

CANADA / JUDGMENT

Buckingham v. Hobza

2023 BCSC 399

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2023 BCSC 399 Buckingham v. Hobza

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Buckingham v. Hobza,

2023 BCSC 399

Date: 20230316

Docket: S178935

Registry: Vancouver

Between:

Eric Peter Brooks Buckingham

Plaintiff

And

Dr. Petr Hobza, Dr. Genevieve Law and Loblaws Inc.

Defendants

Before: The Honourable Justice Schultes

Reasons for Judgment

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Counsel for Defendants:

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A.J. Lepp

Place and Date of Trial:

Vancouver, B.C.

November 15-19, 22-24, 2021

Place and Date of Judgment:

Vancouver, B.C.

March 16, 2023

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Introduction

- [1] In this medical negligence case, the plaintiff Mr. Buckingham seeks findings of liability against the defendants Dr. Hobza, his former family doctor, and Dr. Law, a rheumatologist to whom he was referred, arising from the manner in which they prescribed the steroid prednisone to him in 2015, for an inflammatory condition called dermatomyositis.
- [2] Mr. Buckingham alleges that he developed glaucoma due to elevated intraocular pressure (pressure within the eye), a known potential side effect of prednisone, which has seriously damaged his vision.
- [3] It is alleged that these doctors failed to obtain informed consent from Mr. Buckingham before prescribing the medication to him; and that they failed to meet the standard of care in monitoring his condition after he began taking it.
- [4] In addition to maintaining that they appropriately communicated the risks of taking prednisone to Mr. Buckingham, and met the appropriate standard of care in their treatment of him, the defendants dispute that he has glaucoma, or that the prednisone otherwise contributed to his visual problems. Instead, they suggest that these problems were likely caused by a relatively rare toxic effect of another drug - methotrexate - that he was given to help him wean off of the prednisone.
- [5] In the event that liability is found, only Mr. Buckingham's non-pecuniary damages are in dispute.

- [6] The action has been discontinued against Loblaws, which operated the pharmacy where some of the medication in question was dispensed.

Overview

Focus of the Evidence

- [7] Understandably given his situation, Mr. Buckingham had difficulty at times providing a clear chronology of his interactions with the defendants and his other medical care providers. In addition, his recollection of those interactions was sometimes at odds with the entries in their records, or with his answers during examination for discovery. This included differences on such issues as the progress of his dermatomyositis symptoms, the respective effects of prednisone and methotrexate in reducing those symptoms, and his level of compliance with the medical advice that he received.
- [8] The defendants' counsel thoroughly explored these differences in cross-examination, in support of a general submission that Mr. Buckingham's testimony was not reliable.
- [9] However, as I will explain, the breaches of the duty to provide informed consent and the standard of care that Mr. Buckingham's counsel actually alleges are very focused, and depend only on the absence of warnings and monitoring in that the defendants concede they did not provide. Mr. Buckingham's case on causation similarly depends on inferences being drawn from undisputed facts. As a result, his version of events on the disputed points was not put forward by his counsel as the basis for the defendants' liability.
- [10] For their part, the defendants' counsel led evidence to show the diligence of the care provided by the defendants, including the appropriateness of their choice of prednisone to treat his condition, the dosage prescribed, and the period for which Mr. Buckingham was to take it. Once again, none of that turns out to be in issue - Mr. Buckingham's counsel concedes that prednisone was the drug of choice in this situation, and that the defendants' breaches were only with respect to the lack of warning and monitoring of the risk of elevated eye pressures to accompany it.
- [11] What this all means is that the review of the evidence can mainly be confined to undisputed matters, as well as those matters that appear to have been reliably recorded in the medical records. In terms of its subject matter, the review can focus primarily on the absence of the warnings and monitoring in issue, and on the facts that are relevant to causation of Mr. Buckingham's visual problems.

Complaint and Initial Treatment

- [12] Mr. Buckingham was born in 1955 and was 60 years old when he began seeing Dr. Hobza. He and his wife live in Sooke. He worked for many years in the construction industry.

- [13] Before the present issues arose, he had no previous problems with his vision. He does not have a family history of glaucoma. Although its relevance to his risk for developing glaucoma is in dispute, his sisters and his mother all suffered from diabetes.
- [14] In approximately April 2015 he developed an itchy rash on his back, sides, arms and hands, which was accompanied by muscle weakness.
- [15] He did not have a family doctor, so he went to a walk-in clinic several times. The assistance that he received from the doctors there did not solve the problem. This included two doctors at the clinic prescribing prednisone to him for brief periods, on May 4 and 25, 2015, at a dose of 25 mgs per day.
- [16] It emerged from the evidence that prednisone, although very effective in treating conditions such as this one, has a wide variety of side effects. The goal of physicians is therefore to have the patient use it for as short a period as is consistent with the effective treatment of their condition. However, stopping prednisone immediately can also have serious adverse effects, so the patient has to be weaned off of it gradually.
- [17] The walk-in clinic advised Mr. Buckingham that Dr. Hobza was accepting new patients, and he saw Dr. Hobza for the first time on June 16, 2015. Following an examination, Dr. Hobza strongly suspected that Mr. Buckingham had dermatomyositis, and prescribed prednisone to him, at a dose of 50 mgs per day, for 14 days. He also referred Mr. Buckingham to the Urgent Medical Assessment Clinic in Victoria for a consultation with a specialist.
- [18] When Dr. Hobza saw Mr. Buckingham again on June 24, he prescribed prednisone to him, at the same dose, for an additional 14 days. It is common ground that this was the last time he was responsible for prescribing prednisone to Mr. Buckingham, and that once Dr. Law began treating him that responsibility passed to her.
- [19] An internal medicine specialist at the Urgent Medical Assessment Clinic, Dr. Pewarchuk, saw Mr. Buckingham on July 5 and 16. Through further testing he was able to confirm the diagnosis of dermatomyositis. He referred Mr. Buckingham to Dr. Law for ongoing management of his condition.
- [20] Dr. Law saw him for the first time on July 16. Following her examination, she agreed with the diagnosis made by Dr. Pewarchuk and noted "presumed dermatomyositis". She prescribed prednisone at the same dosage for 30 days, and requested that he come back to see her at the conclusion of that period. She anticipated being able to reduce his prednisone dosage in 10 mg increments, once she received the results of the lab tests that she had ordered.
- [21] During Mr. Buckingham's appointment with Dr. Hobza on July 31 they discussed the progress of his treatment for dermatomyositis, although that was not the main purpose of the appointment.

- [22] He saw Dr. Law again on August 22. As previously envisioned, she directed that he reduce his dosage of the prednisone by 10 mgs per month, until he reached 20 mgs.
- [23] She also prescribed 25 mgs of methotrexate, to be taken once per week. In this situation, methotrexate is used as a "steroid-sparing agent", which means that it can be used to reduce the patient's reliance on prednisone.
- [24] She gave Mr. Buckingham a standing lab requisition for methotrexate testing, which is required to monitor some of its potential side effects, and also directed that he take folate (vitamin B-9), which is thought to reduce the chances of it causing nerve damage.
- [25] Dr. Hobza saw him on August 31 and October 14. His ongoing reduction of prednisone in accordance with Dr. Law's direction was discussed with him on both visits. By the October visit he reported that his dosage was 25 mgs per day (Dr. Hobza was unsure how Dr. Law's direction to reduce the dosage by 10 mgs per month had resulted in Mr. Buckingham being on 25 mgs a day at this point).

Onset of Visual Symptoms and Response

- [26] At his November 10 appointment, Mr. Buckingham reported to Dr. Hobza that he was "losing his sight". Specifically, he felt that the vision in both eyes was blurred. He had difficulty reading smaller print, was unable to drive, and had to take time off of work. He also had a blind spot in his right lateral field of vision (that is, on the periphery of his vision, not in the area of central focus). These vision problems had arisen since he began taking the prednisone and methotrexate, he advised. Dr. Hobza's examination of his eyes did not reveal anything abnormal. He recommended that Mr. Buckingham make an appointment with an optometrist for testing.
- [27] In cross-examination Mr. Buckingham accepted the evidence from his examination for discovery that he had begun to notice difficulties with his vision about two weeks before he saw Dr. Hobza about it.
- [28] On November 18, he saw Dr. Gill, an optometrist. She noted the presence of cataracts in both of his eyes and said he would need surgery on at least the right one (cataracts are another recognized side effect of prednisone, but since they were addressed by subsequent surgery they do not form part of Mr. Buckingham's claim).
- [29] More significantly for the present purposes, his interocular pressures were 22 mmHg (millimetres of mercury), which Dr. Gill described as "slightly elevated". According to her exam summary form, "21mm Hg is normal".
- [30] She referred Mr. Buckingham to an ophthalmologist for these cataract and eye pressure issues.

