SUPREME COURT OF NOVA SCOTIA
Citation: *MacNeil v. D*r. *Kajetanowicz*, 2023 NSSC 333

Date: 20230620
Docket: 416222
Registry: Sydney

Between:

Alexander MacNeil, by his Litigation Guardian, Tania Bond-MacNeil

Plaintiff

v.

Dr. Andrzej Kajetanowicz

Defendant

Judge:	The Honourable Justice Patrick J. Murray
Heard:	March 22, 23, 24, 25, 28, 29, 30, 31 and April 1, 4, 5, 6, 2022 in Sydney, Nova Scotia
Written Submissions:	May 9, 2022 and May 10, 2022
Written Decision:	June 20, 2023
Counsel:	Lyndsay Jardine, Nick Hooper and Lauren Harper for Alexander MacNeil Brian Downie, KC and Joseph Herschorn for Dr. Kajetanowicz

By the Court:

Introduction

[1] Alexander MacNeil ("Alexander") was born on April 9, 2009. His mother, Tania Bond-MacNeil ("Tania"), gave birth to twin boys, Alexander and his brother, William.

[2] Within 24 hours Alexander had a blood test completed, as do all babies born in Nova Scotia, to detect any abnormal diseases or irregularities that may not be apparent upon a physical examination.

[3] The provincial Newborn Screening Program ("NBS") tests blood samples collected at the birthing hospital, which in Alexander's case was the Cape Breton Regional Hospital ("CBRH"). The sample was forwarded to the IWK Health Care Centre ("IWK") in Halifax, and received by them on April 11, 2009, for testing.

[4] When the test results were returned to the CBRH, they showed Alexander's blood had an abnormally high thyroid stimulating hormone (TSH). The Newborn Screen result from the IWK read "abnormal screen result 'P'".

[5] The IWK laboratory returned the Newborn Screen Report, (the lab report), by regular mail and the results were stamped as received by the CBRH on April 22, 2008.

[6] Dr. Kajetanowicz was a neonatologist at the CBRH. In 2007 he put a system in place whereby he would review copies of all abnormal reports and screen them to ensure they would not be "missed".

[7] Dr. Kajetanowicz did receive and review a copy of Alexander's report as directed by him. He underlined the abnormal screen result and placed an asterisk next to "TSH Neo Natal", under the heading "thyroid screen".

[8] On the lab report was a statement that read "Recall has been initiated by the IWK Health Centre". It is undisputed that the Defendant signed the report. His wife, Dr. Danuta Kajetanowicz was shown on the IWK report as the "submitting doctor". The evidence indicates that she did not receive the report.

[9] The baby, Alexander, was not recalled or brought back for re-testing. Neither his mother nor family physician received notification of the abnormal result.

[10] Alexander did not develop as expected. His mother expressed concern early on about his health. Following testing, that occurred the following year, he was diagnosed as having congenital hypothyroidism, 14 months after this birth.

[11] It is acknowledged by the medical experts that congenital hypothyroidism is entirely preventable if treatment (thyroid replacement) is started in the early weeks of life.

[12] Medically, it is also accepted that the lack of timely treatment can lead to severe cognitive and developmental delays, and if untreated can have serious permanent consequences.

[13] The main issue in this case is whether the Defendant, Dr. Kajetanowicz was negligent. He testified that he was "shocked" to learn that Alexander had not been recalled for testing by the IWK Health Centre.

[14] The Plaintiff has submitted considerable medical and other evidence to establish that he has suffered serious and permanent harm. His mother, Tania, gave evidence to support her son's claim.

[15] The Plaintiff maintains the standard of care required a physician in the Defendant's position to ensure that test results were acted upon. In this case, it is alleged that Dr. Kajetanowicz fell below the required standard of care required of a medical professional in his position in relation to Alexander's circumstances.

[16] Dr. Kajetanowicz respectfully says that although Alexander was wronged, the negligent omission at the root of this action was not his own. He satisfied himself that the IWK had undertaken the responsibility to follow-up on the abnormal results.

[17] The burden of proof rests with the Plaintiff to show that the Defendant was negligent.

Background[1]

[18] Alexander's mother, Tania, testified that Dr. Danuta Kajetanowicz followed her during her pregnancy.

[19] Dr. A. Gardner, an obstetrician, was the doctor who delivered Alexander, which delivery was uneventful. He performed the delivery as Tania was considered a "high risk" pregnancy. Tania was 35 years old when she gave birth to Alexander.

[20] Dr. Danuta Kajetanowicz was present during the delivery and is listed as the submitting physician although her husband, Dr. Andrzej Kajetanowicz, performed the initial physical examination. His Apgar scores were 9 and 10 at birth which are normal values.

[21] Alexander was "screened" for certain disorders that are not detected on a clinical examination. The purpose of the newborn screening is to detect disorders, which if treated early enough, could prevent late diagnosis and provide a healthy outcome. Congenital hypothyroidism is one such disorder. It was later determined that Alexander was born without a thyroid gland.

[22] The provincial NBS in Nova Scotia was managed by the IWK. It is a provincially mandated program. The CBRH, as a birthing hospital, participated in the program. Its procedures for newborns required the nursing staff to submit a blood sample for screening (testing).

[23] The laboratory at the IWK processes the samples received for the entire province. The screening laboratory forwards the test results to a "Newborn Screen Coordinator", ("coordinator").

[24] The evidence indicated that the birthing hospital would submit a list of the names for all newborns. The coordinator of the program would match the names on the screen results to the list of newborns provided to ensure that all babies had a test result. The coordinator would also contact the physician whose name was listed on the screening test to advise them if an abnormal screening test needed to be repeated or if confirmatory testing was required. This process was termed a "recall".

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[1] The facts as summarized in the Introduction and Background are largely uncontested, supported by the evidence, and/or referred to in the medical records entered by the parties as Joint Exhibit Book 1.

[25] The program coordinator would document, in a binder, the screen result and who had been contacted with respect to the recall.

[26] In Alexander's case, the result was mailed by the lab to the CBRH on April 18, 2009, and received by the CBRH on April 22, 2008. (Attached as Appendix "A") The CBRH laboratory would routinely file them directly into the hospital's medical record system.

[27] In 2007, Dr. Kajetanowicz directed CBRH staffing that he was to receive a copy of the screen result test prior to entry in the CBRH's medical records. He was the only neonatologist employed at that hospital. He wanted to ensure that no abnormal screens for babies at his hospital were "missed".

Issues

1. Did Dr. Kajetanowicz owe a duty of care to Alexander?
2. If so, what was the standard of care applicable to Dr. Kajetanowicz, and did he fulfil his duty by meeting the standard of care?
3. If Dr. Kajetanowicz did not meet the standard of care, did he cause Alexander's injuries?
4. If causation is proven, what is Dr. Kajetanowicz's degree of responsibility relative to the degree of fault of the IWK and the CBRH?
5. If the analysis reaches this stage, what are Alexander's proven damages?
6. If a degree of responsibility is apportioned to Dr. Kajetanowicz, what is Dr. Kajetanowicz's several liability for Alexander's damages?

The Medical Opinions – General

Dr. Jaques Belik

[28] Dr. Jaques Belik is an experienced medical doctor who has practiced in the fields of pediatrics and neonatology for decades. His extensive curriculum vitae shows the depth of his practice, academic work, and publications over a career spanning 45 years.

[29] Dr. Belik was qualified as an expert in the field of neonatology capable of giving opinion evidence on the standard of care and provided opinion evidence on the liability of the Defendant and its causal impacts on Alexander.

[30] Dr. Belik testified that he was familiar with newborn screening programs, the role they play, and their goal of detecting congenital diseases such as hypothyroidism.

[31] He further testified as to the hormone TSH and the role it plays in stimulating the thyroid. The reading Alexander had, the newborn screen of 15.5, was well above normal and created a high risk that, if untreated, permanent brain damage would result. Dr. Belik, like the other experts, opined that the risk of injury is a medical certainty.

[32] At the same time, he said, the solution was known and straightforward. If timely treatment occurs with medication (Synthroid), the probability of recovery is also a medical certainty. Treatment, however, must be administered within the first two weeks of a baby's life.

[33] Dr. Belik noted the newborn screen result shows the letter "P" which stands for panic. He stressed the importance of the physician acting immediately, stating the level of care must be commensurate with the risk. In Alexander's case the risk was high, and in this circumstance a physician must be double, triple, quadruple sure that the matter is being dealt with, he testified.

[34] Dr. Belik stated this was especially so given that when the test was received on April 22, 2008, it was one day less than the two-week boundary for treatment. It was the thirteenth day of the "14 day window".

[35] Dr. Kajetanowicz, he said, inserted himself into the circle of care by implementing a system to make sure a test at the CBRH did not get "missed". This was the note of Dr. Kajetanowicz, that he receive all abnormal newborn screen results before they were filed with medical records at the CBRH.

[36] Dr. Belik testified (as did Dr. Dooley) that as commendable as Dr. Kajetanowicz's goal was, he needed to have in place a follow-up system to ensure that the abnormal results were acted upon. He did not. This is contained in Dr. Dooley's report at paragraphs 3 and 5. In Dr. Belik's view, as the degree of risk increases so does the duty upon the physician to respond accordingly.

[37] In short, Dr. Belik's professional opinion is that the standard of care is commensurate to the risk. Dr. Kajetanowicz, he said, was the only physician at the CBRH to see the abnormal result. In simply noting it and signing off on it, he fell below the standard of care in Alexander's case.

[38] In his report, Dr. Belik commented on the standard of care:

> The ordering Physician is always responsible for reviewing test results, communicating their clinical significance to the patient and/or parent, as well as taking proper action to ensure that all required preventative and/or therapeutic measures are followed. In this case, Alexander was under Dr. Danuta Kajetanowicz care since she was listed in the patient's chart as the Family/Admitting/Attending Physician. She signed Alexander's Admission "Routine Standing Orders Infants" set that included the order to obtain "PKU and Thyroid screen prior to discharge, after 48 hours".
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> Yet, Dr. Danuta Kajetanowicz never saw, and was never informed of Alexander's neonatal screen results. This was so because Dr. Andrzej Kajetanowicz, the CBRH Neonatologist, had a procured in place whereby all neonatal screening test results were set to him, for review, instead of the newborn's Admitting Physician.
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> Congenital hypothyroidism is a serious disorder by virtue of its subtle, or absent clinical manifestations at birth and entirely preventable brain damage, when adequate thyroid replacement treatment is started within the first 2-4 weeks of life. (1) By the time Alexander's abnormal thyroid screening result was made available to the CBRH (April 22), he was already 13 days old. as such, if confirmed to have congenital hypothyroidism, Alexander required urgent thyroid replacement therapy to prevent neurocognitive sequalae from this condition. Dr. Andrzej Kajetanowicz, as the only Physician reviewing Alexander's thyroid screening result fell below standard of care for not pursuing immediate action to ensure that Alexander was further investigated and urgently treated for congenital hypothyroidism.
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> When a physician becomes aware of an abnormal test result – particularly one which, if left untreated, can result in permanent serious consequences – the standard of care requires them to ensure that the test results have been acted upon. In my practice, if I received a concerning test result such as Alexander's TSH one, I would have immediately ensured that appropriate follow-up action had been taken.

[39] The basic premise of Dr. Belik's report is that such a serious abnormality gave rise to a positive obligation for the physician to act, such that it was unreasonable for Dr. Kajetanowicz to assume, without making inquiries, that someone else recognized the urgency of the situation and will be dealing with it.

[40] Dr. Belik in his report cited a statement issued by the Canadian Medical Protective Association (CMPA) in 2011, reminding physicians of their professional obligations relative to patient testing and follow-up which included the following:

> 1) Physicians ordering diagnostic test have a duty to communicate the results to the patient and to make reasonable efforts to ensure appropriate follow-up is arranged; 2) Physicians who receive an abnormal report, even incidentally, may have an obligation to appropriately respond to it or to redirect it, even if the patient is no longer, or never was in their care; 3) Physicians should document their review of tests results and what follow-up action they initiated; and 4) When caring for a patient who is at a higher risk of receiving a clinically significant result, it is prudent to follow-up more closely.

[41] Dr. Belik also referred to another paper published in 2019 that stated if there is an abnormal result, you ask who is the most responsible physician and act on it to determine if other physicians should be brought into the circle. In his own province he referred to the College of Physicians and Surgeons of Ontario (CPSO) guidelines published in 2019 that state, when a physician receives a critical test result, they must take additional clinically appropriate actions when timelines depend on the test result.

[42] He stated, although these were published after this case, they are "long established" physician duties.

[43] Dr. Belik concluded that the Defendant did not meet the standard of care in this case.

Dr. Joseph Dooley

[44] Dr. Dooley brings a wealth of experience to this matter. He provided an earlier opinion at the trial in 2018. His practice serves a host of communities in Sioux Lookout, in Northern Ontario. He is not a neonatologist, but he is an obstetrician and has been a medical doctor for 42 years. During this time, he has specialized in pediatrics and has delivered over 10,000 babies.

