Editor's Note: Corrigendum released on January 26, 2007. Original judgment has been corrected with text of corrigendum appended.

Please note that in the recently released judgment - Estate of Lynia Ross, Docket No. 06/35, filed January 10/07, there is an error in paragraph 10, second sentence. Please change 'Dr. Melville' to 'Dr. Melvin'.

2007 NLCA 2 (CanLII)

Date: 20070110
Docket: 06/35 & 06/39
Citation: 2007 NLCA 2

IN THE SUPREME COURT OF NEWFOUNDLAND AND LABRADOR COURT OF APPEAL

BETWEEN:

ESTATE OF LYNIA ROSS, by its Administrator, the REGISTRAR of the Supreme Court of Newfoundland & Labrador FIRST APPELLANT

AND:

ESTATE OF AUTUMN SARAH LYNIA BROWNE, by its representative EDGAR BROWNE SECOND APPELLANT

AND:

EDGAR BROWNE and SHANNON BROWNE and CANDACE BROWNE THIRD APPELLANTS

AND:

JEFFREY G. HISCOCK RESPONDENT

Coram: Roberts, Welsh and Mercer, JJ.A.
Court Appealed From: Supreme Court of Newfoundland & Labrador, Trial Division, 1997012055

Appeal Heard: November 8-9, 2006
Judgment Rendered: January 10, 2007

2007 NLCA 2 (CanLII)

Reasons for Judgment by Roberts J.A.
Concurred in by Welsh and Mercer, JJ.A.

Counsel for the First, Second and Third Appellants: Mr. Chesley Crosbie, Q.C.
Counsel for the Respondent: Mr. Peter Browne and Mr. Liam O'Brien

2007 NLCA 2 (CanLII)

Roberts, J.A.:

[1] This is an appeal from a finding by the trial judge that the respondent Dr. Jeffrey G. Hiscock (Dr. Hiscock) was not negligent in his examination of Lynia Ross (Ms. Ross) and diagnosis of her condition when he saw her at the James Paton Memorial Hospital in Gander (the Gander Hospital) on August 31 and September 1, 1996. Sadly, Ms. Ross, thirty-one years old and in late pregnancy, died a week later, on September 8, 1996 as a result of an aortic dissection. Although her baby daughter was delivered by cesarean section before she passed away, the baby died five days later. Ms. Ross is survived by her husband Edgar Browne and two other children.

Background

[2] Ms. Ross' father and brother both died young of aortic complications resulting from Marfan's Syndrome (Marfan's); her father was thirty-four, her brother twenty-nine. The trial judge, at para. 27 of his reasons, adopted a definition of Marfan's contained in an article, entered as an exhibit, entitled "Management of Aortic Disease in Marfan Syndrome":

> "Marfan's Syndrome (MFS), first described by the French pediatrician Antoine Marfan in 1896, is an autosomal dominant inherited disorder of connective tissue associated with mutations in the fibrillin-1 gene. Multiple tissues and organs, including the heart and aortic root, are affected in MFS. Prognosis is mainly determined by progressive aortic root dilation, potentially leading to aortic dissection and rupture. In the 1970s, most patients with MFS died prematurely of aortic rupture or aortic regurgitation, often by the third decade of life. Over the past few decades, however, developments in medical and surgical management of aortic disease in MFS, as well as better recognition of the syndrome, have resulted in markedly improved life expectancy up to approximately 70 years."

[3] The trial judge continued his description of Marfan's, at paras. 28-30:

> Marfans is a genetic disorder which causes weaknesses in the tendons, ligaments and other connective tissues in the body. It is inherited from one of the parents. Anybody who has Marfans is at risk to have cardiac complications.

Usually there is degeneration of the connective tissue in the aortic wall which will cause the widening of the aorta (aneurysm) which may cause a rupture that will result in massive bleeding.

People who have Marfans almost always exhibit certain clinical manifestations. Fifty percent of them have a subtle displacement of one of the lens in their eyes and approximately eighty to ninety percent exhibit an increased height with disproportionate limb radio (usually long arms and legs with long thin fingers). These physical characteristics usually alert a physician that a patient may have Marfans.

Since fifty percent of children of people with Marfans inherit the disorder, the family history of the patient is very important. It is especially important in cases where the person does not exhibit the classic physical manifestations of Marfans.

2007 NLCA 2 (CanLII)

[4] The trial judge completed this medical discussion at paras. 31-33:

In **Heart Disease (a Textbook of Cardiovascular Medicine**), 4th Edition at page 1535, "acute aortic dissection" is described as follows:

> "Acute aortic dissection is a relatively common catastrophic illness and occurs at the rate of at least 2000 new cases per year in the United States. Over the past two decades, great strides have been made in the diagnosis and the medical and surgical treatment of this highly lethal disease. It has been cogently pointed out that the term **dissection hematoma** describes this entity more accurately than does the commonly used term dissecting aneurysm. More recently, the simpler term **aortic dissection** has gained favor.
>
> Aortic dissection is caused by the sudden development of a tear in the aortic intima, opening the way for a column of blood driven by the force of the arterial pressure to enter the aortic wall, destroying the media and stripping the intima from the adventitia for variable distances along the length of the aorta."

A patient who experiences an acute aortic dissection will have excruciating and sudden pain in central chest area. Although this is the major symptom, there are also other factors which would indicate an aortic dissection. That would include sweating, nausea, elevated blood pressure, lack of a pulse in either the arms or legs and aortic regurgitation murmurs. Although the widening of the aorta may be detected on a chest x-ray or an EKG reading, the most reliable diagnostic equipment to detect a dissection are either a CT Scan, an MRI or a transesophageal echocardiography.

> In almost all cases, an acute aortic dissection is treated by the immediate surgical repair of the aorta. Without surgical intervention death will occur within forty-eight hours.

[5] Marfan's looms large in this appeal because of the trial judge's finding that Ms. Ross purposely neglected to tell Dr. Hiscock of its presence in her family and of the untimely deaths of her father and brother.

