CITATION: Shearer v. Sewchand, 2013 ONSC 4052
PETERBOROUGH COURT FILE NO.: 267/08
DATE: 20130613

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
	)	
STONE SHEARER, a minor, by his Litigation Guardian, Angela Shearer: ANGELA SHEARER, personally and ROBERT SHEARER	)	Mr. Aleks Mladenovic and Mr. Carr Hatch for the Plaintiffs
Plaintiffs	)	
	)	
– and –	)	
Dr. KENNETH SEWCHAND	)	Mr. Mark Veneziano and Ms. Dena Varah, for the Defendant
Defendant	)	

HEARD: May 23, 24 and June 6, 7, 2012

H.K. O'CONNELL, J.

JUDGMENT

Overview

The Claim and Defence

[1] The plaintiff, Stone Shearer is a minor who brings this action, via his mother and litigation guardian Angela Shearer, against Dr. Kenneth Sewchand for negligence as a consequence of surgery performed on September 19, 2006 at the Peterborough Regional Health Centre.

[2] Stone had surgery for removal of a foreign object from his ear. Dr. Sewchand was the surgeon. At its core the negligence alleged as against Dr. Sewchand rests upon a breach of the duty of care that he owed to Stone, which it is said caused or contributed to various permanent and serious injuries to Stone. Those injuries are set out at paragraph 8 of the statement of claim. The full particulars of the negligence alleged are set out at paragraph 9 of the claim.

[3] Stone's parents brought claims under the *Family Law Act*.

[4] Dr. Sewchand defended the action in whole, and denied that he was negligent either pre or during the surgical stage of his treatment of Stone. The injuries and damages asserted were denied to be attributable in whole or in part to any actionable act or omission on the part of Dr. Sewchand.

The Trial

[5] The trial proceeded before me at Peterborough over the course of 4 days. Counsel made submissions at the conclusion of the trial on June 07, 2012, but also provided comprehensive written submissions that were filed in September 2012. The only issue for determination by the court is whether the defendant is liable.

[6] Let me say at the outset of these reasons that it was a pleasure to have the assistance of counsel who were exceptionally prepared and tenacious advocates. At the same time they proved that civility, the cornerstone of professional etiquette, is alive and well.

The Proceedings of May 23, 2012

[7] Counsel advised the court that there were two issues for determination. The first was whether Dr. Sewchand met the applicable standard of care in his treatment of Stone on September 19, 2006. The second was whether on the balance of probabilities any act or omission of Dr. Sewchand which is determined to be a breach of the standard of care, caused or contributed to any injury to Stone. If the answer to both questions is yes, then liability is established. If the answer to either question is no, then the action must be dismissed.

[8] A joint brief of documents was entered on consent as exhibit 1 at trial. Counsel for the plaintiff presented an overview of the case inclusive of the issues that required determination and the facts and evidence that he said would be called to establish liability.

[9] Counsel agreed that there was no issue that Dr. Sewchand treated Stone. Stone was six at the time. Sometime in mid-September 2006 Stone put a pebble[1] in his ear. The exact date of placement was not ascertainable. Upon inspection of the ear, Stone's mother saw the foreign object. She took Stone to the emergency department at the Peterborough Health Centre on September 18, 2006 where he was seen by Dr. Brar. That doctor tried to remove the object in the ear via irrigation and the use of a curette. Neither irrigation, nor use of the curette, dislodged the pebble.

[10] As a consequence a referral was made to Dr. Fagan, who is an ear, nose and throat specialist. Dr. Fagan saw Stone on September 19, 2006. He in turn referred Stone to Dr. Sewchand. Dr. Fagan's contact with Stone and his referral to Dr. Sewchand both occurred on September 19, 2006. Nothing in the record of referral suggested any significant pain prior to the procedure undertaken by Dr. Sewchand. Nothing in the evidence suggests any issue with the inability of Stone to close his eye or with

[1] In these reasons, the words pebble, stone and rock are used interchangeably.

misalignment of his facial symmetry. Nor were there any noted issues with ear pain, prior to Dr. Sewchand's surgery.

[11] Plaintiff's counsel submitted that the evidence will show that this was not a simple error in judgment or surgical misadventure case. Rather Dr. Sewchand fell below the requisite standard of care and that failure caused the injuries that Stone suffered. The plaintiffs allege that the mechanics of the injuries are a consequence of the stone in Stone's ear being pushed into his middle ear, which was a consequence of the breach of the standard of care in this case.

[12] On consent extracts of the examination for discovery of Dr. Sewchand from July 16, 2009 were read into the record and were conceded to have evidentiary value at trial. These extracts were marked as exhibit 2 at trial.

[13] I will now overview the evidence in a comprehensive manner.

Evidence of Angela Shearer

In Chief

[14] Mrs. Shearer is Stone's mother. Stone is one of three children. Stone has global development delay and has difficulty with fine and gross motor skills, speech and language. He struggles with comprehension and expressive language. He had no difficulty with hearing or vision. He had a history of ear infections. Mrs. Shearer said that when he had such infections he could relay to her that it hurt.

[15] On September 17, 2006 Stone told his mom, "ear hurt, hurt mom, ear." He otherwise had a generally happy demeanour. He was not crying. He was, said Mrs. Shearer, in a great mood. Mrs. Shearer saw this as typical of when he had an ear infection. Mrs. Shearer took Stone to the family doctor on September 18, 2006. The family doctor believed that there was a wax build-up in Stone's right ear. She suggested that hydrogen peroxide be used to flush out the wax.

[16] Mrs. Shearer tried peroxide at home, but it didn't work. Mrs. Shearer looked into his ear. She saw what looked like a small rock. There was no bleeding nor was there any discharge from the ear.

[17] As a consequence of her observations, Mrs. Shearer took Stone to the emergency department on September 18, 2006. She was present when the physician on call, Dr. Brar, tried to remove the object by flushing it from the ear canal. However nothing happened in

the removal attempt. The attending physician said he would inquire of an ear, nose and throat doctor. He did. Mrs. Stone and her son were referred to Dr. Fagan.[2]

[18] Stone was otherwise fine and running around. He said his ear hurt. However he showed no concern for pain and had no facial expression issues. He played with his siblings at home. He was fine said his mom.

[19] On September 19, 2006, in the early morning, Mrs. Shearer took Stone as directed to see Dr. Fagan. Dr. Fagan is an otolaryngologist. Dr. Fagan could not remove the stone. He attempted to flush it out. His note to Dr. Brar states that the stone was "very large" and "impossible to budge."

[20] In addition Dr. Fagan told Mrs. Shearer that the stone was "too lodged in to get." Dr. Fagan advised that surgical removal was required. A call was made to get Stone into see a doctor for the surgery. Dr. Fagan wanted to see if the surgeon on call, Dr. Sewchand, could get Stone in for the removal surgery that day. Stone and his mom went home.

[21] Mrs. Shearer awaited a call. It came around 10-10:30am. She was advised that there was a space available for the surgery in the operating room on that same day, September 19, 2006.

[22] Stone was taken back to the hospital. Mrs. Shearer spoke to a nurse in the hallway. Mrs. Shearer believes she was asked if Stone had a fever, or a cough. Dr. Sewchand then examined Stone's ears. He said that a tube in the left ear would remove liquid that was in that ear, and as for the right ear he saw a rock/pebble in the ear. It would take him 5 minutes to put the tube in the left ear and 5-10 minutes to remove the pebble from the right ear.

[23] She specifically recalled Doctor Sewchand looking in both ears with an instrument with a light on it. She believed that he advised that he was going to use a wax curette to remove the pebble.

[24] Mrs. Shearer was advised that her son would be under a general anaesthetic for the procedure. She said that there was no discussion re the risks of the removal of the pebble, nor was there any discussion of any alternate ways to deal with the problem. There was no discussion as to how deep the rock was in the ear, nor of any risks in the procedure. Up to this point Mrs. Shearer had seen no discharge from the ear with the stone in it, nor did Stone appear to be in any significant pain or discomfort. There was no facial asymmetry, nor was there any indication of facial paralysis.

[25] Mrs. Shearer signed the consent form for the surgery. She went into the operating room with Stone, because he was upset about going in. She stayed with him until he was sedated and then she left the room. She estimated that she waited in the waiting room for about ½ hour.

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[2] Neither Dr. Brar nor Dr. Fagan was required to testify. Exhibit 1, the *Joint Document Brief* contains the various medical reports and documents that were prepared in the treatment of Stone.

[26] After the surgery Dr. Sewchand came to see her. He said he put the tube in the left ear without issue. She then heard Stone screaming and crying down the hall. She went to the operating room and saw her son screaming. She described him as being really out of sorts.

[27] Mrs. Shearer described his scream as a scream unlike any that she has ever heard from him. Stone told her that it hurt. Mrs. Shearer noted that his face on the right side where the surgery was performed on his right ear was very flat and nothing was happening with facial expression on that side. His lips were not moving.

[28] Dr. Sewchand was there as well. Dr. Sewchand asked her what was wrong with Stone's face. Dr. Sewchand said it wasn't like that before the surgery. Mrs. Shearer said the same thing to Dr. Sewchand. Dr. Sewchand did not offer any explanation. Stone was taken to the recovery room. Mrs. Shearer inquired about her son's pain. She was advised that he was given a Tylenol suppository.

[29] When she asked about Stone's face, Dr. Sewchand indicated that it could have been nerve pressure or swelling of the nerve because of the surgery. The doctor said that Stone's face should recover within 6 weeks. Stone would not settle down. Mrs. Shearer called her husband and he came to the hospital.

[30] Mrs. Shearer said that Dr. Sewchand did not talk about the malleus[3] coming out during the procedure or of any damage to the tympanic membrane[4]. Nothing was mentioned to her about any complications from the removal of the pebble. Mrs. Shearer said that Dr. Pinto was present when she was discussing Stone with Dr. Sewchand.

[31] Mrs. Shearer and her husband went to get something to eat as her husband was concerned about her. They then went back to see Stone. He could only close his one eye. Another doctor at the hospital that they knew, Dr. Dickie, went with her back to the recovery room to see if he could help. She left the hospital with her husband and Stone. She went to get prescriptions and went back to the hospital to get her husband's briefcase which he had inadvertently left there.

[32] Dr. Sewchand called the Hospital for Sick Children (Sick Kids) and advised Mrs. Shearer that he was waiting to hear back. If he didn't hear back Dr. Sewchand advised he would call Mrs. Shearer the next day.

[33] Dr. Sewchand gave Mrs. Shearer prescriptions to fill as well as advising her to get eye drops for Stone. Mrs. Shearer understood that she was to wait until she heard back from Dr. Sewchand with respect to a follow up. Later that day she got a call from Dr. Sewchand. He told her that something would be happening with Sick Kids.

[34] She then received a call from a Dr. Trimble at Sick Kids who advised her to come to Sick Kids that same day and to go to Emergency for admission. Dr. Trimble advised that he

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[3] The malleus is one of three bones located in the inner ear, along with the stapes and the incus.
[4] The tympanic membrane is commonly referred to as the ear drum.

should be paged once she got to the hospital with Stone. Mrs. Shearer and her husband went to Sick Kids. She had Dr. Trimble paged as instructed. Dr. Trimble came down and looked in Stone's ear. Stone was in pain and out of sorts. She saw discharge and blood from the ear.

[35] Dr. Trimble advised that a cat scan would have to be done. At 1 or 2 am on September 20, 2006 the scan was done. Dr. Trimble advised that Dr. James, an ear and throat specialist, indicated that he would meet with them because reconstructive surgery was required for the ear.

[36] Mrs. Shearer was advised that a lot of damage was done in the ear. According to her she was told "the malleus was missing, the stapes was twisted and the incus was hanging, or something like that." With respect to Stone's face, the doctors advised that something was wrong with the facial nerve. It could be a function of swelling or the nerve could have been severed.

[37] The Shearers met with an audiologist on September 20, 2006 who advised that the ear drum was punctured. The audiologist advised that Stone had no hearing in the ear and the inside of the ear was a mess. This was the first time that Mrs. Shearer had heard this. She understood that surgery had to occur within 24 hours to reconstruct the ear and address the facial nerve issue.

[38] Surgery occurred. She recalled that at Sick Kids the surgeons advised that there was no malleus in the middle ear, that the stapes was crooked and that the incus was twisted or hanging.

[39] Dr. James a specialist in otolaryngology and Dr. Zuker, a plastic surgeon, performed the surgery. Dr. Zuker advised that the ear drum was perforated, and the facial nerve was partially severed, which was a good thing, as distinct from full severance. After surgery Mrs. Shearer described Stone as being ok. His head was wrapped in gauze. She believed he blinked his eye, and was thrilled that he could do so.

