2004 CarswellOnt 6070
Ontario Superior Court of Justice

Itamunoala v. Pierce

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Godknows Itamunoala, Genevieve Itamunoala and Tonye Itamunoala, Fraser Itamunoala and Donna Itamunoala, Minors, by Their Litigation Guardian, Godknows Itamunoala, Plaintiffs and Karen L. Pierce, Gurpul Mand, David S. Swartz, Merrill Smullen and Etobicoke General Hospital, Defendants

Jennings J.

Heard: December 13, 2004
Judgment: December 13, 2004
Docket: 99-CV-181623

Proceedings: additional reasons at *Itamunoala v. Pierce* (2005), 2005 CarswellOnt 958 (Ont. S.C.J.)

Counsel: Mr. S.H. Mandell, for Plaintiffs
Ms M.B. Currie, for Defendants

Subject: Public; Civil Practice and Procedure; Torts; Evidence; Family
Related Abridgment Classifications
Health law
V Malpractice
V.2 Negligence
V.2.a Types of malpractice
V.2.a.ii Failure to diagnose
Remedies
I Damages
I.5 Damages in tort
I.5.a Personal injury
I.5.a.iii Principles relating to non-pecuniary loss
I.5.a.iii.G Miscellaneous
Headnote
Health law --- Malpractice — Negligence — Types of malpractice — Failure to diagnose
On November 21, 1998, when he was 37 years old, plaintiff went to hospital complaining of headaches and dizziness — Emergency room physician Dr. M ordered ultrasound of plaintiff's abdomen, although plaintiff had not complained of abdominal pain — On November 25, plaintiff consulted Dr. P in her office, complaining of headaches, sharp pain when he coughed, dizziness and imbalance — Dr. P advised him that his problem was stress — Plaintiff's symptoms continued and he was seen in emergency by Dr. Sw — Dr. Sw refused to order a CAT Scan for plaintiff and advised plaintiff to take Gravol to alleviate vertigo symptoms — On December 24, plaintiff saw Dr. Sm — Dr. Sm told plaintiff that he had TMJ problem and recommended that he take Iboprofin — On December 27, while plaintiff was in US, his family took him to hospital — Plaintiff was told that he had brain tumour and that immediate operation was recommended — Plaintiff consented and operation was performed next morning — Plaintiff recovered from necessary treatment and was able to carry on all of his pre-accident activities — Plaintiff brought action against Dr. P, Dr. M, Dr. Sw and Dr. Sm, alleging that doctors failed to give him appropriate care by not diagnosing his illness — Action allowed — Each defendant breached standard of care imposed upon him or her — In failing to take proper history, discharging patient without diagnosis,

and failing to consider appropriate differential diagnosis, Dr. M fell below standard of reasonable emergency room physician — Dr. P's failures led to inability to appreciate that continuing symptoms pointed to possibility of neurological pathology, which she ought to have considered as differential diagnosis — Dr. Sw's failure to order immediate CT Scan, combined with failure to make meaningful referral to available on-call neurologist fell below standard — In failing to perform appropriate neurological examination, failing to order CT Scan, and failing to recommend against travel, Dr. Sm fell below standard of reasonable, competent family practitioner — Pursuant to section 4 of Negligence Act, each defendant was equally at fault.

Damages --- Damages in tort — Personal injury — Principles relating to non-pecuniary loss — General

Plaintiff brought successful action against defendant doctors for failing to diagnose brain tumour — Plaintiff consented to operation to remove tumour while in US — Plaintiff recovered from necessary treatment and was able to carry on all of his pre-accident activities — Plaintiff's damages for out-of-pocket expenses were $94,866.31 US and $2,575.44 CDN — Action allowed — Plaintiff was awarded general damages of $15,000 — Damages for pain and suffering, loss of care, guidance and companionship, were restricted to relatively limited time of approximately three to four weeks between when diagnosis of brain tumour ought to have been suspected and CT Scan ordered and when diagnosis was actually made followed by emergency surgery.

Table of Authorities

Cases considered by *Jennings J.*:

Crits v. Sylvester (1956), [1956] O.R. 132, 1 D.L.R. (2d) 502, 1956 CarswellOnt 90 (Ont. C.A.) — followed

Ing (Litigation Guardian of) v. Guest (1993), 1993 CarswellOnt 2594 (Ont. Gen. Div.) — considered

Law Estate v. Simice (1994), 21 C.C.L.T. (2d) 228, 1994 CarswellBC 1117 (B.C. S.C.) — referred to

Statutes considered:

Courts of Justice Act, R.S.O. 1990, c. C.43

s. 121 — referred to

s. 121(3) — referred to

Evidence Act, R.S.O. 1990, c. E.23

s. 4 — referred to

Family Law Act, R.S.O. 1990, c. F.3

Generally — considered

Rules considered:

Rules of Civil Procedure, R.R.O. 1990, Reg. 194

Generally — considered

ACTION in medical malpractice.

***Jennings J.* (orally):**

1 The matter of Godknows Itamunoala against Dr. Pierce and others was heard November 15th, 16th, 17th, 18th, 22nd, 23rd, 24th, 25th, 26th and 29th, and judgment was reserved until this morning. I will now give my judgment.

Overview

2 The plaintiff, Dr. Itamunoala, alleges that the defendant doctors failed to give him appropriate care by not diagnosing his illness. As a consequence of that failure, on December 27th, 1998, he was required to seek emergency medical attention during a visit to his wife's family in the United States. A tumour was removed from his brain. Dr. Itamunoala, an Ontario resident, has been put to an expense of about U.S. $95,000 for the excellent care that he received from the U.S. hospital and its medical personnel, for which he cannot receive reimbursement from the Ontario Hospital Insurance Plan.

3 He claims that had his condition been properly diagnosed by the defendants, he would have been treated in an Ontario hospital by Ontario doctors and, accordingly, his medical expenses would have been covered by the plan.

4 Fortunately, he has made an excellent recovery from the necessary treatment and is able to carry on all of his pre-accident activities. Although he advances a claim for general damages, and his wife a claim for damages under the *Family Law Act*, his main claim is for reimbursement for the uninsured expenses which he says he was required to pay. He has discontinued his claim against the defendant hospital. The *Family Law Act* claims of his children by his first marriage were dismissed on consent at the opening of trial.

The Evidence

5 I will review the evidence of the witnesses in the order that they testified.

Dr. Itamunoala

6 Godknows Itamunoala is a remarkable man. He was born October 12, 1951 in Nigeria. At age 15 he went to the United Kingdom to further his education. He received a degree in Chemistry from the University of London. He took his Masters in Chemical Engineering at the University of Manchester.

7 In 1985, at the age of 23 years, he received his doctorate in Chemical Engineering from the same university. Thereafter he worked in research at the University of Bath. He came to Canada in 1986 and acquired citizenship in 1990. He worked as a consultant in his developing area of expertise, that is, on projects designed to clean up industrial contamination and pollution. He formed his own company. He developed a process which uses microbes to break down contaminants, and as a result was retained by governments to work in Kuwait and elsewhere cleaning up major oil spills. Requiring more capital to expand his business, in 1996 by a series of acquisitions and mergers he ended up as a president of Fiton Technology Inc., a public company of which he and his wife, the plaintiff, Genevieve Itamunoala, are the principle employees.

8 He testified that in the fall of 1998 he was 37 years old. He was extremely fit, working out extensively at least every other day. He was physically well. He had for some time required no medical attention and had no family doctor.

9 At the beginning of November, 1998 he began to feel unwell. His wife located an after-hours medical clinic in Bolton. He went to the clinic on November 6th, 1998, complaining of light-headedness accompanied with a cough. He was seen by the defendant, Dr. Pierce. She told him that whooping cough was going around. She gave him a prescription for an antibiotic and told him to come back in six weeks. In response to his request, she agreed to accept him as patient in her private practice.

10 Between November 8th and November 12th, 1998, Dr. Itamunoala was in Bermuda on business. He began to experience problems with his balance whilst jogging and working out. He noticed that when he coughed he felt a sharp pain in his head. His head pain was relieved when he was swimming. Upon his return to Toronto he did not consult a physician, relying on Dr. Pierce's advice that he had whooping cough that would take six weeks to clear. He continued to take the antibiotics she prescribed. On November 14th he went to England on business and felt fine during his visit. He returned to Canada on November 21st and began to experience a feeling of losing his balance. That evening he experienced headache and increased dizziness when playing with his children. His wife drove him to the Etobicoke General Emergency Department where he presented with complaints of dizziness and severe headache. He was seen by an emergency room physician he now knows to be Dr. Mand. He told Dr. Mand that he was feeling dizzy and had headaches. He said Dr. Mand ordered blood work but he could not tell him what was causing the headaches and dizziness and asked him to return the next day for an ultrasound of his abdomen. Dr. Itamunoala had no idea why that was necessary as he had made no complaints with respect to his abdomen.

11 The unsteadiness when jogging continued, as did the sharp pain in his head when he laughed or coughed. Because of that he consulted Dr. Pierce in her office on November 25th, 1998. He complained to her of headaches, sharp pain when he coughed, dizziness and imbalance. He told her that he had had an ultrasound of his abdomen three days ago at

the Etobicoke General and of his attendance there before Dr. Mand. He said Dr. Pierce advised him that his problem was stress and being over tired and that he should take it easy.

12 He returned to England on business and was there between November 25th and December 1st. When he coughed he experienced a sharp pain in his head on a more frequent basis than previously. His dizziness and sense of being off balance was much more pronounced, to the point where he felt uncomfortable remaining alone in his hotel room. He telephoned to Dr. Pierce in Canada and complained of severe headache, pain, dizziness and being unsteady. They had a discussion about the earliest date when she could see him and settled on December 2nd. He then called his wife to tell her of his problems and his worry. She advised him to write down her name and telephone number in Canada on a piece of paper and carry it in his wallet.

13 Dr. Itamunoala thought that perhaps his dizziness was the result of low blood sugar. He went out for a meal of fish and chips and felt better after consuming it.

14 He returned to Canada on December 1st and saw Dr. Pierce the next day, December 2nd. He repeated what he told her over the phone: that he was worried, had sharp head pain and was losing his balance. She said that she couldn't see anything wrong and that he needed rest. He followed her advice and gave up doing vigorous exercises.

15 On December 6th, 1998, whilst attending church with his wife, he experienced a sharp head pain when singing. The right side of his face and his right leg went numb. He was very unsteady and uncertain walking to the altar rail. He felt dizzy. His wife took him directly to the emergency department at the Etobicoke General Hospital. He felt he was experiencing a minor stroke.

16 He was seen in emergency by Dr. Swartz. He told Dr. Swartz of his sharp head pain, numbness in the right leg and face, of feeling dizzy and losing his balance. He does not recall the examination Dr. Swartz did, but he does recall Dr. Swartz advising that he had an ear infection. He spent about ten minutes with Dr. Swartz and his wife was present. His wife demanded of Dr. Swartz that he be given a CAT Scan immediately. Dr. Swartz looked at Mrs. Itamunoala and said "no, you are not getting one". Dr. Swartz recommended Dr. Itamunoala buy Gravol for his vertigo. To alleviate Dr. Itamunoala's expressed concerns, Dr. Swartz wrote the name and telephone number of a specialist on a piece of paper and gave it to Dr. Itamunoala with the advice that his GP could refer Dr. Itamunoala for a second opinion.