- [31] At some point after this visit, Mr. Buckingham stopped taking prednisone. He told Dr. Law that he did so "by November-December", at which point he was down to a dosage of 10 mgs, because he was afraid that it was worsening his visual problems. In cross-examination he said he was "going to assume" that it was "sometime in the middle of December", but that he did not recall. He told Dr. Lowden, an ophthalmologist whom he saw in January 2016, that he had stopped on January 7 of that year.
- [32] His ophthalmology referral from Dr. Gill had been to Dr. Ritenour, but during pre-testing for that appointment on January 13 his intraocular pressures were so high - 42 mmHg in his right eye and 32 mmHg in his left - that he was taken immediately to see Dr. Lowden, who was available that day.
- [33] After examining Mr. Buckingham, Dr. Lowden's impression, in addition to the presence of cataracts, was "Acute open angle glaucoma - presumed STEROID induced". He prescribed eyedrops to Mr. Buckingham to reduce his intraocular pressure. He thought that "perhaps [Mr. Buckingham's] pressures will start to come down" because he had stopped using prednisone the previous week.
- [34] Dr. Ritenour saw Mr. Buckingham on January 18. His intraocular pressures were now "10/11" (in his right and left eye respectively, I infer). Like Dr. Lowden, Dr. Ritenour proceeded on the basis that Mr. Buckingham had glaucoma.
- [35] Dr. Ritenour preformed cataract surgeries on Mr. Buckingham's eyes - the right eye in February and the left in March. Testing before the surgery showed that he had "significant restrictions and dense visual field loss related to the glaucoma", but tests of his potential visual acuity suggested to Dr. Ritenour that it would still be worth doing the surgery.
- [36] It is worth pointing out that visual acuity refers to a person's ability to see detail, as represented by the well-known measure of 20/20 vision. In contrast, the effect of glaucoma is to create restrictions of the person's visual field and areas in that field, called scotomas, through which nothing, or only a limited amount, can be seen. I infer that the areas of Mr. Buckingham's vision that were not being obstructed by scotomas were what had sufficient potential visual acuity if the cataracts were removed, so it was worth improving those areas by surgery.
- [37] Dr. Ritenour noted that Mr. Buckingham's vision was initially "quite good" after the surgery (in terms of acuity, I infer), although less so by the final post-operative examination.
- [38] Mr. Buckingham's own experience was that the surgery on his right eye only helped briefly, before his vision began to deteriorate, and that the surgery on his left eye did not help at all. In cross-examination he said that his vision started to deteriorate (on the right eye, I infer) about a week after the surgery. At first, he just thought his eye was adjusting to the new lens that had been put in. As he later expressed it in cross-examination, the clearer vision brought about by the cataract surgery revealed that he had another problem, and that his vision was "going bad". I infer that he was describing the gaps in his vision and the decline in

its field.

- [39] After this initial deterioration, his vision has become progressively worse, he said, including a reduction in his peripheral vision.
- [40] Dr. Ritenour later noted, in a letter to Mr. Buckingham's new family doctor, that Mr. Buckingham's subjective experience of poor visual acuity in subsequent tests that the doctor administered was likely due to the impediments caused by the glaucoma.
- [41] In January 2017 Dr. Ritenour referred Mr. Buckingham to Dr. Atkins, a neuro-ophthalmologist. He had appointments with Dr. Atkins on February 20 and April 20.
- [42] It is relevant to explain at this point, in light of the dispute about causation among the expert witnesses in this trial, that there is a small crater-like depression at the head of the optic nerve that is called the "cup". One of the recognized effects of glaucoma (and according to one of the expert witnesses, its hallmark) is to increase the size of this cup, which is described by ophthalmologists as "cupping". It is measured by the patient's "cup to disc ratio", the "disc" being the head of the optic nerve. When he referred Mr. Buckingham to Dr. Atkins, Dr. Ritenour wrote:

[Examination] showed optic nerves that were actually not very impressive for cupping. I was more impressed by the bilateral optic nerve head pallor. This of course raises the issue whether there is an underlying optic nerve neuropathy [a disease or malfunction of the optic nerve] that I have not appreciated in the past.

- [43] Dr. Atkins's impression was of "bilateral optic atrophy secondary to steroid induced glaucoma." Beyond the effects of the glaucoma, he found Mr. Buckingham's visual acuity to be quite good.
- [44] Dr. Lowden, Dr. Ritenour and Dr. Atkins did not provide expert reports in this trial, so their diagnoses, to the extent that they represent opinions, are not admissible for their truth, only for the fact that they were made. Nevertheless, their factual observations are relevant to understanding the course of Mr. Buckingham's visual symptoms, and serve as a relevant factual foundation for some of the expert opinions that were provided.

Further Contact with the Defendants

- [45] What turned out to be Mr. Buckingham's final appointment with Dr. Law was on February 27, 2016. She recorded that he had missed "a few" follow-up appointments before then, and in her testimony said that there were at least three. Mr. Buckingham maintains that he showed up for one scheduled appointment, only to find that Dr. Law was not there, but since the evidence is that she would not have warned him about elevated intraocular pressures or suggested that he have them checked during the period since his last appointment, nothing turns on the difference.

- [46] In that February 27 appointment Dr. Law noted that despite having stopped the prednisone when he was at 10 mgs, Mr. Buckingham "luckily" had not experienced any withdrawal symptoms. There were also no signs of active dermatomyositis. She made no change to his methotrexate prescription, but recommended that if his condition remained in remission for one year they could consider reducing his dosage. Mr. Buckingham had a follow-up appointment with her scheduled for November 2016, but he did not attend for it.
- [47] In an appointment with Dr. Hobza on July 13, 2016 Mr. Buckingham discussed reducing that methotrexate dosage. They agreed to proceed slowly in doing so. Mr. Buckingham was taking 25 mgs per week at that point, which they agreed was to be reduced by 2.5 mg every two weeks, and reviewed monthly.
- [48] By the time he saw Dr. Hobza on October 24, his dosage was 10 mgs per week. There had been no recurrence of the dermatomyositis despite the reduction.
- [49] Mr. Buckingham's last appointment with Dr. Hobza was on June 12, 2017. The impression he had received from Dr. Atkins by then was that other than monitoring his intraocular pressures, there were no other procedures available to assist with his vision. Dr. Hobza noted that Mr. Buckingham was understandably upset about that news. He offered his apologies for his involvement in what had occurred, and for the "adverse effects" that Mr. Buckingham had suffered.
- [50] It is common ground that at no point in their dealings with him did Dr. Hobza or Dr. Law tell Mr. Buckingham about the specific risk of elevated intraocular pressure from prednisone, or recommend that he have his intraocular pressure checked while he was taking it. Mr. Buckingham's evidence was that if he had been informed of this particular risk, he would have "asked for an alternative" medication.

Explanation of Potential Side Effects and Monitoring of Intraocular Pressure

Dr. Hobza

- [51] He explained that in his practice he prescribed prednisone at least once a week. It is used to treat numerous different conditions.
- [52] His strong suspicion during their first appointment that Mr. Buckingham had dermatomyositis meant that there was some urgency to the situation. If it is left untreated, that condition can lead to difficulties with swallowing, profound muscle weakness, and even death.
- [53] He said that the standard approach to dermatomyositis is to give a high dose of prednisone at the outset, to "put the fire out" as quickly as possible and halt the progression of muscle weakness. A high dose of prednisone is the initial "first line" treatment for it, and there are no other options in terms of medication.

- [54] A high dose in this situation is based on one milligram of prednisone for every kilogram that the patient weighs. Based on Mr. Buckingham's weight he would normally have received a dose of 70 mgs daily, but Dr. Hobza recorded that he was "averse" to such a high dosage, so they "compromised" on 50 mgs. Based on that note, Dr. Hobza said that they would have engaged in a "harms vs. benefits" discussion about prednisone.
- [55] His usual practice when prescribing prednisone is to tell the patient that it has a wide number of side effects, potentially affecting the patient "head to toe", and in multiple systems of the body. He asks them to let him know if anything unusual occurs. He said that there are so many risks that it is not possible to go into them, or to alter the management of the patient based on them.
- [56] At the time he gave this prescription to Mr. Buckingham he was aware that prednisone can elevate intraocular pressures, and that these pressures can lead to glaucoma, but it was not his practice to tell patients about it. He was also not aware of any practice that involved having patients monitor their pressures while they were taking prednisone.
- [57] He had Mr. Buckingham's family history of diabetes at that point. He identified Mr. Buckingham as a person who was at high risk of cardiovascular problems because of his blood pressure, cholesterol level and smoking habit, and he acknowledged that this also increased the risk of elevated intraocular pressures and glaucoma. He did not consider Mr. Buckingham's age to be a risk factor specifically in relation to the effect of prednisone on intraocular pressures, but he was aware that older people are at greater risk of elevated pressures in general.
- [58] Addressing his instruction to the patient to report any unusual effects of prednisone, he acknowledged that elevated intraocular pressure is not symptomatic - that is, it is not something that the patient would notice - until their vision is affected. He said that he would refer them to a specialist if any visual symptoms developed.
- [59] His renewal of that prescription at the same dosage at Mr. Buckingham's June 24 visit was intended to take him up to the time that he would be able to see a specialist, who would take over the management of the condition.
- [60] Dr. Hobza said that when Mr. Buckingham told him he was losing his sight at the November 2015 appointment, prednisone was not at the "top of the list" of the suspected causes. This was despite the fact that at various points Mr. Buckingham had disclosed less worrisome effects of prednisone use to him, such as sleep difficulties. Dr. Hobza added that it would have been "tricky" to stop the prednisone at that point.
- [61] He referred Mr. Buckingham to an optometrist because in his experience one can get an appointment more quickly than with an ophthalmologist. He was also aware that Mr. Buckingham had an appointment with Dr. Law scheduled for later than month.

- [62] He acknowledged that it "could have been" in his mind once these vision issues arose that Mr. Buckingham's cataracts might have come from his prednisone. His understanding is that cataracts "come on over long periods of time" however.
- [63] He apologized to Mr. Buckingham during the June 13, 2016 appointment because even though there was no other option to treat the dermatomyositis, he was the one who had started him on the prednisone. He felt bad for Mr. Buckingham and "if there was any part [he] played, [he] wanted to apologize ". He did not express specific regret about not having warned Mr. Buckingham about the risk of elevated intraocular pressures. He explained that there are known harms and potential risks with any medicine, and if the prednisone had not been used Mr. Buckingham's condition could have gotten worse. In other words, at the time the benefits outweighed the potential harms, of which elevated intraocular pressure was "one among many".

