CITATION:.Boutcher v. Cha, 2020 ONSC 7694
COURT FILE NO.: CV-16-563947
DATE: 20201211

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
	)	
LISA BOUTCHER Plaintiff	)	*Richard Bogoroch*, *Toby Samson* and *Kristina Maitland*, for the Plaintiff
	)	
– and –	)	
	)	
DR. LILY CHA and HUMBER RIVER HOSPITAL Defendants	)	*Risa Kirshblum* and *Kelly Hayden*, for the Defendant, Lily Cha
	)	
	)	**HEARD**: November 9, 10, 12, 13, 16, 17 and 20, 2020.

GANS J.

REASONS FOR DECISION

Introduction

[1] Lisa Boutcher went through gynecological and urological hell before the sequelae from the inadvertent placement of sutures in her bladder during a 'routine hysterectomy' was ultimately remediated after almost one year of incontinence and four repair surgeries. I can only imagine the trauma to which she was subjected since I was not permitted to hear this kind of evidence because the parties came to an agreement on damages before trial. It was, however, captured, in some respect, by the heart-felt spontaneous observations made by her gynecologist, the defendant, Lily Cha, at the end of her evidence, which were, alas, of modest consolation.

[2] In this case, because of the manner in which counsel chose to present the evidence, I was left to decide but one issue, namely, whether the placement of two sutures in the base of Ms. Boutcher's bladder wall was the result of the negligence of Dr. Cha or is to be classified as non-negligent surgical misadventure. For the reasons set out below, I conclude that the placement of the sutures was the result of negligence.

The Background Matrix[1]

[3] In the winter of 2014, Ms. Boutcher, who was then 49, was referred to Dr. Cha because she was experiencing heavy bleeding and prolonged menstrual periods. Dr. Cha recommended that she undergo a laparoscopic-assisted vaginal hysterectomy ("LAVH") and the removal of other reproductive organs, including her ovaries and fallopian tubes, all of which were referred to throughout the trial as the "Procedure".

[4] The Procedure, which will be described below in more detail, was performed by Dr. Cha in late September 2014. Ms. Boutcher experienced incontinence almost immediately thereafter. The root cause of the incontinence was diagnosed in mid-November by a urologist as a vesicovaginal fistula, which is an abnormal passage or 'connection' between the bladder and the wall of the vagina.[2]

[5] After a cystoscopy, which is an examination of the plaintiff's bladder by a lighted tubular instrument, the urologist determined that the fistula was caused by two sutures which were seen to be protruding through the posterior or rear wall of Ms. Boutcher's bladder.

[6] Regrettably, Ms. Boutcher had to undergo 4 different surgeries before the fistula was remediated and she regained normal bladder functioning. There is no issue between the parties that the sutures were the 'but for' cause of the fistula. As well, the parties agree that the sutures were inadvertently placed in the lower wall of the bladder by Dr. Cha in the final stages of the Procedure.

[7] As indicated above, the sole issue in this case is whether the plaintiff has established that it is more probable than not that the sutures were inadvertently placed as a result of a breach of the requisite standard of care rather than the result of medical misadventure for which the defendant cannot be found legally responsible.

The Surgical matrix

[8] Dr. Cha is an experienced obstetrician and gynecologist ("OBGYN"), having successfully completed her residency at the University of Toronto in 1988. She maintains an OBGYN practice in Toronto, with full privileges granted at Humber River Hospital at which she performed the subject hysterectomy. She is also an adjunct professor at Queen's University Medical School for which she teaches and supervises residents who complete their OBGYN requirements at Humber River.

[9] Neither Dr. Cha nor Ms. Boutcher has any meaningful recollection of the subject Procedure. Whatever detail can be discerned and described in the circumstances, which is in no respect unusual having regard to the numbers of surgeries Dr. Cha performs in any year, including

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[1] I am indebted to counsel for the preparation of a joint book of documents ("JBD"), which contains Ms. Boutcher's pertinent medical records, the operative report of Dr. Cha in respect of the subject surgery, and the consultation reports and surgical notes of those practitioners by whom she was seen or operated upon to remediate the vesicovaginal fistula, as described above. I am also obliged to counsel for their detailed and well-crafted written arguments from which I have borrowed liberally for a description of the events and procedures which form the basis for the pertinent facts set out in this judgment.