17 Dr. Itamunoala bought a large quantity of Gravol and began taking it. He was still unsteady on his feet, but when he sat down the unsteadiness passed and he could accordingly drive his car. Headaches continued when he laughed. He was subsequently advised by his wife that Dr. Pierce had called her and was very annoyed that he had gone to the emergency room. It was arranged that Dr. Itamunoala would see Dr. Pierce on December 16th.

18 On December 16th Dr. Itamunoala saw Dr. Pierce and told her that he had gone to the emergency department because of head pain, unsteadiness on his feet, numbness in his head and leg and dizziness. He told her of the diagnosis of ear infection. He said his energy level was very low. He told her the emergency room physician had refused a CAT Scan and he asked her for a CAT Scan. He said she laughed at him and said that he was making a big deal out of nothing. She said that a CAT Scan wasn't necessary. He told her that he had been given the name of a specialist to whom she could refer him but Dr. Pierce said that that was also not necessary. He said that it was clear to him that there was something wrong with him and he was becoming worried. He was coughing every so often, but that didn't bother him, rather it was the pain that he felt when he coughed. He had by now a dull pain in his head all of the time which would become sharp when he coughed or spoke quickly.

19 From December 16th to December 24th his condition did not improve. He was still taking Gravol. He began sinking into a state of despair because this was the first time that he had experienced a medical problem of any significance and no one seemed able to tell him what was wrong. He said he felt "left out - in no man's land".

20 On the morning of December 24th his children came for a visit and whilst playing with them and laughing he experienced a sharp pain in his head. Because he and his wife planned to go to visit her family in the United States over

Christmas, he became concerned about his ability to travel. He called Dr. Pierce's office and was told that whilst she was not available he could come in and see one of her associates. He attended the office and was seen by Dr. Smullen. He told Dr. Smullen of his sharp pain with coughing or laughter, that he was unsteady on his feet and that earlier the emergency room physician had diagnosed vertigo. Dr. Smullen was with Dr. Itamunoala between five and ten minutes. Dr. Itamunoala does not recall any examination, but recalls Dr. Smullen looking at his file. He said Dr. Smullen told him that he had a TMJ problem and recommended that he take Iboprofin. Dr. Itamunoala advised Dr. Smullen of his travel plans and received the advice that he should take Iboprofin and that would relieve his pain.

21 On December 25th, 1998 Dr. Itamunoala and his wife flew to Minneapolis. He had difficulty boarding the plane, stumbling and hitting his head on the side of the door. He was unsteady and stumbling disembarking in the United States. He had to be helped out of the car at his wife's family's residence. He was put in a chair for half an hour. Then he was able to get up and walk but he felt unwell. He and his wife went to an hotel. On December 26th he awoke feeling unwell. He tried to exercise and to swim. He lost his balance and had to be assisted. He went to his room to rest. Two hours later he went to a mall with his wife's family. He had to cruise the mall in a wheelchair because of the dizziness. His head pain returned that evening and he went to a clinic at a local hospital where he was seen by a female physician. He told her of his vertigo and that he had been prescribed Iboprofin for his head pain. He received a prescription for a pain reliever, which he filled. He returned to his hotel and slept.

22 On December 27th, after a restless night, he awoke feeling unwell. He had no appetite that day. Towards the evening he asked for and drank a glass of milk. He immediately vomited the milk. His wife's family took him directly to Hennepin County Medical Center. He described his symptoms. He was then given an MRA and following that a CT Scan. He was told that he had a tumour and that an immediate operation was recommended. He consented and the operation was performed early the next morning. He was discharged after five days and returned on January the 8th to have stitches removed. He subsequently was readmitted to hospital because of an infection and discharged on January 19th, 1999, being told to return in three weeks for follow up. On January 30th, whilst in the United States on business, he developed a fever and blacked out. His wife called a neurosurgeon in Toronto to whom he had been referred and to whom he had paid a "get acquainted" visit on January 25th, 1999, but she was unable to make contact. She then called the Hennepin clinic and was told to come in immediately. He was readmitted for ten days and the infection was brought under control.

23 He had been generally well since.

Cross-Examination

24 Dr. Itamunoala was subjected to lengthy and extremely thorough cross-examination. He confirmed he first consulted Dr. Pierce at the after-hours clinic because of light-headedness associated with cough. He was told by her that he probably had whooping cough.

25 On his return from England on November 21st he said his headache pain was sharp, he had problems with his balance and dizziness. He was driven by his wife to the Etobicoke General Hospital that evening, but he drove himself back to the hospital the next day for his ultrasound. He recalled having blurred vision as he came through Immigration at Pearson Airport. He said he attempted to arrange an appointment with Dr. Pierce but she advised him that she was busy and couldn't see him right away. He was quite positive that there was no discussion with Dr. Mand about the abdominal pain and he was never told that he had "abdominal pain - not yet diagnosed".

26 He said he went to Dr. Pierce on November 25th because of a sharp pain in his head. He had finished taking the antibiotics when he was in the United Kingdom. He said that he told Dr. Pierce on November 25th that when he coughed, as he occasionally did, he would feel sharp pain and had the same result if he laughed. He clearly recalled telling her that when he coughed he had headache. He remembers telling her that he had an ultrasound done of his abdomen which he couldn't understand because he complained of pain in his head and dizziness. On November 25th he had two problems, dizziness and sharp pain headaches.

27 He said he recalled Dr. Pierce doing balance tests on two occasions but he couldn't recall which visits they were. He insisted he related to her that he had a constant dull headache, sharp pain in the head on laughter and coughing, dizziness and balance problems. He told her that he had a headache that wouldn't go away - it was a dull pain that never went away, exacerbating to a sharp pain only when he laughed or coughed. Dr. Pierce knew that he was leaving for England that day. He called her from England after having had the incidents that he described in his examination-in-chief. He recalled discussing an appointment date with her and he recalled insisting that she see him the day after he returned to Canada which she ultimately agreed to do.

28 With respect to the December 6th visit to the emergency department, he has no recollection of complaining about ear pain. He did not tell Dr. Swartz that the numbness in the right side of his face and leg had gone away. He did not have ear pain. Dr. Swartz gave him the name of a doctor. He understood the doctor was an ENT specialist. He was supposed to be referred to the specialist by his general practitioner. Dr. Swartz did not tell him he could contact the specialist himself. Subsequently, Dr. Pierce told him he did not need to see the specialist.

29 He said he was in town for the most part between December 6th and when he saw Dr. Pierce on December 16th. He did not seek any other medical attention during that time. When he did see Dr. Pierce on December 16th, the numbness in his face had gone. His dizziness was a constant from the return from the United Kingdom, but it was not that he was constantly dizzy as he could drive when he was sitting down. He recalls clearly telling Dr. Pierce what happened to him at church. The numbness in his face and leg had gone by this visit to Dr. Pierce and that would constitute him feeling very much better.

30 He flew to Montreal on December 17th. No further medical attention was sought until December 24th. The sharp pain on laughing or coughing continued throughout this period and the dull headache was constant. Occasionally he would have a headache that would "feel like my head would explode", but he would rest and it would go away.

31 He was feeling worse on December 24th. He had a severe headache and felt like his head would split open. His visit to Dr. Smullen was very brief. He is not sure if Dr. Smullen conducted a balance test. He told Dr. Smullen he had a sharp pain that wouldn't go away and that he was going to the U.S. for Christmas the next day and that's why he wanted to see the doctor. He was not nauseous and he had some vertigo but could drive a car.

32 He said he went to the Fairview Hospital in Minnesota on December 25th to seek temporary relief from headache pain and recalls telling the physician at the hospital that doctors in Canada told him he had vertigo and that he was taking Iboprofin. He doesn't recall what physical examination was done at the Fairview Hospital but would agree it was probably "the usual exam". He believes the doctor at Fairview told him he was suffering from benign vertigo. A CAT Scan was not offered to him.

33 He was told on his second release from hospital in the United States that the antibiotics might not cure his infection and that further procedures may be required. He returned to Canada to follow up with a referral to a Dr. Bernstein, but he also planned to follow up at the U.S. hospital in three weeks as he had been instructed to do. When he saw Dr. Bernstein on January 25th his wife was with him. He was having periodic fevers and Dr. Bernstein instructed her to monitor him closely and call Dr. Bernstein if there was a problem. Dr. Bernstein wanted to see him weekly. He did not return to see Dr. Bernstein.

34 He continued to travel and to experience headaches and knew he had not fully recovered. On January 25th he told Dr. Bernstein he was going to Philadelphia. For one year he had been trying to obtain a valuable contract with Bethlehem Steel. A meeting was set up in Philadelphia to which he went with his wife and a consultant. He obtained the contract.

35 After the meeting he began to run a fever. The next day, January 30th, he was to return to Toronto.

36 Prior to checking out, he blacked out. His wife called Dr. Bernstein, but could not reach him. She then called the Hennepin clinic and he was instructed to go there immediately. He was readmitted and an operation was performed

to clear up the infection which had not responded to the antibiotics. He was discharged after 10 days and instructed to return for a follow-up examination on February 23rd and for an MRI in three months. He followed instructions and has made a full recovery.

37 In answer to a question from me, he confirmed that he discussed with Dr. Smullen his plan to go to the United States on December 26th.

Genevieve Itamunoala

38 Mrs. Itamunoala is a native of Minnesota where her family continues to live. She came to Canada in 1992 to work for Dr. Itamunoala. They married in July 1998. She has two children by a previous marriage now 26 and 24 years of age respectively.

39 She struck me as being a personable, intelligent and extremely articulate person who gave her evidence calmly and carefully.

40 She testified that her husband prided himself on his health and upon keeping fit. He worked out on a regular basis, notwithstanding his travels. She traveled with him on most of his business trips. He had a slight cold in the fall of 1988 and treated himself with hot lemon and vitamin C. The first time she ever recalls him consulting a physician was when he saw Dr. Pierce on November 6th, 1998. His cold was disappearing by that time but he was complaining of a headache when he coughed. They were living in Kleinberg at the time and she drove him to the Bolton after-hours clinic and waited in the waiting room whilst he saw Dr. Pierce. She thought the diagnosis of whooping cough was peculiar because she had experienced whooping cough with her children and knew that whooping cough sound, which was not the sound of her husband's cough. She was also concerned that nothing was apparently said about the headache which she understood to be her husband's chief complaint.

41 She confirmed her husband's evidence about light-headedness and headache ameliorated by swimming underwater whilst in Bermuda. She became aware during the visit to Bermuda that the headache was not present only when her husband was coughing.

42 She recalled that upon his return from England on November 21st he was playing with the children and he was complaining of headache when he laughed. She accordingly drove him to the emergency room at the Etobicoke General Hospital, leaving him there whilst she returned to look after his children.

43 She recalled talking to him on a daily basis on the telephone after he returned to England on November 25th. She remembered him telling her that he was standing on a curb in London preparing to cross the street when he felt dizzy and almost fainted. He was unsteady on his feet. She made him promise to write her name and phone number on a piece of paper and put it in his wallet in case anything happened to him. He promised he would do that. He told her that he had called Dr. Pierce and arranged for an appointment. She was concerned because he was in London by himself and she was unable to be there to help him.

44 She was with him in church on December 6th. Her husband was walking slowly and needed her help to approach the alter rail. After church he said he was numb on the right hand side of his face and his right leg. She was very concerned. She thought he might have been having a stroke because of her prior experience in dealing with stroke experienced by two members of her family.