[40] The doctors did not say much about prognosis but Dr. Zuker was happy that he was able to flatten out the nerve to reconnect it. They were hopeful of recovery for the face and the correction of the paralysis.

[41] Stone was at Sick Kids for a day or two. Dr. Sewchand had tried calling their home a few times as Mrs. Shearer's mother took a message and Dr. Sewchand left a message on the home answering machine. Mrs. Shearer never called him back as she was upset with Dr. Sewchand who she believed was responsible for Stone's trauma.

Cross Examination of Mrs. Shearer

[42] Mrs. Shearer did not know how the pebble came to be in Stone's ear. She estimated it was there for a few days.

[43] From the time of the unsuccessful attempt by the emergency room doctor to remove the pebble, Stone was very protective of his ear. She said she had no recollection post

procedure of Dr. Sewchand telling her anything about the right ear. She agreed that the referral to Sick Kids was done quickly. Mrs. Shearer had no concern about Stone's capacity to hear until the audiologist mentioned it.

[44] Stone has suffered a 40 decibel loss in his hearing in the right ear where the surgery occurred. He has recovered from his facial paralysis.

Evidence of May 24, 2012

Dr. Rutka, Expert for the Plaintiff

[45] Before this witness testified, counsel agreed that a joint brief of the curriculum vitae of Dr. Rutka and the defence expert Dr. Tom Dickson, would be marked as Exhibit 3.

[46] The reports of the proposed experts, both of whom were duly qualified, were provided to the court as aide memoires.

Voir Dire on Dr. Rutka's Qualifications

[47] Dr. Rutka is an ear, nose and throat specialist, or to use his professional designation, he is a specialist in the field of otolaryngology.

[48] Dr. Sewchand holds the same designation. Dr. Rutka is the staff otolaryngologist at the University Health Centre in Toronto, and practices at the Toronto General Hospital. He also practices at Princess Margaret Hospital, Western Hospital, and most recently the Toronto Rehabilitation Institute.

[49] He has been a staff otolaryngologist since 1986. As part of his practice he has removed foreign objects from patient's ears including from children's ears. He is aware of the standard of care of otolaryngologists. Dr. Rutka also works in northern communities about 3 times per year for a week at a time.

[50] He is also a professor of otolaryngology at the University of Toronto. Between 1999 and 2007 he was an associate professor. As both an associate and full professor he teaches students and residents in the 'ENT' field about the removal of foreign bodies from the ear canal.

[51] He has won two teaching awards for individual teaching excellence in 2005 and 2006 in relation to teaching medical residents how to safely and properly perform their services as otolaryngologists. In addition in 1989 to 1990 he was awarded the post graduate teaching award in otolaryngology.

[52] Dr. Rutka has also provided his expertise in medical legal matters, for both plaintiffs and defendants.

[53] Dr. Rutka testified that he is aware of what can go wrong when the standard of care is not met for removal of foreign objects. He teaches his students about the risks of improper procedures.

[54] Dr. Rutka is aware of the risks to the inner ear by virtue of a foreign object being pushed into the ear canal, including injury to the tympanic membrane and the bones of the middle ear. Dr. Rutka teaches the standards of practice and care for such procedures as well as alternatives that can be used for removal of foreign objects, including incision to gain access to the inner ear, and when that route for removal is required.

Cross Examination on his Qualifications

[55] Dr. Rutka has an interest in neurotology which is the diagnosis and treatment of inner ear problems, as well as an interest in ototoxicity. Since 1986 he has had a special concentration in neurotology.

[56] Dr. Rutka agreed that he is primarily associated with academic hospitals, unlike a community hospital such as Peterborough Health Centre. Dr. Rutka sees children primarily based on his attendances in Sioux Lookout and Dryden, Ontario.

Dr. Rutka is Qualified to give Opinion Evidence

[57] Dr. Rutka was qualified on consent in relation to giving expert evidence on the standard of care and issues of causation as they relate to the removal of foreign objects from the ear of a child, and in particular whether any act or omission on the part of Dr. Sewchand caused or contributed to any injury occasioned by Stone Shearer.

Evidence of Dr. Rutka

[58] Dr, Rutka reviewed the Peterborough Hospital Records, the records from Sick Kids, and the transcripts of Mrs. Shearer and Dr. Sewchand's evidence at their examinations for discovery in preparation for formulating his opinion in this matter.

In Chief

[59] Dr. Rutka was asked at the commencement of his evidence what his view was, after review of the various hospital records and the discovery evidence, as to whether the care of Stone fell below the standard of care expected of otolaryngologists in Ontario. He said that it fell below the standard.

[60] The breach of the standard of care in his opinion caused or contributed to the injuries of Stone. In particular:

> The attempt to remove the foreign body resulted in an auratoral removal of the eardrum, a removal of the malleus, a fracture of the stapes superstructure, a dislocation of the incus and an injury to the facial nerve that resulted in facial paralysis initially.

[61] The doctor was referred to a pictorial representation of the inner ear. He described the three parts of the human ear inclusive of the outer portion; the middle ear and the internal ear. The doctor described the portion of the ear, the middle ear, which contains the malleus, the incus and the stapes. The facial nerve runs through the inner ear.

[62] In relation to the malleus Dr. Rutka said it was very difficult to remove. A tendon has to be cut to remove it, and then it has to be moved down and out to get the malleus out of the boney area of the ear, which is called the attic.

[63] The doctor was referred to exhibit 1, and portions of the medical records for the treatment of Stone. Dr. Rutka described this record for the court. It notes that attempted irrigation and curettage was unsuccessful at first instance to remove a small, smooth, round pea gravel stone deep in the right ear canal. Dr. Rutka said that the effort at removal at this juncture at the emergency department was reasonable.

[64] Nothing on the written report suggested any injury or damage was caused by the emergency room doctor's attempt to remove the object. Dr. Rutka referenced the note of Dr. Fagan which suggested that the object was very large and impossible to budge. Dr. Rutka opined that this suggested that removal would be difficult.

[65] Dr. Rutka said that a doctor would use an otoscope to see inside the ear. This instrument is lit and magnified usually to a level of 1.5 times. Dr. Rutka said an ENT doctor would look in the ear and not push the otoscope onto the foreign body. A doctor would look at the ear canal for signs of bleeding or trauma.

[66] It is important to use the otoscope in order to see what one is dealing with and to see if there was any space between the foreign body and the ear canal. This was necessary as extraction required using an instrument to get the foreign object out.

[67] The witness was referred to the fact that Dr. Sewchand noted that the object was impacted and this suggested to Dr. Rutka that removal "would be very difficult". When asked what the risk was of using such as a curette on an impacted object, Dr. Rutka answered:

> Well you're going to traumatize the ear canal. You're not going to know really even the extent of what the foreign body is and its relationship to the tympanic membrane and it's going to make it much, much more difficult to try and remove by conventional curettage for example.

[68] The risk of trying would be possible displacement of the object immediately, which would mean it would go towards the ear drum. In that case perforation could occur, and "you could disrupt the ossicular chain. You might even injure the inner ear." Otolaryngologists are aware of this risk.

[69] In this scenario of an impacted object it would be prudent to try to gently remove the object from the ear canal without traumatizing the ear canal, but one would also have to have a back-up plan. That plan would entail either an open surgical procedure to create

more room and allow for the use of two hands in the removal, or referral of the patient to someone else.

[70] Dr. Rutka testified that the ear canal in a child is less than a centimetre in span. An incision could be made either behind the ear, or in front of it. The open procedure via an incision creates much better visibility and is a safer procedure in cases of an impacted object. Otolaryngologists are trained in this procedure.

[71] Dr. Rutka reviewed the operative note of Dr. Sewchand. He described the purpose of such a note as constituting a record of the patient's care. Dr. Rutka made reference to various surgical tools that were presented to him at trial, inclusive of two different sizes of speculums that are used to enhance the ear canal; removal forceps; curettes which usually have a ring on the end and are malleable and are used to put the curette behind the object in order to gently remove it from the ear canal; or the use of hooks to deal with an object.

[72] In addition a doctor could use a microscope to visually assist them. A microscope is standard instrumentation for all otolaryngologists who do ear surgery. It allows for magnification of vision, via both eyes, to allow for a three dimensional look.

[73] In the case at bar, it was agreed that a curette was used. Dr. Rutka was asked about that method of removal. He opined that he did not think it was the appropriate instrument to use. This was because you couldn't bend the curette around the foreign body. As a consequence "it would be more likely that you would've continued to push a foreign body in medially."

[74] Dr. Rutka testified that a hook would have been a preferable instrument to use. Dr. Rutka said that an initial attempt to use a curette would not breach the requisite standard of care in this case. An initial attempt with a curette would have worked with a reasonably mobile object, which would have led to quick extraction. Dr. Rutka said a quick extraction would be within a minute.

[75] If the object did not come out easily or was difficult to remove a surgeon should consider "perhaps changing instruments or perhaps stopping, questioning – should I go on- should I do an open procedure? Perhaps go talk to the parents to see what they would like to have done."

[76] These options were appropriate in a non life threatening scenario where one has "time to sit, stop, think again, and again" if one wasn't sure. If one persisted the risk of injuring deeper structures existed. If one persisted at this stage, "you would not uncommonly cause injury to the ear canal. You might cause swelling making things more difficult." As well there was the danger of imbedding the object deeper into the ear.

[77] Reference was made again to Dr. Sewchand's operative note where Dr. Sewchand noted that the object was "impacted deep into the ear canal. Attempts were made to remove with a wax curette but it was snugly fit, making it impossible to remove."

[78] Snugly fit in the context of the record suggested to Dr. Rutka that the object was in the boney position of the ear canal and was as a result snugly fit. Snugly fit suggested to Dr. Rutka that there was no room between the stone and the ear canal.

[79] At this juncture having tried an instrument or perhaps with the use of micro-suction, given that it was so "currently stuck - impossible to remove - you would have had to consider doing an open procedure or to refer to another centre at the time."

[80] Dr. Rutka testified that Dr. Sewchand should have considered an open surgical procedure, whether he was comfortable doing it or not. When asked: "If he (Dr. Sewchand) did not even consider it, do you have an opinion as to whether he met the applicable standard of care in the situation?" He answered: "It was below standard."

[81] Given the notation in the operative note of Dr. Sewchand that he spent some 15 minutes trying to remove the object, Dr. Rutka testified that this was a lot of time trying to remove the object, which meant it was difficult.

[82] In relation to the operative note of Dr. Sewchand which stated: "As I tried to remove the foreign body in the form of a stone from the middle ear cavity the malleus came out," Dr. Rutka opined that this indicated that the object came out with a lot of force. When asked what this told him about the standard of care and whether it was met, Dr. Rutka said, "there was harm done. It was below the standard of care."

[83] It was Dr. Rutka's opinion that excessive force was used in the procedure. He based this on: the documents that he saw; the fact that 90 % of the eardrum was removed and the fact that the malleus came out which is very difficult to move at the best of times; the operative note from Sick Kids and the fact that shards of stone were embedded in the facial nerve. Dr, Rutka said this suggested, "as if there was excessive force, perhaps even causing the stone to break."

[84] Dr. Rutka said that if the object in the ear was moving laterally and not medially, there would not have been injury to the eardrum or the ossicular chain or the facial nerve. Dr. Rutka said that lateral movement would not have led him to expect the eardrum to rupture nor the malleus to be removed.

[85] When asked how one would know that the ear drum was not already ruptured before Dr. Sewchand began his procedure or that the malleus had not already been misplaced or dislodged, Dr. Rutka answered:

> Stone would've been in absolute agony if his eardrum had been ruptured, and if the malleus had been, if you like, dislocated, it would've been extremely painful for him. He wouldn't have wanted anyone near him. He would've been almost inconsolable. But there was no bleeding that's ever mentioned coming from the ear canal, and if the foreign body was moving there was at least some space, you would've expected some blood or something like that that would've been present or when the foreign body was removed, perhaps some old blood clot there or something. That's not mentioned.

[86] Dr. Rutka said that there was nothing in the material that he reviewed to suggest prior trauma to the tympanic membrane or the malleus.

[87] Dr. Rutka reviewed the operative notes of Dr. James and Dr. Zuker who were involved in Stone's surgery at Sick Kids. Dr. Rutka made reference to the injuries that they observed in relation to Stone's ear. Dr. James noted that 90% of the eardrum was removed. The incus was displaced from its normal attachment to the stapes. The stapes was fractured at its stirrup portion. Shards of stone were in the facial nerve, which was 50% severed. In addition shards of granite were found in the fallopian canal. There was also bone damage.