[2] I have endeavoured to avoid, if not eliminate, reference to often confounding 'medical speak', as one counsel described many of the terms used during the trial, in an effort to make this judgment more comprehensible and not force the reader to resort to Stedman's Medical Dictionary, 26th edition (which was at my side throughout much of the course of the trial) or "Dr. Google".

countless hysterectomies, is derived from a review of the operative report,[3] which she dictated relatively shortly after the surgery itself, and from the chronology jointly prepared by counsel.[4]

[10] Hysterectomies are a very common, if not routine, gynecological surgery.[5] I was told that there are three types of hysterectomies: abdominal, laparoscopic, and vaginal. Each has its advantages and disadvantages in terms of patient recovery and inherent complications.

[11] In the final analysis, each of Dr. Cha and the two experts who testified, Dr. Arnold, for the plaintiff, and Dr. Herer, for the defendant, agreed that the choice of a combination of the laparoscopic and vaginal approaches was appropriate in all the circumstances. There was also no disagreement that the steps performed or to be performed as recorded in the operative report were, similarly, appropriate and met the standard of care, as I will define later in these reasons.

[12] In the LAVH Procedure, Dr. Cha would enter Ms. Boutcher's abdomen through small incisions, first in the area of the belly button, at which time she would visualize the pelvic organs, namely, the patient's uterus, cervix, fallopian tubes, and ovaries, through the use of an instrument that permitted organ visualization and their projection onto overhead screens in the operating room.

[13] Dr. Cha then would re-enter the abdomen through ports on the sides of and away from the belly button that she created through additional small incisions, through which she would insert various instruments that would permit her to separate or free up the organs that were to be removed as part of the endgame of the Procedure, all the while keeping a watchful eye on the images then being projected on the operating room screens.

[14] While still proceeding laparoscopically, she would free up and dissect the pelvic organs that were to be removed and manipulate or 'take down' other organs, the bladder by way of example, that were to remain in an unaltered and injury-free state at the conclusion of the surgery. She would cauterize, where necessary, the areas around the pelvic organs during the process of dissection and manipulation.

[15] I digress to observe that all the doctors agreed that the separation part of the Procedure was infused with some risk, as any misadventure at this stage could result in unintended infection, bleeding and injury to adjacent structures. Hence, these recognized risks form part of the informed consent to which the patient accedes in advance of the procedure.

[16] At the conclusion of the laparoscopic part of the Procedure, Dr. Cha would then move between Ms. Boutcher's legs for the vaginal portion of the process during which she would use hand-held instruments to make the final cuts between the vagina and the cervix. She thereupon removed the "specimens", namely, the uterus, cervix, fallopian tubes, and ovaries through the

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[3] Exhibit 1—JBD—Tab 15.

[4] Exhibit 2 – Chronology (Agreed Statement of Facts)

[5] In their written argument, counsel for the defendant suggested that the procedure undertaken in the instant case was "complex". That statement does not accord with my recollection of the evidence and appears contrary to the gynecology articles filed in evidence (Exhibit 19—Excerpt: Chapter 32A Complications of Abdominal Hysterectomy from Te Linde Operative Gynocology 10 Edition; including Table 32A 5: Complications of Hysterectomy; and Exhibit 27—Article from Journal of Minimally Invasive Gynecology Volume 22, Number 7, dated Nov, Dec, 2015) and the observation of the Ontario Court of Appeal in *Bafaro v Dowd*, 2010 ONCA 188, [2010] O.J. No. 979. While perhaps not 'garden variety', it was a relatively routine procedure particularly when one has regard to the lack of anatomical complications with which Ms. Boutcher presented.

vaginal canal. A hole, or vault, remains as a result of the specimen removal between the topmost portion of the vagina and the abdomen, which must then be closed.