45 She told him of her concerns and insisted that she drive him directly to the hospital. She was present in the cubicle when her husband was examined by Dr. Swartz. She told Dr. Swartz her concerns about stroke and the reasons for it, that is her husband was stumbling, had headache and numbness. She said Dr. Swartz did the hand squeezing test. She insisted to Dr. Swartz that a CAT Scan be performed immediately because of the past history of her husband's illness. She said Dr. Swartz told her "you are not going to get one". She described being at a loss for words at that response, not

knowing what to say or think. She does recall Dr. Swartz mentioning something about an ear infection and giving her husband a piece of paper with the name and telephone of a doctor written upon it.

46 She subsequently received a call from Dr. Pierce who had learned of the visit to the emergency department and said words to the effect that "I wish you would quit waisting the taxpayers' money". She described Dr. Pierce's tone as being sharp and spiteful. She herself was shocked. She was not used to being spoken to in that manner. She told Dr. Pierce the reasons for the emergency room attendance and thereafter Dr. Pierce's manner softened considerably.

47 Her husband became angry and upset when he learned from her the conversation that she had had with Dr. Pierce.

48 She did not go to Dr. Pierce's office with her husband on December 16th, 1998. She recalled her husband's distress following the visit at Dr. Pierce's reaction to her husband's request for a CT Scan. She reported her husband as saying that Dr. Pierce said "Godknows, you're making too much of this. There is nothing wrong with you".

49 As Christmas approached she became increasingly worried and concerned. She said her husband was just doing what he had been advised to do, but he wasn't getting any better. His headaches continued. He complained of headache pain and she tried to do what she could to ease things for him. She described him getting slowly out of bed, placing his feet on the ground, standing slowly to get his bearings and walking unsteadily to the bathroom door. On Christmas Eve he was playing with his children in the house and was complaining that his head hurt. He was unsteady on his feet and generally uncomfortable. He went to see a doctor who was covering for Dr. Pierce, Dr. Pierce being unavailable. She remained in the house with the children. He returned from the visit saying that the doctor said that he could have TMJ. Her sister had had TMJ and she was aware of its symptoms of clicking in the jaw, jaw locking and jaw pain. It didn't seem to her like her husband was suffering from TMJ.

50 She confirmed her husband's difficulties boarding and leaving the plane to Minnesota on December 25th, his unsteadiness at her family's home and the necessity of him remaining seated for a period of time. She drove him to a local hospital to obtain a prescription for headache pain on the evening of December 26th. She described her husband as being tired on December 27th and put it down to pain medication which he was taking. He slept on and off during the day. She does not recall him eating. That evening on a visit to her family's home with her husband, he sat in the chair, drank milk and vomited. The family decided to take him immediately to the medical centre where he was examined and given both an MRI and a CT Scan.

51 Subsequent to the operation, and during the period of the infection, she learned how to administer intravenous medication to her husband and she was in constant attendance upon him until he recovered. She confirmed that neither she nor her husband disobeyed any guidelines or instructions given to them by their caregivers. She was with him in Philadelphia on January 30th. She confirmed his blackout in the hotel room and her unsuccessful efforts to reach Dr. Bernstein. She called into Hennepin clinic and was told to get her husband there immediately.

Dr. Edwin R. Brankston

52 Dr. Brankston was called on behalf of the plaintiff. He received his medical degree from Queens University in 1976. He became a certificand of the College of Physicians and Surgeons in family practice and emergency medicine. He had been on the active staff of the family and general medicine program at the Lakeridge Health Hospital in Oshawa from 1977 to the present. He has been retained to give several opinions for the Canadian Medical Protective Association (CMPA) on standards of care of the family practitioner and emergency physician and is presently so retained. He has also given expert opinions in medical malpractice cases on behalf of plaintiffs. He was qualified as an expert on the standard of care of the family practitioner and emergency physician to give evidence of those standards and of causation with respect to the early diagnosis of tumour.

53 He was referred by counsel to Tab A of Exhibit 1, Dr. Pierce's notes of the visit to the after-hours clinic by Dr. Itamunoala on November 6th, 1998. In his opinion, based on the history that was documented, the note and plan were appropriate. However, if he assumed that the plaintiff presented with a primary complaint of light-headedness, in his

opinion there was insufficient documentation and the note fell below standard. In his opinion there should have been further definition of the nature of the light-headedness, together with questions on a presence or absence of vertigo, the onset of light-headedness and any aggravating or improving factors. On the assumption that headache was a primary reason for attending the clinic, the charting was even more insufficient, and if headache was aggravated by coughing to produce sharp, stabbing head pain, symptoms which in his opinion strongly suggest a lesion in the brain, the charting was below standard and, further, a CT Scan would have been appropriate. In his opinion a CT Scan taken at that time would have shown the existence of the tumour.

54 With respect to the emergency room report of November 21st, 1998 (Exhibit 1, Tab 1), Dr. Brankston was of the opinion that Dr. Mand's charting was insufficient. There was no charting of a functional inquiry of the symptoms of dizziness and headache. Further, the final diagnosis of abdominal pain "NYD" was puzzling when the plaintiff had not complained of any abdominal pain. Dr. Brankston was of the opinion that Dr. Mand did not lay the groundwork for making an accurate diagnosis. If he assumed that the plaintiff advised Dr. Mand that he suffered imbalance whilst jogging in Bermuda and had sharp headache pain when coughing or laughing, his opinion of insufficient charting was enhanced. If Dr. Mand had been aware that a visit to the clinic had been precipitated by sharp head pain experienced by Dr. Itamunoala whilst laughing in play with his children, in his opinion Dr. Mand should have been thinking of the possibility of a space occupying lesion in the brain and should have called for CT imaging. Headache worsened by cough, laughing and straining has a significant chance of being indicative of lesion. Had a CT Scan been taken on November 21st, it was highly likely it would have shown the tumour. He was further of the opinion that the slightly raised amylase level was clinically insignificant and did nothing to explain the headache and dizziness.

55 With respect to Dr. Pierce's note of the visit to her office on November 25th, 1998 (Exhibit 1, Tab B, page 1), in Dr. Brankston's opinion there was insufficient documentation with respect to the symptoms of light-headedness associated with coughing. There was not enough documentation of functional inquiry into the symptoms. He also found no reference to a neurological examination with respect to the light-headedness symptoms. If he assumed that Dr. Pierce had been advised of the troubles experienced by Dr. Itamunoala in Bermuda, his opinion as to the poor quality of the charting was enhanced because of the existence of symptoms which indicated a space occupying lesion of the brain. For that reason, in his opinion a CT Scan was indicated. Had one been done, it is highly likely it would have revealed the space occupying tumour. In his opinion, a family physician has the obligation to review the patient's records that have been forwarded from, as in this case, emergency room visits. If the records cannot be read, there is an obligation to obtain more information either from the patient or from the emergency room physician. In his opinion, Dr. Pierce had a positive obligation to review Dr. Mand's notes. The note did not bear her initials indicating that she had not reviewed them and, in his opinion, her failure to do so fell below standard.

56 With respect to Dr. Pierce's notes of the December 2nd, 1998 visit (Exhibit 1, Tab 1, page 2), Dr. Brankston was of the opinion that the record fell below standard, in particular, with respect to insufficient inquiry into the symptoms of dizziness. It was obvious to Dr. Brankston that Dr. Pierce did not show sufficient concern about those symptoms. As this was a follow-up examination, Dr. Pierce had an obligation to review all pertinent records. Questions should have been asked about the headache pain on coughing or laughing, as well as about the nature of the dizziness, the presence or absence of vertigo, double vision, visual loss, nausea or vomiting. The responses should have been charted. A neurological examination was required, and in his opinion there was no evidence in the chart of any neurological examination of any kind. Because of the historical complaints of dizziness, this fell below standard. On being asked to assume that Dr. Itamunoala had telephoned Dr. Pierce from London prior to the December 2nd visit to advise her of the physical symptoms he was experiencing in London and to arrange for an early appointment, his opinion that she did not meet the standard on this occasion was further enhanced.

57 In Dr. Brankston's opinion, Dr. Pierce ought to have been aware by December 2nd of progression of symptoms of dizziness exacerbated by coughing and laughing, difficulty with balance, sharp pain exacerbated by coughing and laughing and underlying dull pain. In his opinion, the progression of symptoms would suggest that the mass in Dr. Itamunoala's brain was by now expanding.

58 With respect to the emergency room record of December 6th, 1998 (Exhibit 1, Tab 2, page 10) Dr. Brankston's opinion was that Dr. Swartz's entry was insufficient. He could find no evidence that Dr. Swartz pursued the complaint of headache. There was no evidence that he checked Dr. Itamunoala's face in detail or that he checked tandem gait or balance, all tests that should have been carried out because of indications of brain lesion. In that regard, his examination, in his opinion, fell below the standard of a competent emergency practitioner.

59 In his opinion the diagnosis "rule out labyrinthitis" was inappropriate. The symptom of concern on this date was the notation of numbness of the right face and foot, neither of which is a symptom of inner ear infection. In Dr. Brankston's opinion, the investigation that ought to have taken place at this date was a CT Scan within a 24 to 48 hour period. Of particular concern to him was that in a previously healthy individual as was Dr. Itamunoala, there had been a progression or evolution of worrying symptoms strongly suggesting the existence of a mass in the brain. In his opinion Dr. Swartz did not meet the reasonable standard of an emergency room physician in his failure to order a CT Scan. If Dr. Itamunoala specifically requested that a CT Scan be carried out, that simply enhanced his opinion. In his opinion Dr. Swartz ought to have been sensitive to the concerns of Dr. Itamunoala and his wife and to have addressed them in determining his course of action.

60 If Dr. Swartz wrote out the name and telephone number of a specialist and gave it to the plaintiff, suggesting that the plaintiff contact the specialist, that manner of referral is simply not acceptable or appropriate and fell below standard.

61 With respect to Dr. Pierce's notes of December 16th, 1998, and on the assumption that she had reviewed Dr. Swartz's notes of December 6th, her notation of this visit is insufficient. There is no documentation of headache made worse by coughing. In his opinion she did not meet the standard because on the assumption she had before her, the record of Dr. Swartz's examination, it was clear to Dr. Brankston that Dr. Pierce did not consider the totality of the symptoms in arriving at her diagnosis. In his opinion a reasonably prudent family doctor would have ordered a CT Scan on that date which would by now certainly have shown the mass in the patient's brain. Assuming that Dr. Itamunoala asked for a CT Scan on this date and as well asked about a referral to a specialist, it was inappropriate for Dr. Pierce to reject both those requests. Further, if Dr. Pierce was aware of pending travel plans she ought to have advised against those plans until a CT Scan had been carried out.

62 With respect to Dr. Smullen's notes of his examination on December 29th, Dr. Brankston was of the opinion that the physical examination is almost negligible and there was no evidence of any neurological examination of any sort. It was clear to Dr. Brankston that Dr. Smullen had not considered a neurological examination for the symptoms revealed in the records that he ought to have reviewed and in that he fell below the standard. Although he considered the possibility of a CT Scan, in Dr. Brankston's opinion he ought to have ordered one within 48 hours. If he had known that the plaintiff planned to leave the next day for the United States, he ought to have advised against travel and he should have charted that advice.

