

CANADA / JUDGMENT

McClelland v. Zacharias

2004 BCSC 1077

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Supreme Court of British Columbia

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2004 BCSC 1077 McClelland v. Zacharias

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

McClelland v. Zacharias,

2004 BCSC 1077

Date: 20040811

Docket: S015613

Registry: Vancouver

Between:

Wendy Jean McClelland

Plaintiff

And:

Dr. James A. Zacharias

Defendant

Before: The Honourable Mr. Justice Paris

Reasons for Judgment

Counsel for the Plaintiff:

A.M. Roos

Counsel for the Defendant:

C.E. Hinkson, Q.C.

K.P. Serné

Date and Place of Trial:

May 31-June 4, 2004,

and June 21-25, 2004

Vancouver, B.C.

Introduction:

[1] This is a claim for damages for negligent medical treatment. The specific allegations are that the defendant, a family physician, failed to diagnose or, more importantly, refer the plaintiff to a specialist for the diagnosis and treatment of a bacterial blood infection (bacteremia) which the plaintiff had contracted and which resulted in the infection and destruction of an intervertebral disc in her low back and the partial destruction of the two adjacent vertebrae. The specific period of time in question was the two months leading up to the end of October 1999.

The Evidence:

- [2] The plaintiff is a 44-year-old single mother of three children, aged 20, 17 and 15. The defendant practices in Abbotsford, British Columbia where the plaintiff lives. Since about 1977 the plaintiff's principal family physician has been Dr. Simone Hacquebard whose office is in Port Coquitlam, about a 1-1½ hour drive from the plaintiff's home. When her children were young the plaintiff started taking her children to the defendant for care. She then occasionally consulted him about her own problems that required more or less immediate attention, although continuing to see Dr. Hacquebard for annual checkups and, generally, matters of a gynaecological nature.
- [3] The plaintiff described herself as "fairly healthy" up to the end of 1998. Two of her friends who testified, Rebecca Hare and Susan Bridger, described her as dynamic, energetic and "larger than life". At the time of the events in question, she had been developing a business as a motivational speaker.
- [4] However, Dr. Zacharias' clinical notes going back to 1989 record a history of migraine headaches, anaemia, depression, fibromyalgia and costo-chondritis (generalized pain or tenderness in the chest wall area). The depression was treated with medication. The plaintiff's father, Mr. Brian McClelland, testified that there was a "history of depression in both families" but, according to him, the plaintiff, although depressed after her separation and divorce in the mid-90's, had "got out of it". Dr. Zacharias described her as somewhat "self-directed" with respect to her health care and in fact from time to time she sought out treatment in various alternative medicines such as reflexology, aromatherapy and "juicing" as well as chiropractic treatments. She has had a history of missing or cancelling appointments with her doctors.

- [5] The plaintiff testified that on June 9, 1999, she visited the defendant experiencing flu-like symptoms including night sweats. The defendant ascribed them to fibromyalgia which he described as a chronic condition or syndrome of symptoms rather than a disease characterized by generalized pain of the soft tissue without the presence of inflammatory cells. She visited him again on June 15th describing herself as improved to about "80% normal". Dr. Zacharias therefore felt her condition had responded to the medication he had prescribed, Flexeril, a muscle relaxant, and that his diagnosis of fibromyalgia had been correct.
- [6] Her condition remained the same until the last week of August. She testified that she then developed a severe fever combined with chills. She did not sleep well and had night sweats which sometimes required her to change her bed clothing two or three times per night. She vomited often. Her low back became very sore. She testified that these symptoms continued and generally intensified during the period up to the end of October, although she acknowledged that they waxed and waned somewhat and she would occasionally have short periods without a high fever or sweats.
- [7] She visited Dr. Zacharias on August 31st and recounted the above symptoms to him. She testified that she visited him during the months of September and October several times and she continued to advise him of all these symptoms and that in fact they were getting worse. During the month of September she had three successive periods of menstrual bleeding. She testified that during her visits in September and October until the last visit or two Dr. Zacharias' advice to her was that she likely had a viral infection - perhaps mononucleosis - of a self-limiting nature that would pass with time.
- [8] I shall return in due course to the defendant's evidence - including a review of his clinical notes - regarding his observations and treatment of the plaintiff during this period.
- [9] The plaintiff testified that during the month of September she was feeling so badly that she could not care for her children and sent them to stay with her ex-husband, of which Dr. Zacharias was aware. She was in bed most of the time and her friends brought her soft foods to eat. Her father visited her often and in fact stayed with her for approximately one week. He described her condition as "terrible", beset by fevers, and constantly soaked in sweat. He said that he had to change her sheets and towels "all the time".
- [10] Ms. Hare and Ms. Bridger testified as to her apparent physical condition during this period. Ms. Hare saw her once or twice per week after September 6th and said that by the end of September she had lost weight, was pale with bags under her eyes, at times flushed, walked slowly as if in pain and constantly sweated and wiped her brow. They discussed whether she might be suffering the onset of symptoms of menopause.
- [11] Ms. Bridger testified that she drove the plaintiff to the defendant's office on September 17th. She had not seen her in eight weeks and was shocked by her appearance. She had lost weight, moved very slowly and had dark circles under her eyes.

- [12] On October 28th, the plaintiff on her own initiative and with the help of Ms. Hare attended at the Emergency Department of the MSA Hospital in Abbotsford. Ms. Hare telephoned the defendant's office to advise him what the plaintiff was doing and he attended at the hospital that day with her chart. There, she was assessed by Dr. Michael Lapin, an internist. Bloods tests and imaging studies were performed as well as a review of previous x-rays. A blood culture revealed a bacterial infection (bacteremia) the specific bacterium being E-Coli. She was diagnosed as having osteomyelitis (bone infection) of the L-4 vertebrae with some destruction of the vertebral body. She was treated with appropriate antibiotics and on November 2, 1999, she was transferred to the spinal unit of the Vancouver General Hospital ("VGH").
- [13] At VGH the plaintiff was assessed and treated by Dr. Marcel Dvorak, an orthopaedic spinal surgeon. He is the medical director of the Combined Neurosurgical & Orthopaedic Spine Program and Head of the Division of Spine, Department of Orthopaedics, at the University of British Columbia. These passages from Dr. Dvorak's medical legal report (Exhibit 8) dated July 31, 2003 outline the assessment and treatment of the plaintiff.

