COURT OF APPEAL FOR ONTARIO

CITATION: Barber v. Humber River Regional Hospital, 2016 ONCA 897
DATE: 20161128
DOCKET: C60824 and M46222

Cronk, Juriansz and Roberts JJ.A.

BETWEEN

Annette Barber, Ashton Jessica Barber, by her
Litigation Guardian, Annette Barber, and Kristyanna Sauder

Plaintiffs (Respondents)

and

Humber River Regional Hospital, Derrick Chang,
David John Shergold, Virat Joshi, Stephen Allan Glazer,
Her Majesty the Queen in Right of the Province of Ontario and
The Superintendent of the Toronto West Detention Centre

Defendants (Appellant)

Erica J. Baron, Sam Rogers and Jordan Katz, for the appellant

Aleks Mladenovic, David R. Neill and Esther J. Roche, for the respondents

Heard: May 24, 2016

On appeal from the judgment of Justice Mary A. Sanderson of the Superior Court of Justice, dated July 7, 2015.

Cronk J.A.:

[1] Mark Barber died on February 17, 2006 at Humber River Regional Hospital (the "Hospital") in Toronto from pneumococcal bacterial meningitis. He was 46 years of age. The respondents, his surviving wife and two daughters, sued two emergency room ("ER") physicians, the appellant Dr. Virat Joshi, and Dr. David

John Shergold, in negligence, alleging that Mr. Barber's death resulted from their failure to properly investigate, diagnose and treat his meningitis.[1]

[2] The trial judge found that, in his care and treatment of Mr. Barber, Dr. Joshi fell below the applicable standard of care in three respects: first, by failing to adequately consider the possibility that Mr. Barber had meningitis at 10:00 a.m. on February 13, 2006 when Dr. Joshi first examined him (the "10:00 a.m. Assessment") and in failing to include meningitis in his differential diagnosis; second, by failing to do a spinal tap or lumbar puncture to rule out the possibility of meningitis; and third, by still failing to suspect and diagnose meningitis and treat it appropriately at 12:30 p.m. on February 13th when Dr. Joshi assessed Mr. Barber a second time. The trial judge further found that causation had been established as against Dr. Joshi because it was more likely than not that, but for his failure to diagnose and properly treat Mr. Barber's bacterial meningitis at the 10:00 a.m. Assessment, Mr. Barber would not have died or suffered serious neurological sequelae.

[3] The trial judge dismissed the action against Dr. Shergold, concluding that while he, too, had breached the standard of care in several respects, the respondents had failed to demonstrate a causal link between his actions and Mr. Barber's death.

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[1] The respondents' claims against other named defendants were resolved or dismissed on consent.

[4] Dr. Joshi appeals from the liability finding against him, arguing that the trial judge erred in both her standard of care and causation analyses. He also seeks leave to appeal that part of the trial judge's costs ruling that requires him to pay the costs found to be owing to Dr. Shergold. For the reasons that follow, I would dismiss the appeal, grant leave to appeal costs, and dismiss the costs appeal.

Background

[5] On January 31, 2006, Mr. Barber surrendered into police custody in relation to various fraud charges. Following his surrender, he was detained at the Metro West Detention Centre in Toronto, to await trial.

[6] Sometime before February 13, 2006, Mr. Barber became ill. He was brought by ambulance to the Hospital at 9:17 a.m. on February 13th, with a history of fever and complaining of chest pain. He was first assessed by nursing staff and then by Dr. Joshi at the 10:00 a.m. Assessment and again at 12:30 p.m. and 2:00 p.m. Dr. Joshi provisionally diagnosed Mr. Barber as suffering from pneumonia and prescribed 400 milligrams of Avelox (also known as Moxifloxacin), a broad spectrum antibiotic, to treat the pneumonia. He did not suspect or investigate meningitis or order treatment for it. He discharged Mr. Barber from the Hospital with orders to follow a course of Avelox for pneumonia, Tylenol for fever, and maintain fluid intake.

[7] Mr. Barber was returned to the detention centre where he remained for about seven hours. However, he was brought back to the Hospital at approximately midnight, after the results of Hospital blood tests revealed bacteria in his blood. His illness progressed and, several hours later, he was diagnosed with pneumococcal bacterial meningitis. He remained gravely ill for the next few days and eventually succumbed to meningitis on February 17, 2006.

[8] At trial, both sides led expert evidence on the applicable standard of care and causation. The respondents called Dr. Ignatius Fong, an infectious disease specialist, and Dr. Edwin Brankston, an emergency medicine expert, to provide opinion evidence on the applicable standard of care and causation. Dr. Joshi relied on the expert evidence of Dr. David Boushy, also an emergency medicine expert, on the standard of care, and the testimony of Dr. Jeff Powis, an infectious disease specialist, and Dr. David Juurlink, a specialist in toxicology, pharmacology and internal medicine, on causation.

[9] There was no dispute among the experts that bacterial meningitis is a serious and sometimes deadly disease. After onset and without proper treatment, it can result in relatively rapid death.

[10] The issue of the appropriate drugs to treat bacterial meningitis and their comparative effectiveness in combatting the disease were matters of considerable controversy at trial. On the trial judge's findings, the standard

treatment for meningitis in 2006 consisted of the administration of two antibiotics, Ceftriaxone and Vancomycin, in combination with Decadron, an anti-inflammatory steroid, either at the same time or just before the administration of the antibiotics (the "Standard Treatment"). The trial judge also found that Avelox can be effective as a second-line, but inferior, treatment for meningitis in some circumstances. I did not understand Dr. Joshi to challenge these factual findings before this court.

[11] Mr. Barber's overall medical condition and his mental status prior to and on arrival at the Hospital on February 13, 2006 and, especially, at the 10:00 a.m. Assessment, were central to the determination of the negligence allegations against Dr. Joshi. Mr. Barber's mental status was crucial because, on the expert evidence at trial, a history of an altered level of consciousness, coupled with a fever, could signify inter-cranial pressure in the brain or meningitis. It is therefore necessary to briefly review the pertinent medical evidence on these issues.

(1) Observations at Detention Centre

[12] At the time of his intake at the detention centre on January 31, 2006, Mr. Barber was examined by Dr. Mueller, who performed a routine physical examination. Dr. Mueller recorded Mr. Barber's history of chest pain, shortness of breath, coronary artery disease, angioplasty and hypertension. On February 7, 2006, Mr. Barber claimed that he was too ill to attend court and asked to see a

doctor. On February 8, after he attended court, he was taken to Toronto General Hospital with complaints of chest pain. Staff at that hospital recorded him as having a fever of 39.9° C and being alert and oriented to person, place and time. After assessment and treatment, he was returned to the detention centre.

[13] Between February 9 and February 12, 2006, Mr. Barber's temperature ranged from 38.2° C to 39.8° C and his blood pressure was elevated, fluctuating between 210/160 and 200/100. He was prescribed a nitroglycerin patch and Tylenol was repeatedly administered.

[14] Mr. Barber was scheduled to again attend court on February 13, 2006. The detention centre records indicated that Dr. Mueller examined him at 8:00 a.m., noting that he had "T [temperature] 39° C. Fever times 3-4 days with cough. Not saying much. Hyperventilating. Dry mouth … Unable to give date and place; Inspiratory crackles, [blood pressure] 150/90 … pneumonia and dehydration." Dr. Mueller concluded that Mr. Barber was too ill to attend court and ordered him transferred to the Hospital for further assessment. In his health care consultation note, which accompanied Mr. Barber to the Hospital, Dr. Mueller stated: "Please see re fever, decreased level of consciousness x 2 [days], dry tongue, left inspiratory chest crackles."

