Mangelana v. *McFadzen et al*, 2005 NWTSC 41

Date: 2005 04 14
Docket: CV 05291

SUPREME COURT OF THE NORTHWEST TERRITORIES

BETWEEN:

SPENCER MANGELANA

Plaintiff

- and -

J. McFADZEN, HELENE BELANGER, LORRIE MEISSNER, INUVIK REGIONAL HEALTH AND SOCIAL SERVICES AUTHORITY, operating facilities known as TUKTOYAKTUK HEALTH CENTRE and INUVIK REGIONAL HOSPITAL, DR. BOTHA

Defendants

Reasons for judgment following trial of an action for medical malpractice.

Heard at Yellowknife, NT: October 25 - November 5, 2004

Reasons filed: April 14, 2005

REASONS FOR JUDGMENT OF THE HONOURABLE JUSTICE J.E. RICHARD

Counsel for the Plaintiff: Sheila Torrance and Joe Miller

Counsel for the Defendants J.McFadzen, Helene Belanger, Lorrie Meissner, and Inuvik Regional Health and Social Services: Garth Malakoe and Terry Nguyen

Counsel for the Defendant Dr. Botha: Jonathan P. Rossall and Alexis Moulton

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REASONS FOR JUDGMENT

[1] In 1992 the plaintiff underwent a tonsillectomy at the Inuvik Regional Hospital. Subsequently he developed pneumonia and adult respiratory distress syndrome resulting in a prolonged and complicated stay in the Intensive Care Unit at a hospital in Edmonton for three months. In these proceedings he alleges negligence by medical personnel in Inuvik and in his home community of Tuktoyaktuk prior to and during the tonsillectomy operation and in his post-operative care. As a result he seeks damages for pain and suffering, loss of enjoyment of life, loss of income, loss of earning capacity and the cost of his lengthy hospitalization and treatment in Edmonton. The trial was held in Yellowknife in the fall of 2004 and what follows are the reasons for the Court's decision.

[2] In 1992, the plaintiff was a 19 year old resident of Tuktoyaktuk. He lived at the home of his parents. He had a grade 8 equivalent education and had seasonal, sporadic employment. He had an active lifestyle, was engaged in sports activities and also traditional hunting and fishing activities.

[3] As a resident of Tuktoyaktuk the plaintiff had many occasions to attend at the Tuktoyaktuk Health Centre for medical treatment. The Tuktoyaktuk Health Centre was staffed by registered nurses who were resident in Tuktoyaktuk. In addition, a physician resident in Inuvik would attend the Tuktoyaktuk Health Centre once a month for a few days and provide medical services to the residents of Tuktoyaktuk.

[4] The plaintiff attended at the Tuktoyaktuk Health Centre a number of times complaining of a sore throat. He was diagnosed with tonsillitis several times by the nurses and in particular in March 1992 and May 1992.

[5] On June 15, 1992, the plaintiff was examined by the defendant Dr. Botha at the Tuktoyaktuk Health Centre. In 1992, Dr. Botha was a physician/surgeon resident in Inuvik who visited the Tuktoyaktuk Health Centre once a month. Dr. Botha had privileges at the Inuvik Regional Hospital.

[6] Following Dr. Botha's examination of the plaintiff on June 15, 1992, he diagnosed the plaintiff as having recurrent tonsillitis and recommended that the plaintiff have his tonsils removed. The surgery was scheduled for July 2, 1992, at the Inuvik Regional Hospital but was later rescheduled for July 7, 1992.

[7] The plaintiff was admitted to the Inuvik Regional Hospital on July 6, 1992 for a tonsillectomy to be performed by Dr. Botha on July 7, 1992. On admission he signed the usual consent forms indicating that the nature and anticipated effects of the surgical procedures had been explained to him, as well as the risks involved. Although at trial 12 years later the plaintiff says he has no memory of signing the consent forms, I am satisfied he gave an informed consent to the surgery.

[8] Upon admission to the hospital the plaintiff was examined by nursing staff. His vital signs (temperature, pulse, respiration rate and blood pressure) were taken and a complete physical examination was done. Blood tests and urinalysis were ordered and done. The blood tests showed an elevated white blood cell count

of 12.4 but was otherwise normal. Urinalysis was normal except for the presence of a trace of blood.

[9] The plaintiff was given pre-operative medication at 7:00 a.m. on July 7 and transported to the operating room at 8:10 a.m. He was seen by the anaesthetist, Dr. DeKock and then Dr. DeKock administered the anaesthetic, commencing at 8:15 a.m. The surgery itself occurred between 8:25 a.m. and 8:37 a.m.

[10] The procedure for administering the anaesthetic involved the insertion of a tube through the plaintiff's nostril down into the trachea. Anaesthetic gasses are then passed through the tube into the lungs. During the process care must be taken to prevent the passage of fluids or other foreign material into the trachea or lungs. This is known as aspiration and is a recognized risk associated with the use of anaesthetics.

[11] During the tonsillectomy surgery itself, Dr. Botha first clamped off the right tonsil and dissected it from the wall of the throat. He then checked the site for bleeding, and then sponged the tonsil bed with a special treated sponge to constrict the small blood vessels and prevent any bleeding. This is termed achieving hemostasis. He then repeated this procedure for the left tonsil. He observed the tonsil bed for bleeding, before turning things over to the anaesthetist to reverse the anaesthetic. Dr. Botha's handwritten "Report of Operation", entered as an exhibit, concludes: "Moderate blood loss. Hemostasis obtained. Anaesthetic reversed. Patient tolerated procedure well".

[12] While the anaesthetic was being reversed following surgery in the operating room, the plaintiff was under observation. He remained in the operating room until 8:55 a.m. when he was transferred to the recovery room and remained there under the observation and care of the recovery room nursing staff until 10:00 a.m. when he was transferred to the ward, ward 200. The nurses' notes indicate he was returned to the ward in satisfactory condition. He coughed up a small to moderate amount of bright red clotted blood.

[13] At 12:30 p.m. on July 7 the nurses took the plaintiff's vital signs and described them as stable. The nurses' notes indicate he coughed up another 15 cc of

bright red blood. These notes are handwritten and there is a dispute whether it reads 75 cc or 15 cc. The notes continue: "unable to assess as to whether bleeding is from tonsil beds or nose as a lot of blood in posterior aspect of mouth. Dr. Botha notified regards to same. Orders received but refuses to come in to assess him. Dr. DeKock made aware and will come in to assess".

[14] Dr. DeKock did attend at the ward to see the plaintiff at the request of the nurses. She made a change order with respect to one of the medications but saw nothing that caused her to contact Dr. Botha.

[15] The nurses took the plaintiff's vital signs during the evening of July 7. At 6:00 p.m. his temperature was recorded at 39.2. At 10:00 p.m. his temperature was recorded at 37.8, and the following morning at 6:00 a.m. and 10:00 a.m. his temperature was recorded at 37.6 and 37.4 respectively.

[16] The plaintiff was discharged from Inuvik Regional Hospital on July 8. One of the trial exhibits indicates that Dr. Botha's discharge order was noted on the chart at 1:00 p.m. on July 8. The plaintiff flew back to his home community of Tuktoyaktuk that same day.

[17] The plaintiff's mother says that when the plaintiff arrived home on July 8 he did not look well.

