

THE TRIAL OF A MEDICAL NEGLIGENCE ACTION

J. THOMAS CURRY

MCCARTHY TÉTRAULT

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INTRODUCTION

Trials against physicians and hospitals for medical negligence present a challenge to the parties, counsel, expert witnesses and the Court. In almost all cases, expert evidence is vital to the successful prosecution or defence of the claim. The legal issues are unique and require counsel (and Judges) to be familiar with a body of law not particularly well understood by many civil litigation practitioners.

This paper reviews the essential elements of a claim for medical negligence including the liability issues of standard of care, informed consent and causation, as well as the issues relating to the proof of damages. The traditional areas of battle during the medical negligence case almost invariably result in a great deal of complexity, even in the most straightforward factual cases. Nonetheless, there are ways and means of reducing the complexity and the expense of a trial of this type. Such methods will be considered in the context of each of the traditional areas of conflict at trial.

By the Numbers: Which Cases Are Tried and Why?

In Ontario, between January 1, 1995 and December 31, 1999, 213 claims against members of the Canadian Medical Protective Association (“CMPA”) were taken to trial. This represented 43% of such cases taken to trial across Canada.

A further (approximately) 2,800 Ontario medical negligence actions were closed according to the records of the CMPA during that same time. This represented 48% of the closed cases (including the trials) across Canada.

The statistics relating to these actions are remarkably consistent over the years.

About two thirds of the claims started against physicians are dismissed before trial without any payment to the Plaintiff. Of the balance, approximately one third are settled and fewer than 10% are taken to trial. Of those, most are dismissed.

One might ask reasonably why, if so many cases are commenced, so few are resolved in favour of the Plaintiff. The answer is itself complex but certainly one major element is what might be called “case selection”. Many cases which are commenced are dismissed without any payment to the Plaintiff because no legal basis for the claim can be established. Plaintiff’s counsel are not always experienced in matters of medical negligence and often claims which have no reasonable prospect of success are brought against physicians. When these cases are dismissed, no one should be surprised and no cries for reform should be heard.

Equally, certain cases are settled on behalf of medical doctors where it can be said there is no reasonable basis for a defence. In fairness to the Defendant, it cannot be said that in such cases, it is obvious at an early stage that there is no reasonable prospect of a successful defence. To the contrary, only when expert witnesses are consulted are such conclusions usually capable of being made. The same is not true of the cases for the Plaintiff. The Plaintiff commences actions knowing that the onus of proof is upon him or her and therefore a direct need to have consulted an expert witness exists before the claim is issued. Almost without exception, experienced counsel will do so.

It is therefore reasonable to suggest that, at a minimum, counsel bringing claims against medical doctors or hospitals arising from allegations of negligence in the provision of care, consult with expert witnesses prior to the commencement of the action in order that claims which are weak or impossible to prove, are not brought. Since the limitation period is sometimes short, there may be situations in which Notices of Action or Statements of Claim must be issued prior to the proper investigation of a claim. Such cases should be rare and before very much occurs, expert witnesses should be consulted. In such cases, the client should be told exactly the basis upon which the claim is being launched.

Client expectations often drive bad cases forward. Frequently, counsel carry the expenses for such clients and then cannot withdraw from the positions taken in the lawsuit because their fees are an issue.

The CMPA has recognized the need to identify and resolve meritorious claims quickly without incurring unreasonable expense on either side. Since an individual physician's entitlement to practice and mobility rights are sometimes impaired by allegations of medical negligence, counsel acting for a physician and the CMPA itself owe a duty to properly investigate claims which are launched and to properly consider all of the circumstances before any settlement is made. This sometimes causes delay and expense. The challenge for counsel for Plaintiffs and Defendants is to identify which cases are which, and to act accordingly.

Liability Issues

(a) Standard of Care

In order to succeed in an action for medical negligence the Plaintiff must show that the Defendant has breached the standard of care as established by the law. Determining the appropriate standard of care in the medical context necessarily involves the use of expert evidence to establish the prevailing and approved practice as well as any changes or advancements in treatment techniques and technology. The medical negligence case is unique in the sense that it involves the exercise of professional judgment and technical skills, and a body of complex scientific knowledge which an ordinary individual will often not comprehend.¹

The standard of care required of a physician is that of a reasonable medical practitioner taking into consideration all of the circumstances. The standard was aptly summarized by the Ontario Court of Appeal in *Crits v. Sylvester*²:

The legal principles involved are plain enough but it is not always easy to apply them to particular circumstances. Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is

¹E.I. Picard and G.B. Robertson, Legal Liabilities of Doctors and Hospitals in Canada, 3rd edition, (Carswell: Toronto, 1996). See also A.M. Linden, Canadian Tort Law, 5th edition, (Butterworths: Toronto, 1993).

