CITATION: Thornhill v. Chong, 2016 ONSC 6353
COURT FILE NO.: CV-09-382518
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DATE: 2016-10-17

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
Janet Thornhill and Fred Gottschalk	)	Aleks Mladenovic, and Deanna Gilbert, for the Plaintiffs
Plaintiffs	)	
-and-	)	
John Chong	)	Thomas Sutton and Moya Graham, for the Defendant
Defendant	)	
	)	**HEARD:** November 16 - 20, 23 - 27, 30, December 1, 9, 2015

JUDGMENT

LACK J.

[1] This is an action against Dr. John Chong in which it is alleged that his medical management of his patient, Janet Thornhill, was negligent.

[2] On June 23, 1998, Ms. Thornhill had her first appointment with Dr. Chong in Toronto. She was suffering from pain in her right forearm. In his consultation note to the referring physician, Dr. Chong wrote that Ms. Thornhill had "an extensor bump and area of inflammation which is very difficult to diagnose using standard nerve conduction studies." Dr. Chong continued to see Ms. Thornhill. He did not order an imaging study until January 2007.

[3] An MRI was performed on Ms. Thornhill's right forearm on May 7, 2007. It put in motion a series of events that led to the diagnosis and surgical removal of a tumour from her forearm on June 20, 2008.

[4] The tumour was an intraneural synovial sarcoma. It is called a sarcoma because it was in the soft tissue. Sarcomas are rare and account for only about one per cent of all cancers. It was in the synovial tissue. Synovial sarcomas only account for about five to ten per cent of sarcomas. It was probably intraneural, which means growing into a nerve. That is very rare. So, Ms. Thornhill had a rare form of a rare form of a rare form of cancer.

The Plaintiffs' Position

[5] The plaintiffs' position is that Dr. Chong fell below the applicable standard of care of any physician by failing to properly assess and investigate Ms. Thornhill's right forearm bump in June of 1998 and thereafter until January 2007. If an MRI of Ms. Thornhill's right forearm had been ordered in June 1998 or thereafter, it would have detected an abnormality. That would have triggered a pathway to the diagnosis of synovial sarcoma leading to the removal of the cancer in keeping with the events that happened after the May 7, 2007 MRI.

The Defendant's Position

[6] The defendant's position is that the standard of care which applies in this case is that of a physician in Ontario practicing in the field of occupational medicine, with a referral-based practice. There may be commonalities between what is expected of a primary care physician and what is expected of a physician whose practice is referral-based, but the standard is not the same in all respects because the context, care and treatment goals are different. The plaintiffs have failed to establish that Dr. Chong breached the standard of care that applied to him. Also, the plaintiffs have not established that "but for" a breach of the applicable standard of care by Dr. Chong between 1998 and 2007 the probable chain of events would have resulted in Ms. Thornhill undergoing surgery before June 2008.

Legal Issues

[7] There is no dispute that Dr. Chong owed Ms. Thornhill a duty of care. The defence concedes that Ms. Thornhill suffered pain during the years prior to her surgery, which reduced her productivity and her ability to contribute at home, at least on a *de minimus* basis. The parties have settled the quantum of damages, if liability is established. The issue is liability. The legal issues to be decided on liability are the standard of care and causation.

[8] The issues arising on standard of care are: (i) what standard of care is applicable to the care provided by Dr. Chong; and (ii) whether Dr. Chong met that standard.

[9] The issues arising on causation are: (i) would Ms. Thornhill have undergone surgery to remove the synovial sarcoma from her forearm "but for" a breach of the standard of care, if one is established; and (ii) if so, how much sooner.

Primary Factual Issues

[10] There are factual issues that must be determined. They include:

> -What did Dr. Chong mean by the "extensor bump and area of inflammation" which he reported observing during his first consultation with Ms. Thornhill on June 23, 1998?
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> -Did Dr. Chong make Ms. Thornhill aware of his findings on June 23, 1998?
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> -Did the bump grow over the course of Dr. Chong's treatment of Ms. Thornhill?
>
> -Was the bump that Dr. Chong saw on June 23, 1998 the same lump that he saw on January 27, 2007 prompting him to order the MRI?

The Danger of Hindsight

[11] It is vital at every step of the factual analysis to avoid the temptation of hindsight. Dr. Chong's conduct must be judged in light of what he knew or should have known at the time he treated Ms. Thornhill, not in light of what happened later. As Lord Denning said in *Roe v. Ministry of Health* (1954) 2 All E.R. 131 (C.A.) at p. 137, we "must not look at the 1947 accident with 1954 spectacles". As Justice L'Heureux Dube wrote in *Lapointe v. Hopital Le Gardeur*, [1992] 1 S.C.R. 351 :

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

The Parties

Ms. Thornhill and Mr. Gottschalk

[12] The plaintiff, Janet Thornhill, was born in 1955. She and the plaintiff, Fred Gottschalk, have been married over 30 years. They lived together in the Havelock area. Mr. Gottschalk is an artist. Ms. Thornhill is an author and illustrator of children's books.

[13] Ms. Thornhill's work involved writing and drawing on her computer. She is right-hand dominant. As part of her work, she also gave presentations of her work and often travelled to do so.

[14] Early in January 1991, Ms. Thornhill began to experience numbness in her right hand and upper right extremity with pain in her hand, forearm, right shoulder and neck. These problems appeared to be triggered and aggravated by activity. Her family doctor, Dr. Abrahamse, referred her to a physiatrist, Dr. Jaikaran. Dr. Jaikaran did a physical examination and performed nerve conduction studies and electromyography. He diagnosed fibrositis [inflammation in the connective tissue]. Ms. Thornhill did not return to see him until 1998.

[15] In 1995, Ms. Thornhill was playing with the family dog and its tooth came into contact with the top of her right forearm about one to two centimetres from her wrist, between the radius and ulna bone. This is the area she came to call "the spot". A second or two after the hit, she felt an intense electric nerve-like pain. The pain lasted a moment and disappeared.

[16] Over time the pain increased. By 1997, Ms. Thornhill no longer needed to be poked in the spot to experience pain. Minor bumping was sufficient. By then, she had changed family doctors and was seeing Dr. Shannon.

[17] This is a convenient time to mention that Ms. Thornhill seems to have had a rather low tolerance level for physicians. She left Dr. Abrahamse's care because she was "not connecting" with him. She then saw Dr. Shannon, as her family doctor, but left because in her view he was inexperienced; he irritated her; he had obnoxious piped-in music in his waiting room. It was a pattern that was repeated with other physicians, including specialists.

[18] In 1997, Dr. Shannon noted a diffuse area of tenderness on the dorsum [colloquially, the top] of her right wrist. He did not make note of a lump or bump. He ordered x-rays of the wrist, which were normal. He diagnosed fasciitis [inflamed connective tissue] and recommended conservative treatment for the wrist.

[19] By 1998, Ms. Thornhill had returned to Dr. Abrahamse as her family physician. She saw him about the arm problem. He referred her back to Dr. Jaikaran. She saw him on January 1998. Dr. Jaikaran noted a history of pain in her right wrist that was aggravated by activity, such as opening jars and shovelling snow, but also by touch. She was also experiencing weakness in her thumb and decreased sensation in several of her fingers. Dr. Jaikaran noted extreme tenderness over the dorsum of the right wrist, approximately 2.5 centimetres proximal to the mid-line of the wrist joint. He could not feel any obvious lump in the area. He did a nerve conduction study, which was suggestive of mild carpal tunnel syndrome. He also ordered a whole body scan. It was normal. He could not diagnose the pain.

[20] On April 1, 1998, Ms. Thornhill saw Dr. Jaikaran again. He repeated electro-diagnostic studies. An x-ray and a bone scan were done. Dr. Jaikaran's working diagnosis was myofascial pain disorder of the extensor indicis, a repetitive strain injury (RSI). [Myofascial pain refers to pain associated with the muscles. The extensor indicis is a muscle.] Dr. Jaikaran wrote in his chart: "? MRI". He did not order an MRI. He ordered a CT scan of the right arm. Ms. Thornhill did not return to see Dr. Jaikaran again. This was because she took exception to the way he touched her arm, causing her pain. Also, he made her feel like a malingerer and a whiner.

[21] On June 4, 1998, Ms. Thornhill asked her family doctor Dr. Abrahamse to refer her to Dr. Chong for treatment of the pain in the spot. She had heard from a musician that Dr. Chong had helped him with a work-related injury to his arm. On June 11, 1998, Dr. Abrahamse faxed a referral to Dr. Chong.

[22] On June 17, 1998, Ms. Thornhill underwent the CT scan of her right forearm that Dr. Jaikaran had ordered.

[23] That is where matters stood when Ms. Thornhill attended at Dr. Chong's office for their first meeting on June 23, 1998.

Dr. Chong

[24] The defendant, Dr. John Chong, graduated from the University of Toronto in 1975 with a Bachelor of Science degree in electrical engineering. He went on to graduate from McMaster University with a medical degree in 1978. Between 1980 and 1984 he completed a fellowship in Public Health and Preventative Medicine, now known as Community Medicine. While doing his fellowship, he also obtained a Master's Degree in clinical epidemiology and biostatistics from McMaster University in 1982. From 1996 onward, he has been the medical director of Musicians' Clinics of Canada, in a full-time capacity. He is also currently a clinical professor of medicine at McMaster University in the Department of Family Medicine.

[25] Dr. Chong has always had a referral-based medical practice, where he has treated work-related injuries. Over time, his clinical focus shifted from workers in general to musicians and other artists. In June 1998, when he first saw Ms. Thornhill his practice at his musicians' clinic was devoted almost exclusively to helping musicians and some other artists recover from work-related injuries. He frequently treated repetitive stress injuries (RSI), writer's cramp, neuropathic pain, chronic pain syndrome (also known as Reflex Sympathetic Dystrophy (RSD)) and psycho-social or other co-morbidities that impair work function. He testified that before he saw Ms. Thornhill he had treated about 5,000 RSI patients.

[26] Dr. Chong testified that his treatment of work-related injuries has always included cognitive, ergonomic and behaviour therapy. He treats both physical and psycho-social aspects of a patient's condition which can be inhibiting the ability to return to productive work. Psycho-social care often involves psychotherapy.

[27] At the time that Dr. Chong treated Ms. Thornhill, he held himself out as a specialist in Occupational Medicine. Dr. Chong is recognized by the Royal College of Physicians and Surgeons of Canada (RCPSC) as a specialist in Community Medicine (formerly Public Health and Preventative Medicine). When he did his fellowship in Public Health and Preventive Medicine, occupational medicine was a component of it. There was no separate category of specialization known as Occupational Medicine – the treatment of work-related injuries. About 20 years ago the RCPSC created the Occupational Medicine speciality designation. Dr. Chong is not recognized by the RCPSC as a specialist in Occupational Medicine. Also, when Dr. Chong treated Ms. Thornhill he had no special training in psychotherapy, apart from what all physicians receive.

[28] So, when Dr. Chong met with Ms. Thornhill on June 23, 1998, he was an accredited specialist in Community Medicine who confined his area of practice to his special interest in treating work-related injuries. He had a great deal of experience in treating repetitive strain injuries. He was not an accredited specialist in either Occupational Medicine or psychotherapy.

Events on and after June 23, 1998

First Visit with Dr. Chong

[29] Ms. Thornhill's initial consultation with Dr. Chong was on June 23, 1998, at his Toronto office. She took along her artist's tools.

[30] Dr. Abrahamse had faxed a request for consultation to Dr. Chong on June 4, 1998. It was a request for Dr. Chong's opinion and treatment for: "right forearm & wrist". Dr. Abrahamse wrote that an EMG [electromyography – a test of electrical conduction] and a bone scan were negative. As well, he sent physiatrist Dr. Jaikaran's letter of February 27, 1998, referring to Ms. Thornhill's pain in the dorsum of the right wrist. It stated:

> On examination, there is acute tenderness between the radius and the ulna approximately 4 cm. above the wrist. Stressing the extensor tendons or extensor indicis does not increase the pain. The tender area is deep to the extensor tendons. Diagnosis: Pain right distal forearm NYD. Rule out myofascial pain disorder extensor indicis.
>
> [NYD means not yet diagnosed.]

[31] At Dr. Chong's office Ms. Thornhill completed an intake questionnaire in which she wrote her history. She wrote that her reason for being there was her right wrist pain, which was increasing. She wrote: "Spring 1997. No longer needed to be poked between wrist bone to experience pain. Minor bumping sufficient." Under previous injuries, she referred to a "long-term problem in right shoulder - diagnosed as bursitis in 1970." On a diagram, she indicated that her pain locations were on her back below the neck on the right side; on her upper right wrist and on her right hand above the pinkie. She indicated

that she had undergone a CT scan in June 1998, but did not have the results. On another form she wrote that "right wrist pain" was the problem she wanted Dr. Chong to address.

[32] Dr. Chong reviewed the intake material, including the consultation notes, and took an oral history from Ms. Thornhill. He observed and diagrammed Ms. Thornhill's occupational activities using her artist's tools – what he called her biomechanics as she worked. He conducted a detailed physical examination of her head, neck and upper extremities, including her right arm, forearm, wrist and hand.

[33] Dr. Chong sent one reporting letter over the course of his treatment of Ms. Thornhill, a consultation note dated June 23, 1998 to the family doctor, Dr. Abrahamse. Dr. Chong diagnosed repetitive strain injury (RSI). He reported as follows:

> She has a complicated repetitive strain injury of the right upper extremity….
>
> … [W]e will have to make sure that the entrapment of the superficial radial nerve which I found clinically settles down. There is no question of an extensor bump and area of inflammation which is very difficult to diagnose using standard nerve conduction studies. Because of the dystonia the nerve is trapped between the extensor digitorum, indicis and extensor pollicis longus and this really needs to settle down.
>
> [Dystonia is an abnormal tone of muscles]

[34] There are factual issues which arise over the meaning and location of the "extensor bump and area of inflammation" that Dr. Chong observed at this first visit. For the time being, it is sufficient to note that in his examination in chief, Dr. Chong testified that the location of the extensor bump and area of inflammation that he found on June 23, 1998 was located at the juncture of three muscles, the extensor digitorum, extensor indicis and extensor pollicis longus. He marked the location on Exhibit 16, an anatomical diagram of a forearm. He testified that the bump and area of inflammation was small, the size of a thumbtack. It was not painful when he palpated it. He did not note the size of the bump or area of inflammation in his chart. Dr. Chong testified that his brain goes through a whole list of diagnosis.

[35] Dr. Chong testified that his hypothesis was that the three muscles were overloaded, that is, over worked. Overuse can lead to scarring. The bump and area of inflammation confirmed his hypothesis of overuse and that it had been going on for a long time. He said that he sees chronic overuse injury routinely in his practice. For him, the findings were not unexpected. He described the muscles as superficial and the area of overuse not that deep. It was not difficult to diagnose. He testified that he did not order an MRI because it was not clinically indicated in the picture. Dr. Chong said that he diagnosed RSI because of the history. Ms. Thornhill had chronic pain and swelling and it improved in some situations and relapsed sometimes.