[17] She would then proceed to close the hole by suturing and joining the vaginal 'cuff' that had been created as part of the separation process to prevent internal organs from dropping down and unintentionally falling into the vagina and out of the body. Before proceeding with the suturing process, she would assess the position of the bladder by palpating or feeling for it through the above-described hole since she would be, at this point in the procedure, unable to readily visualize the bladder since it is situated outside the vaginal tunnel.[6]

[18] I do not intend to review and repeat, at this moment in time, the detailed summary of the Procedure that defendant's counsel has set out at paragraph 19 of their written argument.[7] They have done a skilful job of marrying the operative report with Dr. Cha's testimony, and have set out the steps that must be undertaken in order to comport with the requisite standard of care in the circumstances of this surgery. The experts agree that if all the steps articulated in that paragraph were appropriately accomplished, then the standard of care would have been met.

[19] To preview for but a moment the balance of the judgment, it is the plaintiff's position that not all the requisite steps in the Procedure were, in fact, accomplished appropriately. Simply put, the plaintiff asserts that a breach in the standard of care occurred because Dr. Cha failed to adequately mobilize the bladder leaving it in harm's way when she came to suture the vaginal hole.

Legal Matrix

[20] As I would expect of counsel well-schooled in medical negligence cases, there is very little to separate the parties on the applicable principles of law. Each side, to a greater or lesser extent, relies on the oft-repeated concepts contained in many of the same cases, with particularized emphasis on excerpts which they hope will drive their sought-after conclusion.

[21] One of the tidiest encapsulations of the applicable legal principles is found in the judgment of Feldman J.A., expressed in the unanimous decision of the Court of Appeal in *Hassen* v *Anvari*, in which, at paragraph 9, she summarized the law, which is equally applicable to the case at hand, as follows:

> The trial judge first set out the legal principles applicable in a medical negligence case involving surgery. He referred first to the accepted concepts that all surgery has risks, so that mere misadventure must not be considered negligence: *Crits v. Sylvester* [1956] O.R. 132 (Ont. C.A.); a surgeon "should not be held liable for mere errors of judgment": *Lapointe c. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351 (S.C.C.) at para. 29; and a bad outcome does not by itself require a finding of negligence: *Dumais v. Zarnett* (1996), 30 O.R. (3d) 431 (Ont. Gen. Div.); *Sanders v. Sheridan*, [2000] S.J. No. 403 (Sask. Q.B.). Second, he stated that the standard of care required for a specialist is higher than that for a general practitioner; a specialist must use diligence, care,

[6] I digress to observe that there is discrepancy between what I recollect Dr. Arnold said in his testimony and what is attributed to him by defendant's counsel in their argument. I have reviewed the evidence on this point and have concluded that Dr. Arnold and counsel were talking at cross purposes. I accept the fact that the bladder is not visible at this stage of the Procedure through the vaginal tunnel without first lifting the cuff, if that process were undertaken, and is clearly not visible after suturing and, perhaps, once the suturing process begins.

[7] I hasten to observe that plaintiff's counsel has done an equally proficient job in as even-handed a fashion in their own description of the requisite surgical steps, found at paragraphs 20-38 of their written argument.

> knowledge, skill and caution: *Gent v. Wilson*, [1956] O.R. 257 (Ont. C.A.), at 265. Third, the trial judge accurately described the onus of proof, following the abolition of the *res ipsa loquitur* maxim by the Supreme Court of Canada in *Fontaine v. British Columbia (Official Administrator)* (1997), [1998] 1 S.C.R. 424 (S.C.C.). The onus is on the plaintiff to prove that negligence by the defendant caused the plaintiff's injury. That onus may be satisfied by circumstantial evidence that allows an inference of negligence to be made, unless the defendant negates the inference with an explanation that is at least as consistent with no negligence as with negligence.[8]

[22] There are several other principles of which I must be mindful, as well, when considering whether, in all the circumstances, Dr. Cha fell below the standard of care of a gynecologist performing a LAVH.[9]

[23] While it is a truism to say that trial judges must assiduously avoid improper reasoning and inferences in defining the applicable standard of care, it is of particular importance to recall that the conclusion on this issue cannot be driven by a results-based retrospective approach.[10] Put otherwise, negligence is to be determined by analyzing the means by which a prudent surgeon would undertake the task at hand and not by the results sought to be attained or avoided.[11]

[24] The absence of specific details in an operative note regarding steps taken during surgery should not impact a trial judge's findings, particularly where the surgery is commonplace in the defendant doctor's practice. In that situation, the 'invariable practice' of the professional is to be given significant weight.[12]

