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ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:	)	
	)	
Alfred Newman, Executor and Trustee for the Estate of Theresa Newman, Deceased, and Alfred Newman, personally	)	Sloan H. Mandel, for the Plaintiffs
Plaintiffs	)	
- and -	)	
William G. Swales	)	William G. Scott, for the Defendant
Defendant	)	
	)	**HEARD:** October 4,5,9,10,11,12,16, 2001

Lack J.

[1] This is an action against Dr. William C. Swales in which it is alleged that his medical management of his patient, Theresa Newman, was negligent.

[2] On May 7, 1993 Mrs. Newman had her first appointment with Dr. Swales in Lakefield, Ontario. She complained to Dr. Swales of pelvic pain, rectal bleeding and a change in bowel habits. Dr. Swales ordered an air contrast barium enema. Six weeks later Mrs. Newman was given a complete medical examination. No further investigations took place. Over the next 3 years Mrs. Newman saw Dr. Swales many times. On November 4, 1996 while vacationing in Florida Mrs. Newman was diagnosed with colorectal cancer. After surgery and treatment she succumbed to the cancer on August 1, 1998.

[3] It is conceded that if further investigation had occurred in 1993 it would have disclosed a polyp in the rectosigmoid area of Mrs. Newman's colon. It could have been removed. That would have prevented development of the cancerous growth, which metastasized and led to Mrs. Newman's death.

The Plaintiffs' Position

[4] The plaintiffs say that Dr. Swales' management of Mrs. Newman on May 7, 1993 and afterwards failed to meet the generally accepted standard of care reasonably expected of a general practitioner in a small Ontario town at the time. The failure alleged is that he failed to consider colon cancer or a precursor to colon cancer as a potential explanation for Mrs. Newman's May 7, 1993 symptoms. Alternatively, he failed to appropriately assess Mrs. Newman and investigate the cause of her presenting symptoms.

The Defendant's Position

[5] The defendant denies that his care of Mrs. Newman fell below the applicable standard of care. He ordered an air contrast barium enema on May 7, 1993 to rule out cancer or a precursor to cancer. He scheduled a physical examination for Mrs. Newman. The results ruled out ominous cause. Mrs. Newman did not complain to him of any further bowel symptoms after that.

Legal Issues

[6] The first legal issue is whether Dr. Swales' medical management of Mrs. Newman's bowel dysfunction on or after May 7, 1993 fell below the standard expected of a reasonably competent family physician at that time in that place.

[7] The second issue with respect to liability is causation. If Dr. Swales' management of Mrs. Newman fell below standard did it result in Mrs. Newman's subsequent death? As I have said, causation is conceded on the basis set out above.

[8] The third issue is what damages have been suffered by the Estate pursuant to section 38 of the *Trustee Act*, R.S.O. 1990, c. T.23 and by Mrs. Newman's husband Alfred Newman under the *Family Law Act*, R.S.O. 1990, c. F.3, if liability is established.

Factual Issues

[9] What clinical judgment did Dr. Swales exercise on May 7, 1993?

[10] Did Mrs. Newman have symptoms of bowel dysfunction after May 7, 1993?

[11] Did Dr. Swales know of those symptoms of bowel dysfunction, if she had them?

[12] What clinical judgment did Dr. Swales exercise after May 7, 1993 in investigating or treating Mrs. Newman's symptoms of bowel dysfunction?

The Danger of Hindsight

[13] As Justice A. Campbell wrote in *Stell v. Obedkoff*, [2000] O.J. 4011, it is vital at every step of the factual analysis to avoid the temptation of hindsight. As L'Heureux Dube J. said in *Lapointe v. Hopital Le Gardeur*, [1992] 1 S.C.R. 351:

> Courts should be careful not to rely upon the perfect vision afforded by hindsight. In order to evaluate a particular exercise of judgment fairly, the doctor's limited ability to foresee future events when determining a course of conduct must be borne in mind. Otherwise, the doctor will not be assessed according to the norms of the average doctor of reasonable ability in the same circumstances, but rather will be held accountable for mistakes that are apparent only after the fact.

[14] The danger of hindsight is particularly great where there has been evolution in the knowledge of the condition and in the techniques to detect the condition from which the patient is now known to have suffered. It is difficult for experts to put their minds back 8 years ago and testify on what the standard of care was. It is also difficult for other witnesses to put their minds back 8 years to testify about events.

The Parties

[15] In May 1993 Mrs. Newman was 54 years old. She had 3 grown children from her first marriage. In April 1987 she married Alfred Newman. She left England. She and her husband lived in Canada but divided their time between Lakefield and Florida with occasional trips to England and elsewhere. She had a family doctor in Lakefield and also saw family doctors in Florida and England, as the need arose. On May 7, 1993, Mrs. Newman had her first appointment with Dr. Swales.

[16] Dr. William Swales graduated in medicine from Magill University in 1988. He completed an internship in family practice at Queen Elizabeth Hospital in Montreal. He then practised family medicine for 3 years in Nova Scotia. He took time off from practising medicine from January to June 1992 when he took over the practice of the doctor in Lakefield who was Mrs. Newman's family physician. Lakefield is a small town near Peterborough. The practice then had about 4000 patients, about two-thirds of whom were over the age of 50. As a family physician in 1993 Dr. Swales saw 2 or 3 patients a week with bleeding from the bowel and about two-thirds of them were over 50 years old. He saw about one patient every 2 weeks with bleeding from the bowel who was also suffering from altered bowel habit.

Medical Records

[17] Counsel agreed that Exhibits 1 and 2, which contain Mrs. Newman's medical records, were admitted into evidence for the truth of their contents under section 35 and section 52 of the *Evidence Act*, R.S.O. 1990, c. E.23. There was one exception to the agreement. In some of those records Mrs. Newman made statements to her doctors about her medical history while under the care of Dr. Swales. The statements are hearsay. Counsel for the defence objected to

their admission. I admitted them. In doing so, I was dealing with the threshold issue of admissibility of the statements. It remains for me to decide what weight I will put on them.

The May 7, 1993 Visit

[18] Dr. Swales testified that he has no recall of the May 7, 1993 meeting or any other meeting he had with Mrs. Newman. He referred to his chart in giving his testimony. The chart consists of handwritten, dated, chronological entries on lined paper. The patient's history is on a separate sheet. The results of complete physical examinations, or what might be called annual check-ups, are recorded on separate sheets specifically for those examinations. Problems or concerns arising out of a complete physical examination are recorded in the day-to-day section of the chart. On May 7, 1993 Dr. Swales saw Mrs. Newman for the first time. He said that when he saw a patient for the first time he introduced himself and asked what problems the person was having. He usually told them to get a complete check-up.

[19] Dr. Swales testified that it was office procedure for the nurse to take the patient to the examination room and discuss and chart the purpose of the visit. The relevant first part of the May 7, 1993 chart entry reads:

S [subjective] 2. [second issue] pelvic pain. frank blood in stool. doctor in Florida ? hemorrhoids[1]

[20] Dr. Swales testified that recording was the nurse's notes of her discussion with Mrs. Newman. He said that the note means that the second issue that Mrs. Newman wished to discuss with him on May 7 was her pelvic pain and frank blood in her stool. "Frank" means visible. The doctor in Florida had said that the cause of the bleeding was hemorrhoids.

[21] The relevant portion of Doctor Swales' own notes on the chart for May 7 reads:

symbol [other issues] symbol [change] bowel habits X [times] 4 months
symbol 0 weight [no weight change]
BRBPR [bright red blood per rectum]
Discussions re options
P [plan] ? [question mark] barium enema

[22] Dr. Swales testified that this note records that Mrs. Newman had a change in her bowel habits of 4-months duration. She had not lost any weight. She had bright red blood from her rectum. The chart shows discussions of options.

[23] Dr. Swales testified that the main causes of bleeding from the bowel are hemorrhoids, inflammatory bowel disease, diverticulosis, cancer, polyps and salmonella. He said that 95 to 96% of the time the cause of the bleeding is benign. He said that he would investigate every case

[1] When I quote from medical records I will reproduce the actual writings, where possible, and in square brackets set out the interpretation of the symbols and short forms. There is no issue of the interpretation of the actual short form or symbol unless I discuss it.

unless the rectal bleeding was caused by an obvious thing like hemorrhoids. He would give the patient 3 options: 1) to do nothing 2) to have a barium enema and if positive to see a specialist and 3) to have a referral to a specialist.

[24] On cross-examination he was asked how he would have managed a case of rectal bleeding in 1993. He said he would have found out the nature of the bleeding, how much, how long, the colour, the symptoms, and the cause. He said that the initial step in the investigation is a barium enema, a general examination and blood work.

[25] Dr. Swales testified that in 1993 he ordered barium enemas. It took a couple of weeks to get one. In 1993 he also ordered colonoscopies. They could be done at the Peterborough Civic Hospital within a month or two on an outpatient basis. In 1993 it took 3 to 4 months to get an appointment with a general surgeon or a gastroenterologist. With a case of rectal bleeding he would have made the referral to either Dr. Lee or Dr. Byron. In cross-examination he said that in 1993 he had access to colonoscopy through specialists. He knew that gastroenterologists did colonoscopy in 1993, but he was not sure if surgeons did it then. He also said that he was not aware if a 60-cm. sigmoidoscopy was available in 1993 or if Dr. Lee and Dr. Byron were doing sigmoidoscopy in 1993.

[26] In looking at the chart entries for May 7, 1993, Dr. Swales testified he would have discussed 3 options with Mrs. Newman: 1) to do nothing 2) to have a barium enema and if negative and if further complications see a specialist, and 3) to see a specialist. He would have discussed the tests and the waiting times. He said that he had no idea what option Mrs. Newman selected but that the consultative decision was to do the barium enema. He said that was the plan as recorded on the chart.

[27] Dr. Swales testified that a barium enema is a good technique to extend the colon to see if there is narrowing, stricture, fistulas or ulcerated colitis. He said that in 1993 he believed that a barium enema was a reasonably accurate way of looking for polyps in the colon.

[28] Dr. Swales testified that he consulted a textbook Cecil's Essentials of Medicine on a day-to-day basis. In 1993 he used the 1986 edition of Cecil's, the one he had as a resident in 1989. He said that he used Harrison's Internal Medicine in 1993 but not on a day-to-day basis because it was impractical. He said he used Harrison's for rarer things. The edition that he used was the 1988 edition.

[29] As part of his evidence, Dr. Swales read from Cecil's under the heading of gastroenterology the following:

> For patients with chronic GI blood loss, the approach is usually more leisurely and the initial search for a responsible lesion is undertaken with barium studies followed, as indicated, by endoscopic evaluation and biopsy of lesions suspicious of malignancy. Angiography is occasionally employed, particularly to search for vascular lesions of the bowel.

[30] Dr. Swales also referred to the chapter of radiographic and endoscopic procedures in gastroenterology. It stated:

> Single- and double - (pneumocolon) contrast (or "air contrast") radiographs of the colon have long been the standard for identifying lesions in the colon. With the use of pneumocolon, radiographic detection of even subtle lesions such as polyps and early inflammatory bowel disease is excellent, although generally colonoscopy detects more lesions and allows a more thorough examination of the rectum.

[31] Dr. Swales also referred in his evidence to a chart in Cecil's. It shows that a double-contrast barium enema "shows polyps, tumors, fistulas, diverticula and other structural changes (e.g. inflammatory bowel disease) well". One of the disadvantages indicated is that the double-contrast barium enema may miss superficial mucosal lesions and rectal lesions. Colonoscopy is shown as having the advantage of "direct visualization of large bowel. Permits biopsy and polypectomy, electrocautery and laser treatment of bleeding." The disadvantages are that it is "expensive, invasive and [has a] higher rate of complication than barium enema."

[32] Dr. Swales did not do a physical examination of Mrs. Newman on May 7, 1993. He testified that he referred her for a complete physical examination, as part of his management of her symptoms. He thought that he would be doing the physical examination. He booked it sooner than it would normally have been booked.

[33] On his examination for discovery, in a sequence read in as part of the plaintiffs' case, Dr. Swales was asked if there was a particular article or text that he considered authoritative in terms of colon cancer or colorectal polyps or rectal bleeding. He answered; "Not a specific text on that topic alone, but the texts that I use generally day-to-day in the office are Cecil's Essentials of Medicine and Harrison's and sometimes the Merck Manual."[2] On cross-examination Dr. Swales said that he meant that he used Harrison's on a regular basis. He agreed that there was a 1991 edition of Harrison's that was available. He did not have the 1991 text in 1993. Plaintiffs' counsel did not cross-examine Dr. Swales on the passages that he read from Cecil's Essentials of Medicine.