²(1956), 1 D.L.R. (2d) 502 at 508 (Ont. C.A.), aff'd [1956] S.C.R. 991.

bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

The standard which is applied in any given situation will depend on the circumstances surrounding that situation. Therefore, although the test of the “reasonably prudent physician” is objective in nature, certain factors will tend to alter the standard to be applied. These include the experience and training of the physician³, the locality of practice⁴, the resources available to the physician and the timing of the alleged negligent act⁵. The standard is not to be applied in the abstract.

Although the basic standard to be applied in the case of medical negligence has remained substantially similar over the years, some issues have arisen in regards to its application in certain situations. For instance, over the years, the courts have addressed issues relating to who should set the standard of care in any given case and what factors should be considered in setting that standard. More recently, the courts have been asked to address issues relating to informed consent and the standard of disclosure, the duty to report and the role of the trier of fact in setting the appropriate standard of care and applying it to a particular fact situation.

As noted above, in the past, it has been assumed that no judge or jury would be in position to compare the conduct of a doctor to that required of a reasonable practitioner without the assistance of expert evidence. The physician was not usually found to be negligent unless they failed to conform with the approved practice in their field. That fact

³Picard, supra; *Vail v. MacDonald* (1976), 66 D.L.R. (3d) 530 (S.C.C.); *Eady v. Tenderenda*, [1975] 2 S.C.R. 599.

⁴See section labelled “Locality Principle” below.

⁵See *McLean v. Weir* (1980), 18 B.C.L.R. 325 (C.A.) where the court states that the physicians conduct is to be judged according to the standards at the time the incident occurred and not when the action is heard or at some other later date. See also *Lapointe v. Hopital LeGardeur* (1992), 10 C.C.L.T. (2d) 101 (S.C.C.) where the court stated that courts should be careful not to rely on the perfect vision of hindsight in judging a doctors conduct at any given time.

has been moderated somewhat by decisions permitting triers of fact to find a breach of a standard in claims where the standard is fraught with risk. Such cases are very rare.

(b) Causation

Claims alleging medical malpractice are like icebergs; the largest and most difficult issues lie below the surface. Causation is one such issue. Experienced Defendant's counsel begin to consider causation on day one of the lawsuit and Plaintiff's counsel are well advised to do the same.

Causation is an expression of the relationship that must be found to exist between the tortious act of the wrongdoer and the injury to the victim in order to justify compensation of the latter out of the pocket of the former.⁶

In a medical malpractice case, the Plaintiff must establish not only that the doctor's conduct fell below the expected standard of care, but also that the breach of duty caused or contributed to the Plaintiff's injuries. The legal standard of causation is different, however, from the scientific standard. The usual test for causation is the "but for" test or "sine qua non" test, according to which the Plaintiff must demonstrate that "but for" the negligence of the Defendant doctor, he or she would not have suffered the injury or loss. The Plaintiff is not required to establish that the Defendants' negligence was the sole cause of the injury. The Plaintiff must also establish, where applicable, that the Defendant's negligence was the "proximate" or legal cause of his injuries. This is essentially an analysis of reasonable foreseeability. In both cases, the burden of proof lies upon the Plaintiff on a balance of probabilities.

(i) Strategic Considerations

Questions of causation are questions of fact. Defence counsel will approach a medical legal problem with several key factual issues (including causation) in mind. The

⁶ *Snell v. Farrell* (1991) 72 DLR (4th) 289 (SCC) per Sopinka J.

first point to remember is that almost all of the Plaintiff's starting a claim have had a bad result.

A whole series of defences involve proof of the breach of any duty of care owed; including locality, the nature of the specialty and the standard applicable at the time.

Most Plaintiff's counsel focus on these issues; partly because these are the issues which are often the most obvious and difficult to prove. These are the issues above the surface of the water. But for the Defendant's counsel, the fun doesn't stop at proof of a breach of the care. Proof of causation lurks around the corner and may be a complete defence.