[18] Early the next morning the plaintiff's mother phoned the Tuktoyaktuk Health Centre and told the duty nurse, the defendant Helene Belanger, that the plaintiff was not feeling well following his tonsillectomy. Nurse Belanger spoke to the plaintiff on the telephone and asked him to come to the Health Centre. The plaintiff arrived at the Health Centre at 8:35 a.m. on July 9. Her notes indicate that he complained that his throat was painful and that his breathing was "hard". She examined his throat and observed white healing tissue. In her testimony she says she believes she took his temperature as she made a note that he was "afebrile", meaning no fever. There is no indication in the records that she took any other vital signs. She increased his Tylenol #2 medication to Tylenol #3 as the plaintiff indicated the Tylenol #2 was not working for the pain. She told him to return to the Health Centre if his situation worsened or if he developed a fever. At the time of this visit the plaintiff was not coughing and he told nurse Belanger that his breathing was not bothering him.

[19] The plaintiff returned to the Tuktoyaktuk Health Centre at 6:40 p.m. on July 9. He was seen by another nurse, the defendant Jan McFadzen. He complained of headache and fever. He stated that he had vomited 3 times that day and he vomited again while at the Health Centre. Nurse McFadzen took his vital signs and examined him. She made a differential diagnosis - either his symptoms were normal following a tonsillectomy 2 days earlier, or the nausea and headache were symptoms of the start of an infection. She gave him gravol for the nausea and some more tylenol and sent him home and told him to return in the morning if he was still feverish.

[20] There is no evidence of any contact between the plaintiff and the Tuktoyaktuk Health Centre on Friday, July 10.

[21] At 8:40 a.m. on Saturday, July 11, the plaintiff's mother called the Health Centre regarding the plaintiff's condition. The nurse on duty was the senior nurse at the Health Centre, the defendant Lorrie Meissner. The plaintiff's mother told nurse Meissner that the plaintiff had a fever and was vomiting. Nurse Meissner asked that the plaintiff come to the Health Centre. Nurse Meissner was aware that the plaintiff had had a tonsillectomy on July 7 and that he had been to the Health Centre a few times since his return to Tuktoyaktuk, so she decided to call Dr. Botha to seek his advice. This she did prior to the plaintiff's arrival at the Health Centre. She told Dr. Botha of the plaintiff's visits to the Health Centre, and she would have had access to the plaintiff's file in doing so. Dr. Botha told her to leave the plaintiff on his existing medications for the time being, so long as he wasn't febrile, and that the plaintiff should be told to expect to feel "rough" for several days. When the plaintiff arrived at the Health Centre, nurse Meissner examined him and took his vital signs. He did not appear dehydrated. There were no signs that he was in respiratory distress. His throat was reddened but there was no blood. Her note at the time states he "appears more irritable at being ill than ill". Under "Assessment" her note reads "post-tonsillectomy". She repeated Dr. Botha's advice that he should continue on his existing medication and that he should expect to feel rough for several days. She drew a blood sample from him to send for testing and gave him some more Tylenol pills.

[22] At 2:00 p.m. on Sunday, July 12, the plaintiff's mother again phoned the Health Centre and spoke to the duty nurse, nurse Meissner. She said the plaintiff was not well and was breathing rapidly. Nurse Meissner could hear the plaintiff coughing in the background and asked to speak to him. Nurse Meissner insisted that the plaintiff come to the Health Centre. Her notes indicate that he was reluctant to do so. When he arrived at the Health Centre, he was breathing rapidly. He stated that he rode on his bicycle to the Health Centre.

[23] Nurse Meissner examined the plaintiff and took his vital signs. He had rapid breathing, his respirations were shallow and moist, he had a congested cough. A chest osculation indicated a decreased air entry in the bases of his lungs, with coarse breath sounds. She did a chest x-ray and it revealed bilateral lower lobe pneumonia. She telephoned Dr. Botha in Inuvik to seek his advice. He recommended 5 million units of penicillin to be given intravenously right away, and again in the evening. Nurse Meissner gave the intravenous penicillin at 3:00 p.m. The plaintiff's respirations eased and he started to rest comfortably. Nurse Meissner sent the plaintiff home in a cab at 3:40 p.m. and told him to return at 6:30 p.m. for a second infusion of penicillin, as directed by Dr. Botha. Her note under "Assessment" at the time of this visit was "bilateral lower lobe pneumonia".

[24] At 6:00 p.m. the plaintiff's family called Nurse Meissner at the Health Centre. They were quite upset that the plaintiff was not getting better. Nurse Meissner knew that there was a scheduled flight to Inuvik at 8:00 p.m. She phoned Dr. Botha in Inuvik and recommended that the plaintiff be sent to Inuvik on that flight for re-admission to the Inuvik Regional Hospital and Dr. Botha agreed. It was Nurse Meissner's assessment that the plaintiff was well enough to tolerate flying on the scheduled flight on his own unaccompanied. She arranged for a taxi to pick up the plaintiff at his home and bring him to the Health Centre where she could see him again before he left. When he arrived in the taxi, her observation was that he had freshly showered, had changed his clothes and was not in distress. She gave him his plane ticket and his chest x-ray and he left in the taxi and then flew on the scheduled flight to Inuvik where he was re-admitted to the Inuvik Regional Hospital at 8:35 p.m.

[25] At the Inuvik Regional Hospital the plaintiff's condition continued to deteriorate. He was intubated and eventually, in the early morning hours of July 13, he was med-evac'd to the University of Alberta Hospital in Edmonton for critical care treatment.

[26] While at the University of Alberta Hospital, the plaintiff developed adult respiratory distress syndrome and septicemia. His diagnosis included bilateral streptococcus pneumonia. He also suffered a number of complications including recurrent pneumothoraces requiring chest tubes, difficulty with nutrition, renal dysfunction, plastic surgery for abscess formation in intravenous sites, cholecystitis requiring gall bladder removal, and a grand mal seizure.

[27] The plaintiff was discharged from University of Alberta Hospital back to Inuvik Regional Hospital on October 14, 1992, and remained at the Inuvik Regional Hospital for rehabilitation under the care of Dr. Botha until October 26, 1992. He then returned to his home in Tuktoyaktuk for further rehabilitation and convalescence.

[28] The within proceedings were commenced by the plaintiff on July 5, 1994. In his statement of claim he alleges that the injuries which he suffered were caused by the negligence of one or more of the defendants. The particulars of that negligence, he says, include:

a) failing to properly investigate the plaintiff's symptoms and complaints;

b) failing to order all reasonable diagnostic tests or aides;

c) failing to take a proper history;

d) failing to provide proper treatment of the plaintiff's illness;

e) failing to properly follow-up and monitor the plaintiff's condition;

f) failing to refer the plaintiff to the appropriate facilities or experts; and

g) failing to instruct the plaintiff on the proper care of his condition.

[29] The plaintiff gave evidence at trial, as did his mother Margaret Klengenberg. In addition, the plaintiff called two medical experts, Dr. Hugh Paterson and Dr. George Douchet, and a nursing expert, Mary Gardiner. The expert reports of Dr. Brian Sproule and Dr. Dale Lien were admitted into evidence by agreement.

