

2006 01 H 0035

IN THE SUPREME COURT OF NEWFOUNDLAND AND LABRADOR
COURT OF APPEAL

BETWEEN:

ESTATE OF LYNIA ROSS, by its Administrator,
the REGISTRAR of the SUPREME COURT OF
NEWFOUNDLAND

FIRST APPELLANT

AND:

ESTATE OF AUTUMN SARAH LYNIA
BROWNE, by its representative EDGAR
BROWNE

SECOND APPELLANT

AND:

EDGAR BROWNE and SHANNON BROWNE
and CANDACE BROWNE

THIRD APPELLANTS

AND:

JEFFREY G. HISCOCK

RESPONDENT

FACTUM OF THE APPELLANTS

CHES CROSBIE BARRISTERS
Solicitors for the Appellants
whose address for service is:
169 Water Street, 4th Floor
St. John's, NL A1C 1B1
Attention: Chesley F. Crosbie, Q.C.

TO: CURTIS, DAWE
Solicitors for the Respondent
11th Floor, 139 Water Street
St. John's, NL A1C 5J9
Attention: Peter N. Browne

TABLE OF CONTENTS

	<u>Page</u>
PART I – CONCISE STATEMENT OF FACTS	1
Chest Pain and New Murmur.....	6
Charting Rushed and Substandard	9
The Expert Witnesses	16
PART II – LIST OF ISSUES.....	18
PART III – ARGUMENT.....	20
Summary of the Appeal	20
Standard of Review.....	21
Issue 1 – Deceased Plaintiff Lied To Her Physicians	24
Issue 2 – Discharged Fact Finding Duties in a Manner Not Supported by Expert Medical Evidence.....	32
<i>Admissibility of Evidence of Non Peer</i>	32
Issue 3 – Misstated the Issue in the Case	35
<i>Lack of Analytical Coherence</i>	35
<i>Negligent Failure to Consider Pregnancy</i>	37
Issue 4 – Overruled Objections to Expert Testimony	41
Issue 5 – Failed to Weigh Credibility of Expert Evidence.....	45
Issue 6 – Failed to Resolve Evidence as to Negligence using Test of Unreasonable Risk of Harm.....	52
<i>Differential Diagnosis – First Error</i>	52
<i>Method for Family History Taking – Second Error</i>	56
PART IV – RELIEF REQUESTED	61

APPENDIX 1	1
Medical Literature.....	1
Cross-Examination of Dr. Christakis.....	3
Cross-Examination of Dr. Hiscock on Chicken Bone	5
Cross-Examination of Dr. Hiscock on Failure to Rule out Dissection	5
Cross-Examination of Dr. O'Reilly as to Morbid Obesity	6
Testimony of Doris Rogers.....	7
<i>Knowledge of Terms</i>	7
<i>Knowledge of Risks</i>	8
<i>Dr. Kravitz visit</i>	9
<i>Hated Doctors</i>	13
<i>Doctor says I'm O.K.</i>	14

APPENDIX 2 – GLOSSARY OF MEDICAL TERMS

APPENDIX A – AUTHORITIES CITED

PART I – CONCISE STATEMENT OF FACTS

1. Lynia Ross presented in late pregnancy at the James Paton Memorial Hospital in Gander, with elevated blood pressure and retrosternal chest pain, on August 30, 1996. The Defendant medical consultant diagnosed a non-life threatening condition. A week after discharge, at age 31, Ms. Ross was dead. After another five days, Ms. Ross' daughter Autumn, delivered by caesarian section, died in her father's arms.
 2. The Defendant is a specialist in internal medicine and a consultant for chest pain for the regional hospital.
 3. Lynia Ross' father and brother both died young, of aortic complications of Marfan's disease (not heart disease). Her father died age 34, her brother died age 29.
 4. If the consultant had obtained the family history, he admits he would have sent the patient to St. John's for investigations available at St. John's and for definitive diagnosis and management by cardiology and cardiac surgery. As the trial judge found, the death of Ms. Ross and her child "would probably have been avoided."
- Decision, paras. 113-115
5. Marfan's disease is a rare connective tissue disorder which runs in families, and affects the aorta, the main blood vessel from the heart. Defence and plaintiff experts agreed that the first paragraph of D.B. #7 is a good general description of Marfan's syndrome, and this was quoted by the trial judge at para. 27 of his Decision.

6. The trial judge quoted a textbook description of aortic dissection at para. 31 of his Decision.

7. The incidence of Marfan's given in the leading text is 1 in 10,000, including those with phenotypic presentation (clinical features) and those without. Dr. Melvin's impression and that of those in the Adult Congenital Clinic was that the incidence is higher in Newfoundland. The incidence of those with the phenotype is 1 in 20,000, which would mean that half the Marfan's population does not have the obvious phenotype.

Transcript, Dr. Melvin, p. 11, lines 16-20, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 15

8. Marfan's makes the aorta prone to dissect. Dissection can happen with or without bulging or aneurysm of the vessel. In Ms. Ross' case, dissection occurred without aneurysm. The classic cause of death is either aneurysm of the ascending aorta with rupture, or dissection with rupture, as in Ms. Ross' case.

Transcript, Dr. Melvin, p. 6, line 11, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 15

9. Rupture of the aorta is the leading killer of Marfan's patients. However with modern medical and surgical management, patients enjoy a nearly normal life expectancy.

The life expectancy in 1972 is 45 years of age, and in 1995 it had gone up to 72 years of age.

Transcript, Dr. Melvin, p. 11, line 72, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 15

10. Marfan's is an autosomal dominant inherited disorder, which means, as noted by the trial judge at para. 30, that there is a 50 percent chance of inheriting the disorder from a parent.
11. Ms. Ross knew the family history of early aortic death. A month after her brother died, she visited her then family doctor at the clinic for counselling. Dr. Sheldon offered an EKG, and raised the possibility of a chest x-ray and an abdominal ultrasound:

“May need CXR ? U/S” and “E.K.G.”

Dr. Sheldon's Clinic Note, February 12, 1993, Consent Book, Vol. 1, Tab 6, p. 002

12. Ms. Ross followed up and had all the tests suggested by Dr. Sheldon, and they were normal. Dr. Sheldon reassured her that she did not have the disease.
13. Ms. Ross again reviewed the situation as to Marfan's with her family doctor, now Dr. Furlong, in November 1994. She had complied with Dr. Sheldon's advice and received the chest x-ray, the abdominal aortic ultrasound, and the EKG, which were all negative. Dr. Furlong recommended a further test, an echocardiogram. This is an ultrasound study of the heart done through the chest, or transthoracically. Ms. Ross decided not to have an echocardiogram. Dr. Furlong recorded:

Ø echo done and she refuses same – doesn't want to know if she is going to die.

Notre Dame Bay Memorial Hospital chart, Patient Profile, printed November, 1994, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-C, p. 001

14. The purpose of doing an echocardiogram on Ms. Ross was to look for signs of the cardiac complications of Marfan's disease, such as bulging or dilatation of the aorta, or problems with the valves of the heart which occur if the root of the aorta begins to dilate.
15. In hindsight, these conditions were not present before August 30, 1996, and an echocardiogram would have been negative:

Q. And again, if the patient had received an echocardiogram prior to August 1996, what was the likelihood that it would have been diagnostic of dissection?

A. Probably very low.

Transcript, Dr. Melvin, p. 7, lines 29-32, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 15

16. To Ms. Ross' understanding, the presence of Marfan's represented a death sentence; she did not "want to know if she is going to die." Her understanding that Marfan's was a death sentence was not correct, because medical and surgical treatment options were available to prolong life to "the early seventies".

Transcript, Dr. Beanlands, p. 13, line 36, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 16; and see Dr. Melvin, para. 9 above

17. Before August 1996, when Ms. Ross suffered chest pain symptoms, an echocardiogram would not have diagnosed a cardiac problem (see Dr. Melvin para. 15 above), and the absence of an echocardiogram did not contribute to the outcome.
18. Ms. Ross did not seem to have the obvious physical or clinical features (phenotype) of Marfan's. Her family doctors did not believe she had Marfan's. The trial judge appeared to accept this. There was evidence, not discussed by the judge, that Ms. Ross accepted the

opinion of the doctors. Edgar Browne testified as to their conversation on the way to hospital on August 30:

She said the doctors said she didn't have no hint of Marfan's syndrome.

Transcript, Edgar Browne, p. 7, lines 22-23, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 14. See also p. 7, lines 1-8.

19. There was evidence that it was well known in general medical circles that pregnancy is a risk factor for aortic rupture, even without Marfan's syndrome: see Issue 3, under "Failure to Consider Pregnancy".
20. It was unknown to Ms. Ross, because she was not so informed by her doctors, that in Marfan's syndrome 50% of all dissections occur during pregnancy. The findings at paras. 47-50 of the Decision are contested. Their resolution requires consideration of the effect of the cross-examination of Dr. Furlong, commencing p. 18, Tab 22. For an executive sample, see p. 21, line 46 to p. 22, line 22, which could be entitled "Lethal Condition but No Notes".
21. At paras. 47 and 48, the trial judge made findings of fact that Ms. Ross knew she had a 50% risk of having Marfan's, that Dr. Furlong assured her that with medication and surgical intervention she could live a normal lifetime, and that Dr. Furlong offered her an echocardiogram and a cardiological consult. The Appellants say that these findings are not

available on consideration of the whole of the evidence, and on consideration of the cross-examination of Dr. Furlong: see Issue 1.

22. The Appellants accept the judge's statement of the facts at paras. 34 to 42, except the Appellants say that Ms. Ross' father died of aortic rupture, not heart attack (para. 36), and Ms. Rogers had more than one reason to encourage the attendance on Dr. Kravitz in St. John's. See Appendix 1 hereto, pp. 9-13 for testimony of Doris Rogers as to the reasons for the visit to Dr. Kravitz and what transpired there. The judge's description of the visit at paras. 43 and 44 of the Decision is, in the Appellants' respectful submission, clearly unreasonable, keeping in mind that Dr. Kravitz had no independent recollection. The interpretation and significance of the consult with Dr. Kravitz is treated under Issue 1 below.

Chest Pain and New Murmur

23. On August 30, 1996, while eight months pregnant with her third child, Ms. Ross developed retrosternal chest pain. Her fisherman husband Edgar Browne drove her to the medical clinic near their home in Summerford.
24. At the clinic, Dr. Furlong took the history and did a physical. He heard a new heart murmur. He arrived at a differential diagnosis, or list of potential diagnoses consistent with the presentation. He thought that gut grief was the likely diagnosis. He considered complications of Marfan's in his differential, but thought this highly unlikely:

- (1) Likely gut grief 2° chicken ...
- (4) Keep family history in mind but highly unlikely.

Clinic Note of Dr. Furlong dated August 30, 1996,
Appeal Book, Part II – Evidence, Volume 1 – Exhibits,
Tab 10-C, p. 10

25. When at para. 15 of the Decision the judge says “she was convinced the pain was caused by the chicken bone”, this was the working diagnosis of Dr. Furlong, who reassured Ms. Ross (despite a new heart murmur, elevated blood pressure, and the family history) that the pain was secondary to chicken.
26. On the possibility he might be wrong about the diagnosis of gut grief, Dr. Furlong advised the couple to go to Gander. With the understanding that the problem was a chicken bone, and although the pain had lessened, they drove to the James Paton Memorial Hospital in Gander, an hour or more drive, where more specialized care was available.
27. At para. 14 of his Decision, the trial judge states that Dr. Furlong contacted Dr. Cole, the family physician in Gander who was managing Ms. Ross’ obstetrics. The trial judge stated incorrectly that Dr. Cole “made arrangements for another doctor to see her [Ms. Ross] at the hospital because she was going to be ‘away’ that weekend.” Dr. Cole did not testify, and there is no evidence that she contacted anyone at the Gander hospital. The emergency physician Dr. St. Croix testified that she attempted to contact Dr. Cole, but was unable to do so.

