Grennan v. Reddoch, 2001 YKSC 512

Date: 20010228
Docket: 97-A0190

IN THE SUPREME COURT OF THE YUKON TERRITORY

THE COURT:

THE HONOURABLE MR. JUSTICE HOWARD L. IRVING

BETWEEN:

SIMON EDWARD GRENNAN, ADMINISTRATOR OF THE ESTATE OF MARY-ANN GRENNAN, DECEASED

Plaintiff

- and -

DR. SUSAN ALTON, DR. LYLE GALLOWAY, DR. DANUSIA KANACHOWSKI, DR. ALAN REDDOCH, WHITEHORSE GENERAL HOSPITAL, NURSE JANE DOE 1, NURSE JANE DOE 2, NURSE JANE DOE 3, NURSE JAN DOE 4, NURSE JANE DOE 5, NURSE JANE DOE 6, NURSE JANE DOE 7

Defendants

REASONS FOR DECISION OF THE HONOURABLE MR. JUSTICE IRVING

COUNSEL:

R.D. Gibbens and Robert Garson
For the Plaintiff

C.E. Hinkson, Q.C. and N.L. Treventhan
For the Defendant - Dr. Reddoch

J.C. Grauer
For the Defendant - Whitehorse General Hospital

REASONS FOR DECISION OF THE HONOURABLE MR. JUSTICE IRVING

[1] The Plaintiff Administrator of the estate of Mary-Ann Grennan, deceased, seeks damages from the Defendant Dr. Reddoch and the Defendant Whitehorse General Hospital (the "Hospital") for serious injury to and the subsequent death of Mary-Ann Grennan arising from alleged negligent medical and Hospital services provided by these Defendants to Ms. Grennan in the period of September 8 to September 11, 1995. The action against the other Defendants was discontinued at the opening of the trial.

THE FACTUAL BACKGROUND

[2] Ms. Grennan attended at the Emergency Department of the Defendant Hospital on three occasions on September 8 and 9, and was admitted to the Hospital on the third attendance. She was treated in the Hospital under the care of Dr. Alton until the afternoon of September 10 when her family doctor, the Defendant Dr. Reddoch, assumed her care. Ms. Grennan suffered cardiopulmonary arrests in the late evening of September 11, so that oxygen deprivation caused irreversible brain damage. She remained in a persistent vegetative or comatose state until she died on April 26, 1996.

[3] Ms. Grennan had been a healthy 16 year old girl in September 1995 and was just starting her grade 10 school year in Whitehorse.

[4] Ms. Grennan's father, Simon Edward Grennan, after catching some pike fish, treated the fish in brine, and then smoked it on Wednesday, September 6. He consumed some of the fish at lunch on Thursday, September 7, and Ms. Grennan and her boyfriend also consumed some of the fish during that day. The Hospital charts suggest that Mr. Grennan ate less of the fish than his daughter.

[5] Ms. Grennan, her boyfriend, and Mr. Grennan all became ill in the early morning hours of Friday, September 8. Mr. Grennan and Ms. Grennan went together to the Emergency Department of the Defendant Hospital about 9.00am that morning and were seen by Dr. Kanachowski. Ms. Grennan's complaints were that she was weak and dizzy, had been throwing up, with stomach cramps, but without diarrhea. She had mild dehydration and the diagnosis made was gastroenteritis (an infectious or inflammatory condition which affects the stomach and/or intestines). She was sent home but told to return if the symptoms persisted.

[6] Still feeling quite ill, Ms. Grennan returned to the Hospital Emergency Department about midnight on Friday, September 8, and saw Dr. Galloway. She explained that she had been vomiting all day, was feeling weak and unwell, and had abdominal cramps although no diarrhea.

She was given fluid intravenously and sent home, but told to return if the vomiting or the pain persisted. The diagnosis again was gastroenteritis.

[7] Her difficulties continued, so Ms. Grennan returned to the Hospital on Saturday evening, September 9, and was seen by the nursing staff and Dr. Alton. Her complaints then were that she was unable to keep down fluids, her mouth and throat were dry and she found it hard to swallow, but that the nausea had improved. The diagnosis was again gastroenteritis and Ms. Grennan was admitted to the Hospital about 9.00pm so that she could be given fluids intravenously. Her admission was intended to be under the care of her family physician, the Defendant Dr. Reddoch, although he was off duty that weekend.

[8] The Hospital charts relating to Ms. Grennan's illness included Emergency Department Reports, the Case History, Reports of the First Nation Liaison Worker, all Doctors Orders, all Nurses' Notes and all Laboratory Reports, etc, etc.

[9] Dr. Alton noted in Ms. Grennan's Hospital charts at the time of her admission:

> "Today the vomiting and pain subsided but she's been unable to swallow. Denies real pain on swallowing but water just won't go down. Unable to drink more than a small sip in observation in OPD."

[10] Dr. Alton saw her again on Sunday morning, September 10, and noted in part:

> "Hydration status normal now. Weak with some improvement of dysphagia. Electrolytes and Complete Blood Count normal."

Dysphagia is difficulty in swallowing. Dr. Alton also noted that Ms. Grennan's neurological reflexes were normal and her hand grip was evident.

[11] Dr. Reddoch came to the Hospital to see Ms. Grennan at 3.00pm that Sunday afternoon and first reviewed Ms. Grennan's Hospital charts. Dr. Alton had left a message for him that Ms. Grennan had been admitted to his care as her family physician and he had also already been contacted earlier about the illness by Ms. Grennan's mother, Patsy Vance.

[12] Dr. Reddoch described his Sunday visit as being supportive. He took no history then (nor at any time) nor did he do any physical examination. He did observe that Ms. Grennan was pale, but thought that she was improving. They discussed her great grandmother's death, and funeral which was being held that day and which he thought caused her to be emotionally upset. He

discussed her menstrual periods because he noted some suggestion of anaemia. Then Dr. Reddoch noted in Ms. Grennan's Hospital charts: "Plan on discharge tomorrow on oral iron."

[13] Nurse McDonald was the duty nurse on the medical ward from 8.00pm Sunday night to 8.00am Monday morning. Nurse McDonald gave evidence that she spent most of her shift that night with Ms. Grennan; she arranged that her Aide attend to the other medical patients. Nurse McDonald considered that Ms. Grennan was "a very sick girl." Nurse McDonald made extensive entries into the charts. Twice during the night she contacted Dr. Alton (who was on duty) about Ms. Grennan. On the first occasion Dr. Alton attended about midnight, and saw Ms. Grennan in relation to her swallowing difficulties. Dr. Alton diagnosed tonsillitis and prescribed an antibiotic for the sore throat complaint. Nurse McDonald contacted Dr. Alton again about 3.00am for an analgesic (codeine) for her sore throat; she also tried to contact Dr. Alton on a third occasion, but he was not available, and so about 7.30am that Monday morning, Nurse McDonald telephoned Dr. Reddoch at his home and he promised to come over shortly. He arrived within about 15 minutes, he reviewed Ms. Grennan's Hospital charts, and spoke briefly to Nurse McDonald, following which he saw Ms. Grennan. Nurse McDonald was not with him when he saw Ms. Grennan, nor did he discuss her with Nurse McDonald afterwards.

[14] In her evidence, Nurse McDonald described that during that night, Ms. Grennan had stated that she was too weak to open her mouth or too weak to hold a water glass. She denied any cramping, nausea or diarrhea. She required assistance to go to the commode. Nurse McDonald made a number of references to Ms. Grennan's "whining" voice and about her hyperventilating when she had company, and about dramatizing her illness. She explained that she ascribed some of these instances as dramatizing because they would not otherwise fit within the diagnosis of gastroenteritis. She described "Patient remains weak and will not assist with any movement 'like a rag doll'." Because of her complaining of being unable to breathe, Nurse McDonald did a respiratory assessment and found it clear. A blood oxygenation reading was also done and was found to be normal at 95%. Nurse McDonald suggested that she was not really sure what plan of treatment was intended for Ms. Grennan.

[15] After seeing Ms. Grennan that Monday morning, Dr. Reddoch made an entry in Ms. Grennan's Hospital charts as follows:

> "September 11, 1995
> Globus hystericus. Throat clear. Chest clear. Discuss anxiety, etc."

