SUPREME COURT OF YUKON

Citation: *Tupper v. Reddoch*, 2013 YKSC 113

Date: 20131108
S.C. No. 08-A0050
Registry: Whitehorse

Between:

Chrystal Lynn Tupper

Plaintiff

And

Dr. Allon Reddoch, Dr. Gerald B. Doersam, Dr. Roger S. Mitchell,
Dr. Wayne MacNicol and Dr. Stephanie Starks

Defendants

Before: Mr. Justice G.C. Hawco

Appearances:

Susan Roothman	Counsel for the Plaintiff
Nigel Trevethan	Counsel for the Defendants, Dr. Doersam
Djuna Field	and Dr. Mitchell

REASONS FOR JUDGMENT

INTRODUCTION

[1] The Plaintiff, Ms. Chrystal Lynn Tupper, has had gynecological difficulties for over 30 years. She is presently 54 years of age.

[2] When she was 17 years old, Ms. Tupper had a child. In 1978, at the age of 19, she had an IUD inserted. She began experiencing vaginal discharge shortly afterwards as well as abnormal bleeding and inflammation of the uterine lining (endometritis). In October of 1979, she had that IUD removed.

[3] On March 18, 1985, some eight weeks after the birth of another child, Ms. Tupper had her family physician, Dr. Allon Reddoch, insert another IUD, which was a copper Nova-T IUD. The insertion was unremarkable and the IUD strings were palpable.

[4] Over the next year, Ms. Tupper did complain of some lower abdominal cramps, however she did not complain of any pain during intercourse (dyspareunia), which had been a problem in the past. On March 25, 1986, however, Ms. Tupper did complain of dyspareunia, lower abdominal cramps and vaginal discharge.

[5] On June 17, 1986, Ms. Tupper asked Dr. Reddoch to perform a tubal ligation and to remove her IUD. However, on July 10, 1986, Ms. Tupper discovered that she was pregnant again, notwithstanding the presence of the IUD and asked Dr. Reddoch to perform a therapeutic abortion, as well as a tubal ligation. She also requested that her IUD be removed. Ms. Tupper's concern was about the health and normalcy of her fetus.

[6] On July 16, 1986, Ms. Tupper was seen by Dr. Roger S. Mitchell who noted that Ms. Tupper's IUD had been in place since 1985 but that the string had not been palpable for some time.

[7] On July 21, 1986, Ms. Tupper saw Dr. Gerald B. Doersam for an assessment in respect of a therapeutic abortion and tubal ligation. He performed an examination on her and noted that the IUD strings could not be seen.

[8] On July 23, 1986, Dr. Mitchell performed a therapeutic abortion on Ms. Tupper. He then transferred her to Dr. Doersam who performed a laparoscopic tubal ligation. Dr. Doersam gave evidence. He stated that he had had a good view of the pelvis and noted that the uterus was unremarkable. He stated that his examination would have

included an examination of the cul-de-sac and the uterus for signs of perforation and any evidence of an IUD. He observed no such signs or clues.

[9] The abortion consisted of a process wherein a suction tube was inserted into the uterus and the fetus and all other tissue associated with it would be sucked into a pathology bag. Following this, he went into the uterus with a curette and checked the uterus to satisfy himself that all of the fetal material had been removed. Dr. Mitchell did not examine the products in the pathology bag as this was frowned upon by the pathologist's office, apparently. The pathology bag would be sealed and delivered to a pathologist for his/her examination. He could not tell if the IUD had been sucked out during this process. He received no report back from the pathologist with respect to the presence of an IUD. He made no inquiries.

[10] Dr. Mitchell's evidence was that the laparoscopic examination which he carried out was considered to be "the gold standard" at the time. He did not observe an IUD, nor did he observe any evidence of the IUD having perforated the uterine wall. His view, at the time, was that the IUD was either in the pathology bag or had been expelled some time before the abortion.

