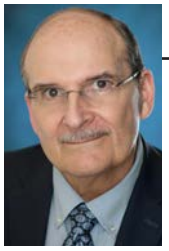
MEDICAL MALPRACTICE

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Failure to Mitigate

INTRODUCTION

It is accepted in tort actions that a plaintiff who has suffered a loss due to negligence has a "duty to mitigate" the loss; the plaintiff cannot recover from the defendant damages which he could have avoided by taking reasonable steps.[1] When a plaintiff has suffered physical or psychological injuries due to the negligence of others, mitigation often requires intervention from the health care community – therapies, medications, procedures – all aimed at improving the well-being and ultimately restoring the plaintiff as closely as possible to the state he enjoyed prior to the injury.

In this paper we will consider what constitutes an unreasonable refusal to undergo therapy and how two specific issues have been viewed by the courts: the plaintiff's right to choose or reject non-mainstream therapies, and the interplay of religious and cultural beliefs and a plaintiff's duty to undergo recommended treatments or therapies.

THE PRINCIPLES OF FAILURE TO MITIGATE

A line of English cases established that a plaintiff's unreasonable failure to undergo medical treatments that could reduce their injuries was an intervening cause, a *novus actus*, that cut off the liability of the initial tortfeasor.[2] The Supreme Court of Canada has rejected that approach; here, it is open to the courts to take into account factors including the chance of success of the refused course of therapy, and still award the plaintiff some compensation for future losses, even in the face of an apparent failure to mitigate.[3]

Although the plaintiff has the burden of proving both liability and the quantum of damage, the burden of proof shifts to the defendant if he alleges that the plaintiff could have and should have mitigated his loss.[4] To succeed in a failure to mitigate argument the defendant must prove that the plaintiff acted unreasonably in not undergoing the recommended treatment and the extent to which the plaintiff's damages would have been reduced had he acted reasonably.[5] It is the notion of the 'unreasonableness' of the plaintiff that is central to the analysis in a failure to mitigate claim.

WHAT CONSTITUTES AN "UNREASONABLE REFUSAL"?

In England, as recently as1954, Lord Denning suggested that people with anxiety have a better chance of recovery if they are expected to behave reasonably rather than "as weaklings who can give way to their weakness and expect to get paid for it." [6] For the most part at least, the court's view of injured plaintiffs has progressed since then. *Janiak v. Ippolito*, [1985] 1 SCR 146, 1985 CanLII 62 (SCC) is the leading case on failure to mitigate. In this case the plaintiff was injured in a motor vehicle accident. He had an innate fear of surgery and refused surgery that offered a 100% chance of recovery and could allow him to return to work. Based on an objective analysis, the trial judge found the plaintiff was unreasonable in his refusal of the surgery, and only awarded damages up to the time that he would have been able to return to work if he had the surgery. The Supreme Court of Canada upheld that result.

When is a plaintiff's refusal to undertake recommended healthcare unreasonable? The initial analysis is on the capacity of the plaintiff to make a reasonable choice.[7] In *Janiak,* the court concluded that not every pre-existing state of mind will be taken into account in determining the question of reasonableness and mitigation.[8] The court distinguished between plaintiffs who are capable of making a rational decision regarding their own care and those who, due to some pre-existing psychological condition, are not capable of making such a decision. In the latter case the thin skull principles apply and the plaintiff is not made to bear the cost of unreasonable decisions once liability has been proven. However, where a plaintiff has the capacity to act reasonably the defendant need not bear the costs of the plaintiff's unreasonable behaviour.

In the absence of a pre-existing condition affecting capacity, the test of what constitutes reasonable behaviour has been described as a subjective/objective test,[9] and as an objective test.[10,11] In either case, the elements of the test are: whether the reasonable patient, having all the information at hand that the plaintiff possessed, ought to have undergone the recommended treatment.[12]

The decision in *Janiak* focuses on the timing of the development of the incapacity - plaintiffs with a pre-existing lack of capacity could expect the defendant to bear the full cost of their damages, but in the absence of a pre-existing condition the objective test of reasonableness would prevail. The BC Court of Appeal has taken a modified approach to this issue, focusing on the incapacity itself rather than on the timing of the development of the incapacity: [13]

> [26] [I]f, by virtue of the injury sustained in an accident, a plaintiff is unable to make a reasonable decision about treatment, the plaintiff is in no different position with respect to mitigating the loss suffered than would be the case if, for other reasons unrelated to the accident, the plaintiff's capacity to make reasonable decisions about treatment was lacking. … I consider that if a plaintiff had the capacity to make the decision about treatment it is said ought to have been made, and the advice was sound, the mitigation question in each instance must be what would be expected of a reasonable person in the circumstances having regard for the plaintiff's medical condition at the material time and the advice given concerning treatment. If, through no fault of his own, the plaintiff did not have the capacity to make the decision, or the advice was not sound, the question would not arise.

