COURT FILE NO.: 99-CV-172328
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ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:	)	
	)	
Gail Taylor, Stanford Taylor, Andrew Taylor, Catherine Taylor, Anthony Taylor, Glenn Millar and Rod Begg	)	*Sloan Mandel and Wendy Moore Johns* for the Plaintiffs
Plaintiffs	)	
- **and –**	)	
	)	
Robert Morrison, Vincenzo Arcieri-Piersanti, Jane Doe and Peterborough Civic Hospital	)	*Darryl Cruz and Erica Barron* for the Defendants
Defendants	)	
	)	**HEARD:** February 14-17, 20-24, 27 and 28 and March 1 and 3, 2006

H. Spiegel J.

Reasons For Judgment

INTRODUCTION

[1] On July 8, 1998, Elwin Taylor died in the Emergency Department of the Peterborough Civic Hospital as a result of a heart attack. He was just short 58 years of age. A postmortem examination revealed that Mr. Taylor had severe coronary artery disease (CAD).

[2] The defendant Robert Morrison was Mr. Taylor's family physician for approximately 22 years prior to his death.

[3] The plaintiff Gail Taylor is Mr. Taylor's surviving spouse and the other plaintiffs are his stepchildren. They bring this action pursuant to the provisions of the *Family Law Act*, alleging that Dr. Morrison fell below the required standard of care in investigating, diagnosing and treating Mr. Taylor's heart condition, and that this resulted in his untimely death. The action against the other defendants was resolved prior to trial.

[4] It will not be necessary for me to assess damages in this case. The parties have agreed upon a method of calculating the quantum of damages dependent upon the Court's finding as to

the life expectancy of Mr. Taylor had there been no breach of the standard of care by Dr. Morrison.

FACTUAL BACKGROUND

[5] Mr. Taylor was a man of Native Canadian descent, living in the Town of Lakefield in the Peterborough area of Ontario. He was born in August 1940. At the time of his death, he had been Dr. Morrison's patient for about 22 years. Over this period, Mr. Taylor kept all of his appointments save for three occasions: one in May 1989, one in August 1996 and one in March 1997. Mr. Taylor attended every specialist to whom he was referred by Dr. Morrison. Dr. Morrison described Mr. Taylor as a very nice, pleasant, polite gentleman whom it was a pleasure to have as a patient.

[6] Mr. Taylor met his spouse Gail in 1973. They lived together in a common law relationship for 23 years and married in 1997. Mr. Taylor was a long time cigarette smoker who smoked approximately one-and-a-half packages a day until he was diagnosed as a diabetic in September 1993, when he cut back to half a package per day. He was overweight and found it difficult to lose weight. He had a rather sedentary lifestyle. It is common ground that his risk profile for developing CAD was high.

[7] Dr. Morrison has been a duly qualified medical practitioner since 1973. He carried on a private family practice in Lakefield since 1974, when he took over the practice of a Dr. Sherin who had previously been Mr. Taylor's family doctor. According to Dr. Morrison's clinical notes and records, there were 36 medical attendances by Mr. Taylor over the 22-year period that he was a patient of Dr. Morrison's.

[8] In September 1993, and again in June 1998, Mr. Taylor attended on Dr. Morrison with complaints of chest pain. Dr. Morrison made a diagnosis of heartburn[1] and prescribed an antacid medication. Dr. Morrison states that on both occasions he considered a cardiac cause as part of his differential diagnosis but decided that heartburn was the most probable diagnosis. At no time did Dr. Morrison order or perform any diagnostic tests to rule out a cardiac cause or advise Mr. Taylor that any of his complaints could be related to a cardiac cause.

ISSUES

(i) Did Dr. Morrison breach the standard of care in failing to consider a cardiac cause for Mr. Taylor's complaints or, alternatively, failing to properly investigate, diagnose and treat Mr. Taylor's underlying CAD?

(ii) If the answer to issue (i) is in the affirmative, was the breach causally connected to Mr. Taylor's death in July 1998?

(iii) If the standard of care had not been breached and Mr. Taylor had received appropriate treatment for his CAD, how long could he have been expected to live?

[1] In medical terms, hiatus hernia/gastroesophageal reflux disease (HH/GERD).

(iv) If the answer to issues (i) and (ii) is in the affirmative, was Mr. Taylor contributorily negligent and, if so, to what extent?

Mr. Taylor's relevant medical history while a patient of Dr. Morrison

[9] Between November 1976 and February 1989, Mr. Taylor saw Dr. Morrison on 10 occasions, for reasons that are not particularly relevant to the issues in this case. The parties agree that there are three main periods of time to be considered in evaluating the care that Dr. Morrison provided. These periods are September 1993, May 1996, and June 1998. However, it is necessary to consider certain aspects of Dr. Morrison's care prior to these periods, as they impact on the assessment of the care during the periods mentioned.

The March 1989 Blood Tests

[10] In February 1989, Mr. Taylor attended upon Dr. Morrison with a complaint of pain in his knee. Dr. Morrison prescribed Naprosyn and asked Mr. Taylor to return for blood tests.

[11] Mr. Taylor returned on March 15, 1989 and a fasting blood sample was taken for laboratory analysis. Mr. Taylor was then instructed to have something to eat and return two hours later when his blood sugars were tested with a glucometer which showed that his two-hour glucose was 8.7,[2] which was indicative of borderline diabetes. Mr. Taylor's weight on this date was 270.5 pounds. Dr. Morrison counseled him about the importance of losing weight. It was noted that the Naprosyn was helping his knee but he was still having problems and he was referred to Dr. Legault, an orthopedic surgeon.

[12] On April 14, 1989, Dr. Morrison reviewed with Mr. Taylor the results of the lab tests. The fasting glucose was 6.2, the upper range of normal; his triglycerides were 4.44, which was higher than the normal range; his total cholesterol was 6.76, with the LDL cholesterol recorded at 3.91 and the HDL cholesterol at 0.83. The lab report notes that all the cholesterol readings indicated an elevated risk of CAD. Dr. Morrison testified that he further counseled Mr. Taylor about diet and the need to lose weight, which on that occasion was noted to be 264 pounds. He was asked to return in six weeks for a repeat blood work.

[13] Dr. Morrison's clinical notes indicate that Mr. Taylor did not show up for the May 31, 1989 appointment that was scheduled for blood work. Mr. Taylor did attend upon Dr. Legault on May 20, 1989. Dr. Legault noted that Mr. Taylor weighed 265 pounds and was five foot nine in height. He explained to him the importance of weight loss as a means of reducing the symptoms in his knees. Over the next three months, Dr. Morrison saw Mr. Taylor on four occasions with reference to his knee problems. On November 6, 1989, it was noted that his left knee was getting worse but the right knee was not as bad. Mr. Taylor's weight was down to 250½ pounds. Dr. Morrison prescribed a different medication.

The March 1992 Pre-Operative Tests and Examinations

[2] The results of all blood tests are expressed in mmol/l unless otherwise stated.

[14] On March 30, 1992, Mr. Taylor had an operation under general anesthetic for the removal of sixteen teeth. As part of the standard procedure prior to the operation, Mr. Taylor was required to undergo a physical examination and an electrocardiogram (ECG). On March 20, 1992, Dr. Sharin performed the physical examination and completed the required History and Physical Examination Form (Tab 3B of Exhibit 1). The ECG performed on March 20, 1992 was noted as abnormal (Tab 3A of Exhibit 1). Mr. Taylor was also required to complete a Pre-anesthetic Questionnaire, which was done on March 21, 1992 (Tab 3E of Exhibit 1). On March 30, 1992, the attending anesthetist performed a pre-anesthetic evaluation (Tab 3H of Exhibit 1). The defence relies on the records of these pre-operative examinations because none of them mention any complaints or findings with respect to cardiac problems. The plaintiffs, on the other hand, point to the ECG, which they claim is highly suggestive of CAD. Dr. Morrison testified that he did not see the March 1992 ECG prior to Mr. Taylor's death.