[6] As mentioned above, Dr. Hiscock saw Ms. Ross on August 31, 1996. She had been admitted to the Gander Hospital on the previous day after developing retrosternal chest pains. When she had first felt the pain, her husband drove her to the medical clinic near their home in Summerford. There she saw her family doctor, Dr. Steven Furlong, who took a history and did a physical. Dr. Furlong examined her and found a systolic ejection murmur over the pericardium (the sac surrounding the heart). He made a preliminary diagnosis of "gut grief secondary to eating chicken". Dr. Furlong, because of his previous knowledge of Ms. Ross' family history, did consider Marfan's, but based on her clinical presentation and his examination, he thought it "highly unlikely". He did recommend to Ms. Ross, however, that she go to the Gander Hospital for a more extensive examination. Ms. Ross resisted this suggestion, saying that she did not need further medical treatment. Later in the day, after much discussion and insistence on the part of her husband, she changed her mind.

[7] Ms. Ross was admitted at the Gander Hospital on the evening of August 30, 1996. There was no note of her family history, in particular of Marfan's, on the admission record or by the attending physicians before the consultation with Dr. Hiscock on the following morning. By that time, Ms. Ross' chest pain had gone. According to the trial judge, at para. 62:

> Hiscock reviewed her hospital chart and met with Ross at 11:15 a.m. on August 31st. Prior to the physical examination Hiscock asked Ross about the history of her present illness and her past medical history. He also attempted to obtain the family medical history. In that regard he testified as follows:
>
> "Question: "What approach would you apply in taking a family history in a patient like Ms. Ross?
>
> Answer: I would have taken a family history from Ms. Ross the way I do with every one of my patients. It's a two part question. The first part is are there any major medical diseases in your family, and if they hesitate, I say the term "blood relatives", people who are related to you. I then follow that up with are you aware of

2007 NLCA 2 (CanLII)

anybody in your family having the condition that you have right now.

Question: Doctor, what's your practice or approach when a patient gives you a positive response to either of these questions?

Answer: When I get a positive response to either of these questions, I then obtain as many details about the positive response as I can. Who was it, how old were they, what are their true relationship to you...fathers, cousins, just get the details of that, and make sure there wasn't somebody else with that...re-ask it and make sure there wasn't somebody else with that condition now that I've got...whatever details I've achieved, I make sure that that's the only person that's got that, but I get all the details that I can.

Question: Do you follow a particular approach in terms of documenting family history?

Answer: I generally always document positive family history but I fear if there's nothing in the family history I might not even mention it."

[8] The trial judge further wrote concerning Dr. Hiscock, at paras. 66-70:

During his examination of Ross' cardiovascular system, Hiscock heard a pericardial friction rub. His testimony in that regard was as follows:

> "By my description, and I recall a bit of this, she did have a loud sound that everybody else had been calling a systolic murmur. It was loud, it was all over the heart. It had no particularly relationship to heart valves. By that, what I mean, sir, is that when certain murmurs occur on some heart valves they are heard in certain parts of the chest and not in others, helping us to determine which valve is involved. Her sound was heard everywhere, equally intense.
>
> Then I said she had a large systolic ejection sound, loud is loud...systolic is referring to the part of the heart cycle that the heart is pumping and pushing blood into the rest of the body, and ejection refers to, again, the action of the heart where it ejects the blood out from it, into the arterial tree.
>
> It was very rough, I could even hear it into the cartoids, which means off the chest and actually into the neck a little bit. And I then go on to say, underneath that there are two other phasic sounds, so that this lady has a triphasic rub with the systolic component being particularly loud."

On the basis of his cardiovascular examination of Ross, Hiscock concluded that she was suffering from viral pericarditis. In order to determine the cause of

2007 NLCA 2 (CanLII)

> the pericarditis he asked Ross about lupus, skin rashes or unusual heart diseases in the family. She denied that there was any such history.
>
> Pericarditis is caused by inflammation of the fibrous sac that surrounds the heart. Its characteristics include chest pain which may be aggravated by breathing or positioning and a triphasic pericardial friction rub. The chest pain usually increases if the patient coughs, sneezes or changes position. There are a number of causes of the condition, however, idiopathic and viral pericarditis are the most common forms of the condition.
>
> Hiscock ordered a chest x-ray to assess the size of her heart. It would also disclose if there was any fluid around the heart. The x-ray indicated that there was no problem in that regard. The normal treatment for pericarditis was a non-steroid anti-inflammatory agent.
>
> On September 1, 1996 Hiscock again visited Ross. She advised him that she had no chest pain and wanted to go home. He agreed to discharge her, however, he asked her to see him the next time she came to Gander to see her obstetrician. Since Ross was sensitive to aspirin, he prescribed no treatment. He expected her condition to resolve in a short period of time. He also advised her that if the pain returned she should immediately see her family doctor or return to the hospital.

[9] Ms. Ross had a reoccurrence of her chest pain on September 7. She and her husband decided to go immediately to the Gander Hospital. This time, new doctors got the family history and the new consultant wrote across the emergency record:

> Acute Aortic Dissection
>
> - Urgent Transfer to
>
> St. John's by air ambulance
>
> STAT.

[10] The new consultant spoke with Dr. Kevin Melvin at the Health Sciences Centre in St. John's and he and a surgical team stood ready for Ms. Ross' arrival. Although Dr. Melvin's surgery was successful, Ms. Ross could not be brought off cardiopulmonary by-pass. She died the following day.

Issues

[11] The appellants argue that the trial judge erred, either in fact or in law, in the following ways:

2007 NLCA 2 (CanLII)

(1) In finding that Ms. Ross "lied" to her physicians about her family medical history;

(2) In admitting medical evidence objected to by the appellants; and

(3) In determining the correct legal issues, in weighing the credibility of the expert evidence and in failing to appropriately resolve conflicting evidence regarding the standard of care.