Transcript, Dr. St. Croix, p. 9, line 3, Appeal Book, Part
II – Evidence, Volume 2 – Transcripts, Tab 17

28. The Decision at para. 16 records that Nurse Proudfoot “took her vital signs and obtained a history of her complaint which she noted to be ‘pregnancy with acute chest pain’.” Nurse Proudfoot also contemporaneously described the patient as “36 weeks gestation who developed ~~central~~ retrosternal chest pain while sitting and eating dinner at 1430 hours today.” The chart contains the above correction. The patient pointed to where the pain was. Retrosternal is a more precise description of the position of the pain than central. The rupture was just 2 centimetres or 1 inch above the heart, behind the sternum or breastbone, where the tearing of the aorta first began.

Appeal Book, Part II – Evidence, Volume 1 – Exhibits,
Tab 10-B, p. 53

29. During the drive the question of Marfan’s came up. Ms. Ross’ understanding of her family doctors’ advice is reflected in her statement to her spouse that “the doctors said she didn’t have no hint of Marfan’s syndrome.”

Transcript, Edgar Browne, p. 7, lines 22-23; p. 19, line
34, Appeal Book, Part II – Evidence, Volume 2 –
Transcripts, Tab 14

30. Ms. Ross arrived at the Emergency Room at 6:30 PM. It was Friday, August 30, the start of the Labour Day weekend.

31. In the hospital Emergency Room, Ms. Ross was “scared”, and she had good reason. The nurse had to ask some questions more than once. Doris Rogers responded to the trial judge that: “She must have had tremendous fear.”

Transcript, Nurse Slade, p. 9, lines 43-60, and
Transcript, Doris Rogers, p. 21, lines 40-41, Appeal
Book, Part II – Evidence, Volume 2 – Transcripts, Tabs
11, 13

32. When Ms. Ross' spouse Edgar Browne got out of the car at the Emergency entrance, he told the intake clerk that Ms. Ross had Marfan's. He then had to leave and park the car.

Transcript, Edgar Browne, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 14

33. The intake clerk was not the right person to take critical medical history, but other tragic failures occurred. Dr. Furlong had not given Ms. Ross a note of the reason for his referral.
34. Dr. St. Croix, the emergency physician at the Paton Hospital, was “perplexed” and concerned by the new, loud blowing murmur, and did not know Dr. Furlong's reason for referral. She tried to get him on the telephone. She was unable to reach him. She tried to get the doctor managing the pregnancy on the telephone. She was unable to reach her.

Charting Rushed and Substandard

35. That Friday evening, the emergency physician was “in a rush”, and attended the patient “piecemeal”. She did not record a family history of early cardiac death or of Marfan's. She did not record any family history, positive or negative. She was rushed.

Transcript, Dr. St. Croix, p. 18, lines 15-31, p. 22, lines 31-62, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 17

36. Counsel challenged the physician that her charting of the history was incomplete:

Crosbie, QC: Dr. Hutton told us earlier that the chart is an important instrument of communication between caregivers, do you agree with that?

Dr. St. Croix: Yes.

Crosbie, QC: And that that is a reason for complete charting?

Dr. St. Croix: Yes.

Crosbie, QC: Would you agree that your charting is not up to your usual standards?

Dr. St. Croix: I would.

[Emphasis added]

Transcript, Dr. St. Croix, p. 23, lines 45-62, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 17

37. No reference to family history appears anywhere in the contemporaneous chart of the August 30-September 1 admission. A reference to family history does appear in the Discharge Report signed by Dr. Yousif and dictated eleven days after the patient had died. All physicians who testified, whether for plaintiff or defence, stated that they note only positive family history, but Dr. Yousif’s record is a negative finding: “Family History: Nil.” The learned judge did not consider these facts.

Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab B, pp. 2-3

38. At para. 60 of the Decision, the trial judge found that Dr. Yousif asked the patient “anyone in her family had died at an early age”. If this is a true finding, then the patient should have been able to answer affirmatively. However the Appellants submit that the judge’s findings at para. 60 are palpably wrong, as addressed further under Issue 1 below.
39. The learned judge says at para. 17 that the patient “failed to tell [Dr. St. Croix] about the history of heart disease in her family.” This is true, but neither Marfan’s nor aortic disease are heart diseases. There was no family history of heart disease. The Decision speaks of a

family history of heart disease in numerous places, but this finding has no basis in the evidence:

Marfan's is not a cardiac condition, it's a vascular condition.

Transcript, Dr. Beanlands, p. 18, line 46, p. 25, line 75, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 16

Marfan's is not a heart problem.

Transcript, Dr. O'Reilly, p. 35, line 72, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 20

40. Ms. Ross knew the term Marfan's, but with respect to the deaths of her father and brother, never used the words dissection or rupture to her confidant and aunt, Doris Rogers, a nurse. "Lynia would refer to them as aneurysms to me".

Excerpts of Testimony of Doris Rogers, Appendix 1, p. 7

41. The medical records show that Ms. Ross never used the term heart disease or any similar term in stating her family history on occasions prior to her acute presentation on August 30.
42. If the average person were asked if they had a family history of heart disease, he or she would think in terms of heart attacks:

Mr. Crosbie, QC: Doesn't the average layperson tend to think of heart disease as meaning hardening of the arteries and heart attacks? A. Yes.

Transcript, Dr. O'Reilly, p. 35, lines 60-72, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 20

43. The Amended Statement of Claim para. 6(d) pleaded “the patient denied any relevant family history”, but did not allege deception. Neither did the medical experts:

The Court: She didn’t lie to you?

Dr. Furlong: No.

Transcript, Dr. Furlong, p. 24, lines 58-59, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 22

Mr. Crosbie, QC: But you have no grounds to opine that if asked questions about age of parents at death, and cause of death, that she would lie about that?

Dr. O’Reilly: I have no reason to believe that she would, no.

Transcript, Dr. O’Reilly, p. 26, lines 69-73, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 20

Dr. Beanlands: There is some suggestion ... that she lied, and I think that I don’t go along with that suggestion.

Transcript, Dr. Beanlands, p. 10, line 70, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 16

A. There’s no reason for her to lie if the specific questions had been asked.

Transcript, Dr. Beanlands, p. 29, line 89, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 16

44. Edgar Browne had the couple’s two-year-old, Candace, with him, and was obliged to return home with her to care for her and the older child, Shannon. Ms. Ross encouraged him to stay home, and he was not present for the consultation with the Defendant the following morning, a Saturday.

45. At paras. 51-53 of the Decision, the judge described the circumstances of the August 30 admission and made the finding that Mr. Browne, Ms. Ross' spouse, confused the first hospital admission with the second one. Except for a contradiction between Mr. Browne's recollection that Ms. Ross left emergency in a wheelchair and Nurse Slade's testimony that a wheelchair was not used, none of the judge's factual descriptions and findings in these paragraphs have any basis in the evidence.
46. Mr. Browne's evidence of the conversation with the nurse, at which Ms. Ross mentioned that her father and brother died young, was that it occurred at discharge, on September 1, two days after admission. The judge mistakenly thought the date was August 30, the date of admission. The Plaintiffs respectfully submit that the judge was plainly wrong in his findings in paras. 51-53.
47. Ms. Ross' chest pain was gone by late Saturday morning, when the Defendant attended her. He recorded no family history and no personal medical history, beyond the presenting symptoms. He recorded no history of gut grief secondary to chicken, which had been at the top of Dr. Furlong's differential when he referred the patient to Gander.
48. The Defendant diagnosed the patient with probable viral induced pericarditis.

Report of Dr. Hiscock dated August 31, 1996, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-B, pp. 11-12

49. Pericarditis is an inflammation of the sac around the heart. There was differing opinion as to whether Ms. Ross had pericarditis from a virus, or whether the inflammation was from aortic dissection below where the pericardial sac joined the aorta, but which had not yet

torn completely through the aortic wall. Dr. Hutton found no evidence of viral pericarditis at autopsy. However, the debate is largely academic, because as the trial judge found, if the family history had been obtained, Ms. Ross would have been sent to St. John's, diagnosed, and treated: see para. 4 above.

50. Edgar Browne spoke by telephone with Ms. Ross several times on Saturday, and returned to take her home on discharge Sunday morning. Dr. Hiscock reassured her she was fine and the discharge plan was that Dr. Hiscock would like to see her when she next visited the doctor in Gander who was managing the pregnancy (Dr. Cole).
51. Ms. Ross was discharged on Sunday, September 1. Ms. Ross' pain had resolved by then, and it was during the discharge procedure that Ms. Ross in chatting with the discharge nurse talked about her family history of early death. Dr. Hiscock was in the room. This is the visit by Dr. Hiscock described by the judge at para. 70 of the Decision, but which he misdated. The judge omitted to consider Edgar Browne's testimony at p. 8, lines 74-77, that:

Lyn mentioned to the nurse there that her father died when she was young and her brother died a few years ago, and after that she got discharged and we went on home.

Appeal Book, Part II – Evidence, Volume 2 –
Transcripts, Tab 13

52. At para. 71 of the Decision, the trial judge found that “although Ross returned to Gander on September 6, 1996 to see her obstetrician, she did not make an appointment to see Hiscock.” The judge failed to add that Ms. Ross tried to make the appointment.

53. Ms. Ross followed up as advised and did try to contact Dr. Hiscock at 12:24 the following Friday, September 6, but his clinic was closed. This is shown by telephone records.

Transcript, Edgar Browne, p. 14, line 15, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 14;

Consent #3

54. That Saturday, September 7, Mr. Browne was repairing a bed for Candace. Ms. Ross got bad chest pain and they decided to go back to the Gander hospital immediately.

55. This time, new doctors got the family history and the new consultant scrawled across the emergency record:

Acute aortic dissection
- Urgent transfer to
St. John's by air ambulance
STAT.

Emergency Department Record, 07/09/96, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-B, p. 55

56. The new consultant spoke with cardiac surgeon Dr. Melvin at the Health Sciences Centre, and the surgical team was waiting in St. John's. The surgery was successful, but the window of opportunity to save lives had closed. Ms. Ross could not be brought off cardiopulmonary bypass. She died on September 8, 1996. Her daughter Autumn died in her father's arms five days later.

The Expert Witnesses

57. Dr. Charles Hutton is an experienced forensic pathologist who performed the autopsy. The case came to his office because it was a pregnant death.
58. In addition to Dr. Hutton, the expert medical witnesses were qualified by the trial judge as follows:
- (a) Dr. Kevin Melvin (called by Plaintiffs) – “an expert in the field of cardiovascular and thoracic surgery”: p. 1, line 62, Tab 15;
 - (b) Dr. Donald Beanlands (called by Plaintiffs) – “an expert and may testify with respect to internal medicine and also cardiology”: p. 5, line 9, Tab 16;
 - (c) Dr. Michael O’Reilly (called by Defendant) – “an expert in internal medicine as well as the sub-speciality of cardiology”: p. 2, line 100, Tab 20; and,
 - (d) Dr. George Christakis (called by Defendant) – “an expert in cardiovascular surgery and clinical epidemiology”: p. 10, lines 52-57, Tab 21.
59. Dr. Hutton presented several anatomical exhibits which he had prepared for trial. Dr. Hutton’s location of aortic rupture at 2 centimetres above the aortic valve (C.H. #3 and #3a), was vigorously challenged in cross-examination, but was approved both by Dr. Melvin and by Dr. Beanlands (eg. p. 6, line 76 of the Beanlands transcript). Dr. Hutton also approved a medical glossary attached at Appendix 2 hereto.

60. At para. 26, the judge stated that Marfan's "caused a degeneration of the aortic wall of her heart." This statement has no basis in the anatomical and medical evidence. The heart does not have an aortic wall.