(2) Paramedics' Observations

[15] An ambulance and paramedics arrived at the detention centre at 8:40 a.m. on February 13th. The paramedics noted in their ambulance call report that Mr. Barber was being sent to the Hospital due to a two-day history of fever, decreased level of consciousness and dry mouth. They also indicated that he was alert and oriented, had no visual field abnormalities, dizziness or head or neck problems, and that he had a temperature of 37.6° C.

[16] Enroute to the Hospital, the paramedics recorded that Mr. Barber was complaining of chest pain, that he was diaphoretic (sweaty), and that he was not co-operative and was unwilling or unable to answer questions, thereby preventing a thorough assessment. At 8:43 a.m., they recorded his blood pressure as 170/100 and his temperature as 37.6° C. Fifteen minutes later, his temperature was 37.9° C and his blood pressure had increased to 183/113. The paramedics also performed a test known as a Glasgow Coma Scale ("GCS"), which measures a patient's mental status by assessing motor responses, verbal skills and eye response, scored out of a total of 15. Mr. Barber had two perfect GCS scores (15/15), at 8:43 a.m. and 8:58 a.m.

(3) Nursing Observations

[17] On arrival in the ER, Mr. Barber was assessed by a triage nurse at 9:17 a.m. She recorded his chief complaint of chest pain and charted that he had an

ashen skin colour, a diaphoretic (sweaty) brow, an elevated blood pressure of 187/113, a temperature of 37.9° C, and a respiratory rate of 22 breaths per minute. She also noted that he was non-communicative and uncooperative. Mr. Barber was placed in a telemetry (monitoring) room where his heart rate and oxygen saturation could be monitored in 'real time'.

[18] At 9:55 a.m., a second nursing assessment was conducted. This nurse charted that Mr. Barber was short of breath and very sweaty, that he had an increased respiratory rate of 29-35 breaths per minute, decreased air entry and crackles/rales in his left lung, that he was reporting intermittent chest pain that he described as "heavy", and that his history was "vague" and he was unable to focus on conversation. The nurse also recorded that Mr. Barber was alert and "oriented x 3", and then crossed out that latter entry, suggesting that he was not oriented to person, place and time. Five minutes later, at 10:00 a.m., Mr. Barber continued to have a temperature of 37.9° C. He also had a pulse rate of 80, an increased respiratory rate of 40 breaths per minute and blood pressure of 175/96.

(4) 10:00 a.m. Assessment

[19] Dr. Joshi first examined Mr. Barber at 10:00 a.m. on February 13th. He testified that he conducted a focused physical examination and a mental examination of Mr. Barber, including assessments of his neurological, respiratory

and cardiovascular status. Dr. Joshi recorded Mr. Barber as having a cough, a temperature of 37.9° C, a heart rate of 90 beats per minute (within the normal range), a respiratory rate of 20 breaths per minute and elevated blood pressure of 178/90. He noted that Mr. Barber was feverish, thirsty, and had dry mucous membranes and coarse respiratory crackles at the base of his left lung, consistent with pneumonia. He also charted a GCS score of 14/15, reduced by one point on the verbal scale, noting that Mr. Barber was "confused".

[20] Dr. Joshi provisionally diagnosed Mr. Barber with pneumonia. He undertook investigations for pneumonia and to rule out cardiac problems by ordering a chest x-ray, sputum and blood cultures and cardiac blood tests. He also ordered a bolus dose of intravenous normal saline for dehydration, a 400 milligram intravenous dose of Avelox for the suspected pneumonia, and Tylenol and Ibuprofen for Mr. Barber's underlying fever. Critically, he did not suspect, diagnose or investigate possible meningitis.

[21] At trial, Dr. Fong testified that, by the 10:00 a.m. Assessment, Mr. Barber likely already had bacterial meningitis. He noted that, by the morning of February 13th, Mr. Barber had a documented history of fever, a decreased level of consciousness, an ashen appearance, had not been oriented to person, place and time, was sweating profusely and was uncommunicative. Given these symptoms, it was Dr. Fong's opinion that Mr. Barber was exhibiting signs of brain dysfunction, mandating a full examination of his head and neck, an assessment

of his level of consciousness, and, unless contra-indicated, the performance of a lumbar puncture to rule out the possibility of meningitis.

[22] Certain of the defence expert evidence was consistent with this conclusion. Dr. Powis conceded that, by about 9:36 a.m. on February 13th, Mr. Barber already had bacteria in his blood, although he (Dr. Powis) did not know exactly when it spread to his brain, and that sufficient clinical evidence was present at 10:00 a.m. to consider a differential diagnosis of bacterial meningitis. Dr. Juurlink said that it was very likely that the bacteria in Mr. Barber's blood had already reached his brain at about the time his blood cultures were drawn. In contrast, Dr. Brankston testified that, while Mr. Barber was not exhibiting symptoms of meningitis at 10:00 a.m., he was very sick and should have been admitted to the Hospital.

[23] Dr. Joshi disagreed. He testified that Mr. Barber was not exhibiting any signs or symptoms of meningitis and did not have a decreased level of consciousness at 10:00 a.m. or, indeed, at any point during Dr. Joshi's interactions with him. Dr. Joshi did acknowledge that his own note from the 10:00 a.m. Assessment indicated that Mr. Barber was "confused". However, he maintained that "confusion" does not equate to a decreased level of consciousness. The former term, Dr. Joshi said, relates to cognition, while the latter term connotes alertness or arousal. I will turn to the issue of the significance of Dr. Joshi's notation of "confusion" later in these reasons.

[24] Dr. Joshi testified that he considered three possible explanations for Mr. Barber's confusion: i) an infective process, like pneumonia; ii) fever; or iii) decreased fluid intake/dehydration. He acknowledged that he did not consider the possibility of meningitis, did not include it in his provisional diagnosis, and did not order a lumbar puncture to rule it out.

(5) Re-assessments and Discharge

[25] The saline bolus for dehydration was started shortly after 10:00 a.m. on February 13th. At 10:20 a.m., Mr. Barber received the intravenous Avelox for pneumonia prescribed by Dr. Joshi. Tylenol was administered at 10:30 a.m. for fever.

[26] A further nursing assessment was conducted at 11:25 a.m. Mr. Barber continued to be diaphoretic and had an increased respiratory rate of 42 breaths per minute with shallow breathing, an elevated blood pressure of 176/98 and a temperature of 36.2° C. While the nurse recorded that Mr. Barber "remains alert", she did not note his orientation to person, place and time. Nor did she undertake a neurological assessment. Saline was administered again at 12:05 p.m.

[27] Dr. Joshi assessed Mr. Barber for a second time at 12:30 p.m. and ordered repeat blood tests of Mr. Barber's cardiac marker (troponin) levels. He recorded "a slight improvement" in Mr. Barber's breathing and a temperature of 36.1° C,

but did not record his respiratory rate. Contrary to the nursing observation at 11:25 a.m. (a respiratory rate of 42 breaths per minute), Dr. Joshi testified that Mr. Barber's respiratory rate was normal at 12:30 p.m. and, for this reason, he made no note of it. Similarly, Dr. Joshi stated that he did not record Mr. Barber's mental status at 12:30 p.m. because there was "no abnormality". In his view, whatever confusion Mr. Barber may have had at 10:00 a.m. had resolved and was no longer present.

[28] By 2:00 p.m., the results of the further blood work were available, Mr. Barber's troponin levels were normal, and Dr. Joshi concluded that he should be discharged. Mr. Barber was discharged at 2:40 p.m., with orders to take 400 milligrams of Avelox orally, Tylenol orally for fever, and maintain fluid intake. Between 12:30 p.m. and his discharge at 2:40 p.m., no vital signs other than temperature were recorded on Mr. Barber's chart. By about 3:30 p.m., he had been returned to the detention centre.