[25] There is very little to separate the parties, as well, in defining the requisite standard of care applicable to the latter portion of the Procedure, the vault closure, there being agreement between the parties on the requisite process to the point of separating the bladder from the other organs to which it is proximate. The steps necessarily to be undertaken were set out in the defendant's written argument as follows:

> (a) Dissection of the bladder from the uterus, cervix and upper vagina, which has also been referred to as "taking the bladder down", "moving" or "mobilizing" the bladder. The surgeon should dissect enough to leave a cuff so the vault can be properly sutured at the end of the procedure, but not too far such that a direct injury occurs;
>
> (b) Inspection of the degree of dissection prior to making a cut into the anterior vaginal canal; and
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> (c) Inspection of the location of the bladder prior to commencing the suturing of the vaginal vault.[13]

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[8] [2003] O.J. No. 3543 at para. 9. leave to appeal to SCC refused, (2004), [2003] S.C.C.A. No. 490.
[9] I have borrowed liberally from the defendant's written argument in this section of the judgment, in particular, at paragraphs 27-33.
[10] *Bafaro v Dowd*, *supra* note 5.
[11] *Armstrong v Royal Victoria Hospital*, 2019 ONCA 963, [2019] O.J. No. 6187 at paras. 39-42
[12] *Bollman v Soenan*, 2012 ONSC 7090 at para 25; rev'd on other grounds 2014 ONCA 36; *Bafaro v Dowd*, *supra* note 5 at para. 29
[13] Defendant's Written Argument, para. 36

[26] Dr. Herer, about whose evidence I will comment momentarily, described the above steps in the Procedure as follows:

(a) "So the standard of care in dissecting the bladder is to visualize the bladder, to ensure the ureters are moved away laterally for where they are entering the bladder, to ensure no harm has come to the bladder through an inadvertent cystotomy, and to give yourself a cut that separates the vagina from the bladder in such an angle and such a distance to give you a cuff to suture at the end of the procedure." (emphasis added)[14]

Expert testimony

[27] Before making observations on the expert evidence I heard in the instant action, it behooves me to comment upon certain elements of expert evidence, in general, and some of the expert evidence issues that developed in this case.

[28] As a precursor to my comments, I would observe, yet again, that triers of fact would benefit from experts hot-tubbing before they testify, particularly where the issues have been winnowed away, as in the matter now before me. I would also endorse the comments of the Hon. Stephen Goudge that courts would benefit from hearing from a member of a panel of experts in medical negligence cases, rather than those routinely 'hired' to espouse the theories consonant with those of their retaining counsel.[15]

[29] In this matter, each side 'criticized' the evidence of the expert proffered by side other for a variety of reasons, which I do not intend to canvass at this moment in time. Much effort was expended in each of the final arguments commenting upon, if not denigrating, the evidence of the opposing experts and why I was obliged to prefer one over the other.

[30] Suffice to say, I was left to ponder about the impartiality of both Dr. Herer and Dr. Arnold, albeit for different reasons. The clearest and most informative evidence on the gynecological process and issues about which I heard came from the defendant, Dr. Cha, whose evidence I accept, in the main. I found her evidence to be both credible and reliable, but for reasons upon which I will expand later, it did not provide me with a complete answer to the threshold question in issue.

[31] I would first observe that defendant's counsel sought to discredit Dr. Arnold by seeking to cross-examine him on adverse comments made by other jurists in other cases in which he was called to testify. While some might suggest a leopard doesn't change its spots, I ruled at the outset,

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[14] Trial judges in Ontario are labouring under a marked disadvantage to those sitting in review of their handiwork. Unless the parties pay for 'dailies', we no longer have skilled reporters at our disposal and are compelled to wade through digital recordings of the proceedings, which presents significant issues, both in terms of time wasted in listening to 'audios' that seemingly drag on interminably and inaccurate reviews of 'key words', which the monitors struggle with from lack of experience and familiarity with the evidence. This trial was done remotely which meant that counsel could themselves record the proceedings and undertake the painstaking process of creating their own 'transcripts' of the evidence, which I dare say is better than my own typed trial notes which are but a poor summary of the evidence as I hear and understand it. The cost-benefit analysis that was undertaken by the responsible Ministry before the decision to change from reporters to monitors missed or didn't understand the important role a transcription of evidence, even without real-time reporting, plays in a judge's ability to discharge his or her functions in rendering judgement. I am indebted to plaintiff's counsel for filling that gap.