[88] Dr. Rutka testified that perforation of the ear drum could have been caused by pushing of the stone through the membrane or by the curette which was used to try to extract it. Dr. Rutka offered that the malleus came out by virtue of the use of the curette as it would require pulling of this bone and the stone out at the same time. This would require a lot of force.

[89] Dr. Rutka said that the skill and standard of care of Dr. Sewchand fell below that of what would be expected of an otolaryngologist. Dr. Rutka said that given the removal of the malleus, Dr. Sewchand could not have known where the tip of his instrument was. It is vital, he testified, to know where your instrument was to avoid a consequence such as this. The failure to know where the instrument was fell below the required standard of care. To quote Dr. Rutka it is vital to know where the instrument is "because you don't want to disrupt the structures that would be medial to the foreign body."

[90] The incus could have been comprised because of the instrument or the stone. The stapes trauma was more likely a crush type of injury, indicative of excessive force.

[91] Dr. Sewchand, said Dr. Rutka, was not appropriately skilful technically in the carrying out of the procedure. As for the facial nerve it was most likely injured by the stone. The stone must have been pressured into the nerve by the curette. Dr. Rutka said that the level of force used was indicative of being below the requisite standard of care.

[92] Had Dr. Sewchand stopped the procedure sooner, Stone would have had a tympanic membrane perforation, but no removal of the malleus, no displacement of the incus and no fracture of the stapes structure. In addition the facial nerve would not have been injured.

[93] To continue the procedure would have made the surgical removal even more difficult. Dr. Rutka opined that had the procedure been stopped and had an open surgical procedure been done, Stone "would not have had these complications."

[94] Dr. Rutka in all of his years of practice had never seen this "constellation of injuries." He testified that this constellation of injuries would not have occurred if the requisite level of skill and care was undertaken by Dr. Sewchand.

[95] When it was put to Dr. Rutka that maybe this was a judgment call, and not a matter of technical skill, Dr. Rutka answered: "It was a bad judgment call. There was a lack of

clarity of insight and the technical skills were below standard on that day for Dr. Sewchand."

Cross Examination of Dr. Rutka

[96] Dr. Rutka was asked whether he knew Dr. Dickson, the expert witness for Dr. Sewchand. He said he did. He agreed that Dr. Dickson saw patients who were adults and children.

[97] Dr. Rutka was referred to a diagram produced at trial which had noted on it "anterior view of middle ear". Dr. Rutka provided evidence as to the distance, in width, between the malleus to the stapes. The dimensions of a child's inner ear and that of an adult are remarkably similar, but a little smaller in a child.

[98] Once the ear drum is perforated there is access to the middle ear cavity.

[99] Dr. Rutka agreed that an important part of the practice of medicine is clinical judgment. Exercising judgment is a predicate to treatment decisions. In the course of surgery, as with treatment, judgment is exercised. He agreed that differences in the exercise of judgment do not mean that the standard of practice has not been met.

[100] Dr. Dickson opined in his report that Dr. Sewchand exercised reasonable judgment in his treatment of Stone, and that it was reasonable for Dr. Sewchand to continue his attempt to remove the stone. This opinion was put to Dr. Rutka and he disagreed with the opinion of Dr. Dickson.

[101] When asked if Dr. Dickson was in a position to give an opinion just as good as Dr. Rutka's, Dr. Rutka answered: " I think Dr. Dickson, if you put him on the stand and ask him, he'll probably say the complications were excessive and not in keeping with what one would normally see in conventional standard of care practice."

[102] Dr. Rutka said that the doctor who actually sees the patient and assesses them "might" have an advantage over the doctor who reviews documents of the treatment well after the fact. Dr. Rutka agreed that "clarity of insight" may be obtained after the fact.

[103] Dr. Rutka was referred to a transcript of his evidence from a trial some 10 years before where he agreed when asked that the doctor of first instance enjoys an advantage over a doctor who is reviewing that physician's work. He agreed that some deference was due to the treating physician.

[104] Dr. Rutka agreed that in a sense, because the result of the procedure is known, one has to work backwards. He was asked if one had to be careful to use hindsight in assessing decisions made at the time of treatment, and he answered 'possibly'.

[105] Dr. Rutka underscored his opinion that Dr. Sewchand should have stopped, considered a referral, or proceeded to an open procedure of some type. It was reasonable for Dr. Sewchand to have initially attempted removal with a wax curette. Dr. Rutka testified that it would have been more appropriate to use a hook to extract the stone, but that the use of a wax curette initially would not result in him finding fault with that.

[106] Dr. Rutka was referred to his report and agreed that the purpose of the report was to advise the other side of what he was going to say. Dr. Rutka agreed he never said in his report that using a hook would have been appropriate. He disagreed that when he gave his evidence that this was the first time that he referenced a hook. He said he assumed Dr. Sewchand was using a wax curette to hook the object.

[107] Dr. Rutka agreed that removal of foreign objects can be challenging and difficult. He agreed that use of a binocular microscope is an appropriate aid. He agreed that he did not opine that a cat scan was indicated prior to the attempt to remove the stone.

[108] Dr. Rutka agreed that Dr. Sewchand did not know the type of stone that was in the ear, nor did he know if it was fragmented or easily fragmented, nor its size. He would know the diameter of the stone but not its length. Dr. Sewchand knew that the stone was deep in the ear canal, but not how deep or if it was against the ear drum.

[109] Other signs such as a rupture of the ear drum would have rendered some bleeding if there was room for the blood to come out. Dr. Rutka agreed that it was reasonable to make the initial attempt at extraction even when the exact location was not known. In this respect relying upon the experience of the doctor would be fine and this would be within their realm of judgment.

[110] Dr. Rutka agreed that the key thing in his opinion was that Dr. Sewchand was either advertently or inadvertently pushing the stone medially into the middle ear, or his instrument was going there.

[111] Dr. Rutka testified that in his 12 or so removals of foreign bodies between 2000 and 2007 about 6 of those involved the removal of a rock like object, with the patient under general anaesthetic. In his 12 removals the object was not moved medially.

[112] Dr. Rutka agreed that initial medial movement in the ear canal would not be a breach of the standard of care. The breach is continuing to move the object medially and not stopping that constitutes the breach. Dr. Rutka was referred to his report wherein he stated: "Dr. Sewchand fell below an expected standard of care for an otolaryngologist on technical grounds in the causation of these complications and for not appreciating he was causing more harm than good while trying to remove the stone."

[113] Dr. Rutka agreed that he was saying but for the negligence the injury would not have occurred. Dr. Rutka agreed that Dr. Sewchand spent about 10 minutes in total with Stone. Dr. Rutka agreed that the 10 minutes would include removal attempts as well as putting the tube on the other ear.

[114] However Dr. Rutka held firm that to maintain the standard of practice Dr. Sewchand should have stopped shortly into the procedure when it was evident the object was not coming out. There is no set standard of time to remove a foreign object. It is the comfort of the surgeon that governs, and their judgment. Dr. Rutka agreed that generally speaking it may not be possible to determine what caused an ear drum perforation, the surgery, or the foreign object.

[115] Dr. Rutka was referred to a journal called "*The Laryngoscope*". He agreed that it is authoritative. Dr. Rutka agreed that perforation of the ear drum is more likely in patients who have undergone more than one attempt at removal of an object. The journal article was marked as an exhibit at trial, on consent. Dr. Rutka agreed that it was conceivable that the ear drum could have been perforated in part prior to the attempt to remove the stone. Dr. Rutka agreed that it was the immediate post traumatic perforation that would be painful. Afterwards the pain may dissipate.

[116] Dr. Rutka agreed that the object could have been up against the ear drum prior to the first attempt to remove it and that even a careful attempt at removal could cause it to perforate. Once perforation occurred access to the middle ear cavity is permitted. Dr. Rutka said that it was the magnitude of the injury in the case at bar that he was concerned about, however once the curette enters the middle ear cavity as a consequence of a perforation, injury to the structures of the middle ear can occur.

[117] Dr. Rutka reiterated that removal of the malleus was very difficult. It was put to him that Dr. Dickson would say it was very easy to remove. Dr. Rutka said he disagreed with that opinion. Dr. Rutka said his opinion of Dr. Sewchand being aggressive in the procedure was based on the complications suffered.

[118] It was put to Dr. Rutka that Dr. Sewchand would say that this removal was not the most difficult he had ever encountered, that he had done some 100 removals from children's ears, and that he did not move the stone medially at any time. In that scenario Dr. Rutka agreed that it would have been reasonable for Dr. Sewchand not to stop and to continue to try to remove the stone. In this scenario a doctor would not expect the complications that occurred in this case.

[119] Dr. Rutka agreed that a surgeon's judgment is in play in a removal attempt with a curette but maintained that he believed that this was an aggressive removal. Dr. Rutka said it was his opinion that Dr. Sewchand's technique caused the fragmentation of the stone.

Re Examination

[120] Dr. Rutka testified that part of the skill of the surgeon involves finding a passage between the stone and the ear canal to put the instrument into. Dr. Rutka said that in relation to the scenario put to him in cross examination of the stone being up against the ear drum, that Dr. Sewchand did not demonstrate the requisite level of skill in his surgery, based on the magnitude of the injuries which he described as extreme involving as it did removal of part of the ossicular chain and injury to the facial nerve.

The Proceedings of June 06, 2013

[121] The Defence commenced its case. Dr. Sewchand testified.

Evidence of Dr. Sewchand

In Chief

[122] Dr. Sewchand's c.v. was referenced and made an exhibit. His medical employment history was overviewed. In 1976 he obtained a Canadian Fellowship in Otolaryngology. He is therefore a specialist in his field. Since 1980 he has been on staff in Peterborough, at the Regional Health Centre. From 1990-2005 he was the Chief of Otolaryngology at the Peterborough hospital. In September 2006 he was in a general Otolaryngology practice involving "the basic ear, nose and throat problems, medically as well as surgically."

[123] In 2006 some 40-50 percent of his patients were children. Before 2006 he had removed hundreds of foreign objects from children's ears. About 50 percent of those extractions were under general anaesthesia. In addition he was involved in hundreds of middle ear surgeries. He has used an instrument called a wax curette to remove foreign objects, in all occasions where he has removed them. Of the foreign objects roughly 50 percent involved stones or rocks.

[124] Before his procedure on Stone Shearer he had never had a complication such as that which Stone suffered. He had never referred a patient to the Hospital for Sick Children because of a foreign body in their ear. In his experience all of the foreign bodies are in the ear canal. Some were fully impacted and others not.

[125] Dr. Sewchand testified as to the dimensions of the internal workings of a child's ear, and the anatomy of the ear. The incus and the stapes are bone. The eardrum is attached to the malleus, which is also made of bone, via ligaments. The ligaments are not strong as compared to bone. The eardrum itself is between 0.1 and one millimetre. Dr. Sewchand described the ear drum as consisting of three layers. Dislodging the malleus, said Dr. Sewchand, is "not difficult at all."

[126] In respect to perforated ear drums in children he testified that there may or not be symptoms. There may be pain. There may not be. The pain may be mild. Symptoms usually occur at the time of the perforation.

[127] Dr. Sewchand saw Stone on September 19, 2006. He got a call from Dr. Fagan his colleague. He was told that Stone had a foreign body in his ear and was uncooperative, such that removal of the stone could not occur in the office of Dr. Fagan. He was referred to records from the Peterborough Health Centre involving Stone's treatment on this date.

[128] Dr. Sewchand identified the history that he took of his meeting with Stone and his mom. He made notes of his examination of the left and right ear, including that there was a foreign body in the right ear, and that a tube was required for the left ear to drain fluid. Dr. Sewchand's note indicated that there was a large stone in the ear canal. He was able to see it with the aid of an otoscope. He noted that it "occupied the whole diameter of the ear canal." He could not tell if the ear drum had been perforated by the stone via his observations.

[129] He recommended to Mrs. Shearer that the left ear needed to be drained via a tube and the stone removed from the right ear while Stone was under general anaesthetic. He said he recalled telling Mrs. Shearer that he would be using a curette in the form of a hook.

[130] He demonstrated what he did, in court, with the assistance of a wax curette that was marked as an exhibit, and the diagram that was utilized in court. The procedure involved Stone being sedated. Dr. Sewchand was then handed the instruments for the procedures, inclusive of the curette. He did the left ear drainage first and drained the fluid, and inserted a tube. That ear procedure took 4-5 minutes. He then went to the other ear. He used a speculum and a binocular microscope when dealing with the right ear and "visualized the impacted stone in his ear canal."

[131] He testified that he used his curette slightly bent into a hook and tried:

> ...to try to tease it off the stone very gently, slowly, slowly, teasing the cartilage away from the stone. At the same time I'm rotating the stone and trying to bring it-try to bring it laterally outwards and I could see that it was moving outwards as I'm using a binocular microscope- I could see that it as it rotate the stone was moving outwards laterally- that's laterally and I continued to tease, tease, tease between the stone and the cartilage until I was able to get behind the stone.