[34] Plaintiffs' counsel put to Dr. Swales on cross-examination a number of excerpts from Harrison's that appeared in the 1991 text of Harrison's. Dr. Swales agreed with the passage that symptoms of changes in bowel habits, rectal bleeding and pain in the lower part of the abdomen are clues to the presence of colonic cancer. Dr. Swales agreed with the passage that any patient suspected of having a colonic carcinoma should undergo sigmoidoscopy, which is particularly useful in the diagnosis of low-lying rectal cancer, which can be missed on barium enema. He agreed with the passage that differential diagnosis of colon cancer includes almost all the entities which affect that organ because changes in bowel habit and bleeding are common symptoms. He agreed with the passage that in the evaluation of lower gastrointestinal bleeding the most

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[2] Question and Answer 32

important procedures were the digital examination, anoscopy, and sigmoidoscopy, but he said that today colonoscopy is the important procedure. He also agreed with the passage that sigmoidoscopy may identify a bleeding site or document bleeding coming from above the range of the instrument. Colonoscopy is a valuable technique for the evaluation of patients with small to moderate lower gastrointestinal bleed. He also agreed that barium enema has a limited role in the evaluation of acute rectal bleeding, although he said that it has a role. He agreed that although a barium enema may localize potential bleeding sources, it will not define the bleeding site.

[35] Dr. Swales also agreed that any symptoms or history of disease should be investigated. However he said that while symptoms are important it is academic once the doctor has decided to test.

[36] He agreed that colonic neoplasms may also present with bleeding and can be diagnosed usually with barium enema with sigmoidoscopy or colonoscopy. He agreed that fiberoptic colonoscopy is more accurate for the diagnosis of changes of inflammatory bowel disease, or for the detection of colonic neoplasm. However he said that he was not sure if it was available in 1993. He also said he was not sure if the flexible fiberoptic sigmoidoscope was available in 1993. I had some difficulty in understanding these responses. It may be that Dr. Swales misunderstood the passage. I clearly understood him to have said at least twice in his evidence that he ordered colonoscopy in 1993. Colonoscopy was available to Dr. Brankston in Oshawa, a centre not unlike Peterborough. While there may be some doubt that sigmoidoscopy was available in Peterborough in 1993, I find that colonoscopy was available to Dr. Swales.

[37] Dr. Swales also agreed that because approximately half of all colorectal neoplasms lie in the distal 50 cm. of the bowel, sigmoidoscopy is an important diagnostic tool. A rectal carcinoma can be missed on routine barium enema yet easily visualized and biopsied through the sigmoidoscope.

[38] Near the conclusion of his cross-examination on these passages Dr. Swales said that he could not say where he stood in May 1993 in respect to his state of knowledge. I did not take that as a comment in reference to a specific passage, but rather as a general comment. It is important to note that it is not Dr. Swales' knowledge now that is relevant. It is the standard of care in 1993 that is relevant.

[39] Counsel for the plaintiffs read in as part of his case a sequence from Dr. Swales' discovery. In summary, on discovery Dr. Swales said that he did not know what part of the pelvis Mrs. Newman's pain presented in. He did not know and did not record what type of pain it was. She did not tell him how long the pain had presented for. He did not know how much blood was in her stool. He did not know if the blood was mixed in the stool or not. He did not write down and therefore could not recall if she had described the blood as being on the toilet paper or in the bowl. He did not know if she said the bleeding caused pain or if the pelvic pain

was from another source since he had what he had written down and that was all. He could not say if she described pencil thin or large amount on movement.[3]

[40] On cross-examination Dr. Swales was asked if he had needed to know how Mrs. Newman's bowel habits had changed. He said that he did, but he did not record it because once he had decided to investigate it, it was academic.

[41] He agreed on cross-examination that it was important to note the duration of Mrs. Newman's symptoms. He said that he did record the duration of the change in bowel habits but not of the pain or of the bleeding. He admitted that he should chart significant negative findings and diagnosis.

[42] On cross-examination Dr. Swales said that he could not say if in May 1993 he asked Mrs. Newman if there was a family history of cancer. He said it would have been his practice to ask at the physical examination and chart it. It was his practice to chart family history, but he might not have charted a negative. He said if he did not ask Mrs. Newman it would have been a deviation from his practice but with the caveat that she was coming back for a physical examination.

[43] If any of these inquiries had been made I would have expected that Dr. Swales would have charted the answers. I have come to this conclusion based on the evidence of his note taking habits. He wrote as the patient spoke. Therefore to the extent that the answers were not charted I conclude that the inquiries were not made.

[44] On his examination for discovery, in a sequence read in as part of the plaintiffs' case, Dr. Swales was asked what was the most concerning potential cause of Mrs. Newman's rectal bleeding based on her symptomatology presented on May 7, 1993. He answered: "Bowel CA [cancer]. Not the most likely, but the most concerning." He was asked what efforts he made to rule it in or rule it out. He answered: "I sent her for an investigation of her bowel, a barium enema."[4]

[45] On cross-examination Dr. Swales stated that he knew on May 7 that a diagnosis of hemorrhoids was not sufficient. He agreed he did not chart a diagnosis on May 7. He said that the least likely and most concerning diagnosis was bowel cancer. The most likely cause was hemorrhoids. Polyps were more likely than cancer and untreated could lead to cancer.

[46] On cross-examination Dr. Swales was asked if on May 7, 1993 he considered sending Mrs. Newman to a gastroenterologist. He said again that it would have been 1 of the 3 options raised and if raised he and Mrs. Newman would have discussed it. It was put to him that at his discovery he was asked if he had considered sending Mrs. Newman to a general surgeon or a gastroenterologist on May 7, 1993 to further investigate her pelvic pain and blood in stool and he had then said no. At trial he said that the answer that he gave on discovery was not incorrect.

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[3] Questions and Answers 86 to 91 and 96 to 97 and 99 and 107
[4] Questions and Answers 125 and 126

[47] I conclude from this that in Dr. Swales' judgment on May 7, 1993 the most concerning potential diagnosis of Mrs. Newman's symptoms was bowel cancer. In his judgment a barium enema was a reasonably accurate investigative tool to meet his concerns. A physical examination and blood tests were called for but they could be deferred.

[48] The appropriateness of Dr. Swales' response to the symptoms Mrs. Newman told him about on May 7, 1993 is at the heart of this case. The competing expert evidence on that issue will be discussed below.

Terms Defined

[49] This is a convenient point to define the three investigative techniques that were discussed throughout this case. Each of the doctors who testified referred to them in their evidence. These explanations are what I gathered from their combined evidence and there is no controversy about what these techniques are.

[50] An air contrast barium enema is a two-part procedure. A tube is inserted by the radiologist into the rectum and through it he fills the colon with barium. The tube is removed. The patient evacuates. The purpose is to coat the colon with barium. The tube is re-inserted. The cuff is inflated so that air is introduced into the colon. The air contrasts sharply with the barium. An x-ray is done. There is no direct visualization, but a picture is produced.

[51] Colonoscopy was introduced in the early 1970s. A colonoscopy is an examination of the inside of the colon by means of a long, flexible, fiberoptic-viewing instrument with a light at the end. The scope is passed through the anus into the colon up to the cecum, which is the first part of the large intestine. The doctor can see the colon directly through a viewing lens.

[52] A sigmoidoscopy is like a colonoscopy except that the scope or viewing instrument is smaller. The doctor can view the sigmoid, or lower, colon directly. The sigmoidoscope makes it possible to view 40 to 60 cm. of the colon.

[53] The terms diverticulosis and diverticulitis were used in this case. Diverticula are small sacs or pouches that protrude externally from the wall of the intestine, including the colon. Diverticulosis is the presence of diverticula in the intestine, including the colon. Diverticulitis is inflammation of the diverticula in the intestine, particularly in the colon. Diverticulitis is a complication of diverticulosis.

The Air Contrast Barium Enema

[54] The air contrast barium enema was carried out on May 31, 1993. The results read:

> Air Contrast Barium Enema - The colon distended well in all segments. Multiple diverticula were seen throughout the colon. No other constant filing defects were evident. Reflux into a

normal appearing terminal ileum and appendix was obtained. Opinion Diverticulosis of the colon. Dr. D. Swales[5], Radiologist.

[55] The efficacy of an air contrast barium enema for investigating the cause of Mrs. Newman's symptoms is at the heart of this case. The competing expert evidence on that issue will be discussed below.

The June 17, 1993 Visit

[56] Dr. Swales' chart shows that Mrs. Newman was in the office on June 17, 1993 for a physical examination. Dr. Swales testified that he was on holidays at the time and a locum, Dr. Mayer, filled in for him.

[57] Counsel agreed to the following: 1) there is no issue of vicarious liability or responsibility of Dr. Swales for the conduct of Dr. Mayer; 2) the June 17, 1993 chart entries form part of Dr. Swales' office chart and the chart was available to him; and 3) Dr. Swales will not allege that if Dr. Mayer had made him aware of the June 17, 1993 chart entries that he would have changed his management of Mrs. Newman.

[58] Dr. Swales testified that Dr. Mayer would probably have had the results of the barium enema when he saw Mrs. Newman, based on the date of transcription and the fact that results were usually mailed to his office. In light of that and the chart entry for June 17, I accept that Dr. Mayer had the results.

[59] Dr. Mayer's notes on the chart first record "CPX [complete physical examination] See Sheet". Attached to the chart is a green two-sided form entitled "The Peterborough Clinic Physical Exam". Also attached to the chart is a yellow two-sided form entitled "The Peterborough Clinic Functional Inquiry". A functional inquiry is questioning of the patient by the doctor. Dr. Swales testified that these forms are used in his office in conjunction with a patient's annual physical examination. On the forms in a column that is dated, findings are recorded to the right of the various items under the headings. On the physical examination form, one of the columns is dated June 17, 1993. In that column beside the heading "Rectal" next to the items of "Anus", "Hemorrhoids", "Prostate" "Masses" and "Blood" is recorded "N [normal]". On the functional inquiry form, one of the columns is dated June 17, 1993. In that column beside the heading "G.I." next to each of the items "Pain or Dyspepsia" and "Hematemesis" is written a zero with a line through it [none]. Next to the item "Rectal Bleeding" is written "occ'l [occasional]". Next to "Bowel Function" is written " > 1 BM/day [more than one bowel movement per day]". Next to "Change?" is written a zero with a line through it [no change].

[60] In the day-to-day section of the chart for June 17, 1993 it is recorded that Dr. Mayer discussed a number of Mrs. Newman's concerns. The chart records: "smoke 15 cigs/day [she smokes 15 cigarettes a day]". The chart ends:

P [Plan] follow for enlarge node (? reactive) L tonsillar

[5] The radiologist is Dr. Swales' father, which is noted here to avoid any confusion about the name.

bone densitometry[6]
discussed osteoporosis & diverticulitis-diet etc & HRT [hormone replacement therapy]
going away → defer start (unable to
monitor)

[61] The meaning of the word "occ'l [occasional]" next to "G.I. Rectal Bleeding" on Dr. Mayer's functional inquiry is an issue. Another issue is the significance of the notation "more than one bowel movement a day - no change" next to "G.I. Bowel Function - Change?" It is the position of the defence that since Dr. Mayer did not transcribe the symptoms of rectal bleeding or the particulars of the bowel function in the day-to-day notes of June 17 it must mean that the "occasional" bleeding and the bowel function responses were not significant. In the context of doing a functional inquiry, Dr. Swales testified that "occasional bleeding" would not mean much to him. He said he would ask questions about it and move to the problem or day-to-day sheet. I will defer these issues.

[62] The significance of Dr. Mayer's notation "diverticulitis -diet" is also important.

[63] As part of his investigation, Dr. Mayer ordered laboratory tests to be done. Dr. MacKenzie testified that the lab work was not for a targeted purpose. The test results were normal and showed that Mrs. Newman did not have an elevated white blood count. The lab tests took place June 17 and the results were compiled on June 18. Obviously, the results were not available to Dr. Mayer on June 17.

[64] Dr. Swales testified that he did not speak to Dr. Mayer about Mrs. Newman. He also said that he had no recollection of reviewing the physical or functional examination results from June 17. If he ever did, he did not chart it.

The July 8, 1993 Visit

[65] Mrs. Newman had her next appointment on July 8, 1993 with Dr. Swales. It is likely that on this visit Dr. Swales reviewed Dr. Mayer's notes from June 17 in the day-to-day section of the records, based on his practice of looking at the notes from the previous visit in the day-to-day section when a patient comes in again. It would not have been his practice to ask a patient about a previous medical attendance.

[66] The nurse's notes from July 8, 1993 show that Mrs. Newman had returned for a "re-check" and had questions about the use of estrogen. Dr. Swales wrote on the chart "symbol fam. hx. breast CA, symbol hx. uterine CA [no family history of breast cancer - no history uterine cancer]". Dr. Swales testified that this meeting centred on hormone replacement therapy. He said that he would have ended the visit by asking Mrs. Newman if there were any other problems.