[15]See Arthur Gans, "Litigating in the Time of COVID-19: Try Hot-tubbing…While Keeping a Safe Distance" (2020) 39:2 Adv J 37; Ontario, Ministry of Health, "Report to Ontario Ministry of Health and Long Term Care Re: Medical Liability Review" by Hon. Stephen Goudge, Q.C..

without citing authority, that I would not permit this line of questioning, in the trial proper.[16] I am, however, heartened to learn that my 'usual practice' of not permitting such cross-examination has received the imprimatur of the Ontario Court of Appeal.[17]

[32] Although Dr. Arnold had an 'unusual' manner of providing his evidence and used turns of phrase that, arguably, would lead defendant's counsel to suggest he was but 'a hired gun', I did not find his evidence to be overstated. On balance, I found his evidence to be reliable, although I hasten to observe that because his practice appears to have changed markedly in the last few years, he may soon be bumping up against his best-before date in terms of more recent gynecological procedures. Finally, although I found his evidence reliable, I note that his evidence alone is not dispositive of the issues.

[33] Before commenting on Dr. Herer's evidence in and of itself, I make the following observations. As is my practice, and with the consent of counsel, I ask for and receive copies of the experts' reports before trial, which, I might add, are not automatically or routinely marked as exhibits. Such depends on the length and breadth of cross-examination.

[34] The purpose of this exercise is for me to achieve a running start, as it were, on those matters which, by definition, fall outside my ken. It also allows me, particularly in medical negligence cases, to have some understanding of the terminology routinely used by those in the profession who are inclined to speak above my "pay-grade". Put otherwise, when the evidence commences, I can not only spell the terms in play, but have some understanding of the concepts, if only at 30,000 feet, and do not flounder in the early stages of the trial, trying in vain to catch up with counsel.[18]

[35] In the instant case, I found Dr. Herer's reports to be long on conclusions, but somewhat short on detail. While not determinative about the issues on which she would be permitted to testify, as part of my gatekeeper function, I alerted defendant's counsel to the possibility that her evidence might be circumscribed by the 'four-corners' of her report, depending on what was sought to be elicited from her in the trial proper.[19] As anticipated, I was compelled to referee on an almost on-going and flow-disrupting basis the ambit of her evidence, which I found to be an unnecessary distraction.[20]

[36] Finally, a word about the Rule 53.03 'obligations' imposed on experts. Counsel seem to be of the view that the acknowledgements obtained from experts as a condition of their testimony somehow regularizes the forthcoming evidence and makes it, by definition, acceptable, and

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[16] I will leave it to others to determine whether such a challenge can be mounted in the 'qualification' stage or in a case tried with a jury.

[17] See *Bruff-Murphy*, 2017 ONCA 502, 138 O.R. (3d) 584, and *Boone v. O'Kelly*, 2020 ONSC 6932, 2020 CarswellOnt 1734.

[18] I hasten to observe that the advice to obtain copies of the reports was given to me shortly after my appointment by two well-respected and knowledgeable trial judges, Hon. Joseph O'Brien and Hon. John Wilkins, each of whom was a skilled trial lawyer in their earlier lives in the personal injury field (an area of practice which was then completely outside my wheelhouse).

[19] Having had plaintiff's counsel before me in other instances, I had every reason to believe that this would very much be a live and contentious issue, which it indeed was.

[20] R.R.O. 1990, Reg. 194, s. 53.03; *Marchand (Litigation Guardian of) v Public General Hospital Society of Chatham*, [2000] O.J. No. 4428 (Ont. C.A.) at para. 38; *Hoang (Litigation Guardian of) v Vicentini*, 2012 ONSC 1358, O.J. No. 889 at paras. 10-11; *Peller v Oglive-Harris*, 2018 ONSC 725, 23 C.P.C. (8th) 201 at paras.12-14.

unimpeachable, particularly if no challenge is made to the witnesses' expertise, which occurred in this case.