(6) Observations on Return to Detention Centre

[29] The defence argued at trial that Mr. Barber's vital signs and mental status between 3:30 p.m. and 10:40 p.m. were normal. However, the nursing notes made on Mr. Barber's arrival at the detention centre at 3:30 p.m. indicated that his respiratory rate was 16 breaths per minute and "laboured", his temperature

was 36.7° C, he was “sweating profusely”, his blood pressure was elevated at 160/90, and he was scheduled to see a doctor the following morning.

[30] Mr. Barber was assessed again at 8:00 p.m. At that time, Nurse Enza DeToma recorded his temperature as 35.3° C. On March 24, 2006, approximately six weeks later, she expanded on her recorded observations in an occurrence report at the request of the superintendent of the detention centre. In that report, she indicated that, at 8:00 p.m., she had found Mr. Barber to be alert, oriented to person, place and time, in no distress and without any complaints. At trial, she elaborated that his skin colour and his respiratory rate were both normal.

[31] At 8:15 p.m., detention centre staff were informed that blood cultures taken earlier in the day at the Hospital had tested positive for bacteria, most likely streptococcus bacteria, and that, as a result, Mr. Barber was to be returned to the Hospital immediately. Detention centre staff left with Mr. Barber at 10:40 p.m. Shortly before his departure, Nurse DeToma reassessed Mr. Barber, noting no complaints. She recorded his temperature as 35° C.

[32] Mr. Barber arrived back at the Hospital at 11:43 p.m. where he was again assessed by an ER triage nurse. In her note at 11:59 p.m., the triage nurse recorded that Mr. Barber was alert, oriented and cooperative, with regular and effortless breathing and normal skin colour. She noted his temperature as

36.5° C, his pulse as 79, his respiratory rate as 18 breaths per minute and, his blood pressure as 166/111.

[33] Mr. Barber was examined by Dr. Shergold at 3:15 a.m. on February 14th. The trial judge held that his assessment of Mr. Barber fell below the standard of care in several respects. At approximately 10:00 a.m. on February 14th, Mr. Barber was diagnosed with meningitis and Standard Treatment was initiated. However, his condition did not improve and he went on to suffer two cardiac arrests in the late evening of February 14th. He was resuscitated and intubated but remained comatose and gravely ill. He passed away at 5:51 p.m. on February 17, 2006, after having been taken off life support. His post-mortem examination revealed his cause of death as bacterial meningitis.

Trial Judge's Decision

[34] Contrary to Dr. Joshi's account at trial, the trial judge held that multiple signs and symptoms of meningitis were evident at the 10:00 a.m. Assessment. These included continuing confusion, a decreased level of consciousness, a history of fever together with decreased consciousness, a very unwell appearance, pneumonia and elevated respiratory rates. She held that Dr. Joshi should have recognized and considered these signs and symptoms and that he breached the standard of care from the time of his first assessment of Mr.

Barber, by failing to adequately investigate, examine, test for and treat meningitis.

[35] In so holding, the trial judge accepted Dr. Fong's evidence that, given Mr. Barber's documented history and presenting condition at the 10:00 a.m. Assessment, including his condition as noted by Dr. Joshi, Dr. Joshi was required to specifically consider the possibility that meningitis was the explanation for Mr. Barber's confusion and to include meningitis in his differential diagnosis. Instead, Dr. Joshi focused on Mr. Barber's cardiac status, rather than on his existing confusion and his history of a decreased level of consciousness and underlying fever.

[36] The trial judge also accepted Dr. Fong's evidence that Dr. Joshi should and could have done a lumbar puncture at the 10:00 a.m. Assessment to rule out possible meningitis. She held that, if Dr. Joshi had done a lumbar puncture, Mr. Barber's spinal fluid would have revealed the presence of meningitis and Standard Treatment would have commenced immediately with the administration of Ceftriaxone, Vancomycin and Decadron.

[37] The trial judge reached a similar conclusion regarding Dr. Joshi's 12:30 p.m. assessment of Mr. Barber. She found, at para. 384, that Dr. Joshi's conduct continued to fall below the standard of care at that time because he "failed to

suspect meningitis, include it in his differential diagnosis, examine and test, do a lumbar puncture, diagnose meningitis [and] treat meningitis appropriately".

[38] Finally, the trial judge concluded that the respondents had met their onus to establish causation as against Dr. Joshi with respect to the 10:00 a.m. Assessment. She stated, at para. 513 of her reasons:

> In summary, on the basis of the medical literature and the evidence of Fong that Barber would likely have survived without significant neurological deficit if he had been treated with Decadron, Ceftriaxone and Vancomycin shortly after 10 AM on February 13, 2006, given Barber's absence of poor prognostic factors at 10 AM other than a history of pneumonia, I find that the plaintiffs have satisfied the onus of proving that more likely than not, but for the negligence of Joshi in failing to diagnose and properly treat bacterial meningitis at 10:00 AM on February 13, Barber would not have died or suffered serious neurological sequelae.

Issues

[39] The appellant argues that the trial judge erred in assessing the negligence allegations against him:

> (i) by finding that, at the time of the 10:00 a.m. Assessment on February 13, 2006, Mr. Barber had confusion caused by bacterial meningitis;
>
> (ii) by relying exclusively on Dr. Fong's opinion evidence to find that the appellant breached the applicable standard of care; and
>
> (iii) by failing to assess causation with the benefit of hindsight.

[40] Dr. Joshi also seeks leave to appeal and, if leave is granted, appeals from that part of the trial judge's costs ruling requiring him to pay the sum of $43,000 in costs, which the respondents were found to owe to Dr. Shergold in light of his successful defence of the action.

Analysis

(1) Reasonableness of Finding of Confusion Caused by Bacterial Meningitis

[41] Dr. Joshi attacks the trial judge's finding that Mr. Barber had confusion caused by bacterial meningitis at the 10:00 a.m. Assessment on several grounds. As set out in his factum, he contends that the trial judge:

> [R]ejected the evidence of all witnesses who observed Mr. Barber and all contradictory medical records, instead accepting a factual assumption of an expert witness [Dr. Fong] who ignored key aspects of the medical records in arriving at his conclusion. While she was not required to accept that evidence, she was required to consider it and provide a cogent rationale for rejecting it.

I would not accept this contention.

[42] At the outset, I emphasize that deference is owed by this court to the trial judge's factual findings regarding Mr. Barber's mental status, which were based on her appreciation and assessment of the evidence. Absent palpable and overriding error, appellate interference with these findings is precluded.

[43] I see no such error in the trial judge's finding that, by the time of the 10:00 a.m. Assessment, Mr. Barber was suffering from confusion caused by bacterial meningitis. In my opinion, this critical factual finding was open to the trial judge on the record before her and was firmly grounded in the evidence. I say this for the following reasons.

(a) Evidentiary Support for Finding of Confusion

[44] First, contrary to Dr. Joshi's argument, I do not agree that Dr. Fong's evidence regarding Mr. Barber's mental status at the 10:00 a.m. Assessment was based on a factual assumption or "impression" of a level of consciousness that had no support in the evidence. By the time of the 10:00 a.m. Assessment, Mr. Barber's medical records contained numerous entries consistent with a patient experiencing a decreased level of consciousness or altered mental status. Recall that:

> (i) Dr. Mueller had recorded on the transfer of Mr. Barber to the Hospital that he had a history of fever and a decreased level of consciousness for two days, as well as left inspiratory chest crackles;
>
> (ii) the paramedics had noted that Mr. Barber was being sent to the Hospital for a two-day history of fever and a decreased level of consciousness, among other things, and that, while enroute to the Hospital, they had been unable to conduct a thorough assessment of him because he was unwilling or unable to answer questions;

(iii) the ER triage nurse noted at 9:17 a.m. that Mr. Barber had an "ashen" colour and was "non-communicative and uncooperative"; and

(iv) the secondary nursing assessment at 9:55 a.m. recorded that Mr. Barber's history was "vague" and he was unable to focus on conversation. Notably, this assessment was made only five minutes before Dr. Joshi's own examination of the patient.