61. The trial judge expressly requested comprehensive written briefs for summation, and each party obliged his request with lengthy and detailed written submissions, citing transcripts, exhibits and caselaw.

PART II – LIST OF ISSUES

62. The Appellants will present the argument around the issues as stated in the Notice of Appeal, namely that the learned judge:

Issue 1 - made wholly unreasonable findings of fact that the deceased Plaintiff lied to her physicians about her family history and had a long history of lying about her family history, which findings are not only unsupported by the evidence but in contraction to the evidence as contained in the medical charts;

Issue 2 - misapprehended the expert medical evidence, such that he discharged his fact finding duties in a manner not supported by evidence;

Issue 3 - misstated the issue in the case to be whether there was an error in treatment, when the issue was whether there was an error in diagnosis;

Issue 4 - incorrectly admitted expert testimony despite objections that same exceeded the scope of the expert report and the expert was testifying beyond his area of expertise, on which testimony he relied in his Decision;

Issue 5 - failed to weigh the credibility and plausibility of the expert evidence as to standard of care in accordance with criteria from established caselaw which he himself accepted;

Issue 6 - failed to resolve the opposing evidence as to standard of care in accordance with legal principle, specifically, that conduct is negligent if it creates an objectively unreasonable risk of harm.

PART III – ARGUMENT

Summary of the Appeal

63. This case resulted in a miscarriage of justice, and raises an important issue of policy as to acceptable method of forensic fact identification. The reasoning behind the trial judge’s decision to dismiss this cause may be summarized as follows: “I believe the testimony of the treating doctors.” The doctors were Hiscock, Furlong, St. Croix and Yousif, and they testified that the patient was to blame for her own demise. The judge accepted their testimony, even though it was self-serving, given ten years after the event, and contradicted by the contemporaneous record. The judge’s failure to grant the deceased plaintiff the basic courtesy of allowing her to testify in the only way she could – through the contemporaneous record – led directly to dismissal of the case.
64. This factum has developed the argument around the six issues set out in the Notice of Appeal. For further concision, the issues could be condensed to these three:
- (a) the trial judge disregarded the contemporaneous record in the process of fact finding;
 - (b) he failed to grant the Plaintiffs a full and fair trial; and,
 - (c) he misapprehended the very disease in issue as heart disease, and made findings as to correct method for family history taking, and differential diagnosis, which are objectively unreasonable.

Standard of Review

65. The standard to be met for appellate review of findings of fact has been the subject of divergent opinion in the Supreme Court. The standard has been stated in *H.L. v. Canada (Attorney General)*, 2005 SCC 25, para. 4, where with respect to the powers of the Saskatchewan Court of Appeal, the majority stated that:

Like other appellate courts across the country, it may substitute its own view of the evidence and draw its own inferences of fact where the trial judge is shown to have committed a palpable and overriding error or made findings of fact that are clearly wrong, unreasonable or unsupported by the evidence. [Emphasis in original.]

Appendix A, Tab 1

66. At para. 56 of *H.L.*, the Court stated pragmatically:

I need hardly repeat, however, that appellate intervention will only be warranted where the court can explain why or in what respect the impugned finding is unreasonable or unsupported by the evidence. And the reviewing court must of course be persuaded that the impugned factual finding is likely to have affected the result. [Emphasis in original.]

67. In *H.L.*, the Supreme Court was concerned only with the issue of the proper standard of review for inferences drawn from findings of fact. The majority concluded that the standard for review of findings of fact and for review of inferences of fact was the same – palpable and overriding error. The question in *H.L.* was whether or not to infer tortious causation of certain losses. In the earlier case of *Housen v. Nikolaisen*, 2002 SCC 33, a divided Supreme Court was concerned both with the proper standard of review for inferences drawn from findings of primary fact (causation), and with the proper standard of review for questions of mixed law and fact (negligence).

68. A trial judge's determination of negligence requires the application of a legal test to a set of facts, and is therefore characterized as a matter of mixed fact and law. The majority in *Housen* emphasized the following as to the question of negligence:

33 Generally, such a question, once the facts have been established without overriding and palpable error, is to be reviewed on a standard of correctness since the standard of care is normative and is a question of law within the normal purview of both the trial and appellate courts. [Emphasis in original.]

Appendix A, Tab 2

69. Of course, a judge's finding of the facts to which the correct legal test is to be applied in order to determine negligence, is entitled to a high standard of deference, and even higher deference when based in assessment of credibility:

[A]lthough the same high standard of deference applies to the entire range of factual determinations made by the trial judge, where a factual finding is grounded in an assessment of credibility of a witness, the overwhelming advantage of the trial judge in this area must be acknowledged.

Housen, supra, p. 24, Appendix A, Tab 2

70. *R. v. Gagnon*, 2006 SCC 17, concerned the issue of what constitutes sufficient reasons from a trial judge. Many of the comments as to what is expected of the trial judge also apply to civil cases. The Supreme Court reiterated the following:

19 This court has consistently admonished trial judges to explain their reasons on credibility and reasonable doubt in a way that permits adequate review by an appellate court.

Appendix A, Tab 3

71. The Supreme Court added that although there is a requirement, most recently confirmed in *H.L.*, that the trial judge's findings and inferences of fact should be respected absent palpable

and overriding error, a court of appeal should ascertain whether these findings are reasonably available:

21 This does not mean that a court of appeal can abdicate its responsibility for reviewing the record to see whether the findings of fact are reasonably available.

Appendix A, Tab 1

72. Here the trial judge omitted to engage in a comparative weighing of the credibility of the experts, and certainly gave no indication he considered the credibility of the Plaintiffs' experts to be in issue. The findings below do not enjoy the "overwhelming advantage" (*Housen*) which comes with reasoned assessment of credibility.

73. Moreover, the standard of review, where inferences and findings of fact based on conflicting expert evidence are considered, and credibility is not in issue, may be more relaxed, as stated in *Toneguzzo-Norvell (Guardian ad litem of) v. Burnaby Hospital*, [1994] 1 S.C.R. 114, at 122:

I agree that the principle of non-intervention of a Court of Appeal in a trial judge's findings of fact does not apply with the same force to inferences drawn from conflicting testimony of expert witnesses where the credibility of these witnesses is not in issue.

Appendix A, Tab 4

Issue 1 – Deceased Plaintiff Lied To Her Physicians

74. At several points in the Decision, the court below stated findings as to the deceased plaintiff's willingness to tell her family history to physicians.

Decision, paras. 43, 56, 63, 97, 111, 117

75. The findings include that the plaintiff “deliberately hid from Hiscock her family medical history of Marfan’s and that her father and brother died prematurely of heart disease” (63); “was determined to hide from Hiscock the fact that her father and brother had died prematurely of heart disease” (97); “had a long history of hiding the fact that there was Marfan’s in her family” (97); “chose to hide her family’s history of Marfan’s from Hiscock” (113); and “she refused to tell the hospital staff and doctors (including Hiscock) that there was a history of Marfan’s in her family” (117).
76. The Canadian Oxford Dictionary defines “lie” as an intentionally false statement. The judge’s findings are tantamount to a determination that the patient systematically lied to her physicians. There is no evidence that Ms. Ross had ever been deceitful or had lied to anyone involved in her care. Indeed, deceit was never raised as an issue.
77. In reaching this conclusion, the trial judge made no reference to the deceased’s documented history of giving an accurate family medical history, as disclosed by what had been charted prior to her contact with the Defendant. This documented history is unimpeachable and contradicts the judge’s finding of deceit. A deceased plaintiff should be accorded the basic

respect of having her credibility assessed on the basis of a careful consideration of the written record.

78. Lynia Ross' father and brother both died young, of aortic complications of Marfan's disease. Her father died age 34, her brother died age 29. Ms. Ross was able and willing to give this family history to her care providers, and did so on at least six occasions. She gave the following history to Dr. Chalker, who managed the first pregnancy:

Father and brother dead of aneurysm.

Dr. Chalker's Pre-Natal Record, mid 1993, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-A, p. 46

79. She also provided the family connection to Marfan's syndrome to Dr. Cole, the family physician in Gander who managed her third and fatal pregnancy:

Father and brother dead Marfan's syndrome.

Dr. Cole's Pre-Natal Record, early 1996, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-1, p. 41

80. It was on her family doctor's chart:

Brother died 1/12 ago with Marfan's syndrome after brief admission. Father died of aneurysm.

Clinic Chart, Dr. Sheldon, February 12, 1993, Consent Book, Vol. 1, Tab 6, p. 002

Father died at 35, brother died at 29 * Marfan's *.

Clinic Chart, Dr. Furlong's Patient Profile, printed November 1994, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-C, p. 001

81. The family history was also set out in a requisition for testing which the patient followed up and had done by the Paton Hospital in Gander:

Brother recently died with ruptured aneurysm –
as did father at 35.
Marfan’s syndrome.
No clinical evidence of being affected.
? any evidence of vascular abnormality.

Request for Consultation dated Feb. 17, 1993, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-A, p. 35

82. Ms. Ross did not hide her family history during the August 30-September 1 admission. During conversation with the discharge nurse on September 1, Ms. Ross told the nurse that “her father died in his early thirties and her brother died in his late twenties.”

Transcript, Edgar Browne, p. 8, lines 81-82, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 14

83. And on Ms. Ross’ fatal return to Emergency six days later, the emergency physician obtained:

There is a strong family history of premature death; brother and father both had Marfan’s syndrome and are dead at age 34 years and are dead at age 29 years.

James Paton Memorial Hospital Records, Dr. Keong, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-B, p. 61

84. Counsel for the Plaintiffs confronted the Defendant with the medical record of the patient’s statements of family history:

Q. ... I’m simply asking you, I’m putting it to you that there are a number of instances, and I can count five or six where ... we haven’t looked at all of them right, but we could if you wanted to, where she appears to have divulged or provided to the care provider a family history of early death, aneurysm,

aortic aneurysm and/or Marfan's Syndrome. A. Your Honour, I agree, it appears that she did, yes.

Transcript, Dr. Hiscock, p. 21, lines 5-12, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 19

85. No expert witness supported the premise that the patient lied, and the chief means the deceased patient had to testify was through the medical record, to which the trial judge did not refer.
86. On only one of the seven occasions on which the sinister history was obtained is there evidence to support a finding that the information as to family history may have come from a source other than the patient. That occasion is the visit to Dr. Kravitz in St. John's, which features in the trial judge's Decision at paras. 43-45. This requires closer scrutiny.
87. It is worth noting that the Pre-Natal Record is a prescribed form which has a specific box for family history. The physician is prompted or required by the form to ask about family history. On the occasion of the visit to Dr. Kravitz, the following was written in the box:

Brother 29 and Father 34 died aortic aneurysm.