[132] He moved the curette medially (from the side closest to the middle ear) rotating the stone and noticing that the stone was moving outward, laterally. He teased it and got behind the stone at its upper end. He was eventually able to flip the stone completely outwards, out of the ear canal. A child's ear canal is about 4 millimetres in diameter. He was using a microscope with 2.5 times magnification with very bright lights so he could see the stone laterally. The doctor was referred to his operative note which noted the stone was impacted deep in the ear canal, and that he used a wax curette to attempt to remove it, "but it was difficult."

[133] He also noted in his report it was "quite snuggly in the ear, making it impossible to remove." Dr. Sewchand said it was impossible to move as a foreign body in the ear canal as it was not confined to the ear canal. He further noted in his report, "I spent quite a bit of time, over 15 minutes trying to get it out and I subsequently realized that the foreign body was in the middle ear cavity." He testified that he realized this when the malleus came out. He testified that the nurse's report of 10 minutes for the surgery was the accurate version of the time to do the procedure. He thought it was 15 minutes when he made his note.

[134] Dr. Sewchand testified that he never pushed the stone medially into the middle ear. He could see that he wasn't because he was using the microscope, and the fact that the curette was moving the stone laterally. Dr. Sewchand noted in his operative note that the eardrum was completely damaged, there was some bleeding, but there was "no obvious other ossicle lying loose in the middle ear. I did not look for the incus."

[135] He said he did not look for the incus because he didn't see it in the middle ear although he thought as the malleus was out the incus may have come out too. He learned about the facial nerve damage while Stone was in the recovery room.

[136] He told Mrs. Shearer that the nerve could have been injured, or because the work done in the middle ear may have caused swelling. He advised that he would follow up with Sick Kids for an opinion. He called Dr. Trimble the resident at Sick Kids. He heard back from Sick Kids the next day. Dr. James eventually told him that the child had suffered a knick to his facial nerve, but that the stapes and incus were intact.

[137] He had been trying to contact the Shearer family to see how Stone was doing after the Sick Kids surgery.

[138] Dr. Sewchand said he used the technique with the curette the way he had always done it. He never grew frustrated during the surgery. He never considered a post auricular approach, nor a referral as Dr. Rutka suggested that he should have. He said he didn't because, "I was comfortable with what I was doing. I was making progress. The stone was moving laterally at all times and this was not a most difficult stone I've ever removed. I was very comfortable doing the procedure and I never entertained referral or post auricular approach."

[139] He did not consider the stone in the ear to be an emergency that required urgent removal. However he said it needed to be removed because it had been in there for over 24 hours and as an impacted stone it can create swelling and the risk of infection. "It was prudent to proceed on the day of Dr. Fagan asking me to proceed." He said he couldn't exactly describe the shape of the stone but did say that it was "just any regular stone that impacted the whole ear canal."

[140] He was advised that surgery at Sick Kids revealed that the stone was impacted in the facial nerve and that the stapes was injured, the malleus came out, and the incus was displaced. He had never had a stone fractured previously during extraction attempts.

Cross Examination

[141] Dr. Sewchand said he did a relevant history and exam before his surgery. He saw the stone impacted in the ear canal completely. He could not see behind it. Put another way he could not see what was medial to the stone. He could only see the lateral aspect, which was the closest to him. He had no clinical evidence of any damage to the middle ear upon assessment. There was no discharge, or bleeding, or any indicia of hearing loss, nor any indication of significant complaint of pain.

[142] When asked if there was anything about Stone's level of discomfort that suggested anything other than an object in his ear canal, Dr. Sewchand agreed there was nothing else. There was no facial paralysis. Nor was there an inability to close the right eye. The doctor agreed that his conclusion was that there was an impacted stone in the ear canal, restricted to the ear canal. There was no evidence that Stone had been protective of his ear. Dr. Sewchand agreed that he concluded he could safely do the removal under general

anaesthetic without complication. Dr. Sewchand agreed that his course of conduct was all predicated on his belief that the object was restricted to the ear canal.

[143] Dr. Sewchand said it was very uncommon for a child to push an object into the middle ear. He said only 1-2 percent of cases involved an object actually pushed into the middle ear. There was no clinical evidence to suggest that Stone was one of that percentage. He didn't consider the possibility that it was in the middle ear. He agreed he would use a facial nerve monitor if he thought the object was in the middle ear. He didn't order a CT scan because there was no evidence of middle ear penetration.

[144] Dr. Sewchand did not advise Mrs. Shearer of any possible complications as he saw this as a straightforward removal. His discussion with her about risk was limited to saying he hadn't had any complications at all removing objects from the ear canal.

[145] He knew that the emergency room doctor couldn't remove the stone, the day before because Dr. Fagan told him. He did not know what attempts were made by the ER doctor and he did not inquire, nor get the ER records. Dr. Sewchand said he has never got such records for foreign body removals.

[146] When he spoke to Dr. Fagan he did not ask about the attempts that Dr. Fagan had made to remove the object. He did not know if Dr. Fagan used a curette, but he knew that Dr. Fagan said the object wouldn't budge. He agreed that the ER records could have been obtained by him, although he said he did not obtain such records when it came to the removal of foreign bodies, but had with some patients before he did a subsequent procedure.

[147] Dr. Sewchand was referred to his examination for discovery. He agreed that at his examination he had answered that he had made no inquiries of what attempts had been made in the office setting to remove the object. Dr. Sewchand agreed that his reference to the object not budging came from Dr. Fagan's consultation note, and that he did not have it at the time that he operated. He agreed that his reference in his evidence to "impossible to budge" came from that note. Dr. Sewchand indicated that Dr. Fagan had however told him before he operated words to the effect that the stone wouldn't budge.

[148] Dr. Sewchand was asked:

> Q: Had you known what attempts had been made by the emergency room doctor, and had you known the nature of the attempts made by Dr. Fagan in his own office, that might have provided you with some useful information when you made your own decisions about how to remove this foreign body, correct?
>
> He answered:
>
> A: Not necessarily

[149] Mr. Mladenovic referred to the journal article from *The Laryngoscope* that Mr. Veneziano had shown to Dr. Rutka. Dr. Sewchand agreed with the proposition that, as the article suggested, where two or more attempts are made to remove an object it will likely

lead to a higher incidence of eardrum perforation, by answering "possibly." Dr. Sewchand agreed with the article that morbidity increases with failed removal attempts.

[150] When asked if he "would have known or could have known had you bothered to find out what the attempts had been that this patient might be at higher risk for morbidity than other patients in whom there had not been two or more attempts unsuccessfully to remove the foreign body" he answered, "no."

[151] Dr. Sewchand indicated that prior attempts increased the chance of a swollen ear canal and the risk of more impaction which would affect the difficulty at removal. It was put to him that he didn't even consider it because he did not even know what prior attempts had been made. Dr. Sewchand said that he knew that there were two prior attempts, and he had had hundreds of prior procedures more difficult than this one. He never even considered a complication as he had never had one.

[152] Dr. Sewchand agreed that he did not know the nature of the prior attempts made by the other two doctors prior to his procedure. He said had he known what those attempts were they would "not necessarily" have assisted him with some useful information about how to remove the foreign body. He answered "not necessarily" once again when asked if it wouldn't possibly tell him something about the likelihood of complication.

[153] He was next referred to his operative note. He agreed it is an important document. It is a requirement of every surgical procedure. Dr. Sewchand agreed that the operative note "tells us the story of the operation," inclusive of the significant events and progress made that lead to findings.

[154] Dr. Sewchand agreed that he made careful notes about the treatment to the left ear where he removed the fluid. It was a relatively quick procedure that lasted less than 5 minutes. He agreed that as the total surgery took about 10 minutes he spent slightly more than 5 minutes on the right ear, using the curette. He recognized that when he started the removal process it was more difficult than he expected.

[155] He agreed that removal of an object in the ear canal required getting the curette behind the object and pulling it out. This is usually straightforward, involving putting in the curette, and pulling it and the object out of the ear. This procedure can happen in a minute or less.

[156] Dr. Sewchand agreed that it didn't happen that easily with Stone. When asked if "this was a more difficult foreign body", Dr. Sewchand answered it was "more difficult than some I've done." He agreed that he knew that "going in." When asked, "And you didn't expect it to be difficult, right?" he answered: "not as difficult". He was then asked "well you weren't expecting it to be difficult at all," and he answered that he agreed.

[157] He agreed that he spent most of his time trying to get the curette behind the object. Once he got it behind it came out immediately. Dr. Sewchand said he was teasing the stone along for most of the 5 minutes. He said "I'm very careful in moving it laterally." The witness said that teasing and rotating the stone went together. He said he was rotating the stone to find a space, a crack, between the object and the ear canal.

[158] He was referred to his examination for discovery. He agreed that other than mentioning rotating he never referred to teasing the object. He never mentioned manipulating the cartilage.

[159] Dr. Sewchand agreed that when the stone was removed he looked at it. It was at least 8 or 9 millimetres in diameter. He agreed he never documented that it was irregular in shape, as he said it was, in his evidence. He agreed that it was snug and impacted in the ear canal. He agreed that the diameter of the ear is less than 8 or 9 millimetres. Its snugness in the canal was what made it difficult to remove.

[160] Dr. Sewchand agreed that in his operative note he indicated that the stone fit so snugly that it was impossible to remove. Dr. Sewchand agreed that he meant that it fit so snugly in the ear canal that it was impossible to remove, and not that it was impossible to remove because it was not limited to the ear canal.

[161] He agreed that if he had wanted to make the distinction he could have and when then asked, "and that would have been an important piece of significant information", Dr. Sewchand responded, "probably".

[162] It was suggested to Dr. Sewchand that the very first time he had said anything about it being impossible to remove because it was not limited to the ear canal, was during this litigation. Dr. Sewchand agreed that the first time he mentioned it was at his discovery. He had never said it was impossible to remove because it was not limited to the ear canal at any prior time in any record of the surgery. When asked if someone reading his operative note "would be led to believe that it was impossible to remove because it fit snugly", the doctor answered: "probably."

[163] He agreed that his reference to how deeply wedged and how impossible it was to remove the stone was consistent with Dr. Fagan's note that it was impossible to budge. He agreed that Dr. Fagan didn't say it was impossible to budge because it wasn't limited to the external ear canal.

[164] When asked if an object is severely impacted in the ear canal, that an incision may be required, he said 'no'. He agreed that it was an option when the operating surgeon found it unsafe to remove. He said he excluded himself from that notional operating surgeon, given his experience.

[165] He agreed that he had difficulty with this particular stone in the ear. He agreed that it was what he had said in his report, after he asked counsel to define 'difficulty'. The following exchange occurred between counsel and Dr. Sewchand:

> Q: And we've already talked about what it meant by difficult. You were having trouble getting behind the stone with the curette.
>
> A: No I didn't say that
>
> Q: You weren't having trouble getting behind the stone?

A: I was having difficulty because it was a difficult one-it was not easy, that's what I meant by being difficult.

Q: And the reason that it was not easy was you were having some challenges getting behind the stone, right?

A: Towards the end, right

Q: Towards the end?

A: Yes.

Q: No, throughout the whole procedure you were having difficulty getting your curette behind the stone, right? It was only at the very end of the procedure that you actually succeeded in getting your curette behind the stone, right?

A: No I didn't say I was having difficulty, it was a difficult one.

Q: You weren't having difficulty, but it was difficult?

A: It was difficult, correct.

Q: But you were having difficulty?

A: I've done more difficult cases than that -foreign bodies- I get them on....

Q: Doctor all I am trying to establish with you, and I think we've already established it, is that you were having some difficulty with this object because you couldn't get your curette back behind the object in the speed and manner that you thought you were going to have, right?

A: Correct, right.

[166] Dr. Sewchand agreed that notwithstanding the difficulty he was having he persisted. He testified it was a judgment call. Dr. Sewchand agreed that in exercising his judgment he didn't even consider an incision procedure. In Dr. Sewchand's words, there "wasn't a need for me to." He did not consider it at all. He agreed that he didn't even consider it as he was able to rotate the stone and move it. He also agreed that these were "very significant observations in the context of this procedure."

[167] Dr. Sewchand agreed that there was no notation in his operative note either in relation to the rotation or lateral movement of the stone. Dr. Sewchand said that he does these procedures hundreds of times and he never mentions these procedures.

[168] Dr. Sewchand agreed he made his operative notes after he was aware of the complications, and that these complications were unprecedented in his career. He agreed that this case involved the documentation of an event that was a first for him. Dr.

