

CANADA / JUDGMENT

Marszalek et al v. Bishop et al

2007 BCSC 324

COURT

Supreme Court of British Columbia

DECIDED

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2007 BCSC 324 Marszalek et al v. Bishop et al

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Marszalek et al v. Bishop et al,

2007 BCSC 324

Date: 20070308

Docket: S70732

Registry: New Westminster

Between:

Estate of Eugene Marszalek and Emilia Lil

Plaintiffs

And

Dr. P.B. Bishop, Fraser Health Authority

doing business as Ridge Meadows Hospital,

Dr. D. Bartel, Dr. H. Binder et al

Defendants

Before: The Honourable Madam Justice Fisher

Reasons for Judgment

Emilia Lil

In Person

Counsel for the defendants Dr. D. Bartel and Dr. H. Binder

Counsel for the defendants Fraser Health Authority dba Ridge Meadows Hospital, Nurses Carman, Coveney, Balakrishnan, Bielesch, Derksen and Spurrell

B. Norell

R. Wu

J. Ankenman

Date and Place of Trial/Hearing:

November 27, 28, 29, 30, December 4, 5, 6, 7, 8, 11, 12, 13, 14, 15 2006

New Westminster, B.C.

- [1] On December 10, 1999, Eugene Marszalek died at Royal Columbian Hospital after suffering a massive cerebellar stroke. He was 57 years old. In the three days before his death, he had been receiving care at Ridge Meadows Hospital, a community hospital in Maple Ridge, B.C. The staff there did not suspect that Mr. Marszalek was suffering from a stroke until the evening of December 9, 1999, at which point he was transferred to Royal Columbian Hospital. Unfortunately, by the time he was admitted there and seen by a neurosurgeon, his prognosis was grim.
- [2] This law suit is about the treatment Mr. Marszalek received at Ridge Meadows Hospital in those three days preceding his death.
- [3] Emilia Lil was his long-time companion. She alleges that the defendants were negligent and she brings this action as a common-law spouse under the Family Compensation Act, R.S.B.C. 1996, c. 126, (the Act).
- [4] Ms. Lil proceeded to trial against two physicians, Dr. Douglas Bartel and Dr. Hannah Binder; three nurses, Nurse Coveney, Nurse Balakrishnan and Nurse Bielesch; and the Ridge Meadows Hospital. After Ms. Lil closed her case, the defendants made a no evidence motion under Rule 40(8) of the Rules of Court. I allowed the motion only as against Dr. Bartel, and the action continued against the remaining defendants.
- [5] The defendants allege that Ms. Lil does not have the status to bring this action because she was not a spouse as defined in the Act. They deny that they were negligent and they deny that any act or omission caused or contributed to the death of Mr. Marszalek.

The issues

- [6] In order for Ms. Lil to succeed in her action against the defendants, she must prove, on a balance of probabilities, that
 - (a) she was Mr. Marszalek's "spouse" as defined in the Act;

- (b) the defendants owed Mr. Marszalek a duty of care;
 - (c) the defendants breached the appropriate standard of care; and
 - (d) the conduct of the defendants was the actual and legal cause of Mr. Marszalek's death.
- [7] There is no dispute that the defendants owed Mr. Marszalek a duty of care. The issues are whether Ms. Lil has standing to bring this action under the Act, whether the defendants breached the appropriate standard of care, and if they did, whether their conduct caused or contributed to Mr. Marszalek's death.
- [8] For the reasons that follow, I have concluded that Ms. Lil has the status to bring this action, that certain acts or omissions by Dr. Binder and the nursing staff on December 9, 1999 did not meet an appropriate standard of care, but that Ms. Lil has not proven that any of these negligent acts or omissions caused or contributed to Mr. Marszalek's death. This is because at the time of the negligent acts or omissions, Mr. Marszalek had little to no chance to access surgical treatment that could probably have saved his life.

The plaintiff

- [9] Ms. Lil represented herself in this litigation, and she did so with conviction. She has, in her own words, been "fighting for seven years". She pushed for and obtained an investigation by the Coroner. She complained to the College of Physicians and Surgeons of British Columbia. This trial was her last fight. She feels very strongly that Mr. Marszalek died a horrible death and she believes that he deserved his day in court. She wants the Court to understand what happened from the perspective of patients and ordinary people. She says that the doctors and nurses involved in Mr. Marszalek's care at Ridge Meadows Hospital did not listen either to him or to her.
- [10] Ms. Lil does not claim substantial damages. She says that she cannot put a price on Mr. Marszalek's life, but that he was "worth a fortune" to her. She claims damages of about \$25,000 and she wants Ridge Meadows Hospital to purchase some new equipment in Mr. Marszalek's memory.
- [11] It is, of course, very difficult for a plaintiff to conduct this kind of litigation without counsel. Ms. Lil presented her case as best she could, but there were obvious challenges. It was not easy for her to stay focussed on the relevant issues, but she respected the direction of the Court. She did not adduce expert evidence on some of the critical issues in this case. This in itself, presented significant challenges for the Court.

Evidence issues

- [12] This trial took place eight years after the events surrounding Mr. Marszalek's death. It is not surprising that witnesses who testified about these events had a limited recollection. Dr. Binder, in particular, did remember Mr. Marszalek but she did not recall the specifics of the examinations she did on those days, and her testimony was qualified as to what her standard practice was at the time. There is no question that such a delay puts a defendant like Dr. Binder at some disadvantage.
- [13] Ms. Lil sought to admit into evidence various documents related to the investigations by the Coroner and the College of Physicians and Surgeons. I ruled that these documents were not admissible in this trial, as they relate to different processes.
- [14] Both defendants sought to admit into evidence a transcript of an examination for discovery of Mr. Marszalek, which took place on September 20, 1999. This examination was in respect of an action that Mr. Marszalek had commenced arising from a motor vehicle accident that occurred on November 17, 1998. It is clear that the transcript is hearsay; it is sought to be admitted for the truth of the statements.
- [15] The defendants submitted that the transcript was admissible (1) under Rule 40(4) of the Rules of Court, (2) as an admission by a party, and (3) under the principled exception to the rule against hearsay. They say that the transcript provides evidence that relates to Ms. Lil's standing as a common-law spouse and to the history taken by Dr. Binder of Mr. Marszalek's symptoms in the year before he was admitted to Ridge Meadows Hospital.
- [16] I do not consider counsel's first two bases to apply in this case. Rule 40(4) provides that where a witness is dead, the court may permit a transcript of evidence of that witness taken under oath in any proceeding to be put in evidence. This is a wrongful death action; Mr. Marszalek is neither a witness nor a party. In my opinion, the only basis on which the transcript may be admissible is under the principled exception to hearsay, as set out by the Supreme Court of Canada in *R. v. Khan*, [1990] 2 S.C.R. 531, and numerous other cases, and recently refined in *R. v. Khelawon*, 2006 SCC 57.
- [17] As the Supreme Court explained in *R. v. Khelawon* at para. 35, hearsay is excluded because it is difficult "to assess what weight, if any, should be given to a statement made by a person who has not been seen or heard, and who has not been subject to the test of cross-examination." The principled approach recognizes that some hearsay may be sufficiently necessary and reliable to permit the court to assess its weight. In order for the transcript to be admitted in this case, it must meet the twin criteria of necessity and reliability. Necessity for this purpose means "reasonably necessary": *R. v. Khan* at para. 29. Reliability may be established by showing that the circumstances in which the statement came about provide sufficient comfort in its truth and accuracy, or that its truth and accuracy may be sufficiently tested by means other than contemporaneous cross-examination: *R. v. Khelawon* at paras. 62-63.

- [18] The defendants submitted that the transcript meets the necessity criterion because it provides the best evidence - being the only evidence directly from Mr. Marszalek - about Mr. Marszalek's relationship with Ms. Lil and his physical condition before his death. They say that it is reliable because the statements were under oath, in the nature of a cross-examination, and there is no reason to expect any fabrication.
- [19] Ms. Lil objected to the admissibility of the transcript. She says that it is not necessary because there is ample evidence that relates to her common-law status and to Mr. Marszalek's medical condition before he came to the hospital. She says that it is not reliable because Mr. Marszalek may not have been telling the truth about some matters, but more importantly, Mr. Marszalek did not have a good understanding of the English language, so many of his answers have limited value.
- [20] I have concluded that the transcript is admissible. I agree with the defendants that the evidence is reasonably necessary because evidence of the same quality cannot be otherwise obtained. I also agree that the evidence is sufficiently reliable because of the circumstances in which it came about; Mr. Marszalek was giving evidence under oath in circumstances where one would expect him to disclose all of the symptoms he was experiencing as a result of his injuries. I have some concerns about his answers to questions about his relationship with Ms. Lil, but the accuracy of this was, in my view, sufficiently tested through the evidence of Ms. Lil. I appreciate Ms. Lil's concerns about Mr. Marszalek's limited understanding of English, but this is evident from his answers. In my opinion, any of these concerns about reliability go to weight rather than admissibility.

The plaintiff's standing

- [21] Ms. Lil's standing depends on whether she is a "spouse" as defined in the Act, as the action must be for the benefit of the spouse of the deceased. "Spouse" is defined as a person who "lived and cohabited with the deceased in a marriage-like relationship for a period of at least 2 years ending no earlier than one year before the death".
- [22] Ms. Lil and the deceased had a relationship for many years. She met Mr. Marszalek in 1982 when she first came to Canada. Both were originally from Poland. Except for a short time in those early years, Ms. Lil did not work. She learned how to make things from stained glass and became quite an accomplished artist in that field. Mr. Marszalek had been a seaman before he came to Canada. He had been married in Poland before and he had two children there. In Canada, he became an accomplished carpenter. He had several siding contracting businesses over the years.

- [23] At some point, Ms. Lil and Mr. Marszalek moved to a property in Mission, which was purchased in Ms. Lil's name. She said that a \$2,000 down payment was made with funds she received from her parents and the balance was paid with a mortgage. She did not know the amount of the mortgage. She said that Mr. Marszalek made all of the mortgage payments. She said that Mr. Marszalek looked after all of their financial affairs and always supported her.
- [24] The couple had what Ms. Lil and some of the witnesses described as an unconventional relationship. According to numerous witnesses, Mr. Marszalek was extremely devoted to Ms. Lil, was very proud of her as an artist, and was very proud that he could support her so that she did not have to work. Ms. Lil, who was considerably younger than Mr. Marszalek, constantly strived for independence. She did not refer to Mr. Marszalek as her husband, but he referred to her as his wife. However, they lived together as a couple and were seen as a couple by their friends. Ms. Lil said that each of them had different preferences and habits, so they functioned by having separate bedrooms. However, it is clear that they had an intimate relationship.
- [25] Although he did not make a large income, Mr. Marszalek did extensive work on the Mission property. This property was unusual. It can be described as a small village, with separate buildings for each room. The evidence shows that Mr. Marszalek built a beautiful environment that supported a comfortable lifestyle. As Ms. Lil testified, "we were always broke but we lived like millionaires".
- [26] After living at the Mission property for some years, Ms. Lil became unhappy in the relationship. She said that Mr. Marszalek was very possessive and if he drank, he became angry and difficult. They did not see people very often and she was quite isolated. In April 1994, she left. She transferred the Mission property to Mr. Marszalek and he paid her for ½ of its value. With that money, she purchased a new property in Maple Ridge. This was also an unusual property, in that it was an old church. Ms. Lil was hoping to live there and use part of the building as an art gallery from which she could show and sell her stained glass creations. The building had two suites from which she could earn revenue income.
- [27] According to Grazsnya Plecas, a close friend of both Ms. Lil and Mr. Marszalek, Mr. Marszalek did not see himself living without Ms. Lil and was not happy living on his own. To her, it was obvious that Mr. Marszalek would follow Ms. Lil "almost anywhere".
- [28] Mr. Marszalek and Ms. Lil continued to see each other, and Mr. Marszalek continued to provide financial support. He often came to Maple Ridge to help her with the property. Ms. Plecas said that "even though they were apparently split up, he was always there." By 1995, he had moved from Mission into one of the suites in the church property. Some three to five months after that, he moved into the main building to live with Ms. Lil again. However, they still maintained separate bedrooms in the main house. Mr. Marszalek did renovations and improvements on the church property, as he had in Mission.