Proof of causation pre-supposes a breach of the standard of care, and the Defendant's counsel will begin to formulate a theory of the case on that issue immediately. Essentially, the counsel asks the question; so what? What if the Defendant was negligent in the performance of surgery or failure to advise of a material risk?

Often the answer to the question determines the course of the lawsuit. Here are some practical tips to consider on causation when prosecuting a claim of medical malpractice:

1) CONSIDER CAUSATION EARLY:

As described above, the onus of proving a causal link between the Defendant's breach of duty and the Plaintiff's damages lies upon the Plaintiff. It is not satisfactory to focus on the difficult issues of proof of a breach of the standard of care without also developing the case on causation. From day one ask yourself that "so what" question. Consider what options the Plaintiff and Defendant each had. If the case is one of a failure to disclose then what would a reasonable person have done? Is the loss caused commonly by the Plaintiff's underlying medical condition? Are there other non-negligent causes?

2) DEVELOP THE FACTUAL RECORD:

Just as the breach of the standard of care must be proven on a factual record, so must causation. The proof of causation most often requires proof of lay witnesses like the Plaintiff and evidence of various experts. Experts are discussed below. The lay witnesses must be questioned closely about the factual record relating to the proof of causation. The best examples are cases about informed consent; the Plaintiff must establish that a reasonable patient in his or her circumstances would not have consented to the procedure if a material fact was disclosed. The Plaintiff's counsel should be considering what circumstances the Plaintiff was in to answer that question. Often the Plaintiff had no other option and would have proceeded in any case. This factual inquiry is key and should be made sooner rather than later. Develop the type of record used successfully in *Reibl*.

3) EXPERT EVIDENCE OF CAUSATION:

Expert evidence is required to establish the standard of care in almost every claim against a physician. Sometimes Plaintiff's counsel overlooks the need to develop expert evidence of causation through these same (or other) experts. From the Defendant's perspective, this provides an opportunity to use a Plaintiff's witness to support the Defendant's theory. It is important therefore to obtain expert opinion on each of the elements of the causation argument, including evidence of the objective measure of any informed consent issues. Finally, prepare any expert called to answer questions on causation which may be raised in cross-examination.

4) DEVELOP A COGENT THEORY OF CAUSATION (AND STICK TO IT!):

Medical malpractice claims are tough cases. Both sides need to develop a theory of the case which nonetheless may evolve over the course of the lawsuit. By the time of the trial however, counsel needs to have a theory of the case and to pursue it consistently. This is especially true of causation theories which can unravel if left undeveloped. If the

case on causation is incapable of proof on a scientific or medical standard, even on the general point, the Defendant is in a very strong position.

5) OBSTETRICAL CLAIMS: SPECIAL CAUSATION PROBLEMS:

Claims against physicians for obstetrical negligence merit special attention. At one time the medical community believed that cerebral palsy and other brain injuries were caused by events at or around birth. More recent studies have challenged that conclusion with predictable results for claims against doctors. Plaintiff's counsel sometimes seek opinions from those experts who argue a causal link between perinatal asphyxia and cerebral palsy. Be aware of both sides of this debate and be certain to rule out other common causes of the same condition.

Before pursuing an obstetrical case, counsel are well advised to develop a theory on causation which is consistent with a conventional approach and which does not require the court to bridge a large gap in the evidentiary record. Far better to face the difficult issues of a lack of proof of causation at the outset than during a lengthy trial.

(c) Informed Consent

Part of a doctors duty of care includes a legal obligation to inform a patient regarding the risks associated with any given surgery or procedure. This legal obligation relates to the requirement that a patient consent to a surgery or procedure prior to its commencement. In order for consent to be valid, it must be given voluntarily, by someone who has capacity and given by a patient who is informed. The requirement that a patient be informed underscores and gives meaning to the patients right to self-determination. The common law has recognized that individuals have a fundamental right to make decisions about their bodies no matter what the doctor may or may not believe is the best course of action. This right of self-determination is potentially meaningless unless the patient is given sufficient information to make a real choice⁷.

⁷Picard, *supra* at 110-111.

The Supreme Court of Canada in *Reibl v. Hughes*⁸ and *Hopp v. Lepp*⁹, clarified the legal obligation facing a physician regarding what standard of disclosure is required. The Court expressly disapproved of the position that the standard was best left to the judgment of the doctor who was assessing the patients needs. The Court rejected the professional standard of disclosure which had been applied by the courts until that time. As the court stated in *Hopp v. Lepp*:

In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned disclose to him the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation¹⁰.