[11] It was Dr. Doersam's evidence that his usual practice was that after the abortion was completed by Dr. Mitchell, he would examine the uterus to make sure there was no sign of a perforation by an IUD of the wall of the uterus. He saw none in this case. He said it had crossed his mind that there may have been a perforation but he dismissed that thought when he realized there had been a note by Dr. Reddoch a month earlier that the IUD strings had been palpable. He did not consider an X-ray because he saw no need to expose Ms. Tupper to radiation and felt that due to his "excellent

observation" examination, the IUD must have been expelled as it was clearly not present and there was no evidence of a perforation.

[12] As far as Ms. Tupper was aware, her IUD had been removed. Certainly, no one told her that it had not been removed. What is odd, however, is that in none of the medical reports or notes entered as evidence at the trial, is there any mention of anyone actually seeing the IUD or noting that it had been removed. Neither did anyone note that it had not been seen. There was simply nothing said by anyone to anyone about the IUD

[13] Following the abortion and tubal ligation, Ms. Tupper continued to have abdominal cramps, vaginal discharge and complained of a tender uterus. As well, she complained of pain during intercourse and eventually, heavy periods, which resulted in chronic iron deficiency and anemia. Over the years, she was seen by her family physicians, Dr. Reddoch and Dr. Starks and her gynecologists, Dr. MacNicol and Dr. Bendall, for these problems.

[14] For a period of two years, from approximately April 1988 to sometime in 1990 or 1991, Ms. Tupper lived in Salmon Arm, British Columbia. There were no medical records for that time span.

[15] Upon returning to Whitehorse, Ms. Tupper continued to complain of dyspareunia and tenderness in her pelvic area as well as abdominal discomfort.

[16] Through 1994, Ms. Tupper continued to complain of dyspareunia and tenderness in her pelvic area. In December 1994, a diagnostic laparoscopy was carried out of her pelvis which showed a normal and healthy uterus. Some adhesions were noted in the area of her cervix.

[17] In July 1994, she saw Dr. W. MacNicol for the first time, complaining of left lower quadrant pain and dyspareunia.

[18] In August 1998, she saw Dr. MacNicol with lower quadrant pain, this time in the right side, as well as dyspareunia. In May 2000, she was complaining of fatigue and weight-loss. She was having chronic central and left-sided pelvic pain, forcing her to stop intercourse. Later during that year, she reported low back pain. An ultrasound showed a 5.5 cm fibroid and a 1.5 cm endometrial polyp.

[19] In 2004, she saw Dr. MacNicol again regarding her fibroids, heavy periods and long-standing dyspareunia, presumed to be due to the scar tissue between the rectosigmoid colon and posterior cervix noted in a laparoscopy in 1994 and thought to be endometriosis-related. A hysterectomy was recommended, with bowel preparation due to a rectal adhesion. It was not immediately booked. At this point in time in her life, Ms. Tupper was using cocaine.

[20] In May 2006, Ms. Tupper was assessed by Dr. M. Bendall. At that time, she was still having cramping, discomfort, deep dyspareunia, post-coital bleeding, in addition to her ongoing heavy periods. A hysterectomy was carried out on July 14, 2006 with Dr. Bendall. At that time, she was confirmed to have fibroids and a significant adhesion between the rectosigmoid colon and posterior uterine wall in the region of the cervix. Within this adhesion, the IUD, which she had thought had been removed in 1986, was discovered. The arms of the IUD were contained within the adhesion and the copper stem had penetrated the wall of the rectum and the string was seen to be exiting the rectum from a different point. The IUD was pulled out of the rectum with the assistance

of Dr. F. Huang, a General Surgeon. There was no obvious leakage of bowel contents after the IUD removal.

[21] As Dr. Huang noted in her consultation report of July 17, 2006, she was called in when Dr. Bendall discovered, as he was dissecting the uterus from Ms. Tupper's rectum, that there was an IUD which appeared to be firmly embedded inside the rectum. There had been significant inflammation and thickening of the rectum. On a diagram which was entered as Exhibit 3, Dr. Huang indicated where she believed the IUD was discovered. According to her note, it was "overlying the sacro angle and so I think at the rectosigmoid area."

[22] Dr. Michelle Belanger, a Gynecologist called by the Plaintiff, was actually of the view that the IUD was further down towards the bottom of the uterus. Dr. Bendall agreed with Dr. Belanger's placement of the IUD.