- [29] Ms. Lil was still unhappy in the relationship. Sometime in the spring of 1997, she decided to leave again. This time, she was going to go to the U.S. As she was driving south, she had an "epiphany" and realized the extent of her feelings for Mr. Marszalek. She turned around and went home. They remained together until Mr. Marszalek's death in December 1999.
- [30] Ms. Lil said that Mr. Marszalek always wanted to get married, particularly in the last few years, as he was worried that she would not have an income and he wanted her to have a pension. However, she did not want to get married; she did not see the need to do so, given that they lived together, and she sought to have as much independence as she could. Also in the last few years, Mr. Marszalek started to plan a sailing trip around the world and in the spring of 1999 he began looking for a yacht. Ms. Lil said that it was his dream to do this with her.
- [31] During their years together, Ms. Lil and Mr. Marszalek made financial and business arrangements in a somewhat unusual way and kept separate bank accounts. Ms. Lil was the registered owner of their properties and Mr. Marszalek paid the mortgages. Ms. Lil was also the owner of Mr. Marszalek's siding businesses, from which he was paid a salary. Ms. Lil testified that Mr. Marszalek was responsible for managing all of their financial affairs, as she is not good with numbers. She said that he instructed her about payments and used her bank account for everything. Essentially, Mr. Marszalek always supported Ms. Lil financially. He named her as beneficiary in his life insurance policy.
- [32] In 1998, Mr. Marszalek was injured in a motor vehicle accident. He suffered chronic neck pain and was unable to work. He applied for and received social assistance benefits. In his application, he represented that Ms. Lil was his landlady and that he paid rent to her. Ms. Lil testified that Mr. Marszalek made those representations when he was living upstairs with her. She said that Mr. Marszalek referred to her in official government documents as his landlady, but he did not so do privately. The social assistance payments supported both of them and Mr. Marszalek paid for everything. There were times in previous years when Mr. Marszalek's businesses were not doing well, and he made similar applications and received social assistance. Ms. Lil was not aware of some of these earlier applications.
- [33] Counsel for Dr. Binder submitted that Ms. Lil does not fall within the definition of "spouse" in the Act. Ms. Wu based her submission on a number of facts, such as how the couple treated each other for "official" purposes (income tax, social assistance and other benefits), the way they managed their financial affairs (separate bank accounts, separate ownership of property), the way they lived (in separate bedrooms), how they referred to each other, and ultimately the fact that Ms. Lil did not want to marry Mr. Marszalek. She referred to some of Mr. Marszalek's statements in his examination for discovery, where he referred to his marital status as divorced, to his children as his dependents and to Ms. Lil as his landlady and friend, but not lover.

- [34] Mr. Ankenman acknowledged that the evidence clearly showed that Mr. Marszalek was committed to Ms. Lil. He submitted, however, that Ms. Lil did not discharge the burden of proving that her relationship with Mr. Marszalek was a "marriage-like" relationship within the meaning of the Act, because she, as one of the parties to that relationship, was not committed to the necessary extent, both morally and financially.
- [35] Whether or not a couple has been living together in a marriage-like relationship is a matter of evidence: *McEvoy v. Ford Motor Company*, [1988] B.C.J. No. 1757 (S.C.) (QL), *aff'd* (1992), 63 B.C.L.R. (2d) 397 (C.A.).
- [36] In *Gostlin v. Kergin* (1986), 3 B.C.L.R. (2d) 264 (C.A.), the Court of Appeal considered whether an unmarried couple lived together as husband and wife for the purpose of entitlement to spousal support under the Family Relations Act, then in force. The definition of "spouse" in the Family Relations Act is similar to the definition under the Act. These statutes both relate to the right to support and maintenance of persons who have lived with another in a marriage-like relationship. As a matter of policy the court should apply a similar construction: *McEvoy v. Ford Motor Company*.
- [37] In *Gostlin*, Lambert J.A. looked at whether each partner in the relationship considered himself or herself "committed to life-long financial and moral support" of the other. He developed a test that focuses first on the intention of the parties:

But marriage does not suit every couple who want to share their living accommodation. For religious, moral, sexual, financial or other reasons they may be unable to marry or may prefer not to marry. Some couples may behave towards each other and towards the outside world as if they were married. Their relationship may be one of permanence and of commitment. They may eagerly embrace the obligations of s. 57 [support obligations]. Other couples may prefer quite a different relationship. They may want to retain their independence from each other. They may find long term commitments stifling, and emotional interdependence cloying. They would shun the obligations of s. 57.

Surely society can accommodate those who prefer to live together without commitment. If there are no children involved, there is no reason to force financial commitments on couples who do not want them. Independence should be a choice. But how can couples exercise that choice except by not getting married to each other and not making any commitment to each other? If that is their wish, the expiry of two years from the start of their relationship should not force them into mutual commitments that they do not want.

I would ask whether the unmarried couple's relationship was like the relationship of the married couple in that the unmarried couple have shown that they have voluntarily embraced the permanent support obligations of s. 57. If each partner had been asked, at any time during the relevant period of more than two years, whether, if their partner were to be suddenly disabled for life, would they consider themselves committed to life-long financial and moral support of that partner, and the answer of both of them would have been "Yes", then they are living together as husband and wife. If the answer would have been "No", then they may have been living together,

but not as husband and wife.

- [38] Mr. Ankenman submitted that Ms. Lil chose not to be married and chose not to be in a marriage-like relationship. He says that she was not submissive or dependent on Mr. Marszalek and revelled in their unconventional relationship. Accordingly, she is not now entitled to make a claim under the Act as a spouse.
- [39] The evidence is clear that Ms. Lil preferred not to marry. That in itself does not mean that she was not committed to a relationship of permanence with Mr. Marszalek. It is not necessary for one partner to be submissive or dependent in order to establish a committed relationship, nor is it necessary for a relationship to be "conventional". Ms. Lil wanted her "independence". I interpret this to mean independence in a personal and artistic way; it did not mean independence to become involved in an intimate way with others, or financial independence. The evidence clearly shows that Ms. Lil was financially dependent on Mr. Marszalek for many years. She may have been less emotionally dependent on him than he was on her, but the fact is, she stayed with him for over 17 years, with only two periods of separation - the first in about 1994 -1995 when she moved to Maple Ridge, and the second in 1997 for only a few weeks or months when she thought about going to the U.S. I agree with the comments of Huddart J.A. in *Takacs v. Gallo*, (1998), 48 B.C.L.R. (3d) 265 (C.A.) at para. 40, that conduct often speaks louder than words. That observation clearly applies in this case. Although Ms. Lil may have talked about her "independence", she devoted years to an exclusive and committed relationship with Mr. Marszalek.
- [40] In my view, Ms. Lil was both financially and emotionally dependent on Mr. Marszalek for many years, and by all of her actions, she was committed to a relationship of permanence. Mr. Marszalek was equally, if not more, committed. As Lambert J.A. posed in *Gostlin*, if each of them had been asked at any time during the two years preceding Mr. Marszalek's death, whether, if the other were to be suddenly disabled for life, they would consider themselves committed to life-long financial and moral support of the other, both would have answered "yes".
- [41] I say this with regard to the fact that Ms. Lil did not contribute financially to any significant degree over the years, and when Mr. Marszalek had financial difficulties, he obtained social assistance. Mr. Ankenman submitted that Ms. Lil "actively assisted" Mr. Marszalek "in his descent from the position of primary financial supporter, and took no steps at all consistent with committing her financial resources to him in his time of need." I disagree. Ms. Lil's only means of support in the two years before Mr. Marszalek's death, other than Mr. Marszalek, was the rent she received from the two suites in the Maple Ridge property. There is no evidence that Ms. Lil used these funds only for her own benefit. The evidence supports a finding that all of the sources of income each of them received were combined to support them both. Further, from the evidence of Ms. Lil and the many friends and acquaintances who knew them both over the years, it appears that Mr. Marszalek was very proud to support Ms. Lil and he would not have asked her to make specific financial contributions. In fact, Ms. Lil was not aware of some of Mr. Marszalek's applications for social assistance. I infer

from this that Mr. Marszalek preferred to seek temporary government support rather than lower himself in the eyes of Ms. Lil.

- [42] In *Gostlin*, Lambert J.A. described some "more objective indicators" that may demonstrate a mutual, long-term committed relationship:

Did the couple refer to themselves, when talking to their friends, as husband and wife, or as spouses, or in some equivalent way that recognized a long-term commitment? Did they share the legal rights to their living accommodation? Did they share their property? Did they share their finances and their bank accounts? Did they share their vacations? In short, did they share their lives? And, perhaps most important of all, did one of them surrender financial independence and become economically dependent on the other, in accordance with a mutual arrangement.

All those questions, and no doubt others, may properly be considered as tending to show whether a couple who have lived together for more than two years have done so with the permanent mutual support commitment that, in the relevant sense of the Family Relations legislation, constitutes living together as husband and wife.

- [43] As Bauman J. noted in *Ring v. Bourgeois*, [1998] B.C.J. No. 2576 (S.C.) (QL), it may be more appropriate in today's social reality to look for an indication that the parties have "weaved their financial and economic positions together" rather than to look for a "surrender" of financial independence. Moreover, as noted above, it should be recognized that many individuals in marriage or "marriage-like" relationships are quite independent of each other in many ways, yet remain committed to each other in a long-term or permanent way.
- [44] Any objective factors are relevant to determining the parties' intentions, but they are rarely determinative in and of themselves: *Takacs v. Gallo* at para. 55.
- [45] In my opinion, there are some "more objective" indicators here that show a mutual, long-term commitment. Although Ms. Lil did not call Mr. Marszalek her "husband", she clearly referred to him in a way that recognized a long-term commitment. Mr. Marszalek described her in his examination for discovery as his "best friend of the world". He said, "Not lover, just friend, the best one. We stay together in Canada and try grow up. Like friends, like good friends." Ms. Lil said this meant that they were not "just friends", they were not "just lovers", they were best friends and intimate friends. I accept her explanation of this. It is clear throughout the transcript of Mr. Marszalek's examination for discovery that his ability to clearly express himself in English was limited.
- [46] Ms. Lil's and Mr. Marszalek's friends and acquaintances never questioned the marriage-like nature of their relationship. Although Ms. Lil held legal title to their properties and they had separate bank accounts, they actually shared all of their property and their finances. When Ms. Lil left the Mission property, she recognized that Mr. Marszalek had an equal interest in that property. While they lived unconventionally, I find that they shared their lives in a very significant way. Their financial and economic positions were interwoven, Ms. Lil was economically dependent on Mr. Marszalek for many years, and this was clearly according to

a mutual arrangement.

- [47] For all of these reasons, I find that Ms. Lil is a "spouse" within in the meaning of the Act, and she has the status to bring these proceedings.

Circumstances leading to the death of Eugene Marszalek

- [48] Mr. Marszalek suffered a cerebellar stroke while he was at Ridge Meadows Hospital, which became life threatening during the afternoon and evening of December 9, 1999. No one made the diagnosis until it was too late. He had been treated for acute gastritis and suspected alcohol withdrawal. Just after 20:00, he arrested and was intubated. At that point, it appeared that he had a brain stem stroke. He was transferred to Royal Columbian Hospital on an emergency basis. A CT scan of the head was performed just before 22:00 and the diagnosis of cerebellar stroke was made. He was pronounced dead the next day.
- [49] As noted above, Mr. Marszalek was injured in a motor vehicle accident about a year before his death. He had started an action against the other driver. He was being treated by his family doctor for soft tissue injuries, mainly to his neck, and he had intermittent symptoms of dizziness. He had not been able to work since the accident. On December 6, 1999, Dr. Paul Bishop, an orthopaedic surgeon, conducted an independent medical examination of Mr. Marszalek. After this examination, Mr. Marszalek complained about a significant pain in his neck and some numbing in his hands.
- [50] Ms. Lil took Mr. Marszalek to a local medical clinic, where a doctor examined him and prescribed Tylenol 3 for the pain. They went home. The next day, December 7th, Mr. Marszalek collapsed briefly and became extremely dizzy and nauseous. According to Ms. Lil, she found Mr. Marszalek unconscious on the floor at about noon. He came to and ran to the bathroom to vomit. The vomiting did not stop, and Ms. Lil called 9-1-1.
- [51] An ambulance brought Mr. Marszalek to Ridge Meadows Hospital. The crew report recorded that Mr. Marszalek was conscious when they arrived and the chief complaint was "dizzy/nausea". It also noted that a "bystander" [Ms. Lil] stated that he had collapsed to floor and was unresponsive for one minute, and that Mr. Marszalek stated "he felt fine" in the morning, but took two Ativan at approximately 11:30 because "he felt anxious".
- [52] When he arrived at the hospital, he continued to vomit, he was very pale, sweaty, and he complained of headache at the base of his skull. He was seen by Dr. Douglas Bartel, an emergency room physician. Dr. Bartel took a history from Mr. Marszalek, examined him, and ordered a number of tests. He recorded these findings:

Patient examined yesterday by MD re: MVA injury last year. Had increasing pains in [illegible] & taking several meds for pain - helpful (Naproxyns or T#3's). MVA 1 yr ago left him with neck injury. Ongoing neck pains. This am took 2 Ativans. Anxious - apparently can't stand thought of himself being an "invalid". Previously a very hard worker. Then developed N/V to diaphoresis & collapsed to the floor. Earlier in AM had actually felt not too bad.