[30] The defendant Dr. Botha testified and also called as witnesses the anaesthetist Dr. DeKock and a medical expert Dr. David Butcher.

[31] Each of the defendant nurses, Helene Belanger, Jan McFadzen and Lorrie Meissner testified and those defendants also called medical expert Dr. John Morse and nursing expert Rod Izzard.

[32] Medical records from the Tuktoyaktuk Health Centre, the Inuvik Regional Hospital and the University of Alberta Hospital were entered as exhibits at the trial, as were other documents.

[33] In the words used in his statement of claim, the plaintiff frames his lawsuit in both tort and contract. In the circumstances of the present case, however, the plaintiff concedes there is no practical distinction between the two causes of action. Indeed, the focus of all oral and written argument is on the tort of negligence, and these reasons accordingly address the issues in the context of a tort action.

[34] In any successful negligence action against a medical practitioner, four requirements must be met:

i) the defendant must owe the plaintiff a duty of care;

ii) the defendant must breach the standard of care established by law;

iii) the plaintiff must suffer an injury or loss; and,

iv) the defendant's conduct must have been the actual and legal cause of the plaintiff's injury.

Legal Liability of Doctors and Hospitals in Canada, Picard and Robertson, 3d ed, p.174.

[35] In most cases, as in the within proceedings, it is clear that the medical practitioner, (doctor or nurse) owed a duty of care to the plaintiff. Also in most cases, as in the within proceedings, it is obvious on the evidence presented that the plaintiff suffered injury or loss. The main issues, then, are a) whether one or more of these defendants breached the standard of care and b) whether any such breaches are causally related to the injury or loss suffered by the plaintiff. Upon my careful review of all of the evidence, I find there were instances when one or more of the defendants did not meet the requisite standard of care owed to this plaintiff. However, as stated in the reasons which follow, I have a concern regarding a causal connection between the defendants' conduct and the injury or loss suffered by the plaintiff.

[36] Standard of care: The medical practitioner owes a duty of care to the patient. The standard of care provided by a defendant is measured objectively against that of a reasonable medical practitioner who possesses and exercises the skill, knowledge and judgment of the normal, prudent practitioner of similar experience and standing. The objective comparison is made with reference to the particular circumstances at the material time. Picard and Robertson, *supra*, p. 186. Put another way, the test is whether this plaintiff was given, in each instance of alleged negligence, the medical care that a competent doctor or nurse would give under similar circumstances.

[37] Causation: A plaintiff must prove a causal link between the negligence and the injury. The Supreme Court of Canada addressed the issue of causation in 1996 in *Athey* v. *Leonati* 140 D.L.R. (4th) 235. The Court stated, at paragraphs 13 - 17:

> "Causation is established where the plaintiff proves to the civil standard on a balance of probabilities that the defendant caused or contributed to the injury ....
> The general, but not conclusive, test for causation is the "but for" test, which requires the plaintiff to show that the injury would not have occurred but for the negligence of the defendant ....
>
> The "but for" test is unworkable in some circumstances, so the courts have recognized that causation is established where the defendant's

> negligence "materially contributed" to the occurrence of the injury .... A contributing factor is material if it falls outside the *de minimus* range.
>
> On *Snell* v. *Farell*, this court recently confirmed that the plaintiff must prove that the defendant's tortious conduct caused or contributed to the plaintiff's injury. The causation test is not to be applied too rigidly. Causation need not be determined by scientific precision; .... it is "essentially a practical question of fact which can best be answered by ordinary common sense". Although the burden of proof remains with the plaintiff, in some circumstances an inference of causation may be drawn from the evidence without positive scientific proof.
>
> It is not now necessary, nor has it even been, for the plaintiff to establish that the defendant's negligence was the <u>sole cause</u> of the injury .... As long as a defendant is part of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury".

[38] It is noteworthy that this trial occurred 12 years after the events surrounding the plaintiff's serious illness. Not surprisingly, some of the witnesses have no actual recollection of events, even though they were in fact participants in those events. For example, Dr. DeKock, a colleague of the defendant Dr. Botha, testified as a witness at the trial and stated that she has no actual memory of the events of July 1992. In particular, she has no recollection of attending on the plaintiff on the hospital ward at 12:30 p.m. on the day of surgery July 7. However, from being shown the hospital record which includes a doctor's order which she signed at that time for this plaintiff, she is satisfied that she indeed did so. Much of the testimony of the medical witnesses was necessarily qualified as, or restricted to, "what my standard practice was at that time".

[39] The defendant Dr. Botha has no specific recollection of certain of the events of June/July 1992, e.g., his June 15, 1992 examination of the plaintiff at the Tuktoyaktuk Health Centre, or the actual discharge of the plaintiff from the Inuvik Regional Hospital on July 8, 1992, the day following surgery. Yet, he seems to able to state with some certainty (perhaps defensively), e.g. :

a) that no one advised him that the plaintiff's pre-operative blood tests on July 6, 1992 showed a white blood cell count of 12.4;

b) that no one advised him that the plaintiff had coughed up 75 c.c. of bright red blood at 12:30 p.m. on the day of surgery;

c) that no one advised him of the plaintiff's high temperature reading of 39.2 at 6 p.m. on the day of surgery.

On the other hand, Dr. Botha states that his standard practice before discharging a patient from hospital was to look at the nurses' notes and the patient's chart and he likely would have done this before discharging this plaintiff on July 8, 1992 and accordingly would likely have been aware of, for example, the white blood cell count of 12.4, the post surgery blood loss and the temperature spike of 39.2.

[40] I turn now to the various allegations of professional negligence and will consider these under the following stages: a) the tonsillectomy surgery itself, b) the doctor-nurses communications at the Inuvik Regional Hospital, c) the decision to discharge on July 8, d) post-surgery care by the nurses at the Tuktoyaktuk Health Centre, and e) communications between Dr. Botha and the nurses at the Tuktoyaktuk Health Centre.

[41] The tonsillectomy surgery on July 7, 1992: In adults, tonsillectomy is considered to be major surgery. According to Dr. Botha, who performed this surgery, and Dr. DeKock who was the anaesthetist who witnessed the surgery, and the notes made at the time, the surgery was uneventful. Both Dr. Paterson, an expert witness called by the plaintiff, and Dr. Butcher, an expert called by the defendants, reviewed the medical and hospital records regarding the surgery and describe it as uneventful or routine. Both Dr. Botha and Dr. DeKock made a written note of a nosebleed caused by nasotracheal intubation; however this is not considered an uncommon event, and appears to have been managed without serious concern.

[42] There is no factual evidence of any aspiration of blood or other foreign material into the trachea during this surgery. Dr. DeKock testified that as anaesthetist she monitors the patient very carefully to ensure there are no problems and in particular guards the airway very carefully to ensure that aspiration does not occur. Each of the expert witnesses, Dr. Paterson and Dr. Butcher, are of the view that no aspiration occurred. With respect I do not accept Dr. Douchet's

statement that there was "likely introduction of infectious material into the trachea" as a result of a "traumatic nasopharyngeal intubation". That is speculation at best. There is no evidence that it occurred.

[43] Similarly, I do not accept Dr. Douchet's statement that it was necessary to use ligatures to address bleeding from the tonsil beds, rather than the use of the treated sponges or gauze packs. Dr. Douchet's opinion is based on an assumption that hemostasis was not attempted or attained. That is not the evidence. The evidence is that hemostasis was achieved.