[45] Dr. Joshi acknowledged at trial that all these records, save only for Dr. Mueller's transfer note,[2] were available to him when he first saw Mr. Barber at 10:00 a.m. Moreover, and importantly, Dr. Joshi himself observed and charted that Mr. Barber was "confused" at the 10:00 a.m. Assessment.

[46] Dr. Fong's testimony that Mr. Barber exhibited a reduced level of consciousness at the 10:00 a.m. Assessment was based on his review of the available medical records, including Dr. Joshi's own notes. As the trial judge explained, Dr. Fong was entitled to form his standard of care opinion on the basis that Mr. Barber's medical chart reflected what actually happened. It was for the trial judge to determine whether that assumption was accurate and then weigh his evidence accordingly.

[47] I recognize that the paramedics assigned Mr. Barber two perfect GCS scores (15/15) and that Dr. Joshi recorded a 14/15 GCS score for Mr. Barber at

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[2] The fact that Dr. Joshi may not have read Dr. Mueller's health care consultation note until after the 10:00 a.m. Assessment is immaterial. The paramedics' notes, which were available to Dr. Joshi, clearly stated that Mr. Barber had a two-day history of fever and a decreased level of consciousness, and was being sent to the Hospital for this reason.

the 10:00 a.m. Assessment. It appears that Dr. Fong did not take the GCS scores into account when testifying about Mr. Barber's mental status.

[48] However, the trial judge's reasons confirm that she was alert to these scores, to their significance as potential indicators of Mr. Barber's mental status, and to Dr. Joshi's argument that Dr. Fong's opinion about Mr. Barber's mental status should be given little weight because Dr. Fong had failed to consider them. Having expressly considered these issues, the trial judge concluded that the GCS scores recorded by the paramedics were unreliable because the paramedics had been unable to perform a complete assessment of Mr. Barber and Dr. Fong's opinion should not be discounted on this basis. She stated, at para. 255 of her reasons:

> [S]ince I have also noted that the paramedics had concurrently recorded that Barber had been unwilling or unable to answer questions, and since they had also included a caveat that a thorough assessment had not been possible, I have not discounted Fong's opinion on that basis. Nor have I accepted the submission of counsel for the Defendants that the EMS [paramedics'] comment that a thorough assessment was not possible/was [*sic*] inapplicable to their second GCS assessment.

[49] This weighing of the evidence and the determination of its reliability were squarely within the trial judge's domain. The paramedics' notes, on their face, contained arguably inconsistent information. The recorded GCS scores suggested no impairment in Mr. Barber's mental status. Yet the paramedics also

noted that, because Mr. Barber did not answer their questions, they had been unable to conduct a thorough assessment. It was open to the trial judge to conclude, based on the paramedics' admitted incomplete assessment of Mr. Barber, that their evaluation of his mental status was also incomplete and, hence, unreliable. Certainly it cannot be said that the trial judge ignored or failed to consider the evidence of the GCS tests.

[50] The trial judge's finding is also consistent with Dr. Joshi's notes from the 10:00 a.m. Assessment. Dr. Joshi's recorded GCS score for Mr. Barber was reduced by one point on the verbal scale. This indicates less than perfect verbal responses. And Dr. Joshi also recorded that Mr. Barber was "confused". As I will discuss, this, too, could fairly be interpreted as signalling a diminished level of consciousness.

[51] Finally, the trial judge's finding that Mr. Barber had an altered mental status due to meningitis at 10:00 a.m. was supported not only by the information in Mr. Barber's medical records, described above, and by Dr. Fong's evidence, it was also supported by Dr. Boushy's evidence, the defence emergency medicine expert. In his testimony, Dr. Boushy said that a patient with an altered mental status may be described as "slightly confused or somewhat confused, somebody that [*sic*] is not answering questions properly, somebody that is quite vague when answering questions and when asked to do certain procedures during [an] examination". Mr. Barber's medical records at the 10:00 a.m. Assessment

contained virtually all these descriptors. Further, Dr. Boushy acknowledged, as Dr. Fong testified and as Dr. Joshi himself agreed, that confusion caused by meningitis is not transient.

(b) Contradictory Evidence Was Not Ignored

[52] Dr. Joshi next submits that, in finding that Mr. Barber had a reduced mental status at the time of the 10:00 a.m. Assessment, the trial judge ignored or discounted contradictory evidence, including, in some instances, the observations of fact witnesses recorded in medical records that were admitted at trial on consent for the truth of their contents.

[53] Relatedly, Dr. Joshi submits that the trial judge erred by providing no explanation for rejecting his account of Mr. Barber's mental status and by according no weight to his evidence of his "invariable practice" in charting. Dr. Joshi maintained at trial that, in accordance with his "invariable practice", if Mr. Barber's confusion, noted at 10:00 a.m., had continued at 12:30 p.m., he would have documented it and taken steps to investigate. According to Dr. Joshi, as he made no reference to confusion in his 12:30 p.m. notes, Mr. Barber's confusion must have resolved by then. He took the position that from 12:30 p.m. onwards, Mr. Barber remained alert and oriented until the morning of February 14th.

[54] I do not accept these submissions. The trial judge's reasons reveal that she was cognizant of the evidence said by Dr. Joshi to tell against a finding that

Mr. Barber had a reduced level of consciousness caused by bacterial meningitis at the 10:00 a.m. Assessment. This "contradictory" evidence included the evidence of some of the clinical tests and observations of Mr. Barber (notably, his GCS scores), Dr. Joshi's own testimony, and the nursing notes made at the detention centre and the Hospital after 10:00 p.m. on February 13, 2006. The reasons confirm that, far from ignoring this evidence, the trial judge scrutinized it carefully and provided clear and cogent reasons for rejecting it.

[55] I begin with Dr. Joshi's own evidence. His account of Mr. Barber's condition and mental status stood in stark contrast to Dr. Mueller's, the paramedics', and various nurses' observations of Mr. Barber preceding the 10:00 a.m. Assessment. Moreover, throughout his testimony, Dr. Joshi downplayed the severity of Mr. Barber's presenting condition. For example, he: i) denied that Mr. Barber had any reduced level of consciousness; ii) maintained that Mr. Barber's skin colour was normal at the 10:00 a.m. Assessment, although he did not record this and the triage nurse had noted Mr. Barber's ashen skin colour; iii) attempted to explain Mr. Barber's elevated blood pressure by suggesting that he may have stopped taking his blood pressure medication even though the nursing notes indicated that Mr. Barber was taking his medication; and iv) suggested, contrary to the paramedics' and nurses' observations, that Mr. Barber was not diaphoretic at any time while he was in the ER but, rather, was merely "perspiring".

[56] Most telling is that Dr. Joshi attempted to minimize the significance of his own recorded observation that Mr. Barber was “confused” at the 10:00 a.m. Assessment. The meaning of this note was a significant issue at trial. Notwithstanding the recorded observations of Dr. Mueller, the paramedics and Hospital nursing staff regarding Mr. Barber’s altered mental status, outlined above, Dr. Joshi denied that his reference to “confusion” indicated that Mr. Barber had displayed a reduced level of consciousness. Instead, Dr. Joshi attempted to qualify the meaning of his notation by suggesting that “it was unclear in terms of whether [the patient] was just choosing not to answer questions or whether [the patient] was [displaying] true confusion.”

[57] Dr. Joshi also sought to explain important omissions from his notes by resort to his invariable charting practice. For example, as I have said, he maintained that if Mr. Barber had remained confused at 12:30 p.m., he would have documented it and investigated. Similarly, if Mr. Barber had been experiencing significantly elevated respiratory rates at the 10:00 a.m. Assessment of the type recorded at the secondary nursing assessment, this too would have been documented by him. According to Dr. Joshi, as his notes contain no entries of confusion at 12:30 p.m., or of elevated respiratory rates in the range of 40 breaths per minute at 10:00 a.m., Mr. Barber could not have been exhibiting such symptoms.

