COURT OF APPEAL FOR ONTARIO

CITATION: Brown v. Baum, 2016 ONCA 325
DATE: 20160503
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Feldman, Lauwers and Benotto JJ.A.

BETWEEN

Diana Brown

Plaintiff (Respondent)

and

Dr. Joseph Baum

Defendant (Appellant)

Cynthia B. Kuehl and Stuart Zacharias, for the appellant

Osborne G. Barnwell and Maxine Palomino, for the respondent

Heard: October 29, 2015

On appeal from the order of Justice Mew of the Superior Court of Justice, dated March 10, 2015, with reasons reported at 2015 ONSC 849.

Feldman J.A.:

INTRODUCTION

[1] This appeal raises squarely the issue of discoverability and the commencement of the limitation period when a doctor continues to treat a patient to try to correct damage that occurred during or following surgery.

[2] The respondent (plaintiff), Diana Brown, suffered severe complications following her breast reduction surgery, which was performed by the appellant, Dr. Joseph Baum, on March 25, 2009.

[3] Ms. Brown brought an action against Dr. Baum alleging lack of informed consent (and negligence, but the latter claim was abandoned at the motion) on June 4, 2012, over three years after the initial surgery, but within two years of when Dr. Baum last treated her to correct the original problems. In her statement of claim, Ms. Brown alleges that Dr. Baum did not inform her of the risks or possible outcomes of undergoing breast surgery, and, in particular, of the risks that her obesity and smoking could pose.

[4] Dr. Baum was unsuccessful on his summary judgment motion to dismiss the action as statute barred under the *Limitations Act, 2002*, S.O. 2002, c. 24, Sch. B. The motion judge found that as of July 2009, Ms. Brown knew she had suffered an injury that was caused or contributed to by an act or omission of Dr. Baum and therefore she met the first three limbs of discoverability, as set out in s. 5(1)(a)(i-iii) of the *Limitations Act, 2002* at that date.

[5] However, because Dr. Baum continued to treat Ms. Brown to ameliorate her complications, the motion judge found that the fourth limb, s. 5(1)(a)(iv), was not met because Ms. Brown did not know that “a proceeding would be an appropriate means to seek to remedy” the injury, loss or damage she had

suffered. The limitation period did not commence until June 16, 2010, the date of Ms. Brown's last ameliorative surgery by Dr. Baum. As a result, Ms. Brown's statement of claim, issued on June 4, 2012, was issued within the limitation period.

RELEVANT FACTUAL BACKGROUND

[6] The relevant factual history is clearly set out by Mew J. in his reasons and I can do no better than repeat that history here:

> [7] Ms. Brown first had first seen Dr. Baum in 2004 concerning a possible tummy tuck operation. She ultimately had tummy tuck surgery on 22 February 2008, which was performed by Dr. Baum.
>
> [8] Following this surgery, there were, according to Ms. Brown, complications in that the stitching was "open" and "oozing".
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> [9] Ms. Brown saw Dr. Baum in March 2008 for a follow-up after the tummy tuck surgery. On that visit she also talked to Dr. Baum about possible breast reduction surgery to alleviate her back pain.
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> [10] Dr. Baum's note of that attendance records that Ms. Brown weighed 325 lbs. at the time (based on what was reported by Ms. Brown).
>
> [11] On 26 June 2008, Ms. Brown saw Dr. Baum again. He noted "Needs to lose weight!!", "Wants breast reduction" and "Endocrinologist". Dr. Baum referred Ms. Brown to Dr. Min Wong for an endocrinology consultation for assistance with weight loss in advance of breast reduction surgery. In his referral letter to Dr. Wong, Dr. Baum wrote: "patient has been advised to lose weight before we proceed with breast reduction surgery". Dr. Wong subsequently reported that he had

met with Ms. Brown and discussed with her a diet and exercise regimen as well as strategies to reduce weight.

[12] The plaintiff next saw Dr. Baum on 6 November 2008. He noted that Ms. Brown's weight was 280 lbs. (again, based on what Ms. Brown reported).