[44] The one area of concern at the time of the surgery is the pre-operative assessment. The evidence indicates that Dr. Botha (perhaps) saw the plaintiff around the time of his admission to the hospital on July 6, but did not again see or examine the plaintiff until he (Dr. Botha) entered the operating room on the morning of July 7 and performed the surgery.

[45] Although upon the plaintiff's admission to hospital on July 6 the nurses took the plaintiff's history and did the pre-operative work-up, and although blood tests and urinalysis were done in the hospital laboratory in preparation for surgery and although the anaesthetist Dr. DeKock did a physical examination of the plaintiff prior to the surgery, Dr. Botha himself did not do any physical examination of the plaintiff prior to performing the surgery. He did not speak with the plaintiff prior to the surgery, did not review the hospital charts, nurses' notes or laboratory results.

[46] The expert witnesses, Dr. Paterson, Dr. Douchet and Dr. Butcher all agree that it is unusual and contrary to standard practice for the surgeon himself not to do a pre-operative assessment and actual physical examination. As Dr. Butcher put it, it is important for the surgeon to do a pre-operative assessment for two reasons: "to make sure he is fit for surgery at the time of surgery, and secondly, that the condition still warrants surgery".

[47] Dr. Botha says the practice at the Inuvik Regional Hospital at that time was that the anaesthetist would examine the patient prior to the surgery. He stated: "the practice was the nurse examined the patient, take the history, the patient arrived in the operating room, the anaesthetist do another history and examination and

look at the results .... that was the practice in Inuvik at the time, all four of the physicians".

[48] Dr. Botha's colleague, Dr. DeKock, however, was not quite of the same view. She stated: ".... as anaesthetist it would be my responsibility to make sure that the patient was fit to have an anaesthetic, in other words, that they were in healthy condition before I would give them an anaesthetic. And so that would include looking, examining any investigations that had been done and we, as far as I can remember at that stage, it was mandatory for all patients to have a CBC, in other words, a blood .... kind of a blood count done beforehand and also to have a urinalysis done. And so I would look at those, we would look at the history that was provided. There was also an anaesthetic record or a check list that was performed by the patient and sometimes with the help of one of the nurses before the surgery, so we would look at that, and then we would give them a brief examination to make sure that they did not have an active infection or terrible lung disease or heart problem that would perhaps preclude them from getting an anaesthetic, receiving anaesthetic". When questioned directly as to whether the anaesthetist's role in this regard had to do with ensuring fitness to have the anaesthetic or to have the surgery generally, her response was that it was for the anaesthetic. She saw the anaesthetist's role and responsibility as being separate and apart from that of the surgeon.

[49] In all of the circumstances I find on the evidence that Dr. Botha, in failing to do a pre-operative assessment prior to performing the surgery on July 7, 1992, did not give the level of medical care expected of a competent and prudent surgeon in similar circumstances.

[50] Before moving to the next topic, I refer briefly to the issue of the white blood cell count of 12.4 which was indicated on the pre-operative laboratory results of July 6, 1992. The evidence is that this blood test was ordered by a Dr. DeKlerk at the Inuvik Regional Hospital on July 6 and that the results were seen and reviewed by Dr. DeKock prior to Dr. Botha proceeding with the surgery on July 7. This level of white cell blood count is described as "slightly" or "mildly" elevated by Dr. Paterson, Dr. Butcher and Dr. DeKock. Dr. Paterson states that at the time (i.e., just prior to surgery) this would not be of concern in an otherwise healthy 19 year old man who is asymptomatic and has no abnormal physical findings. I am satisfied on the evidence that Dr. DeKock

was aware of this white blood cell count prior to surgery and did not bring it to Dr. Botha's attention because it did not give her any particular concern. Dr. Botha also stated that that particular laboratory result, on its own, would not be a concern for him in the context of the surgery he was to perform. Upon a consideration of all of the evidence. I find nothing significant in the fact that Dr. Botha performed the tonsillectomy at a time when the plaintiff's white blood cell count was 12.4.

[51] The doctor-nurse communications at Inuvik Regional Hospital: While Dr. Botha was giving his trial testimony, his attention was drawn to certain entries in the hospital records or nurses' notes which reflect significant observations about the plaintiff's condition at particular times. Dr. Botha's testimony (12 years later) was generally to the effect that no one brought these significant observations to his attention at the time. Examples are:

a) the plaintiff's pre-operative blood test showed a white blood cell count of 12.4 which is an elevated level;

b) the amount of blood loss at 12:30 p.m. following surgery was approximately 75 c.c. and it was bright red blood; and

c) the plaintiff's vital signs recorded by the nurses at 6 p.m. following surgery indicated temperature at 39.2, pulse at 100, and respiration rate at 26.

[52] With respect to (b) and (c) above, Dr. Botha stated during cross-examination that had these observations been brought to his attention at the time, he would have personally attended to examine the patient (the plaintiff), and he may have done things differently, e.g., ordered further tests.

[53] Given Dr. Botha's general evidence that he has no actual recollection of much of the events of June/July 1992, I have some difficulty with his categorical statements, 12 years later, that he was not told certain things at certain times.

[54] The expert witness Nurse Gardiner also reviewed the hospital records and noted in particular the entry of a recorded temperature of 39.2 degrees at 6 p.m. of the

day of surgery and was of the opinion that the nurse should have communicated this fact directly to the physician (a normal temperature being approximately 37 degrees). She observes that there is nothing in the hospital record to indicate that this communication occurred.

[55] In all of the circumstances I am unable to find as a fact that the nurses told Dr. Botha of these significant observations on a timely basis, or that they did not. If they did not, they failed to meet the required standard of care expected of competent medical practitioners in similar circumstances. If they did advise him on a timely basis and he did not attend on the patient or arrange for some other physician to do so, then he failed to meet the required standard of care expected of a competent physician in similar circumstances.

[56] Before leaving this topic of communications among professionals at the Inuvik Regional Hospital, I refer again to the entry in the nurses' progress notes at 12:30 p.m. on July 7, 1992, approximately four hours after the tonsillectomy. The notes read: "vital signs stable. Coughed up another $\pm$ 15 c.c. [could be 75 c.c.] of bright red blood. Unable to assess as to whether bleeding is from tonsil beds or nose as a lot of blood in posterior aspect of mouth. Dr. Botha notified with regards to same. Orders received but refuses to come in to assess him. Dr. DeKock made aware and will come in to assess".

[57] In his testimony, Dr. Botha says that he did not refuse to come in to the hospital to see the plaintiff. He testified that he received the phone call at his clinic where he was seeing other patients and as Dr. DeKock was at the hospital, he instructed the nurse to contact Dr. DeKock and have Dr. DeKock assess the patient.

[58] Upon a consideration of the documentary evidence and the testimony of Dr. DeKock, I am satisfied that Dr. DeKock was indeed contacted and Dr. DeKock indeed attended upon the plaintiff between 12:30 p.m. to 1:30 p.m. and further, that Dr. DeKock's examination of the plaintiff did not cause her sufficient concern that led her to contact the surgeon Dr. Botha. She stated that if there had been problems with large amounts of bleeding, she either would have dealt with it herself, or would have contacted Dr. Botha.