The radiographs and CT scan which accompanied the patient from MSA Hospital were highly suggestive of a destructive infectious process at the L4-5 level most likely a septic vertebral discitis which had progressed to a vertebral osteomyelitis possibly with an epidural abscess.

The patient had blood cultures performed at MSA Hospital which grew the bacteria E-Coli (*Escherichia Coli*).

The initial diagnosis was that of a vertebral osteomyelitis at the L4-5 level most likely secondary to an E-Coli infection.

The patient was admitted under my care on the Spine Unit and an Infectious Disease consultation was obtained. The plan was initially to treat the patient with intravenous antibiotics and medical treatment and try to avoid surgical intervention. Due to some persistent vaginal bleeding a Gynaecology consultation was obtained as well.

A needle biopsy of the L4-5 level was performed by the Neuroradiology Department on November 4, 1999. Multiple biopsy fragments were obtained.

The pathology of the biopsy specimens was consistent with an acute bacterial infection. One of the cultures from the biopsy grew E-Coli bacteria despite the fact that the patient had been on several antibiotics prior to the biopsy being obtained.

The Infectious Disease Service recommended a full 6 weeks of intravenous antibiotics to treat this serious bone infection.

During the patient's hospitalization, and due to increasing symptoms of pain, we considered surgical intervention around the end of November. The treatment options were discussed in detail with the patient and she underwent a radiographic re-evaluation. Due to the extent of the bony destruction it was felt that conservative non-surgical treatment was indicated with a view to

a possible reconstructive procedure once the patient had completed the treatment for her infection. A hip spica body cast was applied on December 2, 1999 in the Operating Room. This cast was adjusted several times. On December 31, 1999 the patient was discharged home on oral antibiotics and strong narcotics to control her pain.

The patient returned to her first follow-up visit on January 27, 2000. On that day the body cast was removed. Her neurologic examination was consistent with normal motor power and sensation. The overall radiographic alignment of her spine appeared to be satisfactory. The disc space was affected by the infection, the L4-5 disc space, revealed marked destruction and collapse. The L4 and L5 vertebrae had collapsed one each other. There appeared to be further destruction of both L4 and L5.

[14] Dr. Dvorak testified that in his opinion it was ninety percent likely that the source of the lumbar spine infection was the urinary tract. He described the development of such an infection as follows:

Generally bacteria seed in the urine, that means they grow in the urinary tract, and at some point they enter the bloodstream, either through the bladder or up in the kidneys. And then once they're in the bloodstream, there is a period of time where the patient is bacteremic. That means they have bacteria in the bloodstream. And we believe generally, and that means the academic people that study infections in the spine and clinicians that treat infections in the spine, that these bacteria in the blood end up circulating through the vertebral bodies, through the blood supply in the vertebral bodies and they lodge at the end plates or at the -- at the bottom of the vertebral body adjacent to the disk. And in adults, the most likely progression from that point is that the bacteria start to grow in the disk space first. They destroy the disk space. And the disk collapses, then they destroy the bone adjacent to the disk space, called the end plate. And then the bacteria can seed in the vertebral body and destroy portions of the vertebral body. So the progression is usually from bacteria in the urinary tract, through the blood, into initially the disk space at the level of the end plate, and then potentially further to expand into the bone of the vertebral body.

[15] It was Dr. Dvorak's opinion that if a urinalysis culture had been performed on or shortly after September 23rd, it would have been positive for E-Coli bacteria. He further opined that the infection of the disc space (not the vertebrae) would have occurred within a week to ten days of the original bacterial infection of the blood. He said that given the amount of bone destruction he had observed and the aggressive nature of an E-Coli infection, it had likely been present in her lumbar spine "around two to three months", although he conceded that it was "possible" that it was present either a much longer or a much shorter period of time than that. He agreed that it might be possible to diagnose and treat such an infection at a point where there was damage to a disc but not to the adjacent vertebrae. Mechanical back pain could then result but without the significant spinal deformity and narrowing of the foramina or nerve root openings in the spine with the attendant pain and discomfort.

[16] In his report Dr. Dvorak described the plaintiff's then condition as follows:

In your letter of July 18, 2003, you have asked me to detail Ms. McClelland's current condition as well as my expectations for the future and any functional difficulties that she may have. As a direct result of this infection, Ms. McClelland has been left with a severe lumbar spinal deformity. This has resulted from the structural destruction and collapse of a significant portion of two vertebral bodies. As these vertebrae have been eroded and destroyed by the infection, they have assumed a distorted anatomy that may in and of itself be a source of moderate to severe chronic pain. This type of spinal deformity is most likely to result in some degree of persistent mechanical back pain in my experience. It is unlikely that this will improve substantially although there may be fluctuations in the intensity of the patient's symptoms. It is likely, in my opinion, that physical activities such as bending, twisting and lifting will be permanently impaired to a mild or moderate degree. As well, it is my experience that prolonged activities such as sitting behind a desk, driving a car, standing in line-ups, or maintaining one posture for an extended period of time is likely to lead to significant discomfort.

In addition to the chronic mechanical back pain resulting from this patient's spinal deformity, there is significant narrowing of the neural foraminae at the L4-5 level. These neural foraminae contain the nerve roots of the lumbar plexus which supply movement and sensation to the legs. Compression of these nerve roots may cause pain similar to the discomfort that Ms. McClelland describes. Although there is some ability for nerve roots to accommodate to changing confines both within and outside the spinal canal, it is likely that Ms. McClelland will continue to experience some discomfort into her legs similar to what she described at her last visit to my clinic.

Although it is possible that an extensive spinal reconstructive procedure may help to alleviate some components of nerve root compression and spinal deformity, it is unlikely that even after a successful major spinal reconstructive procedure that this patient will return to normal function. It is my opinion at present that the risks of surgery currently outweigh the potential benefits given this patient's unique situation.

[17] In a second report dated April 8, 2004 (Exhibit 9) Dr. Dvorak said that the following:

On physical examination, Wendy has a flattened lumbar lordosis. She has a limited range of motion of her lumbar spine. She does not exhibit any nerve root tension signs. Objectively her motor function in both lower extremities is normal. Reflexes are equal and symmetrical at the knees however absent at the ankles.

I carefully tested motor strength in both lower extremities and despite some mild pain related tendency to give way it was my opinion that the motor function was intact in both lower extremities.

Wendy continues to have symptoms of back and leg pain and neurologic symptoms, which are consistent with what she has reported previously. Although she is able to work and function in her activities of daily living she is limited in her physical tolerance. There are some recreational and other activities that she is not able to perform due to her pain. It is my opinion that her current level of disability is generally appropriate to her spinal pathology and the resulting

impairment from that spinal abnormality. In my opinion this is likely to continue in the foreseeable future.