[37] Respectfully, the execution of a Form 53 does nothing to assist the trier of fact in wrestling to the ground the impartiality and acceptability of the yet to be tendered evidence. Hence, I, and many of my colleagues, find the tendering of this documentation to be but a waste of time. Experts, as has been stated innumerable times by all manner of courts, are there to assist the trier of fact because their evidence is both necessary and relevant.[21]

[38] In the final analysis, Dr. Herer, in particular, would benefit from a re-reading of Rule 53.03(2.1) (5) and (6), as no doubt she will be called upon to testify yet again before others of my colleagues long after I leave the Bench in a few short months.

[39] None of the above is meant to say that I did not benefit from the evidence provided by Drs. Arnold and Herer. The detail which each provided me on the Procedure, the anatomy, and the rudiments of the surgery in question, which they had to cover multiple times to ensure I understood the 'basics', was of great assistance. In addition, I found both to be unfailingly polite and patient with me. Any errors in the recitation of the gynecological descriptors and processes are to be ascribed to me and not to either of them.

Closing the Vaginal Vault

[40] I now cycle back to the etiology of the errant sutures in the plaintiff's bladder.

[41] As indicated, it is the plaintiff's position, which was advanced, in part, through the evidence of Dr. Arnold, that the only reasonable explanation for Dr. Cha placing the two sutures in Ms. Boutcher's bladder at the time the vaginal vault was closed was that she had not mobilized or moved the bladder down sufficiently to accommodate her surgical closure technique. This error, which was not simply an error in judgment, Dr. Arnold testified, fell below the requisite standard of care in the completion of the Procedure.

[42] This was a conclusion Dr. Arnold testified he arrived at, based not upon the fact that the sutures were found in the bladder, *per se*, but after he eliminated the 'most likely' other causes for its occurrence, which included any recorded abnormalities in Ms. Boutcher's anatomy and the anatomy of the bladder itself, previous surgeries which made the instant surgery all the more difficult, or following some surgical process other than the 'textbook' procedure that all the medical experts agreed had been adopted by Dr. Cha, again, as was recorded in her operative report.

[43] While no fault or criticism was levelled against Dr. Cha for not having noted in her operative report with exactitude how far she dissected the bladder, it leaves open to question in the circumstances of the Procedure whether the dissection was, in fact, adequate. I note that it was Dr. Cha's usual practice to sharply dissect the bladder to between 1-2 centimetres. It was Dr. Arnold's opinion that whatever length the instant dissection was, it was not sufficient to permit Dr. Cha's suturing technique without incident.

[44] Defence counsel, as part of her case, raised various articles during both the evidence in chief of Dr. Herer and in the cross of Dr. Arnold which seemed to suggest that instances of bladder

[21] *R v Mohan*, [1994] 2 S.C.R. 9.

injury in the OBGYN world can occur during the placement of sutures in the closing of the vaginal vault.[22] While I don't pretend to fully grasp the details of each article, which, regrettably, were never parsed for me, I am not persuaded that the frequency of occurrence of sutures in the bladder was described any more succinctly than the evidence of Dr. Herer who said that such occurred but very rarely. Indeed, when listing the known risks of a hysterectomy, even during a LAVH, she did not include 'sutures on closing' as a common or material risk worthy of inclusion as part of an informed consent. Indeed, she did not list it as a 'known' risk in her evidence, at first instance.

[45] In one article which was put to Dr. Arnold in cross, I found the following excerpt to be instructive:

> Although fistulas will never be 100 percent avoidable, one can decrease the likelihood of their development by following certain important operative guidelines. The first way to avoid bladder damage is wide mobilization of the bladder from the cervix and upper vagina during hysterectomy. The bladder should be displaced widely and laterally from the vaginal corners and caudally at least 1 cm below the line of resection in the vagina. To assist in this, one should remember to exert upward traction on the bladder and cephalad countertraction on the uterus. <u>Wide mobilization allows the bladder to fall caudally away from the vagina thus protecting it from damage during suturing of the cuff</u>.[23] (Emphasis added)