The September 1993 Visits – Chest Complaints

[15] Dr. Morrison next saw Mr. Taylor on September 21, 1993. Dr. Morrison's nurse recorded the following history on the patient's chart.[3]

> *Fried foods or if lifts – burning mid-sternum 3/12* [3 months] *or if walks too fast – pain*
> *If burps, helps: if reaches bothers*

[16] The remainder of the chart entry reads as follows:

> O HS ok, chest OK, abd obese, nil else
> A HH/GERD [Hiatus hernia/Gastro Esophageal Reflux Disease]
> P explained do's and don'ts
> Zantac 300q evening (30)
> See after GI exam
> *SJH* [nurses initials] *23/9/93 8*

[17] Mr. Taylor was again seen on September 29, 1993. Dr. Morrison's nurse noted that the GI series was normal. Dr. Morrison made the following note on the chart:

> SO GERD still probable, talked about same cutting back cigarettes
> Finish Zantac 300 mgm
> then Zantac 150 mg

May 1996 – Diabetes Diagnosed

[18] The next attendance of relevance is May 7, 1996, when Mr. Taylor presented with a history of having lost 50-60 pounds in the preceding six weeks. His weight was noted as 217 pounds. On examination, Dr. Morrison found that his heart sounds and chest sounds were normal and that his chest was clear. He observed a severe infection in Mr. Taylor's penis, with swelling and redness extending into the scrotum and a tight, red and itchy foreskin. Dr. Morrison

[3] I was provided with a typed transcription of the hand written chart. Entries on the chart by persons other than Dr. Morrison or his locum are in italics on the transcription. I have followed this format in these reasons.

made a diagnosis of balanitis and thought that Mr. Taylor would require a circumcision. A consultation was arranged with Dr. Meade, a urologist.

[19] A blood sugar test, performed on May 7, 1996, revealed an extremely high reading of 27.1. Dr. Morrison concluded that Mr. Taylor was a diabetic. He gave him an injection of insulin in order to bring down his blood sugars and prescribed 5 mg of Glyburide, to be taken orally for blood sugar control. He also instructed Mr. Taylor to take 10 units of insulin in the afternoon. On May 8, 1996, Dr. Morrison's nurse noted on the chart that she had spoken to Mr. Taylor and had advised him of an appointment with Dr. Meade for July 8, 1996, and that she had been advised by Mr. Taylor that he was taking his medications and that his fasting blood sugar was 12.7. Dr. Morrison saw Mr. Taylor on five occasions in May, June and July 1996, for the purpose of ensuring that his blood sugars were under control.

The July 1996 Pre-Operative Tests and Examination

[20] On July 8, 1996, Mr. Taylor was seen by Dr. Meade, who confirmed that Mr. Taylor required a circumcision and arranged for this to be done under general anesthetic on August 6, 1996, at St. Joseph's Hospital in Peterborough. The same type of pre-operative examinations, tests and forms were completed as were done prior to the 1992 operation. On July 30, 1996, Dr. Morrison performed a physical examination and completed the History and Physical Examination Form (Tab 1Q, Exhibit 1). An ECG, performed on July 30, 1996, was noted as borderline (Tab 4B, C, D, Exhibit 1). The Pre-anesthetic Questionnaire was completed on July 30, 1996 (Tab 4E, Exhibit 1). The attending anesthetist performed the pre-anesthetic evaluation. The record of this evaluation (Tab 4R, Exhibit 1) is not dated but was presumably completed on August 6, 1996, the day of the operation. As in 1992, there was no mention of any cardiac problems or symptoms in any of these preoperative records.The position of the parties with respect to these pre-operative examinations, tests and records are similar to those that were taken prior to the 1992 operation.

The June 1998 Visits

[21] On June 1, 1998, Mr. Taylor again attended on Dr. Morrison. His receptionist noted the following history on the chart:

a) *Heartburn ++ again. Had Upper GI in 1993. Pain worse after eats.*

[22] Dr. Morrison made the following entries in the chart:

Works at Sip n' DipGlyburide BID
EC ASA 1q 2d
HS ok, chest ok
obesity/GERD/DM
See for Big 4
Axid 150 BID (60)
GI if no settle
See 4/52

[23] On June 29, 1998, Mr. Taylor again attended on Dr. Morrison. His nurse noted the following history in the chart:

Axid works great.

[24] Dr. Morrison noted that Mr. Taylor's weight was 244 pounds. On examination, his heart sounds and chest were noted to be OK and his diagnosis at that time was GERD/obesity/diabetes. He again prescribed Axid and made a booking for further blood work to be done.

[25] On July 8, 1998, the date of Mr. Taylor's death, Dr. Morrison recorded the following on Mr. Taylor's chart: "Talked to wife re MI/VT. She says he was getting CP [chest pains] when walking but told her he denied that to me." Dr. Morrison testified that he made this notation after speaking to Mrs. Taylor in a telephone conversation in which he offered his condolences on Mr. Taylor's death. He said that Mrs. Taylor told him that Mr. Taylor had been having chest pains when walking and Dr. Morrison told her that her husband had denied that to him.

STANDARD OF CARE

Legal Principles

[26] The legal principles with respect to the standard of care required of a physician are not in dispute. The problem is to apply them to the particular circumstances of this case.

[27] Every medical practitioner must bring to his task 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 to be a specialist, a higher degree of skill is required of him than one who does not profess to be so qualified by special training and ability.[4]

[28] The conduct of a physician must be considered in light of the knowledge in the possession of the physician at the relevant time. All medical malpractice cases involve a bad outcome, at least insofar as the patient is concerned. As has been often observed, is it is always easy to be wise after the event.

[29] Diagnosis is predominantly an exercise of the physician's judgment based on his training and experience. It is trite to say that a physician is not liable for injuries flowing from errors of judgment (as opposed to actual negligence). The real difficulty lies in determining whether injurious behaviour by a physician is negligence or merely an error in judgment and it is the facts of each case that will determine the answer to this crucial question.[5] Merely describing a doctor's action or inaction as "error in judgment" does not amount to a carte-blanche defence to medical negligence. As Lord Fraser observed in *Whitehouse v. Jordan*, [1981] 1 All. E.R. 267 (HL):

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[4] *Crits v. Sylvester* (1956), 1 D.L.R. (2d) 502 at 508 (Ont. C.A.).
[5] *Dean* v. *York County Hospital et al.*, [1979] O.J. No. 348 at para. 42 (H.C.J.).

> Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not… It depends on the nature of the error. If it is one that would not have been made by a reasonably competent professional man professing to have the standard and type of skill that the defendant held himself as having, and acting with ordinary care, then it is negligent. If on the other hand it is an error that a man, acting with ordinary care might have made then it is not negligence.

[30] The point is perhaps more succinctly made in a frequently cited Canadian text:

> …The mere fact that the doctor's error involves the exercise of judgment does not necessarily shield the doctor from liability. If the error is one which a reasonable doctor would not have made in similar circumstances, liability will be imposed. An error of judgment is not necessarily negligence, but it may be, depending on the circumstances.[6]

The Evidence

[31] The plaintiffs called Mrs. Taylor and four expert witnesses: two family physicians, Dr. Edward Brankston and Dr. Brian Schwartz; and two cardiologists, Dr. David Fitchett and Dr. Kenneth Melvin. All of the plaintiffs' experts were of the opinion that Dr. Morrison had breached the standard of care at each of the relevant time periods and that, but for that breach, Mr. Taylor would not have died in July 1998. Both cardiologists expressed opinions on how long Mr. Taylor would have likely lived beyond July 1998, if Dr. Morrison had not breached the requisite standard of care (the life expectancy issue). Plaintiffs' counsel also read in a large number of admissions made by Dr. Morrison on his examination for discovery. As well, in the course of his cross-examination, plaintiffs' counsel read to Dr. Morrison a number of statements from certain textbooks that he admitted were correct and that he knew them to be so in 1993.

[32] The defence called Dr. Morrison and one expert witness, Dr. John Stewart, a family physician who expressed the opinion that Dr. Morrison's care and treatment of Mr. Taylor met the appropriate standard of care in every respect. He did not address the causation issue or the life expectancy issue.

Undisputed Facts About CAD

[33] CAD is a condition characterized by the narrowing of the coronary arteries due to plaque that develops on the arterial walls. Blood flow to the cardiac muscle is thereby reduced. This can result in the condition known as angina pectoris, which is essentially chest pain resulting from a deficiency of blood to the cardiac muscle. Angina has the characteristic of being provoked by activity, eating, emotion or exposure to cold and is relieved by rest, relaxation, or nitroglycerine. Chest pain with any of these characteristics should be a clue for further evaluation for heart disease.

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[6] E.I. Pickard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*, Third Ed. (Toronto: Carswell, 1996) at 281.

[34] If the obstruction of blood circulation to the heart is severe enough, it can result in an acute myocardial infarction (MI) or, in layman's terms, a heart attack.

[35] CAD is a treatable but not curable condition. It is treated with medical and/or surgical interventions. Medical therapy includes the use of medications such as nitrates, beta-blockers and cholesterol lowering medications. Surgical interventions can include angioplasty, which involves the introduction of a balloon-type device into the affected artery in order to clear the artery of the plaque and installing a stent into the artery to keep it open. If angioplasty is not indicated then the next option is coronary by-pass surgery, in which a vein or artery from another part of the body is grafted onto the blocked artery so as to permit the free flow of blood around the area of blockage.