[45] Dr. Dooley was qualified as an expert in the fields of family medicine and the provision of obstetrical care in a community hospital setting capable of giving expert opinion evidence on the subject of standard of care for the reception and handling of newborn screening results by physicians. He opined that the Defendant breached the standard of care of a reasonably prudent physician by presuming timely recall in the face of an urgent abnormality.

[46] In his report dated June 11, 2021, Dr. Dooley provided his response to "new questions" raised by the Plaintiff. Dr. Dooley expressed that these have allowed him an opportunity to "expand" on his earlier opinion. In response to questions put to him, he wrote, inter alia:

> 1. In undertaking the review and to receive all newborn screen results Dr. Kajetanowicz met the standard of care as the Chief of Neonatology for Cape Breton Regional Hospital. However once the positive result was received the system in place should also have acted to ensure that the follow up investigations were complete that the Health Care Practitioners involved in the care of Alexander MacNeil were fully informed of the initial abnormal result and the follow up of studies. In not ensuring this occurred Dr. Kajetanowicz did not meet the standard of care.
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> …
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> 5. You have asked whether I feel Dr. Kajetanowicz acted as a reasonably prudent physician in the case of Alexander MacNeil. Unfortunately the fact that IWK had indicated that they would initiate a recall did not mean that a recall had been initiated. Dr. Kajetanowicz should have inquired as to whether such a recall had occurred and if not should have ensured that it occurred. Again as mentioned above in undertaking the review of all abnormal test results Dr. Kajetanowicz needed to ensure that the appropriate follow up for all these abnormal result had occurred and that a final diagnosis and treatment plan was in place.

[47] In his testimony at trial Dr. Dooley confirmed his view that Dr. Kajetanowicz did not meet the standard of care. It was unreasonable for him to do nothing, he said. Specifically, it was unreasonable for him to assume that recall had been completed. The standard of care required follow-up.

[48] Dr. Kajetanowicz, he said, had a positive obligation to act and take further steps to ensure Alexander's abnormal test had been followed up on. A simple phone call would have satisfied the standard. The steps required to meet the standard were not onerous.

[49] In his evidence he testified that Dr. Kajetanowicz retained a positive duty to ensure the screen test was followed up on. At the very least, Dr. Dooley stated, he should have contacted the physicians involved to ensure they were aware of the abnormal test. He would have known that further blood work would be needed. Dr. Kajetanowicz should have inquired as to whether such a recall had occurred and, if not, should have made sure that it did.

[50] In Dr. Dooley's June 11, 2021, report, in answer to question 4, he stated that the IWK had reported that recall would take place and did not indicate that it had taken place. (Question 4) Dr. Dooley stated a second time, "the fact that IWK indicated that they would initiate a recall did not mean that a recall had been initiated". The Defendant has argued Dr. Dooley's opinion is grounded in a factual error in his interpretation of the screen report. (Question 5)

[51] Dr. Dooley stated that Dr. Kajetanowicz's system "needed to have an appropriate follow-up to ensure that the tests occurred and that actions to deal with the identified problem were undertaken".

[52] In not having a follow-up system and in not ensuring that the tests occurred, Dr. Dooley opined the Defendant physician fell below the standard of care.

Dr. Marc Blayney

[53] Dr. Blayney is a neonatologist who had practiced for 40 years. His extensive curriculum vitae is attached to his report in Tab 1(B). He obtained his medical degree at the National University of Ireland, graduating in 1980. Since 2010 he had been a Neonatologist and Pediatrician at the Moncton Hospital, in Moncton, New Brunswick.

[54] Dr. Blayney was qualified as an expert in pediatrics and neonatology, capable of giving opinion evidence on the standards to be applied to physicians in the review of newborn screen reports.

[55] Dr. Blayney testified that he was familiar with newborn screening programs, including the program in Nova Scotia. This was a provincial program set up to ensure that all newborn babies were screened, and the results acted upon, he said.

[56] It was Dr. Blayney's opinion that as a prudent physician, Dr. Kajetanowicz, assessed the situation involving Alexander with his knowledge of how the system worked and how it had always worked. That is, the IWK had the responsibility to recall the baby for testing if there was an abnormal screen result. That was the situation in Nova Scotia in 2008, he said.

[57] Further, he stated, Dr. Kajetanowicz satisfied himself that the IWK had started the process as they always had. He provided an example: that if a surgeon says they will perform an operation, you don't call them back to inquire if they will really perform the operation. Instead, you rely on them as a professional to carry

out and complete their duty and do what they said they would do. This is what the Defendant did. Never before had the NBS not recalled the baby.

[58] Dr. Blayney further testified the system put in place by Dr. Kajetanowicz at the CBRH was "local". It amounted to an extra layer of protection, he said, but it was separate. It did not change the responsibilities of the IWK or interfere with the newborn screening program.

[59] In his written report dated September 20, 2021, Dr. Blayney addressed the opinions of Dr. Dooley and Dr. Belik both of whom he disagreed with:

> I have reviewed the statements by Drs. Dooley and J. Belik related to Dr. Andrzej Kajetanowicz's role in the handling of an abnormal newborn screening test in 2008. I am a Neonatologist and Pediatrician, and Professor of Pediatrics, Dalhousie University. I have been practising in the Moncton since 2010, and am very familiar with the Maritime Newborn Screening Program and IWK. I disagree with their findings.

[60] He stated that Dr. Dooley is mistaken when he suggests that the Defendant's review of all newborn screen results replaced the provincially mandated "system":

> The 'system' in place belonged to IWK screening lab and to the CBRH. Dr. Andrzej Kajetanowicz did not review "all" the Newborn Screen results, he only received copies of Positive screens. He was not delegated any responsibility by either party, nor did he assume responsibility by setting up his audit of positive results. Dr. Dooley further states that "the system in place should also have acted to ensure that the Health Care Practitioners were fully informed…". Failure to do so occurred because of failure of the Screening Program system and not because of Dr. Andrzej Kajetanowicz's audit.

[61] Dr. Kajetanowicz's system, he stated, was set up to "verify" if anything more needed to be done locally. He was not charged with any responsibility and was not delegated any responsibility by the IWK or the CBRH.

[62] Dr. Blayney also commented on the report of Dr. Belik, who opined that by merely underlining and signing the report, Dr. Kajetanowicz fell below the standard of care, by not communicating the results to the parent(s):

> In paragraph 2 on page 7, Dr. Belik faults Dr. Andrzej Kajetanowicz's audit system for not meeting "his commendable goal of avoiding an inadequate follow-up". While Dr. Belik stated that Dr. Andrzej Kajetanowicz did acknowledge reviewing Alexander's abnormal TSH result by under-lining this and signing the report, he believes that Dr. Andrzej Kajetanowicz fell below the standard of care for not communicating this result to the parent, a responsibility which I do not believe anyone had granted to him, even when he set up his audit. His further assertion that Dr. Andrzej Kajetanowicz should have

> confirmed what IWK had stated clearly "Recall has been initiated by IWK" is inappropriate, for the same reason I gave regarding Dr. J. Dooley's similar suggestion, namely that a prudent physical would not cross-check a respected institution's commitment.

[63] Dr. Blayney takes issue, among other things, with Dr. Belik's understanding of the statement "Recall has been initiated by IWK Health Centre". Dr. Blayney stated the report did not ask any other physician to become involved and is a statement which Dr. Blayney believed "would be accepted at face value by any prudent medical doctor as indicating that the IWK had indeed initiated follow-up of the abnormal test…".

[64] In respect of the CMPA documents referred to by Dr. Belik, Dr. Blayney stated he did not believe this document to be relevant to screening programs and pertains only to individual physicians who order a test on a patient, further noting, these statements were published after the events of this case. In Nova Scotia the NBS had its own policy.

Dr. Michael Marrin

[65] In his rebuttal report Dr. Marrin was asked to respond to the expert reports of Dr. Belik and Dr. Dooley. In doing so, he provided his opinion in this case.

[66] Dr. Marrin finished medical school in 1980 obtaining his Medical Degree. He completed a residency in pediatrics at the IWK in Halifax in 1984. He completed two years in neonatology becoming a neonatologist in 1986. He was recruited to the medical staff at MacMaster University and since that time has practiced as a full-time neonatologist at MacMaster University Hospital. Dr. Marrin is licenced to practice medicine in Ontario.

[67] Dr. Marrin was qualified as an expert in pediatrics and neonatology, capable of giving opinion evidence on the standards to be applied to physicians in the review of newborn screen reports.

[68] As did the other witnesses who were qualified as experts, Dr. Marrin reviewed the medical and legal documentation, including birth records at the CBRH and the medical records contained in Exhibit #1 (the Joint Exhibit Book). He also reviewed the provincial screen report, the medical information from Dr. Lynk about the diagnosis of hypothyroidism, notes from the meetings following the identification of Alexander's hypothyroidism, as well as the discovery evidence

of the various witnesses, including Dr. Kajetanowicz and the IWK screening program representative, Ms. Elizabeth Campbell.

[69] In his testimony, Dr. Marrin took issue with several statements made by Dr. Belik in his report. The first was Dr. Belik's statement that the screen result was not communicated to Alexander's referring physician, Dr. Danuta Kajetanowicz, because of the procedure that Dr. Andrzej Kajetanowicz put in place that all screen results would be sent to him instead of the referring physician.

[70] Dr. Marrin stated this is simply incorrect and amounted to a misunderstanding of the system the Defendant had arranged. There was no mechanism for Dr. Kajetanowicz to receive the abnormal screen results rather than the ordering (referring) physician. Such a system was not implemented nor was it the practice of the CBRH to send it to the ordering physician, he said. It was up to the screen program to contact the physician with the results.

[71] Secondly, Dr. Marrin indicated there was an important omission in the report of Dr. Belik, in that, although Dr. Belik referred to the abnormal screen result received from the IWK, he did so near the end of his report and then made only brief mention of the statement contained therein, "recall has been initiated by the IWK Health Centre".

[72] This, Dr. Marrin says, is an important omission as it is critical to understanding the standard of care and whether Dr. Kajetanowicz acted appropriately in terms of what a reasonable and prudent physician would have done in these circumstances.

[73] Dr. Marrin testified this leaves the impression that Dr. Kajetanowicz failed to do something he was supposed to do and that he created a system that he failed to follow through on. Dr. Kajetanowicz signed a copy of the report and underlined it, he admits to that, said Dr. Marrin.

[74] In his view, assessing the standard of care involves first, that a reasonable interpretation of the information on the screen test be made. Secondly, it involves a determination of what a reasonable course of action would be, recognizing the purpose of Dr. Kajetanowicz asking that a copy be sent to him was to ensure that the report contained the statement that action was being taken in response to the abnormal screen.

[75] Dr. Marrin agreed with Dr. Belik's suggestion that abnormal screen results are to be acted upon by the physician. Dr. Marrin said if he is the ordering physician and he is receiving an abnormal test result, he has the responsibility to take action in response to that test result, usually by making a referral or performing follow-up testing to deal with the concern raised.

[76] Dr. Marrin agreed with Dr. Belik in that context. In this case, however, Dr. Marrin pointed out there is a difference, in that there exists a NBS designed to follow-up and its responsibility is to communicate or initiate steps in response to a screen result.

[77] This is not a case where Dr. Kajetanowicz had ordered a test outside of the screening program; if he did, then he would have the responsibility to follow-up on the test result himself.

[78] The screen program is a different system with a different mandate, together with policies and procedures that work independently of an individual physician, said Dr. Marrin.

[79] In response to the expert report of Dr. Dooley, a major concern Dr. Marrin had was with respect to Dr. Dooley's characterization of the recall statement on the test result. Dr. Dooley, he said, interpreted the report as if it said recall "would take place", but did not indicate recall "had taken place".

[80] Once again, there is an important distinction in the rephrasing of the statement by Dr. Dooley. He uses future tense as if it is to occur in the future, instead of past tense, which would indicate it "has been initiated".

[81] It was Dr. Marrin's opinion that this does not fairly represent what was on the newborn screening result, and the information that the Defendant had before him at the time he received it for review.

[82] Dr. Marrin testified it is important to go back to the context of the events as they unfolded in 2008, in assessing Dr. Kajetanowicz's frame of mind in reading the results. It was an appropriate frame of mind, he said. History had shown the system had always worked. Dr. Kajetanowicz was reassured that the abnormal result had been flagged with the appropriate action being taken, recall initiated.

[83] That was the system in place, it was a credible system. Any physician reading it, he said, would be reassured that appropriate action had taken place.

[84] Dr. Marrin disagreed with the reports of Dr. Belik and Dr. Dooley. Dr. Marrin concluded that Dr. Kajetanowicz met the standard of care expected of him.

Dr. Kristen Hallett

[85] Dr. Hallett provided expert opinion evidence at the trial in 2021. She earlier provided an opinion by report dated February 2016. She is a pediatrician in Hamilton, Ontario, having been certified by the Royal College of Physicians and Surgeons of Canada in 1999.