Diaphoretic No facial asymmetry. Speech OK. Chest clear Neck - tender L Extr - moves all 4 with no deficit.

- [53] Dr. Bartel made a diagnosis of "Collapse NYD" and a differential diagnosis of (a) myocardial infarction, (b) vasovagal episode, gastritis secondary to medications, (c) transient ischemic attack (TIA), or (4) subarachnoid hemorrhage. He sought a consultation by Dr. Hannah Binder, who was the internal medicine specialist on call at Ridge Meadows Hospital.
- [54] Dr. Binder is one of four internal medicine specialists at Ridge Meadows Hospital. Each has a different sub-specialty. She has a sub-specialty in gastroenterology. Her office practice is 90% gastroenterology. Her hospital practice is general internal medicine. There is no neurological specialist, and at the time there was no CT scanner at Ridge Meadows. For these and other specialized services, physicians at Ridge Meadows refer patients to Royal Columbian Hospital in New Westminster.
- [55] Dr. Binder examined Mr. Marszalek the evening of December 7, 1999. She noted his history of chronic neck pain, the medications he was taking, his symptoms of sudden onset nausea and vomiting, brief collapse, dizziness, and the increase in his neck pain and the numbing and loss of power in his arms the previous day. She noted "no neurological findings". Her differential diagnosis was gastritis related to his medications and pancreatitis. She admitted him for rehydration, ordered tests for pancreas and liver function, and prescribed medications for nausea and pain.
- [56] That night and the next morning, the nurses noted that Mr. Marszalek was sweaty and he complained of headache and extreme dizziness. Dr. Binder saw him at 11:00 on December 8th. His condition had improved to some degree. His vomiting had stopped and he was more conversant. He told Dr. Binder about the problems he had after his motor vehicle accident. Dr. Binder noted that he complained of dizziness and vertigo, and ongoing neck pain, but not headache. She thought he had acute gastritis related to medications, which had resolved, but he still had neck pain and other symptoms from his motor vehicle accident. She ordered a CT scan of the neck and planned to arrange a neurology consult for that purpose.
- [57] The nurses continued to record complaints of headache, which became more and more severe throughout the afternoon and evening, to the point where Mr. Marszalek was given morphine. Early in the morning of December 9th, he was observed to be somewhat disoriented, very restless, very unsteady on his feet, and eventually unable to weight bear. He was moved into a cardiac chair for safety, and he continued to be restless.
- [58] Dr. Binder saw Mr. Marszalek between 9:00 and 9:30 on December 9th. She had read most of the nurses' notes from the night before, but not those that noted him to be "unable to weight bear". Mr. Marszalek was very unwell but he appeared to be oriented. Dr. Binder's examination did not reveal any problems with balance. She asked Mr. Marszalek about alcohol, and he admitted to having one drink every day. Dr. Binder thought that Mr. Marszalek's presentation was consistent with alcohol withdrawal, and she placed him on the hospital's alcohol withdrawal protocol.

- [59] The alcohol withdrawal protocol requires the patient to be monitored every hour for certain periods of time, depending on the patient's "Clinical Institute Withdrawal Assessment" score. For scores greater than 10, anti-anxiety medication is given and the patient is to be reassessed every hour until the score is less than 10 for a specified period of time.
- [60] Mr. Marszalek was assessed twice under the protocol. His first score, at 10:35, was 14, and he was given medication. His second score, at 12:18, was 8. At that time he was noted to be sleeping, occasionally moving his hand toward his face, and no longer restless.
- [61] At 13:00, Mr. Marszalek was transferred out of the emergency department into a medical ward. He was received in the cardiac chair. The nurses in the medical ward noted that he was "unable to rouse," there was "no response to painful stimuli" and his pupils were small and equal.
- [62] At about 15:00, Ms. Lil came to see Mr. Marszalek. She was very upset when she saw him. She described him as sitting in the cardiac chair in a very strange position, with his head twisted, his chin down, almost naked, with a twisted sheet covering him. She thought he was asleep. She asked the nurses about his status. She was told that he had been agitated, and learned that he had been placed on alcohol withdrawal. Ms. Lil was very upset about this, as Mr. Marszalek did not drink. She advised the nurse that this was a mistake. She then spoke to Dr. Binder and told her that Mr. Marszalek had an alcohol problem in the past, but had not had any alcohol for two years. Dr. Binder was not aware that Mr. Marszalek did not respond to painful stimuli and that he was unable to rouse. She understood that Mr. Marszalek was sedated and his vital signs were stable. She put the alcohol withdrawal protocol on hold and gave further telephone orders. After this, she had no further contact with Mr. Marszalek. No one called her about him, and she did not learn of his condition until the next morning.
- [63] Ms. Lil is noted to have left the hospital at 15:30. The nurses' notes state:
- Wife has been in - very upset as patient 'so sleepy' - remains non-responsive, drooling at times from L. side of mouth - head bent to L. - remains in cardiac chair
- [64] This is consistent with Ms. Lil's evidence. She said that the nurses told her to go home and they would call her when Mr Marszalek woke up.
- [65] Mr. Marszalek was still "non-responsive" at 18:30, 19:00 and 19:30. At that point, the nurses notified Dr. Leslie Ervin, who was the internal medicine specialist on call that night. They also called Ms. Lil. Things then deteriorated quickly. At about 20:00, Mr. Marszalek had to be intubated and a Code Blue was called. Steps were then taken to transfer him to Royal Columbian Hospital on an emergency basis. This proved to be a challenge. Dr. Ervin took extraordinary steps to do this. At 21:35, Dr. Ervin personally accompanied Mr. Marszalek to Royal Columbian in an ambulance and had him admitted there. At 21:50 a CT scan of the head was done, which indicated a cerebellar stroke. At 21:55, Mr. Marszalek was examined by Dr. Oldring, an emergency physician, and at 23:30 by Dr. Gittens, a neurosurgeon. He was

maintained on the ventilator until the following day, when he was pronounced dead at 21:10.

The claims against Dr. Binder

[66] Ms. Lil claims that Dr. Binder failed to meet a reasonable standard for her profession, and she failed to diagnose Mr. Marszalek's condition as a result of her negligence and the negligence of the nurses. Particulars of the alleged negligence include:

- (a) failing to conduct a complete neurological examination;
- (b) concluding that Mr. Marszalek showed no neurological signs or symptoms on December 7, 1999 when she did not conduct a complete neurological examination;
- (c) ignoring signs and symptoms of neurological injury which were present at various times, including vomiting, vertigo, dizziness, an episode of fainting and unconsciousness prior to admission, behavioural changes including incoherence and agitation, neck pain, headache, unsteady gait, unresponsiveness to painful stimulus, inability to be aroused from sleep and incontinence;
- (d) failing to review or ignoring hospital records and notes and failing to consider their contents, including the findings and differential diagnosis of Br. Bartel;
- (e) failing to consider the possibility of a cerebral injury;
- (f) failing to order a CT scan of the head on an urgent basis or at all;
- (g) concluding that Mr. Marszalek was suffering from alcohol withdrawal without any evidence in support of that diagnosis;
- (h) implementing an alcohol withdrawal protocol that provided inadequate monitoring and examinations;
- (i) prescribing and administering sedatives that masked neurological signs and symptoms and/or prevented Mr. Marszalek from reporting his signs and symptoms;
- (j) failing to give reasonable instructions to the nursing staff with respect to monitoring and assessing Mr. Marszalek's condition;
- (k) failing to examine Mr. Marszalek after being called by the nursing staff to report developments in his condition;
- (l) failing to refer Mr. Marszalek to an appropriate specialist;
- (m) failing to properly record findings and observations.

The claims against the nurses and the hospital

[67] Ms. Lil claims that the nurses failed to meet a reasonable standard of care for their profession, and were negligent by failing to:

- (a) recognize neurological signs and symptoms and failing to call in physicians in response to signs of deterioration;
 - (b) take vital signs regularly and conduct proper examinations and neurological assessments;
 - (c) properly record signs, symptoms and observations of Mr. Marszalek;
 - (d) follow reasonable nursing practices with respect to conducting examinations, taking vital signs and calling in physicians for assistance.
- [68] She claims that the hospital is vicariously liable for the negligence of the nurses. It is not in dispute that the hospital is vicariously liable for any negligence proven against the nurses.

Expert evidence

- [69] No party called expert evidence regarding the appropriate standard of care for nurses practising in a community hospital. The only expert evidence on the standard of care relevant to Dr. Binder was adduced by the defence. Ms. Lil called one expert witness, a neurosurgeon, who was qualified to give opinion evidence on other issues.
- [70] All expert witnesses relied to a large extent on the medical records. The defence witnesses also relied on an 11-page document containing factual assumptions, which was prepared by counsel.

Dr. Ludwig Auer

- [71] Dr. Ludwig Auer gave evidence for Ms. Lil. Dr. Auer is a neurosurgeon who trained in Austria and practised mainly in Austria and Germany. He is also a trained medical doctor, with experience referring patients to other specialties and subspecialties. He has taught neurosurgery in Austria, Germany, India and Japan. He has published in many peer-reviewed journals and spoken at many national and international congresses of neurosurgeons. He has extensive experience providing medico-legal reports and has given expert evidence in New York, Austria, Germany and Switzerland. He is not licensed to practice medicine in Canada.
- [72] Dr. Auer was qualified as an expert in neurosurgery, with special expertise in cerebral vascular disease. Given his background, training and experience, Dr. Auer was not qualified to give opinion evidence about the standard of care of an internal medicine specialist practising in a community hospital in British Columbia in 1999. He was qualified to give opinion evidence about (1) Mr. Marszalek's diagnosis, the cause of his death, and his chances to survive had he been diagnosed earlier, and (2) the diagnostic steps that should be taken by any physician in order to determine if a referral to a neurosurgical specialist should be considered.

- [73] Despite this qualification, I found Dr. Auer's evidence to be of limited assistance, primarily because his experience involved mainly neurosurgical patients (a very specialized group), within a hospital environment where CT scanners and neurosurgical specialists were on site. This is a very different environment than the one in which Dr. Binder practised in 1999.

Dr. Phillip Teal

- [74] Dr. Phillip Teal gave evidence on behalf of Dr. Binder. Dr. Teal is a neurologist. Since 1992, he has been the Director of the Stroke Program at Vancouver General Hospital. He also maintains a tertiary stroke referral practice and is involved in the delivery of stroke care throughout the province. His research has focussed on cerebrovascular disease in areas of stroke prevention and acute stroke management. He developed Vancouver General Hospital's acute stroke response system. He has served on local, national and international boards related to stroke research and treatment, and he is internationally recognized as a stroke expert. Dr. Teal also trained and practised as an emergency room physician before he specialized in neurology.
- [75] Dr. Teal was qualified as an expert in cerebral vascular disease and stroke, with experience in the delivery of stroke care throughout B.C. He provided opinion evidence about the cause of Mr. Marszalek's stroke and the treatment he would have received had a correct diagnosis been made sooner.

Dr. Clifford Chan-Yan

- [76] Dr. Clifford Chan-Yan also gave evidence on behalf of Dr. Binder. Dr. Chan-Yan is an internal medicine specialist and a clinical professor of medicine at the University of British Columbia. He teaches nephrology and internal medicine at the undergraduate and post-graduate levels. He has served as a member of the National Board of Examiners for the clinical examinations in Internal Medicine. Dr. Chan-Yan also practises in nephrology and internal medicine, with a province-wide referral base. He has visited and worked in small communities as a consultant.
- [77] Dr. Chan-Yan was qualified as a general internal medicine specialist, to give opinion evidence on the standard of care of a general internist at a community hospital in B.C. in 1999.

The standard of care and the need for expert evidence

- [78] What is the appropriate standard of care? Physicians have a duty "to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances" and the conduct of specialists must be assessed "in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field": *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at para. 33. See also: *Wilson v. Swanson*, [1956] S.C.R. 804 at 817. The same principle applies to the nursing

staff at Ridge Meadows Hospital. Their conduct must be assessed against the conduct of other nurses who possess a reasonable level of skill, knowledge and competence expected of their profession.