[18] From August 31, 1999 to October 28, 1999 when the plaintiff went to the Emergency Department of the MSA Hospital, she was seen by the defendant nine times. He conceded that his account of events, particularly for the earlier visits, is the product mainly of his notes and of his knowledge of his usual practice, although augmented somewhat by actual recollection. As to some things put to him of which there is no reference in his notes, he insisted that if any such a thing of significance had occurred, or had been told to him, he would have made a note of it.

[19] I propose now to review those visits as reflected by his notes and testimony.

1. August 31, 1999:

[20] Dr. Zacharias' clinical notes indicate that the plaintiff's complaint that day was "left-sided low back pain" which he localized in the left buttock, which is of course a considerable distance from the L4-L5 vertebrae. He assessed it as "sacroiliitis", a non-specific inflammation of that area. He noted that there was no pain on urination and that her chest pains had gone. There is no reference to the other symptoms from which the plaintiff says that by then she was suffering.

2. September 8, 1999:

[21] On this day there were a number of complaints and symptoms recorded. The defendant testified that they were completely different than those of August 31st and that in fact there were no complaints of back pain. The notes indicate that the plaintiff had lost 4 kilos since the previous visit. Ms. McClelland is a fairly tall woman whose normal weight had been in the range of something over 80 kilos. The following symptoms were noted: "malaise, sore throat, slept for several days, vomiting, anorexic, bloated, inside skin of mouth desquamated, coated tongue, TM'S clear, appears sleepy and speech slurred, tender to percussion over liver and spleen". The defendant's working diagnosis, which he recorded, was mononucleosis. He ordered blood tests in order, he said, to attempt to identify the mononucleosis. He also took a throat swab to test for any bacterial infection of the throat which often occurs with mononucleosis. The tests (Exhibit 1-1-91) were negative for mononucleosis. When pressed on cross-examination he agreed that the evident high white blood cell count was suggestive of a bacterial infection but that he still believed that she likely had a viral infection, probably mononucleosis, because of her clinical picture.

3. September 10, 1999:

[22] On this day the defendant, having received a call that the plaintiff was sick and needed assessment, made a home visit. His notes record the following: "coughing up blood, bed fast(?), did not vomit this AM, chest clear, throat bloody sputum noted, pleuropulmonary(?), mouth white adherent, Dataies(?) noted".

[23] His assessment was a viral infection and he again took a throat swab (which he took to the hospital) to rule out the possibility of diphtheria. He characterized her complaints as being similar to those of September 8th and he was absolutely insistent that neither she nor her father, who was present, made any significant reference to back pain. If so, he said, he would have recorded it and, further, if there had been such back pain, he would have expected an "intelligent patient" like the plaintiff to mention it. He insisted that she did not "bring back pain to the room".

4. September 17, 1999:

[24] Dr. Zacharias' note is surprisingly brief and relates only to the plaintiff's menstrual problems and her blood pressure. It records that she had had three periods in the last month and that her blood pressure was 84/90 while sitting and 70 over an unascertainable figure after standing. As a result the defendant's assessment of the plaintiff was "dehydration" and he arranged to have her receive two litres of fluid intravenously at the hospital. She had lost 4.4 kilos since September 8th. He said that she was less ill than she had been on the 10th because she was able to come to his office. He again ordered blood tests and the results were telephoned to his office the same day (Exhibit 1-1-93).

[25] Dr. Zacharias acknowledged that a laboratory will telephone results of such tests to a doctor's office only when they are important. He agreed (only very reluctantly and after being asked the same question repeatedly) that the results were not only suggestive but "strongly" suggestive of a bacterial infection but he insisted that they could also be the result of her dehydration. He still saw no other clinical signs of a major bacterial infection such as, for example, a large wound. He was still of the view that she likely had a viral infection but he was "now looking for something else too". He said the tests were typical of somebody who was "somewhat shocky or stressed", presumably from dehydration.

5. September 23, 1999:

[26] Dr. Zacharias' notes of this visit indicate the plaintiff told him that she had not been able to keep solids down but was able to keep her antidepressant medication down. Her weight was 73.6 kilos, approximately the same as at the last visit. She complained of dysuria, that is pain upon urinating, which was the first time she had made that complaint. There was redness and a white membrane at the back of her throat, her chest was clear and there was no abnormal bloating. There was tenderness over the liver, spleen and bladder but they were not enlarged. He performed an in-office urinalysis by way of a chemical "dip test" which demonstrated a bacterial infection although it did not identify the specific bacterium involved.

[27] His assessment ("A" in his notes) was of a urinary tract infection (UTI) and a "viral illness".

- [28] His plan ("B") was to have her take more fluids, to order lab tests and to prescribe a broad spectrum antibiotic (Keflex) for the bladder infection. In fact the plaintiff and the defendant attended at the hospital the next day, the 24th, where the defendant arranged to have two litres of fluid and Graval administered to her intravenously.
- [29] The defendant's notes for the 23rd contain no reference to complaints of back pain, fever, sweats, or chills. The blood tests (Exhibit 1-1-94) were still negative for indications of mononucleosis and positive for indications of bacterial infection. However, the principal markers in the latter regard (white blood cells, neutrophils, platelets) although still elevated, were in fact lower than on the tests of the 17th. For the first time the alkaline phosphate readings were elevated. Apparently, that can be indicative, if associated with other signs, of a bone infection but also of some liver dysfunction.
- [30] After the 24th, the plaintiff and the defendant made no specific arrangement regarding her treatment beyond the understanding that she would contact him if necessary. In fact she did not attend again until October 15th.
- [31] Her testimony as to why she did not was somewhat ambivalent. On the one hand, she said she trusted the defendant and believed him when he told her that her illness was self-limiting and would go away. On the other hand, she said she felt that Dr. Zacharias could do no more for her and that she "was trying to get myself better". She in fact improved for a couple of days and then went downhill again, the sweats, chills, and back pains returning. She tried aromatherapy and "juicing". She read books. She attended a chiropractor on October 14th, 15th, and again on the 19th. The first two visits gave her some minor relief for half-an-hour, the third, none at all. She agreed in cross-examination that to some degree she was resisting the idea of going to the hospital. She "couldn't do anything around the house" and her friends and parents had to come to help her.