[59] And with respect to the 12:30 p.m. entry on the progress notes regarding "orders received", I note that there is, on a separate hospital document entitled "Doctor's Orders", an entry indicating that Dr. Botha gave an order by telephone at 12:35 p.m. for 2 tablets of Cyclokapron (a coagulation medication).

[60] Thus, I find on all of the evidence that the plaintiff received proper medical care with respect to the nurses' observation of blood loss at 12:30 p.m. on July 7.

[61] The decision to discharge on July 8, 1992: It was Dr. Botha's evidence that the practice with an adult tonsillectomy patient was to keep the patient in the hospital overnight following the surgery and to discharge the patient the following morning, if there were no complications. It was the opinion evidence of Dr. Butcher that the discharge of a patient such as the plaintiff the day following a routine tonsillectomy, in the absence of complications or unusual symptoms or findings, was an acceptable practice in Inuvik in 1992. None of the other expert witnesses suggested otherwise, save for Nurse Izzard who would draw a distinction if the patient was from an outlying community such as Tuktoyaktuk and would keep such a patient at least in Inuvik near the hospital in case of any complications that might develop. It is Nurse Gardiner's experience that many tonsillectomy patients often have their surgery as day patients and then are discharged that same day.

[62] The issue here, then, is whether Dr. Botha and/or the Inuvik Regional Hospital staff did a proper assessment of the plaintiff's condition prior to making the decision to discharge him back to Tuktoyaktuk.

[63] There is scant information in the hospital records to assist in this regard. One document entitled "Doctors Orders" has the last entry on the page which reads simply "please discharge", initialled by Dr. Botha, and is "noted" by the nurse at 1 p.m. on July 8, 1992. There are 2 other documents entitled "Discharge Care Plan" and "Short Stay Record", both dated July 8, 1992. These documents indicate that he was discharged to his home community of Tuktoyaktuk with prescription medications of Tantum, Tylenol #2, and Naprosyn. The document indicates that he had a tonsillectomy on July 7, 1992, that he had a small amount of blood loss on his initial return to the floor, that he settled well, that his tonsil beds were moist with no oozing and that he was

taking fluids well. He is referred to the Tuktoyaktuk Health Centre for follow up.

[64] Dr. Botha has no specific recollection of discharging this plaintiff from Inuvik Regional Hospital on July 8, 1992. He testified as to what his normal practice was, and that he would have followed his normal practice in the case of this plaintiff.

[65] He stated that it was his normal practice to do rounds at the hospital each morning, i.e., to see each one of his in-patients. He stated that for each patient he would read the charts and the nurses' notes and determine whether there were any observations recorded of any complications or problems with the patient during the night. He stated that he would speak to the patient and inquire whether the patient had any problems or wanted to discuss anything. He stated it was not his practice to do a physical examination of the patient prior to discharge. In the case of a community patient like the plaintiff, he stated he would give the patient instructions, a prescription for medications, and the nurses' discharge notes to give to the community heath centre.

[66] In the case of an adult tonsillectomy patient such as the plaintiff, he stated that he would have told the plaintiff that the first major concern is bleeding, that if there is any bleeding to go to the health centre. And secondly, to go to the health centre if he is running a temperature. He told him that typically his throat will get better and not worse, and if it gets worse, again, to go to the health centre. These instructions to the plaintiff were not reduced to writing.

[67] Dr. Botha acknowledged in his testimony that because of his standard practices he would have, prior to discharging the plaintiff on July 8, examined all of the charts and therefore been aware of, e.g., the laboratory results showing white blood cell count of 12.4 on July 6, the spike in temperature to 39.2, etc. He stated that the one episode of temperature at 39.2 would not have prevented him from discharging the plaintiff.

[68] Dr. Botha acknowledges that it was his duty as a physician to inform himself about the patient's health prior to discharge. He stated that there was nothing out of the ordinary about this plaintiff prior to his discharge on July 8.

[69] The expert witness Dr. Paterson reviewed the nurses' notes regarding the vital signs taken at 6 p.m. on the day of surgery, including the rise in temperature to 39.2 and the increase in heart rate to 100 beats per minute with a further increase to 110 beats per minute at 8:10 p.m. In Dr. Paterson's opinion this was an unusual post operative event which may have raised a concern about infection. Dr. Paterson noted, though, that no particular action was taken as a result of this unusual event. Dr. Paterson also notes that there is nothing in the hospital record to indicate that the plaintiff was attended by a physician on the morning of his discharge, i.e., July 8. Elsewhere in his opinion, and in the context of the plaintiff's condition upon arrival in Tuktoyaktuk, Dr. Paterson queries the plaintiff's fitness for discharge on July 8.

[70] The expert witness Dr. Butcher shares some of Dr. Paterson's concerns regarding the unusual post-operative temperature of 39.2 degrees at 6 p.m. In his opinion this degree of post-operative fever should have triggered concern in the mind of the attending physician such that a physical examination of the patient to rule out infection would have been expected prior to discharge from the hospital.

[71] Dr. Butcher carefully reviewed the recorded vital signs at 2 p.m. (perfectly normal); 6 p.m. (abnormal); 10 p.m. (some concerns); 6 a.m. on July 8 (returning to normal, indicating a normal post-operative course); and 10 a.m. on July 8 (returning to normal), and stated that these vital signs alone would not give cause for concern.

[72] This series of recorded vital signs, taken in its entirety, in the opinion of Dr. Butcher, would be consistent with an underlying infection that was sitting there already.

[73] Even though the plaintiff's vital signs had returned to normal, Dr. Butcher would have done a focused physical examination at the time of discharge. He would have checked the surgical site for signs of infection. Because it was a tonsillectomy, he would have checked the ears and throat and checked for swollen glands, and, in addition, he would have listened to the heart and lungs. He says he also would likely have had a repeat blood count done prior to discharge, and, depending on what he found on the physical examination, possibly a chest x-ray.

[74] These are the actions Dr. Butcher would have taken because of the unusually high temperature the night before. He goes on to say that if the results of his physical examination and the tests were normal, he would have had no problem discharging the patient.

[75] As stated earlier, Dr. Botha testified that he did not do a physical examination of the plaintiff prior to discharging him from hospital the day after his tonsillectomy. He also testified that he would have seen, prior to discharging the plaintiff, the nurses' notes showing the plaintiff's unusual vital signs at 6 p.m. the night before. In consideration of all of the evidence, in particular the opinion evidence of Dr. Paterson and Dr. Butcher, I find that in failing to do a physical examination of the plaintiff in these circumstances, Dr. Botha failed to meet the professional standard of care expected of a competent and prudent medical practitioner in a similar situation.

[76] Post-surgery care by the nurses at Tuktoyaktuk Health Centre: Earlier in these reasons I have summarized the interaction between the plaintiff and the nurses at the Tuktoyaktuk Health Centre after the plaintiff returned to Tuktoyaktuk on July 8 and before he left again for Inuvik Regional Hospital on July 12. Within the context of these contacts between the patient and the health centre, the nurses would have known that this plaintiff had undergone a tonsillectomy in Inuvik on July 7 and that he had been discharged by his physician Dr. Botha on July 8. I find that the nurses in Tuktoyaktuk were entitled to rely on the fact of discharge by the surgeon twenty-four hours post-surgery as indicating there were no complications.

