) 12:2 Current Opinion in Otolaryngology & Head and Neck Surgery at 110.

[64] While Dr. Irvine primarily addressed causation questions, the respondents say that the passage from his report which I have highlighted above is an opinion about the reasonableness of the course of action taken by Dr. Miller and, to that limited extent, it is an opinion of assistance in determining that Dr. Miller met the standard of care. Similarly, they say his evidence was supportive of one aspect of Dr. Best's care.

[65] In light of this evidence, it was not incorrect for the trial judge to include Dr. Irvine in the list of experts whose opinions were favorable with respect to whether Dr. Miller and Dr. Best had met the standard of care. I see no palpable error.

[66] It is also clear to me that Dr. Irvine's opinion was not determinative, as there was no expert opinion in support of the appellant's case which the trial judge accepted, and as the opinions of Drs. Man and Legiehn were strongly supportive of the respondents.

[67] Counsel for the appellant acknowledged, in the course of questioning at the hearing of the appeal, that this alleged error, if established, and standing alone, would not undermine the judgment. In my view, that acknowledgment constitutes appropriate recognition that, even if this error could be made out, it would not amount to an "overriding" error. As Wagner J. (as he was) explained in *Benhaim v. St-Germain*, 2016 SCC 48:

> [38] It is equally useful to recall what is meant by "palpable and overriding error". Stratas J.A. described the deferential standard as follows in *South Yukon Forest Corp. v. R.*, 2012 FCA 165, 4 B.L.R. (5th) 31, at para. 46:
>
> > Palpable and overriding error is a highly deferential standard of review . . . . "Palpable" means an error that is obvious. "Overriding" means an error that goes to the very core of the outcome of the case. When arguing palpable and overriding error, it is not enough to pull at leaves and branches and leave the tree standing. The entire tree must fall.
>
> [39] Or, as Morissette J.A. put it in *J.G. v. Nadeau*, 2016 QCCA 167, at para. 77 (CanLII), [TRANSLATION] "a palpable and overriding error is in the nature not of a needle in a haystack, but of a beam in the eye. And it is impossible to confuse these last two notions."

[68] I would not accede to this ground of appeal.

Attribution of weight to anecdotal evidence

[69] Finally, the appellant contends the judge made a palpable and overriding error by relying on the anecdotal and opinion evidence of Dr. Best that procedures performed at night are associated with higher complication rates as compared to those performed during the day.

[70] Dr. Best testified there were a number of reasons why he did not perform an embolization on the night of December 19, 2018. “First and foremost” among those was the fact that procedures performed after hours have a higher complication rate. He attributed that to fatigue affecting operators, radiologists and assisting staff. He said:

> There’s very good evidence in the literature from surgery and anaesthesia that this is not just anecdotal but perspective studies looking at patients in the context of having procedures done during daytime hours versus those patients having similar procedures done after hours. And there was very robust evidence to indicate that those patients having procedures done after hours have higher complication rates.

[71] He also attributed the higher complication rates to the absence of colleagues to whom all involved in the procedure (operators, radiologists, nurses and technologists) could turn for assistance and advice.

[72] This evidence was not objected to or otherwise challenged. Counsel for the appellant did not suggest that after hours complication rates were not in fact higher but, rather, that higher complication rates were a reason why the medical staff should not have taken the risk that Mr. Focken might require emergency surgery overnight. The following exchange occurred in cross-examination:

> Q … [Y]ou’ve listed several factors as to why you decided not to proceed right away. One of them seemed to revolve around your belief that doing the procedure at that time in that evening was more prone to error; is that right?
>
> A As a general principle, that is correct. The procedures done after hours do have a higher complication rate.
>
> Q Okay.

A So if there is some way that one can defer that safely to the next day, that would be the usual strategy one would want to take.

Q Would that same theory, that people being operated on or worked on by hospital staff at night, also apply to attempts to resuscitate him, that they're more prone to error?

A I think that is a different -- I think that is perhaps a different scenario …

…

Q … [A]s I understood your evidence, doctors, I guess nurses, surgeons operating at night are just more prone to error.

A Yes.

Q Regardless of how they got there, they're just more prone to error.

A Yes.

Q … [M]y question is, when you were thinking about whether doing the embolization right away or leaving it to the next day … one of your considerations would have been we might be more prone to error, "we" being you and whoever was assisting you --

A Yes.

Q -- if we do it at night. Is that -- that was one of your considerations?

A It is a consideration, yes.

[73] No attempt appears to have been made to establish that the evidence of Dr. Best was "anecdotal" as opposed to an opinion based upon the robust evidence to which he referred. Nor was any attempt made to establish that Dr. Best was mistaken in attributing higher complication rates to the causes he described.

[74] In my view, the trial judge did not err in placing weight upon that evidence and accepting that the embolization procedure was more likely to be successful and less susceptible to complications if conducted during the day as opposed to after hours. I cannot say he erred in concluding that Dr. Miller and Dr. Best agreed on a reasonable course of action, and exercised reasonable clinical judgment, by scheduling Mr. Focken's embolization procedure for 8:00 a.m. on December 20, 2018.

Conclusion

[75] It is very unfortunate that, in the hours while he awaited embolization, Mr. Focken suffered a sudden bleed which led almost immediately to devastating consequences including hypoxia and, ultimately, to his death. However, I cannot say the trial judge erred in any respect in addressing the allegations that the care provided to him fell below an acceptable standard. As I indicated at the outset of these reasons, I would dismiss the appeal.

"The Honourable Mr. Justice Willcock"

I agree:

"The Honourable Mr. Justice Harris"

I agree:

"The Honourable Mr. Justice Hunter"