[36] The exact etiology of CAD is not known, however, it is well established that there are a number of factors that increase the risk of developing CAD. The risk factors relevant to Mr. Taylor's case were: masculine gender, age, and cigarette smoking of long duration, obesity, abnormal cholesterol, diabetes, sedentary lifestyle and native Canadian extraction.

The Plaintiffs' Position With Respect To Standard Of Care

[37] The plaintiffs submit that Dr. Morrison breached the standard of care by failing to consider a potential cardiac cause for Mr. Taylor's presentation in September 1993 and June 1998.

[38] Alternatively they submit that if he did consider a cardiac cause, Dr. Morrison breached the standard of care by failing to carry out appropriate investigations to rule out a cardiac cause.

[39] The plaintiffs submit that had Dr. Morrison considered a cardiac cause and carried out appropriate investigations, Mr. Taylor's underlying CAD would have been confirmed and that would have resulted in appropriate referrals and treatment.

[40] The plaintiffs further submit that, in May 1996, when Dr. Morrison made a diagnosis of new onset diabetes, he breached the standard of care by failing to undertake investigations to rule out disease of those organs most likely affected by diabetes (end organ disease). This would have included an investigation of Mr. Taylor's heart, which would have confirmed his underlying CAD and that would have resulted in appropriate referrals and treatment.

[41] The plaintiffs submit that, but for Dr. Morrison's breaches of the standard of care as described above, it is unlikely that Mr. Taylor would have died in July 1998.

The Defence Position With Respect To Standard Of Care

[42] The defence submits that the evidence falls short of establishing any breach of the appropriate standard of care by Dr. Morrison. The defence contends that Dr. Morrison did in fact consider a cardiac condition as part of his differential diagnosis and did question Mr. Taylor about symptoms that, if reported, would raise a concern about such a condition but, on every occasion, Mr. Taylor denied such symptoms. It is submitted that, in the absence of such reported symptoms, Mr. Taylor's presentation on each of the occasions in question was not consistent

with a cardiac cause and that Dr. Morrison's diagnosis and treatment of Mr. Taylor met the appropriate standard of care.

[43] The defence further submits that even if Dr. Morrison had undertaken investigations that led to the confirmation of CAD, the evidence does not support the conclusion that this would have resulted in the extension of Mr. Taylor's life. In particular, the defence submits that it is unlikely that a diagnosis of CAD would have resulted in surgical intervention. The defence contends that it is more likely that Mr. Taylor would have only received medical treatment for his condition, and given his history of non-compliance with lifestyle modification advice and encouragement from Dr. Morrison, it is unlikely that such treatment would have extended his life beyond July 1998.

Did Dr. Morrison Fail To Consider A Cardiac Cause For Mr. Taylor's Presentations In September 1993 Or June 1998?

[44] It will be convenient to deal with these two time periods together because the relevant facts, and my analysis, are similar.

[45] I find that a reasonably prudent family physician should have considered a cardiac explanation for Mr. Taylor's presentation in September 1993, and in June 1998, and that a failure to do so constituted a breach of the standard of care. All of the medical experts were in agreement on this issue. Indeed, Dr. Morrison admitted that, on September 21, 1993, he was required to consider a cardiac explanation, as part of his differential diagnosis for Mr. Taylor's presentation and, while he did not explicitly make a similar admission regarding the attendance in June 1998, I find that to be the effect of his evidence.

[46] Dr. Morrison admitted that, apart from the May 7, 1996 visit, he had no independent recollection of what transpired on any of Mr. Taylor's visits. His evidence was based on his standard practice and his records. Dr. Morrison admits he did not record a cardiac condition as part of his differential diagnosis on the chart at any time. The only diagnosis noted in Mr. Taylor's chart on September 21, 1993 is "HH/GERD". Yet he testified that his differential diagnosis on September 21, 1993 "would have been" abdominal, heart, chest, or musculoskeletal. I interpret this to mean that he had no recollection of what his differential diagnosis actually was on this occasion, but, according to his standard practice, this is what it would have been when a patient like Mr. Taylor's presents with symptoms and history as charted by his nurse.

[47] Dr. Morrison also relied on the fact that the chart noted that he had Mr. Taylor come back on September 29, 1993. He testified that this "most notably" indicated that he considered a potential cardiac explanation on September 21, 1993, because his standard practice was to have patients who complained of GERD come back in one month's time. One of the reasons that he had Mr. Taylor return earlier was to evaluate his cardiac status. Yet he admitted that on September 29, 1993, he did not perform any physical examination, nor did he take Mr. Taylor's blood pressure or pulse or order any blood tests. When asked whether that was in keeping with his standard practice when he has a patient in to address cardiac health, he answered as follows:

A: You keep saying address cardiac health. Basically I wanted to have this man back to see whether he was responding to the treatment for GERD, which I thought it was. Clearly he was responding and I had at that point was reassured and had low concerns of cardiac issues and so I did not do an examination. That just reconfirms to me that I was more content with the way that he had responded to his treatment.

Q: Even though symptoms can wax and wane, even though people can present with concurrent conditions, you were so focused on GERD that you didn't even undertake a physical examination of your patient, right?

A: No, I was so happy for him that his symptoms had improved that I … did not think it was necessary to do a physical examination.

Q: You didn't even think it was necessary to ask him back?

A: Not at that point, no.

Q: You were convinced that it was GERD.

A: You can never be a hundred percent sure but I was at that point obviously content that it was GERD.

Q: Were you convinced?

A: You can never be a hundred percent convinced. I've learned that many years ago, you know, but common things or common and if he responded to the treatment, I was content that day that it was GERD and again I would have told him that day if your symptoms get worse then come back and see me but I did not give him a set appointment to come back that day. [Emphasis added.]

[48] Dr. Morrison also testified that the fact that the chart shows that he prescribed a lower dosage of Zantac indicates that Mr. Taylor was responding to the medication. Accepting that, his explanation for not doing any physical examination is difficult to accept. The GI series had come back as negative. Dr. Morrison admitted that a negative GI series most likely means that there is no hiatus hernia and, most of the time, that means there is no GERD. Yet the charted entry was "so, GERD still probable". He further admitted that a negative GI should have raised a higher degree of suspicion for a cardiac cause for Mr. Taylor's presentation, given his cardiac risk profile. In light of these admissions and in the absence of any note in the chart about his symptoms, Dr. Morrison's assertion that he performed no physical examination at all because of how "happy" he was with the improvement in Mr. Taylor's symptoms is simply not credible.

[49] I also find it significant that, although Dr. Morrison acknowledged that a positive family history for CAD is known to increase the likelihood of a patient suffering from that condition, he made no inquiry into Mr. Taylor's family history of heart disease.

[50] In my view, the absence of any physical examination or testing is more consistent with the conclusion that Dr. Morrison did not consider a cardiac cause for Mr. Taylor's presentation.

[51] In his examination-in-chief, Dr. Morrison testified that his differential diagnosis on June 1, 1998 "would be exactly the same as the differential diagnosis back in September of 1993". I interpret this in the same way as I did his testimony regarding the differential diagnosis on September 21, 1993. This is confirmed on cross-examination, where he admitted that he had no recollection of what occurred on June 1, 1998. When asked how he knew, in the absence of anything in his chart, that cardiac cause was part of his differential diagnosis, his answer was, "it would be my standard of practice to do so."

[52] In my view, the only thing that arguably supports Dr. Morrison's contention that he did consider a cardiac cause as part of his differential diagnosis in September 1993 is his testimony about his standard practice. I accept the defence's submission that evidence of standard practice, or invariable practice as it is sometime called, is often relied upon in professional negligence cases. It is therefore necessary for me consider its applicabity to this case.

Standard or Invariable Practice

[53] Evidence of practice, habit or custom may be admitted as circumstantial evidence of a fact in issue. As was stated by Phillimore L.J. in *Joy v. Phillips, Mills & Co Ltd*, [1916] 1 KB 849 at 854:

> there being no direct evidence, recourse must be had to circumstantial evidence, any evidence as to the habits and ordinary doings of the deceased which may contribute to the circumstances by throwing light upon the probable cause of death is admissible…

[54] The probative value of evidence of practice, habit or custom is the common sense inference that the person acted in accordance with his or her practice, habit or custom on the date in question:

> If a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that surely is evidence and possibly convincing evidence that he did it in that way on the day in question.[7]

[55] Like all circumstantial evidence, the value of evidence of practice lies in the inferences that can reasonably be drawn from it. The inferences that can reasonably be drawn depend on the regularity of the practice and all of the other evidence in the case, particularly other direct or circumstantial evidence that impacts on whether the practice was followed on the instance in question. As was stated by Wigmore in *Evidence in Trials at Common Law* (Toronto: Little, Brown and Co., 1983) at 1608-1609:

[7] *Belknap v. Meakes* (1989), 64 D.L.R. (4th) 452 at 465-466 (B.C.C.A.).