Global hystericus was described as a sensation of something in the throat, but without any organic cause.

[16] Dr. Reddoch also noted that morning in Ms. Grennan's Hospital charts that he was "assuming the case" (despite his attendance the day before) and that the medicine prescribed by Dr. Alton for the sore throat be discontinued because he felt there was no tonsillitis nor fever. He prescribed one dosage of a depressant drug called Ativan and ordered that Ms. Grennan be nebulized with normal saline as necessary. Since her hydration level seemed normal, he discontinued her intravenous fluids. His plan was to keep her in Hospital that day, to encourage her to drink fluids for the gastroenteritis, to use the Ativan to make her more comfortable with the throat sensation, all with the expectation that she would be discharged the following day.

[17] Nurse McDonald's last notes that Monday morning before she completed her shift stated:

> "Ativan 1 mg given for throat spasms re: anxiety. Mum still at bedside and aware of Doctor Reddoch's diagnosis of throat spasms. To keep patient calm and breathing at a normal rate, it is important that she not hyperventilate and get uptight. It is also suggested that Sally Tisiga see patient as her grandmother was buried yesterday and she was quite close to her. Patient remains weak and will not assist with any movement 'like a rag doll'."

[18] On the day shift of Monday, September 11, the senior nurse on the medical ward was Alan Macklon. He recorded in the Nurses Notes at 12 noon:

> "Patient rested all day with boyfriend in room. Patient frequently being held up in a sitting position on the bed", and at 12.35pm: "Urinalysis to lab. Patient assisted to commode by boyfriend and mother. Patient continues to act as a 'rag doll'."

[19] Dr. Reddoch returned to check Ms. Grennan's Hospital chart at 5.30pm that day and ordered Ativan be given as necessary for sleep or anxiety. He also ordered that the intravenous be restarted since Ms. Grennan had not been drinking much during the day. Dr. Reddoch then went to Ms. Grennan's room, opened her door, and saw her in bed with the head of the bed elevated. He waved saying hello, she smiled in return, and he left. He expected that she would be discharged the next day.

[20] Nurse White was the senior nurse on the medical ward at 8.00pm on that Monday evening. At 9.15pm Nurse White noted:

> "Patient's visitors, brother and friend asked to leave to allow patient to rest with less stimuli for a while. Patient communicating with incomprehensible whispers and displaying

> total dependancy on others and as charted previously. Refusing the sips of water; when attempting to give to patient the water just drooled back out of the mouth. Complained of pain with swallowing."

[21] At 10.10pm her note stated:

> "Boyfriend now in to see patient who was seen transferring her to commode. Writer intervened and asked patient [sic] to wait outside of room. No void and patient assisted back to bed by two staff, buckled at the knees and slid to floor stating she was too weak to walk. Very dramatic."

[22] About 10.30pm Nurse White requested her Aide to test the blood oxygenation level; checking the blood oxygenation level was not routine, nor had it been directed to be done by Dr. Reddoch or any physician, but was something the nurses were doing of their own volition. The Aide reported that it began at 84% then stabilized at 88%. This startled Nurse White who decided to recheck the reading. She did so after having Ms. Grennan breathe deeply; the blood oxygenation then was 90%.

[23] Nurse White then decided to make another blood oxygen check before considering if she should alert Dr. Reddoch. She returned to Ms. Grennan's room about 10.45pm to do so but found her sleeping and decided against disturbing her. At 11.07pm she sent her Aide to redo the blood oxygenation test. The Aide returned immediately to report that Ms. Grennan was not breathing, and had no pulse.

[24] Emergency measures were taken immediately for resuscitation by Dr. Todd and others, including Dr. Reddoch. Ms. Grennan was intubated, and her heart function was restored, but without spontaneous respiration. On Tuesday, September 12, she was transferred by air ambulance to St. Paul's Hospital in Vancouver for further treatment. On that day, Dr. Reddoch noted on Ms. Grennan's Hospital charts:

> "Had no ptosis nor diplopia in hospital. ? cause for sudden respiratory arrest. ? myasthenia gravis. Given neostigmine with no response. (Slight response with nerve stimulator). ? botulism. No history of poison nor drug exposure. Two others ate same fish and both developed nausea and vomiting. No fish left for specimen. Prepared for transfer to St. Paul's ICU [Intensive Care Unit]. Father, Edward Grennan, has legal custody. Mother, Patsy Vance."

[25] Ptosis and diplopia are typically early symptoms of botulism. Ptosis is a drooping of the eyelid, and diplopia is double vision. Mr. Grennan had given evidence that his daughter complained of double vision on Friday, September 8; this concerned him and he was anxious that the Hospital should know this. However, it was apparently never reported to anybody at the Hospital. While I considered Mr. Grennan to be an honest witness, I have concluded that he may be mistaken about such a complaint of double vision; four physicians and many nurses had attended Ms. Grennan during that period and neither Ms. Grennan nor anyone on her behalf had suggested diplopia.

[26] Dr. Reddoch's suspicion about botulism in his chart entry on September 12, mentioned above, was confirmed by laboratory tests in Vancouver after Ms. Grennan's transfer to St. Paul's Hospital. Dr. Keyes, a neurologist, explained that botulism would cause the pulmonary arrest, after which the heart would continue functioning briefly until the lack of blood oxygen would arrest it. While the emergency measures taken in Whitehorse restored the heart function, and later treatment at St. Paul's Hospital restored spontaneous respiration, the brain was so damaged by the prolonged absence of oxygen that Ms. Grennan never regained consciousness.

[27] It seems clear from the evidence that even if botulism had been suspected, or known during Ms. Grennan's hospitalization, the paralysis of her respiratory muscles could not have been averted. Dr. Keyes stated in his medical legal report:

> "It is my opinion, that even if the diagnosis of botulism had been confirmed 24 hours prior to this event, the patient would have developed respiratory failure and she would have required intubation and ventilator support in an intensive care unit."

EXPERT WITNESSES

[28] Four physicians were called to give opinion evidence about Dr. Reddoch's diagnosis and treatment of Ms. Grennan. Dr. Paul Assad was called by the Plaintiff, and three by Dr. Reddoch, being Dr. Robert D. Keyes, Dr. David Esler, and Dr. R.N. Ralston. Each provided written reports, which are Exhibits, and gave evidence mostly in cross-examination about the reports.

[29] Dr. Paul Assad is a full-time family practitioner in partnership with other physicians at Langley and South Surrey, near Vancouver. He has specialist training in emergency medicine and practised as such at a hospital from 1981-1992. He then reverted to general practice of family medicine in 1992, and gave up hospital privileges in 1999. Dr. Assad was an impressive witness; he had given evidence at the disciplinary proceedings before the Inquiry Committee of the Yukon Medical Council concerning Dr. Reddoch's treatment of Ms. Grennan in issue here. Mr. Grennan

had made a complaint to the Yukon Medical Council which led to the disciplinary proceedings. Dr. Assad had been provided with the Hospital records concerning Ms. Grennan's attendances and hospitalization from September 8 - 12, 1995. He was also instructed to assume that Ms. Grennan had complained of double vision from September 9 onwards, and that she exhibited diminished or total loss of pupillary light reflex from September 9 onwards. Since I have not accepted that such complaints had been made by Ms. Grennan, Dr. Assad's report and opinions are helpful insofar as they are not influenced by that assumption.

[30] Dr. Robert D. Keyes, B.Sc., M.D., F.R.C.P.(P), is an impressively qualified specialist in the practice of neurology in Vancouver, who gave evidence as an expert in neurology, and in the diagnosis, assessment and treatment of botulism cases. He prepared a detailed 21 page report about Ms. Grennan's illness on September 8 including her respiratory and cardiac arrests on September 11. Dr. Keyes was provided with all relevant clinical records from Whitehorse General Hospital concerning Ms. Grennan from September 8 to September 12, 1995. He was also provided with the Pleadings, and was instructed to make certain assumptions:

> "1. The Whitehorse General Hospital is capable of performing only the most basic laboratory studies. All other investigations must be sent out to Edmonton or to Vancouver.
>
> 2. The Whitehorse General Hospital is capable of performing only the most basic of radiological procedures. Further, there is no on site radiologist.
>
> 3. Specialist coverage at Whitehorse General Hospital is scarce and intermittent. In particular there is no on site general internal medicine of neurology coverage.
>
> 4. Prior to this particular case there had never been a documented case of botulism identified in the Yukon."