[86] Dr. Hallett was qualified as a pediatrician capable of giving opinion evidence on the standards to be applied to physicians reviewing newborn screening reports.

[87] In her report (Exhibit #20) Dr. Hallett provided commentary on the standard of care. She testified, in reviewing the NBS report, that when Dr. Kajetanowicz became aware of the abnormal result he also became aware that the result was stamped "recall was initiated", informing him that someone else, within an established routine, was performing that task.

[88] She testified that newborn screening is not a local issue but a Canada wide issue. She stated it is not only for thyroid testing but for multiple tests taken of infants and that NBS programs can involve many specialists being notified. She said different hospitals have different oversights.

[89] It was Dr. Hallett's opinion that Dr. Kajetanowicz acted appropriately and reasonably in relying on the established program. The report informed him that the IWK had initiated the process and he relied on that system to work. Dr. Hallett's evidence is that Dr. Kajetanowicz was being careful in the manner that such results were dealt with at CBRH.

The Plaintiff's Position

[90] It is the Plaintiff's position that Dr. Kajetanowicz inserted himself into the circle of care for patients whose newborn screening tests had abnormal results. He did this by undertaking to review copies of all newborn screening results for infants at the CBRH, where he was a neonatologist in 2008.

[91] Dr. Kajetanowicz therefore had a duty to act reasonably and proportionally to the risks involved, which in this case included a 100% chance of cognitive impairment (brain damage) if congenital hypothyroidism went untreated.

[92] The Plaintiff argues that it was unreasonable for Dr. Kajetanowicz to simply rely on the "auto generated" form produced showing Alexander's abnormal result that he received by merely signing it and taking no steps to ensure follow-up testing occurred in order to ensure that such a grave risk did not come to fruition.

[93] In the result, the Plaintiff submits, Dr. Kajetanowicz breached the standard of care expected of a neonatologist. He failed to act to prevent harm to the Plaintiff in a matter that was time sensitive, and within his specialized knowledge and training.

[94] Due to the 14-month delay in diagnosis and treatment, Alexander, now suffers from severe neurocognitive delays. Specifically, the Plaintiff suffers from a Learning Disorder ("LD"), Attention Deficit Hyperactivity Disorder ("ADHD") and Autism Spectrum Disorder ("ASD"), all of which have been formally diagnosed.

The Defendant's Position

[95] It is the Defendant's position that until Alexander's newborn screen result, to Dr. Kajetanowicz's knowledge, the NBS had never failed in following up on an abnormal screen it identified.

[96] Any prudent physician would have understood that the IWK had the matter in hand. To hold that Dr. Kajetanowicz had reason to doubt the IWK's representation would be to apply an improper standard, one based on hindsight and imposing a standard of perfection not accepted in law.

[97] The Defendant argues that the IWK had never before failed to initiate the required recall, as one of the best pediatric hospitals in the country, and it was therefore not unreasonable for Dr. Kajetanowicz to rely on a system that had performed well in the past. He maintains that a prudent, reasonable neonatologist was entitled to rely on the IWK's written confirmation that recall had been initiated.

[98] Accordingly, the Defence says, this action in negligence against Dr. Kajetanowicz should be dismissed. The fault is that of the NBS. It was only

discovered after the fact that the required follow-up had not been done. It is undisputed that the program changed its protocol subsequent to this case, shifting the onus upon the physician to contact the coordinator.

The Law

Burden of Proof

[99] In this case, the Plaintiff has the burden of proving on a balance of probabilities the following:

> 1. That Dr. Kajetanowicz was negligent in providing medical care to Alexander.
>
> 2. That but for the negligence of Dr. Kajetanowicz, Alexander would not have suffered injury.
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> 3. If this burden of the Plaintiff is met, the Court is asked to determine the remaining issues, those being 4, 5, and 6 referred to in the issues set out herein. (Page 4)

Balance of Probabilities

[100] In civil trials, the party who has the burden of proof on an issue must convince the Court that what the party asserts is more probable than not - that the balance is tipped in that party's favour. In short, the Court must decide whether the existence of the contested fact is more probable than not.

[101] This burden is also commonly stated as meaning "more likely than not" or a "balance of probabilities".

[102] If the evidence on an issue is evenly balanced, then the Court's decision on that issue must be against the party who had the burden of proving it.

[103] In deciding whether an issue has been proven on a balance of probabilities, the Court must consider all of the evidence relevant to that issue, no matter which party produced it.

Drawing Inferences

[104] The Court may consider all direct and circumstantial evidence. When drawing an inference based on circumstantial evidence the Court must be satisfied, after considering the proven facts and any alternative inferences that may be drawn from them, that the inference is more likely than not to be the correct inference.

Before the Court can draw an inference, there must be a sufficient base of proven facts.

Medical Negligence

[105] In this action, the Plaintiff's claim comes under the heading of negligence. Generally speaking, a person is negligent when they show a lack of care towards another person in circumstances where they owe that person a duty of care. The standard of care is that of a reasonably prudent and careful person in the community of similar training and experience.

[106] Before an injured party (such as the Plaintiff) can recover damages for an act of negligence, they must also prove that the damages they suffered resulted from the negligent conduct of the Defendant.

Elements of Negligence

[107] There are four elements a Plaintiff must prove in a negligence action. They are:

(1) That the Defendant owed a duty of care to the Plaintiff. This is a question of law;

(2) That the Defendant breached that duty of care, in that he failed to meet the standard of care required of a reasonably careful person in the circumstances. This is a question of fact;

(3) That the Plaintiff suffered damages. This is also a question of fact; and

(4) That the Defendant's breach caused the Plaintiff's damage. This is also a question of fact.

[108] These steps are sequential and separate, as made clear by McLachlin, C.J., in ***Mustapha v. Culligan of Canada Ltd***, 2008 SCC 27. Thus, the first question for the Court to decide in a negligence action is whether the Defendant owes the Plaintiff a duty of care. If a duty is owed, the second question is whether the defendant's behaviour breached the applicable standard of care. (***Cleveland (Litigation Guardian of) v. Hamilton Health Sciences Corp.***, 2011 ONCA 244)

First Element: Duty of Care

[109] The first element is a question of law. Physicians owe a duty of care to their patients. A physician's duty is to exercise care in all that he or she does for a patient, including attendance, diagnosis, referral, treatment/procedure, and instruction.

[110] In these circumstances, the Court must decide whether the Defendant owed a duty of care to Alexander at the relevant time. If the Court decides that a duty was owed, the Court then turns to the second element of whether Dr. Kajetanowicz was negligent.

Second Element: Standard of Care

[111] The second element is whether there was a breach of the duty of care, due to a failure to meet the required standard of care. A physician is only required to act reasonably in practising medicine. A doctor does not insure his or her patient's health. An unfortunate result does not prove negligence, and the Court must not attribute to the doctor the perfect vision of hindsight. The Court must consider what knowledge the doctor ought to have reasonably possessed at the time of the alleged negligent event. Not every mistake or error in judgment constitutes negligence. A diagnosis, for instance, can be wrong even though all reasonable care is exercised. The standard of care that the law requires is not insurance against accidental slips. It is the degree of care a normal skillful member of the profession may reasonably be expected to exercise in the actual circumstances.

[112] The law requires a physician to meet the standard of a reasonable medical person considering all the circumstances. Every medical practitioner is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience. A physician's standard of skill will be measured against other physicians in similar communities and similar circumstances.

[113] The standard is one of reasonableness, not perfection. A physician is not required to guarantee successful treatment. Further, a physician may not be negligent for following one of several accepted methods of treatment. Each physician is bound to exercise a degree of care and skill which could reasonably be expected of them.

[114] In this case, Dr. Kajetanowicz was 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.

[115] As stated, the Plaintiff bears the burden of proof to establish that the Defendant was negligent in his care of Alexander, in that he failed to meet the standard of care required of him in the circumstances, and that the negligence caused damage to the Plaintiff.

Analysis

Duty of Care

[116] The Plaintiff submits Dr. Kajetanowicz inserted himself into Alexander's circle of care, and accordingly he had a duty to ensure no harm came to him.

[117] The Defendant acknowledges that Dr. Kajetanowicz owed a duty of care to Alexander. The Defendant argues that his duty of care was grounded in his review of the NBS report and did not arise from a foreseeable risk that the NBS program would fail to initiate recall while representing that it had. He submits therefore that the source of his duty, "his review of the NBS report", must be distinguished from the duty of care owed by the NBS program to newborns. The Defendant does not contest that he owed a duty of care that arose because he took it upon himself to review the NBS report. However, the Defendant submits it was not reasonably foreseeable that the IWK would represent that it had initiated recall when it had not done so.

[118] This is not an ordinary case of a specialist, providing treatment to a patient who has been referred by the patient's primary care physician, such as the patient's (in this case, the Plaintiff's mother's) family doctor. The Defendant undertook to review Alexander's test, and all of the other screen results that were at the CBRH. He was not Alexander's assigned or responsible physician.

[119] Nevertheless, the Plaintiff submits that the Defendant physician cannot limit the duty owed or set parameters on the standard of care. In his pre-trial brief the Plaintiff has submitted that a medical professional's duty of care is comprehensive in nature. As held in ***McEachern v. University Hospitals Board***, 2010 ABQB 253, the relationship is such that the patient is "entitled to rely upon (their doctor's) level of knowledge and training in rendering services. That is, the "duty placed upon the doctor is to exercise care in all that is done to and for the patient". (Pichard, Ellen & Robertson, G.R., *Legal Liability of Doctors and Hospitals in Canada,* 5th ed.)

[120] Simply put, the Plaintiff submits that Dr. Kajetanowicz owed him the following duties of care:

> (i) the duty to review his copy of Alexander's newborn screening test with reasonable diligence and care;

(ii) the duty to understand the nature and timing of harm embodied in the abnormal test results he reviewed, at least to the level of a reasonably prudent neonatologist in 2008;

(iii) the duty to make reasonable efforts to understand the information conveyed by the newborn test results he was reviewing;

(iv) the duty to make reasonable inquiries concerning abnormalities returned on newborn screen test results;

(v) the duty to take reasonable steps to bring time-sensitive abnormalities to the attention of another person, including the duty to inquire whether another caregiver had appreciated the urgency of a particularly time-sensitive abnormality; and

(vi) the duty to take reasonable steps to ensure that the recall initiated in respect of a time-sensitive abnormality was being completed before the risk of permanent harm increased substantially.

[121] The Plaintiff further submits that the duty owed is commensurate to the degree of risk. The Plaintiff's experts testified that Dr. Kajetanowicz would have known that Alexander faced imminent and permanent harm if his condition, congenital hypothyroidism, did not receive timely treatment. This is underscored by the fact that the screen result was received on the thirteenth day of a two-week time frame, testified to by Dr. Belik as the "boundary" for treatment to begin. Dr. Belik testified that the Defendant would have been aware of this requirement from his specialized training as a neonatologist.

[122] The Plaintiff has suggested that Dr. Kajetanowicz examination of Alexander shortly after his birth created a doctor patient relationship that gave rise to a lasting duty of care that continued when the Defendant was later in receipt of Alexander's abnormal newborn screen result. I do not agree that Dr. Kajetanowicz's brief physical examination of Alexander following his birth gave rise to a lasting duty of care. The evidence is clear that newborn screening is designed to detect disorders that are not apparent on physical examination.

[123] The weight of the evidence from the medical experts, including those of the Plaintiff, is that Dr. Kajetanowicz took on a duty to act with a reasonable degree of care and skill in his review of the abnormal screen results. I am satisfied that this is what gave rise to the duty that Dr. Kajetanowicz owed to Alexander, which was to act as an ordinary neonatologist would in these circumstances.

Standard of Care

[124] Given the existence of a duty of care, the main issue is the standard of care expected of a reasonable neonatologist in these circumstances. Once the standard is determined, the issue is whether there has been a breach of that standard by the Defendant.

[125] The Defendant submits whether he met the standard of care must be assessed in the context of a physician operating within, and subject to, the NBS in Nova Scotia in 2008, including Dr. Kajetanowicz's experience with that program.

[126] Each case must be determined on its own facts including an assessment of whether the applicable standard of care has been met. Thus, while caselaw may be persuasive and a helpful guide in setting out the governing principles, it is not determinative.

Steps Required Were Not Onerous

[127] The Plaintiff's experts point to the simplicity of the corrective measures needed. The Defendant, they say, needed only to make a simple phone call to ensure that those who should be aware were, in fact, aware. The steps were simple and straightforward: place a call to the family doctor and to the parents, or even have the family doctor phone the parents. Further, the treatment was well known, hormone replacement.

[128] There are varying opinions from the medical experts as to when treatment must begin in order to prevent cognitive development from being impaired. There is little question however, that timely treatment is necessary to prevent permanent brain damage. Further, the evidence suggests that the "closing window" was a "red flag" in terms of the urgency and the need to act.