[58] The trial judge did not accept Dr. Joshi's evidence of Mr. Barber's mental status. Nor did she attribute much weight to his testimony that, based on his invariable charting practice, the lack of a notation by him about Mr. Barber's mental status or condition necessarily signified normalcy or no material change.

[59] The trial judge regarded Dr. Joshi's charting as "incomplete, to say the least" (at para. 215) and his attempts to explain away key omissions from his notes to be unhelpful, after-the-fact reconstructions of what he believed must have taken place, rather than a recounting of what he remembered actually having taken place. The trial judge put it this way, at para. 219:

> *Joshi's Present Recollection*
>
> [M]uch of Joshi's evidence was reconstructed and based, not on his present recollection of events, but on what he said earlier and on his usual practice. Much of his evidence was about what he thought he would have observed [rather than about what he remembered observing], and about what he thought he would have done, given his usual practice and his own perceived standards [rather than about what he remembered doing]. [Emphasis in original.]

[60] The trial judge addressed Dr. Joshi's reliance on his invariable practice directly. She stated, at paras. 221-23:

> *Evidence of Custom/Invariable Practice*
>
> I recognize that in a busy hospital ER it is difficult to find the time to record every salient finding. I also appreciate the strength and importance of evidence of customary practice and I have carefully considered the

> evidence and the case law with those considerations in mind.
>
> *Reconstruction of Evidence*
>
> I have already noted Joshi's evidence that Barber's mental status at 12:30 and 2:00 PM on February 13, 2006 *must* have been normal because if Barber's mental status had been abnormal, he would have acted differently. In effect, in reconstructing what he must have done, he reasoned that given his own standards and given that the Standard of Care would have required him to act differently than he did had Barber's mental status been abnormal, Barber's mental status must have been normal.
>
> That type of reasoning and reconstruction was of little assistance to this Court. For me to adopt that reasoning would require me to assume in Joshi's favour the answers to the very questions that I must answer/decide. Instead, I have borne in mind all of the evidence and the relevant case law, including the law on usual practice. [Italicized emphasis in original; underlined emphasis added.]

[61] Thus, the trial judge's reasons do explain why she rejected Dr. Joshi's evidence concerning Mr. Barber's mental status and placed little weight on his testimony about his invariable practice. The trial judge was not obliged to accept Dr. Joshi's account of Mr. Barber's mental status or his explanation for omissions in his clinical notes. As Dr. Joshi concedes in his factum, so long as the trial judge considered his evidence on these issues, she was not required to accept that it was accurate. Having considered his evidence, the trial judge simply declined to accept it. This was her call to make.

[62] The trial judge also took account of other evidence, apart from Dr. Joshi's testimony and Mr. Barber's GCS scores, that Dr. Joshi says contradicted the conclusion that Mr. Barber was experiencing a reduced level of consciousness at the 10:00 a.m. Assessment. Two examples will suffice to make this point.

(i) Triage nursing notes

[63] The triage nursing notes made on Mr. Barber's admission to the Hospital near midnight on February 13th suggested no abnormality in Mr. Barber's condition and mental status, instead recording that he was alert, oriented, cooperative, breathing normally and had no fever. The trial judge indicated, at para. 235, that these notes had caused her "much anxious consideration" because if they were accurate, "they could have provided a basis for this Court to infer that Barber's mental status around midnight on February 13 [and earlier] was indeed normal as Joshi [and Boushy] assumed it must have been."

[64] Citing this court's decision in *Ortolan v. Hotel-Dieu Grace Hospital*, 2011 ONCA 456, Dr. Joshi argues that, as the triage nursing notes were admitted at trial on consent for the truth of their contents, it was not open to the trial judge to make a finding – based on Dr. Fong's opinion evidence – that was inconsistent with them. I do not agree.

[65] First, and importantly, the trial judge's key finding about Mr. Barber's mental status at 10:00 a.m. was not based solely on Dr. Fong's testimony.

Rather, it was an inference drawn by her based on all the available evidence, including direct evidence, about his condition and mental status prior to and on admission to the Hospital and at the time of the 10:00 a.m. Assessment.

[66] In any event, in my opinion, the trial judge was not precluded, as a matter of law, from assessing the accuracy and reliability of the triage nursing notes simply because the parties had agreed, for the purpose of admissibility, that the notes should be admitted on consent for the truth of their contents. I do not read *Ortolan* as dictating a contrary conclusion in this case. As I have emphasized, unlike the facts in *Ortolan*, there was evidence here, apart from Dr. Fong's testimony, that anchored the trial judge's standard of care findings.

[67] As the Supreme Court held in *Ares v. Venner*, [1970] S.C.R. 608, at p. 626, the admission of nursing notes for the truth of their contents "should, in no way, preclude a party wishing to challenge the accuracy of the records or entries from doing so." So, too, it is the duty of a trier of fact to weigh and determine the probative value, including the reliability, of evidence bearing on the critical, contested issues at trial. The ultimate reliability of the evidence, and the weight to be attached to it, remain determinations for the trier of fact. See for example, *R. v. Ivy Fisheries Ltd.*, 2009 NSSC 95, at para. 69, aff'd 2009 NSCA 112.

[68] The trial judge provided cogent reasons for concluding that the relevant triage nursing notes could not be taken as accurately portraying Mr. Barber's

mental status on his return to the Hospital. She explained that, because the involved triage nurse did not testify at trial, despite a direct challenge by Dr. Fong to the accuracy of the triage nurse's notes, she was left with incomplete evidence regarding the nature of the assessments carried out by the triage nurse, the circumstances under which she undertook those assessments and whether, when the triage nurse examined Mr. Barber that night, she had in hand his chart from earlier in the day on February 13th.

[69] Furthermore, the triage nurse's recorded observations of Mr. Barber's condition and mental status were inconsistent not only with the evidence of Dr. Fong, but also with that of the defence witnesses Dr. Powis and Dr. Juurlink to the effect that Mr. Barber likely already had meningitis at or soon after the 10:00 a.m. Assessment.

[70] In light of these considerations, the trial judge stated, at para. 240: "Given the conflicting evidence and without the benefit of hearing from the triage nurse, I have done the best that I can, having regard to all of the evidence before me." This is precisely what the trial judge was obliged to do.

[71] I therefore see no basis on which to fault the trial judge's approach to the evidence of the triage nursing notes. That she did not accord to them the weight urged by Dr. Joshi does not mean that she erred in law or ignored material evidence. It simply means that, based on other evidence that she did accept,

including evidence of contemporaneous events, she questioned the accuracy of the triage nursing notes and, hence, their reliability. She was entitled to do so.

(ii) Detention centre nursing notes

[72] I provide a second example, involving the evidence of Nurse DeToma's observations of Mr. Barber on his return to the detention centre during the afternoon of February 13th and before his transport back to the Hospital later that night.

[73] The trial judge did not ignore this evidence either. Indeed, she specifically addressed Dr. Joshi's contention that the detention centre records suggested that Mr. Barber's condition and mental status were normal while he was back at the detention centre, and outlined her reasons for rejecting this claim.

[74] The trial judge stated that the 3:30 p.m. nursing note made on Mr. Barber's return to the detention centre did not reflect normal, but rather abnormal, vital signs and that Nurse DeToma's 10:30 p.m. nursing note did not provide details of his breathing or his mental status. These statements were accurate.