[36] A factual issue arises whether Dr. Chong made Ms. Thornhill aware on June 23, 1998 that he had found a bump in her right forearm. He testified that he dictated his consultation letter to Dr. Abrahamse in her presence. She testified that he did not.

[37] Although Ms. Thornhill saw her family doctor, Dr. Abrahamse, on January 25, 1999 and March 2, 1999, there is no evidence that he discussed Dr. Chong's consultation note with her. Ms. Thornhill testified that he did not.

[38] At the first visit, Dr. Chong ordered an x-ray of Ms. Thornhill's cervical spine, right shoulder, shoulder blade and collarbone. The x-ray of her cervical spine showed early mild degenerative changes. There were no abnormalities in the right shoulder.

CT Scan

[39] On June 17, 1998, Ms. Thornhill had a CT scan of her right forearm, as ordered by Dr. Jaikaran. The radiologist reported:

> No abnormality is seen. If clinical concern persists an MRI examination would be a more sensitive means of excluding a soft tissue mass on the extensor surface of the right forearm.

[40] Ms. Thornhill testified that she was not advised of the results of the CT scan until she telephoned Dr. Abrahamse's office somewhere between her first and second visits with Dr. Chong. She was not advised of the radiologist's comments about an MRI. She was not given a copy of the report. As far as she understood, the results of the CT scan were normal. She reported that to Dr. Chong at her second appointment with him.

[41] Dr. Abrahamse did not send a copy of the CT scan to Dr. Chong.

[42] Dr. Chong testified that he did not request a copy of the CT scan or report because Ms. Thornhill told him that the results were normal. He relied solely on what she said. Dr. Chong testified that he was reassured by it. He knew that radiologists sometimes make recommendations. He said the note would not have changed his analysis or his management. He said: "My analysis was exactly what I thought. I was not suspecting anything unusual, nor would I."

Visits with Dr. Chong August 4, 1998 to November 30, 1999

[43] Based on his diagnosis of RSI, Dr. Chong conducted functional assessments to determine the nature of Ms. Thornhill's symptoms and the ergonomic aspects of her work and activities of daily living on August 4, 1998 and in the next three visits. These assessments were recorded on DVD, which was viewed at trial. Dr. Chong testified that the purpose of the assessments was to assist in making changes to Ms. Thornhill's biomechanics while working. He used several methods of physical therapy and recommended posture changes to that.

[44] Dr. Chong's chart shows that on October 20, 1998 Ms. Thornhill reported that her right forearm muscles were hot but better.

[45] The appointments in January and February 1999 focused on following up on the effect of Dr. Chong's recommendations and exploring other factors that might be contributing to Ms. Thornhill's RSI and pain.

[46] Dr. Chong testified that his therapeutic goal was to allow the artist to do her work with less pain and symptoms. In addition to ergonomic therapy, cognitive and behavior therapy are used as well to reduce stress, which can impair bodily function and affect how it responds.

[47] Dr. Chong began to explore stressors in Ms. Thornhill's life, including work-related and family-related stress. Psychotherapy began. As well, he discussed with Ms. Thornhill her smoking and drinking and her recently diagnosed affliction with Hepatitis C and pain in other areas of her body.

[48] Dr. Chong testified that from a functional and healing perspective it was important for him to explore Ms. Thornhill's general health, including her smoking and alcohol use.

[49] Dr. Chong testified that Ms. Thornhill had physical complaints in early 1999 relating to her right upper back and shoulder. His notes show that on April 15, 1999 she complained of fatigue and Hepatitis C symptoms. On June 10, 1999, she complained that her cluster headaches had returned. Dr. Chong testified that during the period March to December 1999 Ms. Thornhill's chronic RSI and related symptoms and her work productivity were variable. She had improvements at times and set backs at others.

[50] Ms. Thornhill testified that Dr. Chong's approach to the pain in her right forearm was having no impact. She said that, in fact, it was gradually getting worse.

Dr. Shannon's Locum and Dr. Shannon

[51] Ms. Thornhill testified that she was dissatisfied and she wanted a second opinion. By then, Dr. Shannon was her family doctor. On January 14, 2000, she saw a locum in Dr. Shannon's office. The locum documented: "Wrist still painful - had nerve conduction studies – CAT Scan – Reviewed with patient – sees M.D. in Toronto re stress, work habits etc. – discuss tendonitis – referral Dr. McCully". The chart does not show that the locum did a physical examination. Ms. Thornhill testified that the locum did not palpate her wrist.

[52] Ms. Thornhill also saw Dr. Shannon on March 8, 2000. He noted that she was seeing a doctor in Toronto about her wrist pain and wanted another opinion and was seeing Dr. McCully, a rheumatologist, the next day and has seen Dr. Jaikaran.

Visit with Dr. Chong February 1, 2000

[53] On February 1, 2000, Ms. Thornhill saw Dr. Chong. She did not tell him about her upcoming appointment with Dr. McCully. She testified that she was not convinced that Dr. Chong's diagnosis and approach were wrong and she did not want to hurt his feelings.

[54] Dr. Chong's chart shows that Ms. Thornhill had nothing good to report. She was anxious. Her sleep was worse and her right wrist pain was still there. They appear to have discussed life issues including her relationship with her husband and work issues.

Visit with Dr. McCully March 9, 2000

[55] On March 9, 2000, Ms. Thornhill saw rheumatologist Dr. McCully. He appears to have reviewed the June 1998 CT scan.

[56] In his consultation note, Dr. McCully wrote that Ms. Thornhill's skin and nails were normal. She had a full range of motion in her right elbow and wrist. She had "a localized area between the radius and ulna about 4 cm. proximal to the wrist joint where she was markedly tender". He could not find "any significant pathology". He found "nothing to suggest a muscle cause in that there is no pain on resisted movements and she has full active movements". He wrote: "I have indicated to her that it is obviously "a very annoying problem", but the fact that it has persisted for eight years with no objective findings would suggest that there is no underlying sinister cause."

[57] Ms. Thornhill testified that Dr. McCully looked at her wrist, but she did not allow him to palpate it.

[58] Dr. McCully documented that he was making a trial of ultrasound and he would review Ms. Thornhill again in about a month after she had the physiotherapy. Dr. McCully did not order an MRI.

[59] Ms. Thornhill testified that she did some sessions of the therapy that Dr. McCully ordered. The treatment caused more pain, so she stopped. She did not return to see Dr. McCully.

Visit with Dr. Chong March 23, 2000

[60] Ms. Thornhill saw Dr. Chong on March 23, 2000. His note shows that she was writing and presenting her work at schools. She reported that she was not using her wrist and her pain increased with the stress. They appeared to have discussed fertility and other personal issues.

"Raised Area"

[61] As already noted, Ms. Thornhill testified that Dr. Chong did not make her aware that he found a bump in her right forearm in June 1998. She testified that she did not know she had a bump in her forearm. She said that it was not until around half way through the

year 2000 that she noticed a "visible raised area" over the painful spot on her right forearm.

[62] Mr. Gottschalk testified that around 1999/2000 he noticed what looked like subtle swelling in Ms. Thornhill's right forearm in the same spot where she had reported pain after being hit by the dog's tooth in 1995.

Visits with Dr. Chong May 11, 2000 to March 19, 2002

[63] For most of the period May 11, 2000 to August 20, 2002, Dr. Chong's therapeutic approach consisted primarily of psychotherapy.

[64] Dr. Chong testified that Ms. Thornhill's reports of pain were variable.

[65] His note for the visit of August 17, 2000 shows that Ms. Thornhill reported C-T pain. As well, he recorded: "CAN'T WRITE → Arm hurts +++ R Ext" [right extensor]. She was not working. They discussed her depression about her mother and her health. Ms. Thornhill testified that she has a very clear memory of this visit. She recalls looking down at a very subtle raised area on her wrist. Dr. Chong did not palpate it.

[66] On October 17, 2000, Dr. Chong's note shows that Ms. Thornhill reported that her right wrist was much better: "R wrist/ED → much better" [right wrist/extensor digitorum]. She had a positive book launch. They discussed "relevance of creative work vs existence/survival" and "beauty/nature/focus". On both November 28 and January 23, 2001, Ms. Thornhill reported work-related activity. No physical complaints or anything about her wrist were recorded.

[67] On March 13, 2001, Ms. Thornhill reported a productivity crisis, problems with a publisher and a poor turnout for one of her events. She also reported explosive anger and pain.

[68] On May 15, 2001, Ms. Thornhill told Dr. Chong about a November deadline for a book. She described pain working on the computer. He noted: "ST7/ R wrist pain. 2 ½ Sup. ECR" She also reported anxiety and torment.

[69] On July 24, 2001, Ms. Thornhill again described pain in her arm and her neck in the context of work, anger, depression and anxiety, as well as trying to quit smoking and a challenging trip to Newfoundland. Dr. Chong recorded: "Work – Scalenes – R ED". [Scalene muscles are muscles of the neck.]

[70] There is nothing recorded on September 18, 2001 about Ms. Thornhill's wrist.

[71] Ms. Thornhill testified that over the period June to November, 2001 she saw Dr. Shannon a number of times. She said that she did not discuss her wrist with him because Dr. Chong was taking care of it.

[72] On November 27, 2001, Dr. Chong recorded in his chart: "R. Wrist. Numbness++ Lumpy Feeling".

[73] Ms. Thornhill testified that on the visit Dr. Chong remarked that she had swelling in the area of her spot. She told him it did not feel like normal swelling. It was more like a lump. Dr. Chong did not chart that he detected a lump. Ms. Thornhill testified that Dr. Chong explained the lump as swelling. She said that he told her that the brain sends pain signals to the arm. The arm thinks it is injured, which causes swelling. Then the swelling causes real pain that is signaled back to the brain, and the loop continues. Dr. Chong prescribed the anti-depressant, Remeron. Ms. Thornhill testified that it had no effect on her pain, except that it helped her tolerate it.

[74] On March 19, 2002 Ms. Thornhill reported that she had been in a motor vehicle accident. She reported pain in her right arm and hand and neck problems. Dr. Chong referred her for x-rays of her cervical spine. He also completed forms for her in connection with the accident.

"Lump"

[75] Both Ms. Thornhill and Mr. Gottschalk testified that by 2002 the painful raised spot on Ms. Thornhill's forearm appeared more like a lump. She also testified that by then she had discussed the lumpy appearance with Dr. Chong and asked him for an MRI and surgical consultation. According to her, Dr. Chong said no because the CT scan showed no abnormality.

[76] Dr. Chong testified that the bump stayed the same over his treatment of Ms. Thornhill. He denied that Ms. Thornhill ever asked him for an MRI or a surgical consultation. There was nothing about it in his notes. He said that he would remember if a patient asked him for a referral to have something cut out of her arm.

Visits with Dr. Chong April 23, 2002 to August 20, 2002 – Sympathetic Mediated Pain (RSD)

[77] On April 23, 2002, Ms. Thornhill reported being very depressed. She had pain from whiplash. Dr. Chong noted: "↑ pain R extensor". He also charted: "Out of control of my life →Relapse PTSD" and "Relapse – sympathetic mediated pain".

[78] This is the first time that the term PTSD [post-traumatic stress disorder] is used in the chart. Ms. Thornhill testified that she had never been diagnosed as suffering from that condition. She did recall that Dr. Chong told her that events from her past could affect her pain levels.

[79] This is also the first time that "sympathetic mediated pain" appears in Dr. Chong's chart. It is another name for reflex sympathetic dystrophy (RSD). Dr. Chong testified that he diagnosed RSD secondary to RSI. He said that he considered and ultimately diagnosed it because of the chronicity of Ms. Thornhill's condition. She had chronic pain and swelling that improved in some situations and relapsed sometimes. Primarily, he

diagnosed it because her pain changed. It sometimes consisted of zapping or electrical pain, which indicated it was neurological in nature. She had swelling which came and went and was diffuse in nature. Dr. Chong testified that his response to RSD was first to try the drug Remeron, which is often used for depression and sleeping problems.

[80] Ms. Thornhill testified that there had been a change in her pains in the spring of 2002, which she reported to Dr. Chong. Dr. Chong did not chart them until in 2002.

[81] Ms. Thornhill testified, that as far as she understood, RSD was the same pain looping theory that Dr. Chong had previously discussed with her. She said that although she was concerned about the pain and the lump on her right forearm, Dr. Chong was persuasive. He convinced her that it was "all in her head" and she trusted him.

[82] On May 28, 2002, Ms. Thornhill reported right wrist pain and Dr. Chong charted: "RSD".

[83] On August 20, 2002, Dr. Chong referred Ms. Thornhill to Dr. Rhydderch for a right stellate ganglion block. He also referred her to Dr. Kronby for her headaches.

Visit with Dr. Kronby October 7, 2002

[84] Ms. Thornhill saw Dr. Kronby, a neurologist, on October 7, 2002, for her cluster headaches and right-sided head and back pain. Ms. Thornhill testified that they did not talk about her right forearm.

Visits with Dr. Rhydderch September 18, 2002 and October 24, 2002

[85] On September 18, 2002 and October 24, 2002, Ms. Thornhill saw Dr. Rhydderch, an anaesthesiologist, and underwent right stellate ganglion block injections. A stellate ganglion block injection blocks sympathetic nerves. Dr. Chong testified that it was done as part of the investigation and treatment of RSD. Ms. Thornhill testified that she would not allow Dr. Rhydderch to touch the painful area on her arm.

[86] Both Dr. Chong and Ms. Thornhill testified that Ms. Thornhill's first injection did not result in any relief. However, she did have a very brief positive response to the second injection. She testified that the pain relief was limited to about one or two hours and that the injection had no effect on the lump. Ms. Thornhill testified that she did not go back to Dr. Rhydderch because the benefit from the injections was brief and negligible. Dr. Chong testified that the response helped confirm his diagnosis of RSD. This is because the injection blocks specific nerves and, when pain stops with the injection, it shows that the pain comes from those nerves, so it is neuropathic pain.

[87] Ms. Thornhill saw Dr. Chong on October 31, 2002. In making reference to her second treatment by Dr. Rhydderch he wrote: "2 hr. response ↓ SM pin "Could actually touch it" ". Dr. Chong also charted: "O: SMP". [Objective: sympathetic mediated pain.]

Visits with Dr. Chong October 31, 2002 to November 16, 2006

[88] Between October 31, 2002 and November 16, 2006, Ms. Thornhill saw Dr. Chong a number of times. Treatment continued to be primarily psychotherapy.

[89] Dr. Chong's note of the visit on December 19, 2002 shows that Ms. Thornhill continued to have pain in her right wrist, which he charted as "SMP". He continued the Remeron. On February 6, 2003, Ms. Thornhill reported that the Remeron was great. She was productive, but her right arm was harassing her.