[129] The evidence indicates that when Alexander was diagnosed by Dr. Lynk at 14 months (June 2009) he immediately prescribed the drug Synthroid to treat congenital hypothyroidism. His mother, Tania, testified that her son showed almost immediate improvement in his colour and his general appearance.

[130] The required steps were not onerous, says the Plaintiff's experts, they could have been easily taken and should have been taken. Anything less than Dr. Kajetanowicz making the necessary inquiries fell below the standard of care expected of him.

[131] The parties have each argued to some degree, that the other's medical experts had an inaccurate understanding of how the NBS worked in 2008.

Auto-Generated Form

[132] In his claim that the Defendant physician was negligent, the Plaintiff has throughout made the assertion that the abnormal screen test at page 6 of Exhibit #1 was "autogenerated".

[133] Acceptance of this statement as fact by Dr. Kajetanowicz is not in keeping with the actions of a prudent physician, the Plaintiff submits. He argues therefore, that reliance on a computer-generated print out, without human intervention, fell below the standard, especially where a potentially dangerous situation existed.

[134] The Defendant says it has not been proven that the screen result was an autogenerated form. Dr. Kajetanowicz testified he read the form and accepted it for what it said. In fact, he testified that he had not seen a form that did not have such a statement and was both shocked and angry when he learned the form had been generated without the IWK having initiated the recall, as was stated.

[135] The claim that all tests previously received by Dr. Kajetanowicz were automatically produced without the coordinator or the newborn screen staff being aware of the statement, is not well supported by the evidence, certainly not to the degree asserted by the Plaintiff.

History of NBS Screening prior to 2008.

[136] Dr. Kajetanowicz testified he had worked within the NBS program for 20 years. During this time the procedure when an abnormal test result was received from the IWK Lab for his own patients was as follows: he would first receive a phone call from the coordinator of the screening program informing him that an abnormal result had occurred, with a request for him to arrange to have the patient (the baby) returned for testing. He would later receive the written test result, of which he was already aware because he had already received a call.

[137] Dr. Kajetanowicz testified that in the many years he practiced, including in his position as Director, CBRH, the IWK had always performed their role by following up with the reporting physician for further testing to be arranged. In short, he said, the IWK ordered the recalls. As noted by Dr. Blayney, this was Dr. Kajetanowicz's experience. This is what was known to him in April 2008. The

Defendant's evidence on this point is not in contention. This process was essentially confirmed by the discovery evidence of Elizabeth Campbell, of the IWK screening program:

Q: So having read materials when you took on your job,
as you've alluded to…
A: Mm-hmm.
Q: …and having oriented yourself around your job,
as you've indicated, can you tell us what the recall process
was for abnormal screen results in the Newborn in 2008?
A: We used the same algorithm, and each, I guess,
disorder, each test, if there was an abnormal result… refer to
TSH, because that's what's in question now.
Q: Yeah.
A: We knew that a recall was done. The… the first
one, if it was greater than 12 but less than 15… I don't
know what the scientific measures are, but between 12 an 15
it was considered a blotter recall and it would be the same
process. You would initiate a call to the … once it was
identified you'd initiate the call to the physician involved
requesting tht the family have a second blotter collected
and have it sent to the IWK.

[138] In Alexander's case, the TSHN reading was 15.5. According to the Reporting Policy contained in Exhibit #1, his was therefore a "serum recall". The Policy, entitled "Reporting Neonatal TSH Results", reads as follows:

> **Abnormal Results:**
>
> Any initial TSHN value over 9.0 mU/L blood is repeated in duplicate. If both repeated values are less than 12.0 mU/L blood then the sample is reported with the numerical result as well as the following interpretation comment:
>
> **"Normal Screen Result"**
>
> If the replicate TSHN values are greater than 12.0 and less than 15uU/mL blood OR if one of the replicates is greater than 12 and the other less than 12, then the sample is reported with the numerical result as well as the following interpretation comment:

"ABNORMAL Screen Result *P*

Recall has been initiated by the IWK Health Center"

In this case a Blotter Recall is initiated by the Newborn Screen Co-ordinator.

If the replicate TSHN values are greater than 15 uU/mL blood then the results are called to the pediatric endocrinologist on call and a serum recall is initiated.

Any value greater than 20 uU/mL is to be repeated in duplicate and called to the pediatric endocrinologist as soon as possible. In this case a serum recall is initiated and treatment started immediately.

Refer to Newborn Screening Decision Flow Chart July 2008.

Refer to the Reporting Flow Chart November 2008 for the appropriate contact information.

[139] In Alexander's case, Dr. Kajatanowicz was not the reporting physician and therefore he did not expect to receive a call. It is uncontradicted that the IWK had never failed to contact the reporting physician or initiate a recall.

June 18th, 2009, meeting

[140] The Joint Exhibit Book (Page 14) contained the following summary of a meeting on June 18th, 2009, in the IWK Lab Conference room, entitled "Meeting re NBS Incident":

The abnormal report was TSH 15.5. there is a note immediately after "Abnormal screen result" that states "Recall has been initiated by the IWK Health Centre".

There was discussion regarding the levels of recall associated with NBS.

There are three levels of recall for abnormal TSH Results

TSH Level	Type of Recall	Who is notified
12-15	Blotter Recall	NBS Coordinator
15-20	Serum Recall	NBS Coordinator
>20	Baby Recall	Endocrinologist

Note** The NBS Coordinator may also be directed by the Lab to perform "Age Recalls". This recall would be done if a specimen was drawn too early – before 16 Hours of Life.

4. Liz described how the NBS coordinator would usually review results.

Cape Breton (And other birth centers) faxes the birth to the list to the NBS Coordinator.

The NBS Coordinator would compare this list with results forwarded to her by the IWK. She is checking to see that every baby had screening performed and if the results are normal. As the NBS Coordinator reviews the result for a baby, the baby's name is highlighted indicating that results are reviewed.

The NBS Coordinator **writes in a binder any follow up performed** for babies who have abnormal results.

In this **case the baby's name is marked off** as if the results have been reviewed/seen.

There is **no documentation that the NBS coordinator was notified by the Lab** of the abnormal result in the binder where this information would be documented.

There is **no documentation that the NBS Coordinator performed any follow up** on this baby.

The baby's delivery is "highlighted" **leading to the assumption that the report was reviewed** by the NBS Coordinator. **(Emphasis added)**

[141] The record of the 2009 meeting indicated that there was "no documentation that the Newborn Screen Coordinator was notified by the lab of the abnormal result in the binder where this information would be documented". Thus, the steps that Dr. Kajetanowicz said were normally carried out by the NBS were not carried out.

Dr. Kajetanowicz's System

[142] The system put in place by Dr. Kajetanowicz is integral in assessing whether his action or inaction met the standard of care. There was considerable evidence as to what his system was, and what it was expected to accomplish. Dr. Kajetanowicz testified as to his purpose in implementing it, to add an extra layer of safety, he said, under the belief "the more layers of safety, the better". In discovery, Dr. Kajetanowicz gave evidence about his system and its purpose when questioned by Plaintiff's Counsel:

147. Q: So is it, so where I'm confused is that we know that you're, you were not the assigned or responsible physician for Alexander MacNeil.
A: Yes.
148. Q: And so why did the document then come back to you to sign off on?
A: Okay. Then we have to go back a little earlier. When I came to here, I noticed the problem with the family doctor that is sometimes not the one that will follow the baby.

> And because those test reports are coming after several days, then I thought that in case that there will be an abnormal test and IWK screening program will just missed that it was an abnormal and didn't start the process of recalling, then there is a possibility of the situation that the test will be sent but the family doctor will not receive, not know that nothing was done, and it will be a disaster. So I thought that If I gather all the abnormal reports, regardless whether I was the physician that was responsible for these babies or not, then I would screen those abnormal reports and if IWK didn't act on this, they didn't initiate the recall, I would do this. And then I would contact the family doctor or parent or whoever until the end, until I'm satisfied that the test is done again so the system that I designed was to add another layer in for the very specific situation that IWK had an abnormal report but didn't initiate recall. Once the recall was initiated by somebody, if let's say it didn't happen but if let's say there was a test that IWK did not initiate and I would contact the family doctor and pass this to the family doctor and they would tell me we will initiate the recall, then that would be satisfactory, too.

[143] Dr. Kajetanowicz testified that if the report was abnormal, then it was mandated that the NBS program was to arrange to retest the baby. In his experience, when patients of his tested abnormal he would get a call from the screen program and informed of the abnormal report, and they would instruct him what type of blood needed to be collected. He would then receive the printed report that said, "recall initiated", of which he was aware because he had been contacted.

[144] In such a situation, the IWK would contact him by phone because it was they who identified the abnormality, and he would retest the baby on their instructions. They arranged the recall, he said.

[145] The Plaintiff argues that the Defendant was negligent in failing to have a proper follow-up system in place for his own system. Dr. Belik and Dr. Dooley said his system was commendable, in its purpose, but failed in its completion. These experts opined that Dr. Kajetanowicz completed the first step, a review, but not the second, a follow-up within his own system of review. Dr. Belik made the point that Dr. Kajetanowicz was the only physician in a position to assist the Plaintiff.

[146] In cross-examination Dr. Kajetanowicz agreed that it is a physician's obligation to prevent harm wherever possible, and that if he had any reason to doubt that appropriate action was being taken by the IWK, he would have intervened. He said he would probably call the ordering physician, but first he would probably call the NBS system. He further agreed that on review,

Alexander's screen result indicated that he most likely had the disorder of congenital hypothyroidism.

[147] Dr. Kajetanowicz further testified his concern with the IWK was not the situation presented here, where he was provided false information. His concern was the exact opposite, that is the IWK would not see the abnormality and would not start the recall process. His expectation was that if they missed the report, the sentence would not be there. In his review he was looking for missing information, not misinformation. If the sentence was present, then NBS have taken notice and his belief was that the statement "recall initiated" was true. In short, he was looking to see if the information was silent with respect to recall, in which case he would have reason to doubt that action was started, and he would have called the NBS and the family doctor. In this case, he said, he did not have reason to doubt the presence of the statement or its accuracy.

[148] Dr. Kajetanowicz earlier said in cross-examination that his expectation was that the statement was produced with human intervention, and that it would contain accurate information.

[149] It is uncontested that in 2009 the NBS protocol changed, requiring the message to be modified on any newborn screen results to read, "Please notify the Newborn Screen Coordinator at 470-xxxx. This change was to be 'put in place immediately'". Paragraph 5 of the meeting minutes dated June 18, 2009, states as follows:

> 5. Actions:
>
> **Action 1 – Patti will modify the message on any abnormal NBS results. The message will no longer say "Recall has been initiated by the IWK Health Centre".**
>
> **The message will state "Please notify the Newborn Screen Coordinator at 470-XXXXX". This change will be put in place by tomorrow.**
>
> Action 2 – Patti will modify future results so that all abnormal results are bolded.
>
> **(Emphasis added)**

[150] This change occurred in the NBS as a result of Alexander's screen and the handling of same. While it is relevant to understanding the overall context and circumstances of this case, caution must be exercised in assessing the content of the duty of care, and the applicable standard of care, to avoid viewing those

matters in hindsight. These must be viewed through the lens of a neonatal specialist acting within the context of the Newborn Screen Program in 2008.

The Note - Attention Irma and Copies

[151] In evidence is a handwritten note of Dr. Kajetanowicz asking that PKUs be sent to Irma. The note reads:

> Attention: As of Jan 17/07 all PKU's are to be sent to Neo-Natal att: Irma, not to MRD. (after receiving them Back)

[152] In reviewing the note, it does not say "copies" of the PKUs should be sent. There is no evidence that any physician received the screen result, except for the Defendant. (Exhibit #1, Page 32).

[153] Dr. Kajetanowicz stated in both direct and cross-examination that he asked for copies of all reports of babies at the CBRH with abnormal screens to be sent to him. This was not to replace any other report, and not to cover for all possible error, but simply to ensure that on the report, the IWK had recognized the abnormality and that recall was initiated.

Medical Evidence - Cross-Examination

[154] Dr. Belik suggested in his report that Dr. Kajetanowicz interfered with the system by having all tests sent or re-routed to him. I find there is little evidence to support this assertion. It was Dr. Kajetanowicz's evidence that his system was an extra layer to protect babies born at CBRH and did not interfere with the NBS.

[155] In cross-examination, Dr. Belik was asked about his assertion that, in implementing his system, Dr. Kajetanowicz had interrupted the flow of communication between the NBS and the CBRH, thus preventing other medical doctors from receiving a copy of the report. In his opinion, Dr. Kajetanowicz was the only physician in a position to follow-up on Alexander's abnormal screen. It was suggested to Dr. Belik that he was mistaken and that, in fact, Dr. Kajetanowicz's system had not interfered or prevented the reporting physician or family physician from receiving the report at page 6 of Exhibit #1. Dr. Belik replied that from what he read, his understanding was that Dr. Kajetanowicz had asked that all abnormal results be sent to him, but also said that even if that were not the case, his opinion would be unchanged. He maintained that by signing off on such an abnormal result that was time sensitive and certain to cause harm if

untreated, Dr. Kajetanowicz fell below the standard of care of a prudent medical doctor.