Sewchand agreed that in this case, a unique case, documentation of the most important details which are the most significant details about progress would be important.

[169] When it was put to him that he did not document those most important details in his operative note following the complication, he answered "I don't even document that I wasn't making progress."

[170] When asked again about not having mentioned rotating movement or lateral progress in any material, but only having done so at his discovery, he agreed that was the case.

[171] He said that he made contact with the stone in the space he made between the cartilage and the top of the stone. He was then able to rotate the stone and draw it laterally toward him. He said he never pushed it medially.[5]

[172] When asked if there is a risk after making contact with the curette of pushing the object closer into the ear, he answered: "some people run the risk." When asked if the more one rotates an object laterally the greater the risk is that it gets pushed deeper into the ear, Dr. Sewchand answered agreeing that was the case if you rotate it only laterally, however he testified that he was moving it laterally and "superior teasing" at the top. He said he was never working on the lateral aspect[6] of the stone, but in the top of the lateral aspect.

[173] Dr. Sewchand agreed that in exercising judgment the safety of the patient is of paramount importance. He agreed that the exercise of judgment must be reasonable. In order to exercise reasonable judgment it is important to consider the clinical setting. When asked if it was important to consider the patient's history, Dr. Sewchand responded: "in some cases, yes."

[174] He disagreed that the patient's history was a consideration in all cases. He answered: "Depends on what you're doing and what you plan to do - depending on pathology, let's put it that way."

[175] He agreed that it was important in exercising reasonable judgment to consider the physical findings, as well as the possible reasons for the difficulty encountered and the most likely reasons for that difficulty as well as the less likely reasons, that are potentially more ominous. As many options as possible must be considered when difficulties are encountered.

[176] Dr. Sewchand testified that the technical skill of the surgeon was also an important aspect in exercising judgment. He agreed that when one cannot see behind a foreign object the "touch and feel and your appreciation of the anatomy are essential." Not being overly aggressive and not pushing the object into the ear are part of the technical skill.

[177] Knowing where one's instrument is, is part of the technical skill. He answered that he always knew where his instruments were, and that one should. If one didn't the risk to the

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[5] Medially in this case means inward.
[6] The side that he could see.

patient increased. He agreed that in children the spaces are smaller and one has to be more careful.

[178] When it was put to Dr. Sewchand that "there's no question that when you got your hook behind the rock you say that the rock was in the middle ear," he answered, "that's right. That was my impression." He agreed that it stood to reason that if the curette was behind the rock and the rock was in the middle ear, that the curette was also in the middle ear. He agreed, however that he didn't know that. He agreed that in his operative note he stated, "but certainly there was no curetting done in the middle ear."

[179] The following exchange occurred:

> Q: Your curette was in the middle ear.
>
> A: Correct
>
> Q: Right
>
> A: Difference in curetting.
>
> Q: oh, I see there's a difference in using the word "curetting" versus something you do with a curette."
>
> A: Correct
>
> Q: Okay, but there's no question that your curette was in the middle ear and you weren't aware of that until the very end.
>
> A: Correct.

[180] It was put to the witness that although his evidence was that he always moved the stone laterally and not medially, the objective evidence was that it was actually moving medially at some point. The witness answered that he did not say that.

[181] Dr. Sewchand was referred to the joint document brief and the operative note of Dr. Zuker at Sick Kids. Dr. Sewchand agreed that the report was correct. Dr. Zuker noted that fragments of the stone were embedded in the facial nerve, which lacerated it through 50 percent of the nerve's width. Dr. Sewchand agreed that that would explain the post surgery facial paralysis. There was no evidence of such an injury beforehand.

[182] Dr. Sewchand said he originally thought that the facial nerve issue was caused by swelling. When it was suggested that it was therefore possible "that this object moved medially through the middle ear into the facial nerve while you were performing your procedure, isn't that possible?", Dr. Sewchand answered, "Not possible-not necessarily."

[183] When he was asked if that was not the simplest explanation of the fragments being embedded in the nerve in the medial part of the ear, Dr. Sewchand answered no. Counsel suggested to Dr. Sewchand that that was a valid explanation, to which he retorted that it

was not the only explanation. Dr. Sewchand would not acknowledge that this explanation was fairly straightforward.

[184] The doctor agreed that the injury was substantial. He agreed that there was fresh bleeding from the right ear after the procedure. When asked if there was any clotted blood or any evidence of bleeding prior to the procedure, he answered "not that I recall."

The Proceedings of June 7, 2012

Evidence of Dr. Thomas Dickson

In Chief

[185] Dr. Dickson's c.v. was entered as an exhibit. He completed a residence in otolaryngology in 1974. He became a fellow of the Royal College of Surgeons in 1974. From 1975 to 1988 he was on staff at Peel Memorial Hospital as an Otolaryngologist. From 1988 to present he has been on active staff at William Osler Heath Centre in Brampton. He was chief of staff there from 1998-2000. In 1994 he was president of the Ontario Medical Association. He was also chair of the Otolaryngology section of the OMA from 2004-2009. This means he was the lead for all otolaryngologists in Ontario. Currently he is the interim Vice President of medical academic affairs at Lakeridge Health in Oshawa. While he was at Peel and Osler he was a general Otolaryngologist.

[186] He has taught medical students primarily in their first year of residency.

[187] He had a primary focus on the otology of the ear. Roughly a third of his practice dealt with children. For the past two decades about 30-40 percent of his practice involved the ear. He has removed foreign objects from children's ears multiple times, which he defined as hundreds of times.

[188] When a child presents with a foreign object in the ear they are filtered first either or both by a family doctor and Emergency department visit. Foreign objects involving stones "tend to be the ones that are more difficult to grasp, so I see a stone once or twice a year."

[189] Mr. Mladenovic reminded the court that there was no mention in Dr. Dickson's report to address Dr. Rutka's clear reference in his report under the rubric "Causation." The report took no issue with causation. Mr. Mladenovic argued strenuously that the report was in non compliance with Rule 53 of the *Rules of Civil Procedure*. Ms. Varah argued contra, that in this case the causation opinion all relates to the standard of care. In other words they are "one in the same in this case."

[190] With the complete lack of any reference to causation in the report, and the absence of any comment about the malleus, stapes or incus, as well as a lack of reference to the facial nerve, counsel advised that this could lead to numerous objections by him of the "stadium of opinion evidence on the issues of causation," which he otherwise hadn't addressed.

[191] Dr. Dickson in providing his report reviewed all of the medical records, the pleadings, the first report of Dr. Rutka, and the discovery evidence of Dr. Sewchand. He came to the opinion that Dr. Sewchand met the standard of care. Dr. Dickson was presented with a model of the ear for his reference in the giving of his evidence. Dr. Dickson said that the ear canal is about a centimetre and a half to two centimetres in length. That length is pretty close between a child and an adult. A very young child would have a shorter canal of around a centimeter and a bit.

[192] The ear canal leads to the tympanic membrane, also known as the ear drum. This membrane from top to bottom is about the size of a dime. It is extremely thin, and is semi-transparent, and consists of three layers. The middle ear can hold about a cc and a half of fluid. From the malleus to the stapes is about a centimeter and a bit. It is about ½ centimeter from the incus to the stapes structure. Dr. Dickson provided further evidence of the distance from the bottom of the tympanic membrane medially to the bone of the inner ear. The malleus is about a centimeter long. The malleus is embedded in the drum and attaches to the malleus.

[193] When asked how difficult it is to remove a malleus, Dr. Dickson said it would be much easier to dislocate it in a child either deliberately or by accident.

[194] Dr. Dickson opined that if the malleus were removed by rotating it laterally, then pulling against it would rotate the upper part of the malleus medially inwards which would dislocate the incus, which would in turn dislocate or fracture the stapes.

[195] A series of hypotheticals were posed to Dr. Dickson. It was suggested that Stone Shearer had a rock or stone in his ear, and two attempts were made to remove it which were unsuccessful. Dr. Dickson said 90-95 percent of his cases involved such a scenario of previous attempts at removal. When another doctor has tried and failed that suggests to Dr. Dickson that it was beyond their expertise or availability of the equipment that they have, and therefore referral to someone like him is necessary.

[196] The only way to know how far an impacted body is in an ear canal is a judgment call based on experience, seeing how far it is in the canal, and associated pain or bleeding as well as other symptoms. Dr. Dickson was asked to assume that Stone had minimal pain, no noticeable bleeding and no noticeable hearing loss. Dr. Dickson said that the assumption would be that the object is deep in the ear canal. One could not accurately or with any certainty tell if it had contacted the eardrum, gone through it or part of it, or was lying in the middle ear.

[197] Mr. Mladenovic objected when Dr. Dickson was asked if patients that he has had with eardrum perforations have shown symptoms. The basis of the objection was even though Dr. Dickson had Dr. Rutka's report which commented upon this very issue, Dr. Dickson's report did not address it. Indeed Dr. Dickson did not respond to many of the issues addressed in Dr. Rutka's report, including and in particular causation. Counsel took issue with the fact that if he was a causation expert he should have rendered an opinion on point. Counsel made strident submissions about Rule 53 of the *Rules of Civil*

Procedure and the case law, particularly with reference to the decision of the court of appeal in *Marchand v. Public General Hospital Society of Chatham.*[7]

[198] In response Mr. Veleziano advised the court that he never asked Dr. Dickson to address the issue of causation in his report. Dr. Dickson will say that he did not think that Dr. Sewchand was pushing the stone in medially. Mr. Veneziano conceded that the injuries to Stone were caused by the surgery undertaken by Dr. Sewchand. Mr. Mladenovic reminded the court that Dr. Rutka expressly referenced the tympanic membrane and its state prior to surgery in his report, whereas Dr. Dickson never addressed that feature of the case in his report.

[199] Dr. Dickson was asked by the court why he did not address causation in his report. He answered, "...it was my opinion that speculating on the cause would be simply that there are many theories, but they would be speculation." Mr. Mladenovic argued that the very issue of the stone in the ear and being pushed medially is not in Dr. Dickson's report.

[200] When Dr. Dickson re-took the stand he was asked about Dr. Rutka's opinion that on the day of the surgery performed by Dr. Sewchand, the ear drum was not perforated. Dr. Dickson testified that that opinion was not one that could be a certain one. Pain and or bleeding may be "suggestive" in cases where ear drums are perforated or surgically cut, but "it's not an absolute finding."

[201] Dr. Dickson was asked whether the use of general anaesthesia met the standard of care. He answered that given that there were two prior attempts, a local anaesthetic would not be fair to the child. Dr. Dickson answered that that case was not an emergency. He said it was "urgent".

[202] Dr. Dickson was referred to Dr. Sewchand's operative note. In relation to the ear with the tube that was inserted, Dr. Dickson said that the procedure took about 5 minutes. Dr. Dickson said "that sounds quite appropriate." He testified that of the thousands of tube insertions that he has done, none have taken a minute.

[203] As for the use of a wax curette Dr. Dickson said that the use of a curette on an object that was firm and filled the ear canal, "would be the only issue I would start with and likely is the one that I would be successful with." As for the time to remove the stone in this case, Dr. Dickson said it was quite reasonable. He stated: "obviously there was some difficulty initially and the stone was removed but it was within a five minute time frame, which seems appropriate. Not untoward."

[204] With reference to Dr. Rutka's opinion that the foreign body should usually be removed in less than a minute, Dr. Dickson opined that that was "an awfully short time to give up. Some of those are difficult and it takes time to find the appropriate route around the foreign body. To try and probe carefully and slowly, and in my experience you'll always find a means of extracting the foreign body."

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[7] 51 O.R. (3d) 97

[205] Dr. Dickson has spent as much as 20 minutes on a single removal. Dr. Dickson said that finding a space to place the curette behind the stone via pushing up the cartilage and rotating the stone slowly and laterally is the only way to approach an object like this. A doctor can determine if a foreign object is moving laterally or medially via use of the stereoscopic microscope.

[206] Dr. Dickson was asked that assuming Dr. Sewchand, in attempting to remove the stone via rolling it out or sliding it out, kept the curette on the stone and got behind it and flipped it out, would this meet the standard of care. Dr. Dickson said yes as that was the standard approach.

[207] Dr. Dickson was asked about Dr. Rutka's opinion that once the curette was behind the stone and Dr. Sewchand lost sight of where the tip was, that that would constitute a breach of the standard of care. Dr. Dickson disagreed. When asked about rolling or sliding a foreign body and how a surgeon would determine the shape of the object, Dr. Dickson answered that in relation to a stone "it's a bit of a mystery what lies beyond and out of sight, but the only way you can determine whether you're next to it is to, through the tips of your fingers, gently probing and palpating along the stone."