> [i]f we conceive [the evidence of habit] as involving an invariable regularity of action, there can be no doubt that this fixed sequence of acts tends strongly to show the occurrence of a given instance. But in the ordinary affairs of life, a habit or custom seldom has such an invariable regularity. Hence, it is easy to see why in a given instance something that may be loosely called habit or custom should be rejected because it may not in fact have sufficient regularity to make it probable that it would be carried out in every instance or in most instances. Whether or not sufficient regularity exists must depend largely on the circumstances of each case.

[56] In the present case, the evidence is replete with instances where, on Dr. Morrison's own admission, he failed to follow his standard practice in Mr. Taylor's case. Some examples are the following:

- He acknowledged that it was part of his standard practice to comply with the obligation to chart important advice to the patient. However, he stated that, on May 6, 1996, he gave Mr. Taylor extensive advice about management of his diabetic condition but made no note of it in his chart.

- He admits that it was part of his standard practice to chart important history received from the patient that would guide him in his plan of medical management. He admits that on June 29, 1998 he took a history from Mr. Taylor that would have helped him in his plan of medical management but that he did not record it in the chart. Quite candidly he admitted that it was a deviation from his standard practice.

- In examination-in-chief, he stated that, on September 21, 1993, he would have asked Mr. Taylor many detailed questions to assist him in coming to his diagnosis. For example he would ask how he was feeling and ask him to describe the location of the pain and whether he felt it when performing certain functions such as walking and other forms of exertion. On cross-examination, he conceded that he really doesn't know whether he asked the questions that he mentioned in examination-in-chief and further admitted that he didn't know whether they would be part of his standard practice.

- He testified that, in accordance with his standard practice, on September 29, 1993, he would have asked questions similar to those that he would have on September 21, 1993, concerning the nature of the pain, although perhaps not as in much detail. Dr. Morrison based his decision not to carry on any further investigation of a cardiac cause on the fact that Mr. Taylor must have told him that he wasn't suffering anymore chest pain or that the Axid had resolved all of his chest pain. This would have been an important bit of medical history, which, according to Dr. Morrison's standard practice should have been recorded in the chart, however, it was not.

[57] I am not satisfied that what Dr. Morrison described as his standard practice is characterized by the requisite "invariable regularity of action" so as to provide an evidentiary basis for a finding that he considered a cardiac cause for Mr. Taylor's presentation. Indeed, it seems to me that, in this case, Dr. Morrison's standard practice was more honored in its breach than in its observance.

[58] I therefore find it more likely than not, that Dr. Morrison failed to consider a cardiac cause for Mr. Taylor's presentation in September 1993 and June 1998 and, thus, breached the appropriate standard of care.

[59] In the event that I am found to have erred in this finding, I will consider the plaintiff's alternative submission.

If Dr. Morrison Did Consider A Cardiac Cause In September 1993 and June 1998, Did He Breach The Standard Of Care By Failing To Carry Out Appropriate Investigations To Rule Out A Cardiac Cause?

[60] All of the plaintiffs' experts testified that Dr. Morrison breached the standard of care by failing to do any further tests to exclude the possibility of a cardiac cause for Mr. Taylor's presentation.

[61] The defence submits that the plaintiffs' experts were all substantially undermined on cross-examination and rendered opinions without a complete picture as to the facts of the case and on incorrect assumptions, whereas Dr. Stewart made it clear that Dr. Morrison met the standard of care in every respect and was not impeached on his cross-examination.

[62] The defence also points out that all of the plaintiffs' experts were provided with inadmissible materials emanating from proceeding taken against Dr. Morrison at the College of Physicians and Surgeons of Ontario (CPSO) and Drs. Brankston and Melvin made specific reference to those materials in their reports. Drs. Schwartz and Fitchett were provided the material, reviewed it and were advised by plaintiffs' counsel to indicate that they had not relied upon the inadmissible evidence in coming to their opinion. The defence submits that since it is impossible to assess the impact that such inadmissible evidence may have had on the opinions of the plaintiffs' experts, their evidence should be given less weight than that of Dr. Stewart.

[63] Since Dr. Stewart was the only expert witness called by the defence, it is necessary for me to carefully consider both the content of his evidence and the manner in which it was given.

[64] Mr. Mandel, on behalf of the plaintiffs, objected to Dr. Stewart being permitted to express an opinion on Dr. Morrison's standard of care in September 1993, on the grounds that this was not mentioned in Dr. Stewart's report filed pursuant to subrule 53.03(3) of the *Rules of Civil Procedure*. He submitted that the report dealt only with the issue of standard of care in 1998 and cited the concluding sentence of the report, which reads "[g]iven this background [it] is

my opinion that Dr. Morrison met the standard of care as it existed in 1998." I felt there was considerable merit in Mr. Mandel's submission, however I permitted Dr. Stewart to testify on this issue because I found there was no prejudice to the plaintiffs, which could not be compensated for by way of costs or an adjournment. Mr. Mandel did not seek an adjournment.

[65] However, I found Dr. Stewart's efforts to assert that he did in fact address the issue of the standard of care in 1993 in his report to be totally unconvincing. He testified that, on page 2 of his report, he had expressed the opinion that Dr. Morrison's investigations were appropriate for Mr. Taylor's presentation. In fact, what he had written was that appropriate investigations were ordered to explore the possibility of the working diagnosis of hiatus hernia or GERD. The distinction is important. Dr. Stewart acknowledged that Mr. Taylor's presentation on September 21, 1993 required a prudent family physician to consider a cardiac cause as part of his differential diagnosis. There is no dispute that Dr. Morrison's investigations were appropriate for HH /GERD. The question is, however, whether they were appropriate for the cardiac aspect of his differential diagnosis.

[66] Dr. Stewart also testified that he was able to express the opinion that Dr. Morrison met the standard of care solely on the basis of the information in Mr. Taylor's chart on the dates in question. In my view, this statement significantly undermines the credibility of Dr. Stewart on this issue, since Dr. Morrison himself admitted that, on the basis of his charted information alone, he could not have excluded a cardiac explanation.

[67] Moreover, I find that Dr. Stewart's manner of testifying was less than satisfactory. I found him to be non-responsive in many of his answers and indeed answered questions that were not put. He also exhibited a reluctance to admit facts that were self-evident.

[68] An example of the latter is when he was asked on cross-examination, whether it was true that the greater the risk of a potentially ominous cardiac condition, the greater the obligation on the physician to rule out such a condition. It was not until numerous rephrasings of the question, and after intervention from the bench, that he finally admitted what, to me, seemed obvious.

[69] An example of the former is when he was asked if Mr. Taylor's 1993 chest pain were anginal in nature, would that lead one to conclude that it was caused by CAD of a long-standing nature. Dr. Stewart insisted on going into a long recitation about the different understanding that one has at the present time compared to in 1993, although he ultimately admitted when questioned from the bench that CAD is progressive and does in fact progress for a number of years before it becomes recognizable by way of symptoms.

[70] I do not agree with the defendant's submissions with regard to the plaintiffs' experts being provided with CPSO materials. Firstly, I was never apprised of the nature of the material in question so I am unable to assess whether that material had the potential for affecting the witnesses' opinions on the issues before me. Secondly, all of the witnesses testified that they did not rely on anything in the CPSO materials in arriving at their opinions. I have no reason to doubt this assertion.

[71] I find that the opinions of the plaintiffs' experts are amply supported by the evidence before me, most of which was not disputed by Dr. Morrison. Moreover, I find that these opinions accord with good common sense.

[72] On September 21, 1993, Mr. Taylor presented at Dr. Morrison's office with complaints that included a three-month history of recurrent episodic chest pain associated with walking too fast, mid-chest burning with lifting or eating fried foods, and pain with reaching.

[73] Mr. Taylor's presentation was consistent with a diagnosis of CAD, angina and other cardiac conditions. Hiatus Hernia/GERD is the only differential diagnosis recorded by Dr. Morrison.

[74] Dr. Morrison's standard practice would have been to take a history, enquiring into the cardiac symptomolagy, and to chart the history that he obtained. Dr. Morrison did not chart any history in his September 21, 1993 entry.

[75] In September 1993, Dr. Morrison knew that all of the following characteristics increased Mr. Taylor's risk of suffering from CAD:

- he was of male gender;
- he was over the age of 50 years;
- he was a smoker;
- he was obese;
- the most recent and available lab work confirmed that his cholesterol levels were abnormal;
- he was a borderline diabetic (with elevated blood sugars and a positive family history of diabetes);
- he had a sedentary lifestyle; and
- he was Native Canadian.