[90] In an appointment with Dr. Chong on June 12, 2003, Dr. Chong charted that Ms. Thornhill spoke of her recent trip to the Yukon with her husband and reported having no right arm pain. On July 24, 2003, she reported a return of her right arm pain.

"Lump"

[91] Ms. Thornhill testified that by June 2003, around the 5 year anniversary from when she started seeing Dr. Chong, she began to notice that she could see the shape of the lump through her clothing. She remembered that on her trip to Dawson the lump was almond-sized. She testified that the rate of growth was nonetheless slow. Her pain also continued to increase gradually. In the summer of 2004 the pain continued to get worse gradually as the lump grew, but the rate of growth was still slow.

[92] As noted earlier, Dr. Chong's evidence was that the bump he saw on June 23, 1998 stayed the same.

Visit with Dr. Park September 2, 2003

[93] On September 2, 2003, Ms. Thornhill saw family doctor, Dr. Park. From his chart it appears that this is the first time they met. They appear to have discussed a number of issues in what might be described as a "meet and greet". He charted a number of issues including: "cluster headaches and fibromyalgia are problems that have waxed and waned over 16 years."

[94] Ms. Thornhill testified that she made Dr. Park aware that Dr. Chong was dealing with her arm and had diagnosed RSD. She said that Dr. Park gave her his card and asked her to give it to Dr. Chong and ask him to send a progress report. Ms. Thornhill said she did that. Dr. Chong said that he did not recall that.

[95] Dr. Chong testified that he never sent any consultation or progress reports to the family physician, apart from the first one, because of guidelines from the College of Physicians and Surgeons concerning communications about a patient to third parties. He said that he will only dictate a summary if he receives a request and the patient's consent in writing.

Visits with Dr. Chong September 2003 to 2005

[96] On September 11, 2003, Ms. Thornhill reported having too much work to do and Dr. Chong charted: "→Sympathetic – Reflex dystrophy" and "→Mediated PAIN syndrome".

[97] On October 30, 2003, Ms. Thornhill reported working and having a deadline. Dr. Chong charted: "O: R arm – ECR/ED"; "Lightening "zaps" "; "Not related to work load RANDOM" and "SMP Syndrome – "Fred + Me" better". [O stands for objective.] This was the first time that Dr. Chong charted that Ms. Thornhill had reported lightening zaps.

[98] On October 21, 2004, Ms. Thornhill reported continuing pain in her right arm, and Dr. Chong charted: "R Arm Pain +++RSD". Ms. Thornhill said that she never measured the lump. However, she thinks by this time it was about 1 ½ inches long, ¾ inches wide and ¼ inch high. She said the pain was increasing and she complained to Dr. Chong about it. He told her to try opiates. She tried "pot brownies".

[99] Ms. Thornhill testified that she continued to accept Dr. Chong's diagnosis of RSD. In an email she wrote to her sister dated November 8, 2004, Ms. Thornhill described how Dr. Chong had explained this pain-looping phenomenon.

"Lump"

[100] Ms. Thornhill and Mr. Gottschalk testified that starting in and around 2005 the rate of growth of the lump began to change. Ms. Thornhill testified that it started to "pick up". Similarly, Mr. Gottschalk testified that the lump grew subtly over the years until around two years before the MRI of May 7, 2007, when it seemed to "speed up". Ms. Thornhill testified that she was having more and more pain and was more limited.

Absence of Other Symptoms

[101] This is a convenient point to mention that Ms. Thornhill testified that over the course of her treatment by Dr. Chong she had no unusual sweating. She had no changes to the skin around the spot or to her fingernails. She had no temperature changes in the area. She had no tremors or cramping in her right arm. She had no decrease in the range of movement of her right arm. She had no swelling in any area on her right arm, except the area of the lump, about three inches. She had no pain anywhere else in the arm, except for a while after the car accident. She had no weakness in the forearm, except before she began to see Dr. Chong.

2005 and Following

[102] From the beginning of 2005 through to October of 2006, Dr. Chong did not note any material change in Ms. Thornhill's condition. He continued to focus on psychotherapy as Ms. Thornhill's primary treatment.

[103] Ms. Thornhill testified that she understood that if they dug deep enough into her past, they would find a "breakthrough". During this time, Ms. Thornhill continued to take Remeron, but on-and-off, because it made her feel groggy.

Visit with Dr. Park January 3, 2005

[104] On January 3, 2005, Ms. Thornhill saw her family doctor, Dr. Park. His chart shows that they discussed her heart palpitations. As well, he recorded that Ms. Thornhill was seeing Dr. Chong, about a chronic right wrist problem for 6 years, who felt it was due to overuse and RSD. Dr. Park noted it "grumbles along with no significant recent changes". He did not note the presence of a lump on her wrist.

Visits with Dr. Sullivan February 7 and March 28, 2005

[105] On February 7 and March 28, 2005, Ms. Thornhill saw cardiologist, Dr. Sullivan, on referral from Dr. Chong, for irregular heartbeats. Dr. Sullivan did not note the presence of a lump on her wrist.

Lyrica

[106] On October 20, 2005, Ms. Thornhill reported to Dr. Chong an increase in right "hand" pain. She reported she had been active working on a new book, chopping vegetables, and carrying 20 pounds of mushrooms. Dr. Chong charted it as chronic neuropathic pain and for the first time prescribed Lyrica. Dr. Chong testified that since 2003 the drug Lyrica has been used to treat neuropathic pain.

[107] On December 15, 2005, Dr. Chong headed his chart: "AMAZING RESPONSE". He noted: "SWELLING ↓ - Function ↑ Lightening pains are gone after working on computer. O: RSD is under control w/Pregabalin!!!" [Pregabalin is Lyrica.] Dr. Chong testified that this was a breakthrough.

[108] Ms. Thornhill testified that initially the Lyrica had a "miraculous" effect on her lightening pains. However, it had no impact on the other type of pain she was feeling in the spot on her right forearm, and it did not have any impact upon the lump. It continued to grow.

[109] Ms. Thornhill saw Dr. Chong seven more times in 2006. On February 23, 2006, she reported less pain when working in the morning. On August 3, 2006, Dr. Chong noted: "R Arm is 'Lyrica' controlled re: PAIN 'ZAPS' ".

Visit with Dr. Park August 18, 2006

[110] On August 18, 2006 Ms. Thornhill went to see Dr. Park about numbness and a burning pain in her buttocks. Ms. Thornhill testified that Dr. Park asked her about her arm and she told him again that Dr. Chong was looking after it and had diagnosed RSD. Dr. Park did not palpate her arm. He said that he would refer her to a neurologist about her buttocks.

Visit with Dr. Chong November 16, 2006

[111] On November 16, 2006, Dr. Chong noted in his chart: "PTSD – RSD – Stabilized Well". He did not note the presence of a lump on Ms. Thornhill's forearm. Ms. Thornhill testified that Dr. Chong told her that she had normal swelling from RSD.

Visit with Dr. Lan January 23, 2007

[112] On January 23, 2007, Ms. Thornhill was seen by neurologist Dr. Lan. She had been referred to Dr. Lan by Dr. Park. Ms. Thornhill testified that the referral was for the buttock. However, unknown to her, Dr. Park also asked Dr. Lan, as a secondary issue, to consider her right forearm pain. Dr. Park made no mention of a lump in his clinical note or referral letter to Dr. Lan.

[113] In his consultation report to Dr. Park, Dr. Lan noted a lump when he examined Ms. Thornhill's forearm on January 23, 2007. He was of the view that Ms. Thornhill's symptoms were not consistent with the diagnosis of RSD. In the note, Dr. Lan wrote:

> The symptoms started 10 years ago, and she would only develop a brief, shooting, jabbing pain if her right forearm was touched or punched deeply …. Since then, her symptoms have progressed so that in the last 5 years, she has noted a lump coming up, which has steadily enlarged in size and again, if that area is being touched or pounded accidentally, it would give her a minute or 2 of severe pain to the point that she feels faint. At other times, she describes some non-specific shooting pain in the upper arm as well. She has been started on Lyrica, 75 mg. in the morning and 175 mg. at night, and this seems to have reduced some of the painful syndrome that she is describing.
>
> ….
>
> Her upper limb examination is restricted because of the fear that if I touch her forearm, she is going to have severe pain. Hence, the area was examined lightly and carefully, and she does have a nodular lump overlying her distal right forearm. It is approximately 2 inches long by 1 inch. There is no adjoining swelling or inflammation or change in the skin coloration, and indeed, motor and sensory examination in her right hand and fingers and forearms were entirely normal.
>
> ….
>
> It would be impossible to do any nerve conduction studies but clinically her symptoms do not fit in with reflex sympathetic dystrophy syndrome.

Visit with Dr. Chong January 25, 2007

[114] On January 25, 2007, when Ms. Thornhill saw Dr. Chong, she told him about her visit with Dr. Lan. She told him that Dr. Lan's opinion was that she had a neuroma and should have a surgical consultation.

[115] Dr. Chong noted: " 'Burning Butt' → 'Wrist' Surgeon? Lump Bigger + Bigger ?? ECR ED Sup." Dr. Chong testified that he made the entry because Ms. Thornhill told him a lump was getting bigger and bigger. Dr. Chong said that this was the first time Ms. Thornhill had told him that. Ms. Thornhill testified that Dr. Chong did not palpate the lump on that visit. He said maybe we should get an MRI.

[116] Dr. Chong's requisition for an MRI is dated January 31, 2007 and included a diagnostic question of "neuroma vs. tenosynovitis of ECR/ED EPL/B Supinator". There was no reference in the referral to RSD. This was the first notation anywhere in Dr. Chong's chart of "tenosynovitis".

[117] Dr. Chong testified that on this visit he was puzzled. He said that the swelling did not match the biomechanics. He felt the arm and it had a sluggy, mushy feeling, a jelly-like characteristic. It was not what he would expect with repetitive trauma and the location was odd. It did not fit in with what he had been thinking all the way through. Up to this point, the clinical course had been as expected, so he had not ordered an MRI.

MRI May 7, 2007

[118] On May 7, 2007, the MRI was performed. The radiologist reported finding an abnormal soft tissue mass/lesion measuring 3 cm. by 1.5 cm. by .09 cm. in size. It was a solitary mass, which the radiologist believed was a soft-tissue mass. He wrote:

> …Possibilities would include this could represent a nerve sheath tumour or perhaps even a partially thrombosed vascular malformation.
>
> In the first instance I feel the patient would benefit from referral to an orthopedic oncologist/dedicated hand program.
>
> Lesion would be amenable to ultrasound-guided biopsy and we would be happy to perform this at request.

Visits with Plastic Surgeon and Surgical Oncologist

[119] On September 4, 2007, on referral from Dr. Park, Ms. Thornhill was seen by plastic surgeon Dr. Van Brenk. Following his assessment, Dr. Van Brenk arranged for the lump in Ms. Thornhill's right forearm to be biopsied.

[120] On October 16, 2007, the biopsy took place. The initial report indicated a diagnosis of spindle cell neoplasm. However, the pathologist determined that the sample should be reviewed by a specialist. The first addendum report was received November 5, 2007. It was highly suspicious for sarcoma. Around that time, Dr. Van Brenk advised Ms. Thornhill of the results and referred her to a sarcoma clinic.

[121] On November 12, 2007, Ms. Thornhill was seen by Dr. Wunder, a surgical oncologist at a sarcoma clinic. Dr. Wunder wanted to see the pathology results before determining how to proceed. The second addendum report was received November 20, 2007. It confirmed a diagnosis of synovial sarcoma grade II/III. A decision was made for Ms. Thornhill to undergo surgery.

Final Visit with Dr. Chong December 6, 2007

[122] On December 6, 2007, Ms. Thornhill saw Dr. Chong. This was the final time she saw him. In all she saw him 63 times. She testified that she saw him this last time to confront him about misdiagnosing her for all those years, particularly since she had asked him many times for an MRI. Ms. Thornhill testified that Dr. Chong's response was that he did not know why he did not order an MRI. Dr. Chong testified that Ms. Thornhill had never asked him for an MRI. He also denied that at that meeting he said that he did not know why he had not ordered an MRI.

June 20, 2008 Surgery and Aftermath

[123] On June 20, 2008, after having pre-operative chemotherapy and radiation, Ms. Thornhill had a synovial sarcoma surgically removed from her right forearm.

[124] Both Ms. Thornhill and Mr. Gottschalk testified that once Ms. Thornhill recovered from surgery she was pain free in her right forearm.

Primary Factual Issues

[125] The credibility of the parties is at the heart of determining the primary factual issues in this case.

Credibility – The Positions of the Parties

[126] Counsel for Dr. Chong contends that Ms. Thornhill was not a credible or reliable witness on the important factual issues. He advances a number of reasons. Ms. Thornhill gave her version of events by her counsel leading her through Dr. Chong's notes. She was prone to exaggeration and overstatement. Her evidence was inconsistent internally and with other evidence. For example, her evidence about the intensity and persistence of her pain was undermined by medical records that showed she relied on over-the-counter medication and home remedies to deal with pain; she told her family doctor that her pain "waxed and waned" and her wrist problems "grumbled along"; she continued to work and to engage in other activities. Another example is her evidence of the presence of a

visible lump. None of the other physicians whom she saw while she was seeing Dr. Chong noted it. Another example is her evidence about the growth of the lump. The histories that she gave to other physicians about it were different from her evidence. An adverse inference can be drawn from the fact that none of the physicians were called to testify. A similar inference can be drawn because no independent witness corroborated her testimony. As well, her evidence of Dr. Chong's indifference to her lump and her pain is improbable. She continued to see him, which makes no sense in light of her low tolerance for doctors who did not meet her expectations.

[127] Counsel for Ms. Thornhill contends that Dr. Chong was not a credible or reliable witness on the important factual issues. He advances a number of reasons. Dr. Chong exaggerated his qualifications. The reliability of his recall is incredible in light of the cursory nature of his notes, the dearth of detail in them, and the amount of time that has elapsed since the events in question. Dr. Chong's evidence about the location of the bump and its characteristics was inconsistent internally and was inconsistent with his evidence at his examination for discovery. It was also a marked departure from the position he took in his statement of defence.

Credibility - Findings

[128] I do not think that Ms. Thornhill exaggerated her pain. There is no doubt that she had pain in her wrist for years. It was the reason that she saw Dr. Chong in the first place. From Dr. Chong's records and treatment, an inference of increasing pain can be drawn. In 2001, he prescribed Remeron. In May 2002, he diagnosed RSD. He said that Ms. Thornhill's pain was one of the reasons. He tried stellate ganglion block injections. There are increased references to pain during and after 2003. Dr. Chong prescribed Lyrica in October 2005 and marveled at the result. He called it a breakthrough. Not much can be taken from Ms. Thornhill's prior reliance on over-the-counter medicine when Dr. Chong testified that Lyrica was a new drug in treating neurological pain.