Dr. Kravitz' Pre-Natal Record, December 2, 1993, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-E, p. 004

88. The learned trial judge quotes at para. 44 from Dr. Kravitz' consultation letter back to Dr. Chalker, to support his finding that Ms. Ross lied to Dr. Kravitz about her family history. Dr. Kravitz had no independent recollection. However, he left out a significant passage in the consultation report, which we quote below:

The family history revealed her father and her brother died at young ages, i.e., 29 and 34 respectively from an aortic

aneurysm and there's been some question by family members whether or not they may have had Marfan's syndrome.
[Emphasis added]

Dr. Kravitz' consultation letter, December 2, 1993,
Appeal Book, Part II – Evidence, Volume 1 – Exhibits,
Tab 10-D , p. 003

89. The Appellants say this wording is consistent with the evidence of Ms. Ross' aunt, Doris Rogers, and the following scenario: when Dr. Kravitz came back from the examining room into the office, and Ms. Ross was dressing, Doris Rogers quickly raised her concern about the family history. Ms. Rogers cannot remember if she told the obstetrician of the presumption of Marfan's in the family. The term Marfan's is not mentioned on the Pre-Natal Form of either Dr. Chalker or Dr. Kravitz. But the term Marfan's appears in Dr. Kravitz' consult letter, as a "question" of "family members". The family member was Doris Rogers.
90. Dr. Kravitz recognized that the "question" of Marfan's raised an issue. She offered a consult to cardiology. But according to Ms. Rogers, there was no "long discussion". Excerpts of Ms. Rogers' testimony are attached at Appendix 1 hereto, pp. 9-13.
91. This was a patient who had been reassured by family doctors that she did not have Marfan's. In order to make an informed decision as to the merits of coming back to St. John's to see a cardiologist, Ms. Ross needed counselling as to the risk (to her and to her baby) that she had Marfan's, and as to the benefits of the consult.
92. Dr. Chalker rated the pregnancy an "A", or low risk. This was obviously wrong. One need look no further than the provincial standard form "A Guide to Pregnancy Risk Rating",

contained in the Paton hospital chart: Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-A, pp. 5-6. The patient was certainly at least “GRADE B – Pregnancy at risk”, or more correctly a “GRADE C – Pregnancy at high risk”, in which the pregnancy is “so complicated that the fetus and/or mother are obviously in danger.” This was addressed by Dr. Beanlands, himself a cardiologist consultant, when asked how he would regard the risk in a patient with the family history obtained by Dr. Kravitz:

I think it’s high risk since we, since we know that 50 percent of patients with Marfan’s have their aorta ruptured, or dissection during their pregnancy, so that makes them very high risk, and as a cardiologist, my advice would have been to Dr. Kravitz to consider this patient a case of Marfan’s until proven otherwise. [Emphasis added]

Transcript, Dr. Beanlands, pp. 14-15, lines 92-5,
Appeal Book, Part II – Evidence, Volume 2 –
Transcripts, Tab 16

93. Defence expert Dr. O’Reilly confirmed what the attitude should be toward a patient with a 50% risk of carrying the defect:

Q. You, as a caring physician, you’re not going to take chances with that patient, are you? A. No.

Q. You’re going to treat her as presumptively Marfanoid until proven otherwise. A. Yes. [Emphasis added]

Transcript, Dr. O’Reilly, p. 30, lines 56-59, Appeal Book,
Part II – Evidence, Volume 2 – Transcripts, Tab 20

94. Dr. Furlong testified that he understood the risks to the patient. How Dr. Furlong could then write in his differential diagnosis on the acute presentation on August 30, 1996 that Marfan’s was “highly unlikely”, remains unexplained.

95. Dr. Kravitz did not risk-grade her Pre-Natal Form, and said nothing in her consult letter back to Dr. Chalker in Twillingate, as to the high risk the patient posed or the need to deliver in another hospital with greater capabilities – which would be the Health Sciences in St. John’s. This is consistent with what Ms. Rogers described – a very brief interaction which did not communicate to the patient the information necessary to make an informed decision.
96. Dr. Beanlands described the type of interaction which ought to have occurred between Dr. Kravitz and the patient:

Yes, I think the patient’s cooperation depends upon their understanding of the risks and the benefits of the tests, and where there’s significant improvements in their overall outcome over the years, so it’s very important to sit down and spend time with the patient describing what the chances are that she has the disease, and that, what the chances are of her surviving a long time with this disease if the appropriate follow-up and treatment is taken.

Transcript, Dr. Beanlands, p. 18, lines 55-64, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 16

97. The trial judge quoted extensively from Dr. Furlong’s testimony, at paras. 49 and 50 of the Decision, but made no attempt to reconcile the notation that the family history was a “highly unlikely” explanation for the acute presentation, with the fact that Dr. Furlong was faced with a patient who was pregnant, had high blood pressure, and a 50% chance of having Marfan’s. The Appellants say that contrary to his testimony, Dr. Furlong did not understand the gravity of the risk faced by the patient, did not communicate that risk to her, and did not communicate to her that with appropriate management, she did not have to die. Dr. Furlong not only had no chart note to corroborate his testimony, but by his diagnostic note “highly unlikely”, directly contradicts himself by his own record.

98. Ms. Ross did not receive this counselling as to risks and benefits from any of her doctors, including family physicians Dr. Sheldon and Dr. Furlong. At 50% risk, the patient was playing Russian Roulette with three bullets loaded in a six bullet revolver cylinder. The failure of Drs. Sheldon, Furlong, and Kravitz to document appropriate advice and warning to the patient as to the gravity of her risk and its amenability to medical management, was not considered by the learned trial judge in the process of determining the facts. Nor was Dr. Furlong's note after the acute presentation that Marfan's was "highly unlikely". It brings into play the maxim relied on in *Georghiades v. MacLeod*, 2005 CarswellOnt 1680, para. 107 and derived from an earlier case:

In Kolesar's case, the absence of entries permits the inference that nothing was charted because nothing was done.

Appendix A, Tab 5

99. The physicians' failure to communicate appropriately with the patient is corroborated by the patient's belief that "she didn't have no hint of Marfan's syndrome".

Transcript, Edgar Browne, p. 7, lines 22-23, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 14

100. The trial judge found in essence, that he believed Dr. Yousif, Dr. St. Croix, and Dr. Hiscock when they testified that they asked all the appropriate questions. The Appellants say that they will demonstrate in oral argument that these findings are based on self-serving testimony ten years after the event, ungrounded in contemporaneous records, and even contradicted by them.

Issue 2 – Discharged Fact Finding Duties in a Manner Not Supported by Expert Medical Evidence

Admissibility of Evidence of Non Peer

101. Appellate courts have observed that trial courts in civil non-jury trials too often take a relaxed approach to their gatekeeper responsibilities: “The melding of admissibility and weight is too easily undertaken”: *Hoskin v. Han*, 2003 CarswellBC 857 (C.A.), para. 69, Appendix A, Tab 6. This can lead to manifest error in fact finding, as occurred in the present case.
102. An expert practicing in the same area of medicine as the defendant physician will be the most qualified to give evidence of the standard of care that should have been exercised. Where the parties call experts who are practicing in different areas than the defendant, evidentiary issues of admissibility and weight arise. A summary of relevant cases is found in *Keller v. Penkoske et al.* (1999), 256 A.R. 1 (Q.B.) paras. 51-57.

Appendix A, Tab 7

103. In *Connell v. Tanner*, 2002 CarswellOnt 1328 (C.A.), a defendant family physician alleged that the trial judge erred by choosing between two competing medical practices. The Ontario Court of Appeal ruled that the court did not chose between two competing medical practices, because a family physician peer had testified on behalf of the plaintiff as to standard of care, whereas a urologist had testified on behalf of the defendant family physician: paras. 13 foot and 14.

Appendix A, Tab 8

104. The cases show that it will often be appropriate to admit evidence from a specialist as to the standard of a generalist, as in *Briffett v. Gander & District Hospital Board*, 1996 CarswellNfld 76 (C.A.), para. 122, where cardiology opinion was relied on in establishing the diagnostic negligence of generalists working in an emergency room setting. But few courts have received evidence from a specialist impugning the standard of a specialist in a different field.

Appendix A, Tab 9

105. *Dobie v. Dlin*, 2001 CarswellBC 2412, paras. 4-8, is close on point to the present appeal. The defendant cardiologist objected to the testimony of a cardiac surgeon where the standard of care issues involved medical management, not surgical management, of post-operative arrhythmia. While the doctors were both specialists, they did not share the same qualifications. Therefore, the cardiac surgeon was not qualified to give evidence on the medical management undertaken by the cardiologist.

Appendix A, Tab 10

106. “The melding of admissibility and weight is too easily undertaken”: *Hoskin, supra*. In *Hoskin*, the Court of Appeal discussed and applied at paras. 69-72 and 79, statements of the Supreme Court that (a) evidence which goes beyond the qualifications of a medical witness should not be admitted, (b) the trial court should take its gatekeeper role seriously, and (c) the expert should be qualified in all areas in which he or she is to give opinion, and ruled that the trial had been tainted.

Appendix A, Tab 6

107. In the case below, the trial judge admitted evidence of Defence surgeon Dr. Christakis and in so doing violated three of the four *Mohan* criteria described in *Hoskin, supra*. His evidence on diagnostic method for a medical (not surgical) specialist, and on method of family history taking for a medical specialist, may have been relevant, but it was neither properly qualified nor necessary to assist the trier of fact.
108. It also offended exclusionary rules based in exceeding the ambit of the report, and failure to provide complete discovery after formal notice (discussed under Issue 4).
109. The learned judge's legal error in admitting testimony from the surgeon on matters beyond the area of the surgeon's expertise, and the judge's subsequent heavy reliance on the surgeon's opinion in these unqualified areas, resulted in palpably wrong errors in the finding of the facts to which the legal test for negligence must be applied. This is treated further under Issue 6.

Issue 3 – Misstated the Issue in the Case

Lack of Analytical Coherence

110. The learned judge stated:

The issue in this case is whether Hiscock breached his duty of care in the treatment of Ross in either tort or contract.

Decision, para. 11

111. The issue clearly was not treatment, but diagnosis. With diagnosis, a cure was accepted as likely even by Dr. Hiscock. The judge started his reasons with a fundamental misstatement of the issue, which he compounded by repeated references to “heart disease”, which was not in issue.
112. The above formulation of “the issue in this case” also indicates that the learned judge conflated the concepts of duty of care and standard of care. This conflation occurred again at paras. 72 and 73 of the Decision, and is evident in the section heading “Duty (standard) of care”, and again at paras. 98, 103, and 112.
113. Ironically, the need to keep these legal concepts distinct was emphasized in *Ryan v. Victoria (City)*, [1999] 1 S.C.R. 201, paras. 25-27, the very case on which the judge relied at para. 73 of his Decision for its definition of negligence. The duty versus standard distinction is obvious, and is an important matter of analytical coherence:

As discussed below, when the language of "duty" is framed in terms of its degree or content, what is really at issue is not the duty but the applicable standard of care. While the

distinction is obvious, courts from time to time seem to lose sight of that principle.

Ryan, supra, para. 25, Appendix A, Tab 11

As a matter of analytical coherence ... the distinction is important.

Ryan, supra, para. 27, Appendix A, Tab 11

114. Analytical coherence is important because it provides a trier of fact with a framework for proper consideration of the issues. It permits the application of correct legal principles to the facts of a case.
115. The issue could “coherently” have been stated as “whether the Defendant breached his standard of care in the diagnosis of the deceased.”
116. With the issue coherently stated as a question of diagnosis, it is clear that the judge ruled upon the evidence proffered as to the first ground of negligence, namely breach of standard in conducting the family history taking. But he omitted to consider the evidence proffered as to the second ground of negligence, namely breach of standard in failing to consider pregnancy as an independent risk factor for dissection.
117. In rejecting one ground of negligence, but failing to deal with the alternative ground of negligence, the court below deprived the Plaintiffs of a full trial. In *Amador v. Mo*, 2005 BCCA 514 (CanLII), the court ruled:

[17] Both allegations were pleaded and both theories were in issue at trial. There was evidence before the court which could have supported either conclusion. There cannot, in my respectful view, be said to have been a full trial of all the issues raised, where the court rejected one allegation, but

failed to deal with the alternate theory, and the evidence that supported it.

Appendix A, Tab 12

Negligent Failure to Consider Pregnancy

118. Dr. Beanlands' report was clear in its conclusion that there were two breaches of standard:

The possibility of dissection causing the pericarditis should have been suspected because of 1) the family history of Marfan's syndrome, and 2) the fact that aortic dissections are more common during pregnancy.

Report of Dr. Beanlands dated February 2, 1999, p. 3, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-G.

119. Dr. Beanlands testified to the diagnostic significance of pregnancy at p. 5, lines 85-91 of his direct examination:

... it would be reasonable practice of medicine to consider Marfan's Syndrome in this pregnant lady because it's well known in general medical circles that pregnancy is a risk factor for aortic rupture, even without Marfan's Syndrome, and in Marfan's Syndrome, 50 percent of all the dissections occur during pregnancy.