6. October 15, 1999:

- [32] The defendant's notes for this visit are fairly extensive. The plaintiff's weight is noted at 72 kilos, 3.6 kilos less than on September 23rd and following are the rest of his notes in their entirety:

On 11th finally well enough to get up and then on the 12th again bedridden

Spiked fever, sweats, fatigue "I don't feel depressed but I am not feeling well"

Ø (no) sore throat "lump" in throat

Ø (no) NVD (nausea, vomiting, diaherrea)

Able to take fluids

O tender LN (lympnodes) left neck axillae and groins

Ø (no) LKS (liver, kidneys, spleen, not enlarged)

Taking Arthrotec and Ranitidine)

Icing low back 0 (with) benefit

Seeing Reabe d/c (chiropractor) 0 (no) benefit

Can't sleep - avoids sleeping in the day

O Tender LN (lymph) node

Tender small LN axillae

Ø (no) KKS

Ø (no) LN groin

Abd (abdomen) soft BS (??)

Afebrile

Appears pale

[33] I note in particular the word "afebrile".

[34] Dr. Zacharias testified, having reviewed his notes, that his conclusion was that the plaintiff had presented as being better than she had been on September 24th. However, he thought that her condition might have new factors which should be explored. His assessment and plan was to rule out hepatitis and chronic infection by further lab work. Those tests ruled out hepatitis and chronic infection of the liver. The white blood cell count was down to almost normal limits and the platelet count was down, but not substantially. He said he concluded that "whatever she had was gone". There were, however, other factors in the lab tests that were of some concern, for example, the continued elevated alkaline phosphate level.

7. October 19, 1999:

[35] The plaintiff returned by appointment. Her weight had increased four kilos since October 15th (which Dr. Zacharias agreed was a bad sign). He noted that pain in her pelvis and low back was "worsening and not responding to usual chiropractic". In fact, the plaintiff attended a chiropractor the same day. He also made the following notes: "still has night sweats (three changes). Temp. up to 101.5°". He agreed that night sweats were more ominous than day sweating and indicative of a possible infection. He tended to attribute the pain in her pelvis to gynaecological problems but sent her for x-rays nevertheless. That report showed no abnormalities so, he said, it "didn't help me with the elevated alkaline phosphate".

[36] The plaintiff had an appointment with the defendant for the next day, October 20th, but did not show up. On October 21st she cancelled another appointment. She testified that she was not well enough to attend on either day. The defendant testified that he would have made a home visit if asked.

8. October 22, 1999:

[37] The plaintiff attended and Dr. Zacharias' notes record that her legs were painful and that she was now getting hives. His assessment was of a possible "myeloproliferative disease", that is, a disease of the blood forming units such as leukaemia or lymphoma. This was significant and the defendant's attention turned in that direction because the plaintiff's mother and grandmother had both died of leukemia. Dr. Zacharias arranged an appointment for the plaintiff with an internist, Dr. Min, whose locum tenens at that time was Dr. Lapin. He said that "because of the urgency I would have phoned myself". He faxed a "Request for Consultation" form (Exhibit 1-1-41) to Dr. Min's office which contained the following passages:

PROBLEM: Unremitting/recurrent weakness, fever, nausea/vomiting. Began with severe sore throat. Recurrent hives over body.

PURPOSE OF REFFERAL: Concern of the prolongation of what began as a viral like illness. Is this a myeloproliferative disease.

[38] The plaintiff attended Dr. Min's office on October 25th but was "bumped", that is, the doctor could not see her (or the other patients present at that time). She was re-booked for the following week.

[39] The next day, October 26, 1999, she re-attended at the defendant's office without an appointment and told him what had happened at the internist's. He noted her principal complaint as being of pelvic pressure and pain and prescribed a narcotic medication and ordered lab tests with a special request regarding possible leukemia or lymphoma. He agreed on cross-examination that the lab results (which he received the next day) were consistent with a bacterial infection but he had nevertheless not considered her ill enough to have to admit to hospital and he told her he could not do more until she saw the specialist.

[40] As mentioned previously, on October 28th the plaintiff felt so ill she admitted herself to hospital. Upon being advised, Dr. Zacharias attended, which was his usual practice when his patients were admitted to the emergency department. He filled out an Emergency Record form for that day (Exhibit 1-1-42) and the next day prepared a referral report (Exhibit 1-1-49) which contains the following passages apparently setting out his perspective of the plaintiff's history leading to her committal to the hospital:

This woman has been ill for the last two months. It began with a flu-like illness with pharyngitis, stomatis, nausea, vomiting and diarrhea. During that period of time, blood tests done looking for mononucleosis, strep infection and diphtheria were all negative. She became dehydrated and on two occasions in the subsequent weeks, required IV therapy to maintain her fluid level. She gradually improved to where she could manage her self-care but remained unwell. In subsequent laboratory testing, she was noted to have an elevated gamma GT and alkphos; the former had been mildly elevated in the year past. She had had an IDA as well which was attributed to

menstrual bleeds without replacement. She has in the last week, however, developed high fevers again, has measured to 104 and on last blood testing, her Hb was 83 with a ESR of 120.

She has intercurrently developed low back pain which was xrayed negative for any infiltrative process. This was, however, an area no trauma and and no strain or event to explain the situation. She is presently admitted, inasmuch as scheduling cancelled her internal medicine specialist appointment earlier this week and her physical condition continues to deteriorate.

PHYSICAL EXAMINATION

She appears pale and unwell. She is, however, alert and in good humor.

Eyes - PERL.

ENT - clear.

Mouth - clear. She has all her own teeth.

Neck - no lymphadenopathy of import. She does have some tenderness in the left upper neck which is associated with a palpable lymph node.

Chest - clear.

___VS - HS are normal.

Abdomen - soft. She is tender at the liver edge, though there is no gross enlargement of same. She is tender in the LUQ but again no splenic gross enlargement to percussion. No other abdominal masses are noted. She has no lymph nodes abnormal at the groins. No cyanosis or jaundice is noted.

ASSESSMENT

She is apparently harbouring an occult infection or perhaps a myelodysplastic syndrome. She requires hospitalization for intensive investigation and internal medicine consultation.

[41] As mentioned above, the principal criticism of the defendant's conduct is that he failed to refer the plaintiff to an internist for assessment in a timely fashion, specifically, after her September 23rd visit and blood tests. It is also suggested that a urine culture should have been ordered then so as to identify the specific bacterium infecting the plaintiff.