[129] I also found Ms. Thornhill's evidence about the growth of the lump to be credible. There is some corroboration of evolution in what Dr. Chong wrote and did. In June 1998, Dr. Chong found a bump. No physician had previously found one. On November 27, 2001, Dr. Chong charted "++Lumpy Feeling." While he explained it as "swelling", it is the only place in his chart where he noted how the area felt. He added RSD to the diagnosis in 2002 because of what he called "swelling", which implies an increase in it.

[130] Ms. Thornhill's evidence of her pain and the growth of the lump is corroborated by Mr. Gottschalk. While more independent witnesses might have been called, no one would be in a better position than he to observe. I put no weight on the photos she produced because they were not produced until trial.

[131] Ms. Thornhill explained why her family doctors would not have reported seeing the lump while she was in Dr. Chong's care. She said that she seldom discussed her wrist with them, and if she did, she would not permit them to examine it because of the pain. As Dr. Brankston testified, the records of the family doctors suggest that the wrist problem was

only discussed in passing and in the context that Dr. Chong was dealing with it. Even in 2007, when Dr. Park included the wrist in the referral to Dr. Lan, he made no mention of the lump, even though it was there at the time, based on what Dr. Lan reported.

[132] Dr. McCully's report of March 9, 2000 did not note a lump, but Ms. Thornhill's evidence was that she did not notice a lump until mid-way through 2000. I make nothing of the fact that Dr. Kronby, a neurologist, who she saw on October 7, 2002 about headaches and Dr. Sullivan, a cardiologist, who she saw on February 7 and March 28, 2005, did not document a lump on her wrist. On September 18, 2002 and October 24, 2002 she saw Dr. Rhydderch, an anaesthesiologist, for a right stellate ganglion block injection. There was no evidence that either he or Dr. McCully conducted a physical examination of her wrist. Ms. Thornhill testified that she would not let them.

[133] On January 23, 2007, Dr. Lan noted the presence of a nodular lump and no swelling. The history he recorded was of a lump dating back 5 years from January 23, 2007, growing. This is not inconsistent with Ms. Thornhill's evidence.

[134] On September 4, 2007 plastic surgeon Dr. Van Brenk noted "a 10 year history of swollen, painful mass involving the right dorsal forearm….over the last year or two a visible mass has appeared and is slowly increasing [in] size." There is an inconsistency with Ms. Thornhill's evidence about when the lump began to grow. However, I think it is minor because it is implicit in the doctor's description that there was a transition from longstanding swollen, painful mass to the 2005 mass.

[135] The inconsistency comes in the histories recorded in the two surgeons' reports. In his report dated November 12, 2007, Dr. Wunder states: "Over the last two years, she has noticed swelling in the area and then later realized that this was a growing mass." In his report dated November 28, 2007, Dr. Blackstein states: "Approximately 2½ years ago, Jan began to see swelling in this region of the right forearm." Each surgeon had an intermediary take the history. The histories in the surgeons' reports are inconsistent with one another and inconsistent with Dr. Lan's history, with Dr. Van Brenk's history and with Ms. Thornhill's evidence. She does not admit the statements to the intermediaries. She testified that she told everyone that the lump had been present for longer than two years, but since 2005 the rate of growth had increased. None of the physicians were called to attest to what they were told.

[136] I do not draw an adverse inference from the plaintiff's withdrawal of a Notice under s. 52 of the *Evidence Act*, after being required to call the physicians for cross-examination. The responsibility for proving a prior inconsistent statement rested with the defendant. No adjournment was sought for that purpose.

[137] An incident that Ms. Thornhill recounted demonstrated the danger of miscommunicating when using intermediaries. Before surgery, Dr. Blackstein told Ms. Thornhill that her tumour had penetrated very deeply. This was an ominous circumstance. He was immediately taken aside by his fellow. Then Ms. Thornhill was told that Dr. Blackstein had been talking about another patient.

[138] For these reasons, I put little weight on the alleged prior inconsistent statements in assessing Ms. Thornhill's evidence.

[139] Ms. Thornhill stuck with Dr. Chong even though her evidence about his methods would suggest that was not something she would likely have tolerated. She explained that. She said that she accepted what she called Dr. Chong's "looping theory". Equally important, I think, is that she had developed a strong rapport with him. Ms. Thornhill was able to talk to Dr. Chong about all of her problems. He gave her a great deal of support, which she needed.

[140] Overall, I found Ms. Thornhill to be a credible and reliable witness. I have come to that view after considering all of the criticisms, which the defence levelled at her, and after considering all of the evidence.

Credibility Dr. Chong

[141] Dr. Chong was not an impressive witness. He often referred to tangential and unrelated matters in testifying, rather than simply answering the questions posed. His ability to recall events, as fully as he purported to, was not credible. The circumstances were that Ms. Thornhill was one of 10,000 RSI patients he treated - about 5,000 before and about 5,000 after her. The notes to which he referred in testifying were cursory.

[142] Dr. Chong holds himself out as a specialist in occupational medicine. He only admitted that he is not an accredited specialist in the area after he was cross-examined extensively on the issue. He did not produce his curriculum vitae until the beginning of the trial. At his discovery he was asked for it. He said that he did not have one. At trial, he said that he thought the examiner at the discovery was asking if he had his CV there. I do not think that was a credible explanation. In any event, it did not explain why he delayed producing it until trial.

[143] Dr. Chong testified that he dictated his consultation report of June 23, 1998 in Ms. Thornhill's presence. That is hard to accept in light of the contents of the note. Among other insulting images of Ms. Thornhill, Dr. Chong compares her, with her ugly hat and thick glasses, to Jane Goodall working with the apes.

[144] The history of the bump was obviously the most important factual issue in the case. Dr. Chong's evidence about it was confusing and contradictory.

[145] Dr. Chong said in his evidence in chief that the bump he found on June 23, 1998 was not the same lump that he saw on January 25, 2007. It was in a different location. On cross-examination, he initially said that it was clear from his notes where he charted the location of the bump, but later he admitted that he did not chart a specific location. However, he said it was clear in his mind where it was.

[146] Dr. Chong testified that the bump and inflammation that he reported on June 23, 1998 were two differentiated findings. He said the bump and area of inflammation was small,

the size of a thumbtack. It was not painful when he palpated it. However, he did not chart that it was not painful. He did not chart the size or appearance of either the bump or area of inflammation or any differentiation between them. To me, a plain reading of the letter of June 23, 1998 indicates that they were undifferentiated: "an extensor bump and area of inflammation which *is* very difficult to diagnose." [The emphasis is mine.]

[147] Dr. Chong testified that he monitored the area on every visit and only noted changes. He said that the area of swelling fluctuated. The bump never changed. However, he agreed that, other than a reference on December 15, 2005 to a reduction in swelling in response to Lyrica, there was nothing in his notes from October 30, 2003 to January 25, 2007 describing the appearance of the arm. Dr. Chong testified that his use of short forms for the muscle group signified a physical examination (for example, "ED" for extensor digitorum, "EPI" for extensor pollicis longus and "S" for supinator). Yet, there are no such short forms in his chart from October 30, 2003 to November 16, 2006. The inference is that he did not conduct physical examinations during that period.

[148] Dr. Chong's evidence about the bump\lump was inconsistent internally and inconsistent with the admissions he made in his statement of defence and on his examination for discovery, where it was clear that the bump of June 23, 1998 was the same lump he saw on January 25, 2007.

[149] In his statement of defence, Dr. Chong pleaded that on June 23, 1998 he had observed a bump approximately the size of a thumbtack on the extensor area of Ms. Thornhill's forearm. The pleading goes on to state the following. At each appointment he attempted to assess the bump. The size of the bump remained constant until about January 27, 2007 [should read January 25, 2007], when he observed that it had grown to approximately the size of a slug. He immediately ordered an MRI, which showed a homogenous soft tissue mass, leading to a biopsy of the mass, leading to the discovery of a spindle cell neoplasm.

[150] When his statement of defence was put to him, Dr. Chong said that what he saw on June 23, 1998 was clinically different from what he saw on January 25, 2007. He said that what he saw on June 1998 was a fibrous, non-painful area of chronic injury. The January 2007 bump was "slug-like", as he had described in his statement of defence. However, Dr. Chong did not describe it as "slug-like" in his statement of defence. In his statement of defence, he described it as "the size of a slug". Dr. Lan, in his January 2007 note, described it as a "nodular lump".

[151] It was also put to Dr. Chong that he had said something different on his examination for discovery, when he was asked about the lump he saw on January 25, 2007. There he had agreed that the lump on January 25, 2007, then bigger, was the lump that he saw at the outset on June 23, 1998, then the size of a "thumbtack". (See Question 999 to 1009 – examination for discovery April 26, 2011.) At trial, Dr. Chong said that he was not changing his answer from the examination. He was reflecting on the MRI, which was ultimately obtained, and which did not correlate with what he was finding on examination. He agreed that he had never changed or corrected his answers from his examination for discovery before trial.

[152] In his evidence on his re-examination, Dr. Chong testified that on January 25, 2007 he made note of three muscles, only one of which he made note of on June 23, 1998. So, on that evidence, he seemed to be saying that it was a different area that he was referring to on January 25, 2007, closer to the wrist and to the thumb side of the forearm than the muscle groups he referred to on June 23, 1998. However, if as Dr. Chong testified, the bump he saw on June 23, 1998 stayed the same, the inference must be there were two co-existent bumps on January 25, 2007. But, there was no other reference anywhere, including from Dr. Chong, of two bumps in January 2007.

[153] As I said, Dr. Chong testified that he was saying that the January 2007 lump did not match the appearance of the June 1998 lump, because he was reflecting on the MRI, which was eventually obtained, which did not correlate with what he was finding on examination. It is obvious to me that Dr. Chong's testimony was a reconstruction of events in light of after-acquired information, rather than a faithful rendition of what actually happened.

Primary Factual Findings

[154] For these reasons, I do not accept Dr. Chong's evidence. I prefer and accept Ms. Thornhill's evidence where it conflicts with Dr. Chong's evidence.

[155] I find that the nodular lump that Dr. Lan found in January 2007 was the same bump that Dr. Chong had found on June 23, 1998, but bigger, as Dr. Chong admitted in his statement of defence and admitted in his examination for discovery. I find that what Dr. Chong found on June 23, 1998, was a small undifferentiated bump and area of inflammation in Ms. Thornhill's right forearm. He did not make Ms. Thornhill aware of it. The area was painful to touch, as Ms. Thornhill said. It was not until about half-way through 2000 that she became aware of a visible raised area over the spot in her right arm. By November 27, 2001, the area felt lumpy. By 2002, the painful spot appeared more like a lump and, by June 2003, it was visible through clothing. The rate of growth of the lump was slow until around 2005 when the rate of growth picked up. Ms. Thornhill discussed her forearm on every visit with Dr. Chong. She made him aware of the raised area, then the lump, the increasing size and the increasing pain. Dr. Chong rarely took a close look at her forearm and only palpated the spot a couple of times, as she said. In 2002, Ms. Thornhill first asked Dr. Chong to order an MRI, but he did not.

Expert Evidence – Standard of Care

[156] On the standard of care, the plaintiffs called Dr. Edwin Brankston, a general practitioner in the Oshawa, Ontario area, and Dr. Paul Clarkson, an orthopaedic surgical oncologist from Vancouver, British Columbia.

[157] The defence called Dr. Sol Stern, a general practitioner from the Oakville, Ontario area and Dr. Benjamin Deheshi, an orthopaedic surgical oncologist from Hamilton, Ontario.

Dr. Edwin Brankston for the Plaintiffs

[158] Dr. Brankston was called on behalf of the plaintiffs. He graduated from medical school in 1976. For the past 40 years he has been practicing as a family physician, providing primary care to his patients. He also has extensive teaching experience. Since 1979, he has taught third and fourth year medical students. Since 2007 he has been on the faculty of Queen's University as an associate professor. From 2007 to 2010, he was site leader for the Family Medicine Residency Training Program at Lakeridge Health Corporation for Queen's University. For the past three years, he has mentored family medicine residents at his clinic. A significant part of his clinical practice, including during the period 1998 to 2007, includes managing patients who are suffering from lumps and bumps and chronic pain, including pain related to cancer, fibromyalgia, generalized musculoskeletal pain, neuropathic pain, diabetic neuropathy, RSD and RSI. Autoworkers, among those he treats, can be required to carry out the same task with upper extremities 600 to 700 times per shift, which can lead to repetitive strain. From 1994 to 2001, he provided independent medical assessments for Clarica Insurance Company. They involved the capability of autoworkers to return to occupational duties.

[159] He has previously been retained on behalf of both physicians and patients to render expert opinion in the context of medical malpractice cases. He has been qualified to give expert opinion on the issue of standard of care approximately 25 to 30 times in the Superior Court of Justice.

[160] Dr. Brankston was found to be an expert in family medicine. He was permitted to opine on the standard of care in 1997 to 2008 for the diagnosis and investigation of a patient presenting with a lump or bump on an extremity by a primary care physician. A primary care physician was defined as a physician on the frontlines of providing medical care in Ontario.

[161] Dr. Brankston testified that the assessment, investigation and diagnosis of lumps and bumps in the extremities, including where there is associated pain, persistence and growth is basic medicine. The principles are standard and fundamental and at the core of providing medical care on a primary basis. The principles have not changed in years. All physicians are given this underlying knowledge and training in medical school and are expected to use it.

[162] Dr. Brankston testified that, in his opinion, Dr. Chong managed Ms. Thornhill in the style that he would normally associate with a primary care doctor. This was because, aside from the initial consultation note to the family doctor, he sent no follow-up notes back to the family doctor. He appeared to spend most of his time with her on issues unrelated to her right forearm. For example, he discussed Hepatitis C with her. He referred her to a cardiologist and to a neurologist. He discussed smoking and alcohol issues her. He discussed psychological wellbeing. These are things that a family doctor would attend to. She was there for chronic pain in her right forearm.

[163] It was Dr. Brankston's opinion that, in treating Ms. Thornhill, Dr. Chong failed to meet the standard of care applicable to any primary care physician in assessing a lump or bump.

[164] Dr. Brankston testified that when Ms. Thornhill presented with an extensor bump on June 23, 1998, the standard of care, based on training that goes back to medical school, required Dr. Chong to formulate a differential diagnosis for the bump. It should have included a soft tissue tumour, benign or malignant. Nowhere in Dr. Chong's chart on June 23, 1998 or elsewhere, did Dr. Chong list any possible causes for the bump. Consequently, he fell below the standard of care on June 23, 1998.

[165] Dr. Brankston said that, in light of Ms. Thornhill's history, when Dr. Chong discovered the lump, the standard of care required him to immediately order an MRI on June 23, 1998 to rule out a tumour. In failing to do so, Dr. Chong breached the standard of care.