Appeal Book, Part II – Evidence, Volume 2 – Trial Transcripts, Tab 16

120. During cross-examination, Dr. Beanlands confirmed his earlier evidence:

Q. In any event, Doctor, let's move on here. Is aortic dissection rarer than pericarditis in pregnancy? A. I can't answer that question with a certainty. All I can say is that dissection is, is not uncommon in pregnancy, especially in patients with Marfan's. I've already testified that 50 percent of all the dissections in females with Marfan's occurs during pregnancy.

Appeal Book, Part II – Evidence, Volume 2 – Trial Transcripts, p. 27, lines 52-58, Tab 16

121. Dr. Melvin gave corroborating evidence that pregnancy increases risk:

...and of course, she was pregnant, which again increases the risk of aortic dissection, particularly in Marfan's patients.

Transcript, Dr. Melvin, p. 7, lines 50-52, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 15

122. Despite clear notice of the case in negligence, the Defence expert reports did not address the issue of pregnancy as a risk factor for dissection. The trial judge allowed testimony on this issue anyway.

123. Dr. O'Reilly hedged his testimony but agreed that "pregnancy increases the risk". He concluded that if a general intern:

...were seeing a patient with chest pain, that, you know, pregnancy somehow made you elevate aortic dissection higher up in your differential diagnostic work list, no, I wouldn't expect that from a general intern.

Transcript, Dr. O'Reilly, p. 12, line 68, p. 28, lines 8-25, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 20. See also p. 28, line 11, and p. 32, line 22

124. The trial judge fell into error in failing to address the second ground of negligence – that dissection should have been suspected on the basis of pregnancy alone. Dr. O'Reilly testified equivocally, but concluded that he would not expect a general internist to move aortic dissection higher up his differential, in the pregnant non-Marfan's chest pain patient. Dr. O'Reilly avoided the issue in his report, and his testimony may have lacked forthrightness, but is there a decisive ground available to an appeal court on which to resolve the conflict in evidence as to what the Defendant ought to have known?

125. The testimony of Dr. St. Croix, a generalist physician with no speciality qualification, strongly corroborated Dr. Beanlands' opinion that it was "well known in general medical circles that pregnancy is a risk factor for aortic rupture." Dr. St. Croix was called as a defence witness. Under cross-examination, Dr. St. Croix gave evidence that she herself was "aware" that women in the third trimester with elevated blood pressure are more susceptible to aortic dissection, and that pregnancy was a risk factor for dissection: "Yes, I was aware that this could happen." The Plaintiffs submit that if a generalist physician was aware of this risk, then a chest pain specialist such as the Defendant should surely have been aware of this too.

Transcript, Dr. St. Croix, p. 17, lines 8-22, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 17

126. Indeed, Dr. Hiscock admitted that in 1996 he did not know that pregnancy is an independent risk factor for dissection, that he knows this now, and that he had never before had a pregnant patient with pericarditis (which was his working diagnosis).

Q. ... Do you agree that pregnancy is an independent risk factor for dissection? A. Your honour, I do now.

Q. You were not aware of this in 1996? A. I was not aware of that in 1996.

Q. And you've told us earlier today that prior to 1996 you had never before had a pregnant lady with pericarditis? A. That is correct, sir. [Emphasis added]

Transcript, Dr. Hiscock, p. 23, lines 74-81, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 19

127. The Court below made no adverse credibility findings against Dr. Beanlands or Dr. St. Croix. This Court is therefore in a position to consider the alternative ground of negligence which the trial judge failed to address, and to make the finding which the trial judge ought to have made.

The Defendant was negligent in not considering pregnancy as a risk for dissection. This failure of the Defendant is negligent, independently of the issue of negligence in failing to obtain the family history.

Issue 4 – Overruled Objections to Expert Testimony

128. Dr. O'Reilly was the Defence expert in cardiology and internal medicine. His report did not address the central issue in the case, namely standard of care in taking a family history:

Q. You don't spell out, sir, whether your view of what Dr. Beanlands, I believe, has called the critical issue in the case, as to which you have told us you are aware, which is the inadequacy or substandard nature of the questions employed on family history taking. You do not expressly address that, do you? A. I don't explicitly address it, no. [Emphasis added]

Transcript, Dr. O'Reilly, p. 5, lines 70-75 Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 20

Report of Dr. O'Reilly Appeal Book, Part II – Evidence, Volume 1 – Evidence, Tab 10-I

129. Plaintiffs' counsel made objection at the qualification phase. Counsel's objection to scope of testimony was overruled, at p. 6, line 23.

130. Plaintiffs' counsel cross-examined Defence expert Dr. Christakis as to the scope of his report. Dr. Christakis was a cardiovascular surgeon. The same admission as to scope of report was obtained:

Q. And you did not set out the standard of care for taking a family history for an internist. A. No, I was not asked to do that. [Emphasis added]

Transcript, Dr. Christakis, p. 9, lines 78-80, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 21

Report of Dr. Christakis, Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-J

131. The trial judge overruled the objection as to scope of report, even before hearing the full objection. The full objection included a reservation of right to object for failure to address the central issue, which was placed on the record of the deposition:

The Court: It's the same ruling as yesterday, Mr. Crosbie.

Mr. Crosbie, QC: Well, there is one added feature here, when I conducted the deposition under oath on July 6th, 2005, I stated that I reserved my client's right to object to the entry of the report, and the other reports on the basis they've failed to address the central issue, and that's in the transcript, page 7, line 59, and there's been no further reports since that deposition, correct?

Dr. Christakis: That is correct.

Mr. Crosbie, QC: So Justice, I think that's worth noting for the record.

The Court: Okay.

Transcript, Dr. Christakis, p. 10, lines 16-28, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 21

132. Rule 46.07 states that the evidence of an expert witness shall not be admissible unless a report has been given. The rule does not go into detail on the requirements as to scope of report, but the Appellants submit that an expert report should minimally give notice of the substance of the expert's opinion on the critical issues on which the expert is to testify.

The text of the rule is as follows:

Unless an opposite party has, at least ten days before the commencement of a trial, been given a report of an expert witness who is expected to give evidence on a trial, the evidence shall not be admissible without the approval of the court, which may be granted on such terms as are just.

133. At closing argument, the Plaintiffs submitted that the failure of the expert report to address a central issue, once objected to on the record at deposition, was contrary to Rule 30.08A(1), which requires a party to provide complete information in writing:

Where a party has been examined for discovery or a person has been examined for discovery on behalf or in place of, or in addition to the party, and the party subsequently discovers that the answer to a question on the examination

- (a) was incorrect or incomplete when made, or
- (b) is no longer correct and complete,

the party shall immediately provide the information in writing to every other party. [Emphasis added]

134. The Rule required the Defendant to provide complete information in writing to the other parties, in the form of supplementary expert reports. The Appellants submit that it is contrary to the Rules and to fundamental fairness to allow the experts to testify on the “central issue” of the trial, which the experts chose not to address in their reports. The Defendant could have delivered supplementary and complete reports after objection on the deposition record, but chose not to. The court below not only allowed testimony which exceeded the scope of the reports and as to which objection had been made on the record of the deposition, without a fair hearing of the objection at trial, but dismissed the case on the basis of an adverse finding on the very same issue.
135. On one level, the conduct of the experts in failing to address in their reports the central issue of standard of care in taking a family history – indeed, their evasion of this issue – is a reason to doubt their credibility on this issue.

136. But more importantly, the learned judge countenanced fundamental unfairness and an obvious breach of Rule 38.08A(1), and in the instance of Dr. Christakis, made his ruling even before he heard the Plaintiffs' objection.

137. In the Plaintiffs' respectful submission, the learned judge overrode the intent of the Rules to ensure correct and complete disclosure, and thereby prejudiced the Plaintiffs' right to a fair trial. This prejudice matured into dismissal of the case.

Issue 5 – Failed to Weigh Credibility of Expert Evidence

138. In *Cooper v. Cooper*, 2001 CarswellNfld 17, Green JJ.A. discussed the concept of credibility at para. 11:

Credibility means simply worthiness of belief. If evidence is credible, it is of such a character that it is capable of being relied on by the trier of fact. When a court purports to rely on any piece of evidence, it in essence is making an assessment that that evidence is worthy of belief. In making that determination the court will rely, depending on the circumstances of each case, on a host of factors including the consistency with other known facts, its rational strength when viewed against common experience, the reputation and means of knowledge of the witness presenting the evidence and the language employed in its presentation, in addition to the performance of the witness in the courtroom.

Appendix A, Tab 13

139. In *R. v. Gagnon*, *supra*, the Supreme Court explained:

20 Assessing credibility is not a science. It is very difficult for a trial judge to articulate with precision the complex intermingling of impressions that emerge after watching and listening to witnesses and attempting to reconcile the various versions of events. That is why this court decided, most recently in *H.L.*, that in the absence of a palpable and overriding error by the trial judge, his or her perceptions should be respected.

Appendix A, Tab 3

140. Less deference is required where the trial judge has drawn inferences “from conflicting testimony of expert witnesses where the credibility of these witnesses is not in issue”:
Toneguzzo-Norvell, *supra*.

141. The learned judge adopted the criteria from *Malette v. Shulman* (1987), 63 O.R. (2d) 243 for evaluating the reliability or credibility of medical expert assistance provided to the court:

[68] To determine the standard of practice to be reasonably expected of the defendant doctor, the evidence of independent expert medical witnesses must be considered in light of:

- (1) The relevance of their training, experience and speciality to the medical issues before the Court;
- (2) Any reason for the witness to be less than impartial;
- (3) Whether the standard of care propounded reflects the standard of the great majority of medical practitioners in the field in question;
- (4) Whether that testimony appears credible and persuasive compared and contrasted with the other expert testimony at the trial.

Decision, para. 78

142. The Plaintiffs in closing submissions suggested two further criteria:

- (5) Whether the testimony appears credible compared to testimony adopted in caselaw;
- (6) Whether the testimony is reasonably grounded in medical literature.

143. Other caselaw before the judge below supplemented the *Malette* criteria. *Georghiades, supra*, proffered the following additional criteria, at paras. 74 and 78, to quote:

- (7) Expert witnesses must be neutral, objective, independent, and may not advocate a position for one of the parties;

(8) The most credible expert is one who is available and consulted by plaintiffs and defendants, in different cases.

Appendix A, Tab 5

144. *Georghiades* added that the factors for evaluating the assistance of expert testimony “are important when, as here, one counsel is critical of certain expert witnesses”: para. 73, and that “the strength of opinion evidence is dependant on how it is presented by the witness in court and, in particular, how it stands up to cross-examination”: para. 80.
145. As *Hoskin, supra*, para. 65, emphasized, “cross-examination ... is the most important avenue to truth in the adversarial system.”

Appendix A, Tab 6

146. Unfortunately, despite criticisms by counsel, the judge applied none of these criteria in weighing the relative credibility of the expert testimony. He did not demonstrate the careful sifting and evaluation prior to fact determination in the complex and professional matter of medical standard of care, that disputants in the Canadian system of civil justice have a right to expect, and that the Plaintiffs requested. In particular, he failed to consider the effect of cross-examination – designated by Wigmore as “the greatest legal engine for the discovery of truth.”
147. The majority in *Housen, supra*, para. 25 justified a deferential standard of review for inferences of fact, by reference to certain advantages of the trial judge which are not confined to the observation of the demeanour of witnesses:

Advantages enjoyed by the trial judge with respect to the drawing of factual inferences include the trial judge's relative expertise with respect to the weighing and assessing of evidence, and the trial judge's inimitable familiarity with the often vast quantities of evidence. This extensive exposure to the entire factual nexus of a case will be of invaluable assistance when it comes to drawing factual conclusions.