The court held that the materiality of the non-disclosure of certain risks to an informed decision is a matter for the trier of fact who should take into account the medical evidence but also other evidence, including that from the patient and other members of his or her family¹¹. These decisions restrict the medical professions freedom to control the nature and extent of the information received by the patient. The patient plays a far more active role in decision making in relation to the course of medical treatment that will be taken. Medical paternalism in this context is no longer acceptable.

The Ontario Court of Appeal in *Videto v. Kennedy*¹², summarized the responsibility to disclose information, as laid down by the Supreme Court of Canada as follows:

⁸(1980) 14 C.C.L.T. 1 (S.C.C.).

⁹(1980), 13 C.C.L.T. 66 (S.C.C.).

¹⁰*Ibid.*, at 87.

¹¹*Reibl v. Hughes*, supra note 35 at 17.

¹²(1981), 125 D.L.R. (3d) 127 (Ont. C.A.) at 133-134.

1. The question of whether a risk is material and whether there has been a breach of the duty of disclosure are not to be determined solely by the professional standards of the medical profession at the time. The professional standards are a factor to be considered.
2. The duty of disclosure also embraces what the surgeon knows or should know that the patient deems relevant to the patient's decision whether or not to undergo the operation. If the patient asks specific questions about the operation, then the patient is entitled to be given reasonable answers to such questions. In addition to expert medical evidence, other evidence, including evidence from the patient or from members of the patient's family is to be considered...
3. A risk which is a mere possibility ordinarily does not have to be disclosed, but if its occurrence may result in serious consequences, such as paralysis or even death, then it should be treated as a material risk and should be disclosed.
4. The patient is entitled to be given an explanation as to the nature of the operation and its gravity.
5. Subject to the above requirements, the dangers inherent in any operation such as the dangers of the anaesthetic, or the risks of infection, do not have to be disclosed.
6. The scope of the duty of disclosure and whether it has been breached must be decided in relation to the circumstances of each case.
7. The emotional condition of the patient and the patient's apprehension and reluctance to undergo the operation may in certain cases justify the surgeon in withholding or generalizing information as to which he would otherwise be required to be more specific.
8. The question of whether a particular risk is a material risk is a matter for the trier of fact. It is also for the trier of fact to determine whether there has been a breach of the duty of disclosure.

In determining the amount of disclosure which is necessary, the essential issue then, is to determine what a reasonable patient in the position of the Plaintiff would consider to be "material risks" or "special or unusual risks". According to the court in *White v. Turner*¹³, a material risk is a significant risk that poses a real threat to the patient's life, health or comfort. The determination as to whether a risk is material, involves a balancing of the severity of the potential result and the likelihood of that result occurring. Therefore, even if there is only a small chance of serious injury or death, the

¹³(1981), 15 C.C.L.T. 81 (O.H.C.), aff'd (1982), 47 O.R. (2d) 764 (C.A.).

risk may be material. Alternatively, if there is a significant chance of slight injury this too may be held to be material.

“Special or unusual risks” are those that are not ordinary, common or everyday risks. These are risks which are extraordinary and uncommon although they are known to occur occasionally. Although these risks would likely not materialize, because of their unusual or special character, the Supreme Court has declared that they should be described to a reasonable patient. As Laskin, C.J.C. stated, “even if a certain risk is a mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure.”¹⁴

None of this means that a physician or surgeon must explain those risks which are commonly associated with any surgery or procedure. Therefore, a doctor need not warn that if an incision is made, there will be bleeding, some pain and a scar will remain. Similarly, a doctor need not inform the patient about the possibility of infection or the hazards associated with anaesthetic which go along with every surgical procedure. The reasonable patient is taken to know all of these common potential complications¹⁵.

Medical evidence will be required to assist the court in deciding the degree of probability of the risk materializing and the seriousness of the possible injury. In addition, expert evidence may be necessary to assist in the courts characterization of the risk such as whether the risk is common to all surgery or specific to a particular operation. The medical evidence provided will be relevant in determining whether the risk is material however, it will not be determinative. The test is whether a reasonable person in the patient’s position would want to know the risk.