[42] In this regard the evidence of Dr. Ian Gummeson was tendered on behalf of the plaintiff. Dr. Gummeson has been licensed and has practised as a family physician in British Columbia since 1981. He has been a member of the Department of Family Practice at the UBC Faculty of Medicines since 1990 and a Clinical Associate Professor since 2000. He has had a particular interest in back problems, being a participant the Back Pain Clinic of the Vancouver General Hospital and has been a speaker at international conferences on low back pain. Dr. Gummeson's report dated July 20, 2001 was entered as Exhibit 3. The core of his opinions regarding this case are set out at page 2 as follows:

Subsequent to review of all the information provided to me, it is my opinion that the quality of medical care provided to Ms. McClelland by Dr. Zacharias met the acceptable standard of care applying to Family Physicians like myself and Dr. Zacharias up to her visit on September 23, 1999. My understanding of such standards would be the minimally acceptable standard of medical care provided by a physician of similar training and experience in an environment offering similar medical facilities and support. It is my opinion that Dr. Zacharias failed to meet those standards beginning September 23, 1999. On that date, Dr. Zacharias assessed Ms. McClelland and made a tentative diagnosis of urinary tract infection and viral illness. Chart profiles in the week prior to September 23, 1999 as well as on that date did indicate a high probability of a bacterial infection. At minimum, it would have been appropriate to obtain a urinalysis for culture and sensitivity. There is no record that this was done. Within 24 hours, Dr. Zacharias arranged for a second infusion of 2 litres of ringer's lactate; a solution intended to improve the patient's hydration. Doing this on one occasion to assist the patient is appropriate, doing it on a second occasion in the absence of a diagnosis does not, in my opinion, meet the acceptable standard of medical care. Further evaluation and assistance from the speciality staff at the hospital where Ms. McClelland was an ambulatory care patient would have been appropriate. Unfortunately for reasons of her own, Ms. McClelland was lost to care until October 15, 1999 when she returned to Dr. Zacharias' office. She had continued to lose weight and blood work was repeated. This was recorded on October 18, 1999 showing for the first time an ESR of 120, an indication of a significant systemic problem. The remainder of the blood work showed the probability of ongoing bacterial infection. The next visit by Ms. McClelland was October 19, 1999. Ms. McClelland indicated that she was having night time waking because of low back and pelvic pain, as well as night sweats. This is in association with the blood work obtained on the 15th of October would normally be considered an indication for further investigation and consultation with a speciality colleague. Dr. Zacharias did book appropriate follow-ups on October 20 and 21, 1999 and the patient did not show and cancelled respectively. October 22nd she attended and was having leg pain. Appropriately at that point, Dr. Zacharias referred to Dr. Minn, a colleague of Dr. Lapin in Internal Medicine consultation. Unfortunately this appointment was rescheduled. A subsequent visit October 26, 1999 and blood work showed ongoing chronic changes indicating bacterial infection as well as highly elevated ESR, an indication of significant systemic abnormalities.

Ultimately, the patient admitted herself October 28, 1999 to MSA General Hospital and was seen by Dr. Lapin in Internal Medicine consultation who carried out appropriate evaluations leading to the diagnosis of an L3 discitis, osteomyelitis and epidural abscess.

If Dr. Zacharias had sought assistance at an earlier juncture, it is likely that Ms. McClelland would have been diagnosed earlier. This would have presumably led to earlier antibiotic therapy and hopefully a shorter hospitalization and post-hospitalization recovery period. Whether or not earlier treatment would have significantly changed the clinical outcome in terms of Ms. McClelland's long-term physical functioning and pain symptoms is unclear. I would defer to her spine surgeon Dr. Marcel Dvorak to make that assessment.

- [43] I have highlighted in that passage the standard which Dr. Gummeson applied in arriving at his conclusion that Dr. Zacharias fell short of his obligations to the plaintiff as a family physician, following the visit of September 23rd.
- [44] In his testimony at trial, Dr. Gummeson reviewed the lab tests of September 8th, 17th and 23rd, explaining how and why they were indicative of a bacterial infection. He noted that the physical symptoms of the plaintiff lasted beyond the 7-10 days that is usual in the cases of viral infection. Dr. Gummeson's opinion was, therefore, that after the September 23rd visit and lab tests, the defendant should have referred the plaintiff to an internist, either by appointment or by sending her to the emergency department of the hospital for the purpose of determining whether she was suffering from a bacterial infection of her blood and other bodily fluids. Furthermore, the likely urinary tract infection should have been pursued by a culture and sensitivity test so that the specific bacterium involved could be identified and treated with an antibiotic more appropriate than Keflex, different bacteria being more sensitive to different antibiotics.
- [45] He was further of the view that the second fluid replacement of the 24th was inappropriate because by that time the tests combined with the physical symptoms of the plaintiff indicated the likelihood, not just of a viral infection and a urinary tract infection, but of a systemic bacterial infection and therefore something else had to be done. Furthermore, the signs were so significant that a follow-up of the patient had to be pursued when she did not return.
- [46] Dr. Lapin, the internist, as mentioned above, assessed the plaintiff at the hospital on October 28th. His primary concern was the possibility of leukemia or lymphoma. However, he testified that if he had been presented shortly after September 23rd with the results of the plaintiff's lab tests and the history which he had received, he would have ordered the same full battery of tests which he did on October 28th because of the indications of a systemic bacterial infection.
- [47] In response, Dr. Zacharias did not agree that the circumstances immediately after the visit and the tests of the September 23rd required him as a family physician to refer the plaintiff to an internist.
- [48] Firstly, he pointed out the results of the September 23rd blood tests were that the plaintiff's condition was improving, especially insofar as the white blood cells were concerned. He had identified a new condition, a urinary tract infection. He felt that that could be causing some of the plaintiff's symptoms so his attention was directed to dealing with that. He insisted, contrary to the suggestions of the plaintiff and her witnesses, that her general presentation was far better on September 23rd than on the 8th or 10th. He was admittedly not as positive about the 17th because of his sparse notes for that day but he was adamant that her picture was not "alarming" on September 23rd, although it was closer to that on October 15th and 19th. On those days he took the steps called for.