[166] Dr. Brankston testified that Dr. Chong should have obtained a copy of the CT scan and report that he knew that Ms. Thornhill had just undergone. It was important for him to see it. The radiologist's note suggested that if clinical concern persists an MRI would be a more sensitive means of ruling out a soft tissue mass. Dr. Chong had made a new finding of a bump, which qualified as a persisting concern. The report would have prompted him to order an MRI. In failing to obtain a copy of the CT scan and report, Dr. Chong fell below the standard of care.

[167] Dr. Brankston testified that the standard of care required Dr. Chong to repeatedly examine the bump and palpate the area between June 23, 1998 and January 2007. If he did not do so, he failed to meet the standard of care. As well, he was required to document each examination. He should have included in his notes the size of the bump, its consistency, tenderness and pain intensity on a scale of 0 to 10. The object of the examination and documentation was so that he would know if the pathological process was advancing. If Dr. Chong was examining the area, he fell below the standard of care because he did not document his findings.

[168] Dr. Brankston was highly critical of Dr. Chong's charting because he never recorded anything about the presence of the bump after the first visit until 2007. Dr. Chong had said that where he used short forms in his chart it indicated an examination. Dr. Brankston testified that the short forms, when used in the chart, were merely a mention of structures of anatomy, just a collection of words and did not detail any physical findings or tell any sort of story. He said that a doctor's chart should tell the story of what went on during the visit. Nowhere after January 21, 1999 up to November 30, 1999 did Dr. Chong mention Ms. Thornhill's wrist pain. On November 30, 1999, when he charted that her right wrist pain was still there, he did not chart its intensity. In failing to do so, he breached the standard of care. On November 27, 2001, he noted reduced sensation and a lumpy feeling in the wrist. He did not document if it was tender or outline the area and its dimensions. In failing to do so, he breached the standard of care. He also breached the standard of care in failing to order an MRI at that point.

[169] On June 23, 1998, Dr. Chong diagnosed RSI and dystonia (muscle cramping) in the forearm, resulting in nerve entrapment, as part of the RSI. Dr. Brankston acknowledged that a mistaken exercise of clinical judgment is not negligent, provided that the exercise of clinical judgment is reasonable. However, it was Dr. Brankston's opinion that Dr.

Chong's clinical judgment was not exercised reasonably. Dr. Brankston said that dystonia would not result in a lump or bump. A bump in the wrist cannot logically be linked to issues in the neck and shoulder. Dr. Brankston said that it was not reasonable to palpate a lump in the same area where a patient is experiencing chronic neuropathic pain and then either ignore it or not clarify it.

[170] On May 28, 2002, Dr. Chong diagnosed RSD. Dr. Brankston's view was that the diagnosis was not a reasonable exercise of judgment. He explained that RSD is a chronic pain syndrome. It is most commonly associated with an injury to the distal part of the upper or lower extremity. As a result, the patient develops chronic neuropathic pain syndrome, the intensity of which is out of proportion to the severity of the initial injury. It is a diagnosis that is predicated on findings based on history and physical examination. The components of RSD are variable. They include decreased temperature of the skin, compared to the opposite side; increased diffuse swelling, as opposed to localized swelling; a diffuse pink discolouration to the skin on that side, as compared to the skin on the other side; allodynia (light stroking of the patient's skin which produces a significant increase in intensity of pain out of proportion to the stroking); and in the case of RSD in an upper extremity, a reduced range of motion of the wrists and finger joints. Dr. Brankston testified there is no documentation in Dr. Chong's notes of any of the signs or symptoms suggestive of RSD and no assessments to show how Dr. Chong reached the clinical diagnosis of RSD.

[171] Dr. Brankston testified that, if Ms. Thornhill had a visible lump in her arm by 2002, Dr. Chong fell below the standard because he did nothing to clarify the cause of that lump. The way to begin to clarify it was by MRI imaging.

[172] Dr. Brankston testified that the notes from after October 30, 2003 to January 25, 2007 do not document physical examination. Dr. Chong prescribed Lyrica. It is an anti-convulsive medication commonly used in the treatment of neuropathic pain of any sort, not just RSD, to reduce the intensity and severity of the patient's pain. There is nothing in the chart to show whether the Lyrica made a difference in the severity and intensity of Ms. Thornhill's chronic neuropathic pain.

[173] After October 20, 2003, it appeared that Ms. Thornhill was not improving. Dr. Chong's diagnosis continued to be RSD. There is nothing in the chart to show that he ever reconsidered his diagnosis or considered any imaging studies before January 25, 2007. In these respects, he failed to meet the applicable standard of care. He was required on each visit to examine the patient's right forearm and document the characteristics of the lump, and he was required to order MRI imaging to try to clarify the diagnosis of the wrist bump.

[174] Dr. Brankston said that he could not reconcile the record from Dr. Chong's assessment of Ms. Thornhill on November 16, 2006 with Dr. Lan's report from one month later. Dr. Lan reported no clinical signs of RSD and reported a nodular lump on the distal right forearm, approximately two inches long by one inch.

[175] On November 16, 2006, Dr. Chong charted: "PTSD – RSD – Stabilized Well". Dr. Brankston said that he was unsure from the note whether it was Ms. Thornhill's PTSD or RSD that Dr. Chong thought was "stabilized well". There was nothing to suggest in the note that RSD was stabilized. There was nothing in the note to suggest that Dr. Chong was aware of the lump. Dr. Brankston's opinion was that the lump could not have developed between November 16, 2006 when Dr. Chong saw her and January 23, 2006 when Dr. Lan saw Ms. Thornhill. If Dr. Chong failed to appreciate on November 16 what Dr. Lan documented on January 23, then Dr. Chong fell below the standard of care of any physician.

[176] Dr. Brankston testified that on January 25, 2007 Dr. Chong met the standard of care by ordering an MRI of the lump.

[177] Dr. Brankston was asked why Dr. Chong was obliged, over the course of his treatment of Ms. Thornhill, to order an MRI when none of the other doctors she saw did so. He said that there was no evidence that any of them felt a lump. Also, in the case of the family doctors, after the referral to Dr. Chong, the tone of the notes suggest that they believed that Dr. Chong was treating the problem. It appears from their notes that, when Ms. Thornhill mentioned her wrist to any of them, it was generally in passing.

[178] On cross-examination, Dr. Brankston was asked why he felt he could comment on Dr. Chong's practice when he had admitted that he was not qualified to comment on Dr. Jaikaran or Dr. McCully's practice because they were specialist. He said that the difference was how Ms. Thornhill presented to Dr. Chong and how he had managed her over the years. Dr. Chong, in his view, practiced in the style of a primary care or family physician. Also, neither Dr. McCully nor Dr. Jaikaran had found a discrete bump. If they had, Dr. Brankston said that he would have expected them to act on the finding and investigate it with imaging, such as MRI.

[179] Dr. Brankston agreed that the co-morbidities that pertained to Ms. Thornhill could affect the body's reactions biochemically.

[180] Dr. Brankston also agreed that Dr. Abrahamse sought Dr. Chong's opinion and treatment as an occupational medicine specialist to determine if there was a connection between Ms. Thornhill's work and her symptoms. The background against which Dr. Chong saw Ms. Thornhill was that she had already been seen by a physiatrist, Dr. Jaikaran. Dr. Jaikaran's report outlined the investigations he did and that he was considering a diagnosis of myofascial pain disorder, extensor indicis.

[181] Dr. Brankston had testified that Dr. Chong did not exercise his judgment reasonably. He admitted on cross-examination that persistent inflammation from RSI can lead to inflammation in fibrous connective and can cause scar tissue in the muscles sometimes called knots and result in pain and referred pain. As well, various sorts of lesions, fibrous nodule and calcium deposits can cause a bump. He also agreed that myofascial pain syndrome is a form of RSI that can involve the forearm extensors, the shoulder and neck muscles and can be associated with use of a keyboard, a mouse use and other repetitive

uses of the hands. He agreed that it is very difficult to test the superficial radial nerve using nerve conduction studies because of how the nerve branches out below the elbow. However, Dr. Brankston said that his review of Dr. Chong's notes did not show that he considered knots or other lesions as part of his differential diagnosis for the bump. Then various investigative techniques involving imaging could be used to help clarify the nature of those lesions.

[182] Dr. Brankston was cross-examined about the diagnostic criteria for RSD based on a review article. Dr. Brankston was not prepared to agree that RSI can be a triggering event for RSD. He also would not agree that localized swelling fits one of the criterion for RSD, edema. On the issue of the fourth criterion, Dr. Brankston noted that RSD is excluded by the existence of other conditions that would otherwise account for the degree of pain and dysfunction. He said it was a very important criterion and means that RSD is a diagnosis of exclusion. It means you want to exclude other possible causes of the patient's forearm pain and lump. Neither RSI nor RSD cause a lump. So, the condition that Dr. Chong had to exclude was the lump and it was not excluded.

[183] The issue of what other doctors did was explored on cross-examination.

[184] In his initial report, Dr. Brankston had written that any competent family physician would have ordered an MRI, on the basis of the CT scan, because Ms. Thornhill's ongoing chronic right forearm pain constituted a "persisting clinical concern".

[185] Dr. Abrahamse had received the CT scan and knew that the pain was persisting. Dr. Brankston said that he would have expected Dr. Abrahamse to have forwarded the CT report to Dr. Chong. Dr. Abrahamse received Dr. Chong's consultation report. Dr. Brankston said that he would have expected a family physician to discuss a consultation report with a patient. However, he noted it was about 6 months or 8 months after receipt of the report, that Dr. Abrahamse next saw Ms. Thornhill. She had seen Dr. Chong several times in the interim. So, the report might or might not be discussed, depending on why she patient was there.

[186] Dr. Brankston was asked about the failure of the locum in Dr. Shannon's office on January 14, 2000 to order an MRI. Ms. Thornhill discussed her right wrist pain with him. He knew of the CT report. Dr. Brankston was asked why, on the basis of the pain alone, the locum should not have been expected to order an MRI. Dr. Brankston said that the reference in his first report to persisting pain being an indicator for an MRI was done in the context of Dr. Chong having found a bump. The locum did not have access to the second page of Dr. Chong's report about the lump. Also, there is no documentation to show that the locum did a physical examination, although it was Dr. Brankston's expectation that he should have.

[187] Dr. Shannon did a pre-operative examination before Ms. Thornhill had a biopsy for abnormally enlarged lymph nodes and he did not raise any issues about the arm in it. Dr. Brankston said that those issues had no bearing on her risk for general anesthetic for a

breast biopsy. He admitted that the arm problem might affect the ability to put a line in it.

[188] Dr. Brankston agreed that Dr. Park's note of September 2, 2003 when he met Ms. Thornhill for the first time meant that she had no complaints.

[189] On August 18, 2006, Dr. Park referred Ms. Thornhill to Dr. Lan for nerve conduction studies. There was nothing in the chart or referral letter about a growth in the arm. Dr. Brankston agreed that he would expect a reasonable family physician to chart and mention in the referral letter about any concern raised specifically about growth of a lump. He also agreed that he would expect a physician to do his own assessment to decide whether nerve conduction studies were appropriate. He could not tell why Dr. Park did not do a physical assessment. He said that request was an add-on. The flavour of the referral letter is that the information is based on what the patient told him. Dr. Park knew that a doctor in Toronto was largely looking after the problem. He noted that Dr. Park would have known that the neurologist would do a comprehensive assessment.

[190] Dr. Brankston agreed that the care and treatment of RSD includes rehabilitation and physiotherapy, psychological therapy and pharmacological means.

[191] Dr. Chong had sent only one consultation note to the family doctor. Dr. Brankston admitted that, in considering Dr. Chong's failure to report, he had not taken into account the psychotherapy elements of the treatment and any guidelines that specifically applied to the disclosure of that information.

Dr. Paul Clarkson for the Plaintiffs

[192] Dr. Paul Clarkson was called on behalf of the plaintiffs. He graduated from medical school in 1993. He is an orthopaedic surgeon with a sub-specialty in the diagnosis and management of soft-tissue sarcomas. He is one of Canada's leading experts on soft-tissue sarcomas. Specifically, he is one of only 3 or 4 physicians in Canada whose practice is dedicated exclusively to investigation, diagnosis and treatment of soft-tissue and bone tumours in the arms and legs. He is currently the primary surgeon for bone and soft-tissue sarcomas at the Vancouver General Hospital, a unit that diagnoses and treats more bone and soft-tissue sarcomas than any other surgical unit west of Toronto. Dr. Clarkson has been the Chair of the Sarcoma Tumour Group in the BC Cancer Agency since 2011. He also has extensive teaching responsibilities. Prior to and during the period 1998 to 2007, he was responsible for teaching medical students, including those gaining a sub-specialty in occupational medicine. Since 2011, he has been Director of the Undergraduate Medical Education Program in the Department of Orthopaedics at the University of British Columbia. In addition to teaching, he is instrumental in setting the curriculum.

[193] Dr. Clarkson was found to be an expert in the area of surgical oncology, the assessment, diagnosis and treatment relating to cancers of the soft tissue and bones with a

subspecialty in the extremities. There was no issue that he was qualified to give his opinion on the causation issues in this case.

[194] The issue was whether Dr. Clarkson could give opinion evidence on the standard of care in this case. Dr. Clarkson has extensive experience in teaching medical students. He testified that he also teaches primary care doctors and non-surgical physicians about the diagnosis, assessment and investigation of lumps and bumps in the extremities. On that basis, he was permitted to opine on the standard of care of a primary care physician in 1997 to 2008 for the diagnosis and investigation of a patient presenting with a lump or bump on an extremity.

[195] Dr. Clarkson testified that students in medical school are taught about the clinical significance of lumps and bumps. They also learn about differential diagnosis. They are taught that a lump or bump may be a tumour. A tumour is uncommon but it can be catastrophic, so they are told "don't miss it". Students are taught, and all physicians are aware, that it is important to exclude the diagnosis of a tumour in the investigation of a lump or bump.

[196] Dr. Clarkson's opinion was that Dr. Chong fell below the standard of care in his management of Ms. Thornhill's lump.

[197] Dr. Clarkson assumed for purposes of giving his opinion that on June 23, 1998 Dr. Chong found an extensor bump on Ms. Thornhill's forearm the size of a thumbtack. The area was very painful to palpation. He said that where a patient has pain localized to an area and there is a clinical finding of a bump it clearly shows there is some form of localized process going on, like a soft tissue tumour. Tumours are uncommon and lumps and bumps are common, but Dr. Chong's differential diagnosis should have included a soft tissue tumour, benign or malignant, requiring exclusion. If Dr. Chong failed to include a soft tissue tumour as part of his diagnosis, he failed to meet the applicable standard of care.

[198] Dr. Clarkson said that to investigate a possible tumour, a CT scan or MRI would have been available. However, Ms. Thornhill already had a CT scan and it showed no abnormality. The radiologist's report suggested that if clinical concern persists, an MRI scan should be performed. To Dr. Clarkson this meant that if clinical concern persists, the physician should not be reassured by the CT scan. A clinical concern would include pain localized to the area and the presence of a lump or bump. In those circumstances, in light of the CT scan report, which suggested going to an MRI scan, an MRI should have been done next.