¹⁴ *Ibid.*, at 99.

¹⁵ *Ibid.*, at 99.

The Efficient Trial of Liability Issues

There are two main elements of a medical negligence trial which drive costs upward. The first is the expense of expert witnesses both before trial and at trial. The second is simply the length of trial if all issues are litigated. Experts will almost always be required to resolve issues of the standard of care. The question is whether counsel can, by cooperation, reduce the expense incurred by all sides at trial. The timely exchange of expert reports can minimize the expense of retainers for experts to review allegations which may not be in issue. Although obviously this is a problem which is particularly of interest to the Defendant, it is not always possible to persuade Plaintiff's counsel (who have the legal onus of proof) to provide expert reports in a timely way. Many Plaintiff's counsel feel disadvantaged if they serve expert reports and the Defendants focus on these in their reports. Many counsel like to negotiate the exchange of reports outside of the Rules of Practice. This is entirely acceptable.

The most effective method for reducing the expense of liability trials is to eliminate unnecessary witnesses and evidence. There is no need, in most cases, to call witnesses whose only purpose is to prove hospital records and other documents. Many times witnesses are called who are called to avoid adverse inferences or in effect to explain notes and records contained in hospital documents already in the record. These witnesses can be avoided if counsel meet ahead of time to resolve the question of their evidence.

Number of Experts

Somewhat more difficult is the question of the number of liability experts to testify. Some counsel prefer to call more than one witness to testify regarding issues of standard of care or causation. Where such experts approach the matter from different disciplines, those decisions may be reasonable. On the other hand, it is not necessary to have more than one person where one will do. Counsel for the Plaintiff who are uncertain may call two witnesses to establish the standard of practice. This can lead to the Defendant physician and Defendant Hospital to do the same. Trials can be extended by a week on this practice alone. More to the point, experts can often be turned against each other with disastrous results for the case.

Bifurcation

Bifurcated trials divide the issue of standard of care or causation from the issue of damages. The issue of bifurcation is one which has attracted considerable judicial scrutiny in the last few years.¹⁶

The Rules of Practice in Ontario do not provide any guidances to the manner in which a Trial Judge should approach questions of bifurcation. It is fair to say that in the absence of consent, Trial Judges are loathe to split the question of liability from the question of damages. On consent, such an Order may be obtained where the Court agrees that the determination can be made separately.

In medical malpractice cases, it is more common to have the damages agreed between the parties. Where such agreement is not possible, the Court may order that the damages be tried afterwards, if necessary. This happens rarely. In a medical negligence claim, bifurcation should be considered as a second best alternative to an efficient trial with damages either agreed or largely agreed.

(i) Damages

It is during the trial of the damages aspect of the claim that real ground can be made up. It is here where creative and cooperative counsel can collaborate on cases and experts with a view to minimizing time and expense incurred in the claim. Most of the heads of damage can be broken down and a summary prepared of the evidence, expert reports and quantum. By negotiating fairly, openly and with a view to reducing trial time, counsel can often come to agreement in most items of the damage claim. Where this is not possible, mediations may be successful without undue expense.

If the case is tried and damages are not agreed, then at the very least, it ought to be possible to have the trial time reduced by a co-operative approach.

Role of the Trial Judge

The Trial Judge is important in civil actions for medical negligence. Today Judges are under pressure to have trials conducted efficiently. Since medical negligence cases are among those which can result in long trials, these cases sometimes attract judicial scrutiny.

Many people have suggested that one way to increase efficiency at trial in medical malpractice cases is to limit the number of Trial Judges hearing such matters to those experienced in the area.

In his report on Liability and Compensation in Health Care (1990), J. Robert S. Pritchard considered the possibility:

“Another development which offers some potential to facilitate medical malpractice litigation in Canada would be the designation of a small number of justices in each province to assume particular responsibilities for medical and hospital negligence claims. With comparatively frequent exposure to such cases, a handful of judges could gradually accumulate valuable experience and familiarity. The benefits of experience in malpractice cases was stressed repeatedly before us. With good counsel and an experienced judge, all sharing a commitment to expedite the process, the cases are manageable, although often demanding. When any of these elements are lost, trouble begins.” Appendix A, p. 257

Indeed, Professor Pritchard made the further suggestion, adopting a proposal by Professor Gary Watson of the Osgoode Hall Law School, that an effort be made “to develop guidelines and procedures for the proper processing of medical malpractice claims with the emphasis being placed on expedition, simplicity, disclosure, maximum opportunities for settlement and the avoidance of unmeritorious suits continuing longer than necessary”. (at p. 258) Professor Watson’s proposal became a recommendation of the Pritchard report.