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[6] The node, bone test and osteoporosis are not relevant.

[67] Dr. Swales said that he believed that he did not speak to Mrs. Newman again about her symptoms until October 6, 1994. If he did, he did not chart it. He agreed on cross-examination that on July 8, 1993 he did not ask Mrs. Newman about rectal bleeding.

[68] Dr. Swales testified that he could not say if he reviewed the barium enema results. He testified that he might not have. He testified that he assumed that Dr. Mayer dealt with the test results and he relied on him to discuss them with Mrs. Newman. Dr. Swales' initials do not appear on the test results. It was put to Dr. Swales on cross-examination that on his discovery when he was asked if he considered sending Mrs. Newman to a surgeon or gastroenterologist after receiving the barium enema results he said no. His response at trial was that he was not sure that he considered the barium enema tests. It seems unlikely that Dr. Swales reviewed the barium enema results on July 8, 1993. If he did, he did not chart it and he did not chart any discussion with Mrs. Newman about it.

[69] Dr. Swales testified that if he had seen the reference to "occasional bleeding" on the functional inquiry form from July 8, it would not have changed his management of Mrs. Newman. He also said that the symptoms of occasional rectal bleeding and more than one bowel movement a day were consistent with diverticulitis but a mild case only.

[70] Dr. Swales testified that on July 8, 1993 he was no longer concerned about the potential that Mrs. Newman had bowel cancer. Dr. Swales did not chart this conclusion. Dr. Swales was asked why he was no longer concerned about this potential. He said it was because he had investigated it and Dr. Mayer had discussed it with Mrs. Newman and come to a conclusion and no further symptoms were reported. It is implicit in this answer that Dr. Swales accepted diverticulitis as an explanation for Mrs. Newman's symptoms of May 7.

The August 28, 1993 Visit With Dr. Dublon

[71] The defence puts great reliance on Mrs. Newman's failure to complain to other health care professionals who treated her over the period after May 7, 1993 to the end of 1995.

[72] Periodically Mrs. Newman consulted Dr. Dublon a family physician in England. There is an entry on Dr. Dublon's chart dated August 28, 1993 that was referred to. However, the chart entry has a notation added to it: "92/93?" There was no evidence to clarify the date of this visit. If it was in 1992 it is not relevant. Since the date is uncertain, I have concluded that I should not consider the visit.

October 13, 1993 to October 3, 1994 Visits

[73] Mrs. Newman next saw Dr. Swales on October 13, 1993. The chart entry shows that she would be away until May. She saw Dr. Swales next on May 20, 1994. She had another visit on June 30, 1994. The chart shows that she received an antibiotic from a doctor in England. She had appointments with Dr. Swales on July 7, 21, and 26, 1994. On October 3, 1994 she had a "flu" shot. There is no evidence that Mrs. Newman complained to Dr. Swales about her bowel symptoms between October 13, 1993 and October 3, 1994. If she did, he did not chart her complaints.

July 19, 1994 Hospital Attendance

[74] On July 19, 1994, Mrs. Newman attended at the hospital emergency room for treatment for bronchitis. It appears that Mrs. Newman did not complain of any symptoms of bowel dysfunction at the time.

The October 6, 1994 Visit

[75] On October 6, 1994 Mrs. Newman met with Dr. Swales. The nurse's note on the chart reads:

S [subjective] concerns re diverticulosis

[76] Dr. Swales' recordings for October 6th read:

mother recent colon surgery b/o [because of] diverticular disease - had barium enema - showed diverticula - wonders about implications.
P [plan] discussion re diverticula + + Reassurance - sx. [symptoms] of concern to watch for.

[77] In his evidence, Dr. Swales gave his interpretation of the chart entry from October 6. Mrs. Newman's mother recently had surgery for a bowel problem, diverticular disease. Mrs. Newman had a barium enema. She wondered what it meant. She was not complaining. He told her what to watch out for.

[78] Dr. Swales testified that he might have reviewed the barium enema results on October 6, 1994. That appears likely given the focus of the discussion that day, but Dr. Swales did not chart that he reviewed the results.

[79] An issue arose whether Dr. Swales wrote "symptoms of cancer" or "symptoms of concern" in his notes. The issue arose because at trial Dr. Swales volunteered that, although he had said at his discovery that the word he wrote was "cancer", he may have written "concern". He was unsure. I find that he wrote "concern" for these reasons. Dr. Swales appears to use short forms whenever possible. On the July 8 chart when he referred to cancer, he twice wrote it as "CA". In a sequence from his discovery, which plaintiffs' counsel read in as part of his case, Dr. Swales used the expression "CA" to describe cancer.[7] Comparing the writing with other examples of his handwriting it looks to me as though the word he wrote is "concern".

[80] There are two questions that arise out of this visit. The first is whether Mrs. Newman told Dr. Swales that her mother had bowel cancer. It appears on the evidence of Karen Bales, which I accept, that in August or October 1994 Mrs. Newman was under the impression that her mother had bowel surgery for diverticular disease and cancer. Dr. Swales did not chart that Mrs. Newman said that her mother had bowel cancer. Dr. Swales testified that he was not told that until after November 1996. I accept his evidence. It seems likely to me that if she had told him he would have charted it in the same way that he charted "diverticular disease".

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[7] Question and Answer 125

[81] The second question is did Mrs. Newman complain to Dr. Swales of rectal bleeding, abdominal pain or unusual bowel habits on October 6, 1994. This is a perplexing question. On the one hand, Karen Bales testified that in August or September 1994 at the time of her grandmother's surgery she told Mrs. Newman to get checked-out because of her complaints. It seems likely that Mrs. Newman took her advice given the time frame of the visit with Dr. Swales and the focus of the discussion. On the other hand, Dr. Swales did not record any complaints. He testified that since there is no reference to treatment it meant that Mrs. Newman was asymptomatic because if they had discussed symptoms and she had symptoms he would have treated them.

[82] The chart also shows that Dr. Swales gave her a great deal of reassurance. That implies that Mrs. Newman had a fairly high level of anxiety. It leads me to believe that there may have been a discussion about some symptoms she was having. There was a discussion of symptoms of concern to watch out for. It may have been that the symptoms she was describing were not the symptoms that Dr. Swales considered to be symptoms of concern, and on that account Dr. Swales reassured her. Unfortunately, there is no notation about what the symptoms were that Dr. Swales told her to watch out for. It seems obvious that a physician would not reassure a patient without some basis for doing so. So, either Mrs. Newman reported that she had no symptoms, or Dr. Swales did not consider the symptoms that she was complaining of to be symptoms of concern. Dr. Swales testified that he might have discussed diverticulitis with Mrs. Newman on this date. It seems obvious that must have been the discussion. If he did not know that the mother had cancer and they were discussing symptoms of concern in the context of the mother's operation for diverticular disease and Mrs. Newman had diverticula it seems likely the symptoms of concern related to complications from that condition. The point is that I cannot conclude from this chart entry whether Mrs. Newman complained or did not complain of symptoms at the time. I can conclude that Mrs. Newman's inquiries about her diverticula on October 5 did not cause Dr. Swales to change his judgment that he was no longer concerned about the potential that Mrs. Newman had bowel cancer.

The June 24 - 25, 1995 Campbellford Hospital Attendance

[83] On June 24, 1995 Mrs. Newman was involved in a motor vehicle accident which left her with an unusual and debilitating arm condition known as severe reflex sympathetic dystrophy with a full-blown shoulder-hand syndrome. She initially went to the Campbellford Hospital emergency room for treatment and was admitted for two days. A nursing assessment and history was done. Under the "G.I." heading next to "bleeding" the line is left blank although other lines are filled in with "nil" signs. At the bottom of the column next to "Other" is written: "Patient has diverticulitis so has frequent stool."

June 26, 1995 to May 27, 1996

[84] Mrs. Newman then saw Dr. Swales a total of 15 times from June 26, 1995 to October 13, 1995 about her arm injury. She did not see him again until May 27, 1996. None of these visits is relevant to the issues in this proceeding, but the fact that there were visits is relevant. The defence relies on Mrs. Newman's failure to mention any bowel symptoms to Dr. Swales during

these visits. If she did, he did not chart her complaints. The defence also relies on her failure to mention symptoms to the other health care professionals that she saw around this time as showing that she was not having symptoms.

August 24, 1995 to September 8, 1995 - Visits With Other Health Care Professionals

[85] On August 24, 1995 in a report about orthopedic problems, Dr. Blastorah wrote of Mrs. Newman: "general health otherwise reasonably good". On September 1, 1995 in a report about difficulties with her arm, Dr. Martin, a plastic surgeon, wrote of Mrs. Newman: "general health is good no chronic medical problems and no previous psychiatric problems". On September 8, 1995 in a report from a pain clinic again in reference to her arm injury, Dr. Campbell wrote of Mrs. Newman: "otherwise her health is reasonable."

The August 26, 1996 Visit

[86] On August 26, 1996 Mrs. Newman had an appointment with Dr. Swales for a complete physical examination.

[87] On the functional inquiry sheet under the heading "G.I." it is noted that she made negative responses to "Rectal Bleeding" and "Bowel Function - Change?" As part of the examination, Dr. Swales ordered occult blood tests. The purpose of these tests is to detect microscopic blood in the feces. The results were negative. This was done in the ordinary course. The position of the defence is that it would have been unnecessary to look for occult blood in the feces if she had reported symptoms of rectal bleeding. This makes sense to me.

[88] Mrs. Newman saw Dr. Swales on September 26 and October 7, 1996. There were no complaints of bowel symptoms charted.

[89] The chart shows that on October 10, 1996 Mrs. Newman telephoned Dr. Swales' office to have a prescription order sent to a drug store. The prescription is not relevant. The nurse wrote: "Pt [patient] was asked to make an appt.[appointment]/ She refused saying didn't have time. They were leaving to go away. She was having trouble with her divertic pt. [patient] said." The meaning of the note is fairly obvious.

[90] Dr. Swales testified that there was no record of any trouble with diverticulitis up to this point in the chart. He said that every one of his visits with Mrs. Newman would have ended with the question whether there was anything else she wanted to discuss. He said that if she had mentioned symptoms to him there would have been more discussion and he would have decided on what treatment was called for.

Later Events

[91] On November 1, 1996 while in Ocala, Florida Mrs. Newman went to see Dr. McLaughlin, a family doctor. His chart reads in part as follows:

Abd/ pain [abdominal pain]

Past 2 weeks has had stool symbol [with] blood
& mucus symbol [with] 17 bm [bowel movements] day
has lost 17 lbs. in past *illegible*

[92] Dr. McLaughlin referred Mrs. Newman to Dr. Maxwell. The defence admits that on November 4, 1996 Mrs. Newman was admitted to hospital in Ocala, Florida under the care of Dr. R. Maxwell, a gastroenterologist. She attended upon Dr. Maxwell with complaints of rectal bleeding and abdominal pain. On November 6, 1996 she was transferred by air ambulance from Florida to Peterborough Civic Hospital under the care of Dr. Jaime Scott. On November 6, 1996 she underwent a laporotomy and rectosigmoid resection with Hartmann's type procedure. As a result of the colorectal cancer she received medical care from oncologist Dr. Wierzbicki.

[93] In her report of November 7, 1996 Dr. Scott writes:

> She is otherwise quite healthy apart from being a smoker and had only recently had physical examination done by her family physician just prior to going to Florida which had proved negative. On rectal examination, she had an obvious palpable mass that was approximately 8 cm. up and large, circumferential...

[94] Mrs. Newman's cancer was recognized as incurable, shortly after the surgery. She went to Princess Margaret Hospital for treatment. By then it was known that she had liver metastases and possibly lung metastases. Dr. Hodgson prepared an admission summary dated January 10, 1997 which details history, as related by Mrs. Newman. The following portion of the summary was admitted over the objections of the defence:

> This patient was in Florida in October when she began experiencing intermittent abdominal pain and the passage of bloody stools. Because she had a prior history of diverticulitis, she waited for approximately two weeks before seeking medical attention. However, when the bloody stools continued she was seen by a physician in Florida.

[95] The admission summary prepared by Dr. Hodgson also contained the following: "Past Medical History - This patient has had intermittent diverticulitis." Defence counsel did not object to admission of this portion of the report.

[96] Mrs. Newman moved back to England. Dr. M. Seymour, oncologist, compiled her patient history at the Cookridge Hospital Yorkshire Regional Centre for Cancer Treatment. Dr. Seymour repeated the same history in a letter dated March 20, 1997 to Dr. Putnam, another of Mrs. Newman's physicians in England. The following portion of the patient history was admitted over the objection of defence counsel:

> She [Mrs. Newman] gives a history of intermittent abdominal pain and "red bean" stools for at least 3 years, attributed to diverticulosis. The intermittent pain became more severe and

> frequent during the Autumn, and she then presented with frank rectal bleeding and was investigated.

