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TAB 2

Causation on Trial:
Making Sense of Causation in the Most Difficult Cases

A practical model for proving fault in multiple tortfeasors actions

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Introduction

No more ink will be spilled here on academic analysis of the problem of causation and how to articulate it. The purpose of this paper is to outline how to develop the evidence to convince the trier of fact that liability ought to be found where there is more than one at-fault party who may be intermingling with non-negligent actors or events, or alternatively, to get out of a law suit that is a loser.

We all knew what the outcome of former President Trump's trial should have been. The trouble with that trial was the house managers never asked the right questions: what would have happened if Trump had not denounced Mr. Pence as a traitor? What would have happened if Trump had not asked his followers to march on the capital building on that particular day? Asking those questions gets you to the answer to the ultimate question: Did he incite insurrection?

Counsel must proceed with the investigation and analysis of multiple tortfeasor actions by asking the right questions of themselves, witnesses and experts. This is one roadmap to getting to the right question and the right answer.

First Question: What happened and who was involved?

In this step, gather the relevant records, as far back as may be needed. Negligent acts that are further back in time have a greater success of being identified as consequential. In a birth trauma case, the failure to treat a diabetic mother may be an easier target than the physician facing a crash c-section. A solvable problem is the most consequential in any time line.

The comprehensive records must be put in chronological order, and summarized, as close to real-time as possible. Who participated is identified as a discreet item in the time line. That will include the client, visitors, nurses, other patients, and those who document to the chart, perform tests, report tests, and communicate to team members.

The chronology has to be reviewed with an eye to the ultimate outcome. If you are looking at a missed or delayed diagnosis case, you must know the signs and symptoms and diagnostic process in order to evaluate the records and chronology and unearth the relevant information.

A word of caution. This is a critical step in the analysis. Your client may come to you with a ready-made explanation or complaint that has little to do with the cause of the bad result. You must fully understand what happened to be able to evaluate what was the actual cause or causes of the outcome. Do not be drawn in by what appears on its face to be an egregious failing; it may have an innocent explanation or may have nothing to do with the case at all.

Second Question: Were there non-negligent events and how important were they?

Non-negligent events include the natural course of the disease and what may or may not impact its trajectory.

Take the example of sepsis following a work place injury. The patient's pre-existing conditions and health may impact on the efficacy of treatment. The organism infecting the patient may be rare and not amenable to first line treatments given while cultures are examined. The patient may not be able to get to hospital until the sepsis had progressed to the point of being untreatable.

Prognosis for the condition, even with current treatment, is considered here. [That is, assuming it did not eliminate the case at the time of the first call with potential client.]

Non-negligent events and conditions may be sufficient to completely derail the case. Equally, they may be answerable. Either way, it is an error to fail to look for them at the outset of the investigation, and to be alert to them as the case progresses.

Third Question: What did each participant do or not do?

This step is part of the chronology building and is drawn from it. Audit trails, detailed reviews of timing of orders, lab results, nursing notes and other charting will build the story of who did what, when and how long it took to treat the patient. This step is done in concert with the next step which his answering what should each have done. In fact, you truly have to pivot back and forth between steps 3 and 4 or reverse their order.

The ward clerk received the call from the lab about the abnormal readings but did not pass the information along.

The lab tech spilled the sample and did not alert the floor that he had done so.

The nurse went off duty without checking for the results of the stat order. She failed to mention it on report.

The doctor coming on shift looked for the result, and realized antibiotics were required.

Fourth Question: What should each participant have done or not done?

This is the standard of care step.

The ward clerk should have communicated the results to the assigned nurse or charge nurse.

The lab tech should have called up to the floor about the spilled sample.

The nurse should have checked for the stat result and followed up with the lab and identified it on report before she left her shift.

The ordering doctor should have followed up the result.

These answers come from the experts you will retain to advise you on the case even before the statement of claim is issued. It is only with a detailed understanding of the facts, chronology and participants that you can properly review the case with them. How you otherwise prepare for this consultation is beyond the ambit of this paper but suffice to say you cannot go into the consultation cold, but must have educated yourself about the medicine in some detail.

Fifth Question: What would have happened if each acted according to the standard of care?

Liability has not been proven merely by establishing a breach of the standard of care. The plaintiff must prove causation, on a balance of probabilities. Having established breaches of duty under Questions 3 and 4, we now ask the causal question: How would the patient's outcome have changed had the breaches of duty not occurred? The causal question looks at an outcome that did not happen, a hypothetical harm-free world.

Observe that this is a two-part question. The first relates to the *actions* or *steps* that did not occur – what was correct conduct on the part of the medical team? The second relates to the *outcome* that did not occur – how would the patient's outcome have changed if there had been correct conduct?

In cases of multiple tortfeasors, and multiple factors, care must be taken to identify the role of each that bring about an injury.

Consider a delayed diagnosis of sepsis emanating from the failure of one actor, for example, the attending physician, to take a step, such as ordering a blood test in the face of symptoms suggesting post-operative infection. That is straightforward, her failure was the cause of the delayed diagnosis which led to the overwhelming sepsis and injury. Had she attended to the symptoms, ordered the blood work and looked for signs and symptoms, (the actions or steps), the sepsis would have been successfully treated (the outcome).

Contrast that with the example given above where there were many hands participating in the creation of the delay.