Appendix A, Tab 2

148. There are also policy reasons for taking a deferential approach toward a trial judge's inferences of fact, and the Appellants acknowledge that the standard of review is palpable and overriding error. However, when the trial judge fails to demonstrate the desired "inimitable familiarity" with the evidence, and despite his "extensive exposure to the entire factual nexus" fails to consider relevant evidence (eg. the prior charting of the patient's family medical history), fails to consider a whole ground of negligence (eg. the failure to consider the relevance of pregnancy to dissection), and fails to give sufficient or any reasons why he prefers the evidence of one party's medical experts over the evidence of the other party's medical experts, this must give rise to a feeling of unease.
149. But when the trial judge adopts criteria from decisional law for evaluating credibility of medical experts, and then accepts testimony which violates these criteria, unease rises to the level of conviction. The trial judge is not entitled to make findings of fact that are clearly wrong, unreasonable or unsupported by the evidence.
150. The trial judge either violated or failed to apply the criteria for determining standard of care, in the following ways:

- (1) Dr. Christakis was a surgeon and not a peer of the Defendant, yet the trial judge relied on the evidence of Dr. Christakis as to the standard of care for an internal medicine specialist, over the evidence of Dr. Beanlands, who was a medical peer of the Defendant. Plaintiff's expert surgeon Dr. Melvin expressly declined to give an opinion as to the Defendant's standard of care. The trial judge failed to consider whether and to what extent he should rely on Dr. Christakis for the purpose of defining standard of care for a different and non-surgical specialty.
- (2) The trial judge failed to consider the relevance of the evidence of Dr. St. Croix, the emergency physician called as a fact witness by the Defendant, that not all patients would give an accurate family history in response to general questions. The Appellants submit that this is favourable evidence coming from a witness who should be presumed partial to the Defence.
- (3) It was accepted that a specific form of questioning is taught in medical schools, and that it was not followed by the Defendant. The trial judge did not explain why what is taught in medical schools should not be presumed to be the standard of the majority of medical practitioners.
- (4) The trial judge did not compare and contrast relative credibility and persuasiveness. Specifically, he did not take into account the fact that the Defence expert report had failed to identify and discuss the central issue of standard of care in taking a family history.

- (5) Submission was made to the trial judge on the basis of the *Adair Estate* case relied on under Issue 6 below, but he gave no consideration to holdings in caselaw, that “reliance on probability is a violation of the universally accepted diagnostic practice of the profession and is negligent.”
- (6) The trial judge acknowledged that Dr. Beanlands “referred to a number of standard medical textbooks which set out the appropriate method for taking a family history.” The trial judge considered and rejected one of these textbook references, as being intended only for students. He did not consider the other textbook references, nor did he consider that the testimony of the Defence expert witnesses on this issue was not grounded in any literature references.
- (7) Dr. Beanlands was clear that he is available and consulted by both plaintiffs and defendants in medical negligence cases.
- (8) The Appellants say that the reports of both Dr. O’Reilly and Dr. Christakis were evasive, and that the report of Dr. Christakis had an aggressive and partisan tone. Dr. O’Reilly took positions in his report which were demonstrably wrong in cross-examination. Dr. Christakis fell into the category of the highly credentialed but combative expert, who saw his retainer as one of advocacy. See brief excerpts from cross-examination attached at Appendix 1 of this factum, pp. 3 and 4.

151. With respect, the court below did not conduct a full and careful treatment of the evidence. The situation was different in *Briffett, supra*, where at para. 40 this Court of Appeal rejected the claim that the judge failed to adequately support his findings, saying:

In fact, the impugned judgment represents a full and careful analysis and treatment of the evidence, including the sometimes divergent medical opinions. Even if certain elements of proof could be shown to be absent from the trial judge's reasoning, an examination of the transcript shows that there was quite sufficient evidence that could be reasonably accepted by a trier of fact as countervailing contrary fact and opinion and upon which he could base his findings.

Appendix A, Tab 9

152. The foregoing cannot be said of the case at bar.

Issue 6 – Failed to Resolve Evidence as to Negligence using Test of Unreasonable Risk of Harm

153. At para. 73 of his Decision, the learned judge quoted the definition of standard of care stated by Major J. for a unanimous Supreme Court of Canada in *Ryan v. Victoria (City)*, *supra*, para. 28:

Conduct is negligent if it creates an objectively unreasonable risk of harm.

154. Unfortunately, the learned trial judge did not apply this test for negligence in evaluating the contending expert evidence. This error of law in failing to apply the correct test for negligence led to two major errors in fact finding which resulted in dismissal of the suit. The first of these errors is that the judge accepted a fundamentally flawed description of the method of differential diagnosis used in medicine. The second is that he accepted a fundamentally flawed description of the method of taking a family history. The first issue is whether potential diagnoses should be ruled out in order of their probability, or in order of their lethality.

155. Both of these errors are reviewable on a standard of correctness, once the test for negligence is identified and applied.

Differential Diagnosis – First Error

156. The learned judge accepted the evidence of Dr. Christakis and found that in developing the differential diagnosis, the “physician focuses on “probable” diagnoses and not just

“possible” ones”. He quoted a passage of Dr. Christakis’ testimony which includes the statement:

... you’re really thinking of a limited number of things, probabilities...

Decision, para. 107

157. Dr. O’Reilly was more circumspect. A point to recall here is that the judge accepted the evidence of Dr. Christakis on diagnostic issues, who as a surgeon is not a peer of Dr. Hiscock, and is not primarily a diagnostician. He preferred this over the evidence of Dr. Beanlands, who is primarily a diagnostician, and over Dr. Melvin, who is a surgeon and peer of Dr. Christakis. Indeed, the judge recognized the very issue in his brief discussion of the evidence of Dr. Melvin:

[88] Melvin testified that he was not a “peer” of Hiscock and therefore could offer no opinion as to Hiscock’s standard of care in relation to Ross. He explained that his medical practice involved surgery while Hiscock’s practice involved the diagnosis of diseases.

Decision

158. Dr. Beanlands described the process of differential diagnosis as he knows and teaches it.

This requires the physician to rule out life threats first:

That involves the consideration, first, of causes of these symptoms, or this clinical syndrome that are potentially life threatening, and to rule those out. And secondly, to look into potential other causes. The diagnosis that was made here was viral pericarditis, and in actual fact, viral pericarditis is a diagnosis of exclusion, and in this case you would certainly want to exclude dissection as a cause of the pericarditis.

Transcript, Dr. Beanlands, p. 6, lines 22-29, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 16

159. Dr. Melvin also described the process of differential diagnosis (p. 9, lines 71-86) and the role of lethality in ordering priorities: “So even though the probability of a, one diagnosis is less than another, the one with the most lethality is the one that’s pursued”: p. 9, lines 103-105, emphasis added. Aortic dissection is “definitely” part of the differential diagnosis for chest pain: p. 10, line 20.
160. An example of a differential is found in the notes of Dr. Furlong. He considered complications of Marfan’s “highly unlikely”, and gut grief secondary to chicken was at the top of his list, but he prudently sent the patient to the Paton hospital anyway.

Appeal Book, Part II – Evidence, Volume 1 – Exhibits, Tab 10-C, p. 010

161. *Williams v. Bowler*, 2005 CanLII 27526 (ON C.A.) contains a useful review of the jurisprudence on standard of care in medical cases. Where life threats are contained in the differential, the physician must promptly rule them out, or be found negligent: paras. 250-253.

Appendix A, Tab 14

162. The reasoned evidentiary determinations of trial courts in other cases may be given some weight. Other courts have accepted that probability must not displace lethality, and the physician must eliminate worst first:

116 The physician eliminates the peril that has the most severe consequences first. He summed up this idea in his

expert testimony by asserting the simple maxim “worst first”.

151 Treating Mrs. Adair for constipation was also negligent. I arrive at this conclusion because primarily, it is a negligent misapplication of the process of differential diagnosis that is standard practice in the medical profession. Part of this diagnostic system demands a doctor to begin by treating the most severe possibility and working down from there: worst first. Dr. McDonagh did not do this.

153 If doctors were to diagnose based on probability, rare and severe ailments would regularly be ignored in favour of common, non-life threatening alternatives. When faced with symptoms that point to two or more diseases, the universally acceptable system to use is a differential diagnosis that accounts for severity. Given the symptoms, the possibility of a bowel obstruction should reasonably have been at or near the top of the differential diagnoses list of risks. Dr. McDonagh’s reliance on probability is a violation of a universally accepted diagnostic practice of the profession and is negligent. [Emphasis added]

Adair Estate v. Hamilton Health Sciences Corp., 2005 CarswellOnt 2180 (S.C.J.), Appendix A, Tab 15

163. If the foregoing passage from *Adair Estate* is a true finding, then the judge below was led into contradiction of the universally accepted diagnostic practice of the medical profession by the misleading evidence of Dr. Christakis. How to resolve this issue of mixed law and fact?
164. The resolution rests in the test stated by the Supreme Court: “Conduct is negligent if it creates an objectively unreasonable risk of harm.” If Dr. Christakis’ were the only evidence on differential diagnosis before this Court, then the Court’s hands might be tied; but it is not the only evidence. This Court is at liberty to correct the trial judge and adopt

the evidence of differential diagnosis which is objectively reasonable: rule out life threats, or worst first.

165. This is the standard of care Ms. Ross had right to expect, and it is the standard that each of us would expect if we were to present as a chest pain patient. It is not the standard that Ms. Ross received:

Q. So you diagnosed viral pericarditis which is a diagnosis of exclusion, but you did not rule out dissection as the cause of the pericarditis? A. No, I did not.

Transcript, Dr. Hiscock, p. 24, lines 69-71, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 19

Method for Family History Taking – Second Error

166. The second error involving failure to apply the legal test for negligence is that the judge accepted a fundamentally flawed description of the method for taking a family history.
167. As a preliminary point, the entire contemporaneous chart of the August 30 – September 1 admission is devoid of even one mention of the words “family history”. There is no documentation that the Defendant even asked about family history, although the trial judge seems to have accepted the Defendant’s evidence of his general practice, and assumed he asked the question the Defendant said he usually asks.
168. The trial judge was obliged to resolve a controversy among the experts as to whether the accepted standard of questioning for family history was general (Are there any major

medical diseases in your family?), or specific (Is your father still alive? At what age did he die? What did he die from?). The trial judge resolved the controversy as follows:

[96] Having considered the circumstances of this case, I find that I agree with O'Reilly and Christakis that the textbook used at Memorial University was merely a guide for medical students who were about to enter the medical profession. I find that the standard of care which Hiscock was required to adhere to in questioning Ross was the method described by O'Reilly and Christakis. In other words, Hiscock was correct in asking Ross general questions about her family history. It was not necessary for him to "cross-examine" her or challenge her when there was no positive reply to his general questions about a history of heart disease in her family.

Decision

169. First, the questions prescribed by Dr. Beanlands can hardly be described as cross-examination. Cross-examination suggests the answer. The questions prescribed by Dr. Beanlands as standard of care are focused and specific, but suggest no answer.
170. But more importantly, the trial judge arrived at the incongruous conclusion that the standard of care for medical students was higher than the standard of care for medical specialists. In rejecting the Memorial University Teaching Handbook as standard of care, he also rejected other authoritative literature placed in evidence, but which he did not discuss. Dr. Beanlands' testimony was substantiated by reference to various authoritative texts, while the testimony preferred by the judge was substantiated by no text references.
171. Earlier in his Decision, the learned trial judge described Dr. Beanlands' testimony as to standard of care for family history taking:

[82] Beanlands referred to a number of standard medical textbooks which set out the appropriate method for taking a family history. He placed into evidence a document (“textbook”) which was used in teaching medical students at Memorial University of Newfoundland at the time Hiscock was a student at the institution. The following excerpt refers to the method of taking family history:

“Medical case reporting, or history taking...is more important to the practice of medicine than any other technique...