Dr. Law

- [64] She sees at least five to ten patients per week who are taking prednisone.
- [65] It is the invariable treatment for dermatomyositis, she said, and in the approximately 50 previous cases in which she had encountered that condition, she had never had a patient refuse to take prednisone to treat it, although patients have refused to take that medication in other contexts.
- [66] As to the risks of failing to treat it, she referred to its ability to affect the muscles in the neck and throat, as well as those that control breathing.
- [67] In the course of educating the patient about dermatomyositis, she explains that muscle damage occurs as a result of the inflammation that it causes. Sometimes that damage is irreversible, so it is important to gain control of the inflammation at the outset. She also explains that prednisone "calms down" the immune system and brings the inflammation down, thus allowing the physician to gain control over the condition.
- [68] She tells patients that they are not going to stay on prednisone "forever", because of its long-term side effects. Similar to Dr. Hobza's explanation, she elaborates that they can affect almost any system of the body, "head to toe".
- [69] In her letter to Dr. Hobza summarizing the outcome of her initial consultation with Mr. Buckingham, she referred to having specifically discussed the risk of weight gain, cardiovascular events, cataracts, osteoporosis and avascular necrosis (a rare condition in which damage to the bone is caused by a reduced blood supply). She said that she usually also highlights that prednisone, because it is an immune suppressant, can increase the risk of infections, so patients should report any fever, chills or sweats.
- [70] In addition to these comments, she would encourage patients more generally to report any new symptoms that they develop.

- [71] Dr. Law said that she would not have spoken to Mr. Buckingham about the risk of elevated intraocular pressure from prednisone use, which she described as a "very rare side effect" (cataracts are much more common). It was not part of her practice to do so in 2015.
- [72] She acknowledged that, for example, she gave him a specific warning about the risk of avascular necrosis, which is also rare, but explained that the part of the body that it impacts and its effects are within her area of specialty.
- [73] As to her awareness of any side effects that had emerged, she told Mr. Buckingham that the high blood pressure that she noted during their first appointment was likely due to prednisone.
- [74] At that time, she was aware of prednisone's potential to increase intraocular pressures and the potential of elevated pressures to lead to glaucoma. She was not aware of any particular susceptibility of older people, or those with a family history of diabetes to increased pressures from taking the drug however. Those were things that she learned in background reading about steroid-induced glaucoma that she carried out after becoming a defendant in this action.
- [75] During her examination for discovery she had conceded that Mr. Buckingham was "in a higher risk category", and should have been warned about the risk of developing glaucoma. When asked to explain that answer, she said that she was very upset about the serious consequences that Mr. Buckingham had suffered. She became very critical of herself, thinking that "maybe [she] could have warned him more."
- [76] Despite this, she maintained that prednisone was "cornerstone management" of dermatomyositis and that she would still prescribe it in that situation.
- [77] When she was asked if she was surprised when she received the report from Dr. Lowden describing Mr. Buckingham's "presumed steroid induced" glaucoma, she responded, "It's not common." When she was asked whether she avoided discussing glaucoma with him during their February 2016 appointment because it was "a bit awkward" for her, she said that she did not know.
- [78] It is now her practice to warn patients about this particular risk. She does so because of having been sued over the issue, not for any other reason, she said.
- [79] On the question of reducing the dose of prednisone, she explained that there is no definitive guideline - it varies from clinician to clinician. In general, after getting control of the condition, which can take several months, there is a slow gradual taper, which takes anywhere from nine months to more than a year. She wanted to see Mr. Buckingham in November of 2015 because once the prednisone dose gets to that lower level, the normal approach is to slow down the rate at which the dose is reduced.

- [80] She agreed, when referred to Dr. Pewarchuk's assertion that Mr. Buckingham could not remain on the drug in the "long run", that what constitutes such a period is "a little vague". She also agreed that the longer a person is on a high dose of prednisone, the greater the risk of side effects. However, she emphasized that one must balance those risks against the risk of a flare up of the dermatomyositis if the medication is reduced too quickly.
- [81] Although, as I have previously described, 50 mg of prednisone qualifies as a high dose in medical terms, Dr. Law said that in light of his weight and the guidelines for prescribing prednisone, Mr. Buckingham was actually "under dosed a little".
- [82] She prescribes methotrexate even more frequently than prednisone. It is the "anchor drug" for rheumatoid arthritis, in addition to its use as a steroid sparing agent in relation to prednisone use. It also has a number of side effects, some of which she mentioned specifically to Mr. Buckingham.
- [83] Although she learned in her review of the literature after being sued that it can also cause visual problems, she described them as being extremely rare. She warned patients about the risk of lung toxicity, although it is also rare, because it is part of the general approach to methotrexate side effects that she and her colleagues engage in.
- [84] Like prednisone, there is no specific consensus on the process of weaning off of methotrexate, so it comes down to the individual clinician's training.

Expert Opinion - Informed Consent and Standard of Care

Plaintiff

Dr. Stein

- [85] He is an Ontario-based specialist in internal medicine and clinical immunology. He qualified to practice in the former specialty in 1979, and the latter in 1981. He has a special interest in rheumatology. He maintains a practice in internal medicine and rheumatology, and divides his time evenly between that practice and conducting independent medical assessments, and preparing medical-legal reports, in relation to insurance claims.
- [86] Based on his review of the records, he gave the opinion that both Dr. Hobza and Dr. Law fell below the required standard of care in their treatment of Mr. Buckingham. (Although part of his opinion related to the length of time that Mr. Buckingham was on a high dose of prednisone before transitioning to a steroid-sparing agent, the focus on liability by Mr. Buckingham's counsel, as I have described, is on the lack of monitoring of intraocular pressures.)
- [87] He identified Mr. Buckingham's visual issues, in addition to cataracts, as "increased intraocular pressure associated with glaucoma complicated by optic nerve neuropathy". He understood these issues to have been "the direct result of at least six months of high-dose [p]rednisone treatment".

- [88] In his view, the risk factors for Mr. Buckingham developing these complications were his age, his family history of diabetes, "a history of possible increased intraocular pressure in the past, and collagen vascular disease or connective tissue disease [the group of conditions that includes dermatomyositis]." He included elevated blood pressure as a factor that could potentially increase the risk, but did not relate it specifically to Mr. Buckingham.
- [89] According to him, the onset of steroid-induced increases in intraocular pressure can occur "within weeks or months" of starting to take the medication. It generally subsides within one to four weeks of when the patient stops taking it.
- [90] Crucially from his perspective, monitoring of intraocular pressure should begin "at least" two weeks after the prednisone is started, and then be carried out every two to six weeks after that. This provides the physician with the option of either stopping the medication, or introducing a pressure-lowering agent, if high pressures are recorded. In this case of course, no monitoring was carried out until after the visual symptoms appeared.
- [91] His opinion was also that Dr. Hobza fell below the standard of care by having Mr. Buckingham on a high dose of prednisone for up to six months "without careful monitoring of his intraocular pressure". He offered the same opinion with respect Dr. Law.
- [92] In addition to highlighting Dr. Stein's lack of experience or training in the practice of family medicine or rheumatology in British Columbia, the defendants' counsel challenged him on some of the facts that formed the basis of his opinion.
- [93] He acknowledged that he may have misquoted Dr. Atkins when he asserted that Mr. Buckingham had been on a high dose of prednisone for six months, but maintained that a patient can end up with glaucoma after even a few weeks of a high dose.
- [94] He was unable to identify the source in the records of his assertion that Mr. Buckingham had a history of possible increased intraocular pressure, although the subtraction of that as a risk factor would not have altered his overall opinion.
- [95] He agreed that that there are different considerations in discussing risks with a patient when prescribing prednisone for two weeks, as Dr. Hobza initially did, and when doing so for multiple months. The longer period would obviously require a more in-depth conversation.
- [96] More generally, he agreed that there are no published standards or guidelines for family practitioners or rheumatologists that require the monitoring of intraocular pressures that he recommends. He explained that the medical literature suggests that such standards should be established, and agreed that he was describing "something that should be done, not something that necessarily is done." In his view, the prescribing physician should monitor all of the possible complications of prednisone.

- [97] He drew a distinction between other side effects of prednisone (such as cardiovascular complications, effects on bone density or infection), and intraocular pressure, because those other effects can be identified or monitored by the prescribing physicians themselves, or through lab tests, while only an optometrist (and, presumably, an ophthalmologist), can monitor the pressures. Optometrists are not difficult to access for that purpose, in contrast to other medical specialists.
- [98] He was referred to an article on steroid-induced glaucoma that had formed the basis of his opinion. He accepted that the authors had noted that patients with intraocular pressures of between 21 and 25 mmHg "do not necessarily require therapy" and that it is only above 25 mmHg that they should be sent to a glaucoma specialist.
- [99] In addition, he accepted that interruption of steroid therapy usually returns intraocular pressure to normal within two to four weeks, and that it is only when prednisone has been taken for 18 months or more that the elevated levels may persist for longer.
- [100] Although he agreed that neither a review of treatment for idiopathic inflammatory myopathies (which includes dermatomyositis) by the Mayo Clinic, nor Rheuminfo.com (a website maintained by rheumatology practitioners) listed elevated intraocular pressures as a common complication of prednisone use, he said that this omission was "against the evidence", and that the condition should have been mentioned.