[208] Dr. Dickson was asked to assume that if Dr. Sewchand flipped out the foreign body, would the removal of the malleus be an expected or unexpected result. Dr. Dickson said it would be unexpected. When asked if the malleus came out with the foreign body, if that would constitute a breach of the surgical standard of care, Dr. Dickson said based on his use of root cause analysis, the removal of the malleus was a surprising and unusual outcome, given that the technique used to that point was a standard technique.

[209] When it was put to Dr. Dickson that the injuries here involved the malleus, the incus and the chorda tympani, as well as the stapes superstructure, he explained that there is a chain, so disconnecting one has an effect on the other three, either via dislocation or fracture of the stapes and incus. Dr. Dickson said, when asked if these injuries were in accord with the surgical standard of care that would be expected, "well, the surgical technique meets the standard of care as I understand it in the way it was applied."

[210] Dr. Dickson said that " all of the steps, the thinking, the reasoning, the equipment in the situation, the entire approach in a step wise fashion was appropriate and well thought out and well executed, but unfortunately the outcome, in all surgical procedures, have complications. The outcome was unexpected."

[211] Dr. Dickson was then referred to the report from the surgeons at the Hospital for Sick Children, which noted that shards of stone contacted the facial nerve. Mr. Mladenovic objected again to this question on the basis that there was nothing in Dr. Dickson's report that addressed this issue. As with earlier objections interim rulings were made.

[212] Dr. Dickson was provided with a wax curette to demonstrate how a removal is done. He noted that if an object is firmly stuck you push down and drag on the foreign body and rotate it at the same time and "get it to turn like taking a cork out of a bottle."

[213] When asked if Dr. Sewchand's method was overly aggressive, Dr. Dickson said :

> Well it is hard to be aggressive holding a tiny instrument through a small opening down the ear canal and normally the procedure- and Dr. Sewchand's an experienced ear surgeon, you can't exert a lot of force just with your tips of fingers and you're proceeding very slowly. It's not an aggressive approach. It's a very slow approach, particularly once you feel you're past the foreign object. And it's just by feel at that point. There's no visual confirmation of exactly where you are. There never is.

[214] When asked if it would be a breach of the standard of care to move the stone medially, Dr. Dickson said that it would be if one persisted. When asked if the stone was moving medially in this case, Dr. Dickson said:

> Well, my understanding of what occurred they were using a good quality microscope and an experienced surgeon who could see the surface of the foreign body and was probing, and it's my understanding from the description of the note that he felt he was making progress 'cause he continued and got behind it. And you can see pretty –not pretty- very clearly if the object is moving away from you it's very clear that you're using the wrong technique. You abandon and try something different at that stage.

[215] The following set of factors were suggested to Dr. Dickson: that Dr. Sewchand had surgical experience with the removal of over 100 foreign body removals; that it was not the most difficult that Dr. Sewchand had encountered; that he had used the same technique in other situations of removal; and that he was moving the stone laterally. Dr. Dickson said that made it quite reasonable for Dr. Sewchand not to stop in the middle of his procedure.

[216] When asked if abandoning the procedure after a minute of manipulating and making a referral of the patient to the Hospital for Sick Children was reasonable, Dr. Dickson said: "That would be a very unusual way to manage. You normally wouldn't abandon a procedure that quickly." Dr. Dickson said it was quite reasonable not to have made a referral during the procedure.

[217] When asked whether if in mid procedure Dr. Sewchand should have considered an open procedure via a post auricular approach, Dr. Dickson opined that:

> Normally after a minute or two of trying one approach you wouldn't immediately go to an open approach. And generally that would be the next step and in my preference would be to use a slightly different approach, not post auricular, by something called endural, which is a little faster and quicker, better in children.

[218] When presented with the scenario that Dr. Sewchand was making progress and moving the stone laterally, Dr. Dickson was asked whether it was reasonable in those circumstances not to consider a post auricular approach, Dr. Dickson answered: "If he felt he was making progress, doing post auricular or endural, it wouldn't make any sense."

[219] When asked if Dr. Rutka's position that this constellation of injuries could not occur had the proper surgical technique been employed, and therefore that Dr. Sewchand fell below the standard of care, Dr. Dickson said:

> Well, the surgical technique up to the very last moment was quite appropriate and performed appropriately. The outcome meant something had gone amiss and that was likely positioning of the tip of the instrument, but that was not visible to anyone including the surgeon, and that resulted in the outcome, but I wouldn't call that or describe that as falling below the standard of care.

Cross Examination

[220] Dr. Dickson was asked about his report and what he understood to be his obligation in preparing the report, inclusive of the need to note the nature of his opinion on each issue that was going to be commented upon in his testimony at trial.

[221] He answered that he did appreciate that. Counsel noted that Dr. Dickson highlighted five issues in his report. Dr. Dickson indicated that he and Dr. Rutka both agreed in relation to the use of a CT Scan, and it not being required when the attempt to remove was made. In relation to a facial nerve monitor both he and Dr. Rutka agreed that it was not indicated as well. Dr. Dickson agreed that the meat of his report was the issue of judgment and the decision to proceed with the curette.

[222] Dr. Dickson agreed that he did not comment in his report about the unusual outcome in this case. Dr. Dickson agreed that he did not comment in his report about the very detailed opinion proffered in Dr. Rutka's report about how the malleus came out. He agreed and said that the reason was that he considered Dr. Rutka's report in this regard as "pure speculation". Dr. Dickson agreed that his comment about pure speculation was not evident until he testified, and that a person reading his report would not know that that was his opinion.

[223] Dr. Dickson agreed that not only did he not comment in his report about how the malleus came out, he likewise did not comment about the incus injury, the opinion of Dr. Rutka as to the chorda tympani injury, nor did he comment about the facial nerve injury.

[224] He agreed that he focused on the issue of judgment and the use of the curette. Dr. Dickson agreed that he and Dr. Rutka were ad idem as to the initial attempt with the curette. He agreed that in his report he said it was possible to abandon the procedure as an option. However in Dr. Dickson's report it was his opinion, as it was in his evidence, that continuing with the curette was in keeping with the standard of practice.

[225] Dr. Dickson agreed that Dr. Sewchand's history with difficult foreign object removals, which Dr. Dickson gleaned from Dr. Sewchand's discovery evidence, "did not in and of itself mean that this particular foreign body was amenable to safe removal with the curette."

[226] Dr. Dickson when asked if each case had to be considered individually, stated, "oh absolutely." Dr. Dickson agreed that one has to take into account not only the experience

of the surgeon, but the particular set of factors that the surgeon was facing on that day, and the reasonable exercise of competency and experience on that occasion, inclusive of the judgment call to continue with the procedure.

[227] Dr. Dickson agreed that judgment had to be well thought out. Inclusive in exercising judgment is the need of the surgeon to exercise reasonable judgment inclusive of the reasons for difficulty that is being encountered, and that might not be expected. Reasonable judgment involves both the most likely possibilities and the less likely for why difficulty is occurring. Options that need to be exercised also have to be considered when difficulties are being encountered.

[228] When asked "if he doesn't consider all of those things, then he can't be said to have exercised reasonable judgment?" Dr. Dickson agreed. Dr. Dickson likewise agreed that in addition to the judgment to be exercised a surgeon must also exercise the requisite level of technical skill and proficiency in the performance of the procedure.

[229] In this case touch and feel were closely aligned to skill and technical proficiency, especially where one cannot see behind the foreign object. Dr. Dickson agreed that the chance of injury increases in a case where there is a failure to exercise the requisite level of skill and expertise, and technical proficiency.

[230] Dr. Dickson agreed that the chance of injury to the tympanic membrane, the increased risk of dislocating the ossicles of the middle ear, and if "you go really far" chance of injuring the facial nerve, all increased with a failure to exercise the requisite level of skill and expertise and technical proficiency.

[231] Dr. Dickson was aware of the need in some cases to resort to an open approach to remove a foreign body. Dr. Dickson agreed that if an object was impacted and immovable then a surgeon might require use of an open surgical approach. When asked if in some cases where an object is so impacted in the ear canal attempts to manipulate it with the curette may result in further impaction into the ear canal, Dr. Dickson agreed that that was a "potential risk." When asked if that happens then potential damage to the middle ear may occur, he said yes. It was further suggested that if that happens damage to the middle ear structures will occur. He agreed.

[232] When it was put to Dr. Dickson that a surgeon who is having difficulty with a foreign object that is impacted should at least consider an open surgical approach, he testified, "if you were having so much difficulty moving it or progressing then you abandon that approach."

[233] Dr. Dickson agreed that Dr. Sewchand was experiencing some difficulty when he started using the curette and that the foreign body was impacted. Dr. Dickson said that he believed Dr. Sewchand exercised the requisite level of care, based on his reading of Dr. Sewchand's discovery evidence and the progress that Dr. Sewchand said he was making. Dr. Dickson remembered that Dr. Sewchand at discovery had said he was rotating the object, and that the object was moving laterally.

[234] Dr. Dickson agreed that if the evidence was that the object wasn't moving laterally and wasn't being rotated, that his opinion of the standard of care would change. If the object was not moving laterally or was not capable of being rotated on either scenario, the standard of care opinion that he offered would change.

Submissions

Position of the Plaintiffs

[235] For the plaintiffs, Mr. Mladenovic provided a template of his submissions to the court on June 07, 2012. He followed up with detailed written submissions, inclusive of reply submissions.

[236] In a nutshell Mr. Mladenovic argues that the performance of the medical procedure fell below the applicable standard of care as testified to by Dr. Rutka. The object was so impacted in the ear canal that Dr. Sewchand should have known that it could not be safely removed with a curette. In this respect Dr. Sewchand failed to exercise reasonable judgment. His technical skills fell below the standard of care. In particular the plaintiffs claim that Dr. Sewchand negligently pushed the stone inwards and persisted in removal attempts when he knew or ought to have known that he was doing more harm than good when he continued in his extraction efforts with the curette.

[237] This case, say the plaintiffs, was not an emergency. Dr. Sewchand was negligent in not stopping the procedure or in failing to convert it to an open surgical approach. Either approach would have avoided the damage that Stone suffered to his middle ear and facial nerve. Dr. Sewchand lost track of the location of his instrument and thereafter unwittingly placed his curette in the middle ear. Finally the plaintiffs say that Dr. Sewchand employed excessive force.

Position of the Defendant

[238] For the defendant, Mr. Veneziano and Ms. Varah provided a template of their submissions to the court, inclusive of providing a document entitled *Defendants Outline of Law*. Mr. Veneziano also provided a template of his submissions to the court on June 07, 2012. In September 2012 lengthy and detailed written submissions were forwarded to the court.

[239] Mr. Veneziano and Ms. Varah argue that Dr. Sewchand has provided credible, authoritative and persuasive expert evidence from Dr. Dickson to establish that he met a reasonable standard of care in the performance of the surgery. Dr. Sewchand has done this procedure on hundreds of occasions and in each procedure involving a stone he was making progress with the stone moving laterally. He used the same procedure and technique in the case at bar.

[240] Rather than negligence this is a case of surgical misadventure. The resulting complications have nothing to do with Dr. Sewchand's exercise of surgical skill. His surgical technique met with the standard of care in every respect, and is supported by the evidence of Dr. Dickson. Dr. Sewchand rotated the stone and moved it laterally. Continuation of the procedure and non-referral or resort to an open surgical procedure was entirely reasonable. Once the injury was obvious Dr. Sewchand made the referral to The Hospital for Sick Children.

[241] The plaintiffs allegation that Dr. Sewchand moved the stone medially and subsequently 'lied' about it, is without foundation.

The Law

[242] Medical practitioners "must bring to [their] task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. [They are] bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than one who does not profess to be so qualified by special training and ability."[8]

[243] 20/20 hindsight is not the test for deciding if a particular surgical procedure meets the standard of care. Mistakes that are apparent only after the fact are not a gauge to assess the reasonableness of a surgeon's procedure and judgment. Unexpected consequences are likewise not proof of a deviance from a requisite standard of care.

[244] Judgment is to be assessed against the reasonableness of the clinical judgment undertaken and not a simple error of judgment which otherwise would not be negligent.[9] Mere errors in judgment are not synonymous with liability in negligence. However an error in judgment is actionable and can result in a finding of negligence where a physician fails to reasonably exercise clinical judgment, inclusive of failure to consider his or her diagnosis or approach to treatment in the face of difficulty. As the Court stated in *Williams (Litigation Guardian of) v. Bowler* [2005] O.J. No. 3323 (S.C.J.), "the real difficulty lies in determining whether injurious behaviour by a physician was negligence or merely an error in judgment and it is the facts in each case which will determine the answer to this crucial question."