[75] The trial judge also found, at para. 230, that the detention centre staff who testified at trial (including, therefore, Nurse DeToma), "had little present recollection of the events at issue here. Using incomplete contemporaneous notes, they too attempted to reconstruct what must have happened" (emphasis in original). She went on to emphasize that, while Mr. Barber's respiration

appeared to have improved at the detention centre, his breathing had nonetheless been described as “laboured”. And, while his improved temperature could be attributed to his receipt of Tylenol and Ibuprophen, this did not mean that his underlying fever had been cured.

[76] These findings were available to the trial judge on the evidentiary record. They do not support Dr. Joshi’s assertion that the trial judge ignored material evidence that militated against her findings about Mr. Barber’s mental status. Indeed, they suggest the opposite, namely, that the trial judge appreciated the conflicts in the evidence about Mr. Barber’s mental status and came to grips with them.

[77] This ground of appeal therefore fails. The trial judge’s reasons include a thorough review of the evidence of Mr. Barber’s condition and mental status at and leading up to the 10:00 a.m. Assessment. They also explain which evidence she accepted, and why, and set out her reasons for concluding that Mr. Barber was experiencing confusion due to bacterial meningitis at the 10:00 a.m. Assessment. I see no basis for appellate interference.

(2) Reliance on Dr. Fong’s Standard of Care Evidence

[78] Dr. Joshi argues that the trial judge erred in law by relying exclusively on Dr. Fong’s evidence to find that Dr. Joshi breached the standard of care. He makes four submissions in support of this argument.

[79] First, he submits that Dr. Fong is not qualified to offer an opinion on the standard of care applicable to an ER physician in 2006.

[80] Second, he says that the trial judge erred by failing to provide reasons for her rejection of Dr. Brankston's opinion on the standard of care applicable at the 10:00 a.m. Assessment, which Dr. Joshi says directly conflicted with that of Dr. Fong.

[81] Third, Dr. Joshi asserts that Dr. Fong's standard of care opinion was based on the erroneous factual assumption that Dr. Joshi had failed to perform a neurological evaluation at the 10:00 a.m. Assessment. In fact, he performed a GCS test and documented the score it yielded. Finally, Dr. Joshi maintains that Dr. Fong never actually expressed an opinion on what the standard of care required in the circumstances.

[82] I make this preliminary comment. The premise of this ground of appeal is the assertion that the trial judge relied exclusively on Dr. Fong's testimony to find that Dr. Joshi breached the standard of care. I do not accept this premise.

[83] There is no doubt that the trial judge relied heavily on Dr. Fong's evidence in finding that Dr. Joshi breached the standard of care at both the 10:00 a.m. Assessment and during his 12:30 p.m. examination of Mr. Barber. But this was not the only evidence on which she relied. In concluding that Dr. Joshi breached the standard of care at the 10:00 a.m. Assessment, the trial judge also relied on

her factual findings, gleaned from all the evidence, about Dr. Joshi's knowledge at 10:00 a.m. of Mr. Barber's history, presenting condition and mental status, as well as certain of the evidence of some of the other expert witnesses.

[84] With respect to Dr. Joshi's knowledge, following an extensive review of the evidence, the trial judge held that he knew at the time of the 10:00 a.m. Assessment:

> (i) of Mr. Barber's history of fever and of a decreased level of consciousness as documented by the paramedics and ER nursing staff (para. 289);
>
> (ii) that the paramedics had been unable to complete a thorough assessment of Mr. Barber because he had been unwilling or unable to answer questions while enroute to the Hospital (para. 289);
>
> (iii) that only five minutes before the 10:00 a.m. Assessment, Mr. Barber had been noted to be very sweaty, to have a respiratory rate of 29-35 breaths per minute, to be vague, unable to focus on conversation, and to be unoriented (the nursing note suggesting he was oriented as to person, place and time x 3 had been crossed out) (para. 292);
>
> (iv) that Mr. Barber appeared to be very ill when he arrived at the Hospital (paras. 290-91);
>
> (v) that Mr. Barber had been recorded as having much higher respiratory rates than the 20 breaths per minute noted by Dr. Joshi and that his respiratory rates "were far from consistently normal" (paras. 297 and 300);
>
> (vi) that Mr. Barber had already received medication, albeit for chest pains, that could have reduced but not cured his underlying fever (para. 309);

(vii) that Mr. Barber's oxygen saturation was normal, which cut against the possibility that pneumonia was the cause of his confusion (para. 318); and

(viii) that Mr. Barber's skin colour at 9:17 a.m. was observed to be "ashen" and that he had earlier been noted to be sweating profusely (para. 288).

[85] None of these factual findings depended on Dr. Fong's expert evidence. Taken together, they strongly supported the conclusion that a full assessment of Mr. Barber, including a comprehensive neurological evaluation, was required at the 10:00 a.m. Assessment. Dr. Fong, in his testimony, confirmed that this was so.

[86] The trial judge also expressly relied on the evidence of defence witnesses. For example, she relied on Dr. Boushy's testimony that Dr. Joshi should not have ignored Mr. Barber's recorded and very elevated respiratory rates and on his testimony identifying the signs and symptoms of meningitis; and she relied on Dr. Powis' evidence about the significance of elevated blood pressure readings.

[87] I would therefore reject Dr. Joshi's assertion that the trial judge's finding that he breached the standard of care rested entirely on Dr. Fong's evidence. This characterization of the trial judge's reasons takes too narrow a view of her standard of care analysis and her factual findings.

[88] I turn now to Dr. Joshi's specific complaints regarding the trial judge's reliance on Dr. Fong's evidence.

(a) Dr. Fong's Standard of Care Evidence Was Admissible

[89] At trial, the defence challenged the admissibility of Dr. Fong's evidence on the standard of care on the basis that he is not an ER physician, has no practice experience as an ER physician and possesses specialized skills and training that exceed those of an ER physician. The defence maintained that Dr. Joshi's conduct was to be measured against the standard of a reasonable ER physician, not that of an infectious disease specialist like Dr. Fong.[3]

[90] This challenge was addressed, and rejected, by the trial judge. She ruled that, based on his experience teaching medical students in 2006 and his resulting knowledge of what general medical practitioners are taught, Dr. Fong was qualified to offer an opinion on "what he knows that general practitioners were required to know and do in a certain area that he has expertise about in 2006".

[91] I see no reversible error in this ruling. The courts have recognized that, in a proper case, a specialist physician's opinion on the level of care, skill, knowledge and judgment expected from a non-specialist medical practitioner may be admissible having regard to the nature of the medical question at issue: see for example, *Robinson v. St. Joseph's General Hospital* (1999), 117 O.A.C. 331 (C.A.), at para. 8; *Briffett v. Gander and District Hospital* (1996), 137 Nfld. &

[3] At trial, the defence did not challenge the admissibility of Dr. Fong's evidence on causation.

P.E.I.R. 271 (Nfld. C.A.), at paras. 47-48; *Quintal v. Datta* (1988), 68 Sask. R. 104 (C.A.), leave to appeal refused, [1988] S.C.C.A. No. 488. In other words, the opinion of a medical specialist regarding the appropriate standard of care for a general medical practitioner may be admissible as necessary, relevant and helpful to the trier of fact. It is for the trial judge to determine the weight to be given to the specialist physician's opinion, having regard to his or her different work experience and specialized training.

[92] That was the situation here. Dr. Fong's evidence on the standard of care was based on his personal knowledge and expertise regarding the knowledge and training that was common to and expected of all physicians in 2006 who were called upon to care for a patient with Mr. Barber's presenting history and symptoms. It was Dr. Fong's uncontradicted testimony that the knowledge expected of any physician assessing a patient who presents with signs and symptoms of meningitis is at the core of the concepts taught to all physicians. He said, for example, that knowing how a patient presents with a stroke, peritonitis, appendicitis, pneumonia or meningitis are "core things that all medical students should know by the time they finish their training". Dr. Fong was experienced in teaching medical students on these very subjects, specifically, on the minimum standard applicable to all doctors in 2006, including ER physicians.