2007 NLCA 2 (CanLII)

Standard of Review

[12] The relevant standards of review are as set out in **Housen v. Nikolaisen**, [2002] 2 S.C.R. 235:

> [1] A proposition that should be unnecessary to state is that a court of appeal should not interfere with a trial judge's reasons unless there is a palpable and overriding error. The same proposition is sometimes stated as prohibiting an appellate court from reviewing a trial judge's decision if there was some evidence upon which he or she could have relied to reach that conclusion.
>
> …..
>
> [3] The role of the appellate court was aptly defined in *Underwood v. Ocean City Realty Ltd.* (1987), 12 B.C.L.R. (2d) 199 (C.A.), at p. 204, where it was stated:
>
> The appellate court must not retry a case and must not substitute its views for the views of the trial judge according to what the appellate court thinks the evidence establishes on its view of the balance of probabilities.
>
> [4] While the theory has acceptance, consistency in its application is missing. The foundation of the principle is as sound today as 100 years ago. It is premised on the notion that finality is an important aim of litigation. There is no suggestion that appellate court judges are somehow smarter and thus capable of reaching a better result. Their role is not to write better judgments but to review the reasons in light of the arguments of the parties and the relevant evidence, and then to uphold the decision unless a palpable error leading to a wrong result has been made by the trial judge.
>
> [5] What is palpable error? The *New Oxford Dictionary of English* (1998) defines "palpable" as "clear to the mind or plain to see" (p. 1337). The *Cambridge International Dictionary of English* (1996) describes it as "so obvious that it can easily be seen or known" (p. 1020). The *Random House Dictionary of the English Language* (2nd ed. 1987) defines it as "readily or plainly seen" (p. 1399).

…..

A. *Standard of Review for Questions of Law*

[8] On a pure question of law, the basic rule with respect to the review of a trial judge's findings is that an appellate court is free to replace the opinion of the trial judge with its own. Thus the standard of review on a question of law is that of correctness....

…..

B. *Standard of Review for Findings of Fact*

[10] The standard of review for findings of fact is that such findings are not to be reversed unless it can be established that the trial judge made a "palpable and overriding error": *Stein v. The Ship "Kathy K"*, [1976] 2 S.C.R. 802, at p. 808; *Ingles v. Tutkaluk Construction Ltd.*, [2000] 1 S.C.R. 298, 2000 SCC 12, at para. 42; *Ryan v. Victoria (City)*, [1999] 1 S.C.R. 201, at para. 57. …[1]

…..

C. *Standard of Review for Inferences of Fact*

…..

[25] … We conclude, therefore, by emphasizing that there is one, and only one, standard of review applicable to all factual conclusions made by the trial judge – that of palpable and overriding error.

D. *Standard of Review for Questions of Mixed Fact and Law*

…..

[36] … a finding of negligence by a trial judge involves applying a legal standard to a set of facts, and thus is a question of mixed fact and law. Matters of mixed fact and law lie along a spectrum. Where, for instance, an error with respect to a finding of negligence can be attributed to the application of an incorrect standard, a failure to consider a required element of a legal test, or similar error in principle, such an error can be characterized as an error of law, subject to a standard of correctness. … Where the legal principle is not readily extricable, then the matter is one of "mixed law and fact" and is subject to a more stringent standard. The general rule, as stated in *Jaegli Enterprises*, [[1981] 2 S.C.R. 2], is that, where the

[1] Lamer C.J.C. wrote in **R. v. Van der Peet**, [1996] 2 S.C.R. 507, at para. 81, "… I would also note that the principle of appellate court deference has been held to apply equally to findings of fact made on the basis of the trial judge's assessment of the credibility of the testimony of expert witnesses, *N.V. Bocimar S.A. v. Century Insurance Co. of Canada*, [1987] 1 S.C.R. 1247, at pp. 1249-50."

2007 NLCA 2 (CanLII)

> issue on appeal involves the trial judge's interpretation of the evidence as a whole, it should not be overturned absent palpable and overriding error.
>
> [37] … In our view, it is settled law that the determination of whether or not the standard of care was met by the defendant involves the application of a legal standard to a set of facts, a question of mixed fact and law. This question is subject to a standard of palpable and overriding error unless it is clear that the trial judge made some extricable error in principle with respect to the characterization of the standard or its application, in which case the error may amount to an error of law.
>
> [Emphasis added.]

2007 NLCA 2 (CanLII)

[13] Thus, where as in the present case the overriding issue is that of (medical) negligence, the applicable standard of care is a question of law and whether that standard has been met is a question of fact: see also **St-Jean v. Mercier,** [2002] 1 S.C.R. 491, at paras. 48-49; **Ingles v. Tutkaluk Construction Ltd.**, [2000] 1 S.C.R. 298, at para. 42.

[14] A "palpable error" is as defined in para. 5 of **Housen** (above). An overriding error is one that "is sufficiently significant to vitiate the challenged finding of fact. … The appellant must demonstrate that the error goes to the root of the challenged finding of fact such that the fact cannot safely stand in the face of that error….": **Waxman v. Waxman** (2004), 186 O.A.C. 201, at para. 297. In **H.L. v. Canada** (**Attorney General)**, [2005] 1 S.C.R. 401, at para. 110, Fish J., for the majority, described the functional equivalence of palpable and overriding error as including "clearly wrong", "unreasonable" and "not reasonably supported by the evidence".

Analysis

- ***whether the trial judge erred in finding that Ms. Ross lied to her physicians about her family medical history***

[15] The trial judge never used the word "lied". The appellants contend, nevertheless, that the findings of the trial judge, such as, Ms. Ross "deliberately hid from [Dr.] Hiscock her family history of Marfan's and that her father and brother died prematurely of heart disease", were tantamount to saying that she had. "Lied" implies a deceit for personal advantage. There was no advantage to Ms. Ross to "hide" her family history and certainly no illicit intent on her part. The fact remains, however, there was ample evidence to show that Ms. Ross was reluctant to disclose or discuss the history of Marfan's in her family and the premature deaths of her father

and brother. Cogent testimony in that regard was heard from a number of witnesses, including Doris Rogers, a nurse and aunt of Ms. Ross who was also particularly concerned for her health, Dr. Heidi Kravitz, a St. John's obstetrician and gynecologist, and Dr. Steven Furlong, Ms. Ross' family doctor at the time.