- [79] As noted above, Ms. Lil did not adduce expert evidence relevant to the standard of care for Dr. Binder or the nursing staff. In medical negligence cases, expert evidence is usually necessary because judges and juries do not have the necessary expertise to assess technical matters relating to diagnosis or treatment of patients. However, there is no categorical rule. As Sopinka J. stated in *ter Neuzen* at para. 44:

Where a common and accepted course of conduct is adopted based on the specialized and technical expertise of professionals, it is unsatisfactory for a finder of fact to conclude that such a standard was inherently negligent. On the other hand, matters falling within the ordinary common sense of juries can be judged to be negligent. For example, where there are obvious existing alternatives which any reasonable person would utilize in order to avoid a risk, one could conclude that the failure to adopt such measures is negligent notwithstanding that it is the prevailing practice among practitioners in the area.

- [80] Here, the defence adduced expert evidence in support of Dr. Binder. Clearly, the Court would not be justified in disregarding an expert opinion where the issues involve medical knowledge, skill and experience. However, it is open to the trier of fact to reject that evidence and determine an appropriate standard without reliance on it. The opinions of the experts are not conclusive. In this regard, I refer to the comments of Sopinka J. at para. 55 of *ter Neuzen*:

If the alleged act or acts of negligence are such that the jury could reject expert evidence as to standard of practice and set the appropriate standard without reliance on expert evidence, then it can do precisely that where the expert evidence fails to establish a standard practice. In either case, the basic question is whether the nature of the issue can be decided on the basis of the ordinary knowledge possessed by the jury or, on the contrary, the matter requires expert evidence because it is beyond the ken of the average juror.

- [81] I consider several aspects of this case to be rare instances where it is appropriate to determine negligence on the basis of ordinary knowledge.

- [82] I agree with the submissions of Ms. Norell and Mr. Ankenman that errors in clinical judgment by any of the professionals here cannot be found to be negligent absent expert evidence that their conduct fell below an acceptable standard of care. I disagree that expert evidence is necessary to determine whether any professional failed to observe signs and symptoms that were there to be seen. In my opinion, these are issues that can be decided on the basis of ordinary knowledge, and it is open to me to fix an appropriate standard and to determine the question of negligence based on my view as to what prudent and diligent practitioners ought to have done to properly inform themselves or others about Mr. Marszalek's condition.

[83] In my view, the test described in *Rann v. Twitchell* (1909), 82 Vt. 79 at 84, as cited in *Wilson v. Swanson* is applicable in this case:

His negligence is to be determined by reference to the pertinent facts existing at the time of his examination and treatment, of which he knew, or in the exercise of due care, should have known. It may consist of a failure to apply the proper remedy upon a correct determination of existing physical conditions, or it may precede that and result from a failure properly to inform himself of these conditions. If the latter, then it must appear that he had a reasonable opportunity for examination and that the true physical conditions were so apparent that they could have been ascertained by the exercise of the required degree of care and skill. For, if a determination of these physical facts resolves itself into a question of judgment merely, he cannot be held liable for his error.

Liability of Dr. Binder

[84] It is important to note that Dr. Binder is not to be judged on the result, which was obviously devastating, and that she is not to be held liable for an error of judgment. She is only to be held liable if she was negligent, and she is only to be found negligent if she failed to exercise reasonable care, skill and judgment in her treatment of Mr. Marszalek. This must be considered in the context of the hospital environment in which she was working.

[85] There is no question that Dr. Binder did not properly diagnose Mr. Marszalek. That fact does not necessarily mean that Dr. Binder was negligent. As Trainor J. stated in *Agate v. Burrows*, [1988] B.C.J. No. 586 (S.C.)(QL):

Medical judgment is at the core of each diagnosis. That judgment is based on training, experience, and scientific knowledge applied to the factual data properly available. It probably includes an element of intuition or playing one's hunches.

In each diagnosis, the exercise of reasonable care, skill and judgment is required. A mistaken diagnosis may not be a negligent one. A mistaken diagnosis becomes a negligent one if the mistake results from a failure to exercise reasonable care, skill and judgment. It can result from the failure to collect necessary factual data through appropriate tests or a patient's history. However, the obligation to have a further test done is a question of medical judgment to be exercised on the basis of information then available and the possible gain or additional information which might be learned from such a test.

[86] Ms. Lil's claim against Dr. Binder is not based solely on a misdiagnosis. As I understand it, the essence of her claim is that Dr. Binder did not take a careful history from Mr. Marszalek, did not properly consider the observations of the nurses as recorded in their notes, and did not conduct thorough enough examinations such that she missed significant signs and symptoms that were there to be seen. In other words, her failure to at least consider a neurological problem resulted from her failure to collect the necessary factual information about Mr. Marszalek's history and symptoms. As a result, she did not properly diagnose Mr. Marszalek's condition. This, she says, cannot meet the appropriate standard of care.

[87] Dr. Chan-Yan was of the opinion that Dr. Binder acted in accordance with the standard of care expected of a reasonably competent internal medicine specialist in her treatment of Mr. Marszalek. He based this in part on Mr. Marszalek's signs and symptoms as recorded in the hospital records and on specific factual assumptions. Essentially, Dr. Chan-Yan was of the view that Dr. Binder tested Mr. Marszalek appropriately on each of the three occasions she examined him, and made a reasonable diagnosis on the basis of her examinations, the information she received from Mr. Marszalek and the information provided to her by the nursing staff.

[88] I will review each of Dr. Binder's examinations of Mr. Marszalek and the evidence relevant to each.

The first examination - December 7, 1999

(a) The evidence

[89] Dr. Binder examined Mr. Marszalek at 19:45 on December 7, 1999. Before she saw him, she reviewed the information that was available in the hospital chart, including Dr. Bartel's notes. The notes she wrote at the time stated in part:

57 year old Polish man seen regarding sudden onset of nausea & vomiting No previous history of vomiting Has had chronic neck pain for the last year after MVA. Seen and examined by ICBC specialist yesterday. After developed numbing in upper extremity & had loss of power and increased neck pain. Went to the clinic given Naproxyn , taking Tylenol #3 & Ativan. This am sudden onset of vomiting retching. Sweating & collapsed on the floor, however has not lost consciousness. Brought to the hospital. In ER retching, vomiting complained of being dizzy. no allergies, denies hepatitis, does not smoke, denies alcohol construction worker - afraid to work due to neck problems.

[90] Dr. Binder did not independently recall all aspects of her examination of Mr. Marszalek, but she did remember him. She said he gave a sparse history, despite the fact that she also spoke Polish. She testified that it is her standard practice to perform a normal neurological examination.

[91] In her consultation report dictated later that day, Dr. Binder recorded the following:

Physical examination revealed a flushed unwell looking man who is retching lying on the side in bed. He avoids eye contact. His BP is 150/90, pulse 80, resp rate 16, temp 36. He has mild [sic] tattoos. There is no lymphadenopathy, no thyromegaly. There is no jaundice. His pupils are small with minimal reaction to light. His chest is clear to auscultation. JVP at the sternal angle. Normal cardiac sounds. His abdomen is soft, non tender. There is no [sic] nausea, no hepatosplenomegaly, no masses, no peripheral edema.

Neurological examination reveals that he moves his neck freely. There is no neck stiffness. He has symmetrical brisk deep tendon reflexes. His toes are downgoing. There is no ulnar drift. Sensation appears normal. The examination was limited as the patient was retching throughout the examination.

[92] She said that the only limitation to the examination was that she did not ask Mr. Marszalek to stand up, so she did not perform tests regarding his ability to walk. She explained that it is not her practice to record every aspect of an examination and she does not chart all negative findings. She described her standard neurological examination as including an assessment of the eye movements, the symmetry in the face, alertness, orientation, speech, and limb coordination, power and sensation.

[93] Under "impression and recommendations" she noted:

Mr. Marszalek presents with acute onset of vomiting with a very brief collapse. There is no doubt that he is volume depleted.

The differential diagnosis will include gastritis related to his medication, acute pancreatitis though there is no real abdominal pain. I do not believe that his symptoms are related to a spine injury as there are no neurological findings.

He is to be admitted for rehydration. We will obtain his amylase, liver function tests, correct potassium deficiency and treat him with anti-emetics medication and H2 blocker. I will be in touch with his family doctor regarding his previous work up for his neck.

[94] Dr. Binder explained that she did not think that Dr. Bartel's differential diagnosis of TIA or subarachnoid hemorrhage were likely, and she did not believe that Mr. Marszalek's symptoms were related to a spine injury. She said that Mr. Marszalek did not complain of vertigo; he told her that he had dizziness following his motor vehicle accident, which was so severe it precluded him from working. She concluded that his current dizziness was from changes in his cervical spine. She wrote orders prescribing Pepcid, Gravol and Maxeran for nausea, morphine for neck pain, and saline to replace his volume deficit. She ordered a drug screen and cervical spine x-rays. She said that she tried to contact Dr. Tomaszewski, Mr. Marszalek's family doctor, but he was apparently away.

[95] Ms. Lil described Mr. Marszalek's condition that afternoon and evening. She said he was extremely white, continually retching, and very weak. He tried to go to the bathroom, and had to hold his arms out for balance.

(b) Expert opinion

[96] In Dr. Chan-Yan's opinion, Dr. Binder performed an adequate and comprehensive history and physical examination of Mr. Marszalek, and her presumptive diagnosis of gastritis was reasonable, given that Mr. Marszalek had been taking significant doses of medicines that are known to cause gastrointestinal upset. Her initial orders - clear fluid diet, intravenous hydration, anti-emetics to reduce vomiting, medicines to reduce gastric acid and an

analgesic for pain - were appropriate. He said that the amount of fluids she prescribed for hydration was appropriate.

- [97] Dr. Teal described the primary signs of cerebellar stroke as abnormal eye movements, slurred speech and problems with balance and coordination, a variety of other symptoms, such as double vision, nausea, vomiting, and vertigo, and brain stems signs, such as sensory abnormalities and paralysis. In his view, there were several features in Mr. Marszalek's initial presentation that confounded Dr. Binder:

He had a history of chronic neck pain, he was involved in a dispute with ICBC and had recently undergone an IME evaluation in that regard. He had initially collapsed with excessive nausea and vomiting raising several other diagnostic possibilities, including vasovagal attacks, acute gastrointestinal or intra-abdominal crises, or other problems. Neurological exams recorded by the physician in a walk-in clinic on December 6, 1999 and by Dr. Bartel and Dr. Binder on December 7, 1999 did not detect neurological deficits.

- [98] In Dr. Teal's opinion, at the time of Dr. Binder's initial evaluation of Mr. Marszalek on December 7th, it may have been possible to suspect a cerebellar stroke, but there were no compelling neurological findings, as the common features of a cerebellar stroke were initially absent. He stated:

It is my opinion that obvious cerebellar findings were not present or may have been very subtle initially. A likely explanation for this is that initially the stroke affected primarily the medial aspect of the cerebellum. Strokes in this territory can present with isolated vertigo, nausea and vomiting without major symptoms of incoordination.

- [99] Dr. Chan-Yan testified that, as an internist, he is familiar with the typical symptoms of cerebellar stroke. He was not aware of the symptoms associated with a stroke in the medial aspect of the cerebellum, as described by Dr. Teal. Dr. Binder was not aware of this either. According to Dr. Chan-Yan, symptoms of headache, vertigo, nausea and vomiting might be classic signs of cerebellar dysfunction, but they are also very non-specific when put together.

(c) Conclusion

- [100] It appears that Mr. Marszalek did not present initially with many of the typical symptoms of a cerebellar stroke. Ms. Lil's description of his condition is consistent with that described in the medical records. There is some confusion as to whether he complained of headache. Neither Dr. Bartel nor Dr. Binder recorded complaints of headache, but the nurses' recorded that Mr. Marszalek presented initially with complaints of headache at the base of his skull. Dr. Binder recorded normal ocular movements, normal speech, no drift of the arms, and normal movement of the limbs. Dr. Teal noted that Mr. Marszalek was "apparently able to get to the bathroom which requires adequate stability of gait." However, the only evidence that Mr. Marszalek could get to the bathroom on his own was Ms. Lil's description of him holding his arms out for balance. There is no clear evidence as to the

stability of his gait. Dr. Binder did not test Mr. Marszalek's ability to walk, due to his ongoing retching during her examination.

- [101] Despite this, I find that Mr. Marszalek initially presented with symptoms that were quite non-specific, and if there were any typical cerebellar symptoms (such as problems with balance and coordination), they were subtle. Dr. Binder's initial diagnosis was based on a reasonable history and examination of the patient. I agree with Dr. Chan-Yan that she met an appropriate standard of care in her examination and treatment of Mr. Marszalek on December 7, 1999.