Dr. Faber

- [101] He is an ophthalmologist who practices in Vancouver. He completed his training in ophthalmology in 1981 and followed that with a fellowship in neuro-ophthalmology and glaucoma. He is a clinical professor in the Department of Ophthalmology at UBC.
- [102] As I will discuss, the bulk of his report dealt with the causation, current state, and prognosis of Mr. Buckingham's visual issues, but he also offered an opinion with respect to the responsibilities of physicians who prescribe prednisone.
- [103] His opinions were based on a review of Mr. Buckingham's records, rather than on an examination of him.
- [104] In Dr. Faber's view, the side effects of cataracts and glaucoma should be outlined to every patient before they start the medication, and the patient should be questioned about their vision at every follow up visit. Patients who are on oral prednisone for the long term "should be referred for a full ocular evaluation regularly."
- [105] Also like Dr. Stein, Dr. Faber conceded that he was not in a position to comment on the standard of care of a family physician or a rheumatologist.
- [106] As to the actions of these defendants, he was not aware of Dr. Hobza's standard practices when informing patients to whom he prescribes prednisone.

- [107] He agreed that Dr. Law's records show that she discussed several significant side effects of the drug with Mr. Buckingham, including cataracts, and that in their August 22, 2015 appointment, they had discussed that the fact that it was affecting his sleep.
- [108] He conceded that his report was inaccurate when it indicated that Dr. Hobza had not discussed side effects with Mr. Buckingham during their October 14, 2015 appointment, since the records show that Mr. Buckingham had complained of several such effects, although he pointed out that their discussions still did not include visual side effects.
- [109] Notwithstanding those concessions, he maintained that all physicians, regardless of their specialty, need to be aware of all of the potential side effects of medications that they are prescribing, especially if they are powerful ones and the patient is going to be on the medication "long term".
- [110] Once again like Dr. Stein, he accepted that the amount of information that should be given to the patient about side effects would differ between short and long-term use however. He agreed that Dr. Hobza prescribing prednisone for a two-week period would constitute short-term use.
- [111] He accepted that it is unworkable to discuss all of the potential side effects of a medication that has hundreds of them. He suggested that in the case of long-term usage the physician should have their "top twenty or twenty-five" side effects that are discussed.

Defendants

Dr. Bovard

- [112] He has practiced as a family physician in North Vancouver since 1988. (He also has extensive qualifications in the area of sports medicine, which do not directly relate to the issues in this case.)
- [113] He pointed out that Dr. Hobza had not recorded the specific risks that he discussed with Mr. Buckingham in the course of their agreement that 50 mg of prednisone would be prescribed, rather than the 70 mg that would be otherwise indicated as a "high dose". He assumed that such a discussion had taken place however, because of his note that Mr. Buckingham was averse to the 70 mg dose. He was reminded in re-examination that he had been provided with information about Dr. Hobza's standard practice in that regard as one of the factual assumptions for his opinion. He considered the omission from the notes of an explicit reference to risks to be reasonable in the circumstances, given the unusual condition that Dr. Hobza was dealing with.

- [114] Addressing what would be an appropriate explanation of the risks of taking prednisone, Dr. Bovard said that he would not expect a family physician in British Columbia to discuss specific risks with a patient. His practice is to advise them that there are many risks, but that for the condition in question the benefits outweigh those risks. His additional expectation is that the patient would receive detailed information about specific risks from the pharmacy, when they fill their first prescription for the prednisone.
- [115] More particularly, he would not expect a family physician to discuss the risk of vision problems resulting from prednisone use. This is particularly so when the long-term treatment plan will likely be put in place by a specialist. The potential list of risks from taking prednisone is so long and wide ranging that "practically speaking" a physician cannot go through them all. Trying to do so could end up consuming the entire appointment.
- [116] In cross-examination he elaborated that, having explained to the patient that there are risks to taking prednisone that are outweighed by its benefits in that situation, he would answer any specific questions that the patient then posed about those risks. If the patient has specific risk factors in addition to the risks that are present for all patients, he would identify those, but then explain why he still believes that they are outweighed by the benefits for that patient. He agreed that the patient has to understand this "risks vs. benefits" analysis, so that they can make an informed choice.
- [117] He expected that a "more detailed discussion of the risks of prednisone would be expected once it was determined that a longer course [of taking it] was required", and noted that the management of Mr. Buckingham's condition was taken over by Dr. Law. At that point, the family physician would be in more of a supportive role, answering any questions that the patient had as a result of their dealings with the specialist. As a result, it was appropriate for Dr. Hobza to assume that Dr. Law would have had a discussion about prednisone risks with Mr. Buckingham.
- [118] He rejected Dr. Stein's proposed regime of intraocular pressure monitoring. It is not a standard of practice that he would expect of a family physician in this province, and he was unaware of any teaching guidelines for family physicians that recommend it (he is also involved in teaching family medicine). In addition, Dr. Hobza was dealing with two 14-day prescriptions, which Dr. Bovard does not consider to be "long-term". Once again, the management of any such longer-term use was to be placed in the hands of a specialist.

Dr. Wade

- [119] He has been practising as a rheumatologist in Vancouver since 1989. He is a clinical assistant professor in that specialty at the UBC Faculty of Medicine, and has done research and made presentations on some of the effects of the group of steroids that prednisone belongs to. In his career he has treated more than a hundred patients with dermatomyositis.

- [120] In his opinion, Dr. Law's discussion of the significant side effects of prednisone with Mr. Buckingham was appropriate. He would not have expected a rheumatologist in this province "to discuss glaucoma when continuing the use of prednisone."
- [121] Just as Dr. Law had testified, he could not recall a patient refusing prednisone to treat dermatomyositis once the risks had been explained to them in the manner that she did.
- [122] He also disagreed with Dr. Stein's recommendation of ongoing monitoring of intraocular pressure with long-term prednisone use. He does not make that part of his own practice, and it is not what he would expect from a rheumatologist in this province.
- [123] Beyond that general assertion, he said it is not practical to refer a patient to an ophthalmologist for their pressures to be measured two weeks after starting the medication and then every six weeks after that. Instead, if the patient reports any "visual issues of concern", a referral to an ophthalmologist could then be made.
- [124] In cross-examination he said that while he would have "no problem" with telling a patient about the risk of elevated intraocular pressures, and that they could get them checked at any time by an optometrist, it was not something that was expected of a rheumatologist.
- [125] His concern is that when prescribing a powerful drug like prednisone "you have to use your opportunity to focus where the concern needs to be", rather than on a side effect that is "so rare and not a big problem relatively". The danger is including so much information about such issues that the patient becomes lost, or "flooded with information", and cannot focus on what matters about starting prednisone, including its common serious side effects. He characterized it as being a situation of "opportunity/cost" in providing information.
- [126] On that point, he accepted the proposition put by Mr. Buckingham's counsel that visual symptoms from intraocular pressure arise at the point where the damage to the optic nerve is irreversible. Prednisone can have irreversible effects on several systems of the body, he pointed out, the implication being that there are not standard warnings about those other effects either.
- [127] Because the body also makes it, everyone can take prednisone, Dr. Wade explained. Very rarely, a patient will be allergic to the format in which the prednisone is taken, and in urgent situations that means it will have to be given in a different manner than orally, such as intravenously.
- [128] He added that he would take the patient's age, the presence of hypertension or a family history of diabetes into account, but when treating a serious autoimmune disease like dermatomyositis his "first treatment" would still be prednisone. He deferred questions about the specific risks of those factors in relation to developing glaucoma from prednisone to an ophthalmologist.

[129] He found both Dr. Law's initial recommended dose of prednisone and the manner of tapering that she directed to be what he would expect of a rheumatologist in British Columbia in that situation. He explained that the danger of stopping prednisone abruptly, as Mr. Buckingham did, is that the process by which the body makes its own supply of prednisone gets turned off when it is taken as a medication. If the medication then stops without tapering, the body is left with no prednisone at all, which can have serious adverse effects.

[130] He expressed the same positive opinions of Dr. Law's introduction of methotrexate, and her discussion with Mr. Buckingham about its potential side effects.

Expert Opinion- Causation of Visual Problems

Plaintiff

Dr. Faber

[131] His special interests include cataract surgery and ocular trauma. The major focus of his practice is cataract and refractive surgery, but it has a large component of patients with eye diseases, including glaucoma. He explained that he treats his own glaucoma patients, and that in fact cataract surgery has evolved to be the primary treatment for glaucoma .

[132] In response to the question of whether it is more likely than not that Mr. Buckingham's prednisone use caused "steroid induced (reactive) glaucoma with associated optic neuropathy", he wrote in his report that it is "generally felt" that oral prednisone does not cause elevated intraocular pressures as frequently as topical use of it. Nevertheless, it is well-documented in the literature that prednisone use (oral, I took him to mean) can lead to elevated pressure, and then to glaucoma, "if the elevation persists and is not documented promptly". Thus, glaucoma is a well-documented risk of both types of prednisone use.

[133] In the course of defining intraocular pressure for the purposes of his opinion, he explained that its effect is to deprive the optic nerve of the nourishment that it would otherwise receive from the arteries and veins that are present in all tissues. The condition is not called glaucoma until there is documented damage to the nerve.

[134] He wrote in his report that "general medical conditions" such as hypertension and diabetes, or a family history of glaucoma, can increase that risk. However in cross-examination he clarified that he had intended to refer only to a family history of glaucoma. His "clinical feeling" is that this increased risk from a family history applies even in the case of steroid-induced glaucoma, which can "unmask" glaucoma in a patient who has the potential to develop it.

[135] The risk also increases with the age of the patient.