[76] Dr. Morrison did not order an Electrocardiogram (ECG), a non-invasive readily available test. Nor did he perform updated lab work. Dr. Morrison knew that the previous blood study undertaken in March of 1989 was abnormal. Dr. Morrison had no explanation for why he did not obtain an updated blood study prior to the summer of 1996.

[77] Dr. Morrison agreed with statements from authoritative texts that a physician should always undertake an ECG when addressing a patient with recurrent episodic chest pain, and that an ECG is an appropriate baseline test for all patients with suspected cardiovascular conditions and those at high risk for developing such conditions.

[78] Dr. Morrison did not consider a referral to a cardiologist. He could have done so and a cardiologist was readily available.

[79] Dr. Morrison did not order any of the above-noted testing or make any referrals because he felt that Hiatus Hernia/GERD was the diagnosis that was most probable.

[80] On September 29, 1993, Dr. Morrison knew that the G.I. series was negative, a fact that he admits should have heightened his suspicion of a cardiac cause, yet he did nothing by way of examinations or testing to rule out such a cause.

[81] On June 1, 1998, Mr. Taylor was approximately five years older than he was in September 1993, now a confirmed diabetic, and therefore at greater risk for CAD.

[82] Dr. Morrison's secretary recorded a history of "*heartburn ++ again*". Dr. Morrison did not investigate a cardiac cause for Mr. Taylor's complaints, although he testified that, according to his standard practice, he would have considered it as part of his differential diagnosis.

[83] Dr. Morrison did not order a G.I. series, as he had in 1993. Instead, Dr. Morrison prescribed Axid, an antacid. Dr. Morrison did not book a return appointment in one week, as he had in September 1993. Rather, a return appointment was booked for one month later.

[84] Mr. Taylor returned to Dr. Morrison on June 29, 1998, as instructed. His history was taken and recorded by Dr. Morrison's secretary. Mr. Taylor was prescribed more Axid. No investigation was made of any cardiac cause. There is nothing in Dr. Morrison's chart that indicates that the complaints could be cardiac in nature. Dr. Morrison's chart does not include any reference that he advised Mr. Taylor to return for a follow-up or go to hospital, should he suffer any changes in symptomatology.

[85] I find that Dr. Morrison breached the appropriate standard of care in September 1993 and June 1998 by failing to carry out appropriate investigations to rule out a cardiac cause for Mr. Taylor's presentation.

Did Dr. Morrison breach the standard of care in May 1996 when he made a diagnosis diabetes, by failing to investigate potential cardiac disease as part of an end organ disease investigation?

[86] The plaintiffs' experts opined that, in May 1996, patients diagnosed with diabetes mellitus should undergo a full examination to rule out end organ disease, including cardiac disease, and that the failure of Dr. Morrison to conduct such an investigation amounted to a breach of the standard of care.

[87] Dr. Stewart testified that most of the evidence regarding the relationship between diabetes and cardiovascular disease has been published since 1998. Therefore, while by today's standards he would have expected a more aggressive treatment of a diabetic patient, it was not the established standard of care prior to that time.

[88] I have already indicated my reasons for generally preferring the evidence of the plaintiffs' experts to that of Dr. Stewart. I also find that there was ample medical learning in 1996 that indicated that diabetics are at greater risk of developing CAD.

[89] After May 7, 1996, Dr. Morrison knew that, in addition to all the risk factors Mr. Taylor had for CAD in 1993, he was three years older and a confirmed diabetic, which Dr. Morrison admitted, increased the risk of CAD.

[90] I therefore find that Dr. Morrison breached the standard of care by failing to investigate potential cardiac disease as part of an end organ disease investigation.

Was There A Causal Relationship Between Dr. Morrison's Breaches Of The Standard Of Care And Mr. Taylor's Death In July 1998?

[91] In addressing this issue, I am aware that it is not sufficient for a plaintiff to prove that adequate diagnosis and treatment would have afforded him a mere chance of avoiding an unfavourable outcome, unless that chance passes the threshold of "more likely than not". Putting it another way, if, on a balance of probabilities, the plaintiff fails to prove that the unfavourable outcome would have been avoided, causation is not established. See *Cotrelle v. Gerrard* (2003), 67 O.R. (3d) 737 (C.A.), leave to appeal refused, [2003] S.C.C.A. No. 549.

[92] All of the plaintiffs' experts testified that, had Dr. Morrison undertaken a proper investigation of a cardiac cause for Mr. Taylor's presentation in September 1993 and June 1998, it is unlikely that Mr. Taylor would have died on July 8, 1998. They also testified that, had Dr. Morrison undertaken investigations to rule out cardiac disease as part of an end organ disease investigation, his underlying CAD would have been discovered. That would have resulted in the appropriate referrals and treatment and his death in July 1998 would have been avoided.

[93] There was no evidence called by the defence to the contrary.

[94] The defence contends that the evidence does not establish that Mr. Taylor was suffering from symptomatic CAD in 1993 or in 1996. The defence points out that none of the experts testified that the 1992 or 1996 ECGs were diagnostic of CAD. Furthermore, Mr. Taylor, in his preoperative examinations and questionnaires in 1992 and 1996, made no mention of chest pain or cardiac problems and Dr. Morrison's clinical notes record no chest complaints between September 1993 and June 1998. Thus, the defence argues that an ECG or other investigations would not have revealed the presence of CAD and there would have been no reason to refer Mr. Taylor to a cardiologist.

[95] Three of the plaintiffs' experts agreed that it would be highly unlikely for a patient to have symptoms of severe CAD in 1993 that would not re-emerge until 1998. Dr. Fitchett, however, did not think that it was uncommon for a patient with Mr. Taylor's degree of CAD to be asymptomatic for that period of time.

[96] Mrs. Taylor testified that she believed that Mr. Taylor's chest complaints began in the "early 1990's" but she only spicifcally remembers the incident that led to his visit to Dr. Morrison in September 1993, where she and Mr. Taylor were carrying some catering equipment up a hill and he hunched over in pain. She testified that, while the Zantac prescribed in September 1993 helped somewhat, Mr. Taylor's chest symptoms persisted "in the background". By the spring of 1998, Mr. Taylor's pain was waking him at night and interfered with some of

his activities of daily living, such as gardening. I found Mrs. Taylor to be a credible witness and I have no hesitation in accepting her evidence in this regard. Moreover, her evidence is consistent with the autopsy findings and the evidence that CAD progresses slowly, over a long period of time. Of course this raises the question why Mr. Taylor made no mention of his symptoms in the preoperative examination and questionnaire in 1996 or in any of his visits between September 1993 and June 1998.

[97] I agree that most people experiencing the symptoms described by Mrs. Taylor would likely have mentioned it to their family physician or in the course of a preoperative examination and questionnaire. However, I do not agree with the defence contention that it follows that Mr. Taylor did not have these symptoms. I accept Mrs. Taylor's evidence that both she and Mr. Taylor believed, as a result of what Dr. Morrison had said in September 1993 and in June 1998, that Mr. Taylor's symptoms were related to his heartburn and could be alleviated by antacids and proper diet. Given that Mr. Taylor was a person who was very taciturn by nature, I find that this accounts for the apparent absence of any chest complaints between September 1993 and June 1998.

[98] I find that Mr. Taylor was likely suffering from symptomatic CAD from September 1993 on and, had an ECG been performed, it would have produced results similar to the ECGs that were taken in 1992 and 1996 respectively. Dr. Morrison acknowledged that, had he requisitioned an ECG in September 1993 and the result was as abnormal as the 1992 ECG, he would have referred Mr. Taylor to a cardiologist. I am therefore satisfied that, had an ECG been performed, a referral to a cardiologist would have been made and Mr. Taylor would have received treatment and his death in July 1998 would have likely been avoided. My reasons for these findings will be amplified when I address the question of Mr. Taylor's life expectancy.

[99] The defence does not dispute that, in June 1998, Mr. Taylor was suffering from severe CAD. I am satisfied that, had Dr. Morrison undertaken appropriate investigations in June 1998 and advised Mr. Taylor of the fact that he was suffering from CAD, his death would have likely have been avoided on July 8, 1998.

[100] For the same reasoning, I find that, had Dr. Morrison not breached the standard of care by failing to consider a cardiac cause for Mr. Taylor's presentation in September 1993 and June 1998, his death in July 1998 would have been avoided.

Life Expectancy

[101] As I have stated, it is not necessary for me assess damages because the parties have agreed upon a method of calculating the quantum of damages dependent upon the my findings as to the life expectancy of Mr. Taylor had there been no breach of the standard of care by Dr. Morrison. The agreement sets out the quantum of damages for each additional year Mr. Taylor would have lived. As I have found Dr. Morrison negligent in 1993, I will focus on Mr. Taylor's life expectancy had he received appropriate treatment as of that date forward. However, in the event that I am found to be wrong in finding that Dr. Morrison was negligent in 1993, I will also determine Mr. Taylor's life expectancy had I found that Dr. Morrison was negligent only in 1996 or, in the further alternative, 1998.