[93] In admitting Dr. Fong's evidence on the applicable standard of care, the trial judge recognized, correctly, that an ER physician cannot properly be held to

the standard of an infectious disease specialist. But that was not the standard about which Dr. Fong testified. The trial judge limited his evidence on the standard of care to the minimum standard applicable to all medical doctors in 2006. In doing so, she reasoned, at para. 249:

> The minimum standard expected of [ER] physicians in 2006 cannot be lower than the minimum standard expected of all physicians. While I accept the submission that the standard of [ER] doctors could conceivably be higher than the minimum standard expected of all MDs, I do not accept that it could ever be lower.

I agree.

(b) Rejection of Dr. Brankston's Evidence

[94] Dr. Joshi makes two arguments concerning the trial judge's treatment of the evidence of Dr. Brankston, the respondents' emergency medicine expert. First, he argues that, as Dr. Brankston's opinion on the standard of care directly contradicted that of Dr. Fong and because Dr. Brankston is an ER physician, Dr. Brankston's opinion should have been preferred to that of Dr. Fong. Second, he submits that the trial judge erred by failing to reference Dr. Brankston's testimony on the standard of care applicable to the 10:00 a.m. Assessment in her reasons, thereby in turn failing to provide sufficient reasons for her decision.

[95] There are several difficulties with these arguments. First, like Dr. Fong, Dr. Brankston testified that Dr. Joshi's care and treatment of Mr. Barber did not meet

the standard of care expected of an ER physician, albeit for reasons that differed from those of Dr. Fong.

[96] Unlike Dr. Fong, Dr. Brankston testified that Dr. Joshi did a "pretty complete assessment" and "ordered appropriate investigations" at the 10:00 a.m. Assessment and that it did not appear that Mr. Barber had meningitis at 10:00 a.m. However, he also said that Mr. Barber was sick enough to be admitted to the Hospital and should not have been discharged. Rather, given his condition, symptoms and history, Mr. Barber should have been admitted and given intravenous antibiotics. Dr. Brankston therefore offered the opinion that Dr. Joshi breached the standard of care by discharging Mr. Barber from the Hospital. Thus, in this important respect, Dr. Brankston's evidence did not assist Dr. Joshi. It merely provided an alternate basis for a finding of negligence against him.

[97] Second, Dr. Joshi's counsel argued forcefully at trial that little weight should be accorded to Dr. Brankston's testimony. Having urged this outcome on the trial judge and having prevailed, at least to the extent that the trial judge did not rely on Dr. Brankston's standard of care opinion, it does not lie in Dr. Joshi's mouth to now assert that the trial judge fatally erred for doing exactly what he, through counsel, pressed her to do.

[98] Third, based on the evidence of Dr. Fong, Dr. Powis, Dr. Boushy and, to some extent, that of Dr. Joshi himself, the trial judge found as a fact that Mr.

Barber was displaying signs and symptoms of bacterial meningitis at the 10:00 a.m. Assessment. It follows that she rejected Dr. Brankston's contrary opinion, implicitly concluding that his testimony about the appropriate steps to be taken at the 10:00 a.m. Assessment to treat pneumonia was largely irrelevant.

[99] Finally, Dr. Joshi's attack on the adequacy of the trial judge's reasons must be squarely rejected. I have already concluded that her reasons clearly explain why she ruled as she did on the standard of care and that they carefully delineate the basis for her decision. I see nothing in her reasons suggesting that she failed to properly consider Dr. Brankston's evidence. Given his conflicting testimony on the trial judge's key findings and the position taken by Dr. Joshi's counsel regarding his evidence, it is apparent why it was unnecessary to make detailed reference to his testimony.

(c) Incomplete Neurological Assessment

[100] Dr. Joshi's third submission is that Dr. Fong's standard of care opinion was fatally flawed because it was premised on the false assumption that Dr. Joshi did not conduct any neurological evaluation of Mr. Barber at the 10:00 a.m. Assessment, specifically, a GCS assessment. This proposition was not put to Dr. Fong on cross-examination and he was not asked if his opinion would change in light of the GCS scores.

[101] I have already considered Dr. Fong's failure to recognize Mr. Barber's GCS scores. Suffice it to say that the trial judge fully considered and rejected Dr. Joshi's attack on Dr. Fong's evidence on this basis. In my view, she was entitled to do so. The critical point is that Dr. Joshi's notes from the 10:00 a.m. Assessment referred not only to the less than perfect results of a GCS test but, additionally, to Mr. Barber being "confused". On the trial judge's findings, this observation was made at a time when Mr. Barber, to Dr. Joshi's knowledge, had a documented history of fever and a lowered level of consciousness prior to arrival in the ER.

[102] In these circumstances, the trial judge held, at para. 257, that even with the GCS test conducted by him, "[Dr.] Joshi did not do the full and complete neurological testing required in all the circumstances." Dr. Fong was clear in his evidence that where, as here, there is a history of a decreased level of consciousness, coupled with a fever, a lumbar puncture should be performed to rule out possible meningitis. Dr. Powis' evidence was to a similar effect. And, as the trial judge noted at para. 67 of her reasons, Dr. Boushy agreed that, with a history of lowered consciousness for two days and fever, "any emergency physician would be concerned about [it] and would want to determine its cause." He also agreed that Mr. Barber's symptoms on arrival in the ER suggested he was experiencing an altered level of consciousness. Moreover, Dr. Joshi himself acknowledged in his testimony that if there were even the slightest suspicion of

meningitis, testing and treatment for it was required. This did not occur in this case.

(d) Dr. Fong's Standard of Care Opinion

[103] In my view, Dr. Joshi's argument that Dr. Fong did not actually express an opinion on what the standard of care required in this case is unsustainable on this record. I think it beyond dispute that, given the trial judge's ruling about the permissible scope of his testimony, described above, when Dr. Fong testified about the core concepts that he taught to medical students and the common knowledge that all general medical practitioners were expected to have in 2006, he was testifying about the requisite standard of care in 2006. That this was so is made clear by the trial judge's ruling confining the scope of Dr. Fong's testimony on the standard of care and by defence counsel's objections to questions of Dr. Fong that strayed beyond his knowledge of what was taught to, and therefore expected, of general practitioners in 2006.

[104] I would not give effect to this argument.

(3) Causation Analysis

[105] There was no dispute in this case about the governing test for the proof of causation in medical malpractice cases. The trial judge identified it, at para. 437, as requiring proof by the respondents that, but for Dr. Joshi's breach of the standard of care, it was more likely than not that Mr. Barber would not have died.

[106] Citing the Supreme Court's decision in *Ediger v. Johnston*, 2013 SCC 18, [2013] 2 S.C.R. 98, the trial judge also recognized that inherent in the "but for" test for causation is the requirement that the defendant's negligence was necessary to bring about the injury in question. Further, the plaintiff bears the burden of proving causation on a balance of probabilities. As explained in *Ediger*, at para. 36, in determining whether the plaintiff has discharged this burden, the trier of fact may, upon weighing the evidence, "draw an inference against a defendant who does not introduce sufficient evidence contrary to that which supports the plaintiff's theory of causation".

[107] The causation dispute in this case arose from the fact that, on Dr. Joshi's orders, Mr. Barber received the antibiotic Avelox shortly after the 10:00 a.m. Assessment rather than the Standard Treatment for meningitis. Relying on Dr. Fong's testimony and on peer-reviewed medical studies concerning survival statistics for patients with meningitis referenced by Dr. Powis in his testimony, the respondents argued at trial that, although Mr. Barber was seriously ill and confused before the morning of February 14, 2006, he would have survived with the appropriate treatment.