63 In cross-examination Dr. Brankston agreed that the analayse was minimally elevated and stated that it could easily be a false position. It was nowhere near what would be expected with pancreatitis. In his opinion to order an ultrasound on the basis of the analayse elevation did not have a lot of credibility. From the record there was no discussion of abdominal problems. Vertigo was a type of dizziness that needs to be inquired into. It can be, although rarely is, connected to cough. He said the physical examination charted by Dr. Swartz didn't indicate the necessity of a CT Scan, but rather it was the history reported by the patient which indicated the necessity that a CT Scan be carried out. He said that labyrinthitis is a common cause of vertigo but does not cause light-headedness. He agreed that Dr. Itamunoala had decompensated by the time he was seen in hospital on December 27th.

Dr. Herman Hugenholtz

64 Dr. Hugenholtz was called on behalf of the plaintiff. He is a highly qualified neurosurgeon. He did post-graduate study in neurosurgery at the University of Toronto between 1966 and 1971. He received his F.R.C.S. in neurosurgery

in 1971. He became a diplomat of the American Board of Neurological Surgery in 1997. He has published widely in his field. He is presently a professor at the University of Dalhousie and has practiced continually in neurosurgery. For the past seven to eight years his practice has been focused upon brain tumour surgery, operating in that area between 250 and 300 times a year.

65 He has testified in superior courts as an expert witness in his specialty on numerous occasions, about two-thirds of those appearances being for the defence and one-third for the plaintiffs. He has a daily interaction with family physicians with respect to referred cases and in the giving of opinions. He has taught both family doctors and emergency doctors. His extensive curriculum vitae was filed as Exhibit 8.

66 Dr. Hugenholtz reviewed all of the medical documentation in this matter, including the discovery transcripts of the plaintiff and his wife and of the defendant doctors, together with the medical legal reports of Dr. Kovacs, Dr. MacPherson and Dr. Muller delivered on behalf of the defence.

67 In his opinion the consultation note of November 6th, 1998 at the after-hours clinic does not, on its face, permit him to come to any conclusions as to its sufficiency. Asked to assume that the visit was caused by the plaintiff's complaints of headache becoming sharp with coughing and laughing, he opined that those symptoms should have been documented and followed up with amplification and examination. Knowing the ultimate condition that the plaintiff experienced, in his opinion a CT Scan as early as November 6th would have shown abnormalities leading to a diagnosis of cranial mass. That would have in turn required an immediate referral to a neurological or neurosurgical specialist.

68 With respect to the emergency room record of November 21, 1998 Dr. Hugenholtz criticized the lack of characterization of the terms dizziness and headache and no follow-up questioning as to type of dizziness, date of onset, activities aggravating and relieving the condition, all of which were important to create a differential diagnosis. In his opinion a differential diagnosis based on the chart for November 21st should have been included. The file diagnosis does not adequately explain the presenting complaints or address them in any way. Asked to assume that the plaintiff told Dr. Mand on November 21st that he suffered imbalance in Bermuda whilst jogging and a new type of headache being sharp pain while coughing or laughing, Dr. Hugenholtz was of the opinion that Dr. Mand failed in his duty to consider what should have been obvious to most physicians; that these were symptoms suspicious of intracranial pathology. His opinion was reinforced if Dr. Mand had been told that on November 21st, 1998 the visit to the emergency room was precipitated because whilst playing with the children the plaintiff experienced sharp head pain. In his opinion, the simplest and most readily available test that ought to have been ordered was a CT Scan of the brain which would have shown the mass then present.

69 With respect to Dr. Pierce's record of November 25th, 1998, Dr. Hugenholtz said that the entry "light-headed with cough" is not characterized in any manner that allows him to come to a conclusion. It is potentially indicative of intracranial pathology and is therefore important. Assuming Dr. Pierce knew of the problems experienced by the plaintiff in Bermuda, those symptoms were important and warranted consideration.

70 With respect to Dr. Pierce's notes of December 2nd, 1998, Dr. Hugenholtz pointed out that again the complaint of dizziness was not adequately characterized. Asked to assume that Dr. Pierce had shortly before received a call from the plaintiff in the United Kingdom complaining of loss of balance and headache with cough and laughter, he was concerned that that call was not charted. It was his opinion that with that information any competent physician would order a CT Scan. In his words, to order a CT Scan was "a slam dunk"... "It was simply common sense".

71 With respect to the emergency room attendance of December 6th, 1998, Dr. Hugenholtz was of the opinion that Dr. Swartz's notes did not comprise a sufficient medical record because the doctor failed to characterize the symptoms of headache, dizziness and vertigo. He was also concerned about the final diagnosis, as labyrinthitis is a diagnosis of exclusion, and headache and numbness are symptoms inconsistent with labyrinthitis. Assuming Dr. Swartz did a detailed and thorough neurological examination as charted, it by no means excluded cranial pathology. Referring to the chart, Dr. Swartz fell below standard by not considering intracranial pathology as part of a differential diagnosis. Assuming

from his examination for discovery that Dr. Swartz did consider intracranial pathology as a secondary diagnosis, he did nothing to exclude it. Intracranial pathology can have disastrous consequences, and in Dr. Hugenholtz's opinion Dr. Swartz had a positive obligation to pursue the possibility of intracranial pathology "with vigor". Headache, dizziness, numbness and vertigo are all consistent with symptoms of intracranial pathology. On the chart, Dr. Hugenholtz could find no entries inconsistent with intracranial pathology.

72 Assuming Dr. Swartz knew of the Bermuda incidents and the November 21st emergency room attendance, and of the complaints experienced during the visit to England. Dr. Hugenholtz said he clearly had an obligation to consider intracranial pathology. In the words of Dr. Hugenholtz, it simply could not be ignored. The simplest reaction would have been to order a CT Scan as quickly as possible. If there was a technician present in hospital it should have been done immediately, otherwise, it should have been done the next day.

73 Looking only at the written record of December 6th, in Dr. Hugenholtz's opinion a CT Scan should have been ordered within one to two weeks.

74 If Dr. Swartz gave the name of a neurologist to Dr. Itamunoala and asked him to contact him if he desired to do so, this falls quite outside acceptable referral standards. In Dr. Hugenholtz's opinion, a doctor cannot put the onus of follow-up on the patient.

75 If Mrs. Itamunoala asked Dr. Swartz for a CT Scan during his attendance, and given that it was inevitable that a CT Scan should have been ordered on this attendance, it was quite improper for Dr. Swartz to deny the request, and in Dr. Hugenholtz's words, "you are there to help patients - it was a perfectly reasonable request".

76 With respect to the notes of the December 16th attendance before Dr. Pierce, and assuming Dr. Pierce knew as she ought to have done of Dr. Swartz's note, in Dr. Hugenholtz's opinion she did not meet the standard in failing to pursue the symptomology of intracranial pathology. On this occasion a CT Scan should have been ordered as quickly as possible.

77 Lastly, with respect to the attendance before Dr. Smullen on December 24th, 1998, Dr. Hugenholtz said that all he could detect from the record of an examination was a reference to blood pressure, temperature and "tender over temporal mantibular joint". Given the information and symptoms revealed from the records available to Dr. Smullen, Dr. Smullen did not meet the standard of reasonable examination. He was obligated to consider intracranial pathology in a differential diagnosis. In Dr. Hugenholtz's opinion, Dr. Smullen also did not meet the standard in that he should have ordered a CT Scan immediately. Further, if Dr. Smullen was advised of the travel plans of Dr. Itamunoala, it would have been the responsibility of any reasonable physician, having considered the possibility of intracranial pathology, to advise that no travel should be undertaken until the results of the CT Scan were available.

78 On his cross-examination Dr. Hugenholtz was of the opinion that the symptoms complained of by Dr. Itamunoala were progressive and recurrent. It was quite possible he said for symptoms to be present in Bermuda and not be present a week later in Canada. He agreed that Dr. Itamunoala decompensated in the United States after Christmas. He said he would not have been comforted by the absence of symptoms complained of on physical examination. In his experience it was not unusual to show dramatic evidence of instability on one occasion and not upon another, that being a feature of intermittent cranial obstruction. He was of the same opinion with respect to numbness.

Doctor David Swartz

79 Dr. Swartz graduated from Queens University with a degree in medicine in 1990. He subsequently trained in both family practice and as an emergency room specialist. By 1998 he was working as a full-time emergency medical specialist at Etobicoke General Hospital. He had a vague recollection of having seen Dr. Itamunoala. He would have had an opportunity to review Dr. Itamunoala's chart of his previous visit to the emergency department. He frequently sees headache complaints in emergency. Headache is consistent with infection and also with a lesion inside the head. He would generally ask about the onset, duration and location of the headache. He will generally note the significant positives but not the negatives. He understood headache was present on Dr. Itamunoala's earlier visit, but not on December 6th. He

very often sees complaints of numbness in the emergency department, perhaps with fifteen percent of his patients. Local numbness merits an explanation. You don't spend very long with patients in emergency. He said he does the best that is possible in trying to pin down one firm diagnosis. He could not explain Dr. Itamunoala's numbness. He did both an abdominal examination and a neurological examination. He recalls that there was some anxiety being exhibited by Dr. Itamunoala. He found the cranial nerves to be intact and normal, the fundai normal and no symptoms on a side-to-side test. He didn't do a tandem gait test because that was not one of the cerebellum tests he relied on. Reflexes were normal. He felt that Dr. Itamunoala's symptoms were neurological in nature but that the neurological exam was within normal limits. He diagnosed labyrinthitis, the principal symptom of which was vertigo associated with change in posture of the head. He conceded numbness does not fit with a diagnosis of a labyrinthitis but because he felt the numbness had cleared he had no hard symptoms to work with. He said he would have to get the radiologist's permission if he was to order an immediate CT Scan, and in the presence of a normal neurological examination the radiologist would have directed him to order a CT Scan on an out-patient basis. An out-patient CT Scan in December of 1998 could have been done anywhere between two days and two weeks from being ordered. He had vague recollection of a discussion of a CT Scan. He was uncomfortable about the history of numbness and he couldn't fit it into his diagnosis of labyrinthitis. As a result of that he elected to have the patient call up his colleague, Dr. Fu, who was apparently a neurologist who worked in emergency. To do that he wrote Dr. Fu's name and telephone number on a prescription pad and gave it to Dr. Itamunoala. It was up to Dr. Itamunoala to call Dr. Fu.

80 On cross-examination he admitted he was obligated to consider a differential diagnosis. He considered intracranial lesion which he said would be his second or third differential diagnosis. He admitted that on examination for discovery he said the second most likely diagnosis would have been a space occupying lesion. He said that a consequence of an undiagnosed space occupying lesion was permanent disability or death. He agreed he did not chart his differential diagnosis. He agreed a normal neurological examination did not rule out a space occupying lesion. He agreed symptoms of lesion can be intermittent, that is, they can wax and wane and that a CT Scan would have made the diagnosis of lesion. He could not deny that both Dr. and Mrs. Itamunoala asked for a CT Scan. He has a vague recollection that they did so. He said he was comfortable with his diagnosis of labyrinthitis, but he couldn't put it together with numbness and he wanted Dr. Itamunoala to be reviewed on an urgent basis by a neurologist. He had made only something like less than six referrals to a neurologist over the past fifteen years for suspected labyrinthitis.

Dr. Gurpal Mand

81 Dr. Mand took his primary education and medical degree in India where he practiced emergency medicine for three years. He came to Canada in 1975 and did an internship in Regina. He did four years post-graduate work in neurology at Western, graduating in 1981, but not applying for certification. He came to Toronto in 1985 and did "house calls here and there". In 1991 he began working in the emergency department at Etobicoke and also worked in a family practice.