¹⁶See for instance, a very useful editorial on the subject by David Stockwood, Q.C., *Advocates Society Journal*, 1999, Volume 18, No. 3.

The trial of a medical malpractice action is unlike other trials as outlined above. A Trial Judge is required to examine concepts which may be unfamiliar, both in terms of the evidence and legal principles.¹⁷

Recently, it has become common place for Trial Judges, Court administrators and others to stress the role the Trial Judge should undertake in controlling the judicial process. Frequently, Trial Judges make reference to the decision in *Ashmore v. Corp of Lloyd's* [1992] 2 All E.R. 486 to justify judicial supervision and sometimes counsel and the parties are left in the wake of judicial economy.

It is for these reasons that counsel undertaking a complex case like a medical malpractice action has a super-added responsibility to the Court and their client to be well prepared.

It is too late by the time the trial commences to resort to the essential legal cases which establish the framework of a medical malpractice action. Equally, it is too late by the time the trial rolls along to determine whether every element of the Plaintiff's claim can be made out. These notions were very much in the mind of Granger, J. when he wrote his lengthy reasons in *Marchand v. Public General Hospital et al*¹⁸:

“3. Length of Trial

This trial lasted an inordinately long time. Initially, I was advised that the trial would be completed within 8-10 weeks. The trial in fact lasted 165 days, and thus spanned a 20 month period. The trial should never have been allowed to last this long. Not only can the litigants not afford the financial costs associated with a trial of this length, the civil justice system cannot afford as well to allocate this amount of time to the litigants. To allocate this much court time to a single trial is clearly unfair to other litigants who are awaiting their turn in the Southwest Region.

¹⁷ See Marg Ross, Rules of the Road to Judgment in Medical Malpractice Cases; Advocates Quarterly [1998] Volume 20, p.274.

¹⁸ October 7, 1996, 91-GD-16866, at pp. 728-731.

In my view, the words of Lord Roskill in *Ashmore v. Corp of Lloyd's* [1992] 2 All E.R. 486 are most appropriate and apply in this situation. Lord Roskill stated at p. 488:

...

The Court of Appeal appear to have taken the view that the Plaintiffs were entitled as of right to have their case tried to conclusion in such manner as they thought fit and if necessary after all the evidence on both sides had been adduced. With great respect, like my noble and learned friend, I emphatically disagree. In the Commercial Court and indeed in any trial court it is the trial judge who has control of the proceedings.

It is part of his duty to identify the crucial issues and to see they are tried as expeditiously and as inexpensively as possible. It is the duty of the advisers of the parties to assist the trial judge in carrying out his duty. Litigants are not entitled to the uncontrolled use of a trial judge's time. Other litigants await their turn. Litigants are only entitled to so much of the trial judge's time as is necessary for the proper determination of the relevant issues. That was what Gatehouse J, in my view entirely correctly, sought to achieve by the order which he made, an order which as all your Lordships agree should be restored.

Prior to the commencement of this trial, counsel were unable or unwilling to identify and narrow the issues to be determined. It was clear during this trial that prior to the commencement of the trial, [counsel for the Plaintiff] had not determined the method that he would employ to prove the facts upon which his experts would rely. The failure to narrow the issues, determine the facts to be proven and the method of proof greatly lengthened this trial. In my view, the time has come for the judiciary, prior to the commencement of a trial, to become involved in determining the issues to be tried, the evidence to be called and the method of proving facts. In addition, the judiciary should consider placing time limits on direct examination and cross-examination of witnesses."

The need for judicial economy must of course be balanced by the need to adhere to principles of fairness and justice. Not every Trial Judge strikes this balance perfectly.

In his article, “*Temptations at the Bench*”¹⁹, The Honourable Sir Robert McGarry then vice-chancellor of the Chancellor Division, High Court of Justice, wrote of five temptations to which judges are exposed.

In his paper, Justice McGarry described how that both judicial silence and judicial intervention both have the effect of lengthening a trial. He found that the best course for a Trial Judge was to stay out of the action and allow counsel the leeway to present the case in the manner best suited to them. Of course the Trial Judge could not know what the evidence will be and must not try to take over the presentation of the case for one side or the other.