[199] An MRI is a much more sensitive test for a soft tissue mass than a CT scan. Dr. Chong was required to obtain a copy of the CT scan report because as a matter of common sense all relevant investigations should have obtained when Dr. Chong had been asked to give an opinion and assessment. Also, if Dr. Chong had not entertained the possibility of a soft tissue tumour in the differential diagnosis of the bump, reading the CT scan would

have prompted him to do so. In failing to obtain a copy of the CT report, Dr. Chong failed to meet the applicable standard of care.

[200] Combining the results of the CT scan with the clinical presentation of the lump, any reasonable physician would have ordered an MRI scan. Failing to do so, Dr. Chong failed to meet the applicable standard of care.

[201] Dr. Clarkson clarified on cross-examination that he was assuming that on literally every visit Ms. Thornhill told Dr. Chong that her right forearm and wrist were becoming increasingly debilitating and were significantly interfering with her career.

[202] Dr. Clarkson testified that between 1998 and 2002, Dr. Chong did not meet the applicable standard of care. In the face of a patient with a palpable bump on the forearm, which was persisting and not responding to other treatments, he did not follow up on the CT scan report with further investigations, or with a referral to an appropriate specialist. "Persisting" means six to twelve months. If something is not getting better, a physician should change tack. Dr. Chong breached the standard of care by failing to reconsider the differential diagnosis.

[203] If Ms. Thornhill's evidence is accepted and the spot was growing in size and visibly evident from the years 2001 and 2002 and continuing to be symptomatic, further investigation was mandatory. If Dr. Chong's evidence is accepted and the bump simply persisted in size and was not growing, it was a persisting mass remaining symptomatic and it required further investigation in the form of either an MRI or a referral to a specialist. In either case, Dr. Chong failed to meet the standard of care.

[204] If, by 2002, the area had grown into a lump and the lump grew slowly until 2005 when it increased more rapidly, and then grew more rapidly after 2007, a reasonable physician would not have persisted with treatment in the form of psychotherapy and ergonomic and other management techniques when the patient's symptoms were not responding to them.

[205] Dr. Clarkson said that if Ms. Thornhill asked Dr. Chong to order an MRI, and he did not, that was not a breach of the standard of care. A physician is not required to order a scan simply because a patient requests it.

[206] It was established on cross-examination that Dr. Clarkson assumed for purposes of his reports that on literally every visit Ms. Thornhill told Dr. Chong that the right forearm and wrist were becoming increasingly debilitating and were significantly interfering with her career. Dr. Clarkson said those were part of the facts provided to him in a letter he received from counsel. He said that he made his assumptions clear in his report and would have noted any difference between the assumptions and the records, as he did his review. Dr. Clarkson agreed that those assumptions despite the fact that Dr. Chong did not chart these statements from Ms. Thornhill. He said that not all statements by a patient are documented. However, he admitted that he did not make the same assumption in reviewing the records of the other physicians in the case. The reason for the difference

was because Dr. Chong's notes were incomplete and difficult to decipher and he had no reason to doubt the accuracy of Ms. Thornhill's report.

[207] It was also established that Dr. Clarkson made other factual assumptions as follows: Ms. Thornhill had an area of localized pain; in June 1998, Dr. Chong detected an extensor bump the size of a thumbtack; the CT report registered no abnormality; there was a palpable mass that was painful; there was a localized process, as a result of that; the pain was neuropathic pain and lightning pains; there was a raised mass by 2001 or 2002; the mass grew slowly until 2005; then it grew more rapidly; it grew even faster in 2007. Dr. Clarkson said he also assumed that the extensor bump was the beginning of the mass that was diagnosed in 2007 as synovial sarcoma. He said he made that assumption because he believed it was.

[208] Dr. Clarkson said that the differential diagnosis for a lump or swelling on the dorsum of the wrist would include a number of things such as a neuroma, ganglion, soft tissue tumour, but he would not expect that someone could feel it and say that is a synovial sarcoma.

[209] Dr. Clarkson also confirmed that the responsibility of his residents or fellows is to compile a new patient history. Doing that would include speaking to the patient. He would also speak to the patient and make sure the history was accurate.

Dr. Sol Stern for the Defendants

[210] Dr. Sol Stern was called on behalf of the defendant. He graduated from medical school in 1982. He has practiced as a family physician since 1983. He has an interest in chronic pain. During the period 1998 to 2007, about 20% to 25% of the 1200 patients that he was treating had the condition. He receives patients on referral from other physicians for the treatment of chronic pain. His chronic pain patients include those with RSI (particularly of the extremities) and RSD. Like any family physician, he regularly assesses and treats lumps and bumps. He also does it in the context of patients with RSI and RSD.

[211] Dr. Stern has been involved in planning professional educational programs and has made hundreds of continuing medical education presentations to hospitals and clinics in Ontario about the assessment and treatment of chronic pain. He has also volunteered with the College of Physicians and Surgeons doing compliance monitoring of physicians who have had practice issues. He has provided expert opinions to the College in complaint cases. From 2001 to 2006 he was Chief of Staff for the three Halton Hills hospitals, an administrative position where his duties included reviewing the standard of care for all physicians in the hospitals. When there were complaints, he was called upon to give his opinion respecting competency.

[212] Dr. Stern is a family physician with a focus in chronic pain management. He was permitted to opine on the standard of care from 1997 to 2008 for the assessment, diagnosis and treatment provided by primary care and front-line care physicians, including those who receive referrals from other physicians, in relation to chronic pain

management, including for repetitive strain injuries in patients who present with lumps and bumps.

[213] Dr. Stern testified that, based on his review of all the records, it was his opinion that Dr. Chong's care of Ms. Thornhill between 1998 and 2007 met the standard of practice of the profession.

[214] The reason for the consultation was right forearm and wrist. Ms. Thornhill wrote in her comments that she was an illustrator and was having problems with her right wrist and forearm. The referral showed what testing had been done and what medications and treatment had been tried. Dr. Jaikaran's opinion showed "pain right distal forearm", not yet been diagnosed, and he wanted to rule out myofascial pain disorder of the extensor indicis muscle.

[215] The initial consultation on June 23, 1998 was conducted in accordance with the standard of practice. The chart shows a history was taken. There are handwritten notes. The consultation note to the family physician described the findings, both from history and physical. Dr. Chong was going to follow up with the patient, so he would have other opportunities to do more history and physical. It is virtually impossible in one visit to do everything in a case.

[216] "Index of suspicion" is a clinical decision a physician makes when evaluating the differential diagnosis, as a guide to further management. Dr. Stern said that he would expect a low index of suspicion of malignancy, based on the clinical information that Dr. Chong had on June 23, 1998. It would not have prompted a clinician practising in Ontario, at the time, to order an MRI.

[217] Dr. Stern testified that physicians use imaging such as MRI, CT and ultrasound to help clarify diagnosis, based on clinical need and assessment. An MRI cannot be ordered on every patient. Based on Dr. Chong's consult note, there was nothing in the clinical presentation that would prompt a physician to order an MRI for Ms. Thornhill. That was because the diagnosis was appropriate and based on the clinical picture. In his intake, Dr. Chong described that Ms. Thornhill had fibromyalgia and she had issues with function and she had a repetitive strain injury and she had a radial nerve entrapment. All of these go hand in hand with her decreased ability to perform her job as an illustrator. Dr. Stern said that is what he got out of Dr. Chong's consult report.

[218] Dr. Stern said that when Ms. Thornhill told Dr. Chong that her CT scan was normal he was not required to request a copy of it. The reason was because a CT aids in the diagnosis, if there is any abnormality. However, based on the clinical impression, as set out in the consult report, Dr. Chong would not have ordered a CT scan. So, it did not add to the management that the CT report was good.

[219] Here the CT scan was ordered because of recurrent pain. The radiologist said no abnormality was seen. He noted that if clinical concern persists an MRI examination would be a more sensitive means of excluding a soft tissue mass on the extensor surface

of the right forearm. The average clinician in 1998 knew that. If the report was abnormal, it would be the responsibility of the family physician to forward that report to the consultant.

[220] Dr. Stern testified that Dr. Chong's diagnosis of RSD was reasonable. Dr. Stern referred to the diagnostic criteria set out in a review article.

[221] Criterion one is an initiating event or trauma. In Dr. Stern's view, RSI can be that trauma. Regardless, only criteria two to four must be satisfied in making the diagnosis.

[222] Criterion two is continuing pain and allodynia, so-called neuropathic pain. Dr. Stern said that according to the medical record, Ms. Thornhill had continuing pain. There was also evidence of allodynia, which is excruciating pain caused by light touch. She also had areas of hyperalgesia, which are areas where touch gives more than expected pain or tenderness.

[223] Criterion three is evidence of edema, which is swelling. Dr. Stern said that the record showed there was swelling. The swelling can be diffuse or localized. He was not aware of skin changes or change in skin temperature. There may have been sudomotor activity, which is sweating too much, because he seemed to recall that Ms. Thornhill said that her symptoms were worse in the summer.

[224] Criterion four is exclusion of other conditions that would account for the degree of pain and dysfunction. Dr. Stern said that this is the critical criterion and the challenging one. He thought that Dr. Chong made reasonable attempts to exclude other diagnoses. An MRI was not required because there was enough clinical information to satisfy the criterion.

[225] Dr. Stern said that Dr. Chong's management of Ms. Thornhill was appropriate. Once the RSD diagnosis is made, there are three areas of treatment: physical, psychological and medical to improve the function of the patient and Dr. Chong used them. Chronic pain affects the whole body. Physical management includes a variety of physical therapies. Psychological management is required to deal with the psychological manifestation of chronic pain. Medical management is done with pharmacological treatment. It includes Lyrica for neuropathic pain and some clinicians used anti-depressants and topical treatments. Ms. Thornhill had the classic presentation of someone with chronic pain. It appears that when things were going relatively well, her symptoms were well controlled, and when things were not going well, her symptoms were not as controlled.

[226] Co-morbidities affect management because the doctor is treating the whole patient. So, for example, it was important to know about Ms. Thornhill's Hepatitis C because that viral load may affect her immune system.

[227] Dr. Stern said that if Ms. Thornhill's symptoms were variable with work and other physical and psychological stresses, there was no clinical indication for Dr. Chong to order an MRI between 1998 and 2002, based on his records. This was because Dr.

Chong's working diagnosis was RSI based on history, physical examination and evaluation. The treatment he offered and the examinations he did were consistent with the diagnosis.

[228] Dr. Stern said that if Ms. Thornhill's symptoms continued to be variable with stresses and she had edema in her right forearm, there was no clinical indication for Dr. Chong to order an MRI between 2002 and 2005, based on his records. This was because edema was consistent with his working diagnosis of RSI and then with RSD. It had been ongoing for years and the functional problems and pain were consistent with the clinical picture.

[229] If Ms. Thornhill's symptoms continued to be variable with stresses, and the swelling in her right arm and her pain was responsive to Lyrica, there was no clinical indication for Dr. Chong to order an MRI between 2005 and 2007, based on his records.

[230] Dr. Stern said that there is no cure for chronic pain. The focus in treating RSI and RSD is function. If the treatment improves quality of life and function and allows the patient to do her work as an artist, the physician can say: "We're having some successes."

[231] Dr. Stern testified that it was reasonable for Dr. Chong to have maintained his diagnosis of RSI and later of RSD from 1998 to 2007 because the initial presentation, the follow-up, the assessments Dr. Chong did clinically, fit the picture of the condition, as well as the other physicians who saw and treated Mrs. Thornhill during that period of time.

[232] Dr. Stern said that there appeared to be a clinical change in Ms. Thornhill's presentation in January 2007. The swelling had changed, documented by Dr. Chong, leading him to the decision that an MRI was indicated.

[233] Dr. Stern said that a family physician making a referral for a second opinion from another doctor, should review the reason. The family doctor should write a referral letter, outlining the most important elements of history, physical and any diagnostic testing. He should also do a clinical review of history and do a physical exam and document it.

[234] Dr. Stern's opinion was that a primary-care physician is a physician who not only sees a patient on the frontline but provides ongoing care for that patient, in the majority of cases, for the entire system. So, with that definition, he said that Dr. Chong was not Mrs. Thornhill's primary-care physician.

[235] Dr. Stern was extensively cross-examined about Dr. Chong's notes. Dr. Stern said that he concluded from his review that Dr. Chong kept detailed notes. He assumed that what happened at each visit was properly charted. He also assumed that at the first visit Dr. Chong palpated an extensor bump that was the size of a thumbtack. He agreed that he did not base that assumption on the notes, but on the statement of defence. He also agreed that he assumed that Dr. Chong conducted physical assessments of Ms. Thornhill's forearm, and that the assessments were thorough during the entire period.

[236] Dr. Stern said that, based on his review of the chart, he was satisfied that the clinical condition of the bump that started in 1998 did not change appreciably until January 2007. He said that in one-third of the visits over that time Dr. Chong identified the characteristics of the area and bump. Then, he agreed that, in those visits, the characteristics of the bump were not identified. He also agreed that, after June 1998 up to 2002, the word "bump" never occurred in the notes and there are no documented physical findings associated with the bump.

[237] Dr. Stern said that the record-keeping was appropriate with the diagnosis of RSI and the overall clinical picture, because the diagnosis fit the entire clinical picture of the patient, not just the bump.

[238] On re-examination, Dr. Stern testified that what he meant by this was that Dr. Chong made an initial diagnosis that was detailed. He had a clinical diagnosis. Part of the treatment for that diagnosis involved multi-faceted treatment of the patient, which was physical, psychological and medical. The visits were not just about the forearm; they were about the whole body. So, Dr. Chong he did not document the forearm symptoms on each of the fifty-seven visits, but he documented everything else that was critical, in Dr. Stern's opinion, in the treatment to help restore function. Ms. Thornhill was referred to Dr. Chong because she is an artist and needed to improve function and that is what he was focusing on.

[239] Dr. Stern agreed, on cross-examination, that a doctor is expected to document the physical findings on an assessment, including a bump or a lump. He agreed that the finding of a lump or a bump is a significant finding and it is important to follow it. He said it is not always necessary to follow it by palpating it. It depends on the initial diagnosis and reason for the bump. A lump or a bump can be followed with inspection and if other records are there, other physicians have seen it and there is other information about the area on the wrist that can be obtained during the clinical exam. If it corroborates the working diagnosis and nothing else changes in the whole clinical picture, that is sufficient.

[240] On re-examination, Dr. Stern testified that he had wanted to add that the differential diagnosis of a bump or lump in the wrist is so varied in terms of benign and malignant and inflammatory and non-inflammatory that the clinical assessment of a lump is not just feeling it, it is looking at the entire picture and the entire story of the patient and the whole over months or years. It is much more complicated than just feeling a lump.