The second examination - December 8, 1999

(a) The evidence

- [102] Mr. Marszalek was still in the emergency ward the next morning. During the night and early morning, nurses noted complaints of sweating, dizziness and headache. At 23:30 he was noted to be diaphoretic and "still very dizzy when up." At 6:55 he was "awake, diaphoretic again c/o headache"; at 8:30, "c/o posterior headache + extreme dizziness when moving. Sweaty."
- [103] Dr. Binder saw him at 11:00. She did not recall how long she was with him. She said he was "much improved." He was sitting in bed, he was not vomiting and he was able to drink. He was more open with her, and he talked about the problems he experienced after his motor vehicle accident. He was afraid to work because his dizziness made him more prone to injury, and in addition to his neck pain, he had intermittent numbness in his hands. Dr. Binder did not form the impression that Mr. Marszalek was malingering and she planned to assess the degree of injury to his cervical spine.
- [104] Dr. Binder did not recall the specifics of the examination she did that morning. She noted "dizziness & vertigo. ongoing neck pain. moving all extremities." Regarding the dizziness, she said that Mr. Marszalek said he felt the room spinning; she did not distinguish this symptom as separate from his complaints of dizziness following his motor vehicle accident. She said that her note about "moving all extremities" was her shorthand for her neurological examination. She said she would have done a standard neurological exam that second day. If there were any abnormalities, she would have charted them.
- [105] Dr. Binder said that Mr. Marszalek did not complain of headache. She said she was puzzled by the nurses' notes of headache, and she asked Mr. Marszalek about this. According to Dr. Binder, Mr. Marszalek told her that the nature of his pain had not changed over the year; the only difference was that after the examination by Dr. Bishop, the pain became more intense. Dr. Binder said that she spoke to the nurses and advised them that Mr. Marszalek was having chronic neck pain, not headache. She attributed the nurses' notes to a language barrier.

[106] Dr. Binder thought Mr. Marszalek's symptoms were consistent with acute gastritis related to medications. Her "working diagnosis" was that the acute gastritis had resolved, and she still had to deal with Mr. Marszalek's neck pain and the symptoms from his injury. She ordered a CT scan of the neck, which was to be done the next day at Royal Columbian Hospital, and planned to arrange a neurology consult.

(b) Expert opinion

[107] With respect to the second examination, Dr. Chan-Yan stated:

Dr. Binder visited Mr. Marszalek again during the morning of December 8, 1999. She noted that his vomiting had ceased but that he had persistent dizziness and vertigo and he continued to experience neck pain. She found that he moved all extremities and noted no other abnormalities. She appropriately intended to review the neck X-ray; arrange a CT scan of the neck and seek consultation with a neurologist.

He also noted:

Her findings did not lead her to believe there was anything of urgency and she was going to wait until after the CT scan was done. It is noted that there was no neurologist on staff at the Ridge Meadows Hospital at the time and referral would presumably have required Mr. Marszalek to be sent elsewhere specifically for consultation. It is noted that Mr. Marszalek's neck pains and dizziness were already chronic and severe enough that he had been unable to work during the year following the MVA.

[109] Dr. Chan-Yan testified that Dr. Binder's initial assessment was important. He did not think that an urgent referral to a neurologist was required on December 8th, because Dr. Binder had excluded a neurological problem and Mr. Marszalek's condition had improved.

[110] According to Dr. Teal, on the morning of December 8th, Mr. Marszalek was

relatively stable from a neurological perspective and his impending rapid deterioration was not clinically apparent. He was awake, alert, and still ambulatory without major cerebellar findings and without signs or symptoms of impending deterioration. He did not have any brainstem signs based on the recorded observations.

[111] Dr. Teal's opinion was based on these facts:

Mr. Marszalek was re-evaluated by Dr. Binder. He apparently made eye contact. There was no retching or vomiting. He had persisting dizziness and vertigo as well as neck pain, which had been fairly longstanding complaints, although the neck pain was more severe at this time. Mr. Marszalek reported he did not have a headache. He was able to move all extremities. There was no weakness or lack of coordination noted.

On the morning of December 8, 1999 Mr. Marszalek had apparently been able to walk to the bathroom.

(c) Conclusion

[112] Dr. Binder described Mr. Marszalek as being "much improved" on the morning of December 8th. I find this difficult to accept, in light of the continuing symptoms recorded in the clinical chart. He had been given medication for his nausea, which had clearly helped, and his vomiting had subsided. However, his other symptoms persisted; he continued to be sweaty, very dizzy and to have headache. The evidence indicates that he had improved only slightly.

[113] Both Dr. Chan-Yan and Dr. Teal assumed that Mr. Marszalek's symptoms of dizziness were consistent with the dizziness he had experienced after his motor vehicle accident. This assumption is not consistent with the evidence. Dr. Binder said that he described feeling like the "room was spinning". Ms. Lil described his symptoms at the hospital as very different from the dizziness he described to her and that she observed after his accident. She said that during that year he was not dizzy continuously, but he complained about dizziness on heights.

[114] Ms. Lil's evidence about this is consistent with Mr. Marszalek's complaints following his motor vehicle accident, as recorded by Dr. Tomaszewski in his clinical records, and as described by Mr. Marszalek himself in his examination for discovery on September 20, 1999.

[115] Dr. Tomaszewski recorded complaints of dizzy spells, occipital headache and neck and upper back pain on November 21, 1998, four days after the motor vehicle accident. On December 11, 1998, he recorded complaints of dizzy spells with neck motion. After that, the records note primarily neck pain and occipital headache; there do not appear to be any notations of dizziness. Mr. Marszalek was referred to Dr. Iain Dommissie, an orthopaedic surgeon, who provided a consultation report to Dr. Tomaszewski on October 20, 1999. The presenting complaints were noted to be "fairly significant neck pain" and there was no mention of dizziness.

[116] In the examination for discovery, Mr. Marszalek described his dizziness as follows:

406 A 17th, exactly, after the accident. And something happened with me I never had before, make me dizzy or something. I must sit on the plank and wait few minutes, but, uh - I get up and continue after another two hours.

776 Q Was there anything else unusual about your day other than that you left work early?

A Like - like I - I tell you at work I have a couple times dizzy and I come home, everything is like normal. But I - I think the next day be a little bit - my muscle be a problem.

843 Q Anything else that you - that we haven't put on our list? And then we'll go through each of your problems.

A Yeah. The - if I use the stairs to go up, make me dizzy.

990 Q Now, you talked about dizziness, was that something separate from the headaches or the neck pain?

A Yeah. The dizzy makes me - after the sharp - sharp pain, I tell you the few seconds.

991 Q So the dizziness comes after the sharp pain?

A Yeah, after. After makes me -

992 Q Do you always get dizziness after the sharp pain?

A Yeah, every time the sharp pain attack me, I am dizzy.

993 Q How long does it last?

A Oh. Just two, three minutes.

994 Q Okay. Did you ever lose your balance from the dizziness?

A Yes. I must sit. I must sit on the chair, if I have with me chair. But I must sit, with the attack I must sit.

[117] When Dr. Tomaszewski saw Mr. Marszalek soon after the accident, he advised him not to work, as it would be too dangerous. This evidence also appears in Mr. Marszalek's examination and is confirmed in a medical legal report written by Dr. Tomaszewski on July 16, 2001.

[118] The defendants submitted that Mr. Marszalek's description of his earlier symptoms was consistent with the history taken by Dr. Binder. According to Dr. Binder, Mr. Marszalek said the dizziness he felt after his accident was so severe it precluded him from working. While this is consistent with Dr. Tomaszewski's advice, it is not consistent with Mr. Marszalek's descriptions of dizzy spells lasting two to three minutes. It is unfortunate that Dr. Binder was not able to make contact with Dr. Tomaszewski as she had planned to do.

[119] I have difficulty with Dr. Binder's evidence that she did not distinguish Mr. Marszalek's dizziness from his earlier dizziness. The complaints recorded in the hospital records show that Mr. Marszalek's symptoms involved intense and rather constant dizziness, which may more accurately be described as vertigo. Dr. Binder used that term in her own notes of December 8th. At 8:30, before Dr. Binder saw him, the nurses recorded "extreme dizziness when moving". These descriptions of Mr. Marszalek's dizziness while at the hospital are quite different from his own descriptions of dizzy spells after his motor vehicle accident. However, there is no evidence, other than Dr. Binder's, as to what Mr. Marszalek said about his prior dizziness.

[120] Dr. Teal also assumed that Mr. Marszalek was able to walk on his own without any weakness or lack of coordination. This is not consistent with the evidence. Although Dr. Binder said she did a neurological examination that morning, she did not test his ability to walk. There is no evidence that Mr. Marszalek had walked to the bathroom without any difficulty (which

is the factual assumption on which Dr. Teal relied). There is a nurse's note that Mr. Marszalek was up to the bathroom with his wife, but Ms. Lil said she was not at the hospital that morning. There is no evidence that anyone checked his leg strength and coordination.

- [121] I also have difficulty with Dr. Binder's evidence that Mr. Marszalek did not complain to her of headaches. The nurses' notes clearly record a complaint of posterior headache an hour and a half before she saw him, and at the same time she saw him, Tylenol #3 was given for headache. She said she spoke to Mr. Marszalek about this and she then told the nurses that his complaint was neck pain. Yet, there is no note of this, and the nurses continued to record complaints of frequent and increasingly severe headache, to the point where he was given more Tylenol #3 and then morphine, in accordance with Dr. Binder's orders as recorded in the chart.
- [122] The best I can infer from the evidence is that Mr. Marszalek had increasingly severe pain at the base of his skull, which could have been interpreted as either neck pain or headache. Dr. Binder testified that notes of headaches would alert any doctor, and she acknowledged that headache and neck pain are different; each requires a different diagnosis. While she may have taken steps to clarify this with Mr. Marszalek, I have considerable difficulty with her rather detailed evidence that she told the nurses that his complaint was not headache, particularly given her limited recollection of the specifics of her examination of Mr. Marszalek. I do not accept her evidence that she advised the nurses of what he told her, as this was not noted in the chart at all and they continued to record headaches.
- [123] The opinions of Dr. Chan-Yan and Dr. Teal related to the second examination have limited weight, as some of the factual assumptions on which they are based are not correct. Neither Dr. Chan-Yan nor Dr. Teal addressed the severity of Mr. Marszalek's dizziness or vertigo, the recorded complaints of headache, and they did not consider that Mr. Marszalek may have exhibited some symptoms of limb weakness or lack of coordination.
- [124] It appears that Dr. Binder did not consider the severity of Mr. Marszalek's symptoms on December 8th. She may not have taken an accurate history of his previous symptoms of dizziness, she did not consider that his complaint of neck pain may have been headache at the base of the skull, and she did not assess his ability to stand and walk. Having said that, I do not consider that it is appropriate for the Court to make a finding of negligence in these circumstances absent expert evidence. The implications of Mr. Marszalek's previous and current symptoms of dizziness, whether he had neck pain or headache, and whether or not Dr. Binder should have tested his limb coordination are matters that require medical expertise.

The third examination - December 9, 1999

(a) The evidence

- [125] As I have noted, the nurses continued to record complaints of headache, which became more severe throughout the afternoon and evening of December 8th. This is consistent with Ms. Lil's evidence. She was with him after about 14:00. She said that by about 15:00, he "begged" her to talk to someone about giving him something for his headache, and for ice. Mr. Marszalek was given Tylenol #3. He continued to have some nausea and dizziness when sitting up. He is noted to be feeling improved at 18:00. Ms. Lil stayed with him until about 19:00. That was the last time she saw him conscious.
- [126] By 20:00, Mr. Marszalek is noted to complain of "severe headache again" and was given Tylenol #3. He then slept until 23:00, when he is noted to wake up with headache again, "requesting analgesic". At 2:00 on December 9th, he was given morphine for "extreme headache". By 5:00 he was observed to be "somewhat dizzy and thrashing in bed" and did not seem "to comprehend". At 5:30 he was "trying to climb out of bed, with his head hanging down". At 6:00 he was observed to climb out of bed and was "very unsteady on his feet". He pulled his IV out several times and was still very restless at 7:00. At 7:30 the nurses recorded that Mr. Marszalek was again trying to get out of bed. He was noted as "very unsteady - unable to weight bear." He was moved into a cardiac chair for safety reasons. He continued to be restless and attempted to climb out of the chair.
- [127] At 8:30 the nurses were informed that the CT scan was not going to be done that morning. The nurses notified Dr. Binder about this, and also advised her that Mr. Marszalek was agitated and restless. Dr. Binder gave a telephone order for Ativan and she called the radiologist. They were trying to have the CT scan done later in the day or the following morning. She then went to see Mr. Marszalek. She read the nurses notes to 7:00; she did not see the notes recorded after that. She was aware of the complaints of headache, restlessness and unsteadiness. She was not aware that Mr. Marszalek was noted as "unable to weight bear". She said that this was a new symptom in his presentation and had she known about it, she would have tested for this; she said this would have alarmed her and she would have considered a diagnosis other than alcohol withdrawal, "it could be he was suffering from something serious."
- [128] When Dr. Binder saw Mr. Marszalek, he was sitting in the cardiac chair. He had been moved to an overflow area in the emergency department. The chair was in front of the nurses' station. Mr. Marszalek was very unwell. Dr. Binder observed that he was restless and flushed and was constantly moving his hands. However, she said he was oriented, in that he recognized her and knew where he was. She said that the nurses suggested that perhaps he had been taking alcohol on a regular basis.
- [129] Dr. Binder said that she did a standard examination of Mr. Marszalek - she looked at his pupils and she looked for signs of weakness and coordination. She did not get him out of the chair, but she said that there was "no evidence of problems with balance". She asked him if he was taking any alcohol, and he admitted to one rum and coke every day. She said it was not unusual that patients deny alcohol intake and families do not know. In Dr. Binder's opinion, Mr. Marszalek's presentation was consistent with alcohol withdrawal. She

noted: "Agitated. Restless. Moves all extremities. Admit to one rum and coke every day. I do believe he has alcohol withdrawal " She ordered that he be placed on the hospital's alcohol withdrawal protocol.