82 He identified his signature on the emergency room report (Exhibit 1, Tab 1) of November 21, 1998. He did not have too much recollection of the events, but he can "think after reading my notes". When he saw him, Dr. Itamunoala was dizzy and complaining of headache, both of which were common complaints. He asked the duration of the headaches and whether there was any stress. He made no notes of the responses because the complaints were non-specific. He would probably have charted anything specific. He charted nothing with respect to headache because there was no indication of anything unusual. Headache exacerbated by laughing or coughing would be significant and he would have noted it if he had been told about it. It is very less common with younger persons to have dizziness and headache. He was definitely concerned about neurological issues. He found the head and neck clear and no abnormalities. He checked the eyes and fundai. He did an ENT exam and all was normal. Had the patient complained of blurred vision a few hours before the visit, he would have noted that on his chart. He inspected and palpitated the abdomen and listened to the bowel. His neurological examination was charted as normal. He found analayse to be slightly elevated, which can be caused by pancreatic problems. After reviewing the lab reports he reported to his patient who agreed he had discomfort in his abdomen. That was the only positive symptom he could find and he ordered an abdomen ultrasound to follow-up. There were no indications that he saw that warranted a CT Scan. If the symptoms he saw persisted over a period of

time, then it would have been appropriate to order a CT Scan. He could get a CT Scan done if it absolutely indicated, but he had no indication that one was required.

83 On cross-examination he said that he had no independent recollection of the visit, but that he recapitulated from his notes. Dr. Itamunoala's main complaints were headaches and dizziness. He agreed he had an obligation to chart Dr. Itamunoala's relevant history. He agreed that Dr. Itamunoala's symptoms could be ominous and consistent with diagnosis of intracranial lesion and brain tumour. If he had learned Dr. Itamunoala was unsteady on his feet that would increase his suspicion. He would have asked Dr. Itamunoala about vertigo and a positive response would have increased a suspicion of intracranial lesion. If he had been told of unsteadiness and headache in Bermuda relieved when Dr. Itamunoala was underwater, that would have increased his suspicion. He agreed Dr. Itamunoala did not complain of abdominal pain or he would have charted it in the history portion of his notes. He had no recollection of any conversation with the plaintiff. He had no diagnosis on the plaintiff's discharge. He had no explanation for the ominous symptoms of headache and dizziness. He told Dr. Itamunoala to follow up with his family doctor if the symptoms persisted.

Dr. James Francis Kovacs

84 Dr. Kovacs was called on behalf of the defence. Dr. Kovacs received his medical degree from the University of Western Ontario in 1988 and was licensed to practice in Ontario in 1989. He worked for various hospitals in the Oakville area thereafter. He obtained his LLB from the University of Toronto in 1997 where, according to his CV (Exhibit 11) he specialized "...in medical legal jurisprudence", an option not before now known to me to be available at that institution. He was appointed a coroner in 1998.

85 From 1990 until the present he has been on staff with the Oakville Trafalger Hospital employed in emergency medicine and family medicine. He is not a specialist in emergency medicine and has practiced family medicine only in the hospital context. In 2001 he became Chief of Family Medicine at the Oakville Hospital.

86 Regrettably, I found the evidence given by Dr. Kovacs, in the words of Coo J. in *Ing (Litigation Guardian of) v. Guest*, [1993] O.J. No. 1818 (Ont. Gen. Div.), para. 11, to be "...reflective of an unrealistic and unhelpful advocacy stance which renders most of [the] expressed views unacceptable."

87 Perhaps the difficulty was caused because on occasion the doctor, in his words, used "my coroner's training" to attempt to explain discrepancies between presenting symptoms and diagnosis recorded despite the lack of a factual foundation. In that result I felt it would be unwise to rely overly much upon his opinions.

88 Dr. Kovacs believed the note of November 6th, 1998 was appropriate and from it he would not have ordered a CT Scan.

89 He disagreed with other testimony that the note of November 21st, 1998 was inadequate. He believed the plaintiff complained of abdominal pain. He believed the notes were appropriate. With respect to the notes of November 25th, 1998, he admitted that complaints of light-headedness with cough would change one's mind a little bit, but said that "you can't give a CT Scan to everyone who is light-headed". He agreed that a CT Scan was the appropriate tool to determine the existence of a neurological problem. He agreed that the emergency note of November 21st was an important part of the puzzle and it would be helpful for Dr. Pierce to have it, but in the main "we depend upon the patient to tell us what's going on". He found the note of November 25th, 1998 to be above standard.

90 With respect to the note of December 2nd, 1998, he was of the opinion that Dr. Pierce was establishing an on-going relationship with her patient and inquiring into matters pertaining to his lifestyle. He said the presentation charted was very non-specific and without something else a CT Scan would not be indicated. Dizziness with laughing is a very common complaint in his experience. With respect to the emergency room note of December 6th, 1998, he claimed that it is possible to have migraine and facial numbness at the same time. He found the neurological examination charted to be appropriate. He would not have referred to a neurologist at this point and seemed unaware of Dr. Swartz's position that

an immediate neurological consult was required. He thought Dr. Swartz was acting appropriately to allay the patient's fears in providing a name of a doctor that he could telephone. He found labyrinthitis to be a reasonable diagnosis.

91 He found the notes taken by Dr. Pierce on December 16th to be very reassuring. He would have ordered neither an emergency nor an elective CT Scan on this occasion. If the patient hadn't been feeling better a referral would definitely have been warranted.

92 Reviewing the notes of December 24th taken by Dr. Smullen, he found it unnecessary to do a neurological examination because one had been done eight days prior to the visit. He thought TMJ was a reasonable diagnosis. He thought it appropriate to consider a CT-Scan, but he himself would not have ordered it on the basis of what was charted, nor would he have made a referral.

93 He said that the following day the disease finally manifested itself, and at that point it was possible to say that a CT-Scan was required immediately. He said the diagnosis of cranial lesion could not have been made two days prior.

94 He agreed that the numbness presented on December 6th cannot be explained by Dr. Swartz's diagnosis. He agreed that in coming to his opinion he never accepted the plaintiff's statements given on his examination for discovery as being factually accurate.

Dr. Karen L. Pierce

95 Dr. Pierce received her Masters in surgery from McGill Medical School in 1982 following two years internship at the Montreal General Hospital and at Sunnybrook General Hospital. In 1984 she moved to Bolton and established a family practice at which she continues to the present time. She worked occasionally in an after-hours clinic in Bolton. She remembers the plaintiff, Dr. Itamunoala, whom she described as interesting, engaging and friendly. She described her note-taking process on the "SOAP" principle in which 'S' stands for subjective (presenting complaints), 'O' stands for her observations, 'A' for her assessment and 'P' for her plan. Her practice is to write notes contemporaneously as she proceeds with her examination and as her patient imparts information.

96 She recalled the November 6th visit to the after-hours clinic. She would have asked questions about four weeks of coughing because that is a long time for a cough. She thought Dr. Itamunoala's symptoms were consistent with an upper respiratory infection with which light-headedness is commonly associated. She learned he had no past medical history. He traveled extensively which gave her concerns because of his cough. She believed she overtreated by prescribing antibiotics which would not cure the whooping cough that she suspected to be present, but might have assisted if the plaintiff had some other ailment.

97 She wanted him to follow up with his physician and agreed to take him on in her practice upon learning that he had no family doctor. She believed from her note that light-headedness was not Dr. Itamunoala's primary complaint. She believed the next time she spoke to him was on a long distance call from England. She doesn't remember the details of the call except that she remembers Dr. Itamunoala talking about going to an emergency room; either that he had gone or that he would go. She did not know why he would go to the emergency room. She said that had he mentioned to her dizziness and headache being experienced, she would have been concerned and told him not to fly but to see a local doctor. She has no recollection of him saying anything about those symptoms. She didn't chart the call because she had not a file on him at that time. She did not know when she saw the emergency room note of November 21st, which had been placed in her box at the hospital. She generally glances at reports that she receives.

98 She had not had the report when she saw Dr. Itamunoala on November 25th. She remembers that visit very well. He told her a lot about his background and social history about which she would not usually inquire. He complained of feeling light-headed with his cough which should become intermittent. He said he was there because of his cough. She did not have her after-hours clinic note. There was no mention of headache or she would have documented it. He volunteered that he was feeling unwell periodically. She was not aware that he had been to Bermuda, and if she was aware she thinks she would have documented it. Family doctors should clearly chart complaints of headache, dizziness

and unsteadiness. She was concerned that he may have been exposed to something in his travels. She believes that if she had been told that her patient was suffering from headache and balance problems she would both explore and document those complaints. She called Etobicoke General to get a faxed copy of a chest x-ray. She asked her nurse to do a TB skin test. She ordered a pulmonary function test because of the persistent cough. She doesn't recall Dr. Itamunoala calling her from London after this visit.

99 She said the visit on December 2nd was a follow up from the November 25th visit. She doesn't recall learning that Dr. Itamunoala just returned from London, nor does she recall that he called her from London prior to that visit. She didn't know when he booked the appointment. Her nurse indicated the dizziness and she inquired about it. She didn't document vertigo. She did a cursory exam because of what he had said about dizziness. Her overall impression was that the clinical conditions were improving. If he had complained of headache and balance problems in London she would have documented them because they are serious symptoms. She didn't know he was in London. It is important to keep a record of calls to and from patients, but she didn't document a call with this patient because she did not have a chart.

100 On December 7th she went to the hospital and picked up the emergency room report of December 6th which she reviewed at the end of her rounds that day. She couldn't read Dr. Swartz's notes. She called and spoke to Dr. Itamunoala's wife who told her that her husband had been experiencing numbness in his face and legs and on that account went to the emergency room. She expressed her concern to Mrs. Itamunoala. She was concerned about the event which she described as being a neurological event. She did not document the call with Mrs. Itamunoala because she thought it was "hearsay". She denies expressing anger or dismay at the visit to the emergency room.

101 She recalls the visit of December 16th and Dr. Itamunoala telling her of the numbness in his face and leg that he experienced at church which took him to the Etobicoke hospital. It was most likely that Dr. Itamunoala used the word vertigo because her nurse would not chart a medical term. She thought he was credible and believable on this visit. She had concerns and did a full neurological exam. She was certain he never mentioned having headaches and she had no idea that her patient was experiencing headaches until she subsequently read the notes taken at the U.S. hospital. She didn't really read Dr. Mand's notes and she couldn't read Dr. Swartz's notes. She thought her patient was a very intelligent and informative person who gave her a very complete history. Had she known of distortion in vision she would have reported it. Her whole neurological examination was normal and her impression was the vertigo was improving. She told him to continue taking Gravol which she agreed was for nausea, not vertigo. She agreed he never complained of nausea. She had no recollection of a CT Scan being requested and she would normally document a request of that nature. She did not believe a CT Scan was warranted. She did not suggest that he was making too much of things and she doesn't minimize her patient's symptoms. She does not believe that a referral to a specialist was necessary. She had never heard of Dr. Fu. The progression of symptoms wasn't concerning to her. Had there been another episode of numbness, she would have considered an elective CT Scan. She had sent many patients with headaches to obtain CT Scans.