[97] As I said, when I ruled that the statements contained in the January 10, 1997 admission history and the March 20, 1997 patient history were admissible I was dealing with the threshold issue of admissibility, and not the issue of what weight I would attach to the statements. I now find that the statements are entitled to considerable weight. They were made to physicians in a clinical setting. They were made when Mrs. Newman knew that her condition was grave. She would have been placing all of her hope in these doctors to either save or prolong her life. She would have known that complete candor was necessary. I believe the statements are highly reliable. There is also some corroboration of the statements in proven facts. There is no dispute that Mrs. Newman complained of abdominal pain and bloody stools in May 1993, that Dr. Mayer wrote "diverticulitis" in her chart on July 8 and that Mrs. Newman told the nurses at the Campbellford Hospital in 1995 that she had diverticulitis and so had frequent stool. There is no dispute that she called Dr. Swales' office in October 1996 and said she was having trouble with her "divertic". I also find some corroboration in other evidence that I accept. Mrs. Newman's bowel was almost totally obstructed when she went to Dr. McLaughlin for help. Obviously, she had delayed. I accept that in September 1993 she told Claire Griffiths in the Canary Islands that she had blood in her stools. I accept the evidence of family members that she complained of bloody stools and abdominal pain at times over 1993, 1994, 1995 and into 1996. I also accept that Mrs. Newman adhered to a special diet because she thought that she had diverticulitis.

[98] These statements taken with all of the other evidence persuade me that Mrs. Newman had intermittent abdominal pain and bloody stools for a period of 3 years from September 1993 through to November 1996. In coming to this conclusion I have considered all of the evidence about her visits with Dr. Swales, and her visit with Dr. Mayer. I have also considered the evidence of her consultations with other health care professionals.

Post-Diagnosis Discussions

[99] Mrs. Newman had an office visit with Dr. Swales after her diagnosis with cancer on December 12, 1996. There was no evidence that the visit is relevant to the issues in this proceeding.

[100] Mrs. Newman allegedly wrote 2 letters to Dr. Swales after she was diagnosed with bowel cancer. I ruled those letters to be inadmissible. I have not considered that letters may have been written or the contents of the alleged letters in arriving at my judgment.

Karen Bales

[101] Mrs. Newman's daughter, Karen Bales, testified. Ms. Bales lives in England. She said that she saw her mother about 2 or 3 times a year after Mrs. Newman moved to Canada. The visits were of 1 to 4 weeks in length. Ms. Bales said that her mother told her at the beginning of 1993 that she had blood in her stools. Mrs. Newman told her this a couple of times before December 1994 and a couple of times after, in all a total of 3 or 4 times. Ms. Bales also testified that after 1993 her mother complained to her of abdominal pains.

[102] Although these statements are hearsay, I admitted them into evidence for proof of the contents. I will not repeat my reasons for doing so. Claire Griffiths, Carl Griffiths and Helen Newman each testified about statements made by Mrs. Newman. My ruling extended to the evidence of those statements.

[103] Ms. Bales testified that she noticed that after 1993 Mrs. Newman spent a lot of time in the bathroom. Ms. Bales saw blood in her mother's stools on two occasions, once in the spring of 1996 and once at the end of October 1996. She described the blood that she saw as looking like small red jelly beans.

[104] Ms. Bales testified that in August or September 1994 Mrs. Newman was in England and spoke to her own mother's[8] surgeon. Mrs. Newman told Ms. Bales that Mrs. Newman Sr. had been operated on for bowel cancer and diverticulitis. The latter statement is double hearsay. It was admitted into evidence not for the truth of the contents, but for the fact that it was made by Mrs. Newman and might tend to prove Mrs. Newman's state of mind about Mrs. Newman Sr.'s condition. Karen Bales also testified that she then told her mother to get herself checked-out about her symptoms.

[105] Mrs. Newman Sr. died on December 4, 1994 and the cause of death was rectal cancer.

Claire Griffiths

[106] Claire Griffiths is married to Mrs. Newman's son Carl and lives in England. She testified that before September 1993 Mrs. Newman's health was fine. In September 1993 she accompanied Mrs. Newman on a trip to the Canary Islands. She said that Mrs. Newman spent most mornings in the bathroom. Mrs. Newman told her that she had stomach cramps from diverticulitis and was passing blood in her stool. From 1993 to 1996 Mrs. Griffiths saw Mrs. Newman about 2 or 3 times a year, but in 1995 she did not see her very much. Mrs. Newman told her on every occasion that she was passing blood in her stool. Mrs. Griffiths had to prepare special meals for Mrs. Newman such as fish or chicken. Mrs. Newman did not eat red meat or seeds. Mrs. Griffiths also testified that Mrs. Newman was frightened of cancer. She would not say the word "cancer" because she was so frightened of it. Instead she would call it the "C" word.

Carl Griffiths

[107] Carl Griffiths, Mrs. Newman's son, testified. He said that Mrs. Newman was in England a couple of times a year after she married. He said that her diet changed in 1992 due to diverticulitis. From December 1994 to November 1996 he saw her 2 or 3 times a year. During those visits, she had to have her own meals because of diverticulitis. She was in the bathroom most days until noon.

Helen Newman

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[8] By coincidence, Theresa Newman's mother's surname was also Newman. I will refer to Theresa Newman's mother as Mrs. Newman Sr.

[108] Helen Newman, the daughter-in-law of Alfred Newman, testified. She said that she would see Mrs. Newman 4 or 5 times a year until Mrs. Newman was diagnosed with cancer. She said that for about 2 or 3 years before November 1996 on about 5 or more occasions Mrs. Newman told her that she had red jelly beans in her stools which was diverticulitis. Helen Newman noticed that Mrs. Newman would go into the bathroom in the morning and spend a lot of time there and could not leave the house before noon. She also noticed that Mrs. Newman was very careful about her diet.

Recollection and Reliability

[109] I think it is fair to say that the sincerity of the people who testified in this case was generally not challenged. It was my impression that they each gave their evidence in a sincere manner. Generally, I accepted the facts as they were related to me. However, each of the witnesses was hampered to some extent in the ability to recall by the length of time that has passed since the events in question. Where the reliability of recollection was an issue I assessed the evidence on the basis of its consistency with known facts, with corroborative documents, with evidence which I did accept and with what was reasonable and probable.

[110] Dr. Swales was hampered because he did not have an independent recollection of his meetings with Mrs. Newman. When he testified about events he was either reconstructing a visit based on his chart or he was speaking about what he would have done based on the habits that he has established. Generally I accepted Dr. Swales' evidence where it was corroborated by a chart entry or based on what his habits dictated. However, Dr. Swales' chart notes were so abbreviated and cursory that I was unable to conclude that just because something was not charted it did not happen. I also know that it takes time to establish our habits and even then we do not always conduct ourselves according to our habits. I kept that in mind as I considered Dr. Swales' testimony.

[111] The evidence of Mrs. Newman's family was not challenged to any great degree. If and when Mrs. Newman suffered symptoms is very important in this case. It seemed to me that much of what they testified about would be difficult to forget but hard to put a precise date on. I generally accepted as reliable their evidence about what they heard from Mrs. Newman, or observed about her state of health. There was a consistency in their evidence that did not seem contrived. The type of symptoms was generally consistent with what Mrs. Newman complained to Dr. Swales about in May 1993 and to Dr. McLaughlin in November 1996. The evidence about when she complained was more problematic. They were aided somewhat in their testimony about dates because of the infrequency of their visits with Mrs. Newman. That added to reliability. A few visits a year would be more memorable than weekly or monthly visits. However, I found Carl Griffiths' evidence generally unreliable on dates. He admitted he had trouble with dates. He even had difficulty remembering important family dates. But Karen Bales and Claire Griffiths were able to recall relevant events in relation to other memorable times. I found their evidence reliable. For example, Claire Griffiths was able to testify about what happened in September 1993 by reference to the Canary Island trip. Karen Bales was able to speak of what happened in August or September 1994 and December 1994 by reference to her grandmother's illness. I generally accepted their evidence.

Primary Findings of Fact

[112] For these reasons I find, on the primary facts in dispute between the parties, that:

(i) Mrs. Newman presented in Dr. Swales' office on May 7, 1993 with symptoms of pelvic pain, altered bowel habits of 4-months duration and rectal bleeding. This was the second time that she had sought medical attention for her rectal bleeding.

(ii) In Dr. Swales' clinical judgment on May 7, 1993 bowel cancer was the most concerning potential cause of Mrs. Newman's symptoms and investigation was required. In his judgment a barium enema was an adequate procedure to investigate her symptoms along with a general examination and blood work.

(iii) On May 7, 1993, Dr. Swales did not question Mrs. Newman about the nature, location, duration or cause of her pelvic pain, about the duration or amount of blood or how it presented in relation to her stool, about the amount or nature of her stool, or about her family history for cancer. He did not physically examine her. He did not order targeted blood tests.

(iv) On May 7, 1993 colonoscopy was available to Dr. Swales through specialists in Peterborough.

(v) The barium enema results showed that Mrs. Newman had multiple diverticula in her colon but the results were otherwise normal.

(vi) Dr. Mayer had the results of the barium enema when he saw Mrs. Newman on June 17, 1993. Dr. Mayer noted on the functional inquiry form that Mrs. Newman had occasional rectal bleeding, more than one bowel movement a day and no change in bowel habit. His physical examination did not disclose rectal blood. Dr. Mayer discussed "diverticulitis - diet" with Mrs. Newman.

(vii) The laboratory tests that Dr. Mayer ordered on June 17, 1993 were not for a targeted purpose. They showed that Mrs. Newman had a normal white blood cell count.

(viii) On July 8, 1993 Dr. Swales was no longer concerned about the potential that Mrs. Newman had bowel cancer. To the extent that he exercised clinical judgment in coming to that conclusion it seems likely he could only have exercised it based on Dr. Mayer's chart entry of June 17 and Mrs. Newman's failure to mention bowel symptoms on July 8.

(ix) In August or September 1994 Mrs. Newman became aware that her mother had surgery for diverticulitis and bowel cancer. About the same time, her daughter Karen Bales told her to get herself checked out about her bowel complaints.

(x) Mrs. Newman saw Dr. Swales on October 6, 1994. She told him that her mother had bowel surgery for diverticular disease. They discussed her concerns about the barium enema results that showed she had diverticula. He reassured her and told her the symptoms of concern to watch out for. Whether Mrs. Newman complained of symptoms of bowel dysfunction on that date is unknown.

(xi) In 15 visits from June 26, 1995 to May 27, 1996 and in visits on September 26, 1996 and October 7, 1996 Dr. Swales did not chart any reports by Mrs. Newman of symptoms of bowel dysfunction. Whether Mrs. Newman did complain about bowel problems on any of these visits is unknown.

(xii) On August 26, 1996 Mrs. Newman did not report rectal bleeding to Dr. Swales. Fecal blood tests did not show the presence of blood in her stools. Her white blood cell count was normal.

(xiii) On October 10, 1996 Mrs. Newman called Dr. Swales' office and mentioned problems with her "divertic", meaning problems with her diverticula.

(xiv) Mrs. Newman had intermittent abdominal pain, intermittent bloody stools and often spent an inordinate amount of time in the morning in the bathroom for a period of 3 years from September 1993 through to November 1996. At times she told her family that she attributed her symptoms to diverticulitis.

(xv) In November 1996 Mrs. Newman was diagnosed with the bowel cancer from which she eventually died.

Standard of Care: Expert Evidence

[113] On the standard of care the plaintiffs called Dr. Edwin Brankston, a general practitioner from Oshawa, Ontario. The plaintiffs also called Dr. Scott Geddes, a general surgeon, from Cambridge, Ontario. Dr. Geddes testified principally on the issue of causation. On the standard of care the defence called Dr. Richard MacKenzie, a general practitioner, from North York, Ontario.

[114] This is a convenient point to note that Lakefield is located a short distance from the City of Peterborough. There was no issue that in the geographical circumstances of this case the standard of care that can be expected of a general medical practitioner in Lakefield is not markedly different from that of a general medical practitioner in the City of Oshawa, or the City of North York.

Dr. Brankston for the Plaintiffs

[115] Dr. Edwin Brankston, the plaintiffs' first expert on the standard of care has had a general and family practice in the City of Oshawa since 1977. He is a certified member of the College of Physicians & Surgeons of Ontario and the Canadian Medical Protective Association. He graduated in medicine from Queen's University, Kingston in 1977. He interned at Scarborough

General Hospital. From 1977 to the present he has been on active staff, Department of Family Practice, Oshawa General Hospital. From 1995 to 1999 he held a part-time palliative care appointment at the Oshawa General Hospital. He has served on a number of external and internal committees of the Oshawa General Hospital. He has also held a number of administrative positions at the hospital. In 1980 he was medical director of the Emergency Department. He is currently Medical Director, Hospitalist Program. His teaching activities include clinical supervisor or preceptor for clinical clerks and family practice residents from 1978 to the present time. He has been engaged in a number of clinical research studies. He has provided opinions for the College of Physicians and Surgeons of Ontario involving assessments of standards of physician care. He has also provided opinions to counsel in civil litigation cases involving allegations of medical malpractice. Because of his extensive experience as a family doctor his evidence is admissible and entitled to significant weight.