[16] Ms. Rogers testified that, because of the possibility of Marfan's, she became very worried about Ms. Ross after learning that she was pregnant with her second child in mid 1993. Ms. Ross' brother had died of an aortic rupture the previous January. Ms. Rogers persuaded Ms. Ross to come to St. John's to see Dr. Kravitz. Ms. Rogers said she was afraid to tell Ms. Ross the real reason she was encouraging the visit because she felt that if Ms. Ross did know the real reason she would not make the appointment. Ms. Ross was under the impression that that consultation with Dr. Kravitz was solely about her pregnancy.

[17] The trial judge, at paras. 43-45, related what happened at Dr. Kravitz's office:

> [Dr. Kravitz] prepared a prenatal record because Ross was a new patient. The record included a family medical history section. For whatever reason, Ross refused to tell Kravitz about the premature deaths of her father and brother. Kravitz only became aware of that fact when Rogers told her about it after she was finished examining Ross.
>
> Kravitz immediately asked Ross to come back into her office and confronted her with the omission to tell her about the premature deaths of her father and brother. She recognized the risks associated with pregnancy and Marfans and she urged Ross to undergo "tests" to determine whether she had Marfans. In a letter to [Dr.] Chalker [at the Notre Dame Bay Memorial Hospital, Twillingate] she stressed that:
>
> > "I had a long discussion with Lynia about the family history and encouraged her to see a cardiologist. In addition, I thought she may want to see the genetic counsellors and I offered to set up these appointments. I had written out a slip for PC50, CBC and a coombs test which she forgot to take so I enclose it in this letter to you. I left the decision to come back to me up to her as she wasn't convinced that she wanted to stay in St. John's and I'm also waiting to hear from her as to whether or not she will see the genetic counsellors and the cardiologist. I'm more than pleased to make these arrangements. If you have any questions or concerns, do not hesitate to contact me."

2007 NLCA 2 (CanLII)

> Ross was quite upset that the topic of Marfans was discussed with Kravitz. She told Rogers that she would not see Kravitz again and would not make an appointment with a cardiologist or take any "tests" to determine whether she had Marfans.

[18] I refer to Ms. Roger's testimony, firstly, on direct examination and, then, on cross-examination:

> Ms. Rogers: I took Lynia for the appointment, yes. I went with her. When Lynia went in the examining room with Dr. Kravitz, I sat in Dr. Kravitz' office just outside the examining room.
>
> …..
>
> Ms. Rogers: She went in with Lyn for an examination, did her examination and came out and sat at her office. I felt that whether or not Lyn had discussed her family's, her father's death and her brother's death, I felt that it was something that should have been in the record, so I very, very quickly told Dr. Kravitz that her brother and her father were both dead from aneurysms. And she had been sitting up at her desk and when I mentioned it, she just sat back and looked really surprised. And when Lyn came out like very, very shortly after, she went through some things, and she said to me, she's going to need consults. Well she said to Lyn as well actually, we were both there. You're going to need like this, this and this, and the one thing I remember is a cardiology consult, and I remember that because she looked at me, she said you can make this happen. So I could have, I knew the cardiologists at the time, I could have gotten the cardiology referral here.
>
> (Trans., September 21, 2005, p. 7)
>
> Mr. Browne: Okay. And, I think you have confirmed this in evidence somewhat this morning, she also knew sort of a mechanism of how both her father and brother died in that the main artery in her heart, or their heart, they died from a problem with a rupture with the main artery of their heart, is that correct?
>
> Ms. Rogers: That's correct.
>
> Mr. Browne: Can I suggest as well that she also probably knew that her brother had a, sorry, her brother had a rupture and her father a dissection?
>
> Ms. Rogers: I'd never heard Lyn mention the word dissection or rupture. Lynia would refer to them as aneurysms to me.
>
> …..

2007 NLCA 2 (CanLII)

Mr. Browne: Can you look at lines 63 to 73 [of discovery transcript]? Sorry, in particular, I'm looking at the answer at lines 68 through 73, and I'm going to read that into the record. "She would have understood that her dad and her brother died from the major vessel leading to the heart being a problem, in her brother's case a rupture and with her dad's case a dissection was the actual event, but she was certainly aware of the need, on her second pregnancy, for the need for follow-up." Do you agree?

Ms. Rogers: Yes. That need would have come on her second pregnancy, that need would have come from me with urging and prompting to get the follow-up.

…..

Mr. Browne: Line 65 [of discovery transcript].

The Court: All right.

Mr. Browne: It says, Ms. Rogers said "I feel she may not have fallen for the consult if it had been for her health reasons", and I'm suggesting those health reasons as being because of Marfan's?

Ms. Rogers: Relating to genetics, yes. She had no health problems at the time.

Mr. Browne: Right, right. So if you had told her what I think is your answer here?

Ms. Rogers: Yes.

Mr. Browne: If you had told her, I want you to go in there because I'm concerned about you being pregnant and Marfan's, she wouldn't have gone for that, that's what I take from your answer there. She wouldn't have fallen for that?

Ms. Rogers: That's my answer, and it still would be my answer, but it might be an assumption on my behalf. She may well have gone for the consult had I discussed it with her. I have no way of knowing.

…..

Mr. Browne: You went to Dr. Kravitz and said did you get a history about her Marfan's?

Ms. Rogers: I was sitting on one side of Dr. Kravitz' desk and when she sat down I very quickly asked her if Lyn had discussed with her the early deaths of her father and brother.

Mr. Browne: And you didn't want to do that in front of Lynia, did you?

2007 NLCA 2 (CanLII)

Ms. Rogers: No.

Mr. Browne: And Dr. Kravitz' reaction was obvious to you, wasn't it? It was obvious she never got that history?

Ms. Rogers: I felt that she was surprised over something.

…..

Mr. Browne: [Ms. Ross] was also probably upset by the fact that you had disclosed her family history to Kravitz when she hadn't, and that's why she made that comment to you in the car?

Ms. Rogers: She didn't hold that against me as far as I could tell. She was there, she was pleasant enough.

Mr. Browne: She told you not to bother her anymore on this, didn't she?

Ms. Rogers: Yes, she did.