[31] Dr. David Esler, M.D. C.C.F.P.(EM), is a full-time Emergency Physician practising at the Delta Hospital, which is a small Community Hospital near Vancouver. Dr. Esler gave evidence as an expert in Emergency Medicine. Dr. Esler was provided with the same materials as Dr. Keyes, and was instructed to assume:

> "1. Whitehorse General Hospital is a small community hospital remote from a referral center. It has limited

laboratory facilities and no local specialists in internal medicine or infectious disease.

2. Gastroenteritis is a common problem in Whitehorse, accounting for approximately 25 hospital admissions annually lasting from two to three days.

3. Mary Ann Grennan was a regular patient of Dr. Reddoch and a previously healthy sixteen-year old.

4. Mary Ann and her father consumed home preserved fish on September 7, 1995."

[32] Dr. R.N. Ralston, M.D., is a general practitioner who commenced his practice in Campbell River, B.C. in 1981. He gave expert evidence in the general practice of medicine in a non-tertiary Center, and reviewed the records of Dr. Alan Reddoch and the Whitehorse Hospital records pertaining to Ms. Grennan. He had also reviewed the transcript of the Examination for Discovery of Dr. Reddoch, but was generally unaware of what evidence was put before the Yukon Medical Council in the disciplinary proceedings brought against him.

ISSUE ESTOPPEL

[33] The Plaintiff submits that issue estoppel applies in this action in relation to issues determined by the Yukon Medical Council and McIntyre, J. of this Court in disciplinary proceedings arising out of Dr. Reddoch's treatment of Ms. Grennan.

[34] The Plaintiff Grennan complained to the Yukon Medical Council about Dr. Reddoch's care and treatment of Ms. Grennan at the Whitehorse Hospital during her September 1995 illness.

[35] Under the provisions of the ***Medical Profession Act***, where a complaint has been made to the Yukon Medical Council about a physician, the Council may constitute an Inquiry Committee to investigate and report its findings on the complaint. Upon receiving the report from the Inquiry Committee, the Council will hold a hearing where the physician is entitled to appear and "present argument with respect to the report and findings of the Inquiry Committee". The Council then must decide on whether it will accept the findings in the report, and whether those findings constitute unprofessional conduct and, if so, what penalty should be imposed.

[36] The ***Medical Profession Act*** also provides for an appeal from the Decision of the Council to the Supreme Court of the Yukon Territory.

[37] The allegation made against Dr. Reddoch which was investigated by the Inquiry Committee stated:

> "…. that you, from about September 10, 1995 to about September 11, 1995, failed to take appropriate steps in the management, treatment and care of your patient, Mary Ann Grennan, at Whitehorse General Hospital, in that you did not:
>
> 1. record an adequate history of her present illness;
>
> 2. carry out adequate physical examinations;
>
> 3. make an adequate record of any physical examinations conducted;
>
> 4. record your expected differential diagnosis and working diagnosis; and
>
> 5. record a plan for the management of her illness.

In relation to the foregoing, you have been guilty of infamous or unprofessional conduct."

[38] The allegations made against Dr. Reddoch in this action include the issues considered in the disciplinary proceedings.

[39] The Inquiry Committee, composed of three members who were physicians practising in smaller centres in British Columbia, heard witnesses, including Dr. Reddoch, and issued its Decision in which it found:

> "The Committee heard opinion evidence from Dr. Assad on the charges and also Dr. Reddoch's response to the charges …. 'in that you did not ….'
>
> Charge 1. 'record an adequate history of her present illness.' The Committee heard evidence on the history, the review of records and documentation that should be carried out by the attending physician on assumption of care. There was considerable controversy on this issue between the expert opinion and Dr. Reddoch's opinion. The Committee believes that the attending physician should review the history, physical findings, any other

physician notes, the nurses' notes and the investigations done up to the time he assumes care of the patient. He should focus on the diagnosis and differential diagnosis that has been provided to make an appropriate documentation. The Committee finds that this was not done and this charge is proven.

Charge 2. 'carry out adequate physical examinations.' The Committee listened to opinion evidence as to what an adequate physical examination entailed, the reason for performing one and the examinations that should have been done in this case. On the September 10th visit the examination was described as a visual one. At the 07:00 hours visit on September 11th 1995, the examination was recorded as 'throat clear, chest clear.' We were advised by Dr. Reddoch that he noted that she was able to push herself up in bed. On the 17:30 hours visit on September 11th Dr. Reddoch agreed he performed no physical examination. The Committee feels that in view of all the information available on the chart and in particular the recorded nurses' notes, these were not adequate physical examinations and that this charge is proven.

Charge 3. 'make an adequate record of any physical examinations conducted.' The findings have been recorded under Charge 2 and the Committee finds this charge has been proven.

Charge 4. 'record your expected differential diagnosis and working diagnosis.' Dr. Reddoch admitted that he did not record a differential diagnosis. On the 10th of September visit he recorded that she was anaemic and emotionally upset. On the September 11th visit he said she had globus hystericus. The Committee finds that an adequate differential diagnosis was not recorded and that the diagnosis of globus hystericus should only be considered as a diagnosis of exclusion. The Committee finds this charge proven.

Charge 5. 'record a plan for the management of her illness.' Dr. Reddoch stated that his plan was to be found in the orders he wrote for her on the Doctor's Order Sheet. The Committee does not accept this as adequate. A management plan should be outlined in the progress notes. The written orders can be, at best, only part of the plan. The Committee finds that this charge has been proven."

[40] The Inquiry Committee's Decision came before the Yukon Medical Council on August 19, 1998 which heard representation made on behalf of Dr. Reddoch. It then made its Decision as follows:

> "After careful consideration of the decision of the Inquiry Committee of April 16 and 17, 1998, which found that Dr. Alan Reddoch, in the management, treatment, and care of Mary-Ann Grennan, did not record an adequate history of her present illness, did not carry out adequate physical examinations, did not make an adequate record of physical examinations conducted, did not record a differential diagnosis and a working diagnosis, and did not record a plan for the management of her illness; and having listened to representations from the College counsel, counsel for the Grennan family, and counsel for Dr. Reddoch, we the Yukon Council, have come to the unanimous conclusion that Dr. Reddoch is guilty of unprofessional conduct. The council deliberated on penalty . . . .
>
> The reasons for the decision are as follows. Dr. Reddoch clearly failed to apply the requisite skill and knowledge to the care of Mary Ann Grennan. He failed in all respects to take the normal actions that one would expect of a physician to diagnose and treat a patient with a serious illness. The committee considered mitigating circumstances. These mitigating circumstances consisted of the expression of genuine remorse by Dr. Reddoch. Dr. Reddoch was not indifferent to his patient, visiting her in hospital twice during the short time she was under his care. It is noted that he continued to care for Ms. Grennan throughout the terminal aspect of her illness with diligence. Dr. Reddoch relied too much on the focus and misadvice of other physicians and nursing staff. The Yukon Council did not consider Dr. Reddoch was culpable for not making the diagnosis of botulism. The illness that caused the death of Mary Ann Grennan is rare and had not been heretofore reported in the Yukon Territory. The application of proper medical care and procedures reduces the mortality rate of this disease but does not prevent death in all cases. The purpose of an inquiry is to ensure that adequate medical practice standards are maintained. The council is also mindful of the tragic

circumstances of the outcome and is fully empathetic with the grief of the parents in this matter."

[41] The Decision of the Council was appealed to this Court. McIntyre, J. gave lengthy Reasons for dismissing the appeal on August 18, 1999. He observed that at the Hearing before the Council on August 19, 1998, the parties agreed that the Council had three tasks:

(a) Whether to accept the report of the Inquiry Committee.

(b) Whether the conduct reported on by the Inquiry Committee was infamous conduct or unprofessional conduct.

(c) To assess the penalty if the conduct was characterized as infamous or unprofessional.