[102] The first step is to determine the likely nature of Mr. Taylor's CAD at the relevant time periods. This would have strongly influenced the type of treatment that would have been recommended. The experts agreed that surgery would only have been recommended if Mr. Taylor's CAD was sufficiently severe. Otherwise, he likely would have been treated medically. It was not disputed that surgical intervention leads to a longer life expectancy the medical intervention. Next, I must consider whether Mr. Taylor would have complied with the recommended treatment plan.

[103] In addressing this issue, it is important to note the distinction between past facts and future facts. Past facts are facts that are found to have actually occurred. This finding is made on the balance of probabilities and, once a court determines it is more likely than not, the fact or the event is considered as if it is a certainty.

[104] The determination of future facts, however, is more speculative. Finding future facts requires the court "to gaze more deeply into the crystal ball"[8] and foresee what would have occurred to the plaintiff in the absence of the defendant's wrong or what will happen in the future because of it. The function of the court in assessing damages for future pecuniary loss has been aptly described by the House of Lords in *Mallett v. McMonagle*, [1970] A.C. 166, and adopted by the Supreme Court of Canada in *Naylor Group Inc. v. Ellis-Don Construction Limited* (2001), 204 D.L.R. (4th) 513 at 540:

> In determining what did happen in the past a court decides on the balance of probabilities. Anything that is more probable than not it treats as certain. But in assessing damages, which will depend upon its view as to what will happen in the future or would have happened in the future if something had not happened in the past, the court must make an estimate as to what are the chances that a particular thing will or would have happened and reflect those chances, whether there are more or less than even in the amount of damages which it awards.

[105] In *Athey v. Leonati*, [1996] 3 S.C.R. 458, Major J., writing for the unanimous Supreme Court, held, at para. 27, that "a future or hypothetical possibility will be taken into consideration as long as it is a real and substantial possibility and not mere speculation."

[106] Thus, the nature Mr. Taylor's heart condition in 1993, 1996 and 1998 is a past fact and must be determined on the balance of probabilities. However, the recommended course of treatment, its effect on his life expectancy and deductions for the possibility that he would not adhere to the recommended course of treatment are future facts, and must be assessed on reasonable possibilities. The greater and more substantial the possibility, the more weight the factor is given.

What Was The Nature Of Mr. Taylor's Heart Condition in 1993?

[107] An autopsy performed on Mr. Taylor after his death found the following narrowing of his coronary vessels, 90% in the right vessel, 40% in the left vessel, 75% in the anterior

[8] *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229 at 251.

descending artery and 50% in the circumflex artery. There was evidence of infarction[9], within 24-48 hours from the time of death. Patches of fibrosis consistent with old anoxic damage[10] were also found.

[108] Based upon the autopsy findings, Dr. Fitchett's evidence was that, at time of his death, Mr. Taylor had severe triple vessel disease ("TVD"). He testified that the CAD present in 1993 would likely have been similar to that found on autopsy, as CAD progresses slowly, over a long period of time. In cross-examination, he conceded that the degree of CAD in 1993 would have likely been less than that found on autopsy, because CAD is a progressive disease.

[109] Dr. Fitchett also testified that it was highly likely that Mr. Taylor was suffering from left main equivalent disease ("LMED") at the time of death. However, he admitted that because of the ambiguities in the autopsy findings, it was impossible to be certain of this.

[110] Dr. Melvin was of the opinion that Mr. Taylor had extensive TVD at the time of death. He was also of the opinion that, in 1993, there would have been significant CAD. In cross-examination, he admitted that quantifying the degree of CAD in 1993 is speculative and it is unlikely that the degree of CAD in 1993 was as severe as found on autopsy.

[111] Dr. Melvin could not say whether Mr. Taylor suffered from LMED; although the autopsy estimates did not reveal a textbook definition, it was "almost" LMED. In cross-examination, he appeared to acknowledge that he could not say if Mr. Taylor had left main disease or left main equivalent disease.

[112] In my opinion, the weight of the evidence supports the conclusion that Mr. Taylor suffered from severe TVD in 1993. The extent of which would have been less than found on autopsy, but not significantly so.

[113] In considering whether Mr. Taylor was suffering from LMED in 1993, it is significant that neither Dr. Fitchett nor Dr. Melvin was certain that the autopsy findings demonstrated that Mr. Taylor was suffering from left main equivalent disease at time of his death. Given the progressive nature of CAD, and that none of the experts gave an opinion as to whether Mr. Taylor was suffering from LMED in 1993, in my opinion, it is less than likely that Mr. Taylor was suffering from LMED in 1993.

What Course Of Treatment Would Have Been Recommended?

[114] Dr. Fitchett testified that, if Mr. Taylor had severe TVD in 1993, he would have been recommended to undergo a coronary by-pass surgery. It was highly unlikely that angioplasty would have been considered because of the severity of Mr. Taylor's CAD and that he was a borderline diabetic, as diabetics don't do well with angioplasty.

[115] Dr. Fitchett also testified that a cardiologist would have recommended that Mr. Taylor lose weight, exercise and modify his diet. He may have referred him to a dietician, if available.

[9] Infarction is the damage that occurs in an organ when there is a loss of blood supply.
[10] Damage due to a loss of oxygen.

This would help control his diabetes and the risks that flow from it. A cardiologist would have also recommended that Mr. Taylor quit smoking and would have sent him to a cardiac rehab clinic that had a smoking cessation program attached to it or had the family doctor refer him to a smoking cessation program. In addition, nicotine treatment such as nicotine gum would have been recommended. Cholesterol lowering medications – such as statins – would have been prescribed. While he acknowledged that, in 1993, there was no study that stated that statins would lower cholesterol, there were available studies showing that cholesterol-lowering agents prevented the progression of CAD. Also, in 1994, the 4S study showed that statins reduced four-year mortality and heart attacks in patients with CHD.

[116] Dr. Melvin agreed with Dr. Fitchett, in that if Mr. Taylor had TVD, he would be recommended to undergo by-pass surgery. He also stated Mr. Taylor's rural location would increase the likelihood of a recommendation for by-pass surgery as opposed to only medical intervention, as patients undergoing only medical intervention must be closely monitored. This is not as easily done where a patient is not close to a hospital or cardiologist. Therefore, a definitive therapy such as by-pass surgery was more likely to be recommended.

[117] Dr. Melvin also stated that medical efforts would be made have Mr. Taylor lower his blood pressure, treat his high cholesterol with medication and diet, and to get him to stop smoking. In Dr. Melvin's opinion, it was likely that cholesterol-lowering medication would have been recommended in 1993, as by the time the 4S trial was published in 1994, statin therapy had already become popular in the cardiology community.

[118] I am satisfied that, if the appropriate medical investigations were undertaken, Mr. Taylor would have been recommended to undergo by-pass surgery, lose weight, modify his diet, exercise and quit smoking. I am satisfied that some form of cholesterol lowering medication would have been probably have been prescribed in 1993, and almost certainly after the publication of the 4S study in 1994.

Life Expectancy If The Recommended Course Of Treatment Was Followed

[119] Dr. Fitchett was of the opinion that by-pass surgery alone would have extended Mr. Taylor's life by 7 years. He based his opinion on his many years of clinical cardiological experience and the findings in the CASS Registry study. According to the CASS study, patients treated surgically lived an average of 13.1 years from the date of diagnosis. Patients treated medically, with medication and lifestyle modification but without surgery, lived an average of 6.1 years from the date of diagnosis. Dr. Fitchett appears to have subtracted the the life expectancy benefit of medical treatment from the life expectancy benefit of surgical treatment to arrive at a net benefit to life expectancy of by-pass surgery of 7 years (13.1 years – 6.1 years = 7 years). However, in cross-examination, Dr. Fitchett acknowledged that the CASS Registry data he relied on was based on patients with LMED and, if Mr. Taylor did not have LMED, the CASS data would not be applicable. He also conceded that the CASS study needed to be discounted for the fact that Mr. Taylor was a diabetic and of aboriginal descent. He disagreed that 50% was an appropriate reduction and thought that a reduction of 10-15% was likely correct.

[120] Dr. Fitchett also relied on the Framingham study. According to Framingham, and using Mr. Taylor's 1989 lipid levels, in 1993, Mr. Taylor would have had a 22% chance of developing CHD within 10 years. An average male of his age would have had a 14% risk of developing CHD within 10 years. However, it must be noted that the risk of CHD is not solely the risk of death. CHD includes non-fatal MI, angina and coronary death. According to Dr. Fitchett, on the basis of the HOPE study, which showed a 16% 5 year CAD event rate, 40% of the events are coronary deaths. Appling a 40% coronary death rate to Mr. Taylor's Framingham score, he estimated that Mr. Taylor's ten-year risk of death from CHD is approximately 9-10%.