This leads to another question which is a problem frequently encountered in the trial of medical malpractice cases; the inexperienced counsel. This of course can lead to the Trial Judge taking over the case for one side; usually the Plaintiff. As Justice McGarry wrote, “The more the judge does for counsel that counsel ought to have done for himself, the more the judge moves into counsel’s shoes and into the perils of self-persuasion” and at page 410 on the temptation of brevity:

“Is it not a virtue in a judge for him to keep things short, to dispose of his cases quickly and so make inroads on the full and over-full list of cases waiting to be heard? What merit can there be in not taking the shortest path that will bring about a proper decision in the case? These are cogent and considerations, and they must be given due weight. Yet there is another consideration ... Justice in full takes time: but often it is time well spent”. (pp. 410-411)

Overly Broad Claims (Too Many Defendants, Too Many Plaintiffs)

All too commonly, claims include parties who do not belong in the action. Sometimes these Defendants complicate proceedings beyond belief with extra pleadings, discoveries, experts and trial time. Since Defendants do not usually recover costs even where successful, there is little incentive to focus on the key Defendants. Counsel should, wherever possible, focus

¹⁹ [1978] Volume XVI Alberta Law Review, p. 406.

on the Defendants who matter or face the prospect that the action will collapse under its own weight.

Common Experts

Others will address this topic in greater detail but it is worth noting that on occasion a single expert will suffice for both sides. In my own view, this is only realistic for issues of damages.

Witness Statements

Sometimes witnesses who are not central but who must be heard from to avoid adverse inferences or whose evidence is otherwise important can have their evidence filed in the form of an agreed statement.

In each case, counsel must be certain that the exact basis of the evidence is agreed; the Trial Judge should be told that the evidence of the witness as expressed in the statement represents the totality of the witness' evidence, even after cross-examination. Sometimes where documents exist in the record but have not been put to the witness in his or her statement, the Court is left in doubt about the weight of the witness' evidence. Try to be as complete as possible in the preparation of such statements and be certain to interview the witness to satisfy yourself that you have not overlooked anything.

Cross-Examination and Examination in Chief

As Justice Granger observed in *Marchand*, the examination of witnesses in a medical negligence case can be a source of delay and expenses. Counsel should not feel unduly constrained in their preparation for examinations but, as with other types of cases, should endeavour to be as efficient as possible in their examinations.

A couple of points are worth noting:

- (a) try to anticipate how you will prove the various facts in issue and, if there are evidentiary issues, how you will answer them;
- (b) in chief, try to present the witness' evidence in a logical way, paying attention to ensure the witness, trier of fact and even opposing counsel are ready to receive the evidence as it is given;
- (c) define terms as you go along. Use a glossary to assist the Trial Judge;
- (d) make effective, but not overly dramatic, use of demonstrative aids;
- (e) do not spend undue time on CVs;
- (f) in cross-examination, spend the time you need but do remember the hint of human tolerance to absorb information;
- (g) be certain you have read all the literature in the area you are concerned about and that which was applicable at the time;
- (h) make a list of your points; discard those inconsistent with your theory even if they are good points;
- (i) do not impeach for the sake of it; and
- (j) do not be mean unless you have to be. Nobody, not even a mean Trial Judge, likes to see a witness in such a case treated badly, except in very rare cases.

Agreed Medical Records

It is probably now unheard of for counsel to disagree about the admissibility of hospital records. Where any document is admissible and capable of proof, courtesy and efficiency dictate that consideration be given to admitting those documents by agreement.

CONCLUSION

Although trials of medical malpractice actions are complex and difficult, there is no need for these trials to be inordinately lengthy or expensive.

With a co-operative attitude and purposeful approach, counsel, and the Court, can try even the most complex medical cases efficiently. Obstetrical cases are probably the most complex medical negligence cases tried. In the past year, several such cases have been tried in Ontario in 4-6 weeks. In those cases, damages were agreed before the trial and a number of other steps were taken to have the case presented efficiently without any compromise to either side's ability to argue all of the issues or present all of the relevant evidence.

As suggestions for Tort Reform are implemented, it will still be necessary for many cases to be tried in our Courts. With experienced counsel co-operating effectively, those trials can be completed in a timely way to the greater satisfaction of all concerned.