[116] Dr. Brankston's evidence was directed to the standard of care for treatment of a general practitioner in a small Ontario community who in May 1993 was responding to a patient's complaints in the circumstances of this case.

[117] Dr. Brankston testified that in 1993 he practiced family medicine in Oshawa. He had approximately 2000 patients. He said he sees patients complaining of rectal bleeding and change in bowel habits weekly or biweekly.

[118] It was Dr. Brankston's opinion that on May 7, 1993 Dr. Swales fell below the standard of care reasonably expected of a family doctor in the Peterborough area by responding to Mrs. Newman's pelvic pain, frank blood and change in stools by ordering an air contrast barium enema and relying on it. He also said that if Dr. Swale's response was to rely on the enema for her rectal bleeding he fell below the expected standard. It was his opinion that Dr. Swales should have sent Mrs. Newman to a general surgeon or gastroenterologist for a sigmoidoscopy or a colonoscopy.

[119] Dr. Brankston testified that a reasonably prudent family physician in 1993 when presented with abdominal pain, rectal bleeding and altered bowel habit in a female patient over 50, should have responded by taking a complete history with special attention to functional inquiry about the complaints. There should have been a complete physical abdominal, pelvic and rectal examination, a general battery of laboratory investigation, and a pelvic ultrasound. A reference should have been made to a gastroenterologist or general surgeon to conduct a sigmoidoscopy or a colonoscopy. This was because those specialists are most adept at those procedures.

[120] Dr. Brankston said that with someone Mrs. Newman's age with these complaints the physician must rule out the most serious explanation for the symptoms, which is colon cancer. He said that colon cancer commonly presents with rectal bleeding. He noted that all colon cancers develop from the degeneration of a benign polyp in the sigmoid colon to a malignant growth. He said that this was expected and common knowledge of a general practitioner in 1993.

[121] Dr. Brankston was of the opinion that an air contrast barium enema cannot be relied on to exclude polyps and small lesions in the colon. The test is not sensitive enough to detect polyps of the size in which they usually occur. It can easily miss small tumorous masses. Therefore it cannot be relied on, on its own, to rule out all causes of rectal bleeding.

[122] He also testified that it is common in people over the age of 50 to suffer from diverticular disease. Diverticular disease can obscure the finding of polyps and lesions. If there is recurrent diverticular disease it can thicken the bowel wall and make it difficult to diagnose a tumour. It was Dr. Brankston's opinion that family doctors were aware of the importance of not relying on air contrast barium enema to find the cause of rectal bleeding.

[123] Dr. Brankston quoted from the Harrison text: "Colonic diverticula are usually asymptomatic and are an incidental finding on barium enema...Since diverticulosis is quite common in older patients, one must avoid the temptation of attributing symptoms to the diverticula unless other conditions, especially colonic neoplasm, have been excluded." Dr. Brankston said the text is used in medical schools then and now. He was of the opinion that what is contained in that passage should have been within the knowledge of a family doctor in 1993.

[124] Dr. Brankston was asked to review the chart entry for May 7, 1993. He said that it did not appear that Dr. Swales had obtained any of the following details: the location, type or duration of the pain, the colour or the amount of blood in the stool, whether the blood was mixed with the stool or was on the toilet paper or in the bowl, whether the bleeding caused the pain and details of the size of the stool. He was of the opinion that the information on the record was cursory and inadequate since it did nothing to help localize or explain the nature of Mrs. Newman's symptoms. There was no evidence of physical examination. It does not show that Dr. Swales considered ordering blood work or an ultrasound for the pelvic pain.

[125] Dr. Brankston explained that it was important to have an adequate record because a patient presents with undifferentiated symptoms. A thorough inquiry and examination all help to form a hypothesis and to direct further investigation to establish a diagnosis. Dr. Brankston said that there was no change in the way in which medical records have been kept in the last 10 years.

[126] Dr. Brankston was of the opinion that a physical examination and functional inquiry should have been done based on Mrs. Newman's symptoms. The reason was because she had a 4-month history of symptoms. Dr. Brankston said if Dr. Swales' response was to delegate the task to a locum on June 17 then Dr. Swales should have reviewed the results. He should have discussed the results of "occasional rectal bleeding" with the locum Dr. Mayer and with Mrs. Newman and charted the discussions. Dr. Brankston interpreted the notation "occasional rectal bleeding" on the June 17 functional inquiry form to mean ongoing rectal bleeding. Dr. Brankston said that the report of occasional rectal bleeding on June 17 reinforced his opinion in regard to how the May 7 complaints should have been handled. With a female of this age tumours need to be ruled out at the earliest possible time. In light of the May and June complaints, Dr. Swales should have questioned Mrs. Newman on her subsequent visit in July about her rectal bleeding. Dr. Brankston interpreted the notation "no change in bowel habits" to

mean no change from the previous altered bowel habits. He testified that Mrs. Newman's report of no change in her bowel habits on June 17 also reinforced his opinion that she should have been referred for a colonoscopy or a sigmoidoscopy on May 7, 1993.

[127] Referring to the October 6, 1994 visit, Dr. Brankston was asked how Mrs. Newman's concern affected his opinion. He said that without Mrs. Newman Sr.'s history Mrs. Newman should have been referred for a colonoscopy or sigmoidoscopy. He was of the opinion that Dr. Swales ought to have known that Mrs. Newman's mother was diagnosed with cancer. He said that if he had been in Dr. Swales' position with a patient who informed him that her mother had colon surgery he would have asked for the diagnosis. He assumed she would have told him it was rectal cancer. He said that on the basis of that history alone he would have referred the patient for a colonoscopy.

[128] Dr. Brankston said that in 1993 the average waiting period for a referral to a gastroenterologist was 2 to 3 weeks in Oshawa and the waiting period in Peterborough would have been about the same since to his knowledge Oshawa and Peterborough were similar.

[129] On cross-examination Dr. Brankston was asked for his view on Dr. Dublon's chart entry of August 27, 1993 (possibly 1992). Dr. Dublon failed to note whether Mrs. Newman was passing blood when he treated her for diarrhea. Dr. Brankston said that he was critical of that note and he felt that it fell below standard. He was asked about Dr. McLaughlin's chart entry in November 1, 1996 in Florida. Dr. McLaughlin failed to note the history of Mrs. Newman's bleeding apart from the past 2-week period. Dr. Brankston was critical of that note and said that it fell below standard. Dr. Brankston was also asked to comment about the chart entries of Dr. Maxwell, Dr. Scott and Dr. Brierly. He was critical of the history taken by Dr. Maxwell and Dr. Scott but said that since they were specialists he was unable to comment if they fell below expected standard.

[130] On cross-examination Dr. Brankston was asked if he had assumed that Mrs. Newman's rectal bleeding in 1993 was persistent. He said that he did not assume that it was continuous from 1993 to 1996. He said that he had assumed and there was evidence that it was intermittent and that it was communicated. He said that he also assumed that Dr. Swales failed to note it. In closing submissions, the defence took the position that Dr. Brankston was biased in his opinion about May 7, because he made those assumptions.

[131] In cross-examination Dr. Swales was asked about the relevancy to the standard of care in 1993 of the articles which he quoted in his report which were dated 1994 and 1995. He said that he could say with confidence that the information, which he quoted in his report from Harrison's, has been in Harrison's since he was a medical student.

[132] Dr. Brankston agreed on cross-examination that a physician cannot rule out every potential life-threatening situation. He also agreed that in 1993 he ordered barium enemas. He said it is a first step. However, he said in some situations he would go directly to a colonoscopy, and in situations like Mrs. Newman's a barium enema cannot be relied on. He also agreed that he had not mentioned in his report that Dr. Swales should have done a complete medical

examination with emphasis on the abdomen, pelvis and rectum. He agreed that he had not mentioned that Dr. Swales should have ordered a pelvic ultra sound.

[133] Dr. Brankston was asked on cross-examination if diverticulitis is a cause of rectal bleeding. He said that in his experience there is not a lot of bleeding with diverticulitis. He was asked if he felt that Dr. Mayer fell below standard in noting occasional rectal bleeding and not pursuing it. He said that he was not sure that he could conclude it on that basis alone. He also said that he thought that Dr. Mayer's entry of "diverticulitis" on June 17 was an error and what he should have written was "diverticulosis".

[134] Dr. Brankston was asked on cross-examination if in 1993 a patient had rectal bleeding and altered bowel habits of 4-months duration that patient had to be sent to a specialist. He answered: "Yes, a woman of this age and don't wait for a barium enema, but I probably would not have done the barium enema."

[135] On re-examination Dr. Brankston said that it was the failure to refer Mrs. Newman to a specialist on May 7, 1993 that he relied on in coming to his conclusion that Dr. Swales fell below the applicable standard of care.

Dr. Geddes for the Plaintiffs

[136] Dr. Scott Geddes, the plaintiffs' second expert is a general surgeon. He is a certified member of the College of Physicians and Surgeons of Ontario, the Royal College of Physicians and Surgeons of Canada and the Canadian Medical Protective Association. He graduated in medicine from the University of Western Ontario in 1973. He completed rotating internship at St. Paul's Hospital, Vancouver in 1974. He did a general surgery residency at the University of Western Ontario from 1974 to 1978. From 1979 to the present he has been on active consulting staff, at the Cambridge Memorial Hospital. He has held a number of administrative positions. He was Chief of Surgery, Cambridge Memorial Hospital from 1989 to 1992. He is currently senior General Surgeon, Cambridge Memorial Hospital. He has acted as clinical supervisor or preceptor for clinical clerks. He has provided opinions for the College of Physicians and Surgeons of Ontario regarding standard of care issues. He has provided opinions to plaintiffs' counsel regarding medical legal issues. He has provided consultation for the Canadian Medical Protective Association.

[137] The plaintiffs tendered the evidence of Dr. Geddes primarily on the issue of causation. The defence accepted him as an expert on the issue without objection. Dr. Geddes testified on the issue of causation and that testimony was not challenged. It is not necessary to review that evidence.

[138] The defence objected to Dr. Geddes offering opinion evidence on the standard of care reasonably to be expected of a family doctor under the circumstances of this case. Dr. Geddes is not a family doctor and was not one in 1993. I ruled that it would be unfair to allow Dr. Geddes to testify about the standard of care of a family doctor. However since he receives referrals from family doctors on a regular basis in regard to cases of rectal bleeding and altered bowel habits I

did allow him to testify about when referrals are made to him. He also testified, without objection, about the general state of medical knowledge in 1993.

[139] Dr. Geddes testified that he does colonoscopies and sigmoidoscopies 5 to 6 times a week. He testified that in 1974 colonoscopy was emerging. He explained the differences between barium enema, colonoscopy and sigmoidoscopy, which I set out above.

[140] He testified that in 1991 Saviston, a medical text, said that a barium enema will identify only 70% of colonic lesions compared with a colonoscopy which will identify 90% of them. He said that it has long been understood going back to his medical school days in the 1970s that a barium enema is not sufficient. With a barium enema there is no direct visualization. It cannot show a polyp in the rectal sigmoid area. It shows irregularity to the muscosa but it cannot make the distinction. The smaller the polyp, the harder it is to see. A barium enema cannot show a polyp below the size of 1 cm.

[141] Dr. Geddes stated that the presence of multiple diverticula impact on finding polyps. He said that this was stated in Harrison's an authoritative text which was used when he was in medical school. Only about 5 to 10 % of diverticula will bleed. Usually they are asymptomatic. Rectal bleeding is likely not explained by diverticulosis. Mrs. Newman probably did not have diverticulitis. With diverticulitis you see fever, white blood cell count, bowel tenderness.

[142] On cross-examination Dr. Geddes was asked about the statement he made in his first report that a properly performed air contrast barium enema could have a sensitivity of 85% to 95% for detecting colorectal polyps with a false negative rate of 10%. He had also written that a colonoscopy was 12% more accurate than an air contrast barium enema especially for detecting small lesions such as adenomas. In Dr. Geddes' second report dated August 14, 2001 he did not retract the statements in his first report but relied upon a 1995 article in a specialist journal to support the proposition that 25% of cancer and polyps in the rectosigmoid region are missed by air contrast barium enema whereas a combination of flexible sigmoidoscopy and an air contrast barium enema had a sensitive of 98% for carcinoma and 99% for adenomas. At trial, Dr. Geddes testified that the statistics in his first report were erroneous, that he could not locate the source and he must have used older literature.