[245] The Court in *Williams* went on to state that an error that involves the exercise of judgment does not necessarily shield the doctor from liability. If the error is one which a reasonable doctor would not have made in similar circumstances then liability will follow. An error in judgment is not necessarily negligence but it may be depending on the circumstances. Circumstantial evidence may establish that a surgeon's feel and touch have failed him for instance, such that negligence can be inferred.[10]

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[8] *Crits v. Sylvester*, [1956] O.R. 132 (C.A.)
[9] *Lapointe v. Hopital Le Gardeur*, [1992] 1 S.C.R. 351; *Ter Neuzen v. Korn*, [1995] 3 S.C.R. 674
[10] *Hassen v. Anvari*, [2003] O.J. NO. 3543 (C.A.)

[246] If such an inference can be drawn it will be for the defendant to "negate the inference with an explanation as consistent with no negligence as with negligence."[11] In cases where injuries of the type that have occurred "are extremely rare because of the numerous precautions built into the procedure and the care with which it is performed" the trier of fact is "entitled to use this evidence of the extreme unlikelihood of the injury occurring to conclude that it could not have happened based on a non negligent slip."[12]

[247] But it must be remembered that an unfortunate outcome does not constitute proof of negligence. The Court must ask "whether that act or omission would be acceptable behaviour for a reasonably prudent and diligent [surgeon] in the same circumstances. The erroneous approach runs the risk of focusing on the result rather than the means." [13]

[248] Surgical misadventure does not equate with negligence, without more. As Denning L.J. stated in *Roe v. Minister of Health*, [1954] 2 Q.B. 66:

> It is so easy to be wise after the event and to condemn as negligence that which was only a surgical misadventure. We ought always to be on our guard against it. Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every operation is attended by risks. We cannot take the benefits without the risks.

[249] The court is not to simply pick and choose an expert opinion. Practitioners may disagree about the exercise of judgment, however judgment that is an honest exercise of clinically available judgment is not negligible. Mere reference to what one expert would do in a given situation does not establish what the standard of care is nor does it establish that a doctor breached the standard.[14]

REASONS

Standard of Care

[250] The live question for the court is whether Dr. Sewchand provided the requisite standard of care in his treatment of Stone.

[251] I find that he did not.

[252] In relation to the evidence proffered by the experts Dr. Rutka and Dr. Dickson where there is any material conflict, I accept the opinion of Dr. Rutka. I note that Dr. Rutka's report was complete, responsive and detailed with respect to the matters in issue. He testified to the issues identified in his report. Dr. Dickson's report was less detailed and indeed did not address all of the issues on which he testified. Although I allowed

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[11] *Ibid.*
[12] *Ibid.*
[13] *St. Jean v. Mercier*, [2002] S.C.J. No. 17.
[14] *Bafaro v. Dowd* (2008), 169 A.C.W.S. (3d) 437 (Ont.S.C.J.); Upheld on appeal: 2010 ONCA 188

defendant's counsel to posit various scenarios that were put to Dr. Dickson, I did so on the basis that Dr. Dickson's report arguably referenced those areas in a latent respect.

[253] Nonetheless I find there to be a quality of more rigorous and detailed assessment of the factors applicable in this case by Dr. Rutka. In addition as is evident I find that Dr. Dickson's evidence in the context of Dr. Sewchand's evidence and my findings in relation to that evidence, does not give rise to the force of compellability and accuracy of Dr. Rutka's evidence.

[254] I have not simply stacked one expert's opinion against the other's. The court must be careful in assessing the direct evidence in the case, and to not simply trump it with an expert's post facto assessment. Arm chair quarterbacking is impermissible. Moreover I cannot reason backwards from an unfortunate result.

[255] I have carefully considered Dr. Sewchand's surgical approach and in particular his evidence in coming to my conclusion that his standard of care of Stone did not meet that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing.

[256] Dr. Sewchand knew the following before he commenced his surgery: i) the stone was deeply impacted in Stone's ear, as is evidenced by his operative notation and the fact that two other doctors had tried to remove the stone, one in the emergency department and the second in his office at his hospital; ii) Dr. Sewchand testified that he had not read the reports of either Dr. Brar (from the emergency department) wherein he noted that the stone was deep in the right ear canal, nor that of Dr. Fagan who noted that the stone was very large and impossible to budge when he tried to remove it in his office; and iii) although Dr. Sewchand was aware of two failed attempts by those other doctors, he was not aware of the procedure(s) undertaken by those physicians.

[257] Dr. Sewchand's evidence as to the level of difficulty that he encountered and should have expected to encounter, was troubling. I have serious concerns with the abject failure of Dr. Sewchand *to appreciate* the level of difficulty that he was facing. I have referenced above at paragraph 165 an exchange between Dr. Sewchand and Mr. Mladenovic at trial with respect to the level of difficulty of this procedure. I will now repeat it here.

> Q: And we've already talked about what it meant by difficult. You were having trouble getting behind the stone with the curette.
>
> A: No I didn't say that.
>
> Q: You weren't having trouble getting behind the stone?
>
> A: I was having difficulty because it was a difficult one-it was not easy, that's what I meant by being difficult.
>
> Q: And the reason that it was not easy was you were having some challenges getting behind the stone, right?

A: Towards the end, right

Q: Towards the end?

A: Yes.

Q: No, throughout the whole procedure you were having difficulty getting your curette behind the stone, right? It was only at the very end of the procedure that you actually succeeded in getting your curette behind the stone, right?

A: No I didn't say I was having difficulty, it was a difficult one.

Q: You weren't having difficulty, but it was difficult?

A: It was difficult, correct.

Q: But you were having difficulty?

A: I've done more difficult cases than that -foreign bodies- I get them on....

Q: Doctor all I am trying to establish with you, and I think we've already established it, is that you were having some difficulty with this object because you couldn't get your curette back behind the object in the speed and manner that you thought you were going to have, right?

A: Correct, right.

[258] This exchange demonstrates that Dr. Sewchand was loath to answer a fairly straightforward question. Counsel had to persist in the extreme to get what should have been a pretty simple admission, that the removal was difficult. It is also readily apparent that Dr. Sewchand was indeed having difficulty, and that *he knew it at the time*. This was, I underscore, not a routine removal.

[259] I agree with plaintiff's counsel that there are issues with Dr. Sewchand's credibility. On several points his evidence at trial was not consonant with his evidence at discovery.

[260] At trial Dr. Sewchand referenced his teasing of the stone by pushing up the cartilage in the ear and achieving a space for his curette. At no time did he ever reference this manoeuvre at discovery. He was asked expressly at discovery if he performed any other manoeuvres with the stone other than rotating it. His first answer was that he did not recall. His second answer was 'no'.

[261] Clearly Dr. Sewchand turned his mind to the question and thought about it at discovery. He agreed at trial that he never mentioned teasing the stone, nor did he mention manipulating the cartilage, although Dr. Sewchand did say that teasing the stone was part of the basic approach to the removal of a foreign body.

[262] Dr. Sewchand testified at trial that he had spoken to Dr. Fagan about Dr. Fagan's attempt to remove the stone, and that Dr. Fagan told him that it wouldn't budge. At his discovery Dr. Sewchand testified that Dr. Fagan had not told him of attempts to remove the object in his office. Nor did Dr. Sewchand ask.

[263] At trial Dr. Sewchand continued to insist that Dr. Fagan told him that the stone would not budge. Dr. Sewchand agreed that he had read Dr. Fagan's note in the month after the surgery, as that was when Dr. Fagan noted that the stone was impossible to budge. I find that Dr. Sewchand did not make the inquiry of Dr. Fagan that he said he did before he undertook his surgery.

[264] Dr. Sewchand was not aware, on his own evidence I find, of the *nature* of the two prior attempts to remove the stone. Education as to the nature of those attempts would clearly have assisted in the calculus of the level of difficulty to be expected, especially once Dr. Sewchand saw the impacted stone in the ear. A prudent surgeon, faced with his own determination that the stone was deeply impacted and that there had been two prior attempts at removal, should have known that the level of difficulty of the procedure was very much enhanced.

[265] The standard of care, as Dr. Rutka said, was not to push on in these circumstances. It was to consider another option.

[266] In failing to consider those options Dr. Sewchand breached the standard of care. I find that in the circumstances of this patient a prudent surgeon would not have *persisted* in removal attempts with the curette without considering other options. Indeed Dr. Dickson agreed in the extract above at paragraph 214, that a continuation of the movement of the stone medially would breach the standard of care if the surgeon persisted. I find that is exactly what happened here. Dr. Sewchand persisted when he ought not to have.

[267] The same journal article from *The Laryngoscope* put to Dr. Rutka in his cross-examination, was also put to Dr. Sewchand. That article notes that "where there are two or more attempts to remove a foreign body it will likely lead to a higher incidence of eardrum perforation." Dr. Sewchand would not adopt the proposition that his own lawyer put to Dr. Rutka, but rather answered "possibly".

[268] Dr. Sewchand never turned his mind to other options, such as a referral to another doctor or to consider another type of available surgical procedure, in particular an open surgical procedure via entry in front of or behind Stone's ear. His direct evidence confirms this. He persisted to try to remove the stone over the course of over 5 minutes, teasing the cartilage from the top of the stone, and rotating and moving the object laterally with his wax curette.

[269] I pause here to note that it is not suggested by either of the experts that the initial use of the curette fell below the standard of care, nor that the failure to order a cat scan or to place a facial nerve monitor at the beginning of the procedure would breach the standard of care. Nor was there any issue with the use of general anaesthetic.

[270] Dr. Sewchand admitted that the stone was eventually within the middle ear. He likewise acknowledged that his curette must have been in the middle ear. The evidence is clear he unknowingly and unwittingly placed the curette into the very delicate middle ear structure. The consequential damage occurred. The placement of the stone and the curette in the middle ear was the product however of a breach of the standard of care and not simply an unfortunate consequence to the surgery.

[271] I accept in the equation Dr. Rutka's evidence that in this scenario, once the curette was used for in and around a minute mark[15], that Dr. Sewchand should have taken the time to assess the situation, which meant at that stage a cessation of the procedure. Dr. Sewchand had thought he spent some 15 minutes with the curette. As it turns out it was just above the 5 minute mark. Clearly subjectively Dr. Sewchand was experiencing difficulty with this removal. He believed that he had spent a considerable amount of time in the removal process.

[272] Other extracts of Dr. Sewchand's evidence are set out earlier in this judgment. I find that Dr. Sewchand was not as candid as he could have been when he was being cross examined on certain areas. His evidence presented with the aura of obfuscation when he was asked various questions in cross examination. These included providing the answer, "not necessarily" to the question that had he inquired about previous removal attempts they may have provided him with some useful information. When asked if he had inquired about the nature of the prior attempts and whether this would or could have given him an indication of higher morbidity for this patient, he answered "no."

[273] I find his answers problematic. The fact of the prior attempts was germane to what Stone's condition was, inclusive of the risk of higher morbidity.

[274] Dr. Sewchand testified that he never even considered a complication because he had never experienced a complication. When asked for instance if there is a risk that the curette may push an object further into the ear, he answered that "some people run the risk". Apparently he was not one of that class. I accept the evidence of Dr. Rutka that it is the responsibility of a surgeon to consider a complication, inclusive of the risks, when a procedure is being undertaken. Indeed I would think that to be a matter of common sense.

[275] It is also of interest that in his own operative note, Dr. Sewchand indicated that "the right ear showed a stone impacted deep in the ear canal. I attempted to remove it but it was difficult. If fit quite snugly in the ear making it impossible to remove." At trial however Dr. Sewchand noted "that the stone was impossible to remove as a foreign body in the external ear." Mr. Mladenovic posits that Dr. Sewchand attempted to interpret his own operative note "to fit his litigation theory that the stone was not confined to the ear canal but was rather in the middle ear to begin with." I agree with counsel.

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[15] There is no magic in an exact time, however I accept that once it was apparent in and around the minute mark that progress was not being made with the curette, that that was the time to sit and think about the options.

[276] In cross examination Dr. Sewchand agreed that his note indicated that the foreign body "fit quite snugly in the ear, making it impossible to remove" and did not note that "it was impossible to remove because it was limited to the ear canal." Dr. Sewchand agreed that he could have made that "very important distinction" in his operative note. When it was put to Dr. Sewchand he agreed that the first time he mentioned impossibility of removal because it was not limited to the ear canal was during this litigation at discovery, Dr. Sewchand agreed.

[277] Dr. Sewchand testified that someone reading his report would "probably" be led to believe that it was impossible to remove the stone because it fit snugly, and had nothing to do with the object not being limited to the ear canal.