[23] It was Ms. Tupper's evidence that following what she believes had been the removal of the IUD in 1986, she continued to have difficulty with sex, which was painful for her nearly all the time. Her partner on a number of occasions said he felt a "poking sensation" on his penis during sex.

[24] She had vaginal infections continuously over the years and lower abdominal pain from 1986 to 2006.

[25] On top of these symptoms, she always felt tired and had very little appetite. She had numerous visits to her family doctor and to gynecologists, but no one seemed to know what was wrong with her.

[26] In 1993, cysts were discovered on her Fallopian tubes.

[27] In 1998, fibroids became enlarged.

[28] The pain during intercourse was obviously something which affected her sexual relations with her husband. The pain which she suffered also affected many of her activities, including various family activities with her son.

[29] She felt that prior to 1986 she had been a very active outside person, while after 1986, it was very different. She could not participate in the normal family activities. She would often be the first to go home from any activity. During her various employments, she was not able to work as well or as efficiently as she had in the past.

[30] Since having the IUD removed, her sex life is greatly improved and she is doing much, much better. She feels much better and is enjoying life again.

[31] The Plaintiff was not a particularly good witness in that she minimized the gynecological problems which she had prior to the removal, or what she thought was the removal, of her IUD in 1986. She had suffered vaginal infections, post-coital bleeding and pain during intercourse occasionally from the 1970s to 1985.

[32] Her answers at Examinations for Discovery were often inconsistent with her evidence at trial. She maintained that she did not understand that the answers given at Examinations were related to pre-1985. Defence counsel could not have been clearer during examination as to what period of time he was concerned with.

[33] Ms. Tupper obviously had a somewhat selective memory. Her medical records make it clear that she suffered a variety of gynecological problems all her adult life.

[34] Her evidence is clear, however that post-1986, the pain that she suffered during intercourse happened more often and was greater than pre-1986. Her abdominal pains and general discomfort were greater after 1986. The medical records appear to support this.

[35] Ms. Tupper had originally booked an appointment to have her hysterectomy carried out in April 2004 and cancelled that. In 2005, she failed to attend for surgery that had been scheduled. It was re-scheduled for July 2006, when it was eventually carried out.

[36] Ms. Tupper did admit to heavy cocaine use during the period 2004 to 2006. She has been drug-free for a number of years now.

Plaintiff's Positions

[37] The Plaintiff claims that Drs. Mitchell and Doersam were negligent in not having removed her IUD when requested to do so in 1986. They were negligent in failing to make sure that the IUD had either been removed or fallen out. They were negligent in not making sure it was not within her uterus or contiguous areas before completing their procedures.

[38] The Plaintiff claims that as a result of their negligence, she had suffered for over 20 years.

Defendant's Position

[39] The Defence maintains that the Plaintiff has failed to establish negligence on either of their parts. She has failed to satisfy the Court that either of the Defendants failed to meet the standard of care for a general practitioner or a gynecologist in 1986 when the operation took place. She has failed to establish that her problems between 1986 and 2006 were caused by the presence of the IUD.

Issues

1. Whether the Defendants or either of them were negligent in failing to remove the Plaintiff's IUD in 1986.

2. If the Defendants or either of them were negligent, did that negligence cause any injuries to the Plaintiff?

3 If there was pain and suffering to the Plaintiff, which was attributable to the Defendants, what is the quantum of her damages?

Decision

1. Both Dr. Mitchell and Dr. Doersam were negligent in failing to ensure the Plaintiff's IUD was not within her body at the conclusion of the abortion and the tubal ligation procedures.

2. The Plaintiff suffered numerous gynecological problems over the 20 years following the operation to remove her IUD. Not all of them were caused by the failure to remove the IUD, but many of them were.

3. The Plaintiff is entitled to recover damages in the amount of $60,000 plus special damages. She is also entitled to receive the costs of these proceedings.