[121] Dr. Fitchett acknowledged that Framingham underestimates Mr. Taylor's risk of CHD because it does not take into account his Aboriginal ancestry. According to Dr. Fitchett, people of Aboriginal ancestry are at greater risk of developing CHD, primarily because they are at greater risk of developing diabetes. In his opinion, diabetes would increase the risk factor of developing CHD by 10-15%.

[122] However, I accept the defence's argument that Framingham is of limited assistance in determining life expectancy. Framingham is a calculation of the risk of developing CHD by a person that has not been diagnosed with the actual disease. However, I have found that Mr. Taylor had CAD in 1993 that was symptomatic. Therefore, Mr. Taylor's personal risk of CHD in 1993 was substantially higher than the risk based on the Framingham formula.

[123] Dr. Fitchett's opinion was that with appropriate smoking cessation efforts, Mr. Taylor was likely to live up to a further four years beyond the date of his death. Based on the 1994 study, filed as exhibit 11, his evidence was that men between the ages of 50 to 59 who stop smoking will, on average, live 3.75 years longer. However, this study dealt the increase in life expectancy for patients who were free of CHD.

[124] Dr. Fitchett's evidence was that based on recent studies, statin therapy extends mean life expectancy by six months to 1 year.

[125] Considering all of these factors, Dr. Fitchett concluded that with surgical intervention and cardiac risk reduction from medical therapy, Mr. Taylor was likely to live a further seven to eleven years beyond the date of death.

[126] In cross-examination, Dr. Fitchett acknowledged that risk modification was an implicit part of the treatment in all of the studies. Thus, the benefits of by-pass surgery also included some benefits of risk modification resulting from medical treatment. He also agreed with a quote from a text by Dr. Braunwald, filed as exhibit 10, which stated that patients with TVD who were initially treated medically have an 18% chance of living 15 years. In my opinion, Braunwald would be very helpful if the issue was whether Mr. Taylor was likely to have lived 15 years had he initially been treated medically. However, I was not provided with any evidence of how to convert the percentage chance of living 15 years into an estimate of life expectancy. Moreover, I have found that Mr. Taylor would likely have been treated surgically.

[127] Dr. Melvin's opinion was that with surgical intervention and cardiac risk reduction from medical therapy, Mr. Taylor would likely have lived a further twelve to fifteen years beyond the

date of his death. His conclusion was based upon his clinical cardiological experience, the life expectancy table from the Canadian census data, the expected post surgery survival rate, the absence of further complications such as heart failure and sudden death and the beneficial effects of drug therapy. He did recognize, however, that Mr. Taylor was likely to die earlier than the average Canadian male because of his increased risk factors.

[128] In cross-examination, Dr. Melvin agreed with a quote from Braunwald's text, that the five-year mortality rate is approximately 15% for symptomatic patients or survivors of a heart attack where the three major vessels are severely narrowed. He also accepted the quote from Braunwald, that the 15-year survival rate was 18% for patients with TVD who were initially treated medically. In addition to the number of vessels involved, the severity of obstruction is also important. Prognosis in patients with 50 to 75% narrowing is better than in those with more than 75% narrowing. He also acknowledged that while the annual mortality rate is only 4% for patients with TVD and good exercise capacity, Mr. Taylor would likely have had poor exercise capacity, which is a negative prognostic factor. If Mr. Taylor's ejection fraction[11] was poor, then his 4-year survival rate is about 50%.

[129] There is also some question as to whether Mr. Taylor would follow certain aspects of the recommended course of treatment.

[130] I have no difficulty in finding that had it been recommended, Mr. Taylor would have undergone by-pass surgery. It is significant that Mr. Taylor promptly underwent every surgery that had been recommended to him in the 22 years that he was a patient of Dr. Morrison, even when the anticipated consequences of not following his doctor's recommendation would have been far less drastic that those that would follow from a failure to aggressively deal with his CAD.

[131] I similarly find that had it been recommended, he would have taken cholesterol-lowering medication. He took all of the medication for GERD, as prescribed by Dr. Morrison. He also seemed to have been compliant in the control of blood sugars, which likely required regular testing and injections of insulin.

[132] It was strongly argued on behalf of the defendant that Mr. Taylor would not have successfully complied with recommendations with respect to smoking cessation, weight loss and diet and lifestyle modification. Mr. Taylor was a smoker who likely started smoking in his teens and smoked until his death. On average, He smoked one and a half packages a day. Mr. Taylor did reduce his smoking in response to advice from Dr. Morrison to decrease symptoms of GERD. Mrs. Taylor testified that when Mr. Taylor was diagnosed with diabetes in 1996, he attempted to quit smoking but, despite the advice and encouragement of family members and Dr. Morrison, he only succeeded in reducing his smoking to half a package a day. Dr. Fitchett's testified that some of his patients who have previously failed to stop smoking became more compliant when diagnosed with a life threatening disease. Also, Mr. Taylor may have had the support of a smoking cessation clinic and nicotine treatment. In my opinion, it is likely that Mr. Taylor would have reduced his smoking when diagnosed with CAD, but given his ingrained

[11] The percentage of the amount of blood pumped out of the left ventricle on contraction.

addiction and his failure to quit entirely when diagnosed with diabetes, it is less than likely that he would have quit altogether.

[133] I find that it is likely that Mr. Taylor would have lost some weight, exercised and modified his diet, but to not the extent medically recommended. In 1989, Dr. Legault, recommended to Mr. Taylor that he lose weight. Mr. Taylor made efforts to lose weight in response to Dr. Legault's advice and, according to the clinical notes, did lose 20 lbs. However, Mrs. Taylor's evidence was that although several people, including Dr. Morrison, had told him to lose weight, he was unable to do so on a sustained basis. Mr. Taylor was not attentive to some aspects of his health. His poor dental habits resulted in the surgical removal of his teeth. Mrs. Taylor prepared foods in accordance with a diabetic diet, however, it appears that Mr. Taylor did not follow this diet. However, it appears that he did modify his diet and lifestyle sufficiently to keep his blood sugars under control. Also, Mr. Taylor had a relatively sedentary lifestyle and did not exercise very much. After her heart attack, Mrs. Taylor encouraged him to walk with her but he was unable to keep up to her pace. Taking into account all of the evidence, I find that it is likely that Mr. Taylor would have taken some steps to manage his risk factors if he had been diagnosed with CAD and advised of the life threatening consequences of a failure to do so. However, I am not satisfied that his efforts would not have been successful to the extent medically recommended.

Mr. Taylor's Life Expectancy Had He Been Diagnosed in 1993

[134] In my opinion, the evidence of life expectancy is far from clear. However, it is noteworthy that the defendant did not lead any evidence to contradict the plaintiffs' experts on this issue. Plaintiffs' counsel suggested that I should draw an adverse inference for the defendant's failure to call evidence on this issue when the defendant's counsel had announced his intention to do so on the record. The defence contends that an adverse inference is not applicable because the onus is on the plaintiffs to prove their case. I am not prepared to draw an adverse inference in the circumstances of this case. Nonetheless, I am left with the expert evidence of the plaintiffs, which is uncontradicted apart from the testimony elicited in cross-examination, which while carried out with defence counsel's usual skill, did not, in my view, substantially undermine the substance of the experts' evidence on this issue.

[135] Both cardiologists opined that with by-pass surgery, medication and risk management, Mr. Taylor's life would have been extended: a further seven to eleven years beyond the date of death in Dr. Fitchett's opinion; and a further twelve to fifteen years beyond the date of death in Dr. Melvin's opinion. I acknowledge that, to some extent, Dr. Fitchett's opinion was based on somewhat enigmatic calculations from studies that do not directly apply to Mr. Taylor, and Dr. Melvin's evidence was equally problematic in that is was essentially based on the length of time an average person would live with an approximate reduction for Mr. Taylor's cardiac risk factors. Predicting life expectancy is a prime example of a court being required to gaze deeply into a crystal ball,[12] which, in this case, is far from clear. However, only the divine knows with certainty the length of a person's life, so it is perhaps not surprising that the evidence is not as

[12] *Andrews v. Grand & Toy Alberta Ltd., supra*, at 251.

pristine as one would have wished. The following quote from Jamie Cassels, *Remedies: The Law of Damages* (Toronto: Irwin Law, 2000) is apposite:

> Courts will not shirk the assessment of damages merely because the task is difficult or uncertain. Moreover, where the defendant has clearly committed a wrong and has injured the plaintiff, justice requires that the plaintiff should not be denied compensation for harm merely because the quantum of that harm is difficult to measure.
>
> …
> Thus, while the plaintiff should bring forward the best evidence possible to establish the extent of the loss, difficulties of proof will not bar the plaintiff's claim. Where the evidence establishes that an actual loss has been suffered, the court will not refuse to award damages merely because its extent cannot be exactly proved. The court must do its best on the available evidence to quantify the loss.