(Trans., September 21, 2005, pp. 13, 14, 15 and 17)

[19] Concerning Dr. Furlong, the trial judge wrote, at paras. 47-50:

Dr. Stephen Furlong began his professional career at the New World Island Clinic on May 11, 1994. He was Ross' family doctor and he prepared a "patient profile" of her on November 11, 1994. It was at that time he discovered that her father and brother had died prematurely of heart disease. He concluded that there was a family history of Marfans. He researched the condition and discussed it with Ross. It appeared to him that she was quite knowledgeable about Marfans and she knew that it caused the deaths of her father and brother. She also knew that there was a fifty percent chance that she had Marfans.

Ross was convinced that Marfans would eventually "kill" her. However, Furlong explained to her that (with recent advances in medicine) Marfans could be either treated by medication or by surgical intervention. He assured her that she would be able to live a normal lifetime. Furlong wanted to refer her to a cardiologist and urged her to undergo an echocardiogram which would either "rule in or rule out" Marfans.

His testimony in relation to his discussions with Ross about Marfans was as follows:

"Question: "Can you elaborate on those discussions, if you have any recollections about them?

2007 NLCA 2 (CanLII)

Answer: I can. When this form was filled out and we spoke about this positive family history that she had of Marfan's Syndrome, and then clearly summarized that Dr. Sheldon had done these investigations where there was no physical or physiological evidence on physical examination followed by a normal chest x-ray, normal ECG and normal abdominal ultrasound. Lynia and I had a discussion where I told her that the information in these tests was, although it was good information to have these normal tests, it did not rule out that she had Marfan's Syndrome, or that she could possibly have an aortic dilation or aortic aneurism.

Question: And did you suggest, make any suggestions to her with regard to that opinion of yours?

Answer: I told her that as far as I knew from my sources that an echo-cardiogram would be the investigation of choice, that the tests that she had done did not look at her heart or her heart valves, or her aortic route or the aorta that was in her chest. She had only had the one in her abdomen looked at, and that a better test would be an echo-cardiogram followed by or in addition to a referral to a cardiologist.

Question: And do you recall what, if any, response Ms. Ross had to your suggestion?

Answer: In the first one or two conversations that we had regarding this possible Marfan's Syndrome, and the possibility that she may have it, I think it became clear that she knew as much information about Marfan's Syndrome as I did, and her impression of it was that if she had Marfan's Syndrome and if she were to develop an aneurism in her chest of her aortic route, that it was a hopeless case and that she was going to die. This statement that I have here was made one day, this one I remembered very clearly.

Question: Which one are you referring to?

Answer: Doesn't want to know if she's going to die. This was made one day after we had been having a conversation about Marfan's Syndrome, and I think she got quite frustrated within the context of the conversation and got up and as she was leaving the room with her hand on the door, which is what in medical school we were taught is a door knobber, so why would you want to know if you are going to die and then left the clinic. So I believe that if she were to have it investigated and found out that she did have Marfan's Syndrome or was going to develop an aneurism that regardless of what medicine had to offer her, she felt that she was

2007 NLCA 2 (CanLII)

> going to die, and that she could have the same death as her brother and her father in her thirties."

Furlong testified that Ross felt "hopeless" and didn't want to know if she had Marfans. She refused the referral to a cardiologist and the echocardiogram. Furlong felt that Ross had a "somewhat nonchalant approach" to her health problems. At one point she told him that she "hates doctors". In that regard he testified as follows:

> "In this case it definitely wasn't intended personally against me or any other physicians. It was just no boy, I hate doctors, that kind of thing. And a symptom minimizer, what I mean is that Lynia would be quite sick before she would come to the clinic. She wasn't the type to just present for any simple cough or a cold, that if she showed up that something was significant and needed to be done. So she minimized her symptoms until the last minute when medical help was definitely necessary."

[20] The evidence of Edgar Browne, Ms. Ross' husband, is also significant. The first excerpt, from direct examination, shows Ms. Ross' thinking concerning the possibility of her having Marfan's right up to the day of her admission to the Gander Hospital on August 30, 1996:

> Crosbie, QC: Let me back up a little bit. Did you have any conversations with Lynia in the car about the pain she was having?
>
> Edgar Browne: Yes, I did. I asked her was it anything to do with her father's and her brother's death, was it you know, in some way connected. And she told me it wasn't because she was checked out and she was healthy so far as the doctors know, or you know what she told me she was healthy, the doctors told her she was healthy, and she was healthy, you know, she was a healthy woman.
>
> Crosbie, QC: What was, you mentioned the doctors, what was her attitude towards doctors?
>
> Edgar Browne: Well I can't say she hated doctors because she used to have trouble with her asthma. When she used to have trouble with her asthma, we used to go on down, sometimes it was like 2:30 in the morning, we'd go down and get the mask put on, so you know, like she didn't hate them, no.
>
> Crosbie, QC: Anything else said in the car on the way to the hospital about medical issues?
>
> Edgar Browne: I asked her was it the same thing and she said no, she said that she had a clean bill of health. She said the doctors said she didn't have no hint of Marfan's syndrome.

2007 NLCA 2 (CanLII)

Crosbie, QC: Is that word something that she might use or you use?

Edgar Browne: She would have used that, yes.

Crosbie, QC: Did she use that in the car?

Edgar Browne: Yes, and I did too. And we was trying to keep it hush because Shannon was in the back and we didn't want to worry her, it was worry enough for her, you know taking her mother to Gander right.

(Trans., September 21, 2005, pp. 6-7)

[21] Ms. Ross' apparent openness to discuss Marfan's with her husband on the day before seeing Dr. Hiscock is somewhat at odds with Edgar Browne's evidence on cross-examination, which appears more to confirm her general reluctance to disclose:

Mr. Browne: Okay, speaking of tests, Mr. Crosbie just mentioned the word test, you're aware that in 1993, December 1993, Lynia went into St. John's to see an obstetrician, we've heard about Dr. Kravitz?

Edgar Browne: Yes.

Mr. Browne: Okay. Did Lynia tell you that Dr. Kravitz recommended that she have an echocardiogram?

Edgar Browne: I can't remember.

Mr. Browne: Did Lynia tell you that Dr. Kravitz recommended to her that she see a cardiologist?

Edgar Browne: I don't remember.

Mr. Browne: Did Lynia tell you that Dr. Kravitz suggested to her that both she and your daughters have genetic counseling?