[156] The evidence of Dr. Kajetanowicz in his discovery, and at trial, was that he requested that copies of abnormal results be sent to him as a separate layer of safety, independent of the newborn screen protocols. He testified that his system did not interfere with or prevent the reporting physician, Dr. Danuta Kajetanowicz, or Dr. MacDonald, Alexander's family physician, from receiving a copy of the test result. Further, there is no evidence that these physicians received a phone call from the IWK or were contacted in any way. Dr. Kajetanowicz testified in direct and in cross-examination that he requested only a copy of the results, which evidence is largely uncontradicted.

[157] Dr. Belik was further cross-examined on his evaluation of the actions taken by Dr. Kajetanowicz. It was suggested to him that his report did not directly address the statement on the test result that indicated, "recall had been initiated by the IWK". Dr. Belik acknowledged that the IWK was obviously in error, in that they did not get Alexander back in to be retested. He further acknowledged Dr. Kajetanowicz's years of experience that this was the way the system had always worked. He maintained however, that as a physician, he reserved for himself, if the risk is too great, the need to be thorough. There is a big difference, he said, between trusting colleagues to perform their duties, and the physician acting on the information made available to that physician.

[158] In this case Dr. Belik said there were two aspects of the report from the IWK that should be noted. First, an abnormal test result was reported. Second, recall was dependent on the actions of an individual. It was his opinion that Dr. Kajetanowicz decided not to act, without knowing the full extent of what had been done. In his view, Dr. Kajetanowicz did not have much information available to him. It was a big assumption, he said, to assume that all the steps would be taken, in order for the recall to be complete.

[159] It was Dr. Belik's evidence that a medical practitioner must make "doubly, triply, quadruply" sure by taking extra steps to ensure action is taken. If the IWK did take those steps, Dr. Kajetanowicz would have lessened his responsibility, he said.

[160] Dr. Belik stated in cross-examination that in certain high-risk situations, steps must be taken to ensure professional duties are carried out. It is not sufficient for a physician to assume that professional duties have been met. Reliance on

other professionals to do their job is not a "blank cheque". In situations, such as this, extra care must be taken to ensure the recall came to fruition in order for the standard of care to be met.

[161] In his direct evidence, Dr. Marrin was asked about how one should go about evaluating Dr. Kajetanowicz's decision making in this case:

> Q: I'm going to turn you to page 6 of your report. You have a paragraph summarizing your view on Dr. Belik's opinion, it begins in summary, and the final sentence there reads, such his report does not appropriately evaluate Dr. K's decision making, and I think we've been over that already. I'll ask you this, how, in your view, should one go about appropriately evaluating Dr. K's decision making?
>
> A: Well, and I don't mean in any way to sound facetious about this, but I think the first step is to have the correct facts, and secondly in this kind of a context in which the facts are being presented to the Court, I think its approp… they need to be fairly presented, so correct facts, all of the facts of the case disclosed in the report such that it is a fair representation and the opinion is based on correct information.

[162] In his report Dr. Marrin pointed out that Dr. Belik, in commenting on the actions of Dr. Kajetanowicz, addressed the recall statement at end of his written report to this limited extent: "The words "recall has been initiated by the IWK" do not confirm that the necessary steps to urgently investigate Alexander for congenital hypothyroidism had taken place".

[163] It was Dr. Marrin's view that Dr. Belik did not properly evaluate Dr. Kajetanowicz's decision making and that Dr. Kajetanowicz met the standard of care. In his opinion, the statement that recall had been initiated by the IWK was a clear signal that it was handling the recall of the baby, as it was mandated to do, and as it had never failed to do in the past.

[164] Dr. Belik acknowledged in cross-examination that the NBS was centralized in Halifax, and as such, the IWK had in place its own mechanism for screening results, and further, that congenital hypothyroidism is one of the conditions screened for. In addition, he acknowledged that the NBS had a coordinator who would initiate the steps in the recall process. In his discovery evidence, the Defendant was questioned by Plaintiff's counsel as follows (See Exhibit #7):

> 149. Q. Uh-huh. So this is a system that's of your design and direction in terms of…

> A. Yes, on top of. It wasn't required by any standards. I just thought that because of the potentials that I will add another lawyer of safety because the more layers you have even if they are redundant, the more tight the system is.
>
> 150. Q. Uh-huh. Right. So this, just to be, just to restate it, this is a system here that it comes back to you that was not designed by the hospital but rather designed by you as a double-check to ensure that there's initiation taking place.
>
> A. Yes.

[165] The premise of Dr. Marrin's opinion is that history showed the system had always worked. That was Dr. Kajetanowicz's experience. Once recall had been initiated, nothing more was expected of him. A prudent physician would have relied on this trusted entity. Dr. Kajetanowicz himself testified that he had no reason to doubt that the IWK would not do what they said they had done. Dr. Blayney, in his evidence, was of the same view. What prudent physician would expect the statement in the newborn screen result would be false? Dr. Kajetanowicz did not dispute the integrity of the newborn screen system in imposing what he said was his own additional layer of safety, separate and apart from the IWK's responsibilities.

[166] The basic premise of Dr. Dooley's opinion is that follow-up by Dr. Kajetanowicz was required to ensure that the statement in the newborn screen recall actually occurred. Dr. Dooley provided an opinion in 2016 on the involvement of Dr. Kajetanowicz. He stated in 2021 that his previous opinion had not changed.

[167] Dr. Dooley said timelines were critical, and that testing would need to occur within a couple of weeks. It was appropriate for Dr. Kajetanowicz to highlight the results on review, but as far as the steps taken, there did not appear to be any. With newborn screening, he said, it is vital to ensure that the baby has, in fact, been tested. As a result, Alexander's medical practitioners and parents were "in the dark" as to the abnormal result.

[168] In cross-examination, Dr. Dooley was asked about his interpretation of the sentence "recall has been initiated". In direct, Dr. Dooley stated this may be read as the beginning of an attempt, but it does not indicate that any physician has been called or that the parents or medical practitioners were contacted.

[169] In cross-examination, Dr. Dooley agreed the statement did not say the IWK "would do" something in the future, as suggested by the wording in his report that

"recall would take place". He maintained his interpretation that the process had begun, not that the recall was completed. Dr. Dooley agreed that at "face value", Exhibit #1, Page 6 indicated that recall had been initiated. He explained however, that he didn't see any evidence that recall had taken place. This was the reason he wrote his report, he testified.

[170] Dr. Dooley acknowledged that one of the responsibilities of the IWK was follow-up. He further accepted that the NBS had been in place in Nova Scotia for decades, in order to detect rare disorders such as congenital hypothyroidism, by testing blood upon birth. In Alexander's case this occurred 18 hours after birth. Dr. Dooley testified that the IWK Health Centre failed in its obligation in this case, stating they were one of the agencies that failed to call the baby back and had failed in relation to Alexander.

[171] In further cross-examination, Dr. Dooley accepted the premise that the IWK Health Centre was and is a highly regarded medical institution. He was asked if there appeared to be any reason for Dr. Kajetanowicz to disbelieve a representation from the IWK Health Centre.

[172] Dr. Dooley further agreed that the procedures and practices in 2008 in Nova Scotia were devised to ensure the highest standard of care for babies in the testing for congenital diseases.

[173] Dr. Dooley was also asked by the Defence, whether it was essential for each professional in the newborn screen to carry out their duties, such that a neonatologist in 2008 should have been able to rely on the information provided to him or her. Dr. Dooley stated the expectation would be that professionals within the system would complete their tasks. In terms of reliance on the information provided, he agreed with that as well, but indicated that a Neonatologist would be very aware of the impact this could have, and therefore that reliance would be contingent upon the Neonatologist ensuring that testing has taken place. He said, it would be very unexpected if they (the professionals) didn't, but unfortunately that happened in this case, and, as a result, follow-up was needed by the Defendant in order to be certain. In cross-examination Dr. Dooley gave the following evidence:

> Q: And a neonatologist in Nova Scotia in 2008 should have been able to rely upon the information being provided to him or her in a report precisely of the kind that we see at page 6 of Exhibit 1, correct?

A: What I would indicate with that is that, I would agree that the neonatologist, neonatologist would be very aware of the impact of this condition on the child. I agree that would be contacted, but I also feel that it would be contingent upon such neonatologists to work to ensure that it had in fact taken place.

Q: I understand your argument.

A: That's, that's my yes, that's my argument.

Q: I understand your argument.

Court: It's really an opinion, it's his opinion not so much an argument.

Q: It's a contention with an opinion.

A: Yes, that…

Q: But you would agree with me that it would not be unreasonable in April of 2008 for a physician reading a newborn screen report saying recall has been initiated by the IWK Health Centre to reasonably rely on that and conclude that the statement is true.

A: I would agree that again, as I stated earlier, if he had contacted either the physician or the family **he would have been very surprised** that they had not in fact been contacted.

Q: That's right.

A: I would agree with that.

Q: That's right because the, the, operating mentality is that if the IWK, the best baby hospital in Nova Scotia says they are doing something, then they are doing that. That you would agree with me, that, that would be the operating mentality.

A: The operating mentality would be that **it would be very unexpected if they did**[2], but they did not unfortunately as evidenced in this case. It is unfortunately **not certain.** The only way one can **be certain** would be to in fact contact the physicians that are for caring this baby or the family themselves to see, are you aware your baby had this problem or to the practitioner, the family doctor. Did you get a copy of this test result, I am just following up **to be certain**. That's what.. by saying I'm following up to **certain** you're not doubting the IWK you're just ensuring that such a devastating diagnosis is not missed. That's what you're doing. **(Emphasis added)**

[2] The Court is satisfied that in Dr. Dooley's evidence he clearly meant "didn't" in the context of this statement, his answer and his entire evidence.

[174] When asked in cross-examination whether it was unreasonable for Dr. Kajetanowicz to accept the recall statement as a true statement, Dr. Dooley testified:

> Q: And I hear you saying that, my question for you is whether you believe it's unreasonable for a physician to accept that when the IWK says that they have initiated recall of a baby, my question to you is whether it is unreasonable to accept that as a true statement.
>
> A: I would accept, I am sure Dr. Kajetanowicz saw that and assumed it would have taken place.

[175] Dr. Dooley's evidence was that "even though it is expected the system will work, things fall through the cracks". By not making sure, he opined, Dr. Kajetanowicz failed to meet the standard of care given this had the potential to be a "devastating diagnosis".

[176] In cross-examination, Dr. Blayney was asked about several aspects of his report and his opinion that Dr. Kajetanowicz acted as any prudent physician would do in similar circumstances.

[177] Specifically, he was asked about the role of the IWK as compared to Dr. Kajetanowicz's system, which Dr. Blayney described in his report as Dr. Kajetanowicz's "internal audit". Dr. Blayney clarified that these were not Dr. Kajetanowicz's words but his, stating that the Defendant physician was not auditing the IWK, but was only concerned with the possibility of the message not being passed along to the local doctors at the CBRH. He did nothing to add to the responsibilities of the IWK and was not questioning the newborn screening program or changing what they "needed to do, should do and according to their policy, did do."

[178] Dr. Blayney was also cross examined on his report, in which he stated, that prior to 2009, the primary care physician had "no role" in the follow-up of an abnormal screening test, not even a specialist like Dr. Andrzej Kajetanowicz. Dr. Blayney said the IWK in 2008, was both the testing centre and the centre for follow-up. They had full responsibility for communicating the results, and, since this incident, the IWK has added a new layer of responsibility, "they now ask us to confirm, stating, 'they changed the reporting and rather than reporting abnormal test, we look after it', they say 'abnormal test, please contact us'".

[179] In his post trial submission, the Plaintiff argued that Dr. Blayney's evidence as to what was expected arose out of a misapprehension of the NBS system in place in 2008:

> 139. While the defendant's expert Dr. Blayney similarly indicated that this type of "cross-checking" was unreasonable, it appears to have arisen out of a misapprehension of the newborn screening system in place in 2008. Dr. Blayney testified that "local doctors were not involved in the process" and that it was the IWK's responsibility to complete testing and follow-up. We know however, from Dr. Kajetanowicz's own testimony, that local doctors were very much involved in the process and that it was the local doctor who was responsible for ordering the test. **For example, Dr. Kajetanowicz explained that his experience with his own patients was that he would receive a call from the IWK reporting the abnormal results, some hours later he would receive a paper copy, and then he as the local doctor would order the test and ensure the family returned for follow-up. (Emphasis added)**

[180] I note that in this submission the Plaintiff appears to have accepted the Defendant's explanation as how the NBS program worked in 2008 based on his experience with his own patients.