If a plaintiff has suffered a disability that was caused by the medical system, it is no surprise that they may not have confidence in that same system to make them better. In our experience, it is not uncommon for a plaintiff who has suffered an injury due to the negligence of a physician or hospital employee, particularly if

it has resulted in an extended stay in hospital or some degree of permanent disability, to develop a fear of returning to hospital for further procedures to restore their health. Should they be penalized for this even though their fear was caused by the negligent act of the defendants?

There are many examples in which a plaintiff's refusal to undertake recommended therapies was found to have been caused by the defendant's negligence, and damages have not been reduced. In a medical malpractice case a plaintiff refused surgery that had a very high probability of an excellent recovery because she was "gun shy" due to a previous biopsy that caused the injury in the first place. This, combined with the fact that there was no evidence that the plaintiff's treating physicians had recommended the repair surgery to her, led to the judge's finding that she had not failed to mitigate her losses.[14] In another medical malpractice case a plaintiff who did not participate in recommended rehabilitation exercises due to a depression that arose because of her injuries was not found to have failed to mitigate her losses.[15] A plaintiff who did not participate in active exercises due to fatigue, fear of re-injury and recurrent bouts of pain, all of which flowed from her injury, was not found to have acted unreasonably, and her damages award was not reduced.[16]

The courts in BC and elsewhere have also taken contextual factors into consideration when determining if a failure to mitigate should result in a reduction in the plaintiff's damages award. Even if a plaintiff has the capacity to make a reasonable decision to undertake treatment to mitigate their losses, they are not required to make perfect choices in taking steps to minimize their losses.[17] For instance, if medical opinions conflict, if the recommended course of action is not likely to restore the plaintiff's health, if the risks of the intervention are unacceptably great, or if the damages would not be reduced in any case, then the plaintiff's failure to follow medical advice will not impact their compensation.[18] Further, if they can't afford to follow the recommendations or if their life circumstances interfere with their ability to follow the advice, they will not be penalized. As long as the plaintiff makes "contextually reasonable and sincere efforts"[19] they will not be penalized for failing to mitigate their loss.

PLAINTIFF'S AUTONOMY IN CHOOSING THERAPIES

The courts must balance respect for the autonomy of the plaintiff regarding decisions about medical treatment and their desire not to burden the defendant with avoidable losses[20]. Patients' rights to make decisions about their own health care, including choosing alternative therapies, have become more entrenched in our society. People now have ready access to virtually unlimited, but often unreliable, information through the internet, and can connect with others who share their interest in alternative approaches to health. How far does the patient's right to make their own decisions go when it comes to their duty to mitigate loses?

In *Hauer v. Clendenning*[21] the defendant argued that the plaintiff failed to mitigate her damages by not having steroid injections and/or arthroscopic surgery on her shoulder injury. The plaintiff preferred naturopathic remedies, and had been told by a friend that injections can cause muscle tissue breakdown. Despite this, the court found that the plaintiff failed to mitigate her damages by not following the advice of the orthopaedic surgeons and reduced her damages by 30% as a result of that choice.

In *Reed v. Steele*[22] the court considered the impact of a plaintiff's preference for natural healing, her scepticism toward most medical professionals and her willingness to act on anecdotal reports from strangers. Her chiropractor managed her health care and she attended at a naturopathic clinic. The trial judge noted that the plaintiff had a very distinct personality that blended a marked suspicion of most medical professionals with a tendency to accept treatment advice from people who lack medical credentials. The Court of Appeal upheld the trial judge's reduced award of past lost wages up to the time period when she would have been able to return to work had she participated in the more generally accepted treatments that were recommended to her.