[143] In argument defence counsel submitted that the quoting of apparently erroneous statistics in Dr. Geddes' first report demonstrated how medical knowledge and correspondingly the standard of care can evolve over time. He stressed that outdated literature or statistics may be outdated in 2001 but they may not have been outdated in 1993. He stressed that it is not what Dr. Geddes knew as a surgeon or the specialized medical community in North America knew in 1993 that is relevant but what a family doctor practising in Lakefield should have known in 1993 about managing bowel symptoms and the accuracy of a barium enema as an investigative technique that is at issue. I accept this.

Dr. Richard MacKenzie for the Defendant

[144] Dr. Richard MacKenzie, the defendant's expert on the standard of care has had a general and family practice in the City of North York since 1975. He is a certified member of the College of Family Physicians of Ontario. He graduated in medicine from the University of Toronto in 1973. He interned at North York General Hospital and did a residency in Family Medicine at Wellesley Hospital from 1974 to 1975. He is a specialist in family medicine. He has held a number of professional appointments. From 1975 to 1982 he was on active staff at Wellesley Hospital in the Family Practice Unit and an emergency physician. From 1975 to the present he has been on active staff in the Department of Family Medicine at North York General Hospital. He was a preceptor of the Family Medicine Training Program at North York General Hospital from 1978 to 1994. He has been a lecturer, Faculty of Medicine, University of Toronto, from 1978 to the present. He has also held a number of administrative positions. He was Vice-Chair of the Department of Family Medicine at North York General Hospital from 1980 to 1982. From 1988 to the present time, he has been a community appointed member of the Discipline Committee of the College of Physicians and Surgeons of Ontario where cases are referred from the Complaints Department which involve adjudication of standard of care issues. Because of his extensive experience as a family doctor his evidence is admissible and entitled to significant weight.

[145] Dr. MacKenzie's evidence was directed to the standard of care of a general practitioner in a small Ontario community in 1993.

[146] Dr. MacKenzie testified that the physician's obligation is to rule out life threatening causes as opposed to making an actual diagnosis. It is a compendium. A physician works with degrees of certainty. He cannot rule something out completely. The first requirement is to take an adequate history and do a physical examination. Usually a physician can come up with a diagnosis. If he sees a more ominous cause he should move forward and stop when he has ruled out health threatening cause or with certainty made a diagnosis.

[147] Dr. MacKenzie testified that rectal bleeding is very common. He sees patients with it 3 to 5 times a week. Most rectal bleeding is accompanied by altered bowel habit. The cause is usually hemorrhoids and fissures usually with diarrhea or constipation. The biggest concern with rectal bleeding is to rule out malignancy of the lower bowel, polyps and adenoma. Other potential causes are inflammatory bowel disease, blood vessel problem and diverticulosis.

[148] Dr. MacKenzie testified that a very high percentage of people over 50 have polyps. It is not unusual to see incidental polyps removed at colonoscopy. Not all polyps turn into cancer.

[149] In 1993 the investigative techniques used with presenting symptoms of rectal bleeding were a thorough history and physical examination followed by a barium enema, a sigmoidoscopy or a colonoscopy. Dr. MacKenzie testified that in 1993 a barium enema was thought to be an extremely useful tool with a high yield of detecting polyps of any size.

[150] He said that appropriate management would be a physical examination and a history and then going on to other investigations. He disagreed that the standard of care in 1993 was to refer someone with Mrs. Newman's symptoms to a specialist without the family doctor trying to work

through the case first. He said that failing this the family doctor would be relegated to the position of a triage nurse and the system would be crippled. It is only within the last 4 or 5 years that surgeons began doing colonoscopy. Before that only gastroenterologists did it.

[151] Dr. MacKenzie was of the opinion that the barium enema was a good idea. It can be done quickly. It can rule out a lot. A colonoscopy or sigmoidoscopy is harder to arrange. Patients are anxious. Barium enema has its limitations but it is a first step and should be followed up if the symptoms persist. It was within the standard of care of a family doctor. Standards do change.

[152] Dr. MacKenzie said that an ultrasound has no place in the investigation of rectal bleeding. He was of the opinion that the history, which Dr. Swales took, was adequate. The physical examination could be deferred, as Dr. Swales did. He was also of the opinion that it was not necessary for Dr. Swales to make a provisional diagnosis since there are so many potential causes of rectal bleeding.

[153] Dr. MacKenzie did not believe that Dr. Swales was required to review the work of the locum Dr. Mayer. He said that it defeated the purpose of having a locum if the returning physician had to review all of his charts. He also did not see that there was any obligation on Dr. Swales to speak to Dr. Mayer about the results of the barium enema or to speak to Mrs. Newman about the results before October 6, 1994.

[154] In reference to the June 17 visit Dr. MacKenzie testified that he would have expected to see the word "occasional" marked on the functional form because Mrs. Newman had rectal bleeding within the last one and a half months of the examination. He interpreted "occasional" as not indicative of persistent bleeding. To him it meant that Mrs. Newman's bleeding had resolved by June 17, 1993.

[155] Dr. MacKenzie was of the opinion that nothing shows that Dr. Swales was not meeting the standard after June 17. On July 8, 1993 Dr. Swales met the standard of care. The reason for the visit was to discuss estrogen use. On June 17, 1993 Dr. Mayer charted that there should be a re-check for use of estrogen and that is what Dr. Swales did on July 8.

[156] In reference to the October 6, 1994 visit, Dr. MacKenzie testified that when a first-degree relative has bowel cancer it should be highlighted as a risk factor. He would address it in the periodic health check. It raises the stakes and mandates surveillance. Dr. MacKenzie said it was clear that Mrs. Newman raised the issue of diverticular disease. She knew that she had diverticula. The record shows that Dr. Swales discussed either symptoms of cancer or symptoms of concern with her. Dr. MacKenzie said that the symptoms of cancer and symptoms of concern are pretty much the same. If a doctor tells a patient what to look for he would expect that if the patient were experiencing any of the symptoms she would tell him. To him it appeared that Mrs. Newman did not mention any symptoms on October 6.

[157] Dr. MacKenzie was asked if there is any indication that Mrs. Newman had diverticulitis. He said that Dr. Maxwell the G.I. specialist in Florida did not report that she had diverticulitis. In his records he referred to diverticulosis and as a specialist he would know the difference. He

said that it seemed obvious that Mrs. Newman did not report to Dr. Maxwell that she had the symptoms or the diagnosis.

[158] Dr. MacKenzie said that in reviewing the June 17, 1993 chart there is nothing to suggest to him that she is describing diverticulitis. Dr. MacKenzie was hard-pressed to say that Mrs. Newman ever had diverticulitis. Abdominal pain is an indication of diverticulitis, but the blood tests ordered on June 17, 1993 showed Mrs. Newman's white blood count was normal. With diverticulitis there is almost invariably an increase in the white blood cell count.

[159] Dr. MacKenzie was asked about the textbook Harrison's Internal Medicine. He said that all physicians would use it as a reference text but a family doctor would not be expected to know everything in it. He said that textbooks do not set the standard of a family doctor. The standard is to be extracted from the clinical context. Textbooks assist in establishing the standard of care but must be interpreted in light of the clinical picture with which the doctor is presented.

[160] Dr. MacKenzie was asked to interpret the quote from Harrison's that Dr. Brankston referred to, set out above. He conceded that it was accurate. He interpreted it to mean that if a patient has diverticulosis and rectal bleeding there is a higher obligation on the physician to make sure the bleeding is from another cause. In Mrs. Newman's case, there was no history of diverticulosis before her reports of rectal bleeding. Dr. MacKenzie felt that Dr. Swales proceeded with the investigation to rule out cancer before he knew she had diverticulosis and therefore he could not be faulted. Mrs. Newman did not complain of any bowel symptoms after the investigation and therefore Dr. Swales can not be faulted.

[161] Dr. MacKenzie testified that he could see no reference to any bowel symptoms in any of the visits after June 17, 1993 to October 6, 1996.

[162] Dr. MacKenzie agreed with Dr. Geddes that a barium enema is not as reliable in detecting polyps in the lower colon as a colonoscopy. A doctor needs the visualization from a colonoscopy or a sigmoidoscopy. However, if the bleeding had stopped it was within the standard of care for Dr. Swales to have relied on the barium enema.

[163] Dr. MacKenzie referred to the records of Mrs. Newman's attendances with other health care professionals on July 19, 1994, on June 25, 1995, on August 24, 1995, on September 1, 1998 and on September 8, 1995 to show that it did not appear that Mrs. Newman complained of any bowel problems. It should be pointed out that Dr. MacKenzie did not have the full record for July 19, 1994 and did not know of the report on the nursing assessment when he prepared his report.

[164] Dr. MacKenzie testified that because Dr. Swales ordered occult blood tests as part of the August 1996 annual medical examination it signified to him that Mrs. Newman was not telling Dr. Swales that she was bleeding. Her white blood cell count was normal. Again this is an indication that she did not have diverticulitis.

[165] Dr. McLaughlin the general practitioner who saw Mrs. Newman on November 1, 1996 wrote that she was having 17 bowel movements day. Dr. MacKenzie said that he would have expected to see the 3-year history of symptoms noted.

[166] Dr. Maxwell the gastroenterologist who saw Mrs. Newman on November 4, 1996 did not record that she had diverticulitis. He uses the term diverticulosis. As a specialist he would know the difference. This signifies that she did not report symptoms of diverticulitis to him.

[167] Dr. Scott, the surgeon that operated on Mrs. Newman for her bowel tumour, wrote in her report that Mrs. Newman "began passing currant jelly like stools tissue and mucus per rectum. She has noted prior to this a change in bowel habit which she thought was associated with her diverticulosis." The word diverticulosis is used.

[168] Dr. Bailey the internist who dealt with pre-operative concerns on November 7, 1996 wrote that Mrs. Newman describes a history consistent with diverticulitis. He wrote, "she apparently had a barium enema 4 years ago which demonstrated the disease. She developed some of those symptoms or at least what she felt was consistent with those symptoms prior to the above diagnosis [for bowel cancer]." Dr. MacKenzie said that this recording was the first time that Mrs. Newman said that her symptoms were consistent with diverticulitis.

[169] On March 30, 1997, Dr. Putman at Princess Margaret Hospital detailed her history of intermittent abdominal pain and "red bean stools for 3 years, attributed to diverticulosis. The intermittent pain became more severe and frequent during the Autumn, and she then presented with frank rectal blood and was investigated." In view of this report of March 30, 1997, which Dr. MacKenzie found perplexing and at odds with all of the other reports, he offered a number of potential explanations. He said that perhaps Mrs. Newman did have a 3-year history of bleeding, which she had not recognized as significant, and was not reporting. Perhaps on March 30, 1997 she realized she was terminal and reflected back and realized that what she thought normal was abnormal. Perhaps she had the bleeding and from fright was in denial and not reporting it and only on March 30 had come to terms with it. He felt that fright was the most probable explanation. Dr. MacKenzie said there were other possible explanations. However, he found it simply incomprehensible with the number of health care workers that she had seen over the years that at some point she would not have responded in a positive way when asked about her health issues.

[170] On cross-examination Dr. MacKenzie agreed that he assumed that Mrs. Newman's condition had resolved by June 17, 1993. He also agreed that if Dr. Swales knew or ought to have known that Mrs. Newman's symptoms went beyond June 17, 1993 then he would have fallen below the standard of care of a family physician in 1993 for not referring her for colonoscopy or sigmoidoscopy.

[171] On cross-examination Dr. MacKenzie agreed that colorectal malignancies are more common with people with diverticular disease. He agreed that Harrison's Internal Medicine had said that from 1983 to 1994. He agreed that he interpreted Harrison's to mean that a patient with known diverticulosis raises the stakes. He agreed that in May 31, 1993 Mrs. Newman was

known to have diverticulosis. He agreed that after November 4, 1996 when the diagnosis of cancer was made her past history would not have impacted on the management of her case.

[172] On cross-examination Dr. MacKenzie agreed that nowhere in the chart, with two exceptions, is it noted that Mrs. Newman denied rectal bleeding. He agreed that nothing in Dr. Swales' file showed that Mrs. Newman had returned to normal bowel function after May 7.

Absent Witnesses

[173] Theresa Newman was not alive to give her version of events.

[174] None of the physicians who treated Mrs. Newman after May 7, 1993, except Dr. Swales, testified. Apparently, Dr. Mayer has re-located to Phoenix.

[175] Alfred Newman did not testify due to his precarious health. It was agreed that no negative inference should be drawn either way because he did not testify, and it was admitted that he never overheard Dr. Swales and Mrs. Newman discussing her condition.