[181] In his testimony, Dr. Blayney said this was the only test result in 30 to 40 years of practice that read, "abnormal test, don't worry we're looking after it for you, you don't have to do anymore". Dr. Kajetanowicz's system, he said, was independent of any system between the CBRH and IWK.

[182] Plaintiff's counsel further challenged Dr. Blayney's opinion by suggesting that no one at the IWK had authority to order further testing, and therefore that would have to be done locally. In that sense, Plaintiff's Counsel suggested, the IWK had only a supporting role in the recall process.

[183] In cross-examination Dr. Blayney was shown the discovery evidence, given by Elizabeth Campbell, and directed to page 27, lines 23 -25; pages 71, 73, and 74 to line 20; (Attached as Appendix "B"). A portion is set out below:

> Ms. Elizabeth Campbell, Examination by Mr. Wagner
>
> 21. Q: To ensure that the physician is following up to get
> 22. another sample so you can get it (inaudible – talkover).
> 23. A: Well, to request that. it wasn't my place to
> 24. ensure, but it was my place to review… to request that that
> 25. be done, yes.

[184] Once again, Dr. Blayney testified that what he read and what he understood from the discovery evidence was that the IWK were to reach out to the physician and recall the baby for testing. "That call was never made by the IWK", he said, stating that the birthing hospital had no responsibility.

[185] Dr. Blayney further testified that Dr. Kajetanowicz was not delegated any responsibility by the NBS. He assumed responsibility to review copies of the screens but did not insert himself into the system in place, a system that had worked for decades until this case.

[186] Dr. Blayney acknowledged that the IWK administrative personnel could not order lab tests (such as blood work). That would have to come from the physician. They did, however, have the authority, and, according to their policy, the responsibility, to notify the physician. That call should have been made, and it wasn't, said Dr. Blayney. He said the following on cross-examination:

> Q: Essentially as you work through these three sections of Ms. Campbell's discovery evidence, what is clear is that the IWK reaches out to the physician and has the physician request that baby be brought back for additional testing. So if you rely on the evidence given by the IWK representative, your interpretation of the IWK's role isn't strictly accurate is it. It wasn't the only entity involved in the recall process was it?
>
> A: From what I heard there it said the IWK was to reach out to the physician and make that phone call. And that did not happen in this case.
>
> Q: No, it didn't.
>
> A: They did not have care that the message being sent to the referring hospital to the hospital of birth would have any responsibility on that hospital calling anybody or doing anything that had to because what I heard, and what I heard her say was that she wasn't there at the time in April when this baby was born and, but what I heard is that a phone call should have been made by the IWK and that phone call wasn't made.
>
> Q: So Dr. Blayney an administrative personnel or administrative clerk at the IWK would not have the ability to order any type of lab testing would they?
>
> A: No, I don't believe so.
>
> Q: That would have to come from a physician wouldn't it.
>
> A: Or the province yes. One or the other yes.
>
> Q: And so, its fair then to assume that in 2008 an administrative personnel at the IWK would not have had the ability to order any type of follow-up laboratory testing would they?

A: Its given responsibility to make a phone call to the physician to pass along a result. That responsibility was to pass along a message for which the physician would have to respond.

Q: Right but what I was asking you…

A: No.

Q: … in 2008 is it reasonable to assume that an administrative personnel, someone working in an administrative capacity is it fair to assume that would not have had the ability at that time to order laboratory testing.

A: Nor do I believe they would be allowed to do that today, no they can not do that, they could not do that then and they can not do that today.

Q: So doctor you state a couple of times in your report that Dr. Kajetanowicz was not delegated any responsibility by either the IWK or CBRH, correct?

A: That is correct.

Q: And it seems to me that is a fairly central part of your opinion that neither of these institutions delegated any responsibility to Dr. Kajetanowicz to communicate results to the Newborn Screening Program. That's a fair statement isn't it?

A: That was not just Dr. Kajetanowicz but any other physician working within NB, NS and PEI.

Q: Right but I'm speaking specifically with your opinion in this case, and so you've got and its in your concluding paragraph but it essentially it says I do not believe that it was Dr. A. Kajetanowicz 's responsibility to communicate the results of the abnormal screen test as this had not been delegated to him by either IWK or CBRH. So that part I'm reading to you is from page 4.

A: Yes.

Q: And its something that is repeated a couple off times in your opinion so I think you know my reading of that its fair to say that's a fairly central part of your opinion. Fair?

A: That is my opinion that the IWK as the screening centre had the responsibility to not just communicate but also to follow up like they said they were doing, that they would follow up on the abnormal test and...

Q: Right so it was IWK's responsibility but not only that it couldn't have been Dr. K's because it was not delegated to him by either hospital, either the IWK or the CBRH, was not delegated to him, that's, that's what you wrote?

A: That's what I wrote yes.

Q: And so your assumption is that because he was not delegated that responsibility, was never given that responsibility, that he has then zero responsibility to anything upon receipt of this abnormal test result, that's fair isn't it?

A: That is not correct, no, that's not what I'm saying.

> Q: Well that's what you wrote and that's what I'm reading so if its different please explain.
>
> A: Well what I also said is that Dr. Kajetanowicz reviewed the result, assessed the situation, understood the circumstances and the history that he had of working in the CBRH and he came to the opinion that this was something that he had seen before and when the IWK said they would initiate recall that that would happen and it was not for him to question the IWK and therefore as a good physician he assessed the situation, he came to a conclusion and he signed the form saying that GAP understanding that IWK would be following up as they were saying. As I said to you, this is the only lab results that I've seen in my 30 years 40 years now which says abnormal test don't worry we are looking after it, you do not have to do anymore.

[187] In his testimony Dr. Blayney stated it was not simply because Dr. Kajetanowicz was not delegated responsibility by the IWK or CBRH that he believed the Defendant had no responsibility. Dr. Kajetanowicz, he said, reviewed the result and assessed the situation and from those circumstances formed the opinion that the IWK would complete the process they had started, which is what a prudent physician with his experience would do in that situation.

[188] Dr. Blayney acknowledged the form does not say the IWK has completed the investigation, but he concluded that "as a prudent physician" it was reasonable for Dr. Kajetanowicz to expect that the IWK would complete the process that they said they had started. This was, in fact, their obligation, as both the centre for testing and the centre for follow-up of an abnormal screen result. Having assessed the situation, Dr. Kajetanowicz satisfied himself that this would be the case, based on his experience.

[189] In the result, Dr. Blayney stood by his opinion that Dr. Kajetanowicz met the standard of care expected of him. Dr. Blayney was unshaken in his evidence.

[190] The Plaintiff took issue in its post trial submission with Dr. Marrin's opinion that the system must be allowed to work without a physician creating confusion:

> 138. Dr. Michael Marrin, the Defendant's expert, also commented on "mistrust" of the system, suggesting that it would be unreasonable for a physician to not trust the newborn screening system. Dr. Marrin testified that in order to allow the newborn screening system to function, you must have faith that it is working; otherwise, you run the risk of creating confusion by interfering. Respectfully, the standard of care presented by the Plaintiff would not have required Dr. Kajetanowicz to "interfere" with the system. Instead, the standard of care presented by the Plaintiff would simply require that Dr. Kajetanowicz contact either the family physician or the family to ensure that follow-up

> had occurred; to suggest that a simple phone call would create "confusion" is unreasonable.

[191] Dr. Marrin stressed in his evidence that Dr. Kajetanowicz had every reason to trust the system that had been set up to handle reporting screening results. Its history showed that the IWK had never failed. He acknowledged in cross-examination that Dr. Kajetanowicz appeared to have a concern in relation to the CBRH practice to file the records and take no action, including any action on a positive result. Dr. Marrin said the Defendant's desire was to make sure there was an indication on the result that action had been taken.

[192] Dr. Marrin further agreed with Plaintiff's Counsel that the CMPA guidelines, although dated 2019 and 2021, state that when a physician receives a critical test result, they must take clinically appropriate actions when time limits depend on it. In his report, Dr. Marrin stated these were not particularly relevant to evaluating the standard of care in 2008. He agreed that notwithstanding the relevancy of the guidelines, these were long established principles of medicine.

[193] Dr. Marrin testified, that as a free-standing principle, Dr. Belik was correct to suggest that irrespective of how a physician encounters an abnormal test result, the physician must act on the result. Dr. Marrin added however, that if that is the basis of Dr. Belik's opinion, and he believed it was, that the opinion has to be put in the context of the report received by Dr. Kajetanowicz. Dr. Marrin testified that if he encountered an abnormal result and there was no indication that it was communicated to the necessary party, he would communicate it to that party. However, if there was an indication that it was being addressed by the appropriate party, then he would not pursue it any further.

[194] In the context of the NBS, Dr. Marrin stated, it is a provincial program, with a robust system in place. It was therefore appropriate for a physician to trust the statement that it was being dealt with and not intervene. Dr. Kajetanowicz, he said, was in a position to assume that it was a properly designed system. As a comparison, Dr. Marrin said that in Ontario, the design of the screening system is sufficient that he does not have to question it. Unless the system had "let his patients down", he would not question it.

[195] Dr. Marrin said it was the screening coordinator's task to match the lists of births to the samples taken to ensure every baby had a sample taken, and to ensure that the results are followed up if the test result was "flagged" as abnormal.

[196] In cross-examination, Dr. Marrin stated a report that said "recall initiated" is sufficient to show the physician that steps have been initiated, and then it fell to the child's referring physician to follow through with their part of the re-testing.

[197] Dr. Marrin was challenged on the statement in his report that Dr. Belik had left out or omitted the "recall statement" in his report, when in fact Dr. Belik did reference the statement in his report. Dr. Marrin testified that Dr. Belik came around to dealing with the abnormal screen result and the written statement that recall had been initiated near the end. Until then the "flavour or inference" one draws from Dr. Belik's report is that the recall statement is not there, he said.

[198] Dr. Marrin agreed that if there was no mechanism in place, and a physician such as Dr. Kajetanowicz was presented with an abnormal result, it would have been his place to act. To that extent he agreed with Dr. Belik. The difference here, said Dr. Marrin, is that there was a mechanism in place to deal with the result. If the situation was that Dr. Kajetanowicz was presented with an abnormal result and there was no mechanism to deal with it, then it would have been for the Defendant to do so.

[199] It was pointed out in cross-examination that recall efforts can be unsuccessful. Dr. Marrin testified if this is the case, that falls back to the screen program coordinator. It is they who have to ensure there is someone in a position to see the result, and act upon the result.

[200] Dr. Marrin also said if the Defendant had reason to doubt that recall had been initiated, then he would have an obligation to phone the physician, or**,** if reliability of the screen was in doubt, then it would have been appropriate for Dr. Kajetanowicz to confirm with the screen coordinator that they had contacted the relevant physician. Dr. Marrin confirmed he still held these views when he testified. However, the history showed the system had always worked.

[201] Dr. Marrin took the view that the report of Dr. Belik is incomplete in failing to sufficiently address the recall statement and in failing to assess Dr. Kajetanowicz's experience with the system in 2008. With respect to the report of Dr. Dooley, Dr. Marrin's opinion was that he mischaracterized the meaning of the newborn screen statement by using future tense ("recall would take place") not the past tense ("recall has been initiated"). Thus, Dr. Dooley changed the meaning of the statement.

Caselaw

[202] The Court has considered the caselaw put forward by the Plaintiff and the Defendant.

[203] In ***Mustapha v. Culligan of Canada Limited***, 2008 SCC 27, the Supreme Court of Canada ruled that in determining whether a Defendant's conduct is negligent, such conduct is negligent if it creates an unreasonable risk of harm (A.M. Linden and B. Feldthusen, Canadian Tort Law, 8th ed. 2006). In ***Mustapha***, MacLachlin, C.J, made it clear that the first question for the Court to decide in a negligent action is whether the Defendant owes a duty of care to the Plaintiff. If a duty is owed, the second question is the Defendant's behaviour breached the applicable standard of care. (***Cleveland v. Hamilton Health***, 2011 ONCA 244)

[204] In ***Mustapha***, the Supreme Court of Canada held that whether the Defendant owed a duty of care to the Plaintiff is based on the relationship between the parties and whether such a relationship exists depends on foreseeability.

[205] In ***Ter Neuzen v. Korn***, [1995] 3 SCR 674, Sopinka, J., for the majority, discussed the standard of care applicable to physicians and specialists:

> (1) Standard of Care and Evidence of Standard Practice
>
> 33. It is well settled that physicians have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances. In the case of a specialist, such as a gynaecologist and obstetrician, the doctor's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field. A specialist, such as the respondent, who holds himself out as possessing a special degree of skill and knowledge, must exercise the degree of skill of an average specialist in his field...
>
> 34. It is also particularly important to emphasize, in the context of this case, that the conduct of physicians must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence. As Denning L.J. eloquently stated in *Roe v. Ministry of Health*, [1954] 2 All E.R. 131 (C.A.), at p. 137, "[w]e must not look at the 1947 accident with 1954 spectacles". That is, courts must not, with the benefit of hindsight, judge too harshly doctors who act in accordance with prevailing standards of professional knowledge. This point was also emphasized by this Court in *Lapointe, supra*, at pp. 362-63:
>
> > ... courts should be careful not to rely upon the perfect vision afforded by hindsight. In order to evaluate a particular exercise of judgment fairly, the doctor's limited ability to foresee future events when determining a course of conduct must be borne in mind. Otherwise, the doctor will not be assessed according to the norms of

> the average doctor of reasonable ability in the same circumstances, but rather will be held accountable for mistakes that are apparent only after the fact.
>
> No issue is taken with this proposition, which was applied both in the trial judge's charge to the jury and by the Court of Appeal.