[13] On 11 November 2008, Dr. Baum dictated a consultation letter to Ms. Brown's family doctor. After discussing her weight and aspects of her medical history, Dr. Baum wrote:

> The nipple areola complex are quite large laterally and are displaced medially. It is also noted that she has a large lateral fold of skin and breast tissue and will require considerable lateral incisions. To complicate matters further, she is a smoker and I have informed her that she would have to be off cigarettes for a month pre operatively to decrease the risk of infection and wound dehiscence. We will make plans for surgery in the spring and I would suggest that she try her best to get the weight problem under control.

[14] Dr. Baum says that the contents of his letter accurately reflect his discussions with Ms. Brown, including the relation of smoking with the risks described although, he says, in lieu of the term "wound dehiscence", for example, he would have said words to the effect of "a problem with wound healing". Other than the letter to the family doctor, there is no other contemporaneous written record of what was discussed between Dr. Baum and Ms. Brown at that time.

[15] Ms. Brown had breast reduction surgery on 25 March 2009. The day before her surgery, she completed a pre-admission, pre-anesthetic patient questionnaire in which she indicated that she was smoking eight cigarettes per day. Dr. Baum's evidence is that he was not aware that, contrary to his instruction, Ms. Brown was continuing to smoke at that time.

[16] Following her surgery, Ms. Brown developed complications. She said that her wound had opened up the following day and she went to the Emergency Department at Brampton Civic Hospital. She saw Dr. Baum at 31 March 2009 and on 14 and 17 April 2009. Dr. Baum's note of the attendance on 14 April 2009 states that Ms. Brown was still complaining of pain in both breasts and "? Fat, Necrosis".

[17] There was a another attendance at the Emergency Department on 27 April 2009 and on 6 May 2009 Dr. Baum performed further surgery, noting that "the fat necrosis" had affected both breasts. When examined for discovery Dr. Baum explained fat necrosis as:

> A process where there is not enough blood supply going to the tissue. Breast tissue is made of skin, fat breast tissue….but if you lose the blood supply, it's the fat that loses its integrity and if the fat loses its integrity, the fat cells die and that explains what the plaintiff describes as "rotting flesh".

He went on to say that:

> …the fat goes from a solid state to a liquid state that and it's foul smelling…it looks like infection…it's thick, it's yellow, it's terrible looking, has a terrible smell to it."

[18] There was a third surgery on 26 May 2009. The operative note shows that the pre-operative diagnosis was "fat necrosis right breast". It was recorded that "necrotic fat material was dissected from the right breast".

[19] On 2 June 2009, there was additional cutting away of "non-viable tissue".

[20] On 24 July 2009 there was more surgery. The operative note showed that the pre-operative diagnosis indicated "bilateral breast deformities". Dr. Baum indicated that the purpose of the July operation was to reconstruct the areola by using a graft. Asked about

what had been occurring up to the 24 July 2009 surgery, Dr. Baum explained that the plaintiff was having "horrendous complications and that [he] was doing everything…to correct" and that all of the "subsequent operations were logical, systematic approaches to get [the plaintiff] back to some state of normalcy…".

[21] On 12 August 2009 necrotic skin was removed from the reconstructed left areola.

[22] A progress note from Dr. Baum on 15 September 2009 stated that the plaintiff's "breasts were pancake shaped as she lost projection in both breast secondary to the fat necrosis". It was further noted that the plaintiff would require "nipple-areola reconstruction" and that Ms. Brown was not happy with the shape of her breasts. Dr. Baum noted that he would have to "reconstruct the breast mounds to give them protrusion and that "arrangements will be made for an ultrasound to be done of the breast to ascertain that the fat necrosis is contained".

[23] A consultation note of Dr. Baum's indicates that on 24 March 2010 Ms. Brown was scheduled for bilateral reduction of both breasts following fat necrosis as well as a reconstruction of the nipples. However, due to her low haemoglobin, the operation was put off.

[24] On 16 June 2010 Dr. Baum performed a mastopexy in order to improve the shape of the plaintiff's breasts.