3. Family history

Record

Father, Mother and Siblings - age, health,
and if dead, date and cause.

Family Disease...”

[83] Beanlands testified that this method is generally accepted in the medical profession and represents the standard of care for physicians in obtaining the family history of patients.

172. The Defendant agreed that the MUN teaching handbook, Exhibit D.B. #3, quoted by the trial judge in the passage above, was representative of what the other texts tell physicians to do when seeking a family history:

Q. So that’s reflective of the literature? A. So it would seem, sir.

Transcript, Dr. Hiscock, p. 16, lines 65-66, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 19

173. The specific questions take no longer to ask than the general questions, and it was never explained by the Defence experts why the standard teachings were inappropriate to experienced specialists.

174. The value of the specific question approach is grounded by the following passage from the testimony of Defence witness Dr. St. Croix, the emergency physician to whom Ms. Ross presented at the Paton Hospital on August 30:

Crosbie, QC: ...And my notes say that Nurse Slade testified that among things she's heard you ask patients, is your mother still alive, is your father still alive, and if not what did they die from.

Dr. St. Croix: I may well have.

Crosbie, QC: Would you agree that you've asked that of patients on several occasions?

Dr. St. Croix: I do at times.

Crosbie, QC: At times?

Dr. St. Croix: Yes. If I get a positive response to a general question.

Crosbie, QC: Would you agree that it's good practice for a physician presented with a chest pain patient in the emergency setting, to ask those questions?

Dr. St. Croix: I would agree that it is quite reasonable to ask those questions. I would also agree that when you ask most patients a general question about family history that they will come back and ask you, one either what illnesses are you looking for, what did you mean, or who in my family does it concern, is it immediate family or is it cousins, that sort of thing. Most patients will ask you to clarify the question.

Crosbie, QC: But not all?

Dr. St. Croix: Not all, but most patients who have the knowledge of their illnesses will ask. [Emphasis added]

Transcript, Dr. St. Croix, p. 24, line 60 – p. 25, line 12, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 17

175. The standard of care of an emergency physician is not in issue. The objectives of emergency medicine and the conditions in which it is practiced, may be different from the objectives of an internal medicine specialist consulted for chest pain and a murmur in late pregnancy with elevated blood pressure. However Dr. St. Croix did agree that it is “quite reasonable” to ask what Dr. Beanlands described as the standard questions as to age of death and cause of death of parents and siblings. She agreed that although most patients will ask for clarification of a general question about family history, not all will.
176. The issue for this Court of Appeal is whether a few specific questions as to age and cause of death of parents and siblings are mandatory for the internal medicine consultant, when the emergency physician herself admits that general questions will not obtain the required information from all patients.
177. The Appellants submit that the resolution of the conflict in expert testimony as to standard of care in family history taking again rests in the test stated by the Supreme Court: “Conduct is negligent if it creates an objectively unreasonable risk of harm.”
178. Here, the trial judge was presented with a choice for standard of care questioning, between general questions which would elicit accurate answers in most cases, and specific questions which would elicit accurate answers in all cases (unless the patient were untruthful). There was no cost in time or effort as between the two methods. In life safety situations, the choice of standard questioning is obvious: the objectively reasonable method is that of specific questions, as grounded in authoritative literature. Otherwise, life threatening diagnoses will be missed and patients will unnecessarily die.

PART IV – RELIEF REQUESTED

179. The Appellants request that the Decision of the trial judge as to liability be set aside, and judgment be granted with costs to the Appellants, both here and in the Trial Division, and damages to be assessed.

RESPECTFULLY SUBMITTED at St. John's, in the Province of Newfoundland and Labrador, this day of June, 2006.

CHES CROSBIE BARRISTERS

Solicitors for the Appellants

whose address for service is:

169 Water Street, 4th Floor

St. John's, NL A1C 1B1

Attention: Chesley F. Crosbie, Q.C.

TO: CURTIS, DAWE
Solicitors for the Respondent
11th Floor, 139 Water Street
St. John's, NL A1C 5J9
Attention: Peter N. Browne

APPENDIX 1

Medical Literature

1. The Appellants placed into evidence a copy of a booklet entitled “A Guide to the Performance and Recording of the Medical History and Examination, Faculty of Medicine, M.U.N.”. This was contained in D.B. #1. At para. 82 of the Decision, the learned trial judge quoted from the teaching booklet as follows:

Medical case reporting, or history taking...is more important to the practice of medicine than any other technique...

3. Family history
Record
Father, Mother and Siblings - age, health, and if dead, date and cause.
Family Disease...

2. The trial judge noted that Dr. Beanlands, in stating the standard of care in taking the family history, relied on other medical literature also. This included the following, all from D.B. #1:

- (ii) **Family History.**
Record state of health for cause of death of parents, brothers, or sisters, with ages of death, and age of patient....
- (iv) **Personal and Social History.**
... What were your parents like? What sort of relationship did they have? Which one of the them do you take after? Are they still living? If deceased, when did they die? What did they die of?

The Principles and Practice of Medicine, ed. Harvey et al., 19th ed., pp. 16-17.

3. Another text stated:

The family history

Note the patient's position in the family and the ages of the children if any. Usually it is only necessary to record the state of health, the important illnesses, and the cause of death of immediate relatives.

Hutchison's Clinical Methods, ed. Bomford et al., 16th ed., p. 10

4. The Harvey textbook also makes the pertinent observation at p. 15 that:

The predominant emotion of a patient going to see a doctor is often fear.... It is important to appreciate that such fears may deeply affect the patient's personality and his reaction to his illness.... From a practical standpoint, the patient's fears and anxieties colour the clinical information which is obtained by taking the history, and they significantly effect the presentation of the illness itself and its course. For example, a patient suspecting that he has angina or carcinoma may withhold, minimize, exaggerate, or otherwise distort the historical data.

5. Likewise, the Hutchison text observes as to case taking, at p. 3:

It is important to realize that *apparent evasiveness* on the part of the patient is almost never deliberate. It can occasionally be due to subnormal intelligence, but is much more often due to nervousness or actual fright. One must realize that a visit to the doctor or by a doctor is a real ordeal for some patients....

6. Here we may recall that that the admission nurse, Nurse Slade, testified that she had to ask the patient some questions more than once, and that "she must have had tremendous fear".
7. The Defence experts relied on no literature, in testifying that the general question method of taking a family history was standard of care.

Cross-Examination of Dr. Christakis

8. Dr. Christakis testified aggressively in direct for two hours. Plaintiff counsel elected not to engage the expert on the substance of his opinions, but to make a brief collateral attack to show that the witness held extreme, even dogmatic, views.

THE COURT: I'm still trying to get over your CV. I think when this is over I'm taking this CV and I'm going to show it to other people so that they can ... I've never seen the likes of it, my goodness.

DR. CHRISTAKIS: ... (laughter) ...

THE COURT: Yes, we'll need a trolley the next time you come back, doctor, go ahead, Mr. Browne.

...

MR. CROSBIE, QC: ... Sir, it's your opinion that the aortic tissue was not dissecting on August 30th.

DR. CHRISTAKIS: Yes.

Q. And the pain the patient experienced was not the pain of dissection. A. Yes.

Q. And you're 99.9 percent certain of that? A. Yes.

...

Q. Justice, believe it or not, that's all I have.

...

THE COURT: Okay, well, Doctor, my goodness gracious, this is ... I was ready for the whole afternoon here.

DR. CHRISTAKIS: I feel like I was ambushed.

THE COURT: Yeah, well, look, thank you very much, Doctor, for coming down.

Transcript, Dr. Christakis, p. 25, lines 14-18, line 83 – p. 26, line 30, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 21

9. Dr. Hiscock agreed that the questions prescribed by Dr. Beanlands and set out in literature were “good questions”. He disagreed with his own expert Dr. Christakis, who in his report at p. 3 labelled them “exhaustively aggressive”.

Q. So this booklet which you’ve agreed is reflective of the literature says family history, record father, mother and siblings, age, health, and if dead, date and cause. And you’ve agreed, I think, a few minutes ago that these were good questions. If you could indicate your agreement or disagreement? A. Oh, yeah, I guess they’re good questions. I know that that’s the way some people take their family history from the patients.

Q. And that’s the way the literature suggests you should do it, we’ve just seen that, isn’t that so? A. Yes, sir.

Q. So would this amount to, these kinds of questions amount to exhaustively aggressive questioning for family history? A. I’m not so sure, sir, what you mean by that question.

Q. Would these be aggressive questions? A. Again, sir, I apologize, but I am not really sure ... what do you mean by aggressive?

The Court: If they’re too probing.

Dr. Hiscock: No, they’re not too probing, no.

...

Mr. Crosbie, QC: So what he [Dr. Christakis] says here is, “Criticisms have been levelled against Dr. Hiscock for not pursuing an exhaustively aggressive questioning for a family history of Marfan’s Syndrome.” And I’m simply asking you, would that pattern of questioning be exhaustively aggressive?

Dr. Hiscock: No, I wouldn’t think so.” [Emphasis added]

Cross-Examination of Dr. Hiscock on Chicken Bone

10. Although Dr. Furlong had attributed the chest pain to a chicken bone, Dr. Hiscock did not obtain this history either:

Mr. Crosbie, QC: So it could be a list of differential diagnoses?

Dr. Hiscock: Yes.

Q. And what does he put at the top of his list? A. He puts down “Likely gut grief secondary to chicken, but not like usual stomach symptoms”.

Q. Did you consider swallowing of a chicken bone, or gas, or some kind of gastric problem as part of your differential?

A. No, I didn’t get that history of swallowing the chicken bone. I didn’t get any of this gut grief history.

Transcript, Dr. Hiscock, p. 23, lines 64-73, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 19

Cross-Examination of Dr. Hiscock on Failure to Rule out Dissection

11. Although viral pericarditis is a diagnosis of exclusion (there is no test for it that takes less than a month), the Defendant did not rule out other diagnoses, and did not rule out dissection as the cause of the pericarditis.

Q. And now, is viral pericarditis a diagnosis of exclusion?

A. Yes, because there’s no really other way of, there’s no test that would confirm that that is entirely the case.

Q. Yeah, so you arrive at it after ruling out anything else, is that right? A. Well, looking at what the patient has done and given to me, I didn’t really rule out anything else. I didn’t make much (inaudible), I did that with my history, and just the way that she presented, it was what I had heard before.

...

Q. Is that statement from Dr. O'Reilly that he makes in his report, "It does not appear that hemopericardium due to aortic dissection was considered in the differential diagnosis", is that a correct statement? A. That is a correct statement.

Q. So you did not consider hemopericardium in your differential? A. I did not.

Q. Would you agree that one of the causes of hemopericardium is aortic dissection? A. Yes, it is.

Q. So you diagnosed viral pericarditis which is a diagnosis of exclusion, but you did not rule out dissection as the cause of the pericarditis? A. No, I did not. [Emphasis added]

Transcript, Dr. Hiscock, p. 24, lines 9-17; p. 24, lines 60-71, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 19

Cross-Examination of Dr. O'Reilly as to Morbid Obesity

12. In Dr. O'Reilly's report, he had described the deceased as "morbidly obese". Dr. Hutton earlier entered as an exhibit, a standard table used for calculating overweight and obesity on the basis of height and weight. This was marked as C.H. #5. Dr. O'Reilly, after some questioning, conceded that the patient was not morbidly obese, but disagreed with the table for calculating obesity entered as C.H. #5.

Q. ...you're conceding she's not morbidly obese, but you insist she's obese? A. Based on the calculations, I would assume that that's the case.

Q. Well, not based on these calculations because we just saw that she's just overweight, so you disagree with the calculator. A. I disagree with the table at the top.

Transcript, Dr. O'Reilly, p. 24, lines 3-8, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 20

13. When cross-examination resumed the following day, counsel asked if Dr. O'Reilly had come prepared to back up his point that the table was faulty:

MR. CROSBIE, QC: And you've come back prepared to completely refute on that.