102 On cross-examination she agreed that light-headedness was a sign or a symptom consistent with intracranial lesion and the same went for dizziness, headache, light-headedness with cough, dizziness with laughing, reduced energy, numbness of face, numbness of leg, vertigo and vertigo with change in posture. She agreed all those symptoms were recorded in her chart, including the trips to the Etobicoke General Hospital by December 16th, 1998. She acknowledged that she had the December 6th emergency report on December 7th. She knew Dr. Itamunoala did not attend doctors in Ontario prior to her taking him on. She had no idea why he called her from London. Not charting her call to Mrs. Itamunoala was a departure from her standard practice. If she had known that Dr. Itamunoala had complained of headache and dizziness on November 21st, she would have followed it up but she didn't read that report. She may have glanced at it. Generally, the emergency room reports that she receives are very poor. She did not review Dr. Swartz's report until the examination for discovery. On November 25th she did not think of a CT Scan or of referring her patient or of intracranial pathology as part of her differential diagnosis.

103 She probably spent about 10 minutes with Dr. Itamunoala on December 2nd. She made no diagnosis. There was no consideration on that day of intracranial pathology and she doesn't recall if it was part of her differential diagnosis.

104 The visit on December 16th was for 10 minutes and she had time for a complete neurological exam, although she described the procedure on her billing to OHIP as "minor assessment". She had enough time to consider a diagnosis and a differential diagnosis and to chart both. It is not her habit to write down a differential diagnosis although she had the time to do so. She admitted that on discovery she said that she thought of a differential diagnosis but didn't have enough time to write it down. She thought he might have multiple sclerosis. She prescribed Gravol.

105 At trial she believed that if she truly suspected multiple sclerosis she would have made a neurological referral.

106 She agreed that on her examination for discovery she said that she had no explanation as to why numbness occurred on December 6th, 1998. She agreed that on the four visits of November 6th, November 25th, December 6th and December 16th additional symptoms were presented each time but that she saw new symptoms rather than a progression. She didn't consider a neurological referral or a CT Scan.

107 In transferring her file to the family doctor who succeeded her she did not send a copy of her notes but merely a summary. She did not refer to the visit to the clinic. She did not refer to complaints of light-headedness, dizziness or vertigo. She did not refer to Dr. Smullen's findings or the plaintiff's complaint. She agreed the entries that she did not include in her summary were all indicative of intracranial pathology.

Dr. Merrill Smullen

108 Dr. Smullen was a graduate of the University of Glasgow and became licensed to practice medicine in the United Kingdom in 1976. He practiced in Glasgow as a general practitioner until 1980 when he came to Canada. He practiced for two years in Manitoba. In 1982 he opened a practice in Malton, Ontario. He has practiced family medicine in Bolton, Ontario since July of 1985 when he first became associated with Dr. Pierce.

109 In 1998 he was practicing with five doctors in a clinic, each of whom maintained a separate practice but each of whom covered for the other clinicians on an as-needed basis. He recalled seeing Dr. Itamunoala on December 24th. Dr. Itamunoala was a patient of Dr. Pierce's who was on vacation. He would normally speak with the patient and make reference to the record and occasionally he would review the record before he saw the patient of another doctor. His recollection of the appointment is fairly clear because of the plaintiff himself whom he described as being very pleasant, very vocal and very interesting. He would have asked Dr. Itamunoala about his headache, including its location and he would have tried to find a reason for it. He did not notice any prior charting of headache in Dr. Pierce's notes. He believed the emergency room reports were in Dr. Pierce's file and he would have glanced at them. He thought the abdominal complaints charted in the emergency room records were not relevant. The reference to labyrinthitis was consistent with the complaints presented to him. The plaintiff's demeanour was normal and he could communicate well. He said the vertigo he experienced was not constant. When the plaintiff touched his temples with his hands in describing his headache he was led to consider TMJ misfunction. Palpitation of the temple area elicited some tenderness. TMJ is a common source of headache. He understood the plaintiff had experienced headache for one month on an intermittent basis and returned to the clinic that day because the headaches were troubling him. He described intermittent periods of dizziness which concerned Dr. Smullen but was also a feature of TMJ. Dr. Itamunoala didn't seem to be in great distress. He prescribed Iboprofin which is an anti-inflammatory and mentioned he should follow up with Dr. Pierce when she returned from vacation. He felt that there was a suggestion that because of headache and vertigo there could be intracerebral pathology, which is why he suggested a CT Scan be considered by Dr. Pierce. He would have considered an emergency CT Scan with more severe neurological symptoms, for example, constant headache. He did no neurological examination because one had been done eight days before. He recalls a discussion with Dr. Itamunoala about him spending Christmas with his family, but doesn't recall him saying that he was going to the U.S. He would not have thought it would be unreasonable for him to travel at that time.

110 In cross-examination he agreed that although he took a history of one month of headache, he could find no reference to headache in the chart. Dr. Itamunoala presented with a neurological complaint and Dr. Smullen would

have considered a neurological exam. He believed he was required to do so and he did a partial neurological exam. He didn't chart it because it was negative. He would normally chart it. In failing to do so he breached his own standard. Dr. Itamunoala's condition was becoming more pronounced and could have indicated a progression. If a headache was more severe that could indicate progression. Headache aggravated by activity is important. He did not chart any tenderness on opening or closing the jaw and he doesn't believe he heard any clicking or popping sound that is symptomatic of TMJ.

111 He did not document locking of the jaw. He didn't ask about grinding of teeth, which can be a condition associated with TMJ. He agreed vertigo is not consistent with TMJ. He knew the patient had numbness in the face and leg which is inconsistent with TMJ and inconsistent with a muscle contraction headache which he diagnosed. He could have ordered an emergency CT Scan if he had considered it necessary.

Dr. Gail MacPherson

112 Dr. MacPherson, called as an expert witness in family practice by the defence, received her medical degree in 1983 from McMaster University. Following a two-year residency in family practice and some locum work, she set up practice in Oakville in 1986 and has practiced family medicine since then. In 2004 she received her fellowship in the College of Family Physicians of Canada.

113 This was her first appearance in court to give expert opinion evidence and although I believe she did her best to be fair and objective, her inexperience in testifying undoubtedly accounted for the difficulty that she had in responding directly and succinctly to the questions put.

114 In her opinion the note of November 6th was above average, giving a clear indication of the presenting complaint and the supporting symptoms. She did say that if light-headedness is a presenting complaint, it is quite another issue than if it is a complaint associated with another symptom. The latter is not uncommon. She would not have considered a brain tumour as a differential diagnosis. She herself would not have inquired about headache.

115 With respect to emergency room records she said it was her practice to review them with her patient if it was appropriate. If the record was not legible it would not be usual to contact the emergency room physician.

116 Reviewing the note of November 25th, 1998, she said the cough had gone on far too long and was unusual. The history taken was above average. A pulmonary function test was appropriate with a lengthy history of cough. The physical examination as charted was adequate. She thought it was inconceivable that the patient would not have made the doctor aware of the visit to the emergency room three days earlier complaining of headache and dizziness. However, even being aware of the November 21st emergency room attendance, on November 25th Dr. MacPherson would not have had reason to order a CT Scan. With respect to the note of December 2nd, she would not have ordered a CT Scan because the physician was at that time following up on a respiratory illness which appeared to be improving.

117 Regarding the December 6th emergency room visit she was of the opinion that the neurological symptoms would be of concern. She would have done a neurological exam. She might have ordered a CT Scan on elective basis and equally she might not have.

118 On December 16th an appropriate neurological exam was undertaken and the notes are complete. With respect to the December 24th visit, in her opinion the duty of care on Dr. Smullen would have been the same as it was for Dr. Pierce. She believed Dr. Smullen's plan was reasonable and if the symptoms didn't resolve then further investigation would be warranted. She sees nothing that calls for a CT Scan on this date and felt it was reasonable not to do a neurological examination. She said that if Dr. Itamunoala had presented to Dr. Smullen "staggering, vomiting and unable to speak", then she would say that a CT Scan should be ordered immediately.

119 In cross-examination she admitted that the November 25th report of Dr. Pierce made no reference to the emergency room visit of November 21st or the complaints of headache and dizziness then presented. She admitted that on December 2nd the complaint of dizziness charted was not new, and if it had been present on November 25th it should have been

charted. She said the physician had an obligation to review emergency room records. She noted that on the December 6th record that dizziness for two weeks was charted.

Dr. Paul Muller

120 Dr. Muller is an extremely well-qualified neurosurgeon. His CV is filed as Exhibit 13. He was called to give expert opinion evidence on behalf of the defendants and his qualifications to do so were admitted. He was present when Dr. Hugenholtz testified. He knew Dr. Hugenholtz to be a well-qualified, well-known and widely-published neurosurgeon.

121 He testified that the tumour with which Dr. Itamunoala was inflicted was extremely rare and the course of its development was variable. Tumors of this kind can be clinically dormant for years until an obstruction begins which can come on very quickly. They typically present with headache and neurological difficulties. Headache is the most common manifestation, but it is a common complaint. A hallmark is headache that is severe and progressive, as is vertigo. Cough is not associated with a tumour.

122 On the basis of the November 6th record he said it would have been unreasonable to order a CT Scan of the head. He acknowledged that he had made a mistake in reading "LT" as left rather than light. He did not think that anybody could be criticized for not ordering a CT Scan on the basis of the chart of November 21st. The symptoms were non-specific and the neurological examination was normal. He did not think there was any need to document the symptoms of dizziness that he understood Dr. Itamunoala complained of when passing through Immigration upon his return on November 21st from the United Kingdom. In his opinion the clinical manifestations on November 21st were not in keeping with the diagnosis of tumour. Again, on November 25th, 1998, from the documents that he reviewed there was no indication of brain tumour manifesting. He did not know why a physician would not write down headache. In the absence of a diagnosis there was no justification for a CT Scan. He agreed that headache aggravated by coughing or sneezing was quite compatible with brain tumour and if he had found that he might have ordered a CT Scan, but not on an emergency basis.

123 Similarly, on December 2nd from the chart no diagnosis of intracranial pathology could be made and in his opinion one could criticize a physician for ordering a CT Scan on that date.

124 With respect to the emergency room record of December 6th, the notes indicate upper respiratory problems and a CT Scan for the purpose of ruling out brain tumour was not mandatory. In his opinion the standard of care was met. In his opinion it would be extremely unusual for numbness to go away if there was a brain tumour. He could not explain transient facial numbness. Labyrinthitis was not inconsistent with Dr. Swartz's diagnosis. Facial numbness is unusual. He said that if the diagnosis was that there could be either labyrinthitis or brain tumour, then it would be important to order a CT Scan. It was appropriate to do a neurological examination and one was done. He does not think Dr. Swartz fell below the standard by not ordering a CT Scan and not referring to a specialist.

125 On December 16th the note of the neurological examination was normal. In his opinion the tumour hadn't progressed sufficiently to cause objective neurological findings. A CT Scan was unnecessary. A referral to a specialist on this date would not be criticized but it would not be mandatory. Accordingly, in his opinion the standard was met.

126 On December 24th there was a very clear cut complaint of headache. Ringing in the ears is non-specific and pressure in the head was consistent with upper respiratory infection. It was not unreasonable to prescribe Iboprofin and an emergency CT Scan was not indicated.

127 In his opinion there was no manifestation of the plaintiff's ultimate illness until he got to Minnesota where decompensation was the result of a build up of spinal fluid in his head.

128 On cross-examination he admitted that there was no reference anywhere in his report to his having referred to examinations for discovery. He claimed to have had the transcripts and to have read them cover to cover. He admitted he erred in interpreting Dr. Pierce's note of December 16th and concluding that she considered a CT Scan on that date.