Edgar Browne: I don't remember.

Mr. Browne: Do you have any recollection for some time, I think probably about, the evidence will be from about I think May or June or perhaps a little bit later in 1994 up to the time of Lynia's passing, Dr. Stephen Furlong was her general practitioner, and as a matter of fact you on August 30th took your wife to see him, correct?

Edgar Browne: Yes.

2007 NLCA 2 (CanLII)

> Mr. Browne: Do you recall any time your wife was seeing Dr. Furlong whether she told you that he recommended she have an echocardiogram to check out whether or not she had Marfan's?
>
> Edgar Browne: I don't know.
>
> (Trans., September 21, 2005, pp. 19-20)

2007 NLCA 2 (CanLII)

[22] The evidence which the trial judge accepted was that on admission to the Gander Hospital on August 30, 1996 Ms. Ross did not disclose to Margaret Proudfoot (now Slade), the admitting nurse, to Dr. Eileen St. Croix, the casualty officer in the Emergency Department, or to Dr. Thair Yousif, the physician on call for obstetrics (all three of whom testified), the possibility of Marfan's or the early deaths of her father and brother. Dr. Hiscock's attempt to get Ms. Ross' family history and the method of doing it was detailed by the trial judge in para. 62 of his reasons, referred to above at para. 7. Dr. Hiscock's method of taking a family history will be the subject of later consideration, but on the present issue I am satisfied that the evidence supports the trial judge's finding that Ms. Ross did not advise Dr. Hiscock of the presence of Marfan's in her family or that her father and brother had died young. That Ms. Ross may have given that information to other physicians on other occasions, e.g., to Dr. Georgina Chalker at the Notre Dame Bay Memorial Hospital in Twillingate in 1993 or to Dr. Elizabeth Cole in Gander in 1996, was, in the final analysis, not critical. What was critical was the credibility of Dr. Hiscock, whose evidence was accepted. The trial judge's assessment was made having regard to Dr. Hiscock's testimony as a whole and in light of how Ms. Ross had dealt with Marfan's and other related family history on the occasions referred to.

[23] In summary, I am satisfied that the trial judge made no palpable and overriding error in concluding as he did.

- ***whether the trial judge erred in admitting the expert medical testimony objected to by the appellants***

[24] The appellants contend that the trial judge erred in law in admitting testimony from Dr. George Christakis on matters beyond the area of his surgeon's expertise, namely, on the diagnostic method for a medical (not surgical) specialist and on the method of family history taking for a medical specialist. Dr. Christakis had been qualified as an expert in cardiovascular surgery and epidemiology. The appellants refer with emphasis to the

comments of the British Columbia Court of Appeal in **Hoskin v. Han** (2003), 12 B.C.L.R. (4th) 21, at paras. 69, 70 and 79:

> The melding of admissibility and weight is too easily undertaken. They are distinct issues. In *R. v. Marquard* (1993), 85 C.C.C. (3d) 193 (S.C.C.), opinion evidence that went beyond the qualifications of the medical witnesses was admitted. The trial judge nevertheless invited the jury to place weight on the opinions. McLachlin J., for the majority, said that once the evidence is before the jury the trial judge must instruct the jury that the "evidence must be disregarded." It is not a matter of weight.
>
> The following was said by Binnie J. for the Court in *R. v. J.-L.J.*, [2000] 2 S.C.R. 600 at 613:
>
> > In the course of *Mohan* and other judgments, the Court has emphasized that the trial judge should take seriously the role of "gatekeeper". The admissibility of the expert evidence should be scrutinized at the time it is proffered and not allowed too easy an entry on the basis that all of the frailties could go at the end of the day to weight rather than admissibility.
> >
> > …..
> >
> > In *R. v. Mohan*, [1994] 2 S.C.R. 9, the judgment of the Court was delivered by Sopinka J. who said that the first criteria when considering the admission of expert evidence is relevance, followed by necessity in assisting the trier of fact, the absence of any exclusionary rule and a properly qualified expert.

[25] The appellants argue that while the "impugned" evidence of Dr. Christakis may have been relevant, he was not qualified to give it and it was not necessary to assist the trier of fact.

[26] Dr. Christakis is a physician of considerable expertise and experience, licenced to practice medicine in Ontario. He has been certified by the Royal College of Physicians and Surgeons of Canada as a specialist in General Surgery, Cardiac Surgery, Vascular Surgery and Thoracic Surgery, is a full professor of surgery at the University of Toronto and was on the staff at Sunnybrook and Womens' College Health Sciences Centre[2]. He has been practicing cardiovascular surgery since 1990. Dr. Christakis gave evidence that teaching takes up about fifteen percent of his time.

[2] As of April 1, 2006 these are two separate institutions namely, Sunnybrook Health Sciences Centre and The New Womens' College Hospital.

2007 NLCA 2 (CanLII)

[27] An argument similar to the one here was made before this Court, and rejected, in **Briffitt v. Gander and District Hospital Board et al.,** (1996), 137 Nfld. & P.E.I.R. 271, at paras. 47-48:

> Counsel=s objection to the use of the cardiologists= evidence to establish the average standard against which the appellant doctors= conduct was measured is that, not being in general practice, these specialists were not in a position to offer expert testimony as to the relevant norm. In relying on their testimony, he argues, the court was subscribing to a higher standard than what should have been properly prescribed for a general practitioner.
>
> However, this contention is untenable. Both specialists, having been trained as general practitioners before acquiring their specialty, and being members of the faculty teaching student doctors, could be considered well versed in what should be expected from average general practitioners in the proper care of patients with potential heart problems in hospital emergency units in l987. There is no reason why Drs. Stone and MacCallum should be regarded as other than qualified to voice opinions on what should have been the level of skill, knowledge and judgment expected from average casualty officers in the position of Drs. Johnson and Cooper in diagnosing and treating patients with signs of coronary problems, such as Mr. Briffett presented. The trial judge was not, therefore, in error in receiving these cardiologists= evidence as to the appropriate standard of care. [Emphasis added.]