DR. O'REILLY: Now, I wish I had gone on the internet.

MR. CROSBIE, QC: Well, you've now lost your chance, because I'm giving you up to Mr. Browne for redirect.

Transcript, Dr. O'Reilly, p. 4, lines 54-58, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 20

Testimony of Doris Rogers

14. The testimony of the patient's aunt, Doris Rogers, is important for interpretation of the visit to Dr. Kravitz and for the interpretation of Ms. Ross' understanding of her medical condition.

Knowledge of Terms

Mr. Browne: But it seems from here that she seemed to know the term Marfan's in February of 1993?

Ms. Rogers: Yes.

Transcript, Doris Rogers, p. 13, lines 36-39, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Mr. Browne: Can I suggest as well that she also probably knew that her brother had a, sorry, her brother had a rupture and her father had a dissection?

Ms. Rogers: I'd never heard Lyn mention the word dissection or rupture. Lynia would refer to them as aneurysms to me.

Transcript, Doris Rogers, p. 13, lines 54-60, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Knowledge of Risks

Mr. Browne: Would you agree as well that on her second pregnancy Lynia was aware of the need for follow-up because of this?

Ms. Rogers: I'm not sure if she was aware of the need for follow-up. She'd been assured that she didn't have it. You're speaking with regards to the Marfan's syndrome?

Mr. Browne: Marfan's, yes.

Ms. Rogers: I'm not sure. She was not ever told that she could have it, to the best of my knowledge.

Transcript, Doris Rogers, p. 13, lines 64-74, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Ms. Rogers: Well Lyn was termed non-Marfan's, Mr. Browne.

Mr. Browne: You're basing that on what?

Ms. Rogers: On ah Dr. Sheldon's visit. She didn't have the characteristics. Ah, reassurances from her doctor. No red flags with her pregnancies that she was high risk.

Mr. Browne: Reassurances from what doctor?

Ms. Rogers: From the GPs, Dr. Chalker had seen her.

Transcript, Doris Rogers, p. 17, lines 61-70, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Crosbie, QC: I'll be very brief. Were you in a position in terms of knowledge of Marfan's and the likelihood of inheriting Marfan's, to give Lynia any advice about the risk she ran of having it? ...

Ms. Rogers: I had some of that, probably a good bit of that knowledge to have given it, but I don't think I would have been the appropriate person to give it.

Crosbie, QC: Well my next question is did you give her any advice about the risk...

Ms. Rogers: No.

Crosbie, QC: ...of having Marfan's?

Ms. Rogers: No, other than to be checked out because of her pregnancies.

Transcript, Doris Rogers, p. 18, line 73 – p. 19, line 15,
Appeal Book, Part II – Evidence, Volume 2 –
Transcripts, Tab 13

Ms. Rogers: She, I don't know if she didn't want to know or if she was just frightened to death.

The Court: Yeah. My sense is she was frightened to death about this. That's what I'm getting, and I'm reading so far anyway.

Ms. Rogers: I would think she must have had tremendous fear.

Transcript, Doris Rogers, p. 21, lines 35-41, Appeal
Book, Part II – Evidence, Volume 2 – Transcripts, Tab
13

Dr. Kravitz visit

Crosbie, QC: First of all, how did the appointment get arranged?

Ms. Rogers: I asked Lynia to come to St. John's to visit an obstetrician with her second pregnancy, and asked her to obtain a referral and I would make the request for an appointment with Dr. Kravitz.

Transcript, Doris Rogers, p. 5, lines 63-69, Appeal
Book, Part II – Evidence, Volume 2 – Transcripts, Tab
13

Crosbie, QC: The appointment was arranged through whom, there had to be a referral?

Ms. Rogers: Dr. Georgina Chalker wrote the referral.

Crosbie, QC: Can you tell us where Dr. Chalker was based?

Ms. Rogers: Dr. Chalker was a surgeon at Twillingate hospital at the time.

Transcript, Doris Rogers, p. 6, lines 6-13, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Crosbie, QC: So Dr. Chalker's role was what with respect to Lynia?

Ms. Rogers: Dr. Chalker was seeing Lynia at times through her pregnancy. In order for being the referring person, she would have to have been seeing Lynia. Dr. Chalker delivered Candace.

Crosbie, QC: At the Twillingate hospital?

Ms. Rogers: Yes.

Transcript, Doris Rogers, p. 6, lines 22-29, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Crosbie, QC: ... Why were you concerned that Lynia come to St. John's to see an obstetrician? What was your motivation?

Ms. Rogers: My big concern was that she was from an outlying area, the baby was due in the dead of winter, she lived in Summerford, one hospital was in Twillingate, the other was in Gander. I would have just felt more comfortable with her being in the City with all back-up services available if she had a problem.

The Court: This was to come in to have the baby, was it?

Ms. Rogers: This was in preparation. The visit to Dr. Kravitz was in preparation in hopes that she would come to St. John's to have her second child.

Transcript, Doris Rogers, p. 7, lines 2-17, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Ms. Rogers: She went in with Lyn for an examination, did her examination and came out and sat at her office. I felt that whether or not Lyn had discussed her family's, her father's death and her brother's death, I felt that it was something that should have been in the record, so I very, very quickly told Dr. Kravitz that her brother and her father were both dead from aneurysms. And she had been sitting up at her desk and when I mentioned it, she just sat back and looked really surprised. And when Lyn came out like very, very shortly after, she went through some things, and she said to me, she's going to need consults. Well she said to Lyn as well actually, we were both there. You're going to need like this, this and this, and the one thing I remember is a cardiology consult, and I remember that because she looked at me, she said you can make this happen. So I could have, I knew the cardiologists at the time, I could have gotten the cardiology referral here.

Crosbie, QC: Did you say anything else to Kravitz about the family history?

Ms. Rogers: I don't remember fully. The letter here states that it was raised by a family member that it was query Marfan's, so it could only have been me.

Crosbie, QC: Which letter?

Ms. Rogers: The letter back to Dr. Chalker. [Emphasis added]

Transcript, Doris Rogers, p. 7, lines 35-62, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Crosbie, QC: What did Kravitz say about the need for these consults?

Ms. Rogers: Nothing in Lynia's, nothing, nothing that I recall at all. We left the office very, very quickly.

Crosbie, QC: Can you go back to that letter at page 3, you see the third paragraph?

Ms. Rogers: Yes.

Crosbie, QC: "I had a long discussion with Lynia about the family history and encouraged her to see a cardiologist.

In addition I thought she may have to see the genetic counselors.”

Ms. Rogers: The conversation was not long. There wasn't time. We were out of that office very quickly.

Crosbie, QC: Was there a discussion about the family history with Lynia when you were there?

Ms. Rogers: I don't recall one, I don't remember one.

Crosbie, QC: Was there a long discussion when you were there?

Ms. Rogers: Definitely not a long discussion.
[Emphasis added]

Transcript, Doris Rogers, p. 8, lines 37-58, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Ms. Rogers: I was sitting on one side of Dr. Kravitz' desk and when she sat down I very quickly asked her if Lyn had discussed with her the early deaths of her father and brother.

Mr. Browne: And you didn't want to do that in front of Lynia, did you?

Ms. Rogers: No.

Mr. Browne: And Dr. Kravitz' reaction was obvious to you, wasn't it? It was obvious she never got that history?

Ms. Rogers: I felt that she was surprised over something...

...

Ms. Rogers: The time spent with Dr. Kravitz after Lyn came out fully dressed was very, very brief. There weren't many discussions to speak of. She did mention she said to me she needs this, this and this, and one of it being a cardiology consult.

Transcript, Doris Rogers, p. 15, lines 51-74, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Mr. Browne: ...You describe Dr. Kravitz as saying that she went over the whole gamut. I suspect she covered all the bases?

Ms. Rogers: Very quickly. Very quickly. There was no long conversation in Dr. Kravitz' office. [Emphasis added]

Transcript, Doris Rogers, p. 16, lines 63-68, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

The Court: ...But this was a big deal and do you recall whether a discussion occurred about this issue?

Ms. Rogers: The discussion didn't occur about the issue of her health with her on the visit. It was, the understanding from her for an obstetrical consult, I had talked with her with regards to coming in...

...

Ms. Rogers: For the baby, February being a terrible month out there anyway.

The Court: Yes, I can understand that.

Ms. Rogers: And ah, she decided to come, I couldn't answer more than that.

Transcript, Doris Rogers, p. 21, lines 6-19, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Hated Doctors

Mr. Browne: Would you agree she disliked going to see physicians and having contact with hospitals?

Ms. Rogers: I never heard Lyn say that..., but she went to all her prenatal visits and she took her children to the clinics.

Transcript, Doris Rogers, p. 18, lines 9-15, Appeal Book, Part II – Evidence, Volume 2 – Transcripts, Tab 13

Doctor says I'm O.K.

15. Ms. Rogers spoke to Lyn by telephone after she was discharged:

Crosbie, QC: And did you give her any advice?

Ms. Rogers: Yes, I certainly did, I asked her if she would finally get dressed and come to St. John's to be followed up.

Crosbie, QC: And what was her response?

Ms. Rogers: She said over and over and over Aunt Doris the doctor says I'm okay.

Crosbie, QC: Did she inform you as to whether she was having any pain?

Ms. Rogers: She didn't indicate she was having pain, but I did sense a terrible shortness of breath with the conversation. I thought that maybe she had been, had come up the stairs to answer the phone but she hadn't, she'd been sitting back on the sofa, hadn't dressed since she got out of the hospital.

Crosbie, QC: So can you say what day this conversation took place, just so we can get the context? She was discharged on Sunday?

Ms. Rogers: She was discharged on a Sunday and it was possibly Monday or Tuesday, I'm thinking Monday, but I'm not absolutely sure. [Emphasis added]

APPENDIX 2 – GLOSSARY OF MEDICAL TERMS

APPENDIX A – AUTHORITIES CITED

Tab

- 1 *H.L. v. Canada (Attorney General)*, [2005] 1 S.C.R. 401, 2005 SCC 25
- 2 *Housen v. Nikolaisen*, [2002] 2 S.C.R. 235, 2002 SCC 33
- 3 *R. v. Gagnon*, 2006 SCC 17
- 4 *Toneguzzo-Norvell (Guardian ad litem of) v. Burnaby Hospital*, [1994] 1 S.C.R. 114
- 5 *Georghiades v. MacLeod*, [2005] W.D.F.L. 2826, 2005 CarswellOnt 1680 (S.C.J.)
- 6 *Hoskin v. Han*, 2003 BCCA 220, 12 B.C.L.R. (4th) 21, 181 B.C.A.C. 130, 298 W.A.C. 130, 2003 CarswellBC 857
- 7 *Keller v. Penkoske et al.* (1999), 256 A.R. 1 (Q.B.)
- 8 *Connell v. Tanner*, (2002) 158 O.A.C. 268 (C.A.), 2002 CarswellOnt 1328 (C.A.)
- 9 *Briffett v. Gander & District Hospital Board*, (1996) 137 Nfld. & P.E.I.R. 271, 29 C.C.L.T. (2d) 251, 428 A.P.R. 2671, 1996 CarswellNfld 76 (C.A.)
- 10 *Dobie v. Dlin*, (2001) B.C.S.C. 1523, 2001 CarswellBC 2412
- 11 *Ryan v. Victoria (City)*, [1999] 1 S.C.R. 201
- 12 *Amador v. Mo*, 2005 BCCA 514 (CanLII)
- 13 *Cooper v. Cooper*, (2001) NFCA 4, 2001 CarswellNfld 17 (C.A.)
- 14 *Williams v. Bowler*, 2005 ONCA 27526 (CanLII)
- 15 *Adair Estate v. Hamilton Health Sciences Corp.*, [2005] W.D.F.L. 3358, 2005 CarswellOnt 2180 (S.C.J.)