- [136] With respect to the effect of hypertension, he said that "it is not directly established whether or not blood pressure hypertension increases the risk of the development of glaucoma."
- [137] He was under the impression from his review of the records that Mr. Buckingham had been taking prednisone continuously since it was first prescribed to him at the walk-in clinic, rather than that process having been interrupted before he saw Dr. Hobza. When the actual situation was pointed out to him, he conceded that his opinion could have been different if he had been aware of it.
- [138] He also appeared to have misspoken in his report when he described Dr. Law as prescribing a reduced dose of 25 mgs per day of prednisone after she noted Mr. Buckingham's blood pressure being high on August 22, 2015. He confirmed in cross-examination that he was aware that she had ordered Mr. Buckingham to reduce his dose from the existing 50 mgs by 10 mgs at a time.
- [139] Along the same lines, his report described "elevated" intraocular pressures being measured when Mr. Buckingham saw an optometrist on November 18, 2015, whereas, as he agreed, the 22 mmHg measure is "just the upper limits of normal." The material he was provided with indicated that Mr. Buckingham has thick corneas, and he said that patients in that situation tend to have higher intraocular pressures, to the extent that a correction factor is applied to their measurements.
- [140] Perhaps most significantly on the question of causation, Dr. Faber agreed that if Mr. Buckingham had pressures of 22 mmHg on November 18, 2015, and 42 mmHg in one eye on January 13, 2016, and if his pressures were reduced to 10 and 11 within a few days, then any elevation would have been present for less than two months. He added that one would not begin treatment on a patient with a pressure of 22 mmHg and that, because these measurements are "notorious in terms of their accuracy, even a patient with a very high reading would have been brought back in a day or two to double check it."
- [141] With respect to the effects of the glaucoma, Dr. Faber characterized Mr. Buckingham as being "essentially blind in one eye" and having a limited visual field. The good vision that Mr. Buckingham describes in his other eye must be considered, Dr. Faber emphasized, in light of the overall "dramatic" decrease in the quality of his vision. He requires more light to do everyday tasks, has lost depth perception, and will have difficulty with fine visual tasks. This will prevent him from engaging in such activities as driving, reading, watching tv or using a computer.
- [142] When it was put to him that Mr. Buckingham's corrected vision was measured at 20/50 in 2018, he elaborated that vision has a qualitative component, in addition to the measurement of what a patient is able to read on an eye chart (that is, acuity). The various other impediments to vision, such as loss of visual field, must be considered when assessing that quality. He agreed that this means that if the patient's measurements are "reasonable," the qualitative assessment depends on what the patient tells him about their

vision. This qualification applies, he also agreed, to Mr. Buckingham's claims of dramatic vision loss.

- [143] It was put to him that Dr. Ritenour's 2021 measurement of Mr. Buckingham's visual field actually showed an improvement from what was noted in 2017, and that this was inconsistent with a deterioration in his vision. Dr. Faber explained the significant subjective elements of the test that measures a patient's visual field, including the skill and motivation of the patient in taking it and the approach taken by the technician in administering it. He expressed once again the inability of any of the measures that are available to ophthalmologists to capture the quality of the patient's vision in a completely objective way.
- [144] In Dr. Faber's opinion, Mr. Buckingham's "best prognosis" is that he does not lose any further vision. The progressive effect of glaucoma continues even after the elevated pressures are relieved, he explained, as the nerve cells involved continue to destroy themselves. There is even the possibility of total blindness, although most glaucoma patients are left with a small area of vision in their peripheral field. Mr. Buckingham also has an increased risk of deterioration of vision in the eye that has not been as badly affected to this point.
- [145] He agreed that only a minority of patients continue to lose acuity once their intraocular pressures are under control. He added however that the "sicker" patients, which he defined as including older patients and those with cardiovascular issues, "do not do as well". A further difficulty is that intraocular pressures are a relatively "primitive sign" of the disease, by which I took him to mean that they do not always indicate its progress.
- [146] On the extent of his expertise in dealing with glaucoma, he explained that in Vancouver it is so difficult to get a patient in to see a glaucoma specialist, that most ophthalmologists do the screening and primary treatment for it themselves. They only refer to a glaucoma specialist when surgery is required, or there is a question about whether the condition is actually glaucoma.
- [147] With respect to his own practice, he actually used to perform his own glaucoma surgery, although he has given that up, and would normally continue to treat glaucoma patients himself, unless the treatment was not progressing as it should, or the disease was continuing to develop.

Defendants

Dr. Mikelberg

- [148] He has practiced as an ophthalmologist since 1982. He completed a fellowship in glaucoma and his practice is limited to the diagnosis and treatment of that condition. In addition to being a professor in the Department of Ophthalmology and Visual Sciences at UBC, and supervising graduate students who are doing fellowships in glaucoma, he is the past president of the Canadian Glaucoma Society and an invited member of the Glaucoma

Research Society. He has published and presented extensively on the subject of glaucoma, and has received numerous research grants in relation to it.

[149] Unlike the other experts in this case, he actually performed a clinical examination of Mr. Buckingham, in September 2018.

[150] He explained that oral prednisone may cause elevated intraocular pressure in approximately 4% of the population. However, his opinion is that Mr. Buckingham does not have "glaucoma-related optic nerve damage secondary to intraocular pressure elevation". He based this opinion on several factors:

- There is no evidence of cupping (the enlargement of the depression at the head of the optic nerve that I previously described.) No cupping was seen in colour photos of Mr. Buckingham's optic nerves, only "diffuse optic disk pallor". Images taken by OCT (Optical Coherence Tomography - a laser-based instrument that obtains accurate views of the layers of the back of the eye) had the same outcome, as did Dr. Mikelberg's own examination of those nerves. In addition, the 2016 examination by Dr. Lowden and the 2017 examination by Dr. Ritenour showed a lack of significant cupping. In particular, as I have previously summarized, Dr. Ritenour wrote that the nerves "actually were not very impressive for cupping". Dr. Mikelberg could not provide a cup to disc ratio (the usual measure of the extent of the cupping) for Mr. Buckingham's optic nerve, because there was "no significant cup".
- The examination of Mr. Buckingham's visual field shows extensive central depression (of vision) in both eyes, which is not characteristic of glaucoma-related damage. Patients with glaucoma disc optic nerve damage typically have peripheral defects in their vision.
- The measurement of Mr. Buckingham's intraocular pressures on November 18, 2015 (taking into account his thick central corneas which, as I have mentioned, lead to higher readings than the true pressure), would be considered to be in the "high normal population range", This means "the high end of what the normal population is at", he explained, and "not necessarily a level of pressure that is worrisome or damaging". Therefore, the elevated pressures that were measured on January 13, 2016 had been in place for about eight weeks at the most, and likely for a significantly shorter period. In Dr. Mikelberg's opinion, such a duration was "unlikely to result in significant optic nerve damage."
- The timing of Mr. Buckingham's prednisone use is also not consistent with it having caused the elevated pressures that were measured on January 13. Dr. Mikelberg explained that elevation from steroid use usually occurs after four to six weeks, and always returns to the pre-steroid level once their use has been discontinued. That return process usually takes four to eight weeks. When Mr. Buckingham's pressures were measured on November 18, he had been on prednisone since June 16, tapering by that date to 20 mgs. If the elevation had been steroid-related, his pressures would have been elevated in November.

- [151] Because Dr. Mikelberg does not believe that Mr. Buckingham has suffered glaucoma-related optical nerve damage, he does not believe that there will be any further deterioration of his vision on that basis.
- [152] He disagreed that Mr. Buckingham is essentially blind in one eye, as Dr. Faber asserted, noting that Mr. Buckingham showed visual acuity of 20/50 in his right eye and 20/60 in his left during the examination in September 2021. Measurements of his "potential" acuity (the acuity of his vision if impediments to it were corrected) by Dr. Ritenour in 2020 showed an acuity in the same range as Dr. Mikelberg measured, although Mr. Buckingham's actual measured acuity was much worse.
- [153] If, contrary to his opinion, Mr. Buckingham's visual issues are related to glaucoma, he said that Dr. Faber is also incorrect in suggesting that it will continue to progress. In fact, most patients with glaucoma maintain their vision as long as their intraocular pressure is well controlled.
- [154] With respect to the vulnerabilities to glaucoma suggested by Dr. Faber and Dr. Stein, Dr. Mikelberg said that a family history of glaucoma increases the risk of developing it, and the presence of glaucoma increases the risk of prednisone causing elevated intraocular pressures. On the other hand, neither a family history of diabetes nor diabetes in the patient themselves increases the risk of prednisone causing elevated intraocular pressure. The same is true of high blood pressure and the age of the patient. Age is a risk factor for developing glaucoma, but not the steroid-induced kind.
- [155] When he was asked if he relied on any authority for his position with respect to diabetes, he confirmed that it was his own opinion, and acknowledged that there is other literature suggesting that it does have an effect on intraocular pressure. His position with respect to the effect of the patient's age is based on his own experience. He was not aware of any literature expressing a differing view, but acknowledged that there "may be" some.
- [156] In cross-examination he confirmed some of the key propositions that were put to the other witnesses: (1) once the elevated intraocular pressures have caused atrophy of the optic nerve, which is essentially glaucoma at that point, the damage that has been done is permanent; and (2) a person who has elevated intraocular pressures will not be able to tell that themselves - it needs to be tested.
- [157] He agreed with the suggestion that when prednisone is being tapered off, the pressure gradually decreases along with that reduction, "with some lag". He also agreed that since Mr. Buckingham's pressures were never measured from June to October, they could have been elevated throughout that time period. If his pressure had been elevated enough, that would have been a sufficient time period to cause damage to his optic nerve. However, in re-examination he explained that such a scenario would not be consistent with the elevated intraocular pressures that were then measured in January 2016.