[28] The appellants' contention is likewise untenable. The taking of a family history and the approach to making a differential diagnosis are general skills which are applied across all levels of medicine. Dr. Christakis' basis for providing evidence on these questions was based on his medical training, his experience and as a teacher of medical students.

[29] Furthermore, regard must be given to rule 46.07 of the **Rules of the Supreme Court, 1986**, which states:

> **Expert witness; evidence of and report**
>
> **46.07**. Unless an opposite party has, at least ten days before the commencement of a trial, been given a report of an expert witness who is expected to give evidence on a trial, the evidence shall not be admissible without the approval of the Court, which may be granted on such terms as are just. [Emphasis added.]

[30] In other words, the trial judge's ruling to admit Dr. Hiscock's evidence was within his discretion to make. This Court has held that a discretionary ruling should not be interfered with unless the discretion is "exercised beyond jurisdiction, contrary to principle, or on the basis of

2007 NLCA 2 (CanLII)

palpable error in appreciation of facts, or would cause a manifest injustice": **Langor v. Spurrell** (1997), 157 Nfld. & P.E.I.R. 301, at para. 34. I see no breach here of any of these strictures.

[31] The appellants likewise contend that the trial judge erred in admitting the evidence of Dr. O'Reilly on the standard of care in taking a family history and, in particular, that he had not dealt with it in his written report.

[32] Having now reread Dr. O'Reilly's report, I agree with Dr. Hiscock's counsel that contained within its overall review of Dr. Hiscock's management of Ms. Ross is an implicit approval of his questioning technique: see again para. 62 of the trial judge's reasons at para. 7 above. I emphasize once more the discretion given to the trial judge by rule 46.07 and would also note that, following his ruling to allow the evidence of Dr. O'Reilly, the trial judge offered appellants' counsel additional time to prepare for cross-examination, which offer was declined.

[33] This ground of appeal fails.

- ***whether the trial judge erred in determining the correct legal issues, in weighing the credibility of the expert evidence and in failing to appropriately resolve conflicting evidence regarding the standard of care***

[34] The trial judge stated at para. 11 that:

> The issue in this case is whether Hiscock breached his duty of care in the treatment of Ross in either tort or contract.

[35] The appellants argue from this that the trial judge wrongly conflated the concepts of duty of care and standard of care. A review of the trial judge's decision, however, and notwithstanding the wording of para. 11, clearly demonstrates that his sole preoccupation and consideration throughout was the standard of care. Dr. Hiscock's duty of care was never in issue. What was in issue was whether or not he had met the appropriate standard of care in dealing with Ms. Ross on August 31, 1996.

[36] The appellants contend that Dr. Hiscock failed to meet the appropriate standard of care in three separate ways, namely:

(1) he failed to obtain the family history of Marfan's;

2007 NLCA 2 (CanLII)

(2) he failed to include aortic dissection in the "differential diagnosis", having concluded that Ms. Ross was suffering from pericarditis; and

(3) he failed to take into account Ms. Ross' pregnancy.

(Counsel for both the appellants and Dr. Hiscock referred to the description of differential diagnosis given by Harris J. in **Adair Estate v. Hamilton Health Sciences Corp.**, [2005] W.D.F.L. 3358 (Ont. S.C.J.), at para. 116:

> The diagnoses made by the defendants were substandard. Differential diagnoses is the system of determining which of two or more diseases with similar symptoms is the one that a patient is suffering from, through a systematic comparison and contrast of the clinical findings. All experts at trial agreed that this is the proper method of arriving at a diagnosis, leading to the conclusion that it is a universally accepted rule of medicine. Dr. Goldberg expanded on this definition by explaining that after the physician has identified the likely perils, these possible perils must be listed from the most serious to the least serious. The physician eliminates the peril that has the most severe consequences first. He summed this idea up in his expert testimony by asserting the simple maxim "*worst first*".)

[37] The trial judge began his analysis under the subheading "Duty (Standard) of Care". He commenced by stating the appropriate legal test, at para. 73:

> The duty or standard of care of a physician in relation to a patient is based on the conduct of a reasonable practitioner in all the circumstances of the case. Major J. of the Supreme Court of Canada defined the standard of care in **Ryan v. Victoria City et al.,** [1997] 1 S.C.R. 201 … at para. 28 as follows:
>
> > "Conduct is negligent if it creates an objectively unreasonable risk of harm. To avoid liability, a person must exercise the standard of care that would be expected of an ordinary, reasonable and prudent person in the same circumstances. The measure of what is reasonable depends on the facts of each case, including the likelihood of a known or foreseeable harm, the gravity of that harm, and the burden or cost which would be incurred to prevent the injury. In addition, one may look to external indicators of reasonable conduct, such as custom, industry practice, and statutory or regulatory standards."

He then continued, at paras. 74 and 75:

2007 NLCA 2 (CanLII)

> The standard of care of a physician was also described by Schroder J.A. of the Ontario Court of Appeal in **Crits** v. **Sylvester**, [1956] 1 D.L.R. (2d) 502; [1956] O.R. 132 (C.A.) as follows:
>
> > "The legal principles involved are plain enough but it is not always easy to apply them to particular circumstances. Every medical practitioner must bring to his task a reasonable degree of skill and knowledge and must exercise a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal, prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability."
>
> In determining whether the standard of care has been met, the Court must consider a physician's education, experience and qualifications. In addition, such factors as the risk of the treatment, the resources available and the knowledge and conduct of the physician must be also considered (see **McCormick** v. **Marcotte**, [1972] S.C.R. 18, at para. 5).

[38] The trial judge then reviewed the evidence. Expert evidence regarding the standard of care had been given by Dr. Donald S. Beanlands, M.D., F.R.C.P.C., of the University of Ottawa Heart Institute, and Dr. Kevin Melvin, M.D., F.A.C.S., F.R.C.S.C., a cardiovascular surgeon practicing in St. John's, on behalf of the appellants, and by Dr. Michael O'Reilly, M.D., F.R.C.P.C., F.A.C.C., a cardiologist practicing in Kentville, Nova Scotia, and Dr. George Christakis, M.D., F.R.C.S.C., referred to above, on behalf of Dr. Hiscock.