[25] A progress note from Dr. Baum dated 22 June 2010 indicates that the plaintiff's wounds appeared to be healing well with no evidence of infection or fat necrosis. However, he also noted that Ms. Brown exhibited displeasure over the appearance of the nipples and had reverted to aggressive and profane language and that "she again lacks insight as to the difficulty of correcting the problem". The note indicates that "she will return to the office next week for suture removal and to discuss referring her to a tertiary breast reconstructive surgeon".

[26] A letter dated 20 September 2010, authored by Dr. Mitchell Brown, a specialist to whom the plaintiff was referred to for a second opinion, indicated that "the result looks quite good and it was my opinion that [Ms. Brown] should leave things as-is".

[27] Ms. Brown completed signed consent forms prior to her various surgeries. With respect to the form signed by her on 25 March 2009 her evidence, and that of her daughter, Stephanie Reid, is that Ms. Brown was presented with the consent form by Dr. Baum's secretary. Ms. Brown testifies that "It was never the case that Dr. Baum sat across from me at a desk and explained things to me and then asked me to sign". Ms. Reid, however, testifies that she recalls "accompanying my mother to see Dr. Barum [*sic*] just before the surgery on her breasts. That was a conversation about what he was going to do during the surgery. It was not a detailed conversation. Di [*sic*] not last beyond half an hour".

[28] Ms. Brown and her daughter say that Dr. Baum did not ask Ms. Brown, immediately prior to her surgery, whether she was continuing to smoke. Dr. Baum says that subsequent to the 25 March 2009 surgery, he learned that Ms. Brown had, in fact, continued to smoke. He says:

> I do not recall how this came about however, upon discovering this I told Ms. Brown to stop smoking and that I believed the problems she was experiencing were a result of her smoking.

[29] In Dr. Baum's operative report of 25 May 2009 he stated:

> I see no evidence of infection, however, I have again instructed her that she should refrain from smoking as I think this is the cause of the vascular compromise.

[30] Ms. Brown claims that Dr. Baum did not tell her, prior to her surgery in March 2009, that her weight and her smoking could affect her healing. She further claims

that in none of the surgeries that followed did he say to her that the rotting of her breasts was because she was smoking or because she was overweight. She says:

> He never gave me the choice not to proceed with the surgery.

She continues:

> I had no idea that this surgery would lead to such suffering and such scarring mentally and physically. Dr. Baum left me the clear impression that the surgery would be no problem. He left me believing that I had nothing to worry about. I felt that this was a 100% success surgery. If Dr. Baum had said to me that my chances were low, less than 50%, I would not have done this surgery.

And further:

> …if I had the information that smoking and being obese would affect my healing, I would never have proceeded with this elective plastic surgery in March 2009. While I am not that sophisticated, I am surely not that silly to have blindly taken such risks of my health by continuing smoking and carrying around the weight. It was not as if I was dying and had to have this surgery in March 2009. This was something that could have been delayed until I was in a state that would assure a better result. As I stated, I did not have the opportunity to choose.
>
> …At no time did Dr. Baum tell me there could be complications which would require further surgeries. He never told me that once he completed the first surgery, he may have to do additional surgeries if certain things did not go right. The point is,

> I went into the surgery totally ignorant of what was to come.

[31] While Dr. Baum has no specific recollection of many of his discussions with Ms. Brown (and, regrettably, limited contemporaneous notes and correspondence), his evidence is that his routine discussion with every patient who is going in for this sort of surgery goes into all of the risks and possible complications.

[32] Ms. Brown has testified that in May 2009 her breasts looked "hideous" and, in her mind, this was all because of the surgery performed by Dr. Baum. By July 2009 it was her belief that Dr. Baum had made a mistake or done something wrong. She testified that "he didn't put my nipples back on" and "it was infected all this time". In the same timeframe, July 2009, she was frustrated because she felt that Dr. Baum had wronged her. She testified: "Well, just looking at the – what he's done, it – just looking at the boobs, you can tell that they were not right. Anybody could tell that they weren't right".