Medical marijuana is beginning to find its place in the therapeutic armamentarium for some conditions. In *Glesby v. MacMillian*[23] a physician recommended that the plaintiff try medical marijuana to help manage her post-collision symptoms. The plaintiff had reservations about the legality of the acquisition and use of cannabis, and was a committed life-long abstainer from narcotics and drugs of all sorts so she did not follow the physician's recommendation. The defendant argued the damages should be reduced for this failure to mitigate but the Court accepted her explanation and did not reduce her damages award.

Perhaps it is ironic that much of what is generally accepted as standardized medical therapy has not been shown to be effective through randomized double blind controlled trials.[24] The fact that these therapies have been prescribed or recommended by physicians has lent them considerable credence. One of the few times an alternative therapy has been accepted by the court as a valid attempt to mitigate loss, was when there was a lack of medical advice and follow-up from the established medical community.[25]

RELIGIOUS BELIEFS AND CULTURAL INFLUENCES

The role of religious beliefs and cultural influences has not received much attention from the courts in failure to mitigate claims, leaving authors who have considered these issues to speculate on the possible outcomes and sometimes arrive at different conclusions.

Professor Ken Cooper-Stephenson suggests that if a pre-existing religious belief or cultural practice inhibits the plaintiff's capacity to choose a certain treatment, then the plaintiff ought not to be found to have acted unreasonably in that refusal. This opinion accepts the notion that the defendant must take the plaintiff as he finds them including their religion, culture, and socio-economic position.[26] He suggests that there is a move towards subjectivism and that religious belief and cultural practice fit within the notion of 'capacity', as in *Janiak*. Further, he says given that the Canadian Charter of Rights and Freedoms recognizes religious beliefs and cultural practices as fundamental constitutionally-protected values, it is almost certainly required that they be respected in post-action choices for the purposes of the duty to mitigate.[27]

On the other hand, Cassels and Adjin-Tettey[28] note that sincerely held religious objections should only provide an excuse from mitigation if those objections rendered the plaintiff incapable of choice or could be assimilated into the "pathological conditions" referred to in *Janiak*[29] The authors cite two American decisions as guidance.[30] In one of these decisions a judge instructed the jury to determine if the plaintiff had acted reasonably in refusing surgery, not by the standard of a reasonably prudent person, but by the standard of a "reasonable Jehovah's Witness." However the Court of Appeal held that if the court considered the reasonableness of a plaintiff's actions within the narrow context of her own religion, then the government would be stepping beyond recognizing religious freedom, into the realm of endorsing those beliefs.[31] Even in the United States of America where the "reasonable patient" test has a more subjective slant, the court was not prepared to narrow the parameters of a "reasonable patient" by imposing religious constraints on the analysis.

The courts in British Columbia have distilled these concerns into two key issues: to what extent, and under what circumstances will a religious or cultural belief be taken into consideration in addressing the plaintiff's duty to mitigate; and was the plaintiff's failure to follow a recommended course of treatment the result of an adherence to a religious or cultural belief or practice.[32]

The objective test set out in *Janiak* is such that as long as a plaintiff is capable of rational choice, then he must assume the cost of any unreasonable decision.[33] It follows, then, that in order to succeed with a defence that religious or cultural beliefs prevent a plaintiff from participating in recommended therapies, it is not enough to show that the religious or cultural belief would lead the plaintiff to feel embarrassment about a recommended therapy,[34] or that it would make it more difficult for them to undergo that therapy.[35] It would be necessary to lead evidence that the particular belief was so compellingly entrenched in the congregation (and not just in the plaintiff's interpretation of the belief) that the plaintiff was left unable to make an alternative choice. While interesting hypothetical questions arise (for example what if the plaintiff were to suffer banishment from their community if they went ahead with a recommended surgery), these issues remain unanswered.