- [49] He insisted that it was not unreasonable to continue to think of the possibility of a viral illness because of the clinical picture presented by the plaintiff -- her sore throat, tender liver and spleen, and flu-like presentation -- even though he knew from the tests that she had a bacterial infection, namely a urinary tract infection. He pointed out that usually a patient with a bactermia is "deathly ill" and goes to a hospital rather than a doctor's office. He reiterated that during the month of September the plaintiff did not complain to him as strongly about her back pain as she testified she had. His treatment of the urinary tract infection with Keflex was appropriate on September 23rd when it was first identified. He pointed out that the medical protocols say that a urinary culture should not be ordered simply for the purpose of screening.
- [50] Dr. Zacharias also questioned certain statements and assumptions in Dr. Lapin's evidence and his consultation report (Exhibit 1-1-43) of October 28th at the hospital. He pointed out that the plaintiff had not been suffering from a fever for ten months as Dr. Lapin noted. Nor had her ESR (sedimentation rate) been extremely elevated on "various occasions since June", but rather it had been normal in June (Exhibit 1-1-87) and not elevated until the lab tests of October 15, 1999 (Exhibit 1-1-95). He pointed out that much of the plaintiff's history in Dr. Lapin's report either varied from his own notes and observations or, at the very least, had not been communicated to him by the plaintiff. For example, he had not been given a history of as severe and lengthy fevers, sweats and chills as set out by Dr. Lapin nor had the plaintiff complained to him of "exquisite pain in the back" since September 1st, which according to Dr. Lapin had been very important to him in his assessment. He disagreed adamantly that "she got worse over four weeks" (i.e. during September) and insisted that she had in fact improved by the third week.
- [51] The defendant's position was supported by the report (Exhibit 16-3) and testimony of Dr. Stephen Shore. Dr. Shore is a family physician who has been in practice in Langley, B.C. since 1975. Langley, like Abbotsford, is a municipality in the Fraser Valley region of British Columbia. He is a Clinical Associate Professor in the Department of Family Practice at the UBC Faculty of Medicine.
- [52] In his report Dr. Shore reviewed Dr. Zacharias' treatment of the plaintiff, principally by reference to his clinical notes. The core of his conclusions and opinion are set out in page 6 of his report as follows:

I believe that Dr. Zacharias, when made fully aware of the patient's back pain and lack of response, acted appropriately and met the standard of care of an average family physician in the community in the treatment and management of Ms. McClelland's illness leading to her spinal infection.

I believe that he could have been more aggressive in investigation and assessment of her febrile illness and in particular with regard to the weight loss and abnormal blood tests but even with this he would have met the standard by waiting initially for lab investigations to come back and see how the patient responded to prescribed therapy. However, I doubt that this investigation

would necessarily have led any sooner to the discovery of the vertebral infection (discitis) as this is very rare and certainly something that would not be high on the differential diagnosis list of any family practitioner and, as noted in Dr. Lapin's notes, it was well down the list in his original consultation.

[53] In the second paragraph of the above passage, Dr. Shore is referring to the course followed by Dr. Zacharias immediately after September 23rd. In preceding passages of the report he also reviews the defendant's conduct after the plaintiff returned to him on October 15th. In that regard I find the following passage significant:

On October 15, 1999 (page 19) the patient was noted to be improving and except for some tender lymph nodes and appearing pale there were no specific findings. Of note, the patient was now taking fluids orally and was able to be up and about. She had no further sore throat. The patient noted that she was seeing her chiropractor for her back pain. The fact that she was pale was not inconsistent with her history of anemia which was chronic and in particular related to her dysfunctional uterine bleeding. It is also consistent with the patient having a viral and/or bacterial illness. Appropriately, because the patient still wasn't well, further tests were ordered.

According to Dr. Zacharias' notes, this October 19, 1999 visit was the first mention of pelvic and/or low back pain by the patient to him. She had been seeing her chiropractor first and, as mentioned in her own Discovery, her aromatherapist, etc. but not any of her physicians. This certainly delayed any proper medical assessment and therapy, regarding her back condition.

The patient did not show for her October 20th or 21st visit which she actually cancelled. Again, this delayed further assessment and treatment.

On October 22, 1999, because of her significant weight loss, hives and the progressing pain, it was apparent that there was something more serious going on and Dr. Zacharias at this point made an appropriate referral to an Internal Medicine specialist. This visit of October 22nd, 1999 was on a Friday and the appointment was made within three days on October 25th, 1999 which is exceptionally fast. In fact, literally within days of mentioning the hives and radiation of the low back pain, Dr. Zacharias made an urgent and appropriate referral. The patient was subsequently admitted to hospital on October 28th, 1999.

[emphasis added]

[54] Dr. Shore testified that it is recommended medical practice to treat an uncomplicated urinary tract infection immediately as Dr. Zacharias did, with a broad-spectrum antibiotic rather than obtaining a urine culture and have to wait for the 48-72 hours to receive back the lab results. He agreed with Dr. Zacharias' prescription of Keflex in that regard. Given the plaintiff's condition on September 23rd as set out in the notes and her failure to return, it was reasonable for Dr. Zacharias to assume that either she had improved or that she had gone to another physician. He reiterated that as of October 19th, there appeared to be a new dimension to the plaintiff's condition, namely, her pelvic/low back pain and that Dr. Zacharias did escalate his level of treatment with appropriate dispatch. He agreed that the

tests during September were indicative of a bacterial infection but that could be of such an infection anywhere in the body and not necessarily of the blood.

[55] The report (Exhibit 16-2) and testimony of Dr. Barry Koehler was also submitted on behalf of the defendant. Dr. Koehler is a rheumatologist whose post-graduate specialist training involved three years of internal medicine followed by two years of rheumatology. His report contains the following passages:

There is nothing that emerges from the visit of September 23 that greatly changes the perception of Dr. Zacharias that he might be dealing with a viral infection such as infectious mononucleosis. He appropriately continued to manage Ms. McClelland's symptoms and would have had a reasonable expectation that the suspect underlying viral syndrome would have a spontaneous resolution. The subsequent handling of the situation by Dr. Zacharias was that of a conscientious, responsible physician who remained alert for alternative diagnoses and continued to evaluate his patient both clinically and through the laboratory.

It is likely, in retrospect, that the vertebral infection began in late August 1999. Unfortunately, Ms. McClelland does not seem to have communicated her (apparently) continuing problems with low back pain to Dr. Zacharias, for there is no mention of such complaints in the visits of September 8, 10, 17, or 23. Even on the visit of October 15, the back pain seems relatively minor, in that chiropractic manipulation and icing were cited as being helpful. The majority of that visit complaints were of systemic symptoms, which would continue to point to some type of systemic problem such as a viral infection (mononucleosis or hepatitis, for example) or a myeloproliferative disorder. The clinical records do not indicate that Dr. Zacharias could reasonably have suspected a localized disc space/vertebral body infection, even at that time.