[33] On discovery, Ms. Brown said that she had had her daughter take the photographs of her breasts before and after the surgery. Asked why she had done this, she responded "just in case". Pressed further the following exchange occurred:

> Q. Just in case you ended up in a lawsuit like this one. Right?
>
> A. Exactly.
>
> Q. All right.
>
> A. Exactly. Boy was I right.

[34] Yet despite her concerns, Ms. Brown continued to see Dr. Baum and underwent further surgeries performed by him.

[35] The statement of claim was issued on 4 June 2012, approximately 23½ months after the plaintiff's last

> consultation with Dr. Baum and more than 38 months after her first surgery.

The decision of the motion judge

[7] The motion judge first referred to s. 5 of the *Limitations Act, 2002* which sets out the conditions that determine when a claim is discovered:

> 5.(1) A claim is discovered on the earlier of,
>
> (a) the day on which the person with the claim first knew,
>
> (i) that the injury, loss or damage had occurred,
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> (ii) that the injury, loss or damage was caused by or contributed to by an act or omission,
>
> (iii) that the act or omission was that of the person against whom the claim is made, and
>
> (iv) that, having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it; and
>
> (b) the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known of the matters referred to in clause (a).
>
> 5.(2) A person with a claim shall be presumed to have known of the matters referred to in clause (1)(a) on the day the act or omission on which the claim is based took place, unless the contrary is proved.

[8] The motion judge acknowledged the case law that states that in a medical malpractice case, in order to commence an action, a plaintiff does not need to know the precise cause of her injury, but only sufficient facts to base an allegation of negligence against the defendant medical personnel or hospital: *McSween v. Louis* (2000), 132 O.R. (3d) 304, 2000 CanLII 5744 (C.A.), at para.

51*, Lawless v. Anderson,* 2011 ONCA 102, at para. 36*, Khan v. Lee,* 2014 ONCA 889, at para. 17*.*

[9] In this case, based on the record, Ms. Brown knew by July 2009 that the operation had not gone well and she believed that Dr. Baum had done something wrong. The motion judge accepted that by July 2009, Ms. Brown knew the facts required by the first three of the four conditions in s. 5(1)(a) of the *Limitations Act, 2002*. He therefore focused on s. 5(1)(a)(iv): at what point did Ms. Brown first know that "a proceeding would be an appropriate means to seek to remedy" the injury, loss or damage she had suffered? Was it in July 2009, or in June 2010 after all of the remedial surgeries that Dr. Baum performed on her?

[10] The motion judge found that the series of surgeries that Dr. Baum performed over the 13-month period from May 6, 2009 to June 16, 2010 constituted Dr. Baum's attempts "to improve the outcome of the initial surgery". In fact, by September 2010, Dr. Mitchell Brown provided the second opinion that by that point in time "the result looks quite good."

[11] The appellant argued that the limitation period commenced either at the initial surgery in March 2009 or at the latest by July 2009, and that even if the respondent had wanted to refrain from commencing an action until she stopped seeing the appellant, there would have been time for her to have done so following the final consultation visit in June 2010. In other words, the respondent

had two years to continue to be treated by Dr. Baum before she had to commence the action against him.

[12] The motion judge rejected this submission, pointing out that the limitation period does not commence until the injured party first knows that an action is an appropriate remedy. Therefore, the issue was whether, during the period when her doctor was trying to fix the problems she felt that he had caused, she knew it was appropriate to sue him. In considering that issue, he referred to this court's decision in *Markel Insurance Company of Canada v. ING Insurance Company of Canada,* 2012 ONCA 218, 109 O.R. (3d) 652, at para. 34, where Sharpe J.A. discussed the meaning of "appropriate" in the context of s. 5(1)(a)(iv):

> … I fully accept that parties should be discouraged from rushing to litigation or arbitration and encouraged to discuss and negotiate claims. In my view, when s. 5(1)(a)(iv) states that a claim is "discovered" only when "having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it", the word "appropriate" must mean *legally appropriate.* To give "appropriate" an evaluative gloss, allowing a party to delay the commencement of proceedings for some tactical or other reason beyond two years from the date the claim is fully ripened and requiring the court to assess to tone and tenor of communications in search of a clear denial would, in my opinion, inject an unacceptable element of uncertainty into the law of limitation of actions.