[77] In consideration of all of the evidence, including the opinions of the expert witnesses, I am satisfied that the nurses at the Tuktoyaktuk Health Centre gave to the plaintiff the medical care that meets the standard of care expected of competent and prudent nursing practitioners in similar circumstances i.e., working in a community health centre or nursing station. Any shortcomings that have been pointed out in hindsight, e.g., incomplete notes, incomplete examination, etc. do not bring the level of care actually provided below the expected standard of care.

[78] When the plaintiff made his first visit to the health centre on the morning of July 9, I am satisfied, on the trial evidence, that the symptoms presented were not unusual following a tonsillectomy. Although his initial complaint included a statement that he was "breathing hard", when Nurse Belanger asked him to clarify, he indicated his breathing was not bothering him. Nurse Belanger did take his temperature (but not other vital signs) and concluded he did not have a fever. Nurse Belanger does not recall that she consulted Nurse Meissner, a more experienced nurse; however, I am satisfied from the testimony of Nurse Meissner that she did. Both nurses were of the view at the time that they were looking at a normal condition following a normal tonsillectomy.

[79] During the plaintiff's second visit to the health centre on July 9 complaining of headache, fever and vomiting, nurse McFadzen examined him and took his vital signs. She made a differential diagnosis, one aspect of which was the possible start of an infection. She gave him medication and instructed him to return in the morning if he was still feverish. He did not return to the health centre the next day.

[80] When the plaintiff next returned to the health centre, he was seen by the senior nurse, Nurse Meissner. Nurse Meissner consulted by telephone with the plaintiff's physician, Dr. Botha, once on Saturday, July 11, twice on Sunday, July 12. On each of those occasions she apprised Dr. Botha of the plaintiff's condition and symptoms and followed the doctor's instructions.

[81] When the plaintiff showed symptoms of coughing and respiratory difficulties on July 12, Nurse Meissner did a proper examination and investigation and correctly diagnosed the plaintiff's condition as bilateral pneumonia, and so advised the plaintiff's physician. She administered penicillin immediately as instructed by the physician. She had a feeling that they were perhaps going to be sending the plaintiff to Inuvik that day, but the decision was to "wait and see" the effect of the first dosage of penicillin. It was her professional judgement to allow him to go home for a few hours before the next dosage of penicillin.

[82] Once the decision was made - by Nurse Meissner and Dr. Botha - to have the plaintiff return to the Inuvik Regional Hospital on Sunday, July 12, the plaintiff was put on a scheduled flight in a relatively short time span. There is no

indication in the evidence that the plaintiff would in fact have arrived at the Inuvik Regional Hospital any quicker by a med-evac charter aircraft (if such was indeed available). There is no evidence on which I can conclude that a med-evac, or the presence of a medical escort on the scheduled flight, would have changed the ultimate impact of the plaintiff's respiratory condition.

[83] I find on the evidence that until the plaintiff attended the Tuktoyaktuk Health Centre on Sunday, July 12 (and then with some reluctance and only on the insistence of Nurse Meissner), his condition was consistent with a normal but slow recuperation from his tonsillectomy and he received proper care in those circumstances. When he presented with coughing symptoms for the first time on July 12, he was properly examined and diagnosed with pneumonia and again, received proper care, including a transfer that day to the Inuvik Regional Hospital.

[84] Upon arrival at the Inuvik Regional Hospital on Sunday, July 12, the plaintiff was in significant respiratory distress. And then his condition worsened. There is no complaint in this lawsuit about the medical care received by the plaintiff at the Inuvik Regional Hospital upon his re-admission on Sunday evening July 12 or thereafter.

[85] Communications between Dr. Botha and the nurses at the Tuktoyaktuk Health Centre: There were some discrepancies in the trial evidence between the testimony of Dr. Botha and that of the nurses (and nurses' notes).

[86] As one example, Dr. Botha testified that on July 9 or 10 he received a telephone call from the plaintiff's mother advising that the plaintiff was not doing well and as a result Dr. Botha told her to take the plaintiff to the Tuktoyaktuk Health Centre and that he would phone the health centre. He says he phoned the health centre and spoke to Nurse Meissner and instructed Nurse Meissner to examine the plaintiff carefully and if she felt he required antibiotics to give him penicillin. Nurse Meissner has no recollection of any such telephone call on July 9 or 10 and there is nothing on the plaintiff's chart at the Tuktoyaktuk Health Centre regarding such an instruction from the plaintiff's physician on July 9 or 10. Indeed it is inconsistent with the entries made in the plaintiff's chart on July 9 and July 11 and July 12.

[87] Dr. Botha's recollection is based on his handwritten notes. However, these notes were made by him not at the time of the event on July 9 or July 10, but only on the evening of July 12 after the plaintiff had been returned to the Inuvik Regional Hospital in acute respiratory distress and when Dr. Botha was preparing the case history and paperwork to accompany the plaintiff when he was being med-evac'd to the hospital in Edmonton.

[88] Based on all of the evidence, I find that Dr. Botha is mistaken. He may be confusing such a call with the telephone conversations he had with Nurse Meissner on July 11 and July 12. In any event, I am not satisfied that there were telephone calls on July 9 or 10 between Dr. Botha and the plaintiff's mother, and between Dr. Botha and Nurse Meissner.

[89] It was my observation that each of Nurse Belanger, Nurse McFadzen and Nurse Meissner were credible, truthful witnesses who gave their evidence in a forthright fashion regarding their recollection or lack of recollection of events 12 years ago, and regarding interpretation of their notes. There was no attempt to embellish, or overstate, or to be defensive.

[90] It was my observation of Dr. Botha as a witness that he, on the one hand, states (not surprisingly) to have no current recollection of many of the particular events of June/July 1992, yet on the other hand states categorically that he wasn't advised of this, wasn't advised of that, by the nurses. Thus I find some internal consistencies with Dr. Botha's testimony. Also, during his testimony and particularly during cross-examination, he seemed quick to point the blame at the nursing staff for not informing him of certain things 12 years ago, things that he says would have caused him to act differently back then. Given the rest of his testimony, and the passage of so much time, I admit to some difficulty understanding how he can be certain of these things.

[91] Where Dr. Botha's testimony differs from that of the nurses of the Tuktoyaktuk Health Centre or their notes, I find that either a) I prefer the evidence of the nurses or b) I am unable to decide what happened.

[92] In one particular instance, i.e., the telephone call made by Nurse Meissner to Dr. Botha on July 12 advising him that the plaintiff had a bilateral lower lobe

pneumonia, I am satisfied that she indeed told Dr. Botha that it was a “huge” pneumonia, and that it was a bilateral pneumonia.

[93] There is one aspect of the communication between the Inuvik Regional Hospital and the Tuktoyaktuk Health Centre that is of concern, and that is the matter of the Discharge documents from the Inuvik Regional Hospital.

[94] The evidence indicates that the plaintiff’s Discharge Care Plan was probably given to him when he was discharged from Inuvik Regional Hospital on July 8. Dr. Botha stated that the procedure was that it would be given to the patient and if the patient went to the community health centre or nursing station, he was to give the document to the nurse. This, of course, is common sense, as the Discharge Care Plan sets out the treatments and procedures that the patient underwent at the hospital, the medications he was prescribed upon discharge, etc.