Evidentiary Rulings

[176] It is unnecessary to review the evidentiary rulings made. It appears that neither side was taken by surprise over the course of the trial since neither requested an adjournment.

Standard of Care: The Expert Evidence Assessed

[177] The medical experts agreed that the physician's task in assessing and investigating symptoms is and was to first deal with the most serious and concerning potential cause. They agreed that colon cancer was the most serious and concerning potential diagnosis with which Mrs. Newman's symptoms of May 7, 1993 were consistent. In this context colon cancer includes its precursor polyps. They also agreed that a sigmoidoscopy or colonoscopy was a more accurate diagnostic tool to identify colonic polyps or diagnose rectal bleeding than a barium enema. They agreed that Harrison's Internal Medicine was an authoritative text. They also agreed that Mrs. Newman probably never had diverticulitis.

[178] On the standard of care expected of a family physician in 1993 in a community like Lakefield I generally accept the opinion evidence of the plaintiffs' expert Dr. Brankston. He was well qualified and experienced. His opinion was that on May 7, 1993 by not referring Mrs. Newman, at her age, with her presenting symptoms at that time, for a colonoscopy Dr. Swales failed to meet the requisite standard of care. His evidence was fairly and reasonably based on the evidence. To the extent that he referred to events after May 7 they reinforced his opinion about the May 7 events, but they were not the basis of his opinion about May 7. He admitted that he made assumptions about what happened after May 7. His assumption that Mrs. Newman had intermittent symptoms has been found to be true. Her complaints, if any, to Dr. Swales after May 7 remain unknown. However, I do not think that just because Dr. Brankston assumed that after May 7 Mrs. Newman was reporting symptoms to Dr. Swales, which he did not record, that Dr. Brankston's opinion about May 7 is biased, as defence counsel suggested.

[179] I also accept that the literature that he referred to in his report and his evidence, although taken from textbooks published after 1993, represented what was known and published long before 1993, as he said, going back to his days in medical school.

[180] As the defence pointed out, Dr. Brankston was somewhat rigid in his views about what constituted good record keeping. This was a valid criticism. I preferred Dr. MacKenzie's view that the quality of the records would have to be judged in the clinical context. On re-examination Dr. Brankston seemed to be saying that as well.

[181] On the standard of care I generally reject the opinion evidence of the defence medical witness Dr. MacKenzie. He was well qualified to give opinion evidence. I found a number of flaws in his evidence, which I will now set out.

[182] There are five basic flaws in Dr. MacKenzie's evidence:

[183] First, Dr. MacKenzie testified that ordering a barium enema was a good first step and should be followed up by a referral for a colonoscopy or sigmoidoscopy if the symptoms persisted. However, if the bleeding had stopped it was within the standard of care for Dr. Swales to have relied on the barium enema. In other words, Dr. MacKenzie's criterion for not relying on the barium enema results was persistent symptoms. The record shows that Mrs. Newman bled in Florida. The May 7 visit was the second time that she had complained to a doctor about rectal bleeding. She complained of altered bowel habits of 4-months duration. Those were persistent symptoms. Consequently, on Dr. MacKenzie's own criterion Mrs. Newman should have been referred to a specialist on May 7.

[184] Second, the point of Dr. Swale's investigation was to exclude the most concerning potential cause of Mrs. Newman's symptoms, colon cancer or its precursors. Dr. MacKenzie agreed with Dr. Geddes that a barium enema was not as reliable as a colonoscopy in detecting polyps in the lower colon. The barium enema could not be relied on to exclude colon cancer. Consequently, the barium enema could not do what Dr. Swales, on Dr. MacKenzie's evidence, was obliged to try to do - exclude the precursor of bowel cancer to the extent possible.

[185] Third, over 50% of older people have diverticula. In 1993 it was generally known that diverticula are common in older patients, generally asymptomatic, an incidental finding on a barium enema and should not be considered the cause of rectal bleeding unless colonic neoplasm had been excluded. Dr. MacKenzie acknowledged that. His interpretation was that where a patient complaining of rectal bleeding is known to have diverticula there is a greater obligation on a doctor to exclude cancer before relying on the diverticula as a cause of the bleeding. In Mrs. Newman's case because she was not known to have diverticula before the barium enema it was his opinion that Dr. Swales could not be faulted for relying on the barium enema because he was using it to exclude cancer before he knew that she had diverticula. There is an inherent problem with Dr. MacKenzie's interpretation. Since it may be expected that diverticula will be found on a barium enema, it leaves unanswered what the response should be where the only finding on the barium enema is diverticula. Dr. MacKenzie said if the bleeding persists the barium enema should be followed up with a colonoscopy or sigmoidoscopy. His approach

leaves the cause of the presenting bleeding as unfinished business where the bleeding does not persist. The unfinished business was the object of the investigation in the first place.

[186] Fourth, Dr. MacKenzie's opinion is premised on the assumption that Mrs. Newman's symptoms did not persist after May 7. On Dr. MacKenzie's view, Mrs. Newman's symptoms had resolved by June 17, 1993. Yet he testified that the result of the functional inquiry on June 17 of "occasional bleeding" and "more than one bowel movement a day" were positive findings. There was not evidence that the word "occasional" had a special meaning when used in a medical context. "Occasional" should be given its plain meaning which is "happening infrequently" or "irregular". "No change in bowel habits" must mean no change from the previously reported altered bowel habits because following a habit of 4-months duration anything else would be a change. With these positive findings, Mrs. Newman's symptoms had not resolved by June 17 and therefore Dr. MacKenzie's premise that she did not have recurrent symptoms after May 7 is faulty.

[187] Fifth, Dr. MacKenzie was of the view that there was no obligation on Dr. Swales to discuss with Dr. Mayer the results of the June 17 inquiry or otherwise satisfy himself that Mrs. Newman's symptoms had resolved. Apart from the chart entry of May 7, Dr. Mayer did not have the benefit of Dr. Swales' insight. Dr. Swales only reviewed the June 17 day-to-day chart with its reference to "diverticulitis- diet." Dr. MacKenzie had difficulty understanding the use of the word "diverticulitis" on the chart. With the use of the word "diet" he thought it might have been intended to refer to diverticulosis generally. Dr. MacKenzie's opinion that Dr. Swales was not obliged to look beyond the June 17 entry is hard to reconcile with his opinion that the use of the word diverticulitis on the chart was erroneous. Dr. Swales seemed to accept diverticulitis as a diagnosis. Dr. MacKenzie relied on Mrs. Newman's failure to complain about her ongoing symptoms after June 17 as support for his view that her symptoms had resolved. He found the March 30, 1997 reference to a history of 3 years of intermittent pain and bleeding to be perplexing. He suggested a number of potential reasons why if Mrs. Newman did have a history of 3 years of rectal bleeding she did not report it. However, he did not suggest that one of the reasons may have been an erroneous diagnosis with diverticulitis that was never addressed and to which she may have attributed her symptoms and as a result did not complain. His failure to address that seemed to me to be a significant shortcoming in his evidence.

[188] For these reasons, I place no reliance on Dr. MacKenzie's opinion that Dr. Swales met the standard of care.

The Legal Standard of Care

[189] The standard of care is not in dispute. Every medical practitioner must bring to his or her task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He or she is bound to exercise that degree of care and skill, which could reasonably be expected of a normal, prudent practitioner of the same experience and standing.

[190] The plaintiff must show that any lapse is more than an error in judgment. It must rise to the level of unskilfulness, or carelessness or lack of knowledge.

[191] In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion. A physician is not negligent merely because his or her conclusion differs from that of other professional men and women.

Standard of Care: Secondary Findings

[192] For these reasons I conclude that:

> Mrs. Newman's symptoms on May 7, 1993 of pelvic pain, altered bowel habit for 4 months and rectal bleeding, being her second complaint to a doctor of rectal bleeding, required investigation by way of referral to a specialist to conduct a colonoscopy or sigmoidoscopy. It would have been reasonable and within the standard of care for Dr. Swales to have sent her to a specialist for a colonoscopy. It was unreasonable for Dr. Swales not to have done so and in failing to do so he fell below the standard of care.
>
> Dr. Swales exercised clinical judgment on May 7, 1993 that a barium enema on its own was an adequate procedure to investigate Mrs. Newman's bowel symptoms unless there were positive findings on the barium enema or unless there were negative findings on the barium enema but her symptoms persisted. That judgment was not reasonable.
>
> It was noted above that if Dr. Swales exercised any clinical judgment in no longer being concerned on July 8, 1993 about the potential that Mrs. Newman had bowel cancer he did so on the basis of Dr. Mayer's day-to-day chart entry of June 17, 1993 and Mrs. Newman's failure to complain of further bowel symptoms on July 8, 1993. To the extent that Dr. Swales's lack of concern resulted from the exercise of clinical judgment that judgment was not reasonable. Dr. Mayer's day-to-day chart entry on its face contained an obvious erroneous reference to diverticulitis. On July 8, 1993 Dr. Swales did not question Mrs. Newman about bowel symptoms. Neither the chart entry nor the visit of July 8 was a reasonable basis for Dr. Swales not referring Mrs. Newman for further investigation by way of colonoscopy.
>
> Dr. Swales had a continuing duty as Mrs. Newman's doctor to adequately assess and investigate her complaints of May 7 either by referring her to a specialist or by exercising some reasonable clinical judgment that there was no longer the potential that Mrs. Newman had bowel cancer. By failing to question Mrs. Newman directly about her bowel symptoms on July 8, 1993 and afterwards the assessment and investigation of Mrs. Newman's symptoms of May 7 remained unfinished business and was never resolved between Dr. Swales and Mrs. Newman. By failing to do so he fell below the standard of care.

Conclusion

[193] For these reasons, I conclude that Dr. Swales in his treatment of Mrs. Newman between May 7, 1993 and October 7, 1996 fell below the standard of care reasonably expected of him in

the circumstances. It is admitted that if Dr. Swales had referred Mrs. Newman for a colonoscopy in 1993 it would have prevented the development of the cancer from which she died.

Non-pecuniary General Damages

[194] The quantum claimed in paragraph 1(b) of the statement of claim was amended to $150,000 on consent.

[195] Mrs. Newman's pain and suffering began in May 1993 with intermittent rectal bleeding, abdominal pain and a change in bowel habits. This often impacted on her ability to take part in events until the afternoon. She adhered to an altered diet. This continued for a period of approximately three and half years until her symptoms became very severe just before November 1996.

[196] On November 4, 1996 Mrs. Newman was diagnosed with an obstructing mass, and flown by air ambulance to Peterborough where she underwent surgery. In the procedure 20 cm. of her colon was removed and she was fitted with a colostomy. She left hospital on November 15 in a wheelchair. She required sponge bathing, support and pain killing medication. She was restricted in activity. She was not able to return to her own residence, which was a trailer in the summer months not suitable for the winter weather. She and her husband moved in with friends in the Peterborough area. She saw a number of doctors to learn more about her health, her prospects and treatment. Her options were limited because she had liver and lung metastases.

[197] In light of the treatment options available she returned to England to be with her children. From mid-March 1997 to September 1997 she lived with her son Carl. Her husband could not join her until May 1997. Due to the effects of chemotherapy she had difficulty climbing stairs to the bathroom on the second floor of her son's home. In August or September 1997 she and her husband moved into her apartment, previously rented out. She remained there until her death.

[198] She began chemotherapy right away in England. She was fitted with a venous portocath for administration of chemotherapy that was done by surgery on April 14, 1997. From April 30 1997 to April 29, 1998 Mrs. Newman had 60 sessions of chemotherapy treatment. At first it was for 3 days, every 2 weeks, and then reduced to 2 days every 2 weeks. She had to drive 40 miles to get to the hospital. Treatments were one day long. She participated in a random trial.

[199] The side effects of chemotherapy were fatigue and weakness, diarrhea, a sore mouth and cold sores, nausea, skin breakdown and rash and hair loss. She received oxaliplatin. The side effects were vomiting, numbness of the fingers and toes and occasionally an unusual sensation in the throat.

[200] The parathesia in her fingers was particularly troubling. She had trouble doing up her buttons or tying her shoes. At first it was intermittent and lasted 5 to 7 days after treatment. Eventually it became permanent. She had to use creams to treat her cold sores and a special mouthwash for mouth ulcers.

[201] She found the use of a colostomy bag humiliating. It could smell. She carried spray to counteract the odour. She did not like to go out to social events due to her medical conditions. On one occasion when she was out with friends her colostomy bag broke.

[202] Without in any way disparaging Mrs. Newman's sufferings, the defence asked me to recognize that in the initial period from May 1993 Mrs. Newman was not severely disabled and was able to travel and generally go about her normal activities. Counsel also pointed out that in many cases where damages for pain and suffering are being assessed the court is considering situations where it will continue into the future. With death, there is release. The defence also reminded me of the "high water mark" of general damages and asked me to keep proportionality in mind.