[13] The motion judge concluded that on the record in this case "[i]t would be unreasonable and inappropriate…to start the two-year limitation clock running against Ms. Brown while the defendant's good faith efforts to achieve a medical

remedy continued." In so finding, he emphasized that he was not finding as a rule that the limitation period will not commence until the doctor-patient relationship ends in every case where the relationship is ongoing after the injury, loss or damage has occurred – only that it might not, depending on the facts and circumstances of each case.

ISSUE

[14] Did the motion judge err in law in his application of s. 5(1)(a)(iv) of the *Limitations Act, 2002* to the facts of this case?

ANALYSIS

[15] On this appeal, the appellant challenges the finding by the motion judge that although by July 2009 Ms. Brown knew that an injury, loss or damage had occurred (undergoing breast reduction surgery without having been informed of the risks) and that the injury, loss or damage had been caused or contributed to by an act of Dr. Baum (his failure to inform her), she did not know that bringing a legal action would be an appropriate remedy. The appellant points to the fact that Ms. Brown was taking photographs of her breasts for months following the initial surgery "just in case [she] ended up in a lawsuit like this one."

[16] The appellant cites two errors it alleges Justice Mew made in his analysis. First, the appellant says that the motion judge erred in his interpretation of s. 5(1)(a)(iv) in stating, at para 50 of his reasons, that the point of the subsection "is

to delay the commencement of the limitation period until such time as initiating a proceeding is an appropriate remedy." The appellant argues that the motion judge erred by conflating a claim to a legal right with taking legal proceedings to pursue that right.

[17] I do not agree that the motion judge erred in his interpretation of the section. I agree with the motion judge that the fourth condition of discoverability under the Act is met at the point when the claimant not only knows the factual circumstances of the loss she has suffered, but also knows that "having regard to the nature of the injury, loss or damage", an action is an appropriate remedy. Once she knows that, she has two years to initiate that action.

[18] The motion judge's application of the subsection to the facts on this record was particularly apt: he concluded that because the doctor was continuing to treat his patient to try to fix the problems that arose from the initial surgery, that is, to eliminate her damage, it would not have been appropriate for the patient to sue the doctor then, because he might well have been successful in correcting the complications and improving the outcome of the original surgery. On the evidence of Dr. Brown, the specialist who provided Ms. Brown with a second opinion, by September 2010, Dr. Baum in fact was successful in ameliorating Ms. Brown's damage.

[19] Second, the appellant submits that the motion judge gave the term "appropriate" an "evaluative gloss" rather than applying the meaning of "legally appropriate", contrary to this court's decision in *Markel*. Again I do not agree. The motion judge was entitled to conclude on the facts of the case that Ms. Brown did not know that bringing an action against her doctor would be an appropriate means to remedy the injuries and damage she sustained following her breast reduction surgery until June 16 2010, after Dr. Baum performed the last surgery.

[20] Further, I am satisfied that the test in s. 5(1)(b) is met. A reasonable person in Ms. Brown's circumstances would not consider it legally appropriate to sue her doctor while he was in the process of correcting his error and hopefully correcting or at least reducing her damage. Where the damages are minimized, the need for an action may be obviated.

[21] I would also add this observation: the *Markel* case involved insurance transfer payments and considerations of the appropriateness of possibly delaying the commencement of legal action in order to negotiate a settlement. The considerations for when it is appropriate for a patient to delay suing her doctor when that doctor is continuing to treat her are quite different. I certainly agree with the motion judge that there are many factual issues that will influence the outcome. The fact that a number of recent cases (for example, *Tremain v. Muir (Litigation guardian of)*, 2014 ONSC 185, *Chelli-Greco v. Rizk*, 2015 ONSC 6963, *Novello v. Glick*, 2016 ONSC 975 (Div. Ct.), and *Barry v. Pye,* 2014 ONSC 1937)

have considered this very issue with different outcomes is a testament to this approach.