[95] The evidence at this trial, however, does not satisfy me that a copy of the Discharge Care Plan was on this plaintiff’s chart at the Tuktoyaktuk Health Centre during the period July 9 - 12, 1992. It is true that a copy of the document eventually found its way to the plaintiff’s chart at the Tuktoyaktuk Health Centre but it is not known when it arrived there, and whether it came from the plaintiff personally or in the mail.

[96] Nurse Meissner testified that it was not unusual that a patient’s discharge documents from the Inuvik Regional Hospital would show up in the pilot pouch (air mail) a week or more later. At least it seems this was the procedure in 1992.

[97] I find this procedure wanting. Surely it is important, perhaps vital, for the community health nurse to know the discharge care plan for the returning patient, e.g. the prescription medication he/she is on, etc., and to know this immediately upon the patient’s return to the community. In this very case, there is evidence that the nurses at the Tuktoyaktuk Health Centre, in the period July 9 - 12, were uncertain whether the plaintiff was on Tylenol #2 or Tylenol #3, and whether he was/was not on penicillin prescribed at the time of discharge.

[98] Having this important information at hand and on a timely basis should not depend on the patient bringing it to the health centre.

[99] I make no finding here that this lack of adequate or timely communication between the Inuvik Regional Hospital and the Tuktoyaktuk Health Centre in July 1992 amounts to professional negligence. As will be discussed later in these reasons under the "causation" topic, this shortcoming had no causal link to the injury suffered by the plaintiff in any event.

[100] Other than as specifically noted in the preceding paragraphs, I find on all of the evidence, including that of the expert witnesses, that the defendants met the standard of care expected of reasonable and prudent medical practitioners. To summarize the instances where the level of care fell below that standard:

(1) Dr. Botha, in failing to do a pre-operative assessment prior to performing the surgery on July 7, 1992, did not give the level of care expected of a competent and prudent surgeon in similar circumstances.

(2) Dr. Botha, in failing to do a physical examination of the plaintiff prior to discharging him from the hospital the day after his tonsillectomy, failed to meet the professional standard of care expected of a competent and prudent medical practitioner in a similar situation.

(3) Either the Inuvik Regional Hospital nursing staff did not bring certain significant observations to the timely attention of Dr. Botha on July 7/8, or they did and he did not do anything as a result. In either case the defendants (i.e., Inuvik Regional Health and Social Services Authority and Dr. Botha) failed to meet the required standard of care expected of competent medical practitioners in similar circumstances.

[101] Next, I turn to the injury or loss or losses suffered by the plaintiff. There is no question that the plaintiff suffered, in particular during the period July 12 - October 26, 1992. The pneumonia that was detected in his lungs on July 12, 1992, developed into adult respiratory distress syndrome. The latter is a life-threatening condition. As one of the expert witnesses put it, whereas pneumonia can range from mild to severe, adult respiratory distress syndrome is a clinical syndrome that is at the far end of the spectrum. It is a clinical

syndrome which requires intensive therapy and intervention. It is a serious situation, and people do die from it. Among other things there is a serious loss of ventilatory capacity.

[102] The infection that was detected in the plaintiff's lungs on July 12 developed into a life-threatening infection and a lengthy illness.

[103] He was hospitalized in the intensive care unit of the University of Alberta hospital from July 13 to October 1, 1992. While there he was "intubated, ventilated and paralysed", i.e., paralysed with medication for purposes of ventilation. He was not weaned off the ventilator until September 1992. On July 20, 1992, he underwent a tracheostomy, i.e., a tube was surgically inserted into his throat for long-term ventilation. On July 29, 1992, he suffered a cardiac arrest and had to be resuscitated. On August 6, 1992, he suffered a grand mal seizure. On September 21, 1992, he had surgery for removal of his gall bladder. As indicated earlier in these reasons, there were other complications during his hospital stay, including a number of pneumothoraces, i.e., fluid or other material in his lungs that required drainage by a chest tube. As a result he has today numerous puncture scars on his chest and he also has surgical scars from the gall bladder surgery and the tracheostomy.

[104] While the plaintiff was in the Edmonton hospital, he lost 40 -50 pounds. He has little memory of his stay at the intensive care unit in Edmonton. Indeed today he has no memory of Dr. Botha or of the tonsillectomy. He says everything is blocked out.

[105] The plaintiff was transferred from the University of Alberta hospital to Inuvik Regional Hospital on October 14, 1992 and remained there for rehabilitation until October 26, 1992, when he returned to his home in Tuktoyaktuk. While at the Inuvik Regional Hospital he underwent a physiotherapy program to regain his strength. He says it was a few months after he returned to Tuktoyaktuk before he started to feel stronger and became physically active again.

[106] In January 1993, the plaintiff had some follow-up testing done at the Inuvik Regional Hospital, i.e., x-rays of his respiratory system and blood tests. He has not had occasion to seek or receive medical care for respiratory reasons since October 1992. He says he is today pretty well back to his pre-illness condition,

with the exception of what he says is reduced stamina or reduced strength. Any such residual condition may be attributable to the fact that he has not quit smoking, nor has he exercised regularly, both of which have been recommended by his doctors.

[107] On all of the evidence, I find that the plaintiff is back to his pre-July 1992 condition with little on-going effects on his health or his lifestyle or his ability to earn an income.

[108] Causation: As stated earlier in these reasons, a plaintiff, to be successful, must prove a causal link between the negligence of the defendants and the injury suffered by the plaintiff. Justice Sopinka stated in *Snell* v. *Farrell* (1990) 72 D.L.R. (4th) 289 that causation is essentially a practical question of fact which is best answered by ordinary common sense and by taking a robust and pragmatic approach to the facts.

[109] In the present case, the injury suffered by the plaintiff was the pneumonia which developed into adult respiratory distress syndrome.

[110] In the present case, the negligence of the defendants was threefold:

(1) the negligence of Dr. Botha in failing to do a pre-operative assessment prior to performing the tonsillectomy on July 7.

(2) the negligence of Dr. Botha in failing to do a physical examination of the plaintiff prior to discharging him from hospital on July 8.

(3) the collective negligence of the defendants in not addressing, on a timely basis, certain significant physical observations during the plaintiff's stay at the Inuvik Regional Hospital on July 7 - 8.

[111] In each of these three instances of negligence, I an unable to say that "but for" that negligence the plaintiff's injury would not have occurred. Also, I am unable to say that any of these instances of negligence "materially contributed" to the occurrence of the plaintiff's injury.

[112] From the opinion evidence of the expert witnesses, I find that pneumonia is a very rare complication of a tonsillectomy. It was not an expected occurrence.

[113] From the facts adduced at trial, and the (helpful) opinion evidence of the experts, I am unable to determine the cause or the genesis of the infection which led to the plaintiff's pneumonia, on a balance of probabilities.

[114] There is simply no evidence that aspiration occurred during the tonsillectomy. Aspirations during surgery are normally detected, none was detected here.