[46] A similar observation was made in another excerpt from a text to which reference was made by Dr. Arnold in his evidence:

> Injury may also result from inadequate mobilization of the bladder inferiorly and laterally so that clamps and sutures placed in the cardinal ligament and anterior vaginal cuff may "pinch" the bladder base. The vesicovaginal space should be developed completely and the bladder thoroughly mobilized both inferiorly and laterally.[24]

[47] It is of some moment to note that Dr. Herer acknowledged in her examination-in-chief that a mechanism for the location of the sutures in the bladder might have been due to the fact that the bladder wasn't 'separated enough' on dissection. Furthermore, neither she nor Dr. Cha were able to proffer any other explanation for their existence in the bladder.

Analysis

[48] Before drilling down to the essence of this decision, I repeat one bedrock principle recently articulated in a majority decision of the Court of Appeal in a medical negligence case, which I paraphrased above:

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[22] Exhibit 20—Article Obstetrics, and Gynecological Survey Vol. 49 Number 12: Review Vesicovaginal Fistula by Thomas Margolis, and Division of Gynecologic Surgery Northwestern University, Chicago, Illinois; Exhibit 21—Excerpts from Up to Date Publication on Urinary Tract and Gynecological Surgery Published July 2020; and Exhibit 27—Article from Journal of Minimally Invasive Gynecology Volume 22, Number 7, dated Nov, Dec, 2015.

[23] Exhibit 20 at page 842 (footnotes deleted)

[24] See first page of Exhibit 17—Pgs. 211-212 of "Nichols Text"; Reoperative Gynecological, and Obstetric Surgery.

> Negligence standards of care are to be measured by the behaviour that a relevant prudent person would undertake, rather than the results that prudent person would seek to attain or avoid. [25]

[49] To repeat the obvious, there is no direct evidence about the manner in which the sutures were inadvertently placed in the bladder. Indeed, Dr. Cha could not assist in that regard because, as I stated, she had no explanation for this event.

[50] I am, however, permitted to consider whether the plaintiff has, through a review of all the other evidence which I find to be reliable, including circumstantial evidence, raised a *prima facie* case or an inference of negligence which, on the weight of authority, requires the defendant to offer an explanation to negate such inference.[26]

[51] In my opinion, the evidence supports a *prima facie* inference of negligence that Dr. Cha, notwithstanding the exercise of good clinical judgment, failed to manipulate the bladder during the sharp dissection process to ensure that it was out of harm's way to accommodate her manner of suturing the vaginal vault in, at least, this case. Such, as I recollect, has never previously occurred in her extensive gynecological practice.

[52] I am also of the opinion that the defendant has not led any evidence to "neutralize the inference of negligence" such that the plaintiff's case must fail because she has not met the evidentiary and legal burden of proof.[27]

[53] Instead, the defendant has trumpeted the decision of the majority decision in *Armstrong* to suggest that I would fall into error if I permitted the plaintiff to succeed without negating all manner of reasonable non-negligent causes. In this regard, the defendant seeks to rely upon the statement of Paciocco J.A. as found at paragraph 56 of that judgement:

> A trial judge who is prepared to proceed on the basis that only negligence could cause the relevant injury is obliged to consider and rule out non-negligent causes. Only if this is done, can the trial judge properly use success as the standard of care. In determining whether this is so, the burden is not on the defendant to raise potential non-negligent causes with evidence, nor is it improper speculation for a trial judge to consider potential non-negligent causes that are open on the evidence but that the plaintiff has failed to address. A plaintiff whose liability theory is that only negligence could have caused the injury in question is obliged to demonstrate that this is so, and the trial judge is required to accept this before finding liability. That did not occur in this case.[28]

[54] In the first place, I am not persuaded that the majority intended to express an evidentiary rule that, respectfully, casts aside centuries of jurisprudence or, alternatively, flies in the face of that which the SCC expressed in *Fontaine* and the other decisions cited in footnote 25, above.