[108] In contrast, Dr. Joshi maintained that Mr. Barber's "actual outcome" following the administration of Avelox was the appropriate measure of the probability of his survival. As Mr. Barber unfortunately died notwithstanding his receipt of Avelox, a recognized second-line of treatment for meningitis, his

likelihood of survival with or without significant neurological damage was low. Simply put, the defence argued that Mr. Barber would have died even if he had received the Standard Treatment for meningitis.

[109] The trial judge rejected Dr. Joshi's causation argument. She held that the best evidence before her of Mr. Barber's probable outcome had he received the Standard Treatment for meningitis was contained in the medical studies cited by Dr. Powis and in the prognosticating factors outlined in those studies and by Dr. Fong. Based on that evidence, she held that the respondents had established that it was more likely than not that, but for Dr. Joshi's negligence in failing to diagnose and properly treat meningitis at the 10:00 a.m. Assessment, Mr. Barber would not have died or sustained serious neurological injury.

[110] Dr. Joshi argues that the trial judge erred in so holding because she failed to assess causation in light of all the evidence and, in particular, with the benefit of hindsight. Specifically, he submits that the trial judge erred by ignoring Mr. Barber's actual outcome and failing to use it to determine the likelihood of Mr. Barber's survival "but for" Dr. Joshi's breach of the standard of care.

[111] I disagree.

[112] The trial judge's reasons confirm that she appreciated the two competing causation theories advanced at trial, the evidence marshalled in support of each, and the fact that Dr. Joshi's theory hinged on Mr. Barber's "actual outcome"

following the administration of Avelox. The trial judge did not ignore Dr. Joshi's "actual outcome" approach to causation. She simply did not accept it. In my view, for the reasons that follow, she cannot be faulted for this decision.

[113] Dr. Powis was the primary proponent at trial of the causation theory posited by the defence. He testified that Mr. Barber's actual outcome following the administration of Avelox was the best prognosticator of his likely outcome had he received the Standard Treatment for meningitis shortly after the 10:00 a.m. Assessment. However, several factors significantly undercut this proposition.

[114] First, Dr. Fong and Dr. Powis agreed, and the trial judge found, that Avelox is not the standard treatment for bacterial meningitis. Although Dr. Juurlink testified that Avelox was an appropriate therapy for Mr. Barber's type of bacterial meningitis, he did not suggest that Avelox was the accepted standard treatment for meningitis.

[115] Further, there was no evidence at trial that Avelox is as effective in treating meningitis as the Standard Treatment of Ceftriaxone, Vancomycin and Decadron. As the trial judge put it, at para. 500, Avelox is "a 'second-line' treatment for unspecified types of meningitis [that is suitable for use] in specific limited circumstances where the Standard of Care treatment is contraindicated [*sic*] because of allergy or resistance".

[116] Second, the medical studies relied upon by Dr. Powis in his evidence indicated that the mortality rate for all patients with pneumococcal meningitis following Standard Treatment is about 20 percent to 40 percent. Dr. Fong, relying on the prognosticating factors that he regarded as relevant, estimated that Mr. Barber's mortality rate was even lower – at 10 percent. He testified that Mr. Barber's probability of survival if the Standard Treatment had been employed was about 90 percent.

[117] Third, Dr. Powis' own evidence at trial supported the conclusion that with Standard Treatment for meningitis commenced shortly after the 10:00 a.m. Assessment, Mr. Barber was more likely than not to have survived or not suffered serious neurological deficits.

[118] Specifically, Dr. Powis testified that a patient's best chance of surviving bacterial meningitis (that is, realizing a positive outcome), is early diagnosis and prompt treatment. He also acknowledged that if a lumbar puncture had been performed on Mr. Barber shortly after the 10:00 a.m. Assessment, it was likely that his spinal fluid would have revealed the presence of bacteria. Further, and critically, Dr. Powis conceded that if the statistical outcomes based on the prognosticating factors identified in the medical literature that he cited were applied to Mr. Barber (to project his likely outcome at 10:00 a.m. on February 13th when, on the trial judge's findings, the Standard Treatment should have

been administered), Mr. Barber's likelihood "for not only survival but [for] very mild, if any impairment" were "pretty good".

[119] Fourth, apart from the fact of Mr. Barber's death after the administration of Avelox, Dr. Powis provided no rationale for ignoring the statistical outcomes identified in the medical studies he cited. As the trial judge observed, at paras. 494 and 498, Dr. Powis, in effect, maintained that the fact of Mr. Barber's death following the receipt of Avelox, by itself, was sufficient justification to "trump the medical/statistical evidence on the effectiveness of the Standard of Care treatment for pneumococcal meningitis" even though there was a paucity of evidence at trial regarding the comparative effectiveness of Avelox and the Standard Treatment for meningitis.

[120] The trial judge recognized this for what it was: a plea to disregard the evidence of reported statistical outcomes for patients with meningitis who received the Standard Treatment that should have been administered to Mr. Barber, in favour of what the trial judge found, at para. 509, was "an outcome after a different inferior treatment" (emphasis in original). The trial judge was not obliged to accept this plea. On the evidence before her, she was entitled to conclude, as she essentially did, that the defence "actual outcome" theory was not the relevant point of comparison.

[121] The trial judge's causation analysis was thoughtful and thorough. Faced with conflicting expert evidence on the determination of Mr. Barber's probable outcome had he received the Standard Treatment for meningitis, she declined to adopt the defence "actual outcome" theory of causation, instead relying on the medical studies and statistical outcomes evidence proferred by Dr. Powis, Dr. Fong's evidence and, significantly, Dr. Powis's own testimony. The assessment of the conflicting evidence on this issue was at the core of the trial judge's function.

[122] I therefore conclude that the trial judge's causation analysis and her causation finding in respect of Dr. Joshi, which also attract deference from this court, are unassailable.

(4) Sanderson Costs Order

[123] The trial judge awarded the respondents $315,000 in costs, inclusive of disbursements and applicable taxes, as against Dr. Joshi. There is no challenge on appeal to this aspect of the trial judge's overall costs award.

[124] However, the trial judge also made a "Sanderson order", requiring Dr. Joshi, rather than the respondents, to pay the amount of $43,000, inclusive of disbursements and applicable taxes, on account of those partial indemnity costs to which Dr. Shergold was found to be entitled on account of his successful

defence of the action. It is this component of the trial judge's costs ruling that Dr. Joshi now seeks to appeal, arguing that it was unreasonable.

[125] The jurisdiction of this court to interfere with a trial judge's costs award is very limited. Unless the impugned award is plainly wrong or tainted by an error in principle, a reviewing court is precluded from interfering with it: *Hamilton v. Open Window Bakery Ltd.*, [2004] 1 S.C.R. 303, at p. 313.

[126] I see no basis for appellate interference with the trial judge's discretionary Sanderson order. The trial judge's costs reasons confirm that she considered the governing principles for granting a Sanderson order and the test for such an order outlined by this court in *Moore v. Wienecke*, 2008 ONCA 162, 90 O.R. (3d) 463, and related authorities. Her application of that test to the facts as she found them was neither plainly wrong nor infected by reviewable error. In particular, her holding that, in the circumstances here, it would be unfair to require the respondents, who are of limited means, to pay Dr. Shergold's costs when it was reasonable for them to join him in the action, is unimpeachable.

[127] Accordingly, while I would grant leave to appeal costs, I would decline to interfere with the trial judge's Sanderson order.

Disposition

[128] For the reasons given, I would dismiss the appeal, grant leave to appeal costs and dismiss the costs appeal. The respondents are entitled to their costs

of the appeal, including the costs of the leave to appeal motion, which I would fix in the total amount of $50,000, inclusive of disbursements and all applicable taxes.

Released:

“EAC”
“NOV 28 2016”

“E.A. Cronk J.A.”
“I agree R.G. Juriansz J.A.”
“I agree L.B. Roberts J.A.”