[115] There is no evidence upon which I can conclude, or even draw an inference, that the time of onset of the infection which led to the plaintiff's pneumonia was prior to July 12. Perhaps more importantly, I cannot say that that infection could have been detected prior to July 12. The evidence does not establish that there was a delay in diagnosing or treating the plaintiff's pneumonia.

[116] As I have found, some of the defendants were negligent. However, in my view, as a matter of common sense and logic, those instances of negligence cannot constitute a foundation for a finding of liability for the plaintiff's injury.

[117] None of these specific acts of negligence caused or contributed to the plaintiff's injury.

[118] Had Dr. Botha personally performed a pre-operative assessment prior to the tonsillectomy, I cannot infer that events would have unfolded differently.

[119] Had Dr. Botha done a physical examination of the plaintiff on the morning of his discharge, I cannot infer that events would have unfolded differently. There is no evidence to indicate that such a physical examination, or the ordering of more tests, would have led to the discovery of an early pneumonia or an infective source. To suggest it <u>may</u> have been discovered is speculation.

[120] Had Dr. Botha and the Inuvik nurses communicated successfully about the temperature spike and other physical observations and had Dr. Botha attended to the plaintiff at those times as he says he "would have", I cannot infer that events would have unfolded differently.

[121] I find that the plaintiff's action fails as the plaintiff has not established, on a balance of probabilities, a causal link between the defendants' acts of negligence and the plaintiff's injury.

[122] Damages: Notwithstanding my decision on liability, I set forth herein my findings on damages.

[123] General damages: I have earlier in these reasons described the injuries suffered by this plaintiff. On account of those injuries I would provisionally award general damages for pain and suffering and loss of amenities. I have carefully reviewed the written submissions of the three parties on the quantum of general damages, and the cases referred to by counsel. In all of the circumstances I would provisionally award general damages in the amount of $50,000.00. These general damages are essentially related to the plaintiff's experience in the hospital in Edmonton and to the brief period of recovery which followed. Accordingly, as stated below, there is no reduction on account of the failure to mitigate.

[124] Loss of income: While noting that he was only 19 years of age at the time, the evidence is that the plaintiff had a sporadic employment record prior to July 1992, e.g., seasonal construction work. There is accordingly scant evidence on which to make a finding on the loss of income suffered by him during the period of his lengthy hospitalization in Edmonton and Inuvik in the period July 13 - October 26, 1992, and during his recuperation in Tuktoyaktuk in the few months following October 26, 1992.

[125] The trial evidence indicates that since 1992 the plaintiff has continued to have a sporadic employment record, mainly seasonal work such as construction and environmental monitoring.

[126] I would provisionally award damages for loss of income for the time period July 13, 1992 - December 31, 1992, in the nominal amount of $10,000.00.

[127] Loss of earning capacity: Taking into consideration all of the evidence, I find that the plaintiff has not proven that his ability to take advantage of any job opportunities which might have come available to him, in Tuktoyaktuk or elsewhere, has been impaired because of the injury he suffered in 1992.

[128] Special damages: The parties are agreed that the quantum of special damages is $150,000.00 (being the subrograted claim of the GNWT Department of Health and Social Services).

[129] Mitigation: A plaintiff in a personal injury lawsuit has a duty to reduce or minimize his own losses by taking reasonable steps to mitigate those losses. Taking reasonable steps includes following medical advice when appropriate. See *Janiak* v. *Ippolito* [1985] 1 S.C.R. 146; *Silvaniuk* v. *Stevens* 1999 ABCA 191.

[130] Following his substantial recovery in October 1992, the plaintiff received advice from his health care providers that he should quit smoking and that he should engage in a regular exercise regime, in order to improve his respiration ability and in order to improve his strength and stamina. At trial, he acknowledged that he failed to follow this advice. I find that this was unreasonable conduct and amounts to a failure to mitigate.

[131] However, a failure to mitigate does not act to reduce all damage awards, only those which represent the losses or damages which the plaintiff could have mitigated but did not. As the provisional award of $50,000.00 for general damages relates primarily to the pain and suffering and loss of amenities endured by the plaintiff in the period July 1992 to October 1992, there ought to be no reduction of this figure on account of the failure to mitigate post-October 1992 (i.e., the smoking and the lack of an exercise regime). For the same reason, there can be no reduction in the provisional award for loss of income. Had there been an award for loss of earning capacity, the failure to mitigate may have resulted in a reduction in any such award.

[132] Pre-judgment interest: The *Judicature Act* provides that a plaintiff who obtains a judgment is generally entitled to an award of interest on the judgment amount from the date of notice of the claim to the date of judgment. The rate of interest is the "prime business rate" published by the Bank of Canada. The interest is calculated for each six-month period, at the prime business rate published for that period. However, s.56.2 of the Act provides that the trial judge has a discretion to disallow the interest claim, or to set a lower or higher rate of interest.

[133] One of the factors to take into consideration in exercising that discretion is any inordinate delay in moving the lawsuit along to trial, and hence to the day of judgment. There has been inordinate delay in this case. Notice of the claim was given in December 1994, thus the plaintiff, if successful, would have been ordinarily entitled to an award of interest for a period of 10 years, not an insignificant sum. My initial inclination is to reduce the interest award by one-half on account of inordinate delay. However, I hesitate to do so in the absence of a fuller picture of the reasons for the delay. I acknowledge that it is the plaintiff who has conduct of an action; however, the requested reduction in pre-judgment interest on account of inordinate delay ought to have been addressed as an issue more fully. As I have stated it was, potentially, a significant dollar amount.

[134] I make a provisional award of pre-judgment interest. Interest is payable for the period December 1, 1994 to the day of judgment. I set the interest rate as the average prime business rate published by the Bank of Canada during those years.

[135] Conclusion: For the foregoing reasons, the plaintiff's action is dismissed.

[136] With respect to costs, counsel are to file and serve written submissions as follows:

a) written submissions of the defendants, within 30 days of the filing of these reasons (if costs are sought against the Government of the NWT, counsel are to serve a copy on counsel for GNWT).

b) written submissions of the plaintiff, within 10 days of receipt of the later of the defendants' submissions.

c) written submissions of the GNWT, if applicable, within 10 days of receipt of the later of the defendants' submissions.

d) defendants' submissions in reply, within 10 days of receipt of the later of the plaintiff's and GNWT's submissions.

J.E. Richard,
J.S.C.

Dated at Yellowknife, NT
this 14th day of April 2005

Counsel for the Plaintiff:	Sheila Torrance and Joe Miller
Counsel for the Defendants J.McFadzen, Helene Belanger, Lorrie Meissner, and Inuvik Regional Health and Social Services:	Garth Malakoe and Terry Nguyen
Counsel for the Defendant Dr. Botha:	Jonathan P. Rossall and Alexis Moulton

CV 05291

IN THE SUPREME COURT OF
THE NORTHWEST TERRITORIES

BETWEEN:

SPENCER MANGELANA

Plaintiff

- and -

J. McFADZEN, HELENE BELANGER, LORRIE MEISSNER, INUVIK REGIONAL HEALTH AND SOCIAL SERVICES AUTHORITY, operating facilities known as TUKTOYAKTUK HEALTH CENTRE and INUVIK REGIONAL HOSPITAL, DR. BOTHA

Defendants

REASONS FOR JUDGMENT OF
THE HONOURABLE JUSTICE J.E. RICHARD