Reasoning

1. Negligence of Doctors

[40] Dr. Belanger's evidence was critical in this regard. The Defendants took exception to her opining on the standard of care in 1986. However, at the trial, having heard Dr. Belanger and having been referred to her extensive *curriculum vitae* and having heard argument from Defence on what was argued to be a lack of expertise with respect to the practice of a General Practitioner in the mid-80s and the then current practice of an obstetrician/gynecologist, I ruled that I was satisfied as to Dr. Belanger's qualifications to give evidence with respect to general obstetrics and gynecology. I

stated then, and am still of the opinion, that I was satisfied as to her expertise and therefore her ability to opine upon the practice in 1986, to the extent that she was aware of it and the difference, to the extent that she was aware of it, as of today.

[41] It was, quite frankly, somewhat surprising to me that the Defendants would argue that because Dr. Belanger only received her medical degree in 1995 and completed her residency in obstetrics and gynecology in 2000, that she was not in a position to give evidence with respect to what was or should have been the accepted practice in a rural setting in 1986. Dr. Belanger's expertise is acquired not simply through her practice but through her extensive studies and training. Although she was obviously not in practice in a rural setting (such as Whitehorse would have been considered in 1986, with all due respect), she did research into the standard of care in Yukon in 1986. She studied papers and textbooks. She was aware of the technology available at the time. I accepted Dr. Belanger as an expert in the field of obstetrics and gynecology and accepted her expertise with respect to the standard of care of a general practitioner position in that area at the time.

[42] Dr. Belanger was of the opinion that insertion of the IUD in the Plaintiff in 1985 was complicated by a uterine perforation and the fact that the IUD migrated into the abdominal cavity in the area called the cul-de-sac, which is a space between the back wall of the uterus and cervix, and extended into the rectum.

[43] It was Dr. Belanger's opinion that when the Plaintiff presented for her procedure, that is the procedure to have the fetus removed, a tubal ligation performed, and the IUD removed, it was determined that the IUD strings could no longer be seen. To quote from Dr. Belanger's report (Exhibit 5):

> When IUD strings go missing, there are only three possibilities:
>
> 1. The IUD is in a normal location in the uterus, and the strings have simply migrated up the cervical canal. …
>
> 2. The IUD has been expelled. …
>
> 3. The IUD has perforated the uterine wall and is located in an abnormal location, usually the abdominal cavity. This is the most serious situation.

[44] Dr. Belanger went on to state in her report:

> "Missing IUDs" must be accounted for, because of the possibility of an intra-abdominal IUD. Copper IUDs are known to cause an intense inflammatory response, which can lead to scarring, pain and even perforations of the hollow organs such as the bladder or bowel, if they are involved. Because of these potential complications, abdominal IUDs require prompt surgical removal. This is typically done by laparoscopy (minimally invasive surgery with telescope through the belly-button) and laparotomy (open surgery) may be necessary in rare cases. To locate an IUD with missing strings, one typically starts with an ultrasound. If the IUD is seen in a normal position in the uterine cavity, nothing further is required. Ultrasound is not very good at finding IUDs that are outside the uterus, however. As such, if there is no intra-uterine IUD seen on ultrasound, an abdominal and pelvic X-ray should be the next step. Copper IUDs are radio-opaque and will always be seen on an X-ray, though the X-ray does not necessarily pinpoint the IUD's exact location. If the X-ray shows no IUD, one can assume that the IUD was expelled. If an IUD is found, one must assume an intra-abdominal location and a laparoscopy should be arranged. Please note that, in the mid-80s, gynaecologic ultrasound was likely not as available or accurate as it is today. As such, first line management might have involved instrumentation of the uterus to see if an IUD was palpable and if it wasn't, an X-ray. To determine the location of the IUD (intra or extra-uterine) with an X-ray would have involved inserting a sound or contrast media into the cavity during the X-ray.

[45] It is clear that if the IUD in this particular case was not found during either procedure, that is the abortion or the tubal ligation, and if it had not clearly been expelled, then as Dr. Doersam agreed, it must have been inside her.

[46] If the IUD is unaccounted for, then the duty of care in Dr. Belanger's opinion, as it was in Dr. Weibe's opinion as well, is that an X-ray be taken after the procedure. If there had been an X-ray taken in this case, then the IUD would have been discovered.