(b) Expert opinion

[130] In his report, Dr. Chan-Yan stated:

On the morning of December 9, 1999, Dr. Binder found Mr. Marszalek to be agitated and restless. She noted that he moved all extremities and noted no other abnormalities. Mr. Marszalek was oriented enough to admit to consuming one rum and coke every day. Because Dr. Binder was of the opinion at this time that Mr. Marszalek was suffering from alcohol withdrawal she appropriately ordered an alcohol withdrawal protocol.

[131] Dr. Chan-Yan testified that Mr. Marszalek's symptoms that morning - delirium, racing pulse, global restlessness and agitation - were consistent with alcohol withdrawal. He said that physicians often uncover alcohol withdrawal syndromes despite the fact that the patient denies drinking, and the family is not aware. In his opinion, placing Mr. Marszalek on the alcohol withdrawal protocol was prudent and relatively harmless, as it requires frequent monitoring and administering vitamins and a sedative if required.

[132] Dr. Chan-Yan assumed that Dr. Binder had conducted a neurological examination that morning, and he said that there were no obvious findings "on specific testing". He said that if there were cerebellar signs, such as a lack of coordination, unilateral movements, jerky movements in the eyes (nystagmus), smaller pupils, facial asymmetry, they would be obvious. On that basis, he did not think an urgent neurological referral was required.

[133] Dr. Teal was of the view that Mr. Marszalek began to show evidence of neurological deterioration between 6:00 and 7:30 on December 9th, but he did not show evidence of major brainstem compression by the time Dr. Binder examined him, which was between 9:00 and 9:30.

(c) Conclusion

[134] I accept Dr. Teal's opinion that Mr. Marszalek was not yet showing signs of major brainstem compression at the time Dr. Binder saw him on the morning of December 9th. If he had, this would have been obvious. Dr. Chan-Yan said that there cannot be a compression of that magnitude without noticing.

[135] Dr. Binder had no specific recollection of her examination of Mr. Marszalek that morning. The only neurological sign that she noted was that he moved all extremities. She said that the only symptom he had was neck pain of the same nature he had for the last year, which increased after the independent medical examination.

[136] I find Dr. Binder's lack of neurological findings that morning to be inconsistent with the observations recorded by the nurses earlier that morning, and described by Dr. Teal as showing evidence of neurological deterioration. Dr. Binder read the nurses' notes that

recorded their observations from 13:45 on December 8th to 7:00 on December 9th. She was aware that between 5:00 and 7:00 on December 9th Mr. Marszalek was observed to be somewhat dizzy, thrashing in bed, not seeming to comprehend, trying to climb out of bed "with his head hanging down", and "very unsteady on his feet". She was also aware that Mr. Marszalek continued to have some nausea, continued to be very dizzy, and complained about increasingly severe headaches, despite her discussion with him the day before that he was really complaining about neck pain. The headaches were so severe that the nurses replaced Tylenol #3 with morphine, in accordance with Dr. Binder's orders.

- [137] Despite having this information, there is no evidence that Dr. Binder took any steps to clarify the nature and extent of any of these symptoms with Mr. Marszalek when she examined him on December 9th. Despite her own evidence that complaints of headache "would alert any doctor," she did not address the notes of increasingly severe headaches, particularly in light of her evidence that his only symptom was neck pain. She said there was "no evidence of problems with balance" but she could not recall if Mr. Marszalek was restrained in the cardiac chair and she had not at any time tested his ability to walk. I do not accept Dr. Binder's evidence that she conducted her standard neurological examination that morning. If she had, she probably would have noted least some neurological abnormalities, such as intense headache and vertigo and problems with balance and coordination, since these symptoms had been present for several hours.
- [138] I cannot give Dr. Chan-Yan's opinion on this aspect of Dr. Binder's care any weight. He did not consider whether Dr. Binder took account of the symptoms of neurological abnormalities recorded by the nurses, and he assumed that she conducted a standard neurological examination. It is implicit in this evidence, however, that the standard of care would require that such an examination be done.
- [139] While Mr. Marszalek's presentation may have been consistent with alcohol withdrawal, I find that his true physical condition was becoming apparent, and that Dr. Binder had a reasonable opportunity for examination. In order to determine if this constitutes negligence, his true physical conditions must have been so apparent that they could have been ascertained by the exercise of the required degree of care and skill. I find that some neurological symptoms were apparent, and that Dr. Binder failed to take appropriate steps, by conducting a standard neurological examination, to inform herself of Mr. Marszalek's true condition. A prudent and diligent specialist practising in a community hospital at the time would have done so. Her failure to do so, in my opinion, fell below an appropriate standard of care.

Events subsequent to the third examination

- [140] Following Dr. Binder's order putting Mr. Marszalek on the alcohol withdrawal protocol, the nurses assessed him at a score that called for a sedative to be administered, and at 10:35 he was given diazepam. He settled down after this, and was noted to be sleeping. Mr. Marszalek was finally transferred into a medical ward at 13:00. At that point, he was unable to rouse and he did not respond to painful stimuli.
- [141] Ms. Lil arrived at the hospital at about 15:00. When she learned that he had been placed on alcohol withdrawal, she spoke to Dr. Binder on the telephone and told her that Mr. Marszalek had not had any alcohol for two years. Dr. Binder said that she then spoke to the nurse, who told her that Mr. Marszalek was sedated and that his vital signs were stable. At 15:10, Dr. Binder put the alcohol withdrawal protocol on hold, and gave telephone orders for Ativan and Thiamine (a vitamin), which were recorded in the chart. She said that she also gave an order for the nurses to check vitals, but this was not recorded.
- [142] The concern I have with this evidence is that Dr. Binder did not consider any other possible diagnoses once she took Mr. Marszalek off the alcohol withdrawal protocol, and she did not go back to the hospital to see him. If he was not in alcohol withdrawal, what was wrong with him? She acknowledged that he was very unwell. Dr. Chan-Yan did not give an opinion on this aspect of her care, but he did say that he might have kept Mr. Marszalek on alcohol withdrawal anyway, as the protocol requires vitamins and sedatives only, with frequent monitoring.
- [143] Dr. Binder's evidence about her orders to check Mr. Marszalek's vital signs was unclear. In her letter to the College of Physicians and Surgeons, written on October 1, 2001, she stated that she asked the nurse to do frequent vital signs and to let her know about a change in status. In her testimony at trial, she said only that she gave an order to "check vitals". The evidence is unclear as to whether vitals were checked at that time. The hospital records show that they may have been checked sometime that afternoon, possibly at about 16:00, and that they were checked at 18:30 and following. Had an order been made for this to be done frequently or at regular intervals, more than likely this would have been recorded by the nurse, as all other orders appear to have been written quite precisely. I do not accept Dr. Binder's evidence that she gave such an order.
- [144] Dr. Binder said that she was not aware that Mr. Marszalek was unable to rouse and was not responding to painful stimuli. She said that if she had known this, she would have gone immediately to the hospital. I accept her evidence about this. However, she still had a patient who was very ill, and she had no considered diagnosis for his continuing symptoms. She admitted that she would need to see Mr. Marszalek in order to determine what was wrong. Her explanation was that she did not necessarily think Mr. Marszalek was not in alcohol withdrawal, and she expected the nurses to notify her if there was any change in his condition. Dr. Binder's evidence about her diagnosis was vague and her evidence about the orders she gave was unclear. While it would have been prudent for the nurses to call her if

Mr. Marszalek's condition changed (and, as I find below, they ought to have notified her of his level of unconsciousness), I find that she gave no specific order for the nurses to do so. Given his condition when she last saw him, and the information she later received from Ms. Lil, it is simply common sense to conclude that Dr. Binder ought to have gone back to see Mr. Marszalek whether or not the nurses called her. In my opinion, her failure to do anything at that time did not meet an acceptable standard of care.

Liability of the nurses

- [145] The nursing staff are not to be held liable because of a bad result or for an error in judgment, and they are not to be found negligent unless they failed to exercise an appropriate level of care, skill and knowledge. As discussed above, their conduct is normally assessed against the conduct of other nurses who possess a reasonable level of skill, knowledge and competence expected of their profession. This standard is normally based on expert evidence, unless the court is able to determine an appropriate standard of care based on ordinary knowledge or common sense.
- [146] Ms. Lil says that the nurses were negligent because they did not properly record Mr. Marszalek's symptoms, did not take his vital signs or assess him regularly, did not recognize neurological symptoms and failed to call in physicians when his condition was clearly deteriorating.
- [147] None of the nurses testified. I draw no adverse inference from this. The only evidence regarding the actions of the nurses is the hospital chart and the testimony of Dr. Binder and Ms. Lil. There is no expert evidence regarding the applicable standard of care for the nurses. Mr. Ankenman submitted that Ms. Lil failed to prove that any act or omission on the part of the nurses fell below the appropriate standard of care and was negligent, and in any event, nothing they did or failed to do had any bearing on the unfortunate outcome.
- [148] There were instances where the hospital records appeared incomplete or were unclear, but absent any expert evidence about the appropriate standard of record-keeping, there is no basis to determine whether the record-keeping in this case was negligent. However, for the reasons set out below, despite the lack of expert evidence, I have concluded that the nursing staff failed to meet an appropriate standard of care on December 9, 1999, by failing to monitor and assess Mr. Marszalek in accordance with the alcohol withdrawal protocol, and by failing to inform Dr. Binder of the extent of his level of unconsciousness or to notify any physician of his condition before 19:30.
- (a) Alcohol withdrawal assessments
- [149] The alcohol withdrawal protocol requires the patient to be assessed on a regular basis. Where a score is 10 or more, the patient is to be assessed every hour until the score falls below 10. Then, the patient is to be assessed every hour for 3 hours, then less frequently.