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[25] *Armstrong, supra* note 11, at paras 33 and 44.
[26] *Hassen v. Anvari*, *supra* note 8 at para. 9; *Austin v. Bubela*, 2011 ONSC 1958, 125 A.C.W.S. (3d) 171 at paras. 13, 43; *O'Neill-Renouf and Renouf v. Ibrahim*, 2019 ONSC 4369, 203 A.C.W.S. (3d) 427 at para. 13.
[27] *Fontaine v British Columbia (Office Administrator)*, [1998] 1 S.C.R. 424 at para. 24.
[28] *Armstrong¸ supra* note 11 at para. 56.

[55] In my respectful opinion, the above excerpted comment applies to the facts of *Armstrong* where the majority was of the view that the defendant doctor, first in his own evidence and in the evidence of his expert, provided an alternative theory to that which the trial judge accepted. As I previously said, no such alternative mechanism was offered up by the defendant.

[56] Furthermore, if necessary, I would be inclined to the view expressed by Justice Van Rensburg, in dissent, where she made the following observation:

> The burden of proof was on Ms. Armstrong to establish that Dr. Ward failed to meet the standard of care of a reasonable competent surgeon when her ureter was injured in the course of the laparoscopic removal of her colon. A trial judge is not obliged to consider potential non-negligent causes where there is no evidentiary foundation to do so. (emphasis added)[29]

[57] In my opinion, the last-mentioned extract is perfectly consonant with the excerpted portion of the majority's decision since alternative non-negligent mechanisms were put in evidence in *Armstrong* as distinguished from the instant case.

[58] The best that can be said in the matter before me is that the bladder was but a scant few millimetres away from the vaginal cuff during suturing and unexplained misadventures, albeit in but rare instances, can occur. Respectfully, that statement in and of itself, without an evidentiary foundation, is not adequate to bring the scales back into balance.[30]

[59] Furthermore, while I agree that the standard of care is infused with the notion of 'good clinical judgement', I am not persuaded that the exercise of clinical judgement is a complete answer or defence to all claims of medical negligence, or, alternatively, as in the instant case, is sufficient to bring the scales back into balance. While not endorsing the 'impassioned' plea of plaintiff's counsel on this issue,[31] there is judicial support for the notion that the exercise of judgment is not intended to trump all. As was observed by Macdonald J.J. in *Lewis v Joutsi*, "Exercising judgment and acting negligently are not mutually exclusive".[32] Put otherwise, an error of judgment may be negligent, depending on the circumstances.[33]

Conclusion

[60] In the final analysis, I think it is more probable than not that in the instant case, Dr. Cha did not mobilize the bladder sufficiently in the circumstances which resulted in the placement of the sutures in Ms. Boutcher's bladder, for which she is responsible at law.

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[29] *Armstrong, supra* note 11 para. 134.

[30] Counsel for the defendant sought to establish during cross-examination an alternative theory for the location of the sutures in the bladder based upon a notion of 'suture migration'. Dr. Arnold to whom this theory was put, was having no part of it. Since the concept or theory was not touched on by Dr. Herer in her reports, this notion and other suggested non-negligent theories were not pursued in evidence.

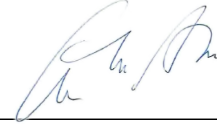
[31] Plaintiff's Written Argument, para 129.

[32] [1995] O.J. No. 2076 (Ont. Ct J). J. Macdonald J. did a detailed review of the law to that moment in time describing the intersection between clinical judgment and medical negligence. He considered the decisions of the House of Lords in *Whitehouse v. Jordan*, [1981] 1 All E.R. 267 (H.L.) and the SCC in *Wilson v. Swanson*, [1956] S.C.R. 804. I came upon *Lewis v Joutsi* when considering *O'Neill-Renouf and Renouf v. Ibrahim, supra* note 26*,* and the cases therein referenced.

[33] *Wilson v Byrne*, [2004] O.J. No. 2360 (Ont. S.C.J.) at para. 28.

[61] Judgment will issue for the plaintiff in accordance with the reasons expressed above in the amount settled by agreement in advance of trial.

[62] I may be contacted to deal with costs of these proceedings if counsel are unable to reach agreement on that issue.



GANS J.

Released: December 11, 2020

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COURT FILE NO.: CV-16-563947
DATE: 20201211

LISA BOUTCHER

Plaintiff

– and –

LILY CHA and HUMBER RIVER HOSPITAL

Defendants

REASONS FOR DECISION

GANS J.

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