Dr. Zacharias exhibited concern and diligence in his care of Ms. McClelland throughout the period from late August through late October 2003. He entertained appropriate diagnoses and pursued these appropriately. Initially he wondered about a viral or bacterial infection, such as diphtheria (which he ruled out by throat culture) or infectious mononucleosis. The course of Ms. McClelland illness through September was in keeping with a severe case of infectious mononucleosis and Dr. Zacharias appropriately continued with symptomatic management, given that the natural history of such a disease is to resolve gradually and spontaneously. However, in the visit of October 15 (after a hiatus of three weeks) Dr. Zacharias re-evaluated Ms. McClelland, both clinically and through the laboratory, considering alternative diagnoses, such as hepatitis. On October 19, responding to a complaint of "worsening back pain not responding to usual chiropracty", x-rays were done of hip and pelvis ---- which were correctly reported to be normal. Dr. Zacharias wondered about a possible myeloproliferative disorder and initiated an Internal Medicine referral on October 22.

It is understandable that he would be reassured by the three week hiatus in Ms. McClelland's visits to the office. The majority of physicians would understand this to indicate that the patient was improving. Nevertheless, he thoroughly re-evaluated her on her visit on October 15, and took nothing for granted.

[56] As to the discrepancy between the plaintiff and Dr. Zacharias as to the extent to which she recounted to him her symptoms of back pain, Dr. Koehler testified that he tended to rely on Dr. Zacharias' notes as more reliable and gave them more credence in instances of contradiction because they were contemporaneous to the events in question. However, he conceded that his opinion as to the reasonableness of Dr. Zacharias' working diagnosis of mononucleosis was affected by a misunderstanding on his part (Dr. Koehler's) as to the blood tests in September, namely, that the white cells (the neutrophils, specifically) were much lower than they in fact were and that the mononuclear cells were much higher than they in fact were. However, notwithstanding that the actual readings made a bacterial infection a more significant possibility he said that it was still not the number one possibility given the other clinical factors that Dr. Zacharias was apparently presented with. Besides, apparently Dr. Zacharias had considered the possibility of bacterial infection given that he had taken throat swabs from the plaintiff.

The Law:

[57] The law relating to medical negligence is in general terms simply the application of general principles regarding negligence to the context of medical treatment. The greater difficulty arises in determining the appropriate standard of care that is called for in any particular case. As a backdrop for the consideration of the factual issues in this case, I find the following statements of principle germane and helpful.

[58] I note firstly certain statements from the text "The Law and Medicine in Canada" Second Edition - Butterworths 1987 by Gilbert Sharpe at page ____ and following:

The doctor is bound to exercise that degree of skill which could "reasonably" be expected of a normal, prudent practitioner of the same experience and standing.

A physician is required to exercise only the degree of care and skill that could reasonably be expected of a prudent practitioner of the same experience and standing. Something more than a mere error of judgment must be proved before a physician can be found liable.

For example, if a physician has two treatment choices available and chooses the wrong one, so long as a reasonable physician might have chosen either in the circumstances, no liability will result from the wrong choice. Physicians, unlike judges, are not expected to have crystal balls.

Where a physician makes a mistake after having honestly applied his or her mind and falls within the standard of care, it is an "error of judgment" which does not result in liability. Where, however, after similar thought, the error falls below the appropriate standard of care for a reasonable physician, it amounts to negligence.

The difference between "negligence" and "error of judgment" was illustrated in a decision where medical testimony indicated that the condition under scrutiny was a rare one. The fact that other physicians might have made different findings was not sufficient to fix the doctor with negligence and liability. The most that could be said in this case was that the physician's failure to perform a certain test, which would have revealed the condition, was unfortunate. It was not itself an

indication of negligence. Here, the diagnosis reached by the defendant doctor was consistent with the complaints presented by the patient. While it may have been an error of judgment for the physician not to have taken the complaints more seriously and pursued other lines of inquiry, failure to do so constituted an error of judgment, rather than negligence.

[59] [Unfortunately, Mr. Sharpe does not set out in his end notes the specific case citation for the above "decision".]

[60] In *Wilson v. Swanson* [1956] S.C.R. 804 at page 811, the Supreme Court of Canada set out the duty owed by a physician to his patient as follows:

There is here only the question of judgment; what of that? That test can be no more than this: Was the decision the result of the exercise of the surgical intelligence professed? Or was what was done such that, disregarding it may be the exceptional case or individual, in all the circumstances, at least the preponderant opinion of the group would have been against it? If a substantial opinion confirms it, there is no breach or failure.

An error in judgment has long been distinguished from an act of unskilfulness or carelessness or due to lack of knowledge. Although universally-accepted procedures must be observed, they furnish little or no assistance in resolving such a predicament as faced the surgeon here. In such a situation a decision must be made without delay based on limited known and unknown factors; and the honest and intelligent exercise of judgment has long been recognized as satisfying the professional obligation.

[61] It is not up to the Court to resolve differences of medical opinion or schools of thought within the medical profession. In *ter Neuzen v. Korn* (1995), 11 B.C.L.R. (3d) 201, the Supreme Court of Canada said at para. 38:

It is generally accepted that when a doctor acts in accordance with a recognized and respectable practice of the profession, he or she will not be found to be negligent. This is because courts do not ordinarily have the expertise to tell professionals that they are not behaving appropriately in their field. In a sense, the medical profession as a whole is assumed to have adopted procedures which are in the best interests of patients and are not inherently negligent. As L'Heureux-Dubé J. stated in *Lapointe*, in the context of the Quebec Civil Code (at pp. 363-64):

Given the number of available methods of treatment from which medical professionals must at times choose, and the distinction between error and fault, a doctor will not be found liable if the diagnosis and treatment given to a patient correspond to those recognized by medical science at the time, even in the face of competing theories.

[62] In *Belknap v. Meakes* (1989), 64 D.L.R. (4th) 452 at page 474, the British Columbia Court of Appeal adopted a statement from the House of Lords in a previous case as follows:

In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men ... The true test for establishing negligence in diagnosis or treatment on the part of a doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty of if acting with ordinary care

[emphasis added]

[63] I find the last sentence above to be particularly noteworthy and helpful in my analysis of the principal factual issue in this case, that is, whether Dr. Zacharias met the applicable standard of care.