[42] In his Reasons, McIntyre, J. commented on whether Dr. Reddoch had any right of appeal because of the position he had taken before the Council:

"B. Effect of Dr. Reddoch's Admissions before the Yukon Medical Council

38 There is a real question whether Dr. Reddoch can appeal the findings of the Inquiry Committee and Council. He seems to be taking a different position on appeal than he did before the Council. There is authority that an agreement that an inquiry report should be accepted by the council of a medical college is analogous to a consent judgment, such that it is not now open to Dr. Reddoch to challenge any of the findings of the Inquiry Committee. See: *Charalambous v. College of Physicians and Surgeons of British Columbia*, June 21, 1988, (B.C.S.C.) at 4.

39 Mr. Hinkson, Q.C., argues that the Council had no choice but to accept the report of the Inquiry Committee. He argues the only opportunity Dr. Reddoch has to challenge the facts is at the appeal level. Indeed section 33(4) of the Act specifically deems an appeal from the decision of the Council to be an appeal from the findings and report of the Inquiry Committee. The observations of Gibbs J. in *Charalambous* are said to be *obiter*, because Gibbs J.

did go on to assess the merits of the appeal, in case his analogy to the inability to appeal a consent judgment was incorrect. Further it is said, the Council cannot discipline for negligence unless the legislation permits it.

40 Mr. Martin points out that pursuant to section 16 of the Regulations to the *Act* the doctor and lawyer are entitled to appear before the Council and 'present argument with respect to the report and findings of the inquiry committee' and as to costs. Dr. Reddoch, he argues, did not argue against the report and findings but rather agreed that the report should be accepted and agreed that the conduct was unprofessional. Dr. Reddoch had the opportunity to argue against acceptance of the report and did not. His statements were the equivalent of an admission, from which Dr. Reddoch cannot resile.

41 For my part, I consider Dr. Reddoch to be bound by the position he took before the Council. Dr. Reddoch took this position after reflection and obviously, in consultation with his lawyer: 'I should say that it's not an easy thing for Dr. Reddoch to instruct me to take this position with respect to the charge' (Transcript 38/4-8). Dr. Reddoch intended that the Council rely on his position as articulated by his lawyer. He could have made all the arguments to Council he made to this court. I assume he did not in order to demonstrate his professionalism in accepting the criticisms found in the report. Further, this acceptance of criticism would be of benefit to him in the penalty phase. The Council had no misapprehension about the position taken by Dr. Reddoch. As noted, it did not find it necessary to adjourn to arrive at the conclusion Dr. Reddoch's conduct was unprofessional (Transcript 146/22).

42 The Council relied on Dr. Reddoch's 'expression of genuine remorse' in arriving at its decision. (The decision of the Yukon Council Characterization and Penalty Regarding Dr. Allan Reddoch, 19 August, 1998, page 1). I consider Dr. Reddoch's position before the Council to be analogous to that of someone who has pleaded guilty to an offence and asks that the plea to be taken into account in sentencing. I acknowledge that guilty pleas and consent judgments can be set aside, but that was not the

> position taken before me. Rather, it was said that the admissions were simply a recognition of the inevitable. That is, that the Council would accept the report of the Inquiry Committee and that Dr. Reddoch would be able to argue against those findings at this level. For the reasons expressed, I do not accept that characterization.
>
> 43 However, I intend to go on to consider each argument made by Dr. Reddoch. I do so because I may be wrong that Dr. Reddoch is bound by his position before the Council. Second, it is trite that with respect to jurisdiction, parties cannot consent to jurisdiction if it is not there."

[43] McIntyre, J. then considered each of the arguments advanced on behalf of Dr. Reddoch, all of which he rejected. These included:

(a) The jurisdiction of Council to discipline Dr. Reddoch on the facts of the case;

(b) Whether the Inquiry Committee gave adequate Reasons;

(c) Whether Dr. Assad was over-qualified to comment on standards in Whitehorse;

(d) Whether the Inquiry Committee erred in discounting Dr. Reddoch's evidence about the standard of care to be expected of physicians practising in Whitehorse;

(e) On the adequacy of Dr. Reddoch's notes, and of his physical examination of Ms. Grennan, McIntyre, J. said, in part, at p. 10:

> ". . . In chief, . . . he explained that he did not make an elaborate note because he was less than five minutes from the hospital. He would be called. During cross-examination be agreed in retrospect he should have given Mary Ann more extensive neurological testing . . . and that one should err in favour of an neurological

> rather than a psychogenic disease . . . When pinned down, as he was on the adequacy of his charge notes of September 11 at 0700 hours, his explanation simply did not make sense. . . . he admitted that an important part of charting (that is recording notes) is so that other members of the health care team can understand the evolution of the disorder. Yet during his notes of September 11 at 0700 hours he made no record in the chart of his neurological assessment of Mary Ann Grennan. . . He agreed that should have been in the chart . . .
>
> . . . With respect to physical examinations Dr. Assad was of the view Dr. Reddoch should have performed more physical examinations. Dr. Reddoch relied on what other nurses and doctors did. In my view Dr. Reddoch acknowledged that he should have done more."

[44] I have been referred to a number of cases, including ***Raison v. Fenwick*** (1981) 120 C.R. (3d) 622 (B.C.C.A.) where a review committee had terminated a teacher's employment for "less than satisfactory" performance, a test for termination stipulated by the governing act. The teacher later sued for libel, and the Court of Appeal supported the chambers judge's conclusion that the review committee had already decided the very issue fundamental to the libel action.

[45] In ***Ranasen v. Rosemount*** (1994) 17 O.R. (3d) 267 (leave to appeal to the Supreme Court refused) a majority of the Court of Appeal held that an earlier decision of a referee under the ***Employment Standards Act*** about whether the employee was entitled to compensation from his employer arising from termination of his employment estopped the employees subsequent claim for damages for wrongful dismissal. Abella, J.A. held that issue estoppel was applicable. She said at p. 704:

> "The second requirement is that here [sic] be a prior, final, judicial decision. The appellant argued that the procedure before the referee was not sufficiently 'judicial', and that the absence of discovery, costs, production of documents, and a judge rendered it so dissimilar a process to that of the courts that no decision resulting from it should be binding.

> This is an argument, in my opinion, which seriously misperceives the role and function of administrative tribunals. They were expressly created as independent bodies for the purpose of being an alternative to the judicial process, including its procedural panoplies."

And at 705:

> "As long as the hearing process in the tribunal provides parties with an opportunity to know and meet the case against them, and so long as the decision is within the tribunal's jurisdiction, then regardless of how closely the process mirrors a trial or its procedural antecedents, I can see no principled basis for exempting issues adjudicated by tribunals from the operation of issue estoppel in a subsequent action. If the purpose of issue estoppel is to prevent the retrial of 'any right, question, or fact distinctly put in issue and directly determined by a court of competent jurisdiction' (*McIntosh v. Parent*, [(1924), 55 O.L.R. 552 (S.C.A.D.)], then it is difficult to see why the decisions of an administrative tribunal having jurisdiction to decide the issue, would not qualify as decisions of a court of competent jurisdiction so as to preclude the redetermination of the same issues: *Cuddy Chicks Ltd. v. Ontario (Labour Relations Board)* (1991), 81 D.L.R. (4th) 121, [1991] 2 S.C.R. 5, 50 Admin. L.R. 44; *Douglas/Kwantlen Faculty Assn. v. Douglas College* (1990), 77 D.L.R. (4th) 94, [1990] 3 S.C.R. 570, 50 Admin L.R. 69. On the contrary, the policy objectives underlying issue estoppel, such as avoiding duplicative litigation, inconsistent results, undue costs, and inconclusive proceedings are enhanced in appropriate circumstances by acknowledging as binding the integrity of tribunal decisions."

[46] In ***Saskatoon Credit Union v. Central Park Enterprises*** (1988), 22 B.C.L.R. (2d) 89, 47 D.L.R. (4th) 431 (B.C.S.C.), the question was whether the plaintiff could raise the issue estoppel to prevent the Defendants from alleging fraud, an issue which had been decided against the Defendant in earlier proceedings in which the Defendant was not a party. McEachern, C.J. referred with approval to American authorities holding that even where privity could not be shown "trial courts ought to have a broad discretion to determine whether issue estoppel should be applied. Fairness seems to be the test they applied." (at p. 96).