[241] On cross-examination, Dr. Stern agreed that there is nothing in the records to confirm that after the initial visit until 2002 Dr. Chong performed a physical assessment of the wrist or observed the forearm. He said that is a breach of recordkeeping, not necessarily the standard of care. He said that Dr. Chong did an assessment of the entire patient. His diagnosis was made at the beginning, and his clinical assessment of the entire patient during those four years did not breach the standard of care.

[242] Dr. Stern said that Dr. Chong regularly monitored the bump over the nine years. He agreed there was no record of the size of the bump. He rhetorically asked how to measure a radial nerve entrapment coming through muscles. There is nothing to measure. Dr. Stern assumed from the consult note that it was a radial nerve entrapment that caused the bump. It fit the picture of Ms. Thornhill's chronic pain, work and posture. You cannot just isolate a bump in a patient. You treat the whole patient.

[243] Dr. Stern said that Dr. Chong did enough documentation to satisfy him that the bump or the area of swelling did not change significantly until January 2007. In his report, Dr. Stern wrote that Dr. Chong indicated that he was able "to regular monitor" the size of the bump. Dr. Stern based that on the statement of defence. However, Dr. Stern said it also came from his review of the fifty-seven visits in terms of looking at the whole picture, history, physical, his working diagnosis, and changes in clinical picture.

[244] Dr. Stern said that he did not feel that it was important to monitor the size of the bump or lump at every single visit because of the other physicians who saw Ms. Thornhill during this period of time. The monitoring appeared to him to be in keeping with all the clinical findings of the other physicians. There was also a detailed description of the location in the consult note. Based on that, Dr. Chong did not have to monitor it at every visit.

[245] Dr. Stern said that the location of the bump was critical. He said if you have a diagnosis of RSI, consistency of the bump may not help in the aid of the diagnosis. It was put to Dr. Stern that assumes that the diagnosis is correct. Dr. Stern said it is a bit of a "Catch 22". He denied this was circular reasoning. He said you make a clinical decision, on the whole picture, not just the wrist.

[246] Dr. Stern was asked how physical findings relate to diagnosis. It was put to him that you do not make a diagnosis and then relate your physical findings back to your diagnosis; you work the other way around. Dr. Stern said that is not necessarily correct. Dr. Stern said that sometimes, based on history and risk factors, you will come up with a differential diagnosis and then your physical exam will keep in with it - that's how medicine works. You assess the risk factors of a patient. You can often make a differential before a physical exam. A physical exam either reinforces the diagnosis or negates it. That is how doctors make diagnoses. Here there was a bump with an explanation and a diagnosis. Dr. Stern agreed that he just accepted that the physical findings, even though the consistency of this bump is not described, were consistent with the diagnosis of RSI.

[247] Dr. Stern was asked if there was anywhere in the records where the characteristics of the bump were described. He mentioned January 22, 2002 where he inferred there was an examination. On December 15, 2005 there was a note that swelling had decreased. On November 27, 2001 there was a note that the area had a lumpy feeling. Dr. Stern said that he took that to mean swelling. On January 25, 2007 it was noted that the lump is bigger and bigger. Dr. Stern said he considered that swelling. Dr. Stern said that there is not necessarily an important distinction between a lump and swelling. It depends on what part of the body it is.

[248] On January 23, 2007, Dr. Lan documented a lump and no adjoining swelling. Dr. Stern wrote in his report four times that Dr. Lan had found swelling. Dr. Stern said that he used the wrong word in describing Dr. Lan's findings. He said it is just a word.

[249] Dr. Stern agreed that from October 30, 2003 up to January 25, 2007, there is nothing in Dr. Chong's records that documents that he palpated Ms. Thornhill's right forearm.

[250] It was put to Dr. Stern, on cross-examination, that Dr. Chong did not have a reasonable basis to support the diagnosis of RSD on May 28, 2002.

[251] Dr. Stern agreed that, in respect to the criterion of swelling, there was no note of swelling on May 28, 2002. It was put to Dr. Stern that from June 1998 until May 28, 2002 Dr. Chong had not documented anything in his notes about swelling in the forearm and there were no references in 2003, 2004 and 2006 about swelling. Dr. Stern agreed, but noted that on November 27, 2001 there was an entry "lumpy feeling", which he interpreted as consistent with swelling; and on December 15, 2005 there was a note that swelling had gone down.

[252] Dr. Stern disagreed that Dr. Chong had not elicited a history of hyperalgesia. He agreed that Dr. Chong did not record sensory deficits with glove and stocking-like distribution of the affected limb or spreading beyond the affected skin. Dr. Stern disagreed that Dr. Chong did not record evidence of weakness, tremor or exaggerated tendon reflexes. He said that in June 1998 Dr. Chong had found dystonia. He disagreed that there was no evidence of decreased range of motion. He noted that on August 17, 2000 Dr. Chong had noted that Ms. Thornhill's arm hurt "plus, plus, plus right extension", which Dr. Stern interpreted that as impaired range of motion. Dr. Stern agreed there was no evidence of increased hair or nail growth. He disagreed that there was no evidence of increased sweating. He referred to Ms. Thornhill's summertime discomfort.

[253] Dr. Stern also agreed that Dr. Chong did not appear to have done tests to measure skin temperature difference or reviewed x-rays for spotty osteoporotic changes, which can support the diagnosis of RSD. He disagreed that Dr. Chong did not do an MRI scan of the affected extremity to exclude other diseases. He noted that Dr. Chong did order an MRI on January 25, 2007.

[254] Dr. Stern said that Ms. Thornhill had a constellation of symptoms beyond pain and swelling that were consistent with RSD. She had fibromyalgia; she had pain in her shoulder; she had pain in her neck; she had pain in her buttock; she had different areas where neuropathic pain was involved. Her response to a stellate ganglion block supported a diagnosis of RSD because the response is in keeping with sympathetic mediated pain, which occurs in a subset of RSD. Also, Dr. Chong had reasonably ruled out other conditions. The other doctors that she saw never commented on a bump or lump or mass.

[255] Dr. Stern agreed that the differential diagnosis for a growing lump or growing swelling on a person's arm includes a possible tumour. He agreed that if it was growing, so that

by 2002, it was a visible swelling or lump, the diagnosis would have to be clarified and one way to clarify it is with imaging. He agreed that, if after 2002 the lump or the swelling continued to grow, it might be consistent with a tumour and a lot of other diagnoses and it would have to be clarified. He agreed that the standard of care would require Dr. Chong to do so. It was put to him that one way to clarify it would be through imaging. Dr. Stern said that is one way, but it is not the best way. He said that a better way to investigate a growing lump would be to try medication and see what effect it had on the lump, if it was swelling.

Dr. Benjamin Deheshi for the Defendant

[256] Dr. Benjamin Deheshi was called on behalf of the defendants. He graduated from medical school in 1996 and completed a residency in orthopaedic surgery between 2000 and 2005. In 2006 he completed a fellowship in orthopaedic oncology. He is an orthopaedic surgeon with a sub-specialty in the diagnosis and management of bone and soft tissue sarcomas, as well as benign and metastatic bone disease. He began his practice in 2006. While doing that he earned a Master of Science degree, as well doing research focusing on the etiology of sarcoma formation. He is currently an orthopaedic surgeon at the Juravinski Hospital in Hamilton. His practice is referral-based and dedicated 75% to orthopaedic oncology patients having bone and soft tissue sarcomas and 25% to adult patients having hip and knee replacement surgery.

[257] Dr. Deheshi has extensive teaching and medical mentoring experience. He is currently an associate professor of medicine in the Department of Surgery at Hamilton Health Sciences at McMaster University. He has extensive research experience. He is co-director of the Musculo-Skeletal Oncology Research Unit Centre at McMaster University, which is doing the first international clinical trials in the surgical management of patients with bone and soft tissue sarcomas. He has written a number of peer reviewed publications on soft tissue and bone sarcomas and metastatic bone disease.

[258] Dr. Deheshi is an expert in orthopaedic surgical oncology. There was no issue that he was qualified to give his opinion on the causation issues in this case. Dr. Deheshi has extensive teaching experience, a primary objective of which is teaching about the assessment of lumps and bumps. As part of his training and work, as well, he is familiar with how it was approached in 1998 to 2007. On that basis, he was qualified to give opinion evidence on the standard of care applicable to a frontline physician in the assessment, diagnosis and investigation of lumps and bumps during the period 1998 to 2007.

[259] Dr. Deheshi testified that the teaching relating to the assessment of lumps and bumps has stayed the same over time, but teaching about specifics is constantly evolving and greater efforts are being made to educate physicians about the management and diagnosis of soft tissue sarcomas.

[260] Dr. Deheshi said that he would not expect a general practitioner to order an MRI on a lump or bump unless there is clinical suspicion of malignancy. Clinical suspicion is

either a very large mass or a mass that is showing significant growth over time. The rate of growth indicates that cells are dividing and it is more likely to be malignant. Pain is not an indicator of malignancy because the majority of soft tissue sarcomas are painless, unless they are enlarging and pressing on a nerve or muscle compartment.

[261] Dr. Deheshi testified that if a patient presented with a history of pain in the forearm and wrist with a mass, and there is no history of growth or enlargement and there is a recent CT scan showing no abnormality, the applicable standard of care in 1998 would not be to order an MRI or refer the patient to an orthopedic oncologist. The standard of care would be to observe and monitor the area.

[262] Dr. Deheshi said that in the present case, in June 1998, Ms. Thornhill did not present with a growing mass. There were a multitude of etiologies for the mass. In his opinion, if Dr. Chong had a number of benign conditions on his differential diagnosis and a possible malignancy was way down on the differential, he met the standard of care.

[263] Dr. Deheshi interpreted the radiologist's comment, about ordering an MRI if clinical concern persists, to mean that an MRI should be ordered if there was a palpable mass, growing in size, not showing up on the CT scan. Dr. Deheshi agreed with Dr. Clarkson that an MRI is a more sensitive test than a CT scan. However, a CT scan is a good screening tool. So, if there were a growing mass, an MRI should be ordered, but in the absence of an enlarging mass, where the CT scan is negative, the patient should be observed and monitored.

[264] Dr. Deheshi said that the standard of care required Dr. Chong to order an MRI in January 2007, but it did not require him to do so before then. Dr. Deheshi based his opinion on the fact that there was no clinical documentation of growth of the mass in Ms. Thornhill's forearm by any treating physician or specialist, including Dr. Chong, until January 2007. In the intervening period between 1998 and 2007, the clinical suspicion of a malignancy should have been low. There were several reasons he gave for that. Ms. Thornhill had a multitude of other symptoms, some physical and some psychological. Other specialists she saw during the period and did not have a clinical concern for malignancy. Co-morbidities can factor in and make diagnosis difficult, where symptoms are aggravated. Those factors, along with the reported "waxing and waning" of symptoms, would result in less suspicion of malignancy and more suspicion of regional pain syndrome or benign etiology. The fact that Ms. Thornhill got temporary relief from the stellate ganglion block was more in keeping with a neurologic type of etiology than a malignant diagnosis.

[265] The factual assumptions underlying Dr. Deheshi's opinion were explored further in cross-examination. Dr. Deheshi said that he disregarded Ms. Thornhill's version of events about the growth of the mass and about discussing it with Dr. Chong. He also disregarded Dr. Chong's version of events that he felt and assessed the bump over time and it stayed the same. Dr. Deheshi said that they were both biased. Rather, he based his assumptions on the documentation of others, which he considered to be objective. He considered Dr. Wunder and Dr. Van Brenk's clinical records, including the histories in them. As well, the other doctors that Ms. Thornhill saw while she was seeing Dr. Chong

did not document the growth or presence of a mass. It would be contradictory to criticize Dr. Chong when they did not appreciate a growing mass or order an MRI or take steps to investigate a tumour. He did agree, however, on cross-examination, that their notes did not show that any of them were aware of a lump or bump in Ms. Thornhill's arm. He saw references to pain, but Dr. Lan was the first to note a mass in 2007.

[266] Dr. Deheshi agreed, on cross-examination, that in his report he had written that Dr. Rhydderch was of the view that there was no underlying sinister cause and had raised the possibility of neuropathic pain, and Dr. McCully agreed with Dr. Rhydderch. Dr. Deheshi admitted that he got the doctors mixed up, in writing his report. In fact, Dr. Rhydderch had said nothing in his report about objective findings. Also, Dr. McCully saw Ms. Thornhill two years before Dr. Rhydderch did, so there was no possibility of Dr. McCully agreeing with Dr. Rhydderch.

[267] A growing mass is a clinical concern for malignancy. Dr. Deheshi said that if there is a concern about an increase in the size of a lump, the physician should assess the lump. If the patient raises a concern about a lump, that is ignored and not documented, it is a breach of the standard of care. Co-morbidities do not alter this. If the lump does not change and the patient does not report a change, Dr. Deheshi would not expect the doctor to reassess the lump without the patient bringing it up.

[268] In monitoring a lump or bump, it is critical to note the location, size, consistency, deepness of the bump or lump and whether it is painful and whether it is increasing. It is important to have objective findings. That is the standard of care in monitoring, and failing to do so breaches the standard of care.

[269] Dr. Deheshi admitted, on cross-examination, that if Ms. Thornhill told Dr. Chong a number of times that she felt that she had a lump in her arm that was increasing in size, Dr. Chong was obligated to order an MRI, and failing to do so would be a breach of the standard of care. If Dr. Chong palpated the arm, from time to time, and appreciated a change in the size of the mass, and failed to order an MRI, that, too, would be a breach of the standard of care. Dr. Deheshi agreed there was nothing in the chart to show that Dr. Chong routinely palpated the forearm.

Evidentiary Rulings

[270] Dr. Chong is an accredited specialist in community medicine, practicing with a special interest in occupational medicine, whose practice is referral-based. At trial, an issue arose whether either family physicians or orthopaedic surgical oncologists could opine on the standard of care that would have applied to Dr. Chong in treating Ms. Thornhill.

[271] The position of the plaintiffs is that Dr. Chong fell below the standard of care that applies to any physician in Ontario tasked with assessing and investigating lumps and bumps in a patient. The position of the defendant is that while there may be commonalities between what is expected of a frontline physician and what is expected of a physician whose

practice is referral-based, the standard is not the same in all respects because the context, care and treatment goals are different.

[272] I concluded that in light of the positions taken in this case the evidence of the family physicians and surgical oncologists was admissible on the standard of care issues. In closing submissions, neither side took issue with the ruling. I do realize that in the case of the family physicians, any differences between their respective experience, training and role in patient-care and Dr. Chong's must be taken into account in weighing their evidence on the standard of care. I also realize that, in the case of the surgical oncologists, their evidence on the standard of care will "inevitably be coloured and determined by [their] specialty."

[273] It is unnecessary to comment on the many other evidentiary rulings during the course of this hard fought trial. There were no surprises that led either side to request an adjournment or terms.

The Expert Evidence Assessed

[274] The above summary deals only with those parts of the evidence that bear directly on the standard of care.