- [158] The issue of the intraocular pressure measurements as objective indicators of Mr. Buckingham's preceding levels having been raised, I allowed his counsel to re-cross-examine on the accuracy of the November measurements by the optometrist Dr. Gill. Dr. Mikelberg conceded that he did not know how those measurements by the optometrist had been carried out, or whether the most accurate type of measuring instrument available had been used. Despite this, he explained that the errors in the less accurate devices tend to occur with extremely high and low pressures, not in the "normally found" range, like the measurements in question here.
- [159] With respect to the absence of cupping, Dr. Mikelberg explained that the optic nerve is formed when the bundle of axons that connect with the visual receptors in the retina make their way out of the eye. For most people, the axons distribute themselves around the edge of the hole through which they exit the eye, leaving a small depression in the centre, which is the cup. Cups come in different sizes - if the exit is very small the axons will fill up the entire opening and there will be no cup, whereas if it is large the person could end up with a large cup to disc ratio even though they are "normal" (that is, they do not have glaucoma).
- [160] The significance of this from Mr. Buckingham's perspective is that Dr. Mikelberg then agreed that given the range of cup sizes, there needs to be a previous baseline measurement of the cup in order to show that it has changed because of glaucoma. There is no such baseline available in this case, and instead he is looking at the optic nerve and concluding that it does not "appear" to "have been altered at any point."
- [161] However, he then added that he reached that conclusion because "this damage" (by which I took him to mean the damage to Mr. Buckingham's optic nerves) "doesn't have any of the characteristics of glaucoma". He also clarified that while a person with a large cup might be mistakenly thought to have glaucoma, it is not conversely true that glaucoma's presence would be missed in a person with a small cup. This is because the amount of damage necessary to cause visual field damage like Mr. Buckingham's would still show "some sort of significant cupping".
- [162] Although he acknowledged that there have been studies showing variability in the identification of cupping among ophthalmologists, they involved small differences in the images, not the question of "whether there's any significant cupping". Further, those issues arose in the examination of photos of the optic nerve, rather than in OCT scans, which he said do not have any variability.

Dr. Barton

- [163] He is a neurologist and neuro-ophthalmologist. After qualifying as a neurologist, he completed two fellowships in neuro-ophthalmology, as well as a PhD. For eight years he was an associate professor of neurology at Harvard Medical School and director of neuro-ophthalmology at its teaching hospital. Since 2004 he has been clinical director of neuro-ophthalmology at Vancouver General Hospital, while serving as a professor, and holding a

research chair in neurology, ophthalmology and visual sciences, at UBC. Like Dr. Mikelberg, he has also published, presented and conducted research very extensively in his specialties. A particular expertise for which he has been recognized within those specialties is the interpretation of visual field testing.

- [164] In his report Dr. Barton discussed certain "clinical clues" that assist in identifying the cause of Mr. Buckingham's optic neuropathy.
- [165] First of all, both of Mr. Buckingham's eyes are affected. It was difficult to tell whether this was simultaneously in both eyes or one after the other, because initial symptoms in November 2015 could have been from the optic neuropathy, the cataracts, or both. Dr. Barton suspected that it was mainly the cataracts at that time, because of the improvement in Mr. Buckingham's visual acuity after cataract surgery. Certainly by the time the physicians involved realized that there was optic neuropathy going on, in the spring of 2016, both eyes were involved.
- [166] The evolution of Mr. Buckingham's optic neuropathy was not clear from his symptoms, or from the relatively stable post-surgery measurements of his visual acuity. It was best indicated, in Dr. Barton's view, by the measurements of his central and peripheral sensitivity to light. These measurements are called perimetry. They show worsening in both eyes, but more in the left, from April 2016 to January 2017. From January 2017 to September 2020 there was no change.
- [167] With respect to the nature of the defects in his visual field, Dr. Barton noted that Mr. Buckingham has both a depression of vision in the centre of his visual field (a central scotoma), which has progressed to a size at which it joins with the blind spot in normal vision (a cecentral scotoma), and a defect in his peripheral field that arches from the blind spot around the central area of depressed vision (an arcuate peripheral defect). Central or arcuate defects in vision are created depending on which of the bundles of nerve fibres that leave the retina on the way to the brain (as previously described by Dr. Mikelberg) are interfered with.
- [168] Finally, as previous ophthalmologists have commented, Mr. Buckingham's optic discs show paleness, without significant cupping. The change in colouration of the disc occurs "as you start to lose nerve fibres", he explained. All optic neuropathies, of which glaucoma is one type, involves the thinning of the optic nerve layer.
- [169] Dr. Barton also expressed doubts that glaucoma was the cause of Mr. Buckingham's optic neuropathy. In addition to the absence of cupping, he explained that glaucoma does not usually affect the central vision, as it has in Mr. Buckingham's case, until the "severe late stage".

- [170] Further, Mr. Buckingham's condition progressed from April 2016 to 2017. He told Dr. Lowden that he had stopped taking prednisone in early January 2016, and his intraocular pressures were normal once he started taking the drops that he was prescribed to lower them, from January 18, 2016 onwards. Dr. Barton questioned why Mr. Buckingham's vision would continue to deteriorate three to twelve months after his pressures had returned to normal.
- [171] He recommended consultation with an expert on glaucoma on these concerns (his first report was prepared a month before Dr. Mikelberg's first one), and expressed his deference to that expert's conclusions.
- [172] On the assumption that such an expert would conclude that glaucoma was not the cause, Dr. Barton considered the likely explanations that remained.
- [173] He noted that in an attempt to answer this question, Dr. Ritenour had made the referral to Dr. Atkins, who was unable to identify any lesions that might have affected both of Mr. Buckingham's optic nerves.
- [174] While Mr. Buckingham had not followed up on a nodule on his lung that had appeared on a CT scan, and lung cancer can cause a type of optic neuropathy through the creation of antibodies, the fact that he was still alive at the time of Dr. Barton's report four years later suggested that cancer was not the cause of his visual problems.
- [175] In Dr. Barton's opinion, glaucoma and the other causes investigated by Dr. Barton are ruled out, the probable explanation is that Mr. Buckingham had "a toxic bilateral optic neuropathy related to long-term low-dose methotrexate use." "Toxic" refers to neuropathy from an ingested substance or a medication.
- [176] He explained that most optical neuropathies that are caused by a toxin or a nutritional deficiency result in central scotoma. However, methotrexate toxicity contains elements of both a folate deficiency and demyelination (damage to the myelin sheath around nerves, which allows them to connect with other nerves). Folate deficiency results in central scotoma, and demyelination can cause both central scotoma and peripheral arcuate defects. As a result, methotrexate toxicity is capable of causing both types of visual defects.
- [177] The reported cases of methotrexate toxicity are rare, but they have shown central scotoma or arcuate defects in the patients.
- [178] Notably, one study that Dr. Barton reviewed reported that this type of toxicity often occurred with long-term low-dose methotrexate treatment. (He defined "long-term" as a situation in which the person has been on the medication "for weeks or months before the effects start to emerge", in contrast to an acute, or immediate reaction to it.)

- [179] According to his review of the literature, methotrexate toxicity could occur even if the patient was taking a folate supplement, or had normal folate levels. In some cases, the symptoms improved after the methotrexate had stopped, but in other cases they did not improve.
- [180] He was cross-examined on the limited body of cases that make up the medical literature on this subject - five between 1990 and the trial dates. All of the patients in question were women, and the circumstances under which the toxicity had arisen were varied, including one who had received the methotrexate directly into her spinal fluid. (He clarified that the significance of that case was only that the autopsy of that patient revealed that demyelination of the optic nerve had occurred).
- [181] Of the remaining four cases, two involved patients whose vision had improved after they stopped taking it, only one of whom had been taking folate along with it. The patient who had not taken folate had taken methotrexate for ten months, on a lower dose than Mr. Buckingham had been prescribed. In the other two cases the patients' vision did not improve after they stopped taking methotrexate. One of them had not taken folate, and in the other case it was unknown.
- [182] Because of the rarity of this kind of complication, he doubted that there would ever be sufficient information to determine the length of time of a patient taking methotrexate that would be necessary to lead to this toxicity.
- [183] As I have described, Mr. Buckingham's visual symptoms continued to progress when he was no longer taking prednisone and his intraocular pressures had been lowered, but he was still taking methotrexate. They then stabilized after they stopped the methotrexate. Acknowledging the difficulty of inferring a prognosis from the limited number of reported cases, Dr. Barton felt that this chronology of Mr. Buckingham's visual problems was "consistent with a prognosis for a visual defect that will persist indefinitely but not worsen."

Governing Legal Principles

Overview

- [184] For the most part, these are not disputed.
- [185] The elements of negligence that are in issue are whether the defendants breached the standard of care that is applicable to them when they treated Mr. Buckingham with prednisone, and whether that breach caused his injuries. A separate avenue of negligence is whether they obtained his informed consent before prescribing it to him.