And he concluded:

> "Without deciding anything about the question of mutuality, it is my conclusion that, subject to the exceptions I shall mention in a moment, no one can relitigate a cause of action or an issue that has previously been decided against him in the same court or in any equivalent court having jurisdiction in the matter where he has or could have participated in the previous proceedings unless some overriding question of fairness requires a rehearing.
>
> The exceptions to the foregoing include fraud or other misconduct in the earlier proceedings or the discovery of decisive fresh evidence which could not have been adduced at the earlier proceeding by the exercise of reasonable diligence: *McIlkenny*, *supra*, at p. 703. No material has been filed which would create such an exception in the circumstances of this case.
>
> I decline to decide whether the foregoing conclusion represents the application of a species of estoppel by res judicata or abuse of process as the result is the same. The fact that the plaintiff in this action was not a party to the earlier proceedings is of no consequence. With the defendants participating fully, it was judicially determined at trial by Spencer J. that the lease and transfers between the defendants were fraudulent and that is the end of that issue. The defendants are stopped from saying otherwise."

[47] Based on McIntyre, J.'s reasons, I conclude that Dr. Reddoch cannot resile from the admissions he made to the Yukon Medical Council. Alternatively, in the event that Dr. Reddoch is not bound by the admissions that he made before the Council, then I find that issue estoppel is applicable, and prevents Dr. Reddoch from relitigating the issues determined against him by the Yukon Medical Council.

[48] I should also say that even if the findings of the Yukon Medical Council are not admissible at this trial, other evidence adduced before me demonstrated that Dr. Reddoch failed to meet the appropriate standard of care in relation to the particulars found proven before the Council.

[49] However, the issue of causation (whether the particulars found proven by the Council caused or contributed to Ms. Grennan's injury and later death) was not in issue before the Council in the disciplinary proceedings.

BOTULISM

[50] Dr. Keyes discussed botulism in his Report as follows:

> "Finally, we come to the diagnosis of botulism. Botulism comes from a bacterial organism that produces a neurotoxin that is directed to the neuromuscular junction. This toxin binds ultimately to the neuromuscular membrane in an irreversible fashion. It is the presence of this neurotoxin and its binding to the neuromuscular membrane that causes weakness and paralysis in the muscles supplied by the nerves that have been affected by the toxin. This proved to be the ultimate diagnosis of this patient's symptoms and signs.
>
> . . . .
>
> As you can see from the above information, there are a number of different potential causes for patient's to experience weakness and difficulty with swallowing. Even when one suspects a possible primary neurological cause for these symptoms, there are still many potential primary neurological diagnoses that can cause all of the symptoms and signs with which this patient presented to hospital. The specific diagnosis of botulism remains a very difficult diagnosis to make even for neurologists experienced with the many different presentations of this condition. (Report at p. 13)
>
> . . . .
>
> The clostridium botulinum organism has several different strains labeled from A to G. Types A, B and E cause almost all of the disease in humans. Type A is seen on the west coast; Type B is seen on the east coast and Type E is seen in the north and around lake shores and seashores. Type E botulism most commonly comes from contaminated or improperly cooked fish.
>
> . . . .

Recovery from botulism occurs over a period of weeks to months by virtue of sprouting or regrowth of new terminal nerve fibers from which the acetylcholine can then be released. Recovery from botulism may or may not be complete depending on the severity of the disease process. The central nervous system, ie. the brain and spinal cord, are never involved in this disease.

. . . .

The symptoms of botulism develop 12 to 36 hours after ingestion of the toxin. However, symptoms onset may not occur for as long as two weeks after ingestion of this toxin. Patients often develop an initial symptom complex consistent with the diagnosis of gastroenteritis. Specifically, patients complain of abdominal pain, cramps, nausea and vomiting. However, as discussed above, there are many more common causes of gastroenteritis than botulism. Once the toxin begins to bind to the neuromuscular junctions patients begin to develop neurological symptoms and signs. The cranial nerve muscles tend to be involved before muscles of the upper or lower limbs. The muscles controlling eye movement are typically the earliest and most severely involved muscles in botulism. Patients complain of drooping eyelids, blurred vision and double vision. Lower cranial nerve involvement usually follows and results in complaints of difficulties with speech (dysarthria) or difficulties with swallowing (dysphagia). Progressive involvement of upper and lower limb muscles as well as respiratory muscles typically occurs over a period of several days once the initial neurological symptoms commence. Recovery is measured over a period of weeks to months. Recovery is often complete but may be incomplete and patients can be left with weakness in various muscle groups. (Report at pp. 16 & 17)

. . . .

Finally, it is clear from reviewing the records that this patient would have suffered a primary respiratory arrest between the hours of 2245 and 2307 on September 11, 1995. This primary respiratory arrest refers to primary failure of breathing. This

would have resulted from weakness in the respiratory muscles produced by the binding of the botulism neurotoxin at the neuromuscular junction in the respiratory muscles. This patient's cardiac arrest would have been secondary to the respiratory arrest and would have resulted from prolonged oxygen deprivation to the heart muscle. The primary effect on this patient's brain was that of oxygen deprivation secondary to the respiratory arrest. This patient would have continued to receive blood to the brain as long as her heart kept pumping. However, once the heart stopped pumping then blood would no longer get to the brain. The blood going to the brain after the respiratory arrest but before the cardiac arrest would have contained insufficient oxygen to permit the brain cells to remain alive. Cerebral neurons or brain cells begin to die approximately four minutes after complete lack of oxygen. Unfortunately for this patient, by the time she was found by the nursing staff following her cardiopulmonary arrest, this condition had been present for a sufficiently long time as to produce permanent and irreversible cerebral or brain death." (Report at p. 15)

WHAT STANDARD OF CARE IS REQUIRED OF A PHYSICIAN

[51] Picard and Robertson, *Legal Liability of Doctors and Hospitals in Canada* 3rd Edition states at pp. 174-175:

> "While the general principles of negligence are easily stated, an understanding of their application is more difficult to acquire. This is especially so in the typical medical negligence case because it involves members of an honourable calling, the exercise of professional judgment and technical skills, and a body of complex scientific knowledge. Each case requires a decision on its unique facts and therefore, close attention to precedents and adherence to the doctrine of *stare decisis* is often of less value to a judge that it is in some other kinds of cases.
>
> . . . .
>
> To be successful a negligence action must meet four requirements:

(a) the defendant must owe the plaintiff a duty of care;
(b) the defendant must breach the standard of care established by law;
(c) the plaintiff must suffer an injury or loss; and
(d) the defendant's conduct must have been the actual and legal cause of the plaintiff's injury.

If the case fails to meet any of these requirements, the action will be dismissed. Each of the above will now be considered in more detail.

. . . .

2. Duty of Care

(a) Duty to Patients

A pre-condition to any discussion of standard of care, or any of the other elements of the negligence action, is the finding that the defendant owed a duty of care to the plaintiff. If it cannot be shown that there was a duty upon this particular defendant to exercise care with respect to this particular plaintiff, there can be no finding of liability, regardless of how 'negligent' the defendant's conduct may appear.

The duty of a doctor to exercise care with respect to a particular patient springs into being upon the formation of the doctor-patient relationship. In the vast majority of medical negligence cases, the existence of that relationship (and hence, of the duty of care) is not in issue and will usually be conceded; it will be clear that a duty of care was owed, and the real dispute will focus on the scope of that duty. The scope of a duty is closely related to the standard of care, and this is examined in detail later in this chapter.

The duty placed on the doctor is to exercise care in all that is done to and for the patient, which includes attendance, diagnosis, referral, treatment and instruction.

. . . .

3. Standard of Care — General Principles (at pp. 184-85):

(a) Introduction

Under our legal system every person is required to act in such a way as not to cause an unreasonable risk of harm to others. The standard against which individuals are measured is that of the 'reasonable person,' and conduct which fails to meet this standard and causes injury to another will render the wrongdoer liable in damages.