[47] Dr. Ellen Wiebe, an expert produced by the Defendants, obtained her medical degree in 1975 and her specialization in family practice in 1981. She was involved in family practice from 1982 and 1983 and obtained her residency in obstetrics and gynecology in 1997.

[48] In Dr. Wiebe's opinion, Dr. Mitchell's job was to carry out the abortion. He did what he should have done. Once Dr. Mitchell performed the abortion, he turned the case over to Dr. Doersam for the tubal ligation. Having done the abortion, he left the rest of the care to the specialist, Dr. Doersam.

[49] Dr. Wiebe did confirm that when the strings of an IUD go missing, there are only three possibilities. These were the same referred to by Dr. Belanger, that is, 1. they have been expelled, 2. they have migrated, or 3. there has been perforation. In Dr. Wiebe's view, a doctor should confirm what has occurred. While it is most likely that expulsion is a cause for not seeing the IUD strings, Dr. Wiebe agreed that one ought not to assume that the IUD has been expelled.

[50] Dr. Barry Hagen was called to give evidence as to the general practice and standard of care in the mid-1980's. Dr. Hagen received his medical degree in 1965. From 1970 to 2012, Dr. Hagen was a member of the University Hospital of Northern

British Columbia, departments of anesthesia, emergency services, surgery, obstetrics and family practice. From 1974 to 2008, he was one of the two Prince George regional providers of therapeutic medical and surgical abortions averaging about 200 cases per year.

[51] It was Dr. Hagen's opinion that at the time of the surgery, the absence of a detectible IUD should have prompted a discussion to the effect that an immediate search for the IUD and removal of it take place in a timely fashion. Because the laparoscopy did not show the IUD, an X-ray should have been taken.

[52] Dr. Hagen's filed report, Exhibit 15, contained these statements:

> 1. What was the standard of care for general practitioners during the 1980's with respect to the following:
>
> … 1.3 How to account for an IUD in the circumstances where a patient fell pregnant with an IUD and elected an abortion and tubal ligation to be performed at the same time.
>
> The standard of care under such circumstances consisted of dilation of the cervix to a diameter appropriate to the gestational stage, vacuum curettage of the uterine contents, and remove of the IUD with grasping forceps. Depending on the position of the IUD, it could be removed prior to the vacuum curettage or immediately thereafter. Because of the high risk of postoperative infection, the standard of care was to remove the IUD as an integral part of the D&C.
>
> 1.4 How to account for the missing IUD in general.
>
> In the rural setting of the 1980's, the standard of care was that finding a missing IUD would be essential. The search could include laparoscopic examination of the pelvis and abdomen, pelvic ultrasonography, and x-ray examination of the pelvis.
>
> 2. What was the standard of care with respect to clinical notes by a general practitioner about the above three procedures?

> 2.3 The standard of care for clinical notes by a general practitioner carrying out a surgical termination of pregnancy for a patient with a retained IUD was to confirm that the IUD had or had not been successfully removed at the time of the abortion procedure. In a situation in which the abortion-performing physician could not locate the IUD intra-operatively, the standard of care was to initiate appropriate search and removal of the device by secondary means as soon as possible. The 1980's secondary means of IUD location could include intra-operative or high-priority post-operative x-ray examination and urgent intervention by a gynecologist or a general surgeon.

[53] Dr. Hagen was also asked to express his opinion concerning some of Dr. Wiebe's report. He made this statement:

> On this point I cannot agree with Dr. Wiebe. The 1980's standard of care for a physician carrying out an abortion was that, when a missing IUD could not be located and removed in the course of a dilatation and curettage, it was incumbent on that doctor to report immediately the problem to all members of the surgical team, and post-operatively to the patient and her family physician.

[54] Dr. Hagen did opine during his testimony that in his view, Dr. Mitchell would not have been someone he would describe as a "normal" general practitioner because he specialized in abortions.