He agreed that was a significant error in his report that he had not corrected. He admitted a factual error in his report with respect to his analysis of the November 25th note. He agreed with respect to the December 6th note of Dr. Swartz that many of Dr. Swartz's observations were not charted. He agreed Dr. Swartz's knowledge of the circumstances were better than his own. He knew from Dr. Swartz's examination for discovery that Dr. Swartz felt the second diagnosis was intracranial lesion, but he said that "that is no more valid an opinion than is mine today". He saw no conceivable reason to make a secondary diagnosis of brain tumour.

129 He agreed that the December 6th emergency room report showed signs of ataxia and that a definition of ataxia is awkwardness in walking caused by spinal lesion. If a patient presents with ataxia you should examine gait. He agreed that his opinion that a tumour should not cause symptoms to wax and wane is contrary to that of Dr. Hugenholtz and also in contrast to the opinion of Dr. Swartz.

130 He was not aware that Dr. Swartz himself wanted Dr. Itamunoala to see a neurologist on an urgent basis.

131 He said a standard neurological exam should include taking history and observing speech, checking for power, checking reflexes and checking gait. That notwithstanding he agreed that he was not critical of Dr. Smullen's failure to carry out a neurological exam as he just described. He agreed that in his report he said that at the Hennepin clinic in Minnesota Dr. Itamunoala presented with a depressed level of consciousness and ataxia. He admitted that he could not find any contemporaneous record where those symptoms were documented and said that it seemed he must have relied on a discharge note.

132 Dr. Muller acknowledged that he knew Dr. John Edmeads as a specialist in neurology at Sunnybrook Hospital, that he was an authority on headache and that his publication "Critical Decisions and Headache Management" 1998 was authoritative. He agreed with the following quotation from that work "in an ideal situation".

> The second unique headache syndrome is cough or exertional headache. This is a characteristically benign headache syndrome manifested by sudden, brief, severe head pains precipitated by coughing or other maneuvers which raise intracranial pressure. However, intracranial masses or structural abnormalities may be present in two to eleven percent of this population. Therefore all patients with this headache syndrome should be imaged with MRI.
>
> (Emphasis in original)

Documentary Evidence

133 From the emergency records of Hennepin County Medical Center of December 27th, 1998, found under Tab 1 of Exhibit 3, it is noted that Dr. Itamunoala presented on that date complaining of "Headache, dizziness. Dizziness started after Halloween. Worse with mvmt. Walking, flying. Plaintiff notes having HA, gradually worsening every day."

134 From the narrative notes beginning the next day, December 28th, 1998, found at page 14 at the same tab, it is recorded that Dr. Itamunoala "...presents [with] 2 mos. [history of] increasing HA and ataxia."

135 From Exhibit 10, filed on consent, it was agreed that a CT scanner was available at the Etobicoke General Hospital on November 21st, 1998 and December 6th, 1998, and the attending physicians would have been able to refer a patient for a CT Scan on those dates. It is also agreed that a neurologist was on call at the Etobicoke General Hospital on December 6th, 1998.

Issues

Causation

136 Causation is not an issue with respect to the U.S. medical procedures and attendant expenses incurred by Dr. Itamunoala prior to January 30th, 1999. It is agreed that had the diagnosis of brain tumour been made as a result of the attendances in Canada, the necessary operation would have been performed in Canada.

137 The defendants, however, take the position that the hospitalization required on January 30th, 1999 to address post-operative infection was not caused by any alleged negligence on their part but rather by the actions of Dr. Itamunoala in traveling to the United States at a time when he was suffering from infection.

Negligence

138 The issues are:

a) Did either or both of Dr. Pierce and Dr. Smullen breach the standard of care required of a normally competent family practitioner in situations similar to what pertained here?

b) Did Dr. Mand breach the standard of care required of a normally competent emergency room physician in the situation that pertained here?

c) Did Dr. Swartz breach the standard of care required of a normally competent emergency medicine specialist in similar circumstances to what pertained here?

The Law

139 The parties agree that the standard of care is as set out in the often-cited decision of the Court of Appeal of this province in *Crits v. Sylvester*, [1956] O.R. 132 (Ont. C.A.) at p 143:

> Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

140 As is so often the case, it is the application of the agreed-upon standard to the facts of this case that gives rise to the disagreement between the parties.

Specific Findings of Fact

141

1. Dr. Itamunoala is, by my own observation, confirmed by the testimony of virtually everyone with whom he came in contact, an intelligent, articulate, amiable and pleasant person. In 1998, he had virtually no prior medical history. He was extremely fit. He exercised regularly. I accept the statement of his wife that he prided himself on being fit and that fitness was part of his identity.

2. Dr. Itamunoala went to the Bolton after-hours clinic on November 6, 1998 because a cough he associated with a prior cold would not go away. In the words of his wife, when he coughed he would complain of headache. Although he himself was at trial uncertain as to the precise reasons for his attendance, I accept his evidence that given his past non-association with doctors, he would not seek one out solely because he had a cough or sore throat. He told his wife that he was suffering from headaches. He told the emergency department on November 21st that he had headaches. He told the Hennepin clinic on December 27th and 28th that he had been experiencing headaches since after Halloween and for the past two months. It is simply inconceivable that he would not have mentioned headaches to Dr. Pierce probably on the November 6th attendance and certainly by the visit to her office on November 25th and with respect to the latter date I so find.

3. I find he telephoned Dr. Pierce from London not, as she believes, prior to his visit to her of November 25th, but on his subsequent trip to England and probably on November 30th, just before his return to Canada. There

is no dispute that the call came from London, England. Dr. Pierce's understanding that the call was to advise her that he would go to pick up lab tests at the Etobicoke General makes no sense because the lab tests were done on November 21st and November 22nd, the day of and the day following his return from an earlier visit to England. Dr. Itamunoala was in Canada between November 22nd and November 25th when he saw Dr. Pierce at her office. I find that on the telephone call from London he advised Dr. Pierce of his serious concerns regarding his problems with balance and his frequent headache when laughing. Dr. Pierce made no note of the call. Dr. Itamunoala's evidence is corroborated to some extent by his wife, to whom he telephoned following his call to Dr. Pierce. He told his wife that he had called Dr. Pierce and he repeated his symptoms, causing her, as I find, to insist that he write her name and phone number on a piece of paper and carry it in his wallet. I accept Dr. Itamunoala's evidence that on that telephone call, and because of his concerns, he obtained an appointment with Dr. Pierce for the day following his return to Canada. Frankly, for Dr. Itamunoala to go to the trouble and expense of calling Dr. Pierce, unless he was seriously concerned, is contrary to common sense.

4. I find that in her husband's presence, Mrs. Itamunoala demanded that Dr. Swartz give her husband a CT Scan. That evidence was really not contradicted by Dr. Swartz who was fair to say that he had vague recollections of a discussion of a CT Scan.

5. I find that Dr. Itamunoala asked Dr. Pierce for a CT Scan during his visit to her on December 16th, notwithstanding her evidence that she had "no recollection of his asking for a CT Scan". She also testified that she didn't believe on that day that he warranted a CT Scan which would suggest to me that the subject must have been raised, as Dr. Itamunoala testified. I find that on the same visit he raised the question of a referral to a specialist.

General Findings of Fact

142 Following the visit to the clinic on November 6th, 1998, Dr. and Mrs. Itamunoala were in Bermuda on business from the 8th to the 12th of November. I accept Dr. Itamunoala's evidence, confirmed by that of his wife, that in Bermuda he experienced a loss of balance whilst exercising and a sharp pain in his head when he coughed, relieved whilst swimming.

143 Dr. Itamunoala spent one day in Canada and then went to England on the 14th of November, where he stayed until the 21st. I accept his evidence that he had no untoward symptoms whilst in England, but on the evening of the 21st after returning to Canada he experienced a feeling of losing his balance and whilst playing with his children he felt dizzy and experienced head pain. As a result of those symptoms he was driven by his wife to the Etobicoke General Hospital presenting with symptoms of dizziness and headache as recorded in Exhibit 1, Tab 1.

144 As I have said, he returned to England on November 25th and was back in Canada on December 1st. He saw Dr. Pierce on December 2nd. On December 6th I find he experienced head pain whilst singing in church. I accept that he had new symptoms of numbness of his face and leg and was unsteady when walking to the altar rail. As a result of those symptoms he was driven by his wife directly from the church to the Etobicoke General Hospital where he was seen by Dr. Swartz.

145 He saw Dr. Pierce on December 16th. I accept his evidence that following December 16th he continued to experience sharp pain when coughing or laughing and that a dull headache was becoming constant. I accept that he felt worse on December 24th and went to Dr. Pierce's office, where he saw Dr. Smullen, because of continuing headache and his concern that he be able to travel to the United States. I find that at that appointment Dr. Smullen said that if he took Iboprofin it would relieve his pain and he could travel.

146 There was no serious quarrel with the evidence of Dr. and Mrs. Itamunoala as to the events in Minnesota prior to and after his admission there to hospital, the subsequent operation and follow-up treatment and I accept their evidence.

Analysis

147 In considering the evidence to determine what symptoms were before the defendants on what dates, so as to enable them to treat their patient, I have been acutely conscious of the danger of looking at the evidence retrospectively from the standpoint of knowing that a brain tumour was excised at the end of December 1998. I have reminded myself that it is what ought to have been known or reasonably suspected at the time, not what was ultimately proven to be the case that must govern. I have reviewed Dr. Itamunoala's evidence through the same lens, because although I find him to be a credible witness it would be only natural for him to consider, in light of what he went through, what he must have been experiencing during the seven weeks prior to his operation. Where there is a conflict between his evidence and that of the defendants, I have accepted his evidence only after finding it to be more consistent with other evidence which I have accepted.

148 Turning to the medical evidence, I preferred that of Drs. Hugenholtz and Brankston to that of Drs. Muller and MacPherson. The evidence of the doctors called on behalf of the plaintiffs, to put it in simple language, made sense. The difficulty that I had with the evidence of the defence experts (apart from the specific problems that I had with Dr. Kovacs's evidence to which I have previously referred) was that the doctors appeared to analyze each of the seven attendances as stand-alone events which prevented them from assisting me with their opinion on the cumulative effect of what was taking place with this previously very fit and extremely healthy plaintiff.

149 Whereas Drs. Hugenholtz and Brankston did discuss each attendance, they placed them in a context of a repetitive, escalating pattern of continuing symptoms, potentially neurological in nature.

150 Given that Dr. Itamunoala made virtually no demands upon the health care system prior to the November 6th attendance upon Dr. Pierce, again common sense would suggest that by early December the emerging pattern of repetitive requests for medical intervention would, by itself, set off alarm bells in the minds of reasonable physicians.

151 Further, it was quite apparent to me that the defence experts did not take into account the testimony of the parties given on discovery, although the transcripts were apparently made available to them. This caused me concern, particularly with the evidence of Dr. Muller as it pertained to the actions and conclusions of Dr. Swartz on December 6, 1998.

152 I turn to a review of the attendances.

153 On November 6th Dr. Pierce charted light-headedness. Although I strongly suspect that Dr. Itamunoala told her of his headache, his evidence at trial that he did so was really an assumption on his part. The plaintiffs put in as part of their case answers to Questions 134, 139, 156 and 157 given by Dr. Pierce on her examination for discovery. In those answers she admits that she did not ask Dr. Itamunoala what he meant by light-headedness, nor did she ask him for how long he had experienced it. She agreed complaints of dizziness can be ominous and are consistent with a patient who presents with an intracranial lesion.

154 I accept Dr. Brankston's evidence that there should have been a further inquiry into the nature of the light-headedness, including questions about the presence or absence of vertigo, what aggravated or ameliorated the light-headedness and whether there was any associated headache.