Persons who hold themselves out as possessing special skills or abilities must practice their art, profession, or business so as to meet a standard of conduct equivalent to that of a reasonably competent member of their group. Accordingly, the standard of care required of a doctor is that of a reasonable medical practitioner considering all the circumstances. The standard was formulated during the Roman era and remains largely unchanged in modern times. The classic statement is found in the following passage from the judgment of Justice Schroeder in *Crits v. Sylvester* [[1956] 1 D.L.R. (2d) 502 at 508 (Ont. C.A.) affd. 1956 S.C.R. 991]:

> The legal principles involved are plain enough but it is not always easy to apply them to particular circumstances. Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He 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, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

Whether a defendant has met the requisite standard of care is a question of fact for the jury of if there is no jury the trial judge, and one which lies at the heart of every negligence suit. As one Canadian authority has said:

> No court in a negligence suit can escape a decision about whether or not the defendant's conduct breached the standard of care fixed by law. . . . The bulk of legal talent and judicial resources is expended on this matter.

A judge or jury is in no position to compare the conduct of the doctor to that required of the 'reasonable practitioner' without expert evidence. The Court needs such information in order to decide whether the defendant acted according to 'approved practice,' failed to meet the standard of care, or only made an 'error of judgment.' The experts are usually doctors who practise the same speciality as the defendant or who are specialized in the medical area in issue."

. . . .

3. The Duty to Diagnose (at pp. 239-247):

Having undertaken the care of a patient, a doctor is under a duty to make a diagnosis, and to advise the patient of it. If the doctor cannot come to a diagnosis, he or she has a duty to refer the patient to others who can. The duty to diagnose is not as onerous as it might seem. A doctor is not expected to be infallible, only to exercise reasonable care, skill and judgment in coming to a diagnosis. If this is done, the doctor will not be held liable even if the diagnosis is mistaken.

This is an area where the distinction between negligence and error of judgment (which is discussed in detail in the next chapter) is especially important. A mistaken diagnosis is not necessarily a negligent one, because despite the error, the doctor may have met the required standard of care. Perhaps the best statement of this appears in an English authority:

> [N]o human being is infallible; and in the present state of science even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his

> part, regard being had to the ordinary level of skill in the profession.

A number of cases have commented on the care, skill and judgment to be exercised by a doctor when formulating a diagnosis. In *Wade v. Nayernouri* [[1978] 2 L. Med. Q. 67 (Ont. H.C.)], a patient suffering from severe headache, nausea, dizziness, numbness and photophobia was diagnosed in 15 minutes by a doctor employed in an emergency ward as having 'migrainous headaches plus nervous overtone.' In fact he was in the early stages of a subarachnoid haemorrhage, and some days later, a recurrence caused his death. The Court found liability for a misdiagnosis, concluding that:

> In my opinion the cases have established that an erroneous diagnosis does not alone determine the physician's liability. But if the physician, as an aid to diagnosis, does not *avail himself of the scientific means and facilities* open to him for the collection of the best factual data upon which to arrive at his diagnosis, does not accurately obtain the patient's *history*, does not avail himself in this particular case of the need for *referral* to a neurologist, does not perform the stiff neck tests and the lumbar punctive *test*, the net result is not an error in judgment but constitutes negligence. [Emphasis in original]

Thus, a thorough history, proper examination, appropriate tests, and consultations with colleagues and specialists where necessary, are clearly basic to a proper diagnosis. A reasonable doctor should also heed a patient's complaints during treatment for they may be harbingers of change in condition.

While it may be possible to identify some of the steps to be taken in exercising reasonable care and skill, determining whether a misdiagnosis is the result of breach of the standard or only an error of judgment is not easy. This difficulty flows from the important role played by medical judgment. As one Court put it, 'Diagnosis is, above all, an exercise of the physician's judgement based on his training, experience and, perhaps, intuition.'

. . . .

4. The Duty to Refer

(a) When to Refer

Recognizing that no person is infallible or the foundation of all knowledge and skill, the Supreme Court of Canada has said there is a duty upon a doctor in some circumstances to refer a patient to another doctor. The term 'refer' may mean either that the doctor confer with a colleague and then carry on treatment personally, or that the patient is passed completely into the care of another doctor.

There is no absolute test to ascertain when a doctor should refer or consult, but the cases suggest that it is indicated when:

1. the doctor is unable to diagnose the patient's condition;
2. the patient is not responding to the treatment being given;
3. the patient needs treatment which the doctor is not competent to give;
4. the doctor has a duty to guard against his or her own inexperience (e.g., the student doctor); or
5. the doctor cannot continue to treat a patient (e.g. while on vacation).

A critical factor in the duty to refer is the timing. How soon must the counsel of a colleague be sought? In a large hospital or an urban setting this step may be simply and expeditiously taken. Indeed, in a large teaching hospital it will be common. However, a rural general practitioner may have to balance many factors such as personal ability, available equipment and facilities, the patient's prognosis, the distances involved and the effect of a move on the patient before sending the patient to another doctor. Nonetheless, advice and the opportunity to collaborate with a colleague can be achieved quickly by telephone."

ANALYSIS

[52] On admission on Saturday evening, September 9, Dr. Alton noted in the charts:

> "Today the vomiting and pain subsided, but she's been unable to swallow. Denies real pain on swallowing but water just won't go down. Unable to drink more than a small sip in observation in OPD."

[53] On Sunday morning, September 10, Dr. Alton noted:

> "Hydration status normal now. Weak with some improvement of dysphagia. Lytes (electrolytes) and CBC (complete blood count) N (normal)."

Thus, when Dr. Reddoch first saw Ms. Grennan (3 p.m. on Sunday afternoon) the gastroenteritis illness seemed to be resolving. He expected to discharge her the next day.

[54] However, Ms. Grennan's condition changed markedly over that Sunday night. As noted earlier, Nurse McDonald spent nearly all of her 12 hour shift with Ms. Grennan and considered her to be "a very sick girl."

[55] Dr. Keyes states in his Report:

> "Over the next 24 hours between September 10, 1995 and September 11, 1995 the nurses noted fluctuating symptoms whereby the patient would complain and exhibit weakness of the upper and lower limbs at times but at other times seemed to be much stronger. The patient was noted to have a whiney voice at times as well. Late in the evening of September 10, 1995 the nurses noted that the patient was unable to open her mouth for examination by the nurse. During the day the patient required nursing assistance to get her from the bed to the commode and back again. **It is evident at this point, some 24 hours after her admission to hospital and approximately 72 hours after she developed her gastrointestinal systems that the patient was exhibiting symptoms that could not be explained on the basis of gastroenteritis or volume depletion. At this point, the possibility of causes other than gastroenteritis and volume depletion might have been entertained.**

By the morning of September 11, 1995 the nurses noted that the patient continued to exhibit weakness in pulling up her bedclothes and holding her glass. She also developed increased difficulties with swallowing and it was at this time that the first difficulties with respiratory difficulties were noted. In hindsight, it would be my opinion that by the morning of September 11, 1995 this patient had symptoms and signs consistent with widespread neuromuscular disorder. At the time of this patient's Whitehorse Hospital admission a diagnosis of a primary neuromuscular disorder would have been very difficult to make. As I have stated previously, it is possible to see all manner of neurological symptoms and signs resulting from primary psychological dysfunction. Specifically, the symptoms and signs exhibited by this patient on September 11, 1995 could be seen as part of a grief reaction to the patient's grandmother's recent death. Such a diagnosis would have been a diagnosis of exclusion. Thus, there was evidence by approximately 24 hours after this patient's admission to hospital that she had symptoms and signs which could not be explained on the basis of gastroenteritis and associated volume depletion alone. The exact etiology or cause of those symptoms and signs was not clear at that time. Certainly, a specific diagnosis of botulism could not have been made definitively at that time. Botulism would have been only one of several possible diagnoses for the patient's symptoms and signs that might have been entertained at that time. However, for the reasons outlined in the preceding paragraphs, the diagnosis of botulism would have been one of the least likely diagnoses to make in this particular case.