[275] On the standard of care, I generally accept the opinion evidence of the plaintiffs' medical witnesses, Dr. Brankston and Dr. Clarkson. They were well qualified and experienced. Their evidence was fairly and reasonably based on the evidence and on factual assumptions now found as a fact to be true. I found their evidence to be straightforward and easy to understand.

[276] On the standard of care, I generally reject the opinion evidence of the defence medical witnesses, Dr. Stern and Dr. Deheshi.

[277] There were a number of flaws in Dr. Stern's evidence.

[278] Dr. Stern was obviously a partisan witness. For example, Dr. Stern testified that he was satisfied, based on Dr. Chong's chart, that he regularly and thoroughly assessed the bump/lump. It was obvious on cross-examination that the chart could not support what he had said. Dr. Stern then pivoted and said that the charting documented the initial findings. The diagnosis fit the clinical picture. The focus was treatment and the chart documented treatment. So, the charting was sufficient. Another related example is that it became clear, on cross-examination, that Dr. Stern's opinion that Dr. Chong regularly monitored the area was based on assertions made in the statement of defence, which Dr. Stern simply accepted as true.

[279] Dr. Stern accepted that it was appropriate for a physician to make a diagnosis based on history and risk factors and then to relate the physical findings back to the diagnosis. The approach was demonstrated in Dr. Stern's evidence when he testified why Dr. Chong was not required to include a soft tissue tumour as a potential explanation for Ms. Thornhill's

bump on the initial visit. Dr. Stern said that Dr. Chong's initial diagnosis of RSI was a reasonable exercise of judgment because it fit the clinical picture of Ms. Thornhill who had fibromyalgia, issues with function, a repetitive strain injury and a radial nerve entrapment, all of which go hand in hand with decreased ability to perform her job. So, repetitive strain injury can support a diagnosis of repetitive strain injury. The reasoning is circular and conclusory. The approach is antithetical to the concept of a physician formulating differential diagnoses for a condition. Dr. Stern ignored the fact that in his consultation report Dr. Chong wrote of an extensor bump and area of inflammation, which he said was difficult to diagnose using standard nerve conduction studies, and left it at that.

[280] Dr. Stern's conclusory approach was also demonstrated in his insistence that Dr. Chong's diagnosis of RSD was a reasonable exercise of clinical judgment. The cross-examination demonstrated that Dr. Chong did not document what criteria led him to the diagnosis at the time he made it. Nevertheless, Dr. Stern defended the diagnosis and scoured the chart for justification of the diagnosis. An essential criterion is ruling out other conditions. Dr. Stern said that Dr. Chong had reasonably ruled out other conditions. He never explained what, in his opinion, Dr. Chong did to do that.

[281] Dr. Lan, in his report, indicated that there was no swelling adjoining the lump that he found in 2007. Dr. Stern admitted that four times in his report he wrote that Dr. Lan had reported swelling. Dr. Stern said that he had used the wrong word. This was hard to accept, in a case where the presence of a lump was such an important issue.

[282] Dr. Stern's evidence was that medication is a better way to clarify a growing lump or growing swelling than imaging. That simply made no sense.

[283] For these reasons, I place no reliance on Dr. Stern's opinion that Dr. Chong met the standard of care.

[284] Dr. Deheshi was obviously experienced and highly qualified to give evidence in this case.

[285] It was Dr. Deheshi's opinion that the standard of care did not require a general practitioner, on June 23, 1998, to order an MRI on a lump or bump, unless there was clinical suspicion of malignancy, evidenced by either a very large mass or a mass showing significant growth over time. He said that pain was not a reason for ordering an MRI because it is generally not an indicator of malignancy, unless the sarcoma is pressing on a nerve or muscle compartment. This was a major difference between his opinion and that of Dr. Brankston and Dr. Clarkson.

[286] I prefer the opinion of Dr. Brankston and Dr. Clarkson that pain is a factor to take into account. Dr. Clarkson's rationale was that a lump with pain is an indication that some sort of localized process was going on and requires clarification by imaging. This made sense to me. The point is that, at that juncture, the physician does not what is going on. There may very well be pressure on a nerve or muscle causing the pain. There was no basis for Dr. Deheshi to assume that was not the cause of the pain.

[287] For that reason, I place no reliance on Dr. Deheshi's opinion that Dr. Chong met the standard of care.

The Legal Standard of Care

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

[289] The standard of care applicable to physicians is outside the knowledge of the trier of fact. Consequently, a finding of what constitutes the standard of care and a finding of a breach of that standard must be grounded in evidence from appropriate experts.

[290] To establish a breach of the standard of care, the plaintiffs must show that any lapse is more than an error in judgment. It must rise to the level of unskillfulness, or carelessness or lack of knowledge.

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

Finding - The Standard of Care

[292] As noted, the defence took the position that the standard of care which applies in this case is that of a physician in Ontario practicing in the field of occupational medicine, with a referral-based practice, and that standard is different from what is expected of a primary care physician, because the context, care and treatment goals are different. That position was based on the opinion of Dr. Stern. There was nothing in his evidence that established any principled reason why Dr. Chong should not have been subject to the same standard of care of any primary care physician charged with assessing a lump or bump. The principles that apply are fundamental medicine taught in medical school.

Secondary Findings of Fact and Conclusion – Standard of Care

[293] For these reasons I concluded that Dr. Chong fell below the standard of care. He did so by failing to include a tumour, benign or malignant, in his differential diagnosis. He failed to properly chart his physical examinations and findings respecting Ms. Thornhill's right forearm. He failed to properly physically examine and otherwise monitor Ms. Thornhill's lump and monitor her right forearm pain. He failed to properly investigate and manage her lump by ordering an MRI. The timing of the breach occurred first in 1998 when Dr. Chong discovered the new finding of a lump, which he realized was difficult to diagnose with nerve conduction studies, failed to obtain the CT scan, and neglected to order an MRI. The breach continued every year thereafter until 2007 when he finally ordered the MRI.

Causation: Issues

[294] In order to recover damages, Ms. Thornhill must show that there was a causal connection between Dr. Chong's negligence and her damages. That means she must prove, on a balance of probabilities, that Dr. Chong's breach of the standard of care in the assessment and investigation of her lump resulted in delay in the diagnosis and treatment of her synovial sarcoma, causing years of pain and disability, which she would not otherwise have suffered. The basic test for determining causation remains the "but for" test. See *Resurface Corp. v. Hanke*, [2007] S.C.J. No. 7 at paras. 21-22.

[295] The issues arising on causation are: (i) would Ms. Thornhill have undergone surgery to remove the synovial sarcoma from her forearm "but for" Dr. Chong's breach of the standard of care; and (ii) if so, how much sooner would she have undergone the surgery.

[296] The plaintiffs' position is that if an MRI had been done at any time on or after June 23, 1998 it would have set in motion a chain of events leading to the discovery and removal of Ms. Thornhill's synovial sarcoma. The position of the defence is that it is uncertain when an MRI would have triggered the same course of events that unfolded in 2007.

The Context of the Issue

[297] This is the context of the issue that arises on causation. The CT scan took place shortly before June 23, 1998. It showed no abnormality in the forearm. The MRI, which took place on May 7, 2007, showed an abnormality, a soft tissue mass, but not a malignancy. The radiologist who did the MRI recommended a referral to an orthopedic oncologist (a soft tissue tumour specialist) or to a dedicated hand program. On October 16, 2007, a biopsy of the lump took place. It did not show a malignancy, but showed a spindle cell neoplasm. A specialist then reviewed it and determined that it was highly suspicious for sarcoma. Ms. Thornhill was then referred to a sarcoma clinic where she saw Dr. Wunder, a surgical oncologist, on November 12, 2007. Initially, he thought that the clinical picture was of a benign peripheral nerve sheath tumour. It was not until a histological examination was done that a malignancy was reported. Then surgery for removal of the malignancy took place on June 20, 2008.

The Evidence of the Experts

[298] Dr. Clarkson testified on the issues of causation on behalf of the plaintiffs and Dr. Deheshi testified on behalf of the defendant. There is no issue that they were both highly qualified to do so.

[299] Both Dr. Clarkson and Dr. Deheshi agreed upon the typical growth pattern of a synovial sarcoma, which is a long period of little to no growth, followed by sudden acceleration in growth.

Dr. Clarkson's Evidence

[300] Dr. Clarkson made assumptions in arriving at this opinion that correspond with the facts as found in this case. He assumed that Dr. Chong detected an extensor bump the size of a thumbtack on June 1998. He assumed that there was a palpable mass symptomatic with localized pain. He said that based on those assumptions, it was his opinion that there was a localized process going on and the synovial sarcoma was causing Ms. Thornhill's symptoms right from the start. She had an intraneural synovial sarcoma. The tumour was actually growing within the nerve itself. It causes neuropathic pain, is very tender to palpate and causes a palpable mass. The CT scan, in 1998, showed no abnormalities. It was his opinion, on the basis that Dr. Chong was able to palpate a bump the size of a thumbtack (meaning five to ten millimetres in size), that if an MRI had been ordered in 1998, it would not likely have shown a malignancy, but most likely would have confirmed the presence of an abnormality in the area.

[301] Dr. Clarkson testified that the CT scan and the MRI are two completely different technologies and it is possible to have a CT scan that shows no abnormalities and an MRI scan that does. In Dr. Clarkson's view, an MRI in 1998, being more sensitive, would have shown that there was something causing the bump.

[302] It was Dr. Clarkson's opinion that once an abnormality was detected by MRI in 1998 it would have prompted a referral to a plastic surgeon or to a nerve surgeon to have the painful lump removed. He said that it is unlikely that an abnormality would not be followed up on because the lesion was symptomatic. It was causing pain and discomfort, regardless of whether it was benign or malignant. It required direct management and there would likely have been surgery. The surgery would have led to a diagnosis of synovial sarcoma when the mass was sent to pathology. So, while there might not have been an intervening biopsy between MRI and surgery, as there had been in Ms. Thornhill's case, there would have been removal. Once there was removal, there would have been a pathological examination, which would have shown that the abnormality was malignant. Then, there would have been further surgery by an oncologist to make sure the margins were wide enough. The process would have been similar in sequence and timing to what occurred after the MRI in 2007.

[303] It was Dr. Clarkson's evidence that, based on Ms. Thornhill's evidence that by 2001 the area in her right forearm was raised, and that by 2002 it was visible as a lump in her arm which then slowly grew, an MRI after 2002 would have shown similar appearances to the 2007 MRI, except that the mass may have been slightly smaller. Then, the pathway and the timelines would have been the same or similar to those she experienced in 2007.

[304] Dr. Clarkson testified that removing the tumour removes the pain. So, on Dr. Clarkson's evidence, if an MRI scan had been done in 1998 or after, Ms. Thornhill's pain would have stopped after the surgery.

Dr. Deheshi's Evidence

[305] Dr. Deheshi's opinion was that an MRI in 1998 would not likely have detected a mass in Ms. Thornhill's forearm because a CT scan performed during that period did not detect a

mass. Dr. Deheshi explained that although an MRI is more sensitive and specific than a CT scan, for the purpose of identifying the presence of a mass, a CT scan is an acceptable substitute for an MRI.

[306] Dr. Deheshi was of the opinion that an MRI would not likely have shown a malignant type lesion at any time before 2007 because malignancy was not identified by the May 7, 2007 MRI. He said that the main reason that Ms. Thornhill was referred for further biopsy after her MRI in 2007 was because, by that time, there was clinical evidence of a mass with significant malignant-type growth. If there had not been clinical evidence of growth of the mass, it is not clear what procedure would have flowed from an MRI. On these facts, it is unlikely that an MRI conducted before the mass began to grow would have triggered the same course of events that unfolded in 2007.

[307] On cross-examination, Dr. Deheshi agreed that if there was a raised area on the forearm in 2000, as Ms. Thornhill testified, it is quite likely that an MRI would have detected an abnormality. If, by 2002 there was a visible bump, as Ms. Thornhill testified, it is quite likely that an MRI would have detected an abnormality. If, by 2005 there was a lump in the arm, there is no doubt an MRI would have detected an abnormality. So, there is no disagreement between the experts about what an MRI would have shown from 2000 onward.

[308] Dr. Deheshi also agreed, on cross-examination, that once an MRI detected an abnormality the patient would probably have undergone surgery to remove the lump because it was painful. Dr. Deheshi also agreed that a time frame of six months from diagnosis to surgery is in keeping with his experience. So, there is no disagreement between the experts that if an abnormality was detected on an MRI, the pathway and the timelines for diagnosis and treatment would be the same or similar to what Ms. Thornhill experienced in 2007.

[309] In the final analysis, based on the findings of fact in this case, the difference in the two opinions came down to when an abnormality on MRI would likely be detected, specifically whether it was likely that an abnormality would have been detected by MRI between 1998 and 2000.

[310] I prefer Dr. Clarkson's evidence for these reasons. Dr. Deheshi neglected to mention in his examination in chief and did not say until cross-examination that once an abnormality showed up on MRI, surgery would likely have followed because of Ms. Thornhill's pain. This does not bear on the issue of what an MRI between 1998 and 2000 would have detected. However, it does bear on the issue of the reliability of Dr. Deheshi's evidence. It was a significant omission in context, and suggests partisanship. I found no reason to criticize Dr. Clarkson's evidence. Also, Dr. Clarkson is the more experienced of the two experts and his clinical practice is devoted exclusively to surgical oncology.

[311] I accept Dr. Clarkson's evidence on the issue of causation, in its entirety, and reject Dr. Deheshi's evidence, where it is at odds with Dr. Clarkson's.

Causation - Findings

[312] I find that if Dr. Chong had ordered an MRI at any time starting on June 23, 1998, the MRI would have identified an abnormality in Ms. Thornhill's right forearm. The finding of the abnormality on MRI would have put her on the medical pathway to a diagnosis of synovial sarcoma and led to the surgical removal of the sarcoma in essentially the same sequence and timelines that took place following the MRI on May 7, 2007. I find that the surgical removal of the sarcoma eliminated her right forearm pain and associated disability.

[313] The plaintiffs have established the causal connection between Dr. Chong's breach of the standard of care and Ms. Thornhill's damages.

Damages

[314] It is unnecessary for me to deal with the issue of damages because the parties have agreed on a formula to calculate them.

[315] Counsel are to send me, through the trial co-ordinator, a draft judgment reflecting my findings and their agreement within 30 days of the release of these reasons.

Outstanding Issues

[316] If there are any outstanding issues, counsel may take out an appointment by contacting the trial co-ordinator.

"M. L. Lack J."

Released: October 17, 2016

CITATION: Thornhill v. Chong, 2016 ONSC 6353
COURT FILE NO.: CV-09-382518
83410/10

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

Janet Thornhill and Fred Gottschalk

Plaintiffs

-and-

John Chong

Defendant

REASONS FOR JUDGMENT

The Hon. Justice M. L. Lack

Released: October 17, 2016