[203] The defence referred to two cases where awards of $10,000 for pain and suffering and loss of enjoyment of life were made: *Mitchell Estate v. Labow*, [1995] O.J. No. 621 (Gen. Div.), aff'd [1998] O.J. No. 952 (C.A.) and *Lawson v. Laferriere* (1991), 78 D.L.R (4^{th}) 609 (S.C.C.). In both cases late diagnosis was found to have merely reduced life expectancy and increased the pain and suffering because of more invasive and lengthier treatment. Similarly in *Kempton v. Park*, [1994] O.J. No. 320, (Ont. Gen. Div.) aff'd O.J. No. 2651 (C.A.) the deceased would have died even with an earlier diagnosis but she would have had a much more enjoyable life during the 18 months in question. The court assessed general damages for the 18 months at $25,000. I was also referred to *Sutherland Estate v. Hunt*, [2001] O.J. 3859 (Ont. S.C.J.) where the deceased was awarded $30,000 for two years of pain and suffering from damage to his hand. The pain was intense and he was unable to perform the task associated with colostomy care, which was "most distressing and humiliating".

[204] For non-pecuniary general damages for pain, suffering and the loss of enjoyment of life the plaintiffs suggest an assessment in the range of $60,000 to $75,000. The defence suggests an assessment of $30,000 relying on *Kemptom v. Park*, which the defence asserts is closest to the present circumstances.

[205] Mrs. Newman had intermittent pain and suffering and some loss of enjoyment of life for about three and half years before November 1996 but generally could go about her normal activities. She then struggled with cancer, treatment, knowledge that her life was coming to an end for 22 months. In *Stell v. Obedkoof*, A. Campbell, J. assessed the plaintiff's general damages at $135,000 for a 4 and half year struggle with cancer. The details of the circumstances and her suffering are somewhat similar to Mrs. Newman's although at the time of trial Mrs. Stell was alive. Having regard to Mrs. Newman's sufferings before diagnosis and the devastating effect of cancer on her over the final 22 months of her life I assess Mrs. Newman's non-pecuniary general damages at $60,000.

Special Damages (Out-of-pocket Expenses)

[206] It was agreed that the amount owed to OHIP is $3500, the bulk of which was incurred in the fourth quarter of 1996. It was agreed that Mrs. Newman incurred 240 £ for fuel to travel to Cookridge for chemotherapy. It was agreed that the cost of the funeral was 1304.64 £. I am

unclear whether the funeral costs were paid by Mr. Newman personally or out of estate funds. In any event, the defence agrees that these three amounts are properly included in pecuniary damages and I award them.

[207] There were costs involved in Mrs. Newman's move to England. There were also savings which impact on the defence because additional OHIP costs were not incurred. The defence did not take the position that it was unreasonable for Mrs. Newman to move to be with her children.

[208] The largest cost was Mrs. Newman's purchase of a vehicle from Karen Bales for 5000 £. The estate seeks reimbursement for that amount. Also the estate seeks reimbursement for 250 to 300 £ per month that Mrs. Newman would have received for rent from her apartment from August or September 1997 until August 1, 1998. She had been receiving rent before she moved in. Twelve months at 250 £ or a total of 3000 £ is claimed.

[209] The estate also seeks the cost of renovating and the cost of furnishing the apartment when Mrs. Newman moved in at 1500 £ and 2500 £ respectively.

[210] The defence's position is that regardless of where Mrs. Newman lived she would have had a vehicle and incurred housing expenses. It was submitted that there is no evidence that she did not sell her vehicle and furnishings in Ontario and Florida in anticipation of the move. There is no evidence that she would not have done the repairs to the apartment regardless of her ailment. The expenses have not been strictly proven and since Mrs. Newman was alive when the lawsuit began there is no reason why they should not have been.

[211] I agree that the loss of rental is an accommodation expense that would have been incurred in some fashion in any event and is therefore not recoverable. I accept the Mrs. Newman paid 5000 £ for the vehicle. It seems to me, on the evidence, that the principal reason that she bought it was to get to her treatments. It is a recoverable expense. The evidence also persuaded me that the renovations to the apartment, consisting principally of adding a balcony or arrangement to let in more light, were reasonably necessary to Mrs. Newman's comfort during her periods of confinement and would not otherwise have been done. Some furniture costs seem a necessary expense in re-locating overseas. Although the amounts were not proven with complete precision, I accept that the amounts claimed were reasonably close to what was spent. Allowing for some error in the estimates, I assess 3500 £ for the costs of renovation and furnishings necessarily incurred in re-locating to England. I consider the re-location directly attributable to Mrs. Newman's cancer.

[212] The estate also claims the value of services that were provided to Mrs. Newman by her children Karen Bales and Carl Griffiths and his wife Claire Griffiths. The services were provided from March 1997 to May 1997 when Alfred Newman joined Mrs. Newman in England, and provided thereafter to a lesser degree until Mrs. Newman's death. The value of the services is suggested to be $2500. I am certain that her children and daughter-in-law were a great help and support to Mrs. Newman. However, since there is no evidence that the estate paid for their services or owes them any monetary amount for their services, and since they are not claimants

under the *Family Law Act*, the value of the services, which has not been proven in any event, is not compensable.

Damages Family Law Claims

[213] Alfred Newman, the husband of Theresa Newman, claims damages under s. 61 of the *Family Law Act* for the loss of guidance, care and companionship of Mrs. Newman.

[214] In determining the quantum of damages, the following non-exhaustive list of factors is taken into account:

(i) the age, and mental and physical condition of the claimant;

(ii) whether the deceased lived with the claimant, and if not the frequency of the visits;

(iii) the intimacy and quality of the claimant's relationship with the deceased;

(iv) the claimant's emotional self-sufficiency;

(v) whether the deceased's spouse has remarried; and

(vi) the deceased's and the claimant's joint life expectancy, or the probable length of time the relationship would have endured.[9]

[215] Mr. Newman was born on February 21, 1918. He was 20 years Mrs. Newman's senior. It was agreed that he suffers from heart disease and has suffered a heart attack, heart failure and lung cancer. It was agreed that his life expectancy at the time of trial was from under 1 year to 3 years. At Mrs. Newman's death his life expectancy would have been from approximately two and half years to five and a half years.

[216] Plaintiffs' counsel submits that an award from $50,000 to $60,000 is appropriate. Defence counsel submits that $40,000 is appropriate. Both referred me to *Riggs v. Toronto General Hospital*, [1993] O.J. No. 1884 (Ont. Gen. Div.) in which a 77 year old spouse was awarded $50,000 for the loss of his 71 year old spouse. He had suffered from a heart attack and a stroke and had chronic lung disease. He was deprived of 6.6 years of his wife's companionship based on his life expectancy, 3.5 years before trial and 3.3 years after trial. The couple had a long and happy marriage and his loss was found considerable at this late stage of his life.

[217] At her death Mr. and Mrs. Newman had been married eleven and a half years. Both were retired. It appeared that they had a happy marriage and were constant companions. There was evidence that Mr. Newman had "lost his spark" since Mrs. Newman's death. He is lonely and has aged noticeably. Mr. Newman's situation is not unlike Mr. Riggs' circumstances although the Newman marriage was considerably shorter and there was no medical evidence that Mr.

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[9] *Pittman Estate v. Bain* (1994), 112 D.L.R. (4th) 257 (Ont. Gen. Div.), additional reasons at 112 D.L.R (4th) 482; *Kollaras v. Olympia Airway S.A.*, [1999] O.J. No. 1447 (S.C.J.)

Newman is clinically depressed. The *Riggs* assesment is over 8 years old. In the circumstances, I assess Mr. Newman's non-pecuniary claim related to the loss of Mrs. Newman's guidance, care and companionship at $45,000.

[218] The plaintiff Alfred Newman also claims an allowance for the value of services that he provided to Mrs. Newman from November 1996 to March 1997, and from May 1997 until her death. When Mrs. Newman left Peterborough Hospital after her bowel surgery she was in a wheelchair and very restricted in her activity. She required sponge baths. She had to contend with her colostomy. Mr. Newman helped her with all of this. When Mr. Newman joined her in England he did the grocery shopping, household and meal preparation tasks. During the period Mrs. Newman had chemotherapy that left her ill with all of the complaints already noted. She had great difficulty using her fingers. Mr. Newman helped her with fastening her buttons and shoelaces and applying medications and creams and with matters of personal hygiene. Although Mr. Newman did not testify, the evidence of other family members has persuaded me that he rendered substantial service to Mrs. Newman during this period. No evidence was offered of the value of these services and it is difficult to put a pecuniary value on them. I am asked to assess the allowance at $5075. I am of the opinion that amount is fair and reasonable under the circumstances.

Replacement of Services

[219] Alfred Newman also claims his pecuniary loss for the value of care that Mrs. Newman would have provided to him but for her death. He seeks his past loss of the value of that care from the date of her death (November 1996) to the date of the trial (October 2001) and the future loss of the value of that care.

[220] The evidence was that during the marriage Mrs. Newman was the homemaker. According to family members who testified, she did everything such as the housework, the cooking, and the shopping. She did the driving most of the time since Mr. Newman's eyesight is failing. Being 20 years her senior, Mr. Newman had a reasonable expectation that he would receive care from her during the balance of his life. The only factor which would indicate she might not have been able to meet this expectation was her debilitating arm injury. There was evidence that it was beginning to improve. Since her death Mr. Newman suffered a heart attack in May 2001, which is something I can take into account: *Parsons v. Guymer* 101 D.L.R. (4th) 279 (C.A.).

[221] James Newman, Mr. Newman's son and his wife Helen testified that Mr. Newman has required 10 to 15 hours of weekly "care" type assistance since his May 2001 heart attack. Before that his care needs were substantially less, in the range of 3 to 5 hours per week. Mr. Newman generally spent most winters in Florida in a retirement community where care was provided by friends in the community. James and Helen Newman then provided 2 to 3 hours of weekly care. From June to October 2000 Mr. Newman moved into a seniors' retirement home. At that facility, he received lodging, food, housekeeping and laundry assistance, as well as, transportation and the co-ordination of medical appointments. The monthly cost of the home was $2500. His counsel submitted that it would be inappropriate to suggest that the value of his loss of care is

$2500 a month since expenses for lodging, food, hydro, telephone, and cable would be incurred in any event. Mr. Newman's current lodging costs are $350 per month. Using the monthly costs of the retirement home as a benchmark, counsel submitted that Mr. Newman's pecuniary loss for the care that he would have received from Mrs. Newman might reasonably be estimated at $1000 per month.

[222] No expert evidence was called on what care Mrs. Newman provided and how much it would cost to replace that care or what care Mr. Newman now requires that Mrs. Newman could have been expected to provide and what that care is worth. However, the difficulty of assessing a loss does not relieve the court of its responsibility in that respect.[10]

[223] This is not a case where I should quantify past services provided by the son and daughter-in-law. There has been no monetary expenditure other than what was paid to the seniors' residence. I take into account Mr. Newman's age and health difficulties and Mrs. Newman's arm difficulties, which may have impaired her to some degree in assisting him and I use the seniors' residence as a benchmark of sorts. The sum of $1000 monthly attributed to the care aspect of those accommodations is not a strict arithmetic calculation but does strike me as reasonable and modest. In the circumstances, I award $5000 to Mr. Newman for past pecuniary loss.

[224] Taking into consideration Mr. Newman's precarious health, it is likely he will require residential care in the future. I think it is unlikely that he would have needed it if Mrs. Newman were alive. Taking into account the same factors and his limited life expectancy, I award $20,000 for the cost of future care.

Outstanding Issues and Costs

[225] There are three other outstanding issues. The first is the conversion of damage amounts expressed in English pounds into Canadian dollars. Counsel have agreed to leave that issue to further argument if they cannot agree on the appropriate conversation rate. The second is prejudgment interest. The plaintiffs shall have prejudgment interest on the amounts awarded. Counsel have agreed to leave for further argument the issue of the dates at which interest is to begin on the various amounts awarded and therefore the applicable interest rates, if they cannot agree. Finally there is the issue of costs. If counsel do not agree that costs in the ordinary course should be awarded to the plaintiffs on a partial indemnity basis or if they cannot agree on the amount, or if they are unable to agree on either of the other two issues, they may take out an appointment.

M. L. Lack

Released: May 27, 2002

[10] Nielsen et al v. Kaufmann (1986), 26 D.L.R. (4th) 21, 54 O.R. (2d) 188 (C.A.)

COURT FILE NO.: 128947/97
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ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

Alfred Newman, Executor and Trustee for the estate of Theresa Newman, Deceased, and Alfred Newman, personally

Plaintiffs

- and –

William C. Swales

Defendant

REASONS FOR JUDGMENT

Lack J.

Released: May 27, 2002