[22] The motion judge also suggests, as a reason why it is not appropriate to sue during continuing treatment to correct an injury, that in practice, a doctor would not continue treating a patient and trying to fix the injury he caused once the patient sued him. That raises the issue of the professional obligation of doctors to inform a patient when harm is done during the course of treatment. The Disclosure of Harm Policy (Policy Statement #5-10) of the College of Physicians and Surgeons of Ontario states:

> INTRODUCTION
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> Despite best efforts, patients may incur harm during the delivery of health care. Harm is not always preventable nor is it necessarily an indicator of substandard care.
>
> For the purpose of this policy, “harm” means an unintended outcome arising during the course of treatment, which may be reasonably expected to negatively affect a patient’s health and/or quality of life. This includes outcomes that occur as a result of individual or systemic acts or omissions. This also includes adverse events that result in unintended harm related to the care and/or services provided to the patient rather than to the patient’s underlying medical condition.
>
> For the purpose of this policy, “disclosure” means the acknowledgement and discussion of an outcome with the patient or his or her substitute decision-maker.
>
> The objective of disclosure is not the attribution of blame. Rather, disclosure should provide patients with

> the information they need to make autonomous, informed decisions about their health care.
>
> …
>
> POLICY
>
> When a patient has sustained harm while under a physician's care, the physician must ensure that harm is disclosed to the patient or to his or her substitute decision-maker. (This is reinforced in Section 14 of the Canadian Medical Association Code of Ethics: "Take all reasonable steps to prevent harm to patients; should harm occur, disclose it to the patient.")

[23] When a doctor discloses to the patient that he has done harm in accordance with the policy, he would also report to the liability insurer. After that, the issue of further remedial treatment would likely be determined with input from the patient, the doctor and the insurer, including the possibility of a tolling agreement to address the limitation issue. As none of this occurred in this case, the court is not in a position to comment on these very practical issues.

Conclusion on Limitation Issue

[24] In my view, the motion judge made no error in his approach to this issue. He considered all of the relevant case law, and applied it to the facts. He was entitled to find that Ms. Brown did not know that it was appropriate to sue Dr. Baum until after the last surgery he performed to try to correct the complications and improve the outcome of the original surgery. As the motion judge observed, it is not simply an ongoing treatment relationship that will prevent the discovery of the claim under s. 5. In this case, it was the fact that the doctor was engaging in

good faith efforts to remediate the damage and improve the outcome of the initial surgery. This could have avoided the need to sue.

Issue of Cross-Appeal

[25] In response to the respondent's summary judgment motion, the appellant moved for partial summary judgment on the doctor's liability for performing the surgery without obtaining informed consent. The motion judge dismissed that motion as well because the plaintiff had not provided expert evidence on aspects of the standard of care which she alleged Dr. Baum failed to meet and because he found that a trial of the issue of what the plaintiff would have done had she been given all of the required information was required. The motion judge also noted a significant evidentiary conflict between the plaintiff and the defendant as to what information the plaintiff was, in fact, given. He ordered an expedited trial process to begin with a case management conference before him to define the issues and establish the facts not in dispute.

[26] Counsel for Ms. Brown did not cross-appeal this dismissal, but sought leave of the court at the hearing to cross-appeal. The issue was argued briefly by both sides.

[27] In my view, there is no basis to set aside the decision of the motion judge not to grant summary judgment on the claim. First there was no proper cross-appeal (although a late factum was filed by counsel for Ms. Brown) and no

factum from counsel for Dr. Baum on the issue. However, had the cross-appeal been properly filed, I would not have granted it. Although the motion judge acknowledged that the doctor should have discussed the weight and smoking risk factors with Ms. Brown, he found that was not a sufficient basis to grant summary judgment on the informed consent issue. That is a discretionary decision by a motion judge based on the record before him. There is no basis to interfere with it.

Conclusion

[28] I would dismiss the appeal with costs to the respondent in the amount of $12,500 inclusive of disbursements and HST. The cross appeal is also dismissed.

Released: “KF” MAY 3, 2016

“K. Feldman J.A.”
“I agree. P. Lauwers J.A.”
“I agree. M.L. Benotto J.A.”