Therefore, sometime between 24 to 36 hours after her admission to the Whitehorse Hospital, this patient had some symptoms and signs that would have raised the possibility of a primary abnormality of neurological function. A definitive neurological diagnosis would not have been possible at that time. **Clinically, therefore, by the morning of September 11, 1995, this patient's symptoms suggested the possibility of a primary neurological disorder as a cause for her complaints.** From the clinical neurological point of view the possibilities to be considered at that time in my opinion would be localized to abnormalities primarily affecting muscle, peripheral nerve or the

neuromuscular junction or connection between those two areas." [My emphasis]

[56] Dr. Keyes summarized his views in his Report (at p. 16):

> "Thus, based on my review of the clinical records, my summary of the events that occurred in this patient is presented in the following paragraph. The patient ingested the botulism toxin at the time when she ate the smoked or pickled salmon. This toxin would initially have produced the gastrointestinal symptoms that brought the patient to the emergency room at Whitehorse General Hospital over a two-day period prior to her admission. As the botulinum toxin was being progressively absorbed from her gastrointestinal tract it spread throughout her body. The botulinium toxin binds specifically at the neuromuscular membrane and interferes with the function of the muscles whose nerves have been affected by the botulinum toxin. This patient developed her progressive symptoms of weakness, difficulties swallowing and ultimately difficulties breathing, as the amount of botulinum toxin was becoming increasing widespread throughout the neuromuscular junctions in her body. This ultimately resulted in a primary respiratory arrest that was then followed by a cardiac arrest. This cardiopulmonary arrest resulted in severe, widespread and irreversible anoxic brain death. This anoxic brain injury resulted in the patient maintaining brainstem function but absent cerebral hemisphere cortical function for a period of several months following her cardiopulmonary arrest. Ultimately this patient would have died a respiratory death after a decision to stop all active treatment was made several days prior to her death."

[57] Dr. Assad discussed Ms. Grennan's condition on Monday morning, September 11:

> " Progress note # 4: Physician Reddoch September 11, 07:30hrs.
> In this note Dr. Reddoch reported that the chest and throat was clear. He also states that she was suffering from globus hystericus and was anxious. He orders Ativan to keep the patient quiet. In my opinion this note is the most inadequate of all. The nursing notes clearly demonstrate a distraught patient with increasing weakness, inability to swallow or clear the saliva from her mouth, hyperventilation, and agitation from her deterioration

> condition. Dr. Reddoch's note does not reflect any of these nursing observations.
>
> . . . .
>
> As indicated above, as of the morning of September 11, it was becoming evident that the patient's deterioration could not be explained by any of the diagnoses suggested. A review of the patient's history and progress in hospital with a specialist consultation would have most likely shed more light on the true cause of the illness."

[58] When Dr. Reddoch was asked whether Ms. Grennan's condition had deteriorated when he saw her early on Monday morning, September 11, he replied:

> "At the time, the findings seemed to be quite in keeping with what the diagnoses were provided. I'm not sure that it suggested any deterioration."
>
> Q: Did you think at the time that it would be beneficial to consult?
>
> A: No."

[59] I accept Nurse McDonald's evidence that Ms. Grennan was "a very sick girl" on Monday morning, September 11, and I also accept Dr. Assad's view that Ms. Grennan's condition was deteriorating, to the extent it would have been prudent to seek a consultation with a specialist. I also accept Dr. Keyes' conclusion that:

> "Clinically therefore by the morning of September 11th 1995, this patient's symptoms suggested the possibility of a primary neurological disorder as a cause for her complaints."

[60] I have not found Dr. Ralston's report and opinion helpful because his comment about Dr. Reddoch's attendance on Monday morning is limited in his report to:

> "Dr. Reddoch assessed Mary-Ann at 7.30 hrs. He made a diagnosis of globus hystericus. He talked to her about anxiety."

This comment does not reflect the substantial change and deterioration in her condition. Accordingly, I cannot accept Dr. Ralston's conclusion that "Dr. Reddoch met the expected standard of care."

[61] Nor have I found the Report of Dr. Esler to be of assistance on this issue because his comment about Ms. Grennan's condition on that Monday morning is:

> "On September 11 at 0700, Dr. Reddoch attended Ms. Grennan, noted in the medical report 'globus hystericus' ... throat clear ... chest clear. ... He discussed Ms. Grennan's case with her mother. He discontinued IV fluids and erythromycin, and prescribed Ativan and aerosolised normal saline."

and fails in my view to reflect the substantial change and deterioration in Ms. Grennan's condition. Accordingly, I do not accept Dr. Esler's conclusion that Dr. Reddoch's:

> "management was as expected given the clinical situation and met the standard of care in all respects."

[62] Dr. Reddoch's diagnoses on the Monday morning of "globus hystericus" and "anxiety" are psychogenic conditions and are diagnoses of exclusion. That phrase "diagnosis of exclusion" is a diagnosis available if no organic disorder is suggested by the symptoms presented. The evidence persuades me that Dr. Reddoch unduly narrowed his diagnostic focus by assuming that anxiety from being in the Hospital, and grief about her great grandmother's death explained her symptoms and the illness. Dr. Keyes stated that psychological dysfunction can offer all manner of neurological signs and symptoms, but was careful to say that any such diagnosis is one of exclusion.

[63] Dr. Reddoch had never before been faced with a case of botulism. Indeed, prior to Ms. Grennan's illness, the Yukon had never known of a botulism illness. The closest laboratory facilities to confirm such an illness were in Vancouver and Edmonton. On behalf of Dr. Reddoch, it has been strongly urged that gastroenteritis was common, and botulism very rare, and that physicians are taught to anticipate common diseases rather than very rare ones:

> "When you hear hoof beats, think of horses, not zebras."

[64] But that is no answer when, as here, on the Monday morning the patient's condition had been deteriorating, and suggestive of a possible "primary neurological disorder as a cause for her complaints", none of which was recognized by him.

[65] Whitehorse had no neurologist, nor any other specialist. But the Whitehorse Hospital had a close working relationship with St. Paul's Hospital in Vancouver, which was well staffed with specialists including neurologists. The evidence indicated that telephone consultations from Whitehorse physicians to St. Paul's specialists were commonplace. I found it puzzling indeed that Dr. Reddoch took such a narrow view of Ms. Grennan's symptoms that he failed to recognize the deterioration in her condition, and the possibility of a primary neurological disorder as a cause for her complaints. Instead he diagnosed "globus hystericus" a psychogenic condition, and a diagnosis of exclusion. But Ms. Grennan had many organic symptoms, such as her increasing weakness, her trouble in swallowing (it had taken three hours for her to swallow the medicine prescribed by Dr. Alton about Sunday midnight), and the "rag doll" appearance of her limbs, etc, which were suggestive of a neurological disorder.

[66] If Dr. Reddoch had consulted a neurologist in Vancouver after seeing Ms. Grennan on Monday morning, September 11, one would expect the neurologist to suggest, as Dr. Keyes did, a number of differential diagnoses including:

> An acute polymyositis - an unlikely diagnosis because Ms. Grennan did not have significant muscle pain or tenderness.
>
> or
>
> An acute inflammatory neuropathy, which was unlikely because one would expect the patient's reflexes to be absent for this condition.
>
> or
>
> An abnormality localized to the neuromuscular junction related to electrolyte abnormalities.
>
> or
>
> Myasthenia gravis, which is an autoimmune condition which results in the body attacking its own neuromuscular junction, but was an unlikely diagnosis because it develops gradually over weeks or months.
>
> or
>
> Dysfunctions caused by medications, as well as a number of organic toxins that can produce dysfunction at the level of the

> neuromuscular junction, an unlikely diagnosis since Ms. Grennan had received no medications prior to her admission.
>
> or
>
> Dysfunctions caused by environmental toxins such as organic pesticides, which can cause abnormalities at the neuromuscular junction.
>
> or
>
> Botulism, which comes from a bacterial organism that produces a neurotoxin that is directed to the neuromuscular junction.

After Ms. Grennan's cardiopulmonary arrests Dr. Reddoch did suggest myasthenia gravis, and botulism, as possible differential diagnoses.

[67] It was Dr. Keyes' opinion that Ms. Grennan's botulism was "a rare presentation of a rare disease" because the normal symptoms of ptosis (drooping eyelid) and diplopia (double vision) were absent. Therefore, Dr. Keyes considered that botulism was the least likely of the differential diagnoses he suggested. However, the last four of the differential diagnoses suggested above, (including botulism) all affect the neuromuscular junctions, and in Ms. Grennan's case, the botulism toxin's attack on the respiratory neuromuscular junction caused her respiratory arrest.