Generally, when the courts have rejected the plaintiff's reliance on religious beliefs, it has been because insufficient evidence has been led to lay the foundation that these beliefs made it impossible for the plaintiff to follow prescribed therapies.[36] When a defence against failure to mitigate based upon religious beliefs has been accepted by the court, there have been other mitigating factors that the court has considered (such as the plaintiff suffering side effects from recommended medication[37] or having a fear of reinjuring themselves.[38])

CONSEQUENCES OF FAILURE TO MITIGATE

A plaintiff's failure to mitigate is viewed as a contingency and valued as a lost chance rather than a certainty. The damages award is discounted to reflect the chance that the treatment would have been successful.[39] In addition, if a failure to mitigate argument is made out, it is not only the non-pecuniary damages, past wage loss and loss of future earning capacity that can be reduced. If the plaintiff has demonstrated an unwillingness to undertake recommended therapies in the past it is possible that the costs of future care will be reduced as well, to reflect the plaintiff's lack of willingness to participate.[40]

CONCLUSION

Plaintiffs are always free to decline healthcare, treatment or testing, but if that refusal is "unreasonable and arbitrary" the defendant will not be made to bear the cost of the injured party's choice."[41] A number of avenues are open to the plaintiff to defeat a failure to mitigate claim or at least minimize its impact. If the plaintiff's capacity to make a decision is not at issue, then it will be necessary to determine the chance of success of the recommended therapies, to adduce evidence that there were contextual factors such as financial impediments to participation, or determine if factors flowing from the injury itself have interfered with the plaintiff's ability to follow medical advice. V

1 *Reed v Steele*, 1997 CanLII 4023 (BCCA), at para. 47.
2 *Janiak v. Ippolito,* [1985] 1 SCR 146, 1985 CanLII 62 (SCC), at para. 6 [Janiak].
3 *Ibid.* at paras. 4 and 45.
4 *Supra* note 1 at para. 47.
5 *Chiu v. Chiu*, 2002 BCCA 618 at para. 57.
6 *Supra* note 2 at para. 14, citing *Marcroft v Scruttons, Ltd.,* [1954] 1 Lloyd's Rep. 395 (CA).
7 *Supra* note 2 at para. 26.
8 *Supra* note 2 at para. 24.
9 *Gregory v. Insurance Corporation of British Columbia,* 2011 BCCA 144 (CanLII), at para. 56.
10 *Supra* note 2 at paras. 20, 23, 26.
11 *Cassells v. Ladolcetta,* 2012 BCCA 27 (CanLII) at para. 26.
12 *Supra* note 6 at para. 56.
13 *Supra* note 11at para. 26.
14 *Lemay v Peters,* 2012 NBQB 68 (CanLII).
15 *Forde v. Inland Health Authority,* [2010] B.C.J. No. 115.
16 *Rajan v. Hudon,* 2014 BCSC 1678 (CanLII) at para. 331 [Rajan].
17 Jamie Cassels & Elizabeth Adjin-Tettey, *Remedies: the Law of Damages,* 3rd ed. (Toronto: Irwin Law) at 447.
18 *Ibid.* at 448.
19 *Ibid.* at 447.
20 *Supra* note 10 at 447-448.
21 *Hauer v. Clendenning,* 2010 BCSC 366 (CanLII).
22 Supra note 1.
23 *Glesby v. MacMillian,* 2014 BCSC 334 (CanLII).
24 JP Ioannidis, *"Why most published research findings are false"* 2005 Aug;2(8): Epub 2005 Aug 30.
25 *Pedherney v. Jensen,* 2008 ABQB 345 (CanLII).
26 Cooper-Stephenson, Kenneth D, *Personal Injury Damages in Canada*, 2nd ed. (Scarborough, ON.: Carswell, 1996), at 876.
27 *Ibid.* at 879.
28 *Supra* note 10 at 292, 393.
29 *Supra* note 10 at 452-453.
30 *Supra* note 2 at para 26.
31 *Supra* note 10 at 453, 454.
32 *Abdalle v. British Columbia (Public Safety and Solicitor General)*, 2012 BCSC 128 (CanLII), at para. 78.
33 *Supra* note 2 at para 24.
34 *Qiao v Buckley,* 2008 BCSC 1782 (CanLII) at para. 63.
35 *Ibid.*
36 *Supra* note 32.
37 *Sebaa v Ricci,* 2015 BCSC 1492 (CanLII) at para 135.
38 *Supra* note 16.
39 *Supra* note 10 at 454.
40 *Maltese v. Pratap,* 2014 BCSC 18 (CanLII) at para 78.
41 *Supra* note 10 at 449, citing Engel v Kam-Pple holdings Ltd, 1993 1 SCR 306 at 315.