[55] Dr. Laurie Neapole gave evidence on behalf of the Defendants as an expert in obstetrics and gynecology, in particular with respect to the insertion and extraction of IUDs. Dr. Neapole's primary evidence related not so much to the standard of care as to the likelihood that the retained IUD in this particular case caused many of Ms. Tupper's problems.

[56] Dr. Neapole did opine as to the standard of care as performed by Dr. Doersam. In her view, Dr. Doersam provided appropriate care in all the circumstances to

Ms. Tupper and he met the standards expected of a rural physician specializing in obstetrics and gynecology in his care and treatment of Ms. Tupper.

[57] With the greatest respect to Dr. Neapole, I prefer the evidence of Dr. Belanger, supported by Dr. Wiebe and Dr. Hagen. Ms. Tupper went in for an abortion, tubal ligation and the removal of her IUD. It was assumed by both Dr. Mitchell and Dr. Doersam that the IUD had been expelled. Both confirmed that they performed the "gold standard" of care by having a laparoscopy performed. With great respect to both Dr. Mitchell and Dr. Doersam, the "gold standard" of laparoscopy in this case merely showed that on a visual inspection, the IUD was not present. In my respectful view, the standard duty of care at the time required that if the IUD was neither visible nor accounted for, an X-ray ought to have been used to confirm that the IUD was not within the Plaintiff's pelvic area. No discussion at all seems to have taken place between Dr. Mitchell and Dr. Doersam. An assumption was made based merely on a laparoscopic view and the use of the curettage. The fact that the IUD may have perforated the uterus was not considered. No one appears to have concerned themselves whether it had been sucked out or not during the abortion. The pathology report, which does not appear to have been examined in any event, did not refer to the presence of an IUD. The medical notes do not indicate any discussion having taken place between Dr. Mitchell and Dr. Doersam. To all appearances, the removal of the IUD or its absence, simply does not appear to have been considered by them.

2. Causation

[58] As I said earlier, Ms. Tupper was not a particularly credible witness in some respects. She would have the Court accept that she was mistaken during her Examination for Discovery and that all of her gynecological problems began in 1986.

[59] Defence counsel could not have been clearer in his questioning during his Examinations for Discovery. He was attempting to establish that up until 1986, Ms. Tupper had been suffering from many of the same symptoms she had displayed since 1986. He did establish that. The medical records were quite clear that she had problems predating the 1986 procedures.

[60] However, as noted in Dr. Weibe's extensive history on Ms. Tupper (see Exhibit 13) the incidents of dyspareunia, cramping, heavy periods and general pelvic and abdominal pain appeared to have increased significantly after 1986. While Ms. Tupper clearly had some complaints of vaginal infection and discharge, as well as dyspareunia prior to the IUD purportedly being removed, the medical records are quite clear that in the years following 1986, the complaints of both vaginal discharge and dyspareunia increased significantly, as did the instances of pelvic pain.

[61] According to Dr. Belanger, the migration of the IUD through the uterine wall and into the bowel and rectum area created intensive scaring and inflammation. The IUD would cause pelvic pain in general and pain during intercourse.

[62] As Dr. Belanger said in her report (Exhibit 5), two laparoscopies were done, one in 1993 and one in 1994. Both procedures revealed dense scar tissue between the back wall of the uterus and the cervix, and rectosigmoid colon. According to Dr. Belanger, in

hindsight, this adhesion was caused by the inflammatory reaction from the copper IUD. As Dr. Belanger stated:

> The IUD was almost certainly the cause of her dyspareunia and pelvic pain. With penetrative intercourse, there would have been contact between the penis and the inflamed area behind the cervix, where the IUD was located. Pelvic pain could have been caused by the on-going inflammation. Based on the location of the IUD in the wall of the rectosigmoid colon, one might also have expected some bowel problems or pain with defecation, which she did not appear to have had. She was constipated, but this was probably caused by the iron supplements used to treat her chronic anemia.

[63] Dr. Belanger was of the view that Ms. Tupper's recurring vaginal infections were probably completely unrelated to the IUD and that her heavy menstrual bleeding was probably fibroid-related, and thus had nothing to do with the IUD.