[68] Botulism is a dangerous disease, and is treated in an intensive care unit of a hospital because of the risk of respiratory arrest. Therefore, Dr. Reddoch, had he consulted a neurologist and been informed about the various differential diagnoses suggested by Dr. Keyes, would have had to consider what level of nursing observation was called for, either by transfer to an intensive care unit, or otherwise in the medical ward, and also alert the Hospital and nursing staff that they should be watchful because Ms. Grennan's illness, though not yet diagnosed, might be of a primary neurological disorder.

[69] In his submissions, counsel for Dr. Reddoch strongly urged:

> "Missing from the Plaintiff's case is any evidence firstly, that an earlier diagnosis of botulism ought to have been made and secondly, any evidence that any earlier diagnosis of the condition could have altered the unfortunate outcome of this case.
>
> Dr. Keyes was clear in his evidence that both earlier diagnosis was unlikely and, secondly, that an earlier diagnosis would not,

> on a balance of probabilities, have avoided the outcome that Miss Grennan unfortunately experienced."

[70] Dr. Keyes stated that the respiratory arrest would have occurred even if botulism had already been diagnosed. However, it is clear that the brain injury could have been avoided by prompt oxygen intubation after Ms. Grennan suffered her respiratory arrest, if she had been transferred to the intensive care unit, or at least by having an increased level of nursing observation appropriate to such a dangerous illness. Ordinarily, botulism is treated in an intensive care setting so that oxygen intubation can be done quickly should respiratory arrest occur.

[71] In summary, I conclude that Dr. Reddoch failed to meet the standard of care in his treatment of Ms. Grennan, all of which caused or contributed to Ms. Grennan's brain injury and subsequent death, as follows:

(a) He failed to perform an adequate physical examination, particularly on Monday morning, September 11, when an appreciation of her various symptoms, including her weakness, her "rag-doll" presentation, etc, ought to have dissuaded him from concluding that her symptoms were psychogenic.

(b) He failed to consider what organic disorder was suggested by the organic symptoms, but instead concluded that the symptoms presented had a psychogenic basis - a diagnosis of exclusion.

(c) Dr. Reddoch seemed to be so sure that Ms. Grennan's symptoms were psychogenic, that he failed to consider any differential diagnosis.

(d) He failed to recognize on Monday morning, September 11, that the symptoms then presented:

> "Could not be explained on the basis of gastroenteritis or volume depletion",
>
> and
>
> "Suggested the possibility of a primary neurological disorder as a cause for her complaints." (from Dr. Keyes' report)

(e) He failed to consult with a neurologist or, indeed, any other specialist, about Ms. Grennan's illness.

(f) Had Dr. Reddoch consulted with a neurologist, he would have learned that a number of the possible differential neurological diagnoses (including botulism and myasthenia gravis) are dangerous, in that they attack the neuromuscular junction and can affect the muscles of respiration. Dr. Reddoch should have been cautious and considered whether Ms. Grennan should be transferred to the intensive care unit, or, if not, what level of nursing observation was necessary until the illness was diagnosed or otherwise resolved.

(g) Also, and importantly in my view, Dr. Reddoch should have alerted the Hospital and the nursing staff that a neurological illness may be afoot and that the nursing staff should be watchful and report any significant changes promptly. This would normally be accomplished by appropriate entries in Ms. Grennan's Hospital charts.

WERE EMPLOYEES OF THE HOSPITAL NEGLIGENT?

[72] Up to the time of Dr. Reddoch's attendance about 5.30pm on Monday evening, September 11, I do not think there could be any criticism of any of the nurses or other Hospital personnel.

[73] However, some significant incidents occurred during the evening of September 11 as follows:

(a) At 9.15pm - Nurse White noted:
"Patient communicating with incomprehensible whispers and displaying total dependancy on others as charted previously. Refusing sips of H_20, when attempting to give the patient the H_20 just drooled back out of mouth. Complained of pain with swallowing."

(b) At 10.10pm - Nurse White noted:
"Writer intervened and asked patient to wait outside of room. No void and patient assisted back

to bed by 2 staff. Buckled at the knees and slid to floor...."

c) At 10.30pm - Nurse White noted:
"Oxygen saturation to be 84-88%, when patient asked to breath deeply, ↑ to 90% as was earlier today."

[74] Nurse White explained in her evidence that when her Aide reported the blood oxygen saturation at 84% which stabilized at 88%, that she was unsure if that was a reliable reading. She went to Ms. Grennan's room, instructed her to breathe deeply, then took another oxygenation reading and found it to be at 90% (low normal). But that 90% oxygenation reading was after deep breathing and should have suggested that the earlier 84% - 88% reading was probably correct.

[75] The Hospital produced Catherine Farrow as a witness to give opinion evidence about professional standards for nurses in Community Hospitals. Ms. Farrow has impressive nursing qualifications. Her view was that an oxygen saturation of 90% was "low normal", and that a reading of less than 90% requires intervention.

[76] The 9.15pm observation on Monday evening about Ms. Grennan speaking in uncomprehensible whispers and displaying total dependency on others, and having water drooling back out of her mouth when she tried to drink, combined with the 10.10pm observation about her weakness and with knees buckling so that she slid to the floor when returning to her bed from the commode, might well have persuaded Nurse White to alert Dr. Reddoch about them. But the additional 10.30pm observation about the 84-88% blood oxygen reading demanded urgent notification to Dr. Reddoch.

[77] Failure to do so did not meet with the requisite standard of care, and caused or contributed to Ms. Grennan's brain injury and subsequent death.

APPORTIONMENT OF FAULT

[78] I have found fault on the part of both Dr. Reddoch and the Hospital. I consider the greater fault to be that of Dr. Reddoch. I would apportion fault two-thirds to Dr. Reddoch and one-third to the Hospital.

DAMAGES

[79] The Plaintiff's case for damages is based on the decision of the Alberta Court of Appeal in ***Duncan Estate v. Baddeley*** (1997) 196 A.R. 161 which held that a deceased's loss of capacity to earn income was an actual financial loss to his estate, and so survived his death. From that, the

Court held that there should be deducted the costs (inclusive of income tax) the deceased would have incurred for his own living expenses. Additionally, other contingencies may well require some discount.

[80] Experts for the parties provided reports about their calculations of damages. Ms. Brown for the Plaintiff, gave evidence that she made her calculations on two alternative bases: either a 50% or 35% deduction from the present value of the lost earnings to reflect Ms. Grennan's own personal living expenses; and on two different scenarios - that she would, or would not, finish High School. These calculations had similar variables, i.e. would Ms. Grennan have completed High School, or not? Would her own personal living expenses use up 50% or 35% (or some other percentage) of her income?

[81] After hearing the evidence, I concluded that it was not likely that she would complete High School. Ms. Grennan was a likeable, intelligent young girl of 16, just commencing her Grade 10 High School year. She had had some school problems about her truancy. She was apparently deeply involved with her boyfriend and I concluded that she had little interest in continuing in school, but was doing so through parental pressure. Additionally, if she had survived the botulism illness, she might have been hospitalized for some period and might also have been left somewhat disabled. At the very least, her Grade 10 school year would have been substantially interrupted.

[82] What part of her earnings, assuming she was employed, would she have saved after paying her own living expenses? It seems to me that a 50% deduction is not excessive to reflect the net savings she would have available after paying her own expenses.

[83] Additionally, there is a contingency (estimated at 10% by Dr. Keyes) that she might not have survived the botulism illness even if she had received the best of medical care. Assuming she did survive, she might have made a full recovery, or she might have been left with some disability. Some deduction should be made for these latter contingencies, and my best estimate is that a further deduction of 30% should be made.

[84] Ms. Brown gave evidence before me, mostly a cross-examination of details of her report. I was impressed with her evidence, and using Ms. Brown's calculations, and assuming Ms. Grennan would not have completed High School, I therefore would assess damages as follows:

50% of present value of pre-trial and future loss	=	205,500
Deduct 30% for other contingencies	=	61,650
Net loss	=	143,850
		====

[85] Accordingly, the Plaintiff is entitled to damages against the Defendants for $143,850. Costs will follow the event, and may be spoken to if necessary.

JUDGMENT DATED at WHITEHORSE, YUKON
this 28th Day of FEBRUARY, 2001

H. L. Irving

IRVING, J.A.
DEPUTY JUDGE