[206] In ***Rollin v. Baker***, 2010 ONCA 569, the Ontario Court of Appeal, Epstein, JA, for the majority, stated that in assessing the standard of care it is imperative to consider the circumstances surrounding the medical issue, the medical circumstances, and what is realistic and reasonable. She said:

> Simply put, the standard of care regarding follow-up treatment requires a consideration not only of the patient's medical circumstances but also of what is "realistic and reasonable".

[207] The Plaintiff has provided caselaw to support its position that physicians must act on "time sensitive" results, failing which they can be held liable in negligence for breaching the standard of care.

[208] These have also involved situations where the defendant physician was not the primary treating physician or where other physicians, or treatment providers are involved.

[209] In his pre-trial brief the Plaintiff cited ***Braun Estate v. Vaughan***, [2000] MJ No. 63, for the proposition that a medical doctor must understand the vulnerability in a hospital setting or in hospital administration and have a reasonably diligent system that would alert them to, for example, a misplaced report. In ***Braun***, a pap smear test was not acted upon by a gynecologist, resulting in a late diagnosis of cervical cancer. The probability of recovery was 100% if the treatment had occurred on a timely basis.

[210] Similarly, the Plaintiff relies on the case, ***Phillip (Next friend of) v. Bablitz***, 2010 ABQB 566, where two physicians were held liable for damages arising from a delayed diagnosis of the plaintiff's congenital hypothyroidism. In this case, the court sanctioned "non primary physicians" for failing to act. The physicians were not in conventional doctor-patient relationships. They pleaded that they were expecting action on the part of a clinic to which the plaintiff had been referred, would be taken. The plaintiff noted that the court, in ***Phillip***, accepted "that referrals to specialists generally were left to the treating physician unless the symptom observed might impact the child's development". The court found that

these defendants also had "some responsibility" for co-ordinating the follow up care to the plaintiff.

[211] In ***Cleveland***, an infant plaintiff was screened for the disorder phenylketonuria (PKU) using screening known as the "Guthrie Test". The testing was performed by a provincial government laboratory, and the defendant doctor was the regional consultant under the provincial screening program. Positive test results were revealed at 2 days of age for PKU and a blood test taken at 7 days returned the same result. A third "Guthrie" test was ordered at 33 days of age that was reported as normal, "not elevated". No further clinical or laboratory follow-up was ordered. The plaintiff was later diagnosed with PKU and an action in negligence was commenced against the defendant doctor. The trial judge found the applicable standard of care required the ordering of a diagnostic test instead of a third "Guthrie" test after the two positive "Guthrie" tests, which diagnostic test was not performed.

[212] The defendant physician's appeal was dismissed as the trial judge gave cogent reasons for rejecting the defendant's position on the standard of care, which included a finding that the infants "phe" level was likely rising between the first and second tests. The court held that that finding was open to the trial judge, on the evidence.

[213] The Plaintiff here submits that the Defendant's conduct did create an unreasonable risk of harm for Alexander, because as a neonatologist at the CBRH, who became aware of an abnormal test, he was under a duty to take reasonable care to ensure that appropriate steps were being taken to follow-up on the test result.

[214] The case of ***TS v. Adey***, 2017 ONSC 397, involved a pregnancy ultrasound report that was considered outside the realm of a routine scan, given the time sensitivity (being close to the 24-week gestation period). The court held that the defendant radiologist did not meet the standard of care in failing to prioritize the report. Further, the court found that the defendant obstetrician was required to order a follow-up scan on a priority basis or make a timely referral to the fetal development clinic, given that the difficulties were identified in the 21-week ultrasound were significant enough to consider termination of the pregnancy.

[215] In ***Rollin***, the plaintiff suffered a serious wrist fracture (Colles) with a high risk of displacement. It was imperative that x-rays be completed in the weeks following surgery. There was also a concern whether the patient's family

physician would be equipped to handle the after care required. These factors contributed to the trial judge's finding that the standard of care required more hands-on involvement by the defendant physician, Dr. Baker. His failure to inform Ms. Rollin of the seriousness of the fracture and the need for monitoring made his failure to ensure she was placed in the hands of a competent doctor, a breach of the standard of care.

[216] The ***Rollin*** case is not comparable to the present case, in terms of the gravity of the injury and the potential for life altering harm. It is, however, instructive on the factors that must be considered, stating that a court's consideration of what is "realistic and practical" is often obtained through evidence of accepted practice within the profession. (See paragraphs 68, 71, 73 – 78, and ***Tacknyk v. Lake of the Woods Clinic***, [1982] OJ No. 170 (Ont. CA)).

[217] The Defendant has referenced a number of cases setting out the foundational principles to be considered by the Court when assessing the standard of care. It is the Defendant's position that these principles support Dr. Kajetanowicz's defence.

[218] In his post trial brief, the Defendant cited the following passages with respect to judging the performance of a physician as stated by Mr. Justice Tachereau in ***Cardin v. Montreal (City)***, 1961 SCR 655 at page 658):

> [translation] … The doctor is not a guarantor of the operation which he performs or the attention he gives. If he displays normal knowledge, if he gives the medical care which a competent doctor would give under identical conditions, if he prepared his patent before the operation according to the rules of the art, it is difficult to sue him in damages, if by chance an accident occurs. Perfection is a standard required by law no more for a doctor than for other professional men, lawyers, engineers, architects, etc. Accidents, imponderables, what is foreseeable and what is not, must necessarily be taken into account.

[219] The Defendant has further submitted Courts have consistently held that doctors are entitled to rely on "historically dependable systems".

[220] In ***Anderson v. Salvation Army Maternity Hospital***, (1989), 93 N.S.R. (2d) 141, 1989 CarswellNS 157, a baby was born with cerebral palsy and significant challenges. One of the allegations was that the physician caring for the mother was negligent for not being present in the delivery room at the relevant time. Justice Nunn had to consider whether the physician (Dr. Wrixon) was entitled to rely on the system in the hospital for communicating clinical developments to attending physicians. Justice Nunn found "there was a system in effect within the hospital

under which all those involved in the hospital worked and carried out the duties and responsibilities of their professions" (paragraph 124). The court concluded the physician was not negligent in relying on the system in place to notify him of the advent of delivery. Justice Nunn held it was reasonable for the defendant physician to rely on the system in place at the hospital stating at paragraph 126 and 127:

> 126. To hold that reliance on a system such as this in the normal course of the practice of a doctor's profession could render him liable in negligence, absent other factors, would be absolutely catastrophic in the provision of services in a hospital. Hospital rules and procedures are generally devised by those concerned to assure the highest standards of care is given in the most practical and efficient manner.
>
> 127. If something in the system fails, through negligence, then liability attaches, but to the one who was negligent. It must be remembered that here I am not determining whether anyone else was negligent. If any of the paid staff of the hospital were negligent is a question removed from my consideration by the earlier settlement with the hospital. My only concern is, was Dr. Wrixon negligent.

[221] He concluded that, "it was perfectly reasonable for him to expect the system would work" (paragraph 128), as it had before and after the incident.

[222] In ***Braun***, Dr. Vaughan argued that no liability shall attach to him, since the "real failure" was that of the hospital. On appeal this argument was found to be "untenable" because the physician "knew full well that there was no system in place or procedures in effect on the part of the clinic". (Paragraph 33) In addition, the evidence showed the patient's report was not reviewed or examined by the defendant.

[223] In ***Phillip (Next Friend of)***, the court agreed with the expert Dr. Down that as pediatricians, Dr. Andrew and Dr. Robertson had much greater expertise in child medicine than the plaintiff's family physicians. Although they were not the primary treating physicians, the court found they breached the standard of care in failing to arrange a consultation with a pediatric endocrinologist. In the present case, a serum recall should have been requested and a sample sent to the IWK, according to the discovery evidence of Elizabeth Campbell. (See Appendix "B")

[224] In ***Rupert v. Toth***, [2006] OJ No. 882, the defendant physician became aware of a possibly cancerous growth, and flagged the test result, by attaching a note to it that read, "ensure follow-up appointment". It was unknown what happened to the note, but a follow-up appointment was never made. The court

held that the defendant breached the standard of care in his handling of a time sensitive abnormality, finding that the physician had an obligation to communicate immediately with the patient. The court also noted there "will be patients for whom there is literally no time for the method of communication to be played out in the ordinary course".

[225] The principles set out in ***Toth*** favour the Plaintiff's position here. As is often the case, each of these cases are distinguishable based on the medical circumstances and the particular facts.

[226] It has been held that the character of the duty of care must be considered in the context of the degree of risk. (***McArdle Estate v. Cox***, 2003 ABCA 106, at paragraph 27)

[227] The law recognizes that it is appropriate for the Courts in Canada to consider expert opinion in deciding upon issues of professional negligence and the legal liability of physicians.

[228] Dr. Belik suggested that the implementation by Dr. Kajetanowicz of his system belied his awareness of the importance of acting upon abnormal screen results in a timely fashion. Both he and Dr. Dooley, said that relying on the statement without confirming that recall, had in fact been completed, was substandard on the Defendant's part. It was vital to confirm this, they said.

[229] The CMPA guidelines, earlier referred to are instructive, on this issue. In particular, guideline number 4 states:

> 4) When caring for a patient who is at a higher risk of receiving a clinically significant result, it is prudent to follow-up more closely.

[230] Did Dr. Kajetanowicz follow-up on Alexander's result "more closely"? Did "more closely" mean setting up a system, as he did, to follow the abnormal results at his hospital by reviewing each one, looking for the statement that recall has been initiated.

[231] Dr. Blayney and Dr. Marrin both said Dr. Kajetanowicz, had no further obligation once he confirmed for himself that the abnormal test was being addressed. His actions must be viewed as to what was known to him in 2008. For example, Dr. Blayney pointed out that these publications were issued after the birth of Alexander.

Decision

[232] In this case there has been lengthy and detailed evidence given by numerous medical experts stating that the cognitive impairment Alexander MacNeil suffered is severe. I have made no finding as to the extent of those injuries, or as to causation, in fact or in law.

[233] The thorough evidence given by Alexander's mother was that something seemed wrong with her infant son, but she did not know what it was. She attempted to see doctors and to get help. She described her family's ordeal, personally what she went through, her husband being unwell, working nights and caring for her children during the day, sending them to school in taxis, getting very little sleep. This evidence was both "gut-wrenching" and remarkable at the same time, a testament to her uncommon strength. As a family they were attempting to cope with Alexander's growing difficulties, all while having her other children under her care. Alexander's siblings were (and are) attempting to respond to the weighty burden on all of them.

[234] This Court is tasked to be dispassionate and to render an objective, impartial and independent judgment having regard to all of the circumstances in weighing the evidence, determining the facts, and applying the law.

[235] The key questions, are what is the standard of care that applied to Dr. Kajetanowicz, and did he breach that standard of care in reviewing Alexander's abnormal newborn screen result received on April 22, 2008?

[236] The evidence of the medical experts is extensive and detailed. Each was eminently qualified in training and experience to give their opinion. As a trial judge, I may accept all, part, or none of a witness's testimony, including the evidence of medical witnesses. That said, the law states it is appropriate to consider expert medical opinion in assessing professional negligence.

[237] Dr. Belik and Dr. Dooley have decades of combined experience. They each concluded that anything less than an inquiry by Dr. Kajetanowicz in these circumstances, was unreasonable and would undermine basic standards of safety for patients. Dr. Kajetanowicz, they said, needed to do more. This was not routine. On the contrary, this situation was urgent, as the test indicated. The potential for serious harm was imminent and this was known to Dr. Kajetanowicz when he became aware of Alexander's abnormal result. A physician has a duty to act in the patient's best interest by taking steps to ensure harm does not come to the

patient. The follow-up that was necessary by the Defendant here, did not occur, they said.

[238] The Plaintiff's experts further stated that it is not a standard of perfection to require that a simple phone call to advise the reporting physician, the family doctor, and the parents of Alexander of the test result. According to Dr. Dooley, it was unreasonable for Dr. Kajetanowicz to assume that recall had been completed. The standard of care required follow-up. The steps required to meet the standard were not onerous.

[239] All experts agreed that the IWK, the central hospital for the NBS, was at fault in this case. That said, the medical experts held varying opinions as to whether or not Dr. Kajetanowicz was at fault, and whether his actions were substandard; did he act with disregard, or inattention to his duty. It does not matter, said Dr. Dooley, that the IWK erred, the Defendant had a duty in addition to the IWK, and a standard of care to meet.