[64] Dr. Neapole was of the view that although it is possible the retained IUD did cause some of the cramping, low abdominal pain and tender uterus, there was no way to confirm this. She was of the same view with respect to the complaints of the dyspareunia. I note that in her cross-examination, Dr. Neapole stated that she could not definitely say that the IUD caused it.

[65] Where Dr. Neapole's opinion differs from Dr. Belanger, I prefer the opinion of Dr. Belanger. I do so having considered the evidence in chief of both doctors, as well as the cross-examinations.

[66] In addition to the pelvic pain and the dyspareunia, Dr. Belanger was of the view that the endometriosis, while possibly the cause of similar thick adhesions within the uterus, was more likely caused in and of itself by the movement of the IUD.

[67] Dr. Wiebe also gave an opinion with respect to which of Ms. Tupper's complaints were caused by the retained IUD. In Dr. Wiebe's opinion, one would have expected bowel complaints. As Dr. Belanger stated, it was simply fortunate that the IUD did not completely perforate the bowel.

[68] Dr. Wiebe did say that the complaints which could possibly be caused by the retained IUD are: low abdominal pain, dyspareunia, pelvic pressure, discomfort and pain. In Dr. Wiebe's opinion, however, these were more likely to be related to her known conditions of fibroids and endometriosis. Once again, I prefer the opinion of Dr. Belanger with respect to the cause of the dyspareunia and abdominal pain. The presence of a copper IUD which is migrating through the uterus wall over 20 years and the resultant scaring which did take place, together with the instances of the large rise in numbers of complaints relating to both lower back pain and dyspareunia satisfy me that Dr. Belanger's evidence is to be preferred. I am satisfied that the primary contributor to the majority of the complaints of Ms. Tupper was the IUD which had not been removed.

[69] Had the IUD been removed when it should have been, Ms. Tupper would not have had as many instances of pain during intercourse or as many instances of pelvic pain and abdominal pain over the 20 years the IUD was left within her body. I have no difficulty whatsoever in finding that the Defendants' negligence was the cause of years of pain and suffering of the Plaintiff.

3. Damages

[70] Having said that, I am mindful that some of Ms. Tupper's woes were unrelated to the presence of the IUD. In particular, the reoccurring vaginal discharge problem and the heavy menstrual periods were totally unrelated to the IUD.

[71] I am also mindful that Ms. Tupper complained of dyspareunia and had experienced some pelvic pain earlier than 1986. While some of these problems may have continued even if the IUD had been removed, they were certainly greatly exacerbated.

[72] The Defendants have argued that if I were to find them liable, the damage award should be in the range of $30,000. The three cases they have put forward as appropriate are ***Jacks v Dunnett***, 1987 CarswellBC 662 (BCSC), ***Williams v Farrell***, 2006 Carswell Ont 3993, and ***McNeil v Yamamoto***, 2004 MBQB 271.

[73] Those decisions were somewhat helpful but, of course, each case is governed by the particular facts within that situation. Here we have something which goes beyond simply discomfort over a relatively short period of time.

[74] The Plaintiff argues that her injuries have resulted in suffering some 20 years of chronic pain and that I should be looking at not only the severity and duration of that pain, but the loss of the ordinary joys of life which she has endured for years, as well as, specifically, the impairment of her marital relationship over the years.

[75] Taking the Plaintiff's earlier problems into consideration and acknowledging that some of her difficulties were not related to the presence of the IUD, but bearing in mind that I am quite satisfied that the primary contributor to the majority of the Plaintiff's complaints was the presence of the IUD which ought to have been removed, I award the Plaintiff the sum of $60,000 for the pain and suffering she has endured for over 20 years, caused by the Defendants' negligence.

[76] The special damages are set at one-half of the total of the physician's and hospital's claims, which I understand to be $14,109.90. These are claimed on behalf of

the Yukon Health and Social Services. Of the $11,789 for hospital claims, there should be deducted the sum of $2,764 which relate to treatments to her with respect to her drug abuse over a two-year period or so. I calculate the special damage of the Yukon Health and Social Services to be $5,672.95.

[77] The Plaintiff is entitled to her costs.

HAWCO J.