Standard of Care

- [186] A physician's standard of care is to carry out their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances: *ter Neuzen v. Korn*, [1995] 3 SCR 674 at para. 33. Specifically in relation to specialists, it has been said that the standard is "to have and exercise the degree of skill of an average specialist in his field": *Wilson v. Swanson* (1956), 5 D.L.R. (2d) 113 at 124 (S.C.C.).
- [187] The standard has also been expressed more fully as requiring the physician "to exercise a reasonable degree of skill and knowledge and the degree of care that could reasonably be expected of a normal, prudent practitioner of the same experience and standing: *Crits v. Sylvester*, [1956] O.R. 132 (Ont. C.A.), at pp. 142-143, *aff'd*. [1956] S.C.R. 991.
- [188] This standard is one of reasonableness, rather than perfection: *Carlsen v Southerland*, 2006 BCCA 214 at paras. 11, 13.
- [189] If a physician acts in accordance with the recognized practices of their profession, they will usually not be found negligent, because in most cases courts lack the expertise to say that professionals did not know what they were doing. The exception is when the practice itself is negligent, which can only be found when it is "fraught with obvious risks", so that no diagnostic or clinic expertise is required to make that finding, or it "fails to adopt obvious and reasonable precautions which are readily apparent to the ordinary finder of fact". In such cases, expert evidence is not required to make that finding: *ter Neuzen* at paras. 38, 41, 51-52.
- [190] "The differences in the locality of medical practices as between the defendant doctor[s] and experts who have been trained and/or qualified to practise medicine elsewhere in Canada are considerations that go to the weight of the expert evidence, rather than to its admission": *Chen v. Ross*, 2012 BCSC 1605 at para. 47

Causation

- [191] If there has been a breach of the duty of care, the plaintiff must then show on a balance of probabilities that "but for" that negligent act, the injury would not have occurred: *Clements v. Clements*, [2012] 2 SCR 181 at para. 8.
- [192] "The 'but for' causation test must be applied in a robust common sense fashion. There is no need for scientific evidence of the precise contribution the defendant's negligence made to the injury": *Clements* at para. 9.
- [193] The less onerous test of "material contribution" by a defendant to the risk that was created is only appropriate when there is more than one defendant who has been proven to be negligent, but it cannot be proven which one of them "launched the event" that led to the injury. That standard is imposed as a matter of fairness, to prevent negligent defendants to escape liability by pointing fingers at each other: *Clements*, at para. 40-41.

Informed Consent

- [194] The duty of obtaining informed consent to medical treatment requires that the physician "answer any specific questions posed by the patient as to the risks involved and , without being questioned, disclose to him the nature of the proposed [treatment], its gravity, any material risks and any special or unusual risks attendant upon the performance of [it]": Hopp v. Lepp, [1980] 2 SCR 192 at p.210. This includes a "mere possibility" that normally would not need to be disclosed, if its occurrence carries serious consequences. In that case it should be regarded as a material risk: Reibl v. Hughes, [1980] 2 SCR 880 at 885.
- [195] In deciding whether a risk is material, and therefore should be explained to the patient, an objective approach should be taken. The crucial question in determining the issue is whether a reasonable person in the patient's position would want to know of the risk: Ciarlariello v. Schacter, [1993] 2 SCR 119, at para. 36.
- [196] In other words, "a medical person must disclose those risks to which a reasonable patient would be likely to attach significance in deciding whether or not to undergo the proposed treatment. In making this determination, the degree of probability of the risk and its seriousness are relevant factors": Rawlings v. Lindsay, (1982) 20 CCLT 301 (BCSC) per McLachlin J. (as she then was), cited with approval in Brito (Guardian ad litem) v. Woolley, 2003 BCCA 397 at para 32, leave to appeal refused [2003] S.C.C.A. No. 418.
- [197] Expert evidence is not determinative of the materiality of the risk: Reibl at pp.894-895, Brito at para. 36.
- [198] This approach "marks the rejection of the paternalistic approach to determining how much information should be given to patients. It emphasizes the patient's right to know and ensures that patients will have the benefit of a high standard of disclosure": Arndt v. Smith, [1997] 2 SCR 539 at pages 552-53.
- [199] If the court concludes that the physician failed to provide the necessary disclosure, the plaintiff must then demonstrate that a reasonable person in the same circumstances would have refused the recommended treatment, if the undisclosed risk had been disclosed.
- [200] Such a reasonable person should have attributed to them such "objectively ascertainable" circumstances as the "plaintiff's age, income, marital status and other factors", as well as the plaintiff's "reasonable beliefs, fears, desires and expectations": Arndt at para. 9.
- [201] In addition, the trier of fact must take into consideration any "particular concerns" of the plaintiff and any "special considerations affecting the particular" plaintiff in determining whether the plaintiff would have refused treatment if given all the information about the possible risks". However, those particular concerns must be reasonably based: Arndt at para. 6, citing Reibl at pp.898-900.

- [202] While it is a technical requirement that the plaintiff testify that they would have refused the treatment if they had been properly informed, that subjective element is of little use in itself, since a plaintiff in such an action will invariably testify to that effect: Arndt at para. 8, citing Hollis v. Dow Corning Corp., [1995] 4 S.C.R. 634 at pp.688-89.
- [203] Evidence from experts or the defendant physicians that patients in the plaintiff's position generally consent to the treatment in question when the risks have been fully disclosed can be persuasive. For example, in Truant v. Guichon, [1996] B.C.J. No. 1794 (S.C.) at paras. 35-36, the trial judge questioned whether the significant majority of patients who do consent after being properly informed of the risks can be described as unreasonable in making that decision.
- [204] If the plaintiff establishes that a reasonable person in their position would not have consented to the treatment upon a proper explanation of the risks, they must then show that the undisclosed risk materialized, and caused the harm complained of. This stage follows the same causation analysis that applies to breaches of the standard of care.

Discussion

Informed Consent

- [205] I will deal with this issue first because it was the focus of the submissions by Mr. Buckingham's counsel.
- [206] My conclusion is that the framework for analyzing whether informed has been provided does not really fit with the situation that arose here.
- [207] I am satisfied that the risk of continuing with high-dose prednisone for more than four weeks (the point at which Dr. Mikelberg said that intraocular pressures can start to elevate because of it), is a material risk that a reasonable person being prescribed the drug at that dose and duration would want to know about.
- [208] Four percent of the population is vulnerable to their intraocular pressures being raised by prednisone, there are no symptoms until permanent damage has been done to the optic nerve, the patient is not capable of self-monitoring, and the consequences of the glaucoma that elevated pressures can cause include blindness. This clearly falls into the category of "low risk-bad consequences", as it was described in Brito, and required an explanation to Mr. Buckingham, at the very latest, at the point when he was approaching the four-week mark.
- [209] I should say that I would reach this conclusion in relation to any patient, whether or not they had a family history of diabetes or were older than 60, so it is not necessary to resolve the conflicting views of the experts on those points.
- [210] The problem in applying the analysis arises at the second stage, with respect to whether a reasonable person possessed of Mr. Buckingham's attributes would have refused the prednisone as prescribed, if that risk had been explained to them. His counsel concedes

that such a person would not have refused it, but only with the crucial accompanying element of intraocular pressure monitoring. That was a sensible concession, in light of the abundant evidence that prednisone is the first-line treatment for dermatomyositis, that there are no real alternatives to it, and that failing to treat the condition can lead to serious health consequences for the patient.

- [211] However, I do not think the test can be applied in the manner suggested by Mr. Buckingham's counsel. The essence of the "breach" that makes a lack of informed consent negligent is that the physician's failure led the patient to submit to treatment that they would not have agreed to if they had known the true risks. Mr. Buckingham clearly would have taken that treatment even if he had known those risks, and I do not think that monitoring his pressures once he had agreed, which is really an aspect of the ongoing management of that medication after consent has been given, can be grafted onto the informed consent test. In my opinion, it belongs in the analysis of the standard of care.
- [212] Since I have found the issue of informed consent to be inapplicable at this stage of the analysis, it is unnecessary to go on to consider whether the risk that Mr. Buckingham should have been informed of - elevated intraocular pressures leading to glaucoma - actually materialized. I will consider that question in relation to the causation element of the alleged breaches of the standard of care.

Standard of Care

- [213] The evidence of Dr. Bovard and Dr. Wade satisfies me that in this province, at the time that the prednisone was prescribed to Mr. Buckingham, prudent and diligent family physicians in Dr. Hobza's circumstances and rheumatologists in Dr. Law's would not have instituted a regime of intraocular pressure monitoring for a patient to whom they had prescribed high-dose prednisone for more than four weeks. Neither Dr. Stein nor Dr. Faber suggested otherwise - they instead explicitly described the standard as they believed it should be.
- [214] Further, while Dr. Hobza's apology, and Dr. Law's remorse and revision of her own practice after becoming a defendant, do them both credit on a human level, those actions are not informative about the standard that the doctors operated under when these matters arose.
- [215] The real question is whether the standard of care that the defendants both met is itself negligent.
- [216] This is different than the usual situation, in that we have actual expert witnesses who gave opinions that a different standard of care is appropriate, but since their opinions admittedly fall outside of the established standard of care, I think that the analysis from *ter Neuzen* still applies.
- [217] As I have summarized, to be negligent in itself, the existing standard must be one that is fraught with obvious risk and/or that fails to adopt obvious and reasonable precautions which are readily apparent to the ordinary finder of fact. As the trier of fact in this case, I

am aided by the opinions of two medical professionals that those deficiencies exist. I do not think Dr. Stein being based in Ontario and Dr. Faber not being familiar with current practices in family medicine or rheumatology really matter to the weight of their opinions, because their opinions were based on fundamental medical principles that I am satisfied cut across all locations and specialties - that a medication that can seriously affect eyesight in a way that does not manifest until it is too late to be fixed needs to be monitored before that effect occurs.

[218] At the end of the day however, I would reach the same conclusion without those expert opinions, since I am satisfied that the adequacy of the current standard of care is within my ability to determine as an ordinary trier of fact, and does not require diagnostic or clinical knowledge.