- [150] Patients are assessed on a scale of 0 (for normal findings) to 7 (for severe symptoms) for nausea and vomiting, tremor, paroxysmal sweats, anxiety, agitation, orientation, tactile disturbances, visual disturbances and headache or fullness in head. For scores of 10 or more, anti-anxiety (sedative) medication is to be administered.
- [151] The protocol is a doctor's order. The monitoring frequency is set, but the doctor determines the specific tests and medications to be administered.
- [152] Mr. Marszalek was assessed twice under the protocol, at 10:30 and 12:18. At 10:30, he had a score of 14 (for signs of anxiety, agitation and headache) and was given 10 mg of diazepam. At 12:18, he had a score of 8 (for signs of sweats, disorientation and possible headache). He was checked at 13:00 but not assessed under the protocol. He was taken off the protocol at 15:10.
- [153] Dr. Chan-Yan was of the opinion that placing Mr. Marszalek on the alcohol withdrawal protocol was "harmless", partly because the protocol requires frequent monitoring of the patient. He did not comment on the frequency of the monitoring that was actually done, although these facts were included in the factual assumptions on which he relied.
- [154] Mr. Marszalek was not assessed by the nurses in accordance with the protocol and Dr. Binder's orders. When he was received on the medical ward at 13:00, he was clearly unable to rouse to the point where he was not responsive to painful stimuli. Mr. Ankenman submitted that the nurses who received him acted reasonably, since Mr. Marszalek was assumed to be in alcohol withdrawal and sedated. He had been given 10 mg of diazepam at 10:30. I note, however, that the doctor's orders called for 2 mg of lorazepam, not 10 mg of diazepam. Dr. Chan-Yan said that diazepam is a longer-acting sedative than lorazepam. However, there is no evidence that the dosage of diazepam would have caused Mr. Marszalek to be that heavily sedated at 13:00, 2½ hours later. Both Dr. Chan-Yan and Dr. Teal noted that Mr. Marszalek had received this type of medication before, and Dr. Teal said that the dose he was given was not high.
- [155] In my opinion, the alcohol withdrawal protocol establishes the appropriate standard of care for assessing patients who have been placed on the protocol. The nurses were required to monitor the patient and carry out the doctor's orders as specified. Mr. Marszalek should have been reassessed on an hourly basis from 10:30 until Dr. Binder put the protocol on hold at 15:10. The nurses in the medical ward received Mr. Marszalek at 13:00 on the understanding that he was in alcohol withdrawal. Instead of following the protocol, they kept him in the cardiac chair near the nurses' station. No observations were recorded until Ms. Lil came in at about 15:00. By then, he was noted to remain unresponsive, drooling at times from the left side of his mouth, with his head bent to the left.
- [156] There is no direct evidence that anything would have been done differently if hourly assessments had been done under the protocol, but this kind of monitoring may have caused someone to question Mr. Marszalek's degree of apparent sedation. It was Dr. Teal's opinion that Mr. Marszalek began to deteriorate between 10:30 and 12:00 noon, and

demonstrated signs of a "space-occupying cerebellar stroke with progressive loss of consciousness and drowsiness" sometime around 12:00 noon. Dr. Chan-Yan said that brainstem compression of the magnitude he suffered could not occur without being noticed. Three assessments should have been done before Mr. Marszalek was admitted to the medical ward, and two after. If this had been done, the nurse's communication with Dr. Binder at 15:10 may have been different.

[157] I find that from 11:30 on December 9th, the nursing staff failed to meet an appropriate standard of care by not conducting reassessments of Mr. Marszalek at the frequency required under the alcohol withdrawal protocol.

(b) Failure to report to or call in physicians

[158] Mr. Marszalek was unable to rouse and was unresponsive to painful stimuli for over six hours before the nurses notified any physician - from 13:00, when he was initially received by the nurses on the medical ward, until 19:32. By then, his condition was life threatening and his chances of survival were very small.

[159] Mr. Ankenman submitted that there is no basis for the Court to find that this constituted negligence on the part of the nurses. He says that Mr. Marszalek's symptomatic devolution over the afternoon of December 9th was, as a matter of ordinary common sense, not inconsistent with a patient suffering from chronic alcoholism responding to sedation. The nursing staff in the medical ward had received Mr. Marszalek in a sedated condition on the understanding that his diagnosis was alcohol withdrawal. He says that the nursing staff cannot be faulted for failing to recognize neurological signs in those circumstances.

[160] I disagree. I refer again to Dr. Teal's opinion that by about 12:00 noon, Mr. Marszalek showed signs of brainstem compression, by 13:00 he was in a deep coma, and by 15:30 he had serious life-threatening brainstem compression.

[161] With respect to Mr. Marszalek's level of sedation, Dr. Chan-Yan did not say that it was normal. Both Dr. Chan-Yan and Dr. Teal noted that Mr. Marszalek had received this type of medication before. The dose he was given was not high. Dr. Chan-Yan also said that someone who does not respond to painful stimuli is in a deep level of unconsciousness, which would indicate there was clearly something wrong.

[162] I have considerable difficulty with the lack of action by the nursing staff in all of the circumstances. Mr. Marszalek had been given a sedative at 10:30 in the morning. He was clearly in a very deep state of unconsciousness by 13:00 and stayed that way throughout the afternoon and evening. It appears that Nurse Carmen signed the nursing notes from 13:00 to 19:00 on December 9th. At 15:10, Dr. Binder spoke to one of the nurses, apparently Nurse Carmen.

[163] Dr. Binder said that when she put the alcohol withdrawal protocol on hold, she gave telephone orders for Ativan, Thiamine, and check vitals. Nurse Carmen recorded this:

Hold CIWA protocol. Ativan 1-2 mg po q4h pm. Thiamine 50 mg. [illegible] x 3 day. T.O. Dr. Binder.

[164] I have found that Dr. Binder gave no specific order at 15:10 for the nurses to do frequent vital signs and to call her if Mr. Marszalek's condition changed. I have also found that Dr. Binder was not told that Mr. Marszalek was unable to rouse and was not responding to painful stimuli.

[165] Mr. Ankenman submitted that there may be a basis for the Court to find that the conduct of the nursing staff on this issue was less than optimal, but that there is no evidence on which to assess whether such conduct fell below an acceptable standard of care. I disagree. Given the evidence of Mr. Marszalek's condition at about that time - continuing unresponsiveness over four hours after a reasonably moderate sedative had been administered, drooling and head bent to the left side - and given the evidence of Dr. Teal and Dr. Chan-Yan about this, it defies common sense that the nurse would not at least have reported these observations to Dr. Binder. I find that this failure to report obvious and important information about Mr. Marszalek's condition to fall below an acceptable standard of care.

[166] I appreciate that the nursing staff did not have clear orders from Dr. Binder once Mr. Marszalek had been taken off the alcohol withdrawal protocol. However, he was not checked for three hours after that. Nurse Carmen noted at 18:30 that Mr. Marszalek "remains non-responsive". He was put into a bed with the use of a mechanical lift, and did not rouse. His vital signs were taken. At 19:00:

Pupils pinpoint - no response verbally. Does not respond to painful stimuli.

[167] At 19:30, another note in different handwriting:

Received unresponsive. Unable to rouse. Non-responsive to tactile and painful stimuli. Pinpoint pupils & diaphoresis.

[168] The nurse who wrote that note notified Dr. Ervin.

[169] It makes no sense that anyone would consider Mr. Marszalek's deep level of unconsciousness to be consistent with continued sedation from the diazepam he received at 10:30. He was in a deep state of unconsciousness from 13:00 and this did not change. The nursing staff ought to have recognized that his condition was serious and they ought to have communicated his symptoms to Dr. Binder or contacted another on-call physician as soon as they noted the extent of Mr. Marszalek's unresponsiveness. To leave a patient for that long in that condition without notifying a physician does not, in my opinion, meet an appropriate standard of care for the nursing staff, particularly in light of the evidence of Dr. Teal and Dr. Chan-Yan.

Causation

[170] I have found that Dr. Binder was negligent on the morning of December 9, 1999 when she examined Mr. Marszalek, and in the afternoon of the same day when she failed to go to the hospital to see him after putting the alcohol withdrawal protocol on hold. I have found that the nursing staff was negligent from and after 11:30 on December 9, 1999 by failing to monitor and assess Mr. Marszalek in accordance with the alcohol withdrawal protocol and for failing to notify Dr. Binder or any other physician of his deep level of unconsciousness before 19:32.

[171] Ms. Lil has the burden of proving that Mr. Marszalek's death was caused by the negligent acts of Dr. Binder and the nursing staff. The basic test for causation is the "but for" test. The plaintiffs must prove that "but for" the negligent act or omission of each defendant, Mr. Marszalek's death would not have occurred. This test, which applies to single and multi-cause injuries, was recently re-stated by Chief Justice McLachlin in *Resurfice Corp. v. Hanke*, 2007 SCC 7. At para. 23, she explained:

The "but for" test recognizes that compensation for negligent conduct should only be made "where a substantial connection between the injury and defendant's conduct" is present. It ensures that a defendant will not be held liable for the plaintiff's injuries where they "may very well be due to factors unconnected to the defendant and not the fault of anyone": *Snell v. Farrell*, at p. 327, per Sopinka J.

[172] A plaintiff does not have to establish that a defendant's negligence was the sole cause of the injury. Major J. explained this in *Athey v. Leonati*, [1996] 3 S.C.R. 458, at para. 17:

There will frequently be a myriad of other background events which were necessary preconditions to the injury occurring. To borrow an example from Professor Fleming (*The Law of Torts* (8th ed. 1992) at p. 193), a "fire ignited in a wastepaper basket is . . . caused not only by the dropping of a lighted match, but also by the presence of combustible material and oxygen, a failure of the cleaner to empty the basket and so forth". As long as a defendant is part of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury. There is no basis for a reduction of liability because of the existence of other preconditions: defendants remain liable for all injuries caused or contributed to by their negligence.

[173] The same principle applies in medical negligence cases: *Snell v. Farrell*, [1990] 2 S.C.R. 311.

[174] In *Athey*, Major J. emphasized that the causation test is not to be applied too rigidly and it need not be determined by scientific precision. As Lord Salmon stated in *Alphacell Ltd. v. Woodward*, [1972] All E.R. 475 at 490, causation is "essentially a practical question of fact which can best be answered by ordinary common sense". In medical negligence cases, the facts are often within the knowledge of the defendant. The burden of proof remains with the plaintiff, but in some circumstances, an inference of causation may be drawn from the evidence without positive scientific proof: *Athey* at para. 16; *Snell v. Farrell* at para. 30. As

Sopinka J. explained at paras. 32 and 33 of *Snell v. Farrell*:

evidence adduced by the plaintiff may result in an inference being drawn adverse to the defendant. Whether an inference is or is not drawn is a matter of weighing evidence. The defendant runs the risk of an adverse inference in the absence of evidence to the contrary. This is sometimes referred to as imposing on the defendant a provisional or tactical burden. In my opinion, this is not a true burden of proof, and use of an additional label to describe what is an ordinary step in the fact-finding process is unwarranted.

The legal or ultimate burden remains with the plaintiff, but in the absence of evidence to the contrary adduced by the defendant, an inference of causation may be drawn although positive or scientific proof of causation has not been adduced.

[175] Where the "but for" test is unworkable, causation may be established where the defendant's negligence "materially contributed" to the occurrence of the injury. A materially contributing factor is one that falls outside the *di minimus* range: *Athey* at para. 15.

[176] The "material contribution" test is an exception to the "but for" test, and is only to be applied if (1) it is impossible for a plaintiff to prove that the defendant's negligence caused the injury using the "but for" test, and the impossibility must be due to factors outside the plaintiff's control, and (2) it must be clear that the defendant breached a duty of care owed to the plaintiff, thereby exposing the plaintiff to an unreasonable risk of injury, and the plaintiff suffered that form of injury: *Resurfice Corp.* at paras. 24-25. As the Chief Justice explained at para. 25:

In other words, the plaintiff's injury must fall within the ambit of the risk created by the defendant's breach. In those exceptional cases where these two requirements are satisfied, liability may be imposed, even though the "but for" test is not satisfied, because it would offend basic notions of fairness and justice to deny liability by applying a "but for" approach.

[177] She provided two examples where the material contribution test may be applied, at paras. 27 and 28:

One situation requiring an exception to the "but for" test is the situation where it is impossible to say which of two tortious sources caused the injury, as where two shots are carelessly fired at the victim, but it is impossible to say which shot injured him: *Cook v. Lewis*, [1951] S.C.R. 830. Provided that it is established that each of the defendants carelessly or negligently created an unreasonable risk of that type of injury that the plaintiff in fact suffered (i.e. carelessly or negligently fired a shot that could have caused the injury), a material contribution test may be appropriately applied.

A second situation requiring an exception to the "but for" test may be where it is impossible to prove what a particular person in the causal chain would have done had the defendant not committed a negligent act or omission, thus breaking the "but for" chain of causation. For example, although there was no need to rely on the "material contribution" test in *Walker Estate v. York Finch Hospital*, this Court indicated that it could be used where it was impossible to prove

that the donor whose tainted blood infected the plaintiff would not have given blood if the defendant had properly warned him against donating blood. Once again, the impossibility of establishing causation and the element of injury-related risk created by the defendant are central.