If each had met the standard, the lab result would have been reported to the attending physician earlier and acted upon. The question to be asked is whether earlier treatment would have impacted the outcome for the patient.

As a practical matter, it is important to examine the particular breach of duty, the fourth question above, and explore the relation of the specified factor to the sequence of factors needed to bring about the injury. With your causation experts, as well as in your examination for discovery of the defendants, it is vital to explore and compare the pathway to injury that occurred and the divergence from that pathway in the hypothetical world that is causation in tort. As an aside, there are indeed ways to

explore the causation issue with defendants in medical malpractices cases that will not merit objections from defence counsel.

Consider the specified factor that is being explored, with experts or at discovery. Care must be taken to identify the role of the specified factor in the overall sequence of events that brought about the injury. The causal questions need to tease out the way the specified factor altered the sequence of events. Take the example of the ward clerk who fails to pass on abnormal readings to others on the care team. To identify the role of that omission in the outcome, it is crucial to explore the reasons for the test, the value of the test in managing the patient's care, the intended use of the test results, what others down the chain were expected to do with the results, and how that test relates to the other factors.

Where multiple factors are at play, the causal question is more nuanced than merely asking your expert how the outcome would have changed had the specified factor not occurred. Your expert must address how the specified factor facilitated events that led to the outcome. Again, using the failure to report lab results, this omission may have distracted the physicians from the correct diagnostic pathway, even though there were other opportunities to make the correct diagnosis. At discovery, the defendant physician may admit that the lab results were important clinical data to have, that the lab results would have made the correct diagnosis more prominent in her mind, and that delay in reaching the correct diagnosis might have been avoided. The physician's own breaches of duty would not detract from the importance of the unreported lab results in creating the injury. These are the causal issues that must figure in the expert reports you obtain and the expert testimony you offer at trial. In a jury trial, these same issues must be adequately described in the causal questions put to the jury.

The obligation of counsel is to offer proof, on a balance of probabilities. It is not to rely on impossibility of proof to invoke the material contribution to the risk of loss. In some cases, certain evidence is not available because of the negligence of the defendants (the blood test result in the critical time frame is not available because no test was taken that ought to have been) and inferences can be drawn that may be favorable to the plaintiff. [1]

Sixth Question: Was there more than one participant?

This is where the finger pointing happens. Each of the ordering doctor, lab tech, ward clerk and nurse can point up or down the chain to say the fault of another person in the chain was consequential.

There will likely be temporal limitations on when earlier treatment would have eliminated or improved the outcome in a measurable way. Any actor within those temporal parameters participated in the delay. As far as the *plaintiff* is concerned, they caused his loss.

Each of the participants so identified caused some of the delay. If that was due to their negligence, they are liable. They are each like one of the 3 men leaning in unison on a car at the edge of a cliff, where

[1] See for example, Ghiassi v Singh et al 2018 ONCA 764 and Ediger v Johnston 2013 SCC 18

only two may be needed to push the car over the edge. As long as each is a participant (or dare I say, contributor or even, *material* contributor) in pushing the car over, they are liable. If each of a nurse, clerk, tech and physician participated in causing a delay, they are liable.

The notion of "global causation" has been referred to in some cases[2] where it is difficult to identify which defendants, amongst a group of defendants, actually caused the injury. In some cases, it is appropriate to first ask whether the sequence of factors caused by multiple wrongdoers resulted in the injury – the "global" or "threshold" question. Having done so, however, does not relieve the plaintiff from getting more specific about the breach of duty of each wrongdoer to identify its role in creating the injury.

Final Question: How much of the loss is each actor liable for? Apportion Liability

Recall that apportionment of liability is an exercise in comparing degrees of fault. In car crash cases where the plaintiff fails to wear a seat belt and contributes to her own injury, her fault is less, comparatively speaking, than the drunk driver's who smashed into her car. It may be that the seat belt would have wholly prevented her injury, but that is not the issue.

I wonder if this is where much of the confusion comes from in figuring out causation. We conflate two very distinct steps in the analysis. When the plaintiff suffers one injury – overwhelming sepsis, or a lost limb, it is not possible to say that the nurse caused most of it or the doctor's delay caused most of it. The delay in treatment caused the loss, full stop.

Very often a non-physician defendant will take the position that other, superior professionals were also at fault, and that they cannot be held accountable. Again, that is not the law and it is not the issue. The nurse's comparative negligence may be greater if she is the one who failed to report to the physician in a one-to-one patient scenario, or the physician's greater if she failed to heed warnings from the nurse, albeit delayed.

Finger pointing is about apportionment, not liability. Each of the ordering doctor, lab tech, ward clerk and nurse can point up or down the chain to say the fault of another person in the chain was consequential. But so long as each participated in the delay, each is liable subject to apportionment.

Summary

A comprehensive understanding of the events leading to an outcome causing injury is the bedrock of the effort to demonstrate causation as part of the liability analysis in multiple tortfeasor scenarios. How they proceeded and whether they failed to meet the standard of care must underlie the causation theory. Causation must be analyzed by looking at the hypothetical world – the counterfactual. This is the world where correct decisions are made, observations heeded, communication is competent and treatment is afforded in a timely and effective manner. Once a correct decision is made, there is likely to

[2] Sacks v Ross, 2017 ONCA 733 for example

be a series of other changes in the trajectory that must be considered by experts. A cohesive theory that can be put to the trier of fact is only then possible.