[240] In his evidence Dr. Kajetanowicz stated that (for his own patients) it was his experience with the NBS that he would receive the phone call from the coordinator, which call was followed by his receiving the abnormal test result. By that time, he would have already begun to act in having the baby recalled, he said. I accept his evidence on this point.

[241] Dr. Marrin, himself a neonatologist with 30 to 40 years of experience, testified that never before had he seen an abnormal test with the message that he was not required to attend to the abnormality. Dr. Kajetanowicz had seen such a message before. His evidence is consistent with that of Dr. Blayney, that he would never expect the statement from the IWK to be false, because in his experience it never had been.

[242] This leads the Court to consider whether there is evidence that what the Plaintiff's experts say should have been done by the Defendant, ever had been done by a physician in Nova Scotia prior to 2008. The answer to that question appears to be a resounding, "no".

[243] Both Dr. Belik and Dr. Dooley said that Dr. Kajetanowicz's system was laudable, but having undertaken to review them, he had a responsibility to follow-up on the abnormal results. That is, once his system was set up in January 2007, there had to be follow-up to ensure further testing, and there was not.

[244] In contrast, Dr. Blayney and Dr. Marrin, both experienced neonatologists, agreed that once Dr. Kajetanowicz confirmed for himself that the recall process had begun, nothing more needed to be done by him. It was his experience that the system worked and the purpose for the copy of the report was to "ease his mind" that appropriate action was being taken.

[245] Having reviewed the reports and the medical evidence, it is apparent that the experts held (to some degree) varying understandings of the functioning of the NBS in Nova Scotia in 2008. I have already reviewed these and do not propose to repeat those points in detail.

[246] Dr. Belik understood that Dr. Kajetanowicz's system caused the screen result not to be viewed by any other physician. The fact that Dr. Kajetanowicz was the only physician to review the result was an important part of his opinion, as in Dr. Belik's opinion it placed him in the unique position of having the positive obligation to act on the result.

[247] Dr. Blayney noted that the attending or primary physician had no role in the follow-up of an abnormal screening test. I am satisfied the evidence is clear that the reporting physician had the role of calling the baby back for retesting. I have already alluded to the fact that Dr. Blayney was referring in his opinion to the person or entity who had the "responsibility" to ensure follow-up on the recall, that was clearly the IWK and the NBS coordinator.

[248] Dr. Marrin said the message on the screen result was unusual to him. This raises the question of whether that alone ought to have given rise to the need for an inquiry by Dr. Kajetanowicz. It was Dr. Kajetanowicz's evidence that the purpose of his system was to remedy a potential weakness, that the message would not be passed on at the CBRH. This was important, he said, even if his system was redundant. He concluded it was redundant because the IWK were following up.

[249] The approaches taken by the experts also varied with respect to the factors they emphasized in determining the standard of care and whether it had been breached.

[250] As these opinions have already been discussed in detail, I will highlight certain of them.

[251] Dr. Belik and Dr. Dooley focussed on the potential gravity of the injury and the risk of harm, which were both high they said, presenting an urgency. Dr.

Blayney and Dr. Marrin took the view that the reports must be accurate as to how the screen result was reported, and that care must be taken to "go back" and view the standard of care by assessing the circumstances faced by Dr. Kajetanowicz in 2008. The standard of care must be viewed not from a 2021 lens, but from the lens in 2008, as stated clearly in ***Ter Neuzen***.

[252] The Court must ask, in assessing the actions or non-actions of Dr. Kajetanowicz, what was known to him in the context of the NBS, "back then". Having considered the evidence, it is my view that the Plaintiff's experts did not sufficiently consider the position of the Defendant at the relevant time. I conclude that they were viewing his actions with the benefit of hindsight, to at least some degree. This, I find, impacted on their conclusions that the standard of care included a positive obligation upon him to act on the abnormal test result.

[253] Conversely, the opinion of Dr. Blayney was given in the context of the newborn screening program as it actually operated. I find this approach fundamental in assessing what the standard of care required in these circumstances. I find the standard of care did not require the Defendant to do more than he did.

[254] Similarly, Dr. Marrin emphasized the importance of "going back" to view Dr. Kajetanowicz's action as the circumstances existed at the relevant time, and not in hindsight. He said, in his report:

> In my opinion we need to look at what a prudent physician would reasonably conclude from the NBS report, in the context of a reassuring history with the Provincial NBS system. Dr. Kajetanowicz's experience with the system was that it worked.

[255] Dr. Kajetanowicz gave evidence that previous screens similarly marked "P" did not result in him needing to notify the reporting or requesting physicians, as the system had always worked.

[256] This Court accepts the view of the Defendant's experts on the content of the standard of care. Based on all of the evidence, when the medical circumstances are considered, I find that the opinions of Dr. Blayney and Dr. Marrin are each a realistic and practical assessment of the actions of the Defendant (See ***Rollin v. Baker***, at paragraphs 66-78). In his report Dr. Blayney stated, "I believe that the statement on the report would be recognized as factual by any prudent MD, such as Dr. Andrzej Kajetanowicz". I agree with this statement.

[257] When the circumstances are viewed from what was known by the physician in 2008, as best that can be achieved, his reliance on a reliable and respected entity was not unreasonable. It is uncontradicted that the phone call from the IWK was never made. This had always been how the recall process was initiated and communicated to the local hospital, in this case the CBRH. Notwithstanding the dire consequences, the Plaintiff has not proven on a balance of probabilities, that the Defendant failed to meet the relevant standard of care.

[258] The standard of care required Dr. Kajetanowicz to assess the circumstances and confirm for himself that steps were being taken by the responsible entity to address the abnormal test. This meant to him that such testing would be completed based on all of his past experience prior to that time. His actions were that of a reasonable and prudent physician in the circumstances.

[259] In addition, the opinions of Dr. Belik and Dr. Dooley describe a very exacting standard, with Dr. Belik stating the Defendant's duty was to "make sure" that the follow-up had been completed. In his opinion, Dr. Dooley's repeated theme was that the Defendant needed to be "certain" that recall had actually been completed by the IWK. I find these opinions are stated in absolute terms and bring the standard much closer to one of perfection than to the standard of reasonableness, even when the urgency of the situation is considered.

[260] The same reasoning was discussed in ***Braun***, for example, where the Court of Appeal noted that the trial judge set the standard upon the physician "at too high a level", ie. that he was responsible to see that a system was in place to "ensure that a test result was read by the requesting physician". In that case the Court of Appeal held that the trial judge's conclusion "would have undoubtedly been the same applying the correct standard, namely that there was a duty upon the physician to see to it there was a reasonably effective follow up system in place".

[261] In this case, the Plaintiff has not established on the evidence that the Defendant interfered with what the IWK was required to do under the NBS program. I find the evidence has established that: 1) nothing was entered in the binder to show the NBS Coordinator was notified by the lab; 2) there was no documentation to show that the coordinator had performed any follow-up; 3) Alexander's name was marked off as if the results had been reviewed/seen; and 4) the phone call to the reporting physician was never made.

[262] This was not a situation where the Defendant was responsible for the test result not being acted upon. Based on the information he received, I find that Dr.

Kajetanowicz had every reason to believe it was being acted upon in accordance with the procedure that had always been followed.

Conclusion

[263] The Plaintiff has failed to prove that the actions of Dr. Kajetanowicz failed to meet the standard of care.

[264] It was highly unexpected and unforeseeable that the IWK would fail to complete the recall. It was reasonable for the Defendant to expect that they would complete the recall, in accordance with his experience.

[265] In the result the Plaintiff has not established that Dr. Kajetanowicz was negligent. It is therefore unnecessary for me to consider the remaining issues as they are no longer relevant.

[266] The action is therefore dismissed.

[267] If the parties are unable to agree on costs, Counsel may provide written submissions within 60 days.

Murray, J.

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APPENDIX "A"

RUN DATE: 18/04/08 LAB IWK Health Centre *LIVE* PAGE 1
RUN TIME: 0105 ER & Referred in Location Report
RUN USER: DECEDL

PATIENT: BOND-MACNEIL,BABY MALE B ACCT #: C00001199/08 LOC: LAB.CBRF U #:
AGE/SX: 00M 02D/M ROOM: REG: 11/04/08
REG DR: Kajetanowicz,Danuta STATUS: REG REF BED: DIS:
DOB: 09/04/08 HCN: 8000804933 8000804933

SPEC #: 1004:CP00020R COLL: 10/04/08-0740 STATUS: COMP REQ #: 02620010
RECD: 11/04/08-1217 SUBM DR: Kajetanowicz,Danuta

ENTERED: 11/04/08-1217 OTHR DR:
ORDERED: NEWBORN SCRN
QUERIES: HOSP ID #: 00314806
MOTHER'S NAME: TANIA
BIRTH WT: 2800
DATE OF BIRTH: 09/04/08
GEST AGE: 37
HOSPITAL OF BIRTH: CBRF
PKU CARD #: 423519
TIME OF BIRTH: 1310

	Test	Result	Flag	Reference
	NEWBORN SCRN			
>	METABOLIC SCRN	Normal Screen		
		Specimen was screened for the following inherited metabolic disorders:		
		Phenylketonuria(PKU), Medium Chain AcylCoA-dehydrogenase Deficiency(MCADD), Very Long Chain AcylCoA dehydrogenase Deficiency(VLCAD), Long Chain Hydroxy-AcylCoA-dehydrogenase Deficiency(LCHAD), Trifunctional Protein Deficiency(TFP), Glutaric Aciduria Type I (GA-I), Glutaric Aciduria Type II(GA-II), Carnitine Uptake Defect(CUD), Carnitine Palmitoyl Transferase I Deficiency(CPT-I), Carnitine Palmitoyl Transferase II Deficiency(CPT-II), Carnitine Translocase Deficiency (CTL), Isovaleric aciduria(IVA) and Maple Syrup Urine Disease(MSUD)		
		NOTE: Newborn screening does NOT rule out these or other inherited metabolic disorders.		
	PKU SCREEN			
>	Phenylalanine	57		umol/l
		Normal screen		
	MCAD SCREEN			
>	C8 Carnitine	0.05		< 0.7 umol/l
		Normal screen		
	THYROID SCREEN			
>	TSH Neonatal	15.5		mU/L BLD
		ABNORMAL screen result	*P*	
		Recall has been initiated by IWK Health Centre.		
>	Age at Coll'n	18		Hours

** END OF REPORT **

LABORATORY
APR 22 2008
Cape Breton Regional

APPENDIX "B"

71

MS. ELIZABETH CAMPBELL, Exam by Mr. Downie

A: I have no idea.
Q: She's not with the IWK?
A: No, no.
Q: I don't understand your comment about failsafe as it relates to…
A: It's a…
Q: As I think you said the…
MS. BENNETT-CLAYTON: Wait for the question.
MR. DOWNIE: The communication of information…
A: Mm-hmm.
Q: … from the IWK lab to the Cape Breton Regional Hospital lab. I don't understand how you describe that as a failsafe method in circumstances where the report in question indicates that the screen result is abnormal and "recall has been initiated by IWK Health Centre." How is sending that to the lab in Cape Breton from the IWK a failsafe method?
A: I can't answer that. I don't know. If it… anything from the lab and to them. I think what I was trying to say, and probably poorly said, was that our role was supportive in that once I was aware there was an abnormal result I contacted the physician requesting followup.
Q: What physician?
A: In this particular case? I wasn't involved in it at all.

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MS. ELIZABETH CAMPBELL, Exam by Mr. Downie

Q: I think you might be guessing. Because you don't

know. Has anyone said to you, anyone at the IWK said to you that, we called a physician in April of 2008 and spoke with that physician about the thy-…

A: No, I don't believe that happened.

Q: Right.

A: Okay.

Q: So having read materials when you took on your job, as you've alluded to…

A: Mm-hmm.

….

MS. ELIZABETH CAMPBELL, Exam by Mr. Downie

If it was between 15 and 20, then it was a serum recall, which was a different type of sample. I don't understand the scientific…

Q: This one was 15.5, I guess.

A: Yeah, so … so in this case a serum recall should have been requested and a sample sent to the IWK. If the sample was greater than 20, then it was considered a baby recall, and our endocrinologist would automatically contact the hospital, physician. That would have been out of Newborn Screening coordinator's hand.

Q: So in April 2008 was the system of recall, to your knowledge, done internally at the IWK? In other words, the people and processed involved in that system of recall, was that all internal to the IWK? Or did it rely on or depend on persons or entities outside the IWK?

A: I'm not sure I understand, but I'll… the actual follow up from Newborn Screening was internal. The lab results would have been reported from the IWK lab because they would have been tested there. So I'm going to say yes. I'm really not sure I quite understand. I don't…

Q: Well, the report in this case… and Mr. Wagner referred to it by page number. I have it at page 1 of Doctor …