[219] When addressing this issue, it is helpful to consider the kinds of cases in which triers of fact have found the existing standard of care to be negligent:

- *Anderson v. Chasney*, [1949] 4 D.L.R. 71 (MBCA), *aff'd* [1950] 4 D.L.R. 223 (mentioned in *ter Neuzen*): A child died after surgery when a sponge left in his nostril caused suffocation. The accident could have been avoided by using sponges that are harder to misplace, or having a nurse count them to be sure they had all been retrieved, but this was not the standard practice. Justice Coyne observed, at para. 63, that "[o]rdinary common sense dictates that when simple methods to avoid danger have been devised, are known, and are available, non-use [], with fatal results, cannot be justified by saying that others also have been following the same old less-careful practice; and that when such methods are readily comprehensible by the ordinary person, by whom, also, the need to use them or not is easily apprehended, it is quite within the competence of Court or jury, quite as much as of experts, to deal with the issues; and that the existence of a practice which neglects them, even if the practice were general, cannot protect the defendant surgeon."

- *Comeau v. Saint John Regional Hospital*, 2001 NBCA 113: internal medicine specialists discharged a patient who had been referred to them by an emergency room doctor, without consulting with the emergency room doctor or her replacement. The patient then died of a condition that was different than the one that the internal medicine specialists had diagnosed. Despite the internal medicine specialists' actions falling within the existing standard of care, the Court of Appeal upheld the finding of negligence against them that had been made at trial. The specialists' practice failed to recognize that the emergency doctors could have been in a better position to make a decision about discharge. Citing para. 61 of *ter Neuzen*, the Court concluded that the specialists "should be held liable for having followed an 'accepted' practice which, under the circumstances existing at the Hospital, was itself negligent in that it was not 'consistent with the measures which the hypothetical reasonable prudent practitioner would take in the same circumstances.'"

· *Rupert v. Toth*, [2006] O.J. No. 882 (S.C.J.): a patient died of a seizure that resulted from a kind of tissue growth called inverted papilloma. The defendant, an otolaryngologist, had performed surgery on the patient for what were originally believed to be nasal polyps, but the defendant then suspected inverted papilloma. He sent the patient for a CT scan to address that suspicion, but did not book a follow-up appointment. When he received the CT report he flagged it with a sticky note telling his secretary to book a follow up appointment, but for some reason the appointment was not made. The trial judge found that the doctor's practice of not giving test results over the telephone, and of asking the patient to book a follow up appointment to receive and discuss the results, was consistent with that of otolaryngologists in the province.

Nevertheless, the relevant standard of care was not a question of medical science, but rather one of communications management, and thus expert evidence was not determinative. The trial judge concluded that the practice of shifting the responsibility to the patient to attend to receive information as the only mechanism to ensure that information is conveyed will be "fraught with risk in some cases" and that it was indeed fraught with risk in this patient's case (paras.123-128).

[220] The common thread in these findings, it appears to me, is a focus on practical, systems-based, or common-sense considerations, rather than on substantive medical issues.

[221] Similarly, I do not think that finding the standard of care negligent in this case requires any diagnostic or clinic expertise. This standard is fraught with risk in a particular situation and type of patient, and reasonable precautions to avoid that risk - in the form of a system of ongoing monitoring - are obviously available, even from the perspective of the non-medically trained trier of fact.

[222] What distinguishes this particular risk of high-dose prednisone for more than four weeks from the myriad other risks that the existing standard, quite reasonably, leaves to patients to bring to the attention of their physician if anything seems amiss, is that a patient is incapable of monitoring their intraocular pressures themselves, and will not notice anything worthy of bringing to their physician's attention until the pressures have caused irreparable damage to their optic nerves. Statistically, one in every 25 patients who receives such a dose for such a period of time is susceptible to this risk, which is hardly an insignificant frequency.

[223] In short, quite aside from any technical medical considerations, and purely as a matter of common sense, the standard under which Dr. Hobza and Dr. Law operated was negligent because it left a meaningful percentage of patients unable to protect themselves against the onset of a life-altering side effect, when a means of ensuring that protection - regular visits to an optometrist for intraocular pressure monitoring - was easily available.

[224] However, while I am satisfied that this means that Dr. Law is not protected from liability by her adherence to the existing standard of care, I am not satisfied that Dr. Hobza's conduct actually engaged the considerations that make the existing standard negligent.

- [225] It is common ground that his first prescription did not raise concerns about elevated pressures, and his second one took Mr. Buckingham to the boundary of the point where elevation starts to occur. That second prescription was also only intended to take Mr. Buckingham to the point when he would see a specialist for his condition, and once that point was reached Dr. Hobza was entitled to proceed on the basis that the ongoing management of that prednisone use would be in the hands of that specialist. In my opinion, it would ask too much of Dr. Hobza in his role as Mr. Buckingham's family physician to require him to supplement that ongoing specialized care by instituting the necessary system of intraocular pressure monitoring himself.
- [226] Therefore, my finding of negligence, based on adherence to an inadequate standard of care in the monitoring of intraocular pressures when prescribing high-dose prednisone for more than four weeks, applies only to Dr. Law.

Causation

- [227] Mr. Buckingham's counsel quite rightly emphasises the practical manner in which the available inferences with respect to causation should be approached, and the absence of any need for a scientific basis to draw such inferences. The capability of Mr. Buckingham's dose of prednisone and duration of usage to raise his intraocular pressures, and the occurrence of visual symptoms of the kind that result from ongoing elevated pressures, without more, certainly offer a viable chain of reasoning towards causation. Dr. Faber's opinion on causation is not specific, and really does no more than endorse the medical basis of this reasoning process, which is not in dispute.
- [228] Despite this, I conclude that the opinions on behalf of the defendants that there was a non-negligent cause for what happened to Mr. Buckingham are more solidly grounded in the totality of the evidence, and are ultimately more persuasive.
- [229] Mr. Buckingham's counsel very ably cross-examined Dr. Mikelberg on the variability of the cup size in optic discs across the population, and the difficulty of assessing the size of a particular depression without a baseline of its original state. But Dr. Mikelberg responded, convincingly in my opinion, that the damage to Mr. Buckingham's optic nerve did not have any of the characteristics of glaucoma and that, crucially, a person with a naturally small cup would not fail to be diagnosed with glaucoma, because visual symptoms like Mr. Buckingham's would require significant evidence of cupping.
- [230] There was of course additional significant evidence against a glaucoma diagnosis. The type of damage to Mr. Buckingham's visual field is not normally found as a result of glaucoma, and the timing of the measurements of his intraocular pressures and of the tapering of his prednisone are inconsistent with having produced it. Notably, Dr. Mikelberg rejected the possibility of a scenario in which Mr. Buckingham's pressures had initially elevated, causing the visual symptoms, declined by the time they were measured on November 18, and then spiked again in time for the measurements in January.

- [231] Not essential to accepting his evidence, but adding weight to it, Dr. Mikelberg is clearly a very knowledgeable and experienced practitioner in the diagnosis and treatment of glaucoma, and he was fair, balanced and candid in his responses to cross-examination.
- [232] I find therefore, that Mr. Buckingham does not suffer from glaucoma.
- [233] One could certainly argue that this finding is sufficient to resolve the claim. Mr. Buckingham's theory of liability is based on the mechanism of elevated intraocular pressures from prednisone leading to glaucoma and vision loss, and my acceptance of Dr. Mikelberg's opinion deprives that theory of one of its essential supports. Put another way, there is no remaining mechanism in the evidence by which the visual symptoms could have resulted from prednisone use. One could construe that as a failure to prove one of the essential elements of negligence, and the need for the defendants to put forward a more likely non-negligent cause of the visual symptoms would not arise.
- [234] In case there is any doubt on this point however, I will go on and consider Dr. Barton's opinion that these symptoms were caused by methotrexate toxicity.
- [235] Once again, cross-examination by Mr. Buckingham's counsel on the paucity of reported cases of this kind of toxicity was very ably done, as was his highlighting of the variability among the background factors of the patients in those cases. Despite these limitations, as I understood his evidence Dr. Barton was not putting any of those cases forward as exact matches with Mr. Buckingham's circumstances. Instead, he identified relevant similarities in them, such as that methotrexate toxicity has been shown to cause demyelination in addition to folate deficiency, to occur in patients who had been taking folate, to lead to both central and arcuate visual impairment, and to lead to irreparable vision damage. For those purposes, his reliance on them was appropriate.
- [236] Even accepting its rarity, I think that the factors that Dr. Barton relied on in support of methotrexate toxicity as the cause - most importantly the continued deterioration in Mr. Buckingham's vision well after the prednisone had been stopped - are persuasive. Assuming, as turned to be correct on my finding, that glaucoma was not the cause, and noting that Dr. Atkins had excluded most of the other explanations (except for lung cancer, which was excluded as a matter of common sense), methotrexate toxicity was the remaining unexcluded one that fit the facts, and I conclude that Dr. Barton's conclusion that it was probably the cause was the correct one in those circumstances.
- [237] Like Dr. Mikelberg, Dr. Barton is clearly a very experienced and knowledgeable practitioner in his areas of expertise, and he exhibited the same positive attributes in his responses to cross-examination as Dr. Mikelberg. Once again, that is not determinative of the correctness of his opinions, but it adds weight to them.

- [238] Of course, I agree with Mr. Buckingham's counsel that, all other things being equal, a rare condition is a less likely explanation for a set of symptoms than a common one for the purposes of the causation analysis. But we have to keep in mind here that I have found that Mr. Buckingham does not have glaucoma, so that more common explanation is not available as an alternative.
- [239] As a result, on the assumption that it is necessary to make such a finding, I am satisfied that it is more likely than not that the cause of Mr. Buckingham's visual symptoms was methotrexate toxicity.

Conclusion

- [240] The claim must therefore be dismissed.
- [241] This conclusion makes it unnecessary to consider what the amount of Mr. Buckingham's non-pecuniary damages would have been.
- [242] Unless there are additional matters that would affect costs, in which case written submissions can be provided as arranged between counsel, the defendants will receive their costs, at the usual scale of difficulty.

"Schultes J."

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