- [178] Walker Estate v. York Finch General Hospital, 2001 SCC 23, [2001] 1 S.C.R. 647, involved negligent blood donor screening, where it was difficult or impossible for a plaintiff to prove hypothetically what the donor would have done had he or she been properly screened. In that context, Major J. stated that the "but for" test is unworkable where multiple independent causes may bring about a single harm, and that the proper test for causation in cases like that is whether the defendant's negligence "materially contributed" to the occurrence of the injury.
- [179] In this case, the evidence strongly suggests that Mr. Marszalek's death cannot be attributed to a single cause. He died because he suffered a cerebellar stroke and he did not receive surgical treatment to reduce the swelling in his brain. He did not receive surgical treatment for a number of reasons, which I will address below. In this circumstance, it is not possible for the plaintiffs to prove what a particular person in the causal chain would have done had the defendants not committed a negligent act or omission, thus breaking the "but for" chain of causation. The defendants breached a duty of care owed to Mr. Marszalek, thereby exposing him to an unreasonable risk of death, and Mr. Marszalek died. In these circumstances, the material contribution test for causation is applicable.
- [180] The defendants submitted that the evidence in this case establishes only that Mr. Marszalek lost a chance of recovery, that this chance was very small and in any event, that a loss of chance is not compensable at law. In *Laferriere v. Lawson*, [1991] 1 S.C.R. 541, the Supreme Court of Canada extensively reviewed the theory of liability for loss of chance in the medical context, and held that causation must be established on a balance of probabilities and the loss of mere chance cannot be a compensable harm. The Court affirmed the causation principles outlined in *Snell v. Farrell*. This principle was restated in *St-Jean v. Mercier*, 2002 SCC 15, [2002] 1 S.C.R. 491. I note that these cases address medical liability under Quebec civil law. Outside of that context, the "loss of chance" doctrine has been the subject of considerable controversy, as noted by Major J. in *Athey* at paras. 37-38.
- [181] In any event, the law is clear that a plaintiff must prove causation in accordance with the principles I have outlined above. A plaintiff may be able to prove causation in the medical context where the evidence supports a finding that a particular treatment would probably have produced a positive result. Damages would then be assessed according to the level of probability: see *Laferriere* at p. 656.

[182] In this case, the evidence supports a finding that Mr. Marszalek had a better than 50% chance of recovery only if he had decompressive surgery by 12:00 noon on December 9, 1999. The defendants say that in the circumstances, his chance of obtaining surgery within that time period was highly unlikely, if not impossible. As I understand this argument, the defendants say that Ms. Lil cannot establish causation, on either the "but for" or the material contribution test.

(a) The cause of the stroke

[183] It is not in dispute that Mr. Marszalek died as a result of a cerebellar stroke. The actual cause of the stroke is not known, but a likely cause, according to Dr. Teal, was a blood clot in the left posterior-inferior cerebellar artery (PICA). This is the artery at the lowest part of the cerebellum. It is quite close to the vertebral artery. The source of the blood clot was suspected to be from a dissection, or tear, of the vertebral artery. Dr. Teal thought that this was the most likely source because of Mr. Marszalek's neck pain. It is possible that the artery was torn during Mr. Marszalek's examination by the ICBC specialist on December 6, 1999, but there is no way to know if that is the case. Dissections can occur spontaneously in people who have suffered an injury.

(b) Stroke treatment

[184] It is also not in dispute that surgical treatment that could have saved Mr. Marszalek's life would have had to be done before he lost consciousness or developed signs of brainstem compression. The evidence is clear that at the time the staff at Ridge Meadows Hospital called a Code Blue on the evening of December 9, 1999, Mr. Marszalek's chances of survival were small. There is a difference of opinion between Dr. Auer and Dr. Teal as to his chances of survival had an accurate diagnosis been made sooner. This difference of opinion stems from the accessibility of surgical treatment in B.C., particularly for patients outside major urban centres.

[185] The issue, as it relates to causation, is whether Mr. Marszalek would have received surgical treatment had Dr. Binder detected neurological problems when she examined him on the morning of December 9th and if so, whether surgical treatment would have resulted in a favourable outcome. If it is more probable that Mr. Marszalek would have died from the cerebellar stroke whether or not he had surgery, then causation is not proven.

(c) Proof of causation

[186] Dr. Auer stated that the treatment Mr. Marszalek received at Ridge Meadows Hospital left him untreated and exposed to "a very high risk of lethal outcome". It was his opinion that the outcome was dictated by timely diagnosis and treatment, regardless of the cause of the cerebellar stroke:

Deterioration typically starts after some 24 hours and reaches its maximum around 72 hours, when brain edema reaches its maximum. Without adequate treatment, more than 80% of patients in the group of secondary deterioration do not survive due to the rise of intra-cranial pressure and compression of the brainstem. By contrast, appropriate treatment reduces mortality to about 25%.

Timely diagnosis and treatment could have substantially reduced the risk of a lethal outcome and would have given good chances for recovery with no or minor to minimal neurological deficit.

[187] The treatment he referred to was surgery to drain cerebral spinal fluid, or decompressive surgery. He said that patients who are in a deep coma have a 20% or less chance of survival, and patients in Mr. Marszalek's condition (which I understand was his condition on the evening of December 9th when Dr. Ervin attended) have less than a 5% chance of survival.

[188] Dr. Teal's opinion, that surgery is most likely to be successful if carried out before a loss of consciousness or the development of signs of brainstem compression or brain herniation, is consistent with Dr. Auer's opinion on this point.

[189] Dr. Teal stated that on December 9, 1999, Mr. Marszalek suffered a rapid deterioration related to a progressive cerebellar infarct with progressive edema. This led to rapid decompression of his brainstem with loss of consciousness and subsequent loss of brainstem function. This occurred sometime between 10:30 and 12:00 noon. By 13:00 he was in a deep coma and by 15:30 (just after Ms. Lil saw him) he had serious life-threatening brainstem compression. If surgery had been performed at 15:30, his chances of a favourable outcome were less than 50%. In order for surgery to have been "probably life-saving", it would have had to be started "no later than 11:00 hrs and certainly before 12:00 hrs."

Dr. Binder

[190] At the time of Dr. Binder's first negligent act or omission, between 9:00 and 9:30 on December 9, 1999, Mr. Marszalek was still conscious. Had Dr. Binder conducted a standard neurological examination that morning and recognized Mr. Marszalek's neurological symptoms, would he have been transferred to Royal Columbian Hospital, would he have been treated with decompressive surgery, and if so, would the surgery have saved his life?

[191] Where Dr. Teal differs with Dr. Auer is with respect to Mr. Marszalek's chances of having surgery at all or being able to access surgery in time for a favourable outcome. According to Dr. Teal, Mr. Marszalek would have more than likely received only general and supportive care had his stroke been detected, and in any event, had he been transferred to Royal Columbia Hospital on the morning of December 9th, he would not have been operated on in time to alter his outcome.

[192] Dr. Teal explained that the vast majority of stroke patients in B.C. are treated medically with general and supportive care:

The conventional treatment for the majority of strokes, and particularly in those who are not eligible to receive thrombolytic therapy, consists of IV fluids, prevention of aspiration, prevention of formation of blood clots in the legs, and the use of aspirin.

- [193] Thrombolytic therapy - which involves the use of "clot busting" drugs - was not widely practised in 1999 and rarely given at Royal Columbian Hospital. Surgical treatment was and is relatively uncommon. Even in a major teaching hospital such as the Vancouver General Hospital, cerebellar strokes requiring emergency decompressive surgery are infrequent. Dr. Teal estimated that the procedure is undertaken there perhaps once or twice a year, and sometimes not at all. He stated that "[i]t is not widely appreciated by non-neurologists or neurosurgeons that massive strokes or so-called 'space occupying strokes' of the cerebellum can represent a neurosurgical emergency", and there is not always agreement among neurologists and neurosurgeons about the right time to intervene.
- [194] Dr. Teal explained the judgment calls necessary to determine if a patient requires decompressive surgery. He did not say that Mr. Marszalek would not have been a candidate had he been assessed by a neurosurgeon at the appropriate time. In my opinion, the evidence supports a finding that Mr. Marszalek would probably have been a candidate for surgery had he been transferred to the care of a neurosurgeon at Royal Columbian Hospital before he suffered major brainstem compression.
- [195] Mr. Marszalek was not transferred in time because a proper diagnosis was not made until it was too late. A proper diagnosis was not made sooner because his symptoms were not apparent to the treating physicians at Ridge Meadows Hospital. This failure to diagnose was not negligent. The first negligent act that played a part in the chain of causation was Dr. Binder's failure to conduct a standard neurological examination on the morning of December 9th. Had she done so, Mr. Marszalek's risk of death from stroke may have been lessened, but considerable risk would have continued.
- [196] Dr. Teal's opinion that Mr. Marszalek would not have received surgery in time was based on the time it would have taken the medical staff at Ridge Meadows Hospital to set up a CT scan and consultation, arrange a transfer, and for staff at Royal Columbian Hospital to complete a neurological consultation, CT scan, assessment and prepare for surgery. In an emergency situation, such as the actual situation on the evening of December 9th, it took four hours to the point where Mr. Marszalek was evaluated by a neurosurgeon. Had all of this been done the morning of December 9th, it is likely that Mr. Marszalek would not have made it to the operating room in time for a favourable outcome.
- [197] Dr. Teal candidly acknowledged that this is an unfortunate reality for patients in community hospitals who require emergency neurosurgery.
- [198] Dr. Teal's opinion is based in part on past hypothetical events. Although he based his opinion in part on what actually happened on the evening of December 9th, there is no way to know what would have happened that morning had Dr. Binder determined that Mr. Marszalek was showing neurological symptoms. Would she have had Mr. Marszalek

transferred to Royal Columbian Hospital? If she had, how long would this have taken at that time? When would he have been seen by a neurologist or a neurosurgeon? More importantly, how long it would have taken to get Mr. Marszalek to surgery, assuming that the attending physicians agreed that this was indicated?

- [199] While hypothetical events relevant to the assessment of damages may be proven on the basis of possibilities rather than probabilities, past events relevant to causation must be proven on a balance of probabilities. Negligent conduct either is or is not a cause of the injury: *Athey*, at paras. 28-30.
- [200] I accept Dr. Teal's evidence about this, and prefer it to Dr. Auer's opinion, as unfortunate as the situation is. Mr. Marszalek's only hope for survival was access to decompressive surgery. By the morning of December 9, 1999, it was more than likely too late. Given that he was in a community hospital, access to neurosurgery, even on an emergency basis, was not immediate, and given that he did not show brain stem signs at that time, it is more probable that he would not have been transferred to Royal Columbia Hospital on an emergency basis, if he would have been transferred at all. The evidence of Dr. Ervin about how difficult it was to transfer Mr. Marszalek on the evening of December 9th was telling. While there is no way to know whether Mr. Marszalek would have been transferred sooner had this been initiated on the morning of December 9th, the evidence indicates that it is very unlikely that he would have been able to get to surgery by 12:00 noon, when he still had a reasonable chance to survive. This raises a broader issue about the accessibility of health care, which is not the responsibility of individual physicians, and is not relevant to the legal issues in this action.
- [201] Mr. Marszalek already had serious life-threatening brainstem compression by 15:30, when Dr. Binder failed to go back and see him. If she had, there was little, if anything, she could have done to prevent his death.
- [202] In all of these circumstances, there is no basis on which to draw an inference of causation. I find that Dr. Binder's negligence did not materially contribute to Mr. Marszalek's death, and that he would have died in any event. On that basis, the claims against her must be dismissed.

The nurses

- [203] The negligent omissions of the nurses did not occur until 11:30 and later on December 9, 1999. At that time, Mr. Marszalek was quickly deteriorating, and by 13:00 he was in a deep coma. Even if the nurses had notified a doctor, it was too late to get Mr. Marszalek to surgery in time to have a probable favourable outcome. By 13:00 he was already in a deep coma and his chances of survival, even if he had surgery, were less than 50%. Again, in these circumstances, an inference of causation cannot be drawn. I find that the negligence of the nurses did not materially contribute to Mr. Marszalek's death, and that he would have died in any event. The claims against the nursing staff and Ridge Meadows Hospital

must also be dismissed.

Conclusion

- [204] This was a difficult trial. The circumstances - over eight years ago - were clearly tragic. Mr. Marszalek had a very sad and sudden death. He never knew what was wrong with him, and Ms. Lil did not know until it was too late. Had they known, his death would have been easier to accept.
- [205] Doctors and nurses are not infallible. They have difficult jobs and they sometimes make mistakes. Some of those mistakes constitute negligence. In this case, a series of mistakes eventually resulted in the negligent omissions I have described. However, those negligent omissions did not materially contribute to Mr. Marszalek's death. He would have died from his stroke regardless of the negligence.
- [206] Ms. Lil was devastated by the loss of Mr. Marszalek. It is unfortunate that she did not have counsel at trial, but that was her choice. I have done my best to determine the issues that were presented to the court. Hopefully the parties will be able to achieve a sense of closure.
- [207] There has been one positive outcome from this case. Ridge Meadows Hospital now has a CT scanner. This was achieved largely as a result of the efforts of Dr. Leslie Ervin, who was motivated by Mr. Marszalek's unfortunate death.
- [208] I would like to acknowledge the respectful manner in which all counsel for the defendants conducted this trial. They did what they could to be helpful to Ms. Lil and they were of great assistance to the Court.
- [209] All claims against the defendants are dismissed. Costs may be spoken to.

"B. Fisher, J."

The Honourable Madam Justice B. Fisher

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