155 It was Dr. Hugenholtz's opinion, which I accept, that if headache was present and was brought about by laughing, that would be of concern and something which one would expect a physician to explore and chart. Dr. Pierce's failure to put questions regarding light-headedness denied her the opportunity to take a proper history upon which she could base a reasonable, differential diagnosis for follow-up. In failing to do that, in my opinion, she fell below the standard expected of a reasonable family practitioner.

November 21st

156 Dr. Itamunoala was driven to the Etobicoke emergency department by his wife following his return from England because he was experiencing sharp pains when playing with his children. His presenting complaints were dizziness and headache which were confirmed by Dr. Mand in his notes. I accept Dr. Brankston's opinion that Dr. Mand's charting was insufficient because there was nothing to indicate he followed up with a functional inquiry into the presenting symptoms of dizziness and headache, thereby failing to lay the groundwork from which he could make an accurate diagnosis. In Dr. Hugenholtz's opinion the failure to make any characterization or qualification of both dizziness and headache made it impossible to create a differential diagnosis. Both Drs. Brankston and Hugenholtz were concerned with the final diagnosis, firstly, because the patient did not complain of abdominal pain and, secondly, because the final diagnosis, if indeed it can be called that, does not adequately explain the presenting complaints or, in the words of Dr. Hugenholtz, address them at all. Had Dr. Mand explored the history of dizziness and headache, he undoubtedly would have learned of the problems experienced in Bermuda. I accept the opinions of Drs. Brankston and Hugenholtz that on the information available to Dr. Mand a CT Scan ought to have been ordered. The doctor's opinion that a CT Scan taken at that time would have shown the existence of the tumour was not seriously challenged. In failing to take a proper history, discharging his patient without a diagnosis and failing to consider an appropriate differential diagnosis, in my opinion Dr. Mand fell below the standard of a reasonable emergency room physician. He admitted that he could have obtained a CT Scan on that occasion and, in my opinion, assuming he had made himself aware of the true history of the presenting complaints, his failure to request a CT Scan was below standard.

157 Four days later Dr. Itamunoala attended on Dr. Pierce at her office. She noted that he was complaining of being light-headed with a cough. If she had read Dr. Mand's charting of the November 21st emergency room attendance prior to the November 25th visit, she agreed that she would have been aware of Dr. Itamunoala's complaints of dizziness and headache. I find she did not read the chart prior to November 25th or perhaps at all. She certainly didn't follow her normal practice of initialling it to indicate that she had read it. Nothing in her chart of November 25th suggests that she had read it. She did not chart any inquiry into those symptoms. She conducted no neurological examination with respect to the light-headedness symptoms. I accept Dr. Brankston's opinion that Dr. Pierce's charting fell below standard. I accept his opinion that she had a positive obligation to review Dr. Mand's notes and that her failure to do so fell below standard. Those failures lead to an inability to appreciate that the continuing symptoms pointed to the possibility of neurological pathology which she ought to have considered as a differential diagnosis. Had she made herself aware of what had been charted, and made the inquiries that she ought, she would have had sufficient information to order a CT Scan. In the somewhat graphic words of Dr. Hugenholtz, to which I previously referred, ordering a CT Scan at this point was "a slam dunk".

158 By December 2nd matters had worsened. Dr. Pierce had by now, as I find, received the telephone call from London. Her nurse apparently charted complaints of dizziness upon standing and she herself charts dizziness with laughing too much. I accept Dr. Brankston's opinion that by now Dr. Pierce ought to have been aware of a progression of symptoms of dizziness exacerbated by coughing and laughing together with difficulties with balance, all suggestive of an expanding mass in Dr. Itamunoala's brain.

159 On December 6th, Dr. Brankston's opinion was that Dr. Swartz charted no pursuit of the headache complaint and he failed to carry out simple tests required because of the indications of brain lesion. I accept his opinion that that examination fell below the standard of an emergency medicine practitioner of average competence. Diagnosis of labyrinthitis was inappropriate because the new symptom of concern was numbness of the right face and foot, neither of which is symptomatic of inner ear infection. I find on the evidence that Dr. Swartz's failure to order an immediate CT Scan, combined with his failure to make a meaningful referral to the available on-call neurologist, notwithstanding his own concerns in that regard, fell below the standard expected of him.

160 Further, his failure to chart both his differential diagnosis of cerebral tumour and his concern that Dr. Itamunoala be seen by a neurologist within two days is inexplicable. It must necessarily have put obstacles in the way of practitioners conducting a follow-up examination and on that account it fell below standard. See *Law Estate v. Simice*, [1994] B.C.J. No. 979 (B.C. S.C.).

161 Dr. Itamunoala next saw Dr. Pierce on December 16th. In Dr. Hugenholtz's opinion it was incumbent upon Dr. Pierce to have carefully reviewed Dr. Swartz's note which she obtained on December 7th and pursue the symptomology of intracranial pathology. He felt a CT Scan should by now have been ordered as quickly as possible. That opinion appears to me to be unassailable. It is clear Dr. Pierce did not make any careful review of Dr. Swartz's chart until perhaps as late as her examination for discovery.

162 Dr. Brankston found Dr. Pierce's notes of December 16th to be insufficient. He based his opinion on the assumption that Dr. Pierce had reviewed Dr. Swartz's notes, as in his opinion she was obliged to do. In his opinion she failed to consider the totality of the symptoms in arriving at her diagnosis, and a reasonably prudent family doctor should have ordered a CT Scan on December 16th. Again, that opinion seems to me to be unassailable and I accept it. Had a CT Scan been ordered, I find a reasonable family physician would have cautioned against international travel until the results were known.

163 Because of his continuing headache complaint and because of his concern about whether it was appropriate for him to travel to the U.S. for Christmas, Dr. Itamunoala attempted to see Dr. Pierce on December 24th. He was seen in her absence by Dr. Smullen.

164 I find it difficult not to have considerable sympathy for Dr. Smullen. He impressed me on the witness stand as being a careful and thoughtful family practitioner. It appeared to me from his demeanour on the witness stand that he was genuinely concerned that he had not done all that he ought to have done, even though the visit to him was on Christmas Eve. Dr. Smullen appears to have been the first person to have charted concern that a CT Scan be done. That notwithstanding, he did not carry out any neurological examination of any consequence. I accept Dr. Hugenholtz's opinion that with the presenting symptoms and the history available to him, Dr. Smullen was obliged to consider intracranial pathology. I accept the opinion that a CT Scan should have been ordered immediately on an urgent basis and that a reasonably competent physician would have advised that no travel should be undertaken until the results of the CT Scan were available. Dr. Brankston was of the same opinion. In failing to perform an appropriate neurological examination, failing to order a CT Scan and failing to recommend against travel, I find Dr. Smullen fell below the standard of the reasonable, competent family practitioner.

Conclusion on Liability

165 I have found that each of the defendants breached the standard of care imposed upon them. No submissions were made by counsel with respect to the degree of responsibility that should be assigned to each defendant. It is true that Dr. Pierce had more opportunity to consider an appropriate diagnosis than did her three co-defendants. However, there was a cumulative process at work here and each failure to adequately examine and chart to some extent contributed to the difficulty of succeeding physicians on subsequent occasions to spot the progression of the recurrent symptoms.

166 Moreover, from at least November 25th, 1998, there were sequential failures to step back and look at the totality of the presenting history. Had that been done, in my opinion a reasonable practitioner would surely have become concerned that something could be seriously wrong with Dr. Itamunoala. For these reasons, I think it inappropriate and not practicable to determine the respective degree of negligence as amongst the four defendants, and s. 4 of the *Negligence Act* S.O. 1990 C. N1 will operate to make the defendants equally at fault.

Damages

167 The defendants submit that of the total out-of-pocket expenses claimed for treatment in the U.S., a little over $30,000 in U.S. funds and $2,000 in Canadian funds, was attributable to treatment rendered as a result of the hospitalization required on January 30th, 1999, when Dr. Itamunoala was readmitted to the Hennepin clinic because of infection which the antibiotics could not control. It is submitted that if Dr. Bernstein, who was consulted by the plaintiff in Toronto on January 25th, 1999, permitted travel to Philadelphia, that was a separate act of negligence and a

fresh cause of action for which the defendants cannot be held responsible. Dr. Bernstein was not made a party to these proceedings by either the plaintiffs or the defendants.

168 I am unable to accept that submission. The negligence that I have found to have been committed required Dr. Itamunoala to seek medical treatment in the United States. In my opinion it was reasonable of him to continue to follow the orders of his treating physicians in that country. When he was discharged from the Hennepin clinic on January 19th, he was instructed to re-attend for a follow-up treatment. No one told him that he could not travel. He and his wife followed all of the instructions on care that were given to them. It was reasonable for him in the crisis that was precipitated when the infection flared up in Philadelphia to return to Hennepin, particularly when his wife was unable to reach Dr. Bernstein for other instructions.

169 I therefore assess the plaintiff's damages for out-of-pocket expenses as claimed at U.S. $94,866.31, and $2,575.44 Canadian.

170 Having regard to s.121 of the *Courts of Justice Act*, I order that the exchange rate pertaining to the $2,454.46 of U.S. dollar expenses paid for prior to trial be that pertaining on the date of payment. With respect to the balance of the U.S. dollar out-of-pocket expenses, I exercise my discretion under s.121(3) by determining that it would be more equitable to apply the exchange rate pertaining on the date payment is made, by ordering payment of an amount in Canadian currency sufficient to purchase the amount of the remaining U.S. dollar obligations outstanding on that day.

General Damages

171 The assessment of general damages for Dr. Itamunoala and for damages under the *Family Law Act* for Mrs. Itamunoala is not without difficulty. The operation that was ultimately undergone was inevitable, regardless of the negligence that I have found. Fortunately, the result obtained has been excellent. Damages for pain and suffering, and for loss of care, guidance and companionship, are therefore restricted to a relatively limited time between when a diagnosis of brain tumour ought to have been suspected and a CT Scan ordered and when the diagnosis was actually made followed by emergency surgery. Accepting as I do that a scan ought to have been ordered on November 25th and that by December 6th the differential diagnosis should have called for an immediate scan, the period between then and the emergency operation is about three to four weeks long. During that period of time I appreciate that Dr. Itamunoala suffered increasing discomfort and no doubt increasing anxiety and concern because of the multiple explanations being given to him as to what was causing his discomfort, and a seeming inability of the profession to deal with it. I have no doubt that his awkwardness on the flight to Minnesota and his conduct during his visit to his wife's family were both sources of embarrassment and discomfort to him.

172 Counsel for Dr. Itamunoala suggested a range of general damages at something between $7,500 and $35,000. Counsel for the defendants submits damages should be nominal. I think justice will be served by an assessment of general damages at $15,000.

173 Mrs. Itamunoala cared for and administered to her husband during the period of uncertainty. She too was undoubtedly worried and distressed. I assess her damages under the *Family Law Act* at $1,500.

Prejudgment Interest

174 Prejudgment interest on the damages I have assessed is awarded pursuant to the rules.

Costs

175 Counsel have indicated to the trial office that they wish to deal with costs at a later date and they therefore may make an appointment for a cost hearing through the trial office. Any materials to be referred to on the hearing should be filed with my secretary at Osgoode Hall seven days before the hearing date that has been chosen.

176 ...Whereupon proceedings are adjourned at 12:00 p.m.

Action allowed.

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