[39] The trial judge, after considering the evidence, concluded on the question of family history taking, at paras. 95 and 96:

> In determining the standard of care in obtaining a family history from a patient I have the evidence of Beanlands who stated that the questioning should be very specific in nature. On the other hand, there is the evidence of O'Reilly and Christakis that more information will be elicited from the patient if the questions are general in nature which would be followed by specific questions where there is a positive response by the patient.
>
> Having considered the circumstances of this case, I find that I agree with O'Reilly and Christakis that the textbook used at Memorial University [relied upon by Dr. Beanlands] was merely a guide for medical students who were about to enter the medical profession. I find that the standard of care which Hiscock was required to adhere to in questioning Ross was the method described by O'Reilly and Christakis. In other words, Hiscock was correct in asking Ross general questions about her family history. It was not necessary for him to

2007 NLCA 2 (CanLII)

> "cross-examine" her or challenge her when there was no positive reply to his general questions about a history of heart disease in her family.

[40] Dr. Melvin gave no opinion as to the appropriate standard of care. The trial judge noted this earlier in his judgment, at para. 88:

> Melvin testified that he was not a "peer" of Hiscock and therefore could offer no opinion as to Hiscock's standard of care in relation to Ross. He explained that his medical practice involved surgery while Hiscock's practice involved the diagnosis of diseases.

[41] Dr. Beanlands agreed with Drs. O'Reilly and Christakis that Dr. Hiscock was correct in his diagnosis of pericarditis. The trial judge accepted the evidence of Dr. O'Reilly that without knowing there was a history of Marfan's, Dr. Hiscock's treatment of Ms. Ross' complaint was reasonable and competent. Both Dr. O'Reilly and Dr. Christakis supported Dr. Hiscock's decision to exclude aortic dissection from the differential diagnosis and the trial judge accepted the reasoning therefor. Dr. Beanlands was of a different view, predicated, however, on Dr. Hiscock's being aware of the family history of Marfan's. Dr. Beanlands wrote in a report dated February 2, 1999:

> The possibility of dissection causing the pericarditis should have been suspected because of 1.) the family history of Marfan's syndrome, and 2.) the fact that aortic dissections are more common during pregnancy. It is clear from the records that this diagnosis was not entertained at that time.

[42] Dr. Beanlands also predicated a prior knowledge of Marfan's in his testimony:

> Q. Let me ask it to you this way, should dissection have been within the differential?
>
> A. In this particular case, yes, because of the family history of Marfan's Syndrome.
>
> (Trans., Oct. 4, 2005, p. 6)
>
> Q. What's the incidence of errant dissection (*phonetic*) as a cause of pericarditis? One percent?
>
> A. Well, I can't answer that. All I can say is it does occur and it should always be considered in a particular setting. If you know there's a history of Marfan's, and you have pericarditis, you better be ruling that out.

2007 NLCA 2 (CanLII)

> Q. Absolutely, absolutely, so Doctor, not to get ahead of myself, but to summarise your evidence today, is it that assumes that if we get the history…if we've got pericarditis and we get a history of Marfan's, that one should think dissection, is that the essence of what you're saying?
>
> A. That's absolutely correct, because that's a lethal condition.
>
> [Emphasis added.]
>
> (Trans., Oct. 4, 2005, p. 28)

2007 NLCA 2 (CanLII)

[43] On the question of pregnancy as a relevant factor, which the trial judge did not consider but which the appellants say he should have, Dr. O'Reilly's evidence was that pregnancy would increase the risk of aortic dissection in people who are predisposed to aortic disease. He further testified that whether pregnancy itself predisposed a person to aortic disease was a subject of debate and not something he would expect Dr. Hiscock to be familiar with. Dr. O'Reilly was not asked to elucidate.

[44] Dr. Beanlands' report of February 2, 1999 appears to link the greater likelihood of aortic dissection during pregnancy to the family history of Marfan's. What for Dr. Beanlands was crucial to the diagnosis and consideration of aortic dissection was knowledge of Ms. Ross' family history; the additional factors of pericarditis and pregnancy were to be considered in that light.

[45] A review of the trial record shows that at no point was Dr. Beanlands or Dr. Melvin asked whether Dr. Hiscock ought to have considered aortic dissection as part of the differential diagnosis in the absence of the family history of Marfan's.

[46] The principle of appellate court deference to findings of fact based on the trial judge's assessment of credibility of the testimony of expert witnesses was referenced above at para. 12. I would also stress the following statement of L'Heureux Dubé J. in **Lapointe v. Hôpital Le Gardeur,** [1992] 1 S.C.R. 351, at pp. 358-9:

> The privileged position of the trier of fact extends not only to the testimony of ordinary witnesses, but of expert witnesses. In this respect, Spence J. wrote in *Joseph Brant Memorial Hospital v. Koziol*, [1978] 1 S.C.R. 491, at p. 504:

> I am strongly of the view that it is not the function of an appellate court to reconsider that evidence whether it be upon facts or a matter of professional opinion and come to a different conclusion, unless it could be shown that the evidence reasonably could not result in justifying the conclusion made by the trial judge. [Emphasis added in original.]

[47] In the present case, the trial judge dealt in considerable detail with the sometimes conflicting evidence on the critical questions of family history taking and differential diagnosis. The evidence of Drs. O'Reilly and Christakis supporting Dr. Hiscock's method of taking a family history was accepted by the trial judge. The trial judge also preferred the evidence of Drs. O'Reilly and Christakis on Dr. Hiscock's differential diagnosis, although as noted above, the dichotomy between their views and that of Dr. Beanlands is minimal when Dr. Beanlands' assumption of prior knowledge of Marfan's is discounted.

[48] In summary, the trial judge's conclusions were well supported by the expert medical evidence presented and accepted.

Conclusion and Disposition

[49] There is no merit to the various grounds of appeal raised by the appellants. Their appeal, therefore, is dismissed, with party and party costs for one counsel in this Court. There is no basis for varying the award of costs in the court below.

_____

D.M. Roberts, J.A.

I concur: _____

B.G. Welsh, J.A.

2007 NLCA 2 (CanLII)

I concur: _____

K.J. Mercer, J.A.

2007 NLCA 2 (CanLII)