[278] It is important to note that there is nothing in Dr. Sewchand's operative note that speaks to his ability to rotate the stone laterally during his procedure. I find that omission troubling. Had this been what occurred, surgical misadventure would be a more plausible theory. But this experienced surgeon did not make that simple note as to his method of attempted extraction. Given that what occurred in Stone's operation was a first for Dr. Sewchand, one certainly would have expected a complete and concise operative note.

[279] I agree with Mr. Mladenovic that Dr. Sewchand lacks credibility in this respect. Operative notes are very important records as they describe surgical procedures and may very well be relied upon by other physicians, or even in litigation. I find that Dr. Sewchand manipulated his evidence to fit with his theory of the case that the stone had penetrated the tympanic membrane and entered the middle ear before he undertook his removal efforts.

[280] Extracts of Dr. Sewchand's testimony at discovery were filed on consent. They reveal that Dr. Sewchand was alive to the need to not push the stone into the ear. He never however considered the possibility that this was what was happening. When asked at discovery whether he gave any consideration to the possibility that this object might be deeper than he first suspected which was rendering removal more difficult, he said he was using his experience with other stone impactions. He agreed that he did not consider that this stone was deeper than he thought as he was undertaking his curetting.

[281] I agree that on the balance of probabilities that it is *far more likely than not* that there was no rotational or lateral movement of the stone as Dr. Sewchand says once he got the curette in place. The curette had caused the stone to be pushed into the middle ear. The evidence of Dr. Sewchand that the stone was moving laterally at all times is entirely inconsistent with the objective findings, and indeed of the operative notes of Dr. Sewchand which are entirely deficient of such content.

[282] In coming to this conclusion I am well aware that the standard of care must be assessed before causation is addressed, however as counsel recognized the two issues of standard of care and causation in this case are exquisitely proximate. That is not to say that there was no risk that a foreign body would, without negligence, be pushed through the tympanic membrane and into the middle ear.

[283] However the objective evidence in conjunction with the failure of Dr. Sewchand to note rotational and lateral movement prior to the ligitation and my concerns about his credibility satisfy me that Dr. Sewchand was not rotating the stone laterally, as he said he did, throughout the procedure. Lateral movement occurred after the stone was pushed into the middle ear and the curette entered that very delicate space after which it was extracted along with the malleus, and after the stone intersected with the facial nerve and the incus and stapes were interfered with.

[284] I find that contact with the curette on the lateral part of the stone caused the stone to be pushed deeper into the ear canal. This risk was acute and very foreseeable. Absent medial access to the stone, pulling it laterally would be exceedingly difficult.

[285] Dr. Sewchand remained resolute that this was not a difficult extraction to the extent that it required a reconsideration of approach. I find that his resoluteness was founded in part on his belief, misplaced as it was, that he could remove this stone without complication. He erred in his judgment in this respect and his error was not within the realm of clinical judgment.

[286] The objective evidence and indeed the evidence of Dr. Dickson that in the absence of a lateral movement to the stone, the standard of care was breached, is evident. In this respect I adopt the words of Mr. Mladenovic that "it should not be surprising that Dr. Sewchand pushed the stone medially into the middle ear space. It was completely predictable, given the clinical scenario."

[287] Given the credibility issues that Dr. Sewchand manifested in the juxtaposition of his discovery and trial evidence, and my acceptance of the evidence of Dr. Rutka as to the standard of care that was required in this particular case, I find on the balance of probabilities that Dr. Sewchand was negligent in his standard of care of Stone by continuing to press on with the curette and by not stopping to consider his options, which he was aware of and a reasonably situate surgeon would also have been aware of.

[288] This was I find precisely the type of case in which a competent surgeon would at the least consider abandoning his extraction technique by either resorting to an open procedure or abandoning the attempt and seeking a referral. These options were not part of Dr. Sewchand's arsenal of consideration. He breached his standard of care by: not considering the options when he had difficulty initially; failing to appreciate the *nature* of the difficulty that was present; failing to educate himself on the *degree* of difficulty given the nature of the two prior attempts to remove the stone; and not considering the potential complications.

[289] I also find that the technical skill and clinical judgment that Dr. Sewchand brought to his task were deficient and fell below the requisite standard of care. He lost track of where his curette was. It was in a place it never should have been given that the stone was deeply impacted and as I have found he was not engaging in lateral movement until the stone had been pushed medially through the tympanic membrane and into the middle ear via his surgery. In this respect I find that excessive force was used and in this regard accept the evidence of Dr. Rutka.

[290] By losing track of his curette in this particular scenario, I likewise find that Dr. Sewchand failed to demonstrate the requisite degree of technical skill during this procedure.

[291] Although there is an element of blindness to the procedure, in the case at bar I find given what Dr. Sewchand knew or should have known by his own observations, his difficulty in getting the stone out, and the credibility issues that I have alluded to in relation to his evidence, that this is not simply a surgical misadventure but rather a case where the tip of the curette was used blindly without a realistic explanation as to why.

[292] In short he should have known where the tip of his curette was under these circumstances. Dr. Sewchand testified that "he always knows where my instruments are", yet clearly in this case he didn't.

[293] In coming to my conclusion I note that the defence expert Dr. Dickson based his opinion on the complete acceptance of Dr. Sewchand's evidence that he was rotating and moving the stone laterally at all times. Yet Dr. Dickson candidly testified that "if the object is moving away from you, it's very clear that you're using the wrong technique. You abandon and try something different at that stage."

[294] Dr. Dickson was very deferential to Dr. Sewchand. He offered no opinion as to what could cause these substantial injuries. He did say the outcome was unexpected and to hazard an opinion as to what happened would be speculation.

[295] I agree with Mr. Mladenovic that it would only be speculation if it is accepted that the stone was always moving laterally. It is not speculation on the evidence in this case that the only rational explanation for these injuries was the medial movement of the stone during and the procedure and instrumentation of the inner ear with the curette.

[296] I agree that Dr. Dickson's evidence with respect to Dr. Rutka's opinion on causation as being speculation, is to be accorded very little weight, in light of the assumptions that he has made, which I have rejected, and in light of my findings as to what Dr. Sewchand did and didn't do in the removal process.

[297] I note as well that Dr. Dickson did acknowledge that a lack of awareness of the position of surgical instrument and a lack of awareness of the anatomy would increase the risk of harm. As for clinical judgment Dr. Dickson referenced that a surgeon must at least consider alternatives when difficulties occur, inclusive of an open surgical approach in front of or behind the ear.

[298] In short the objective evidence in this case, as well as my findings in relation to the credibility of Dr. Sewchand, and my assessment of the evidence of the experts, satisfies me on a strong balance of probabilities that Dr. Sewchand breached the standard of care of an otolaryngologist in his treatment of Stone Shearer.

Causation

[299] In this case the defence concedes that the injuries suffered by Stone were the result of surgical complications arising as a consequence of the procedure that Dr. Sewchand performed. The "but for" requirement of causation is therefore not an issue.

[300] Leaving aside the concession on causation, it is manifestly apparent given the evidence of Mrs. Shearer in relation to her son's pre surgery state inclusive of the lack of facial asymmetry or facial paralysis prior to the surgery but present immediately after, and the surgery undertaken by doctors at the Hospital for Sick Children, that serious injury occurred to the middle ear, inclusive of partial severance of the facial nerve by shards of stone and displacement of the incus and stapes, as well as damage to the chorda. As Dr. Sewchand testified the malleus actually came out during the initial surgery with the portion of the stone that he removed.

[301] It is manifestly plain as Stone was coming out of his sedated state, which was very close in time to the surgery, that he had suffered clearly *visible* trauma, in particular to his facial nerve. This is all the more reason that the operative note should have been a compendium of the processes undertaken in the surgery.

[302] The trail of damage as discovered at Sick Kids Hospital, in the absence of any intervening event post surgery by Dr. Sewchand makes it plain that the injuries could not have occurred if the object had been moved laterally based on the evidence at this trial. Although Dr. Sewchand suggested that other explanations could explain the damage that occurred the court was not enlightened as to what they might be, nor did the defence expert assist in this regard.

[303] It is equally informative that Dr. Sewchand in his initial assessment of Stone did not note any sign or symptoms of a perforation of the tympanic membrane or any other clinical concern for damage to Stone's middle ear prior to conducting his surgery on Stone.

[304] The partial severance of the facial nerve clearly lead to the facial palsy that Stone exhibited immediately after Dr. Sewchand had completed his procedure.

[305] Dr. Sewchand had a small child as a patient who presented with an impacted stone, deep in his right ear, accompanied by some discomfort. That discomfort was exhibited by Stone telling his mom that his ear hurt. Nothing more suggested any additional issues or complications. There was no discharge, no significant pain, no noticeable trauma.

[306] I find therefore that the only common sense inference from the proven facts is that the surgery precipitated the injuries in this case, and caused the injuries. Put another way, but for the surgery undertaken by Dr. Sewchand, the stone would not have entered the middle ear with the curette and Stone would not have suffered the injuries.

Conclusion

[307] In the context of all of the evidence I am well satisfied on the balance of probabilities having considered the deference due to a treating surgeon, that Dr. Sewchand did not exercise reasonable clinical judgment in this case. He failed to reasonably consider the history of the two prior attempts at removal, the reasons for the difficulty, in particular given the impaction, snugness and deepness of the stone in the ear, and the options that he had above and beyond persistence with the curette.

[308] The time that he was spending at removal, which in his mind was some 15 minutes, although it proved to be some 5 minutes, exhibits the tenacity and determination of his approach. Given the clear difficulty that he was met with, reasonable judgment required a consideration of the options in a case like this. Those options never met the eye of Dr. Sewchand.

[309] Regrettably Dr. Sewchand saw this as not a particularly difficult extraction. I find he continued to treat the extraction as such even when it proved incorrect and he knew it was incorrect. There is no foundation to support the argument that Dr. Sewchand believed the object was always in the middle ear, nor that it was there prior to Dr. Sewchand's attempt at removal.

[310] Dr. Sewchand's post operative note that the stone was in the middle ear is informed only by the obvious at that point. The malleus was out. Clearly at that point, the curette had been in the middle ear. The curette and the stone were in the middle ear due to the negligence of Dr. Sewchand. This was not a predetermined pre-surgical placement.

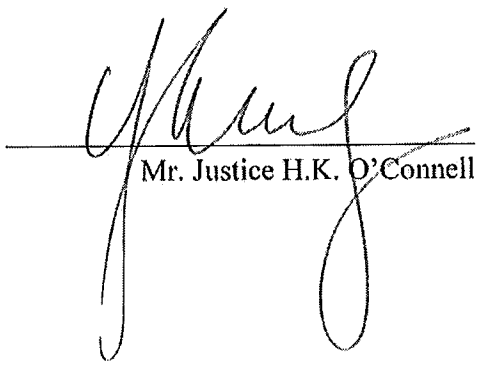
[311] In coming to my conclusion I note that there was no evidence that Dr. Sewchand was callous or intentionally caused harm to a patient. That finding is not available and thankfully would be rarely available in the context of a doctor's professionalism. However the surgical approach, inclusive of actual use of the curette, the failure to stop and think, the lack of requisite technical skill and the lapse in clinical judgment in the treatment of this patient, provide a constellation of factors that satisfy me that Dr. Sewchand was negligent in his treatment of Stone.

[312] I find in sum that on the balance of probabilities, and indeed a very strong balance, that the injuries here must have occurred with the rock being pushed medially during the procedure, and into the middle ear and then the stone contacted and partially severed the facial nerve; that Dr. Sewchand's curette found its way into the middle ear and damaged the ossicular chain; that the opinion of Dr. Rutka with respect to the standard of care in this case should govern given the objective evidence and my findings in relation to the credibility of Dr. Sewchand inclusive of my finding that the alleged rotation and lateral movement of the stone are simply implausible; and the fact that it is mere speculation to suggest that the injuries are a consequence of other than a breach of the standard of care by Dr. Sewchand.

[313] Dr. Sewchand was negligent in his treatment of Stone.

[314] Judgment accordingly in favour of the plaintiffs.

[315] If counsel cannot agree on costs, the plaintiff is to file cost submissions inclusive of bill of costs not to exceed 6 pages by June 28, 2013 with the defendant to file submissions within 10 days of receipt of the plaintiff's materials.



Mr. Justice H.K. O'Connell

Released: June 13, 2013

CITATION: Shearer v. Sewchand, 2013 ONSC 4052
PETERBOROUGH COURT FILE NO.: 267/08
DATE: 20130613

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

STONE SHEARER, a minor, by his Litigation Guardian, Angela Shearer:
ANGELA SHEARER, personally and ROBERT SHEARER

Plaintiffs

– and –

Dr. KENNETH SEWCHAND

Defendant

REASONS FOR JUDGMENT

H.K. O'Connell, J.

Released: June 13, 2013