[136] Considering all the evidence as a whole, I am satisfied that had Mr. Taylor complied, to the extent I have found he would have, with the surgical and medical interventions recommended, it is probable that he would have lived another 5 years beyond the date of his death.

Mr. Taylor's Life Expectancy Had He Been Diagnosed in 1996

[137] As I have found that Mr. Taylor suffered from TVD in 1993 and given the progressive nature of CAD, I find that Mr. Taylor suffered from even more severe TVD in 1996. However, for the reasons given above, I am unable to find that Mr. Taylor was suffering from LMED in 1996.

[138] For the reasons as given above, I also find that Mr. Taylor would have been recommended to undergo by-pass surgery, lose weight, modify his diet, exercise and quit smoking. I am also satisfied that some form of cholesterol lowering medication would have been prescribed. I am also satisfied that Mr. Taylor's response to these recommendations would have been the same as in 1993.

[139] Dr. Fitchett's evidence was that the benefits of surgical intervention, medication and risk modification accrue from the date of diagnosis. Thus, he was of the opinion that even if Mr. Taylor was diagnosed with CAD in 1996, surgical intervention, medication and risk modification would have extended his life by 7 to 11 years from the date of death.

[140] Similarly, Dr. Melvin was of the opinion that Mr. Taylor's life could have been extended twelve to fifteen years regardless of when the diagnosis was made.

[141] In my opinion, both doctors' evidence in this regard is contrary to common sense. Given the progressive nature of CAD, the later the diagnosis, the more severe the patient's CAD is likely to be. While proper treatment may extend a patient's life, an increase in the severity of the patient's CAD prior to treatment must have some effect on the effect of that treatment on life

expectancy. Otherwise, we would have anomalous situation where the later diagnosis, the greater the life expectancy benefit of treatment.

[142] Considering all the evidence as a whole, I am satisfied that had Mr. Taylor complied, to the extent I have found he would have, with the surgical and medical interventions recommended, it is probable that he would have lived another 3 years beyond the date of his death.

Mr. Taylor's Life Expectancy Had He Been Diagnosed in 1998

[143] I find that it is more likely than not that by 1998, Mr. Taylor suffered from both TVD and LMED. While neither Dr. Fitchett nor Dr. Melvin was certain that Mr. Taylor suffered LMED in 1998, certainty is not the standard of proof. Dr. Fitchett's opinion was that it was highly likely that Mr. Taylor was suffering from LMED at the time of death. Dr. Melvin's opinion was that although the autopsy estimates did not reveal a textbook definition, Mr. Taylor "almost" suffered from LMED. I accept Dr. Fitchett's opinion that it was highly likely that Mr. Taylor was suffering from LMED and, given the proximity of the date of death to Dr. Morrison's negligence in 1998, I find that it is more likely than not that Mr. Taylor was suffering from LMED in 1998.

[144] Dr. Fitchett's evidence was that it is never too late to make diagnosis of CAD and administer appropriate treatment. If Mr. Taylor was aware that he suffered from a life threatening condition, he would not have waited as long as he did to go to the hospital and likely have gone as soon as symptoms began. The treatment available at a hospital in 1998 was thrombolytic therapy. If Mr. Taylor went to the hospital within 12 hours of the onset of symptoms, and presented with symptoms of an MI and an electrocardiogram indicated an elevated ST segment, as Dr. Fitchett expects he would have, it is highly likely that such therapy would have been administered. In Dr. Fitchett's opinion, thrombolytic therapy received within 6 hours of symptom onset prolongs life expectancy by 1-3 years.

[145] In Dr. Melvin's opinion, based on the autopsy findings Mr. Taylor's one-year prognosis was dismal.

[146] Had Mr. Taylor been told, in 1998, that he had severe TVD and LMED, I find that it is probable that he would have promptly gone to the hospital at the onset of his symptom and he would have been treated with the thrombolytic therapy described by Dr. Fitchett. Had that occurred, I find that it probable that Mr. Taylor's life would have been extended by one year.

Contributory Negligence

[147] Contributory negligence is "unreasonable conduct on the part of a victim which, along with the negligence of others, has in law contributed to the victim's own injuries."[13]

[13] Klar, *Tort Law*, 3d ed., (Toronto: Thomson Carswell, 2003), at 455-56. See also Picard, *Legal Liability of Doctors and Hospitals in Canada*, 3d ed., (Toronto: Carswell, 1996) at 283.

[148] The defence submits that, in the context of medical treatment by Dr. Morrison, Mr. Taylor as a reasonable patient owed a duty to himself provide relevant information to Dr. Morrison. If it is found that Dr. Morrison did breach the standard of care, Mr. Taylor's failure to report relevant symptoms contributed to Dr. Morrison's failure to properly diagnose Mr. Taylor's condition and the plaintiffs' damages should be reduced accordingly.

[149] The burden of establishing contributory negligence lies on the defendant. In the context of this case, the defendant must establish that:

1. Mr. Taylor had significant cardiac symptoms prior to the September 1993 or, in the alternative, the June 1998 visit;

2. that he acted unreasonably in failing to disclose the symptoms to Dr. Morrison; and

3. that had he disclosed his symptoms that Dr. Morrison would have diagnosed and investigated a cardiac cause for his presentation in 1996 and 1998 and his death in July 1998 would have been avoided.

[150] I am not persuaded that the defendant has satisfied this burden.

[151] This submission is not applicable to my finding that Dr. Morrison failed to consider a cardiac cause for Mr. Taylor's presentation in 1993 and 1998. Nor is it applicable to my alternative finding that he failed to carry out appropriate investigations to rule out a cardiac cause for Mr. Taylor's presentation in 1993, because there is no evidence that Mr. Taylor failed to report relevant symptoms on those dates. Even if he did have cardiac symptoms at the time of the 1992 pre-operative examination and questionnaire, and reported them, it is unlikely that Dr. Morrison would have seen these records. He testified that he did not routinely see the results of the ECGs taken pre-operatively and the pre-operative records were not part of his chart. Moreover, Dr. Morrison did not testify that, if he had known that there were chest complaints in 1992, his diagnosis in September 1993 would have been different.

[152] The only evidence before me about the nature of Mr. Taylor's symptomolagy, apart from what is recorded in his chart, is the testimony of Mrs. Taylor. I have already described in general terms her evidence on this issue and her explanation about why there were no complaints made to Dr. Morrison. When Mr. Taylor did complain of chest problems in September 1993, Dr. Morrison told him that he had stomach problems that could be controlled by diet and medication. Until the spring of 1998, the symptoms were in the background. Mr. Taylor trusted and relied on Dr. Morrison. Dr. Morrison knew that Mr. Taylor was a "man of few words" who was less than forthcoming with information. There was no evidence that Dr. Morrison made any special efforts to elicit information from him.

[153] Under the circumstances, I am not prepared to find that Mr. Taylor acted unreasonably up to the spring of 1998 in failing to disclose the symptoms to Dr. Morrison. Nor am I satisfied that, had he made disclosure, Dr. Morrison's diagnosis would have been different.

[154] However, I find that a reasonable person in Mr. Taylor's circumstances would have complained about the symptoms that developed in the spring of 1998. It is not clear, however, how long these symptoms existed before the June 1, 1998 visit. In light of the fact that on that date, Mr. Taylor's history was taken by Dr. Morrison's secretary, who had no expertise in taking patient histories, I am not prepared to find that Mr. Taylor did not disclose his symptoms on that date.

Conclusion

[155] For the reasons stated, I find that the plaintiffs are entitled to an award of damages against the defendant in an amount calculated in accordance with the agreed upon formula, together with prejudgment interest in accordance with the *Courts of Justice Act*. If the parties cannot agree on the issue of costs I may be spoken to.

[156] I wish to express my gratitude to counsel for their excellent written and oral submissions which were of great assistance to me.

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H. SPIEGEL J.

Released: July 19, 2006

COURT FILE NO.: 99-CV-172328
DATE: 20060719

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

Gail Taylor, Stanford Taylor, Andrew Taylor, Catherine Taylor, Anthony Taylor, Glenn Millar and Rod Begg

Plaintiffs

- and –

Robert Morrison, Vincenzo Arcieri-Piersanti, Jane Doe and Peterborough Civic Hospital

Defendants

REASONS FOR JUDGMENT

H. Spiegel J.

Released: July 19, 2006