Conclusions:

[64] The plaintiff's submission as to the quality of care provided by the defendant is set out in counsel's written argument at para. 2 as follows:

The plaintiff's position is:

- (a) Dr. Zacharias failed to provide Ms. McClelland with a reasonable quality of medical care from and after September 23, 1999;
- (b) His failure to provide Ms. McClelland with a reasonable quality of medical care was a continuous one from and after September 23, 1999 until her admittance to MSA Hospital on October 28, 1999;
- (c) Dr. Zacharias would have provided Ms. McClelland with a reasonable quality of medical care from and after September 23, 1999 had he:
 - i. Either referred her to a specialist in internal medicine (an internist) with the same urgency he displayed when he made a referral to an internist on October 22, 1999, or advised her to go to the MSA Hospital Emergency Room and wait until the on call internist could see her. Had the former option been chosen, Ms. McClelland could have been seen by an internist within three days. Had the latter option been chosen, Ms. McClelland could have been seen by an on call internist on the same day, as occurred on October 28, 1999; and
 - ii. Ordered a urinalysis for culture and sensitivity.

Dr. Zacharias' failure to have Ms. McClelland seen by an internist in a timely fashion is the most causally significant of his two failings;

[65] He further states in para. 16:

The plaintiff's case is that Dr. Zacharias failed to recognize the combination of clinical signs and test results that any general practitioner of ordinary skill would realize were strongly suggestive of a growing and dangerous bacterial infection.

- [66] I agree that the most significant factual issue to be resolved is whether, given the results of the blood tests and the symptoms of the plaintiff as he observed them and as they were recounted to him as of and immediately after September 23, 1999, the defendant should have done more than he did, in particular, refer the plaintiff to an internist for assessment? However, the difficulty in the plaintiff's case from an evidentiary point of view is that her clinical picture as reflected in Dr. Zacharias' notes and his testimony is not the same as that described by her and her witnesses.
- [67] Dr. Zacharias' notes during the month of September do not reflect the complaints of back pain that she insisted she was conveying to him. I find it difficult to accept that if she had been advising him of "exquisite back pain" during that period (as she later advised Dr. Lapin and which played a significant part in the latter's diagnosis and opinions) that Dr. Zacharias would not have made some record of it and that he would not have pursued it more specifically in some way. Back pain is referred to in his notes of October 15th and 19th but the "problem" and "purpose of referral" sections of his Request for Consultation form to the internist on October 22nd (Exhibit 1-1-41) make no mention of back pain, which would be anomalous if such back pain had been a major feature of her presentation.
- [68] The same can be said of her "sweats" or "night sweats", which combined with the blood picture apparently would have been of considerable significance with respect to a differential diagnosis of bacterial infection. There was mention of fever, which led Dr. Zacharias to consider mononucleosis. But there is no mention until October 15th of the severe "sweats" described by the plaintiff. Even at that, his lengthy notes of October 15th as well as containing the notation "spiked fever, sweats" also contain the notation "afebrile", presumably her condition on that day. Again, I find it unlikely that if she had repeatedly mentioned such "sweats" or "night sweats" to Dr. Zacharias during her visits of September that he would not have recorded that.
- [69] The issue is not whether the plaintiff was experiencing those symptoms but whether their severity was being communicated fully to Dr. Zacharias. Similarly, the fact that her father and friends noted a "dramatic change" in her physical appearance does not necessarily mean that she presented that way on her visits to Dr. Zacharias. The evidence was that the plaintiff is, and indeed she struck me as, a forceful, upbeat person who was determined not to give in to her illness. That may well have affected her presentation to Dr. Zacharias during the month of September.
- [70] The evidence relating to her condition on September 23rd specifically is of course of prime importance. As mentioned, Dr. Zacharias insisted strongly in his testimony that her presentation had "markedly improved" since September 8th and the 10th, although he conceded that he could not be as definite about the 17th because of the brevity of his note for that date. According to him she did not "get worse over four weeks. Not at all. She had improved by the third week." Her blood counts for that day, that is, the indications of a bacterial infection, although still elevated, had in fact improved since the 17th. She had stopped losing weight and had gained a kilo since the 17th. He pointed out that she did not

appear to be a person with bacteremia. As mentioned above, he said such persons are "deathly ill. They don't come to the office. They are in emergency."

- [71] To further complicate the diagnosis, he did identify a urinary tract infection. That is much more common in women than in men. He knew it would be a bacterial infection and therefore he thought it might have something to do with her elevated blood counts, particularly when considered with her sore throat and the possibility of a viral infection. He treated it in what he considered to be the usual way, that is with a broad spectrum antibiotic. The evidence was that the protocol of the B.C. Medical Association for the investigation and treatment of uncomplicated urinary tract infections (Exhibit 4) does not call for a culture or sensitivity test. I think it is understandable that Dr. Zacharias was somewhat diverted by the appearance of the urinary tract infection on the 23rd, particularly since, as he testified, looking at the clinical picture as a whole there appeared to be no obvious explanation for a severe bacterial infection such as, for example, a large wound.
- [72] On the 24th, Dr. Zacharias treated the plaintiff for dehydration at the hospital. Contrary to what Dr. Gummesson testified, he insisted that a second such treatment was in accordance with standard practice in his community, namely, Abbotsford.
- [73] Thereafter, the plaintiff was "lost to care", to use Dr. Gummesson's expression. She did not return even though, according to her, after a brief improvement she went "downwards again". As stated above, she was determined to "get herself better" and tried alternative medicine procedures. She was resisting the idea of going to the hospital. Given the circumstances on the 23rd and 24th, I do not think it was unreasonable for the defendant to assume that the plaintiff had either got better or gone to her long-time principal physician, Dr. Hacquebard. I do not think the circumstances called upon him to pursue her and insist that she return for further evaluation.
- [74] The plaintiff returned on October 15th. As set out above the defendant found her condition overall to be better but there were new factors that were of concern and caused him to order more lab work in order to rule out hepatitis and chronic infection. She returned on the 19th. Back pain and night sweats were mentioned and Dr. Zacharias ordered x-rays, which, as noted above, showed no abnormalities. The plaintiff did not show up for appointments on the 19th and 20th. She returned on the 22nd with a new complaint of hives and Dr. Zacharias now referred her to an internist with, as noted above, a specific concern about a "myeloproliferative disease". Given the picture to that point and the history of leukemia in her family it seems to me that that was a reasonable concern. When she returned on the 26th, having been "bumped" at the internist on the 25th but with a new appointment with him for the following week, Dr. Zacharias apparently felt that she should now be assessed and treated by the internist.
- [75] From October 15th to the 26th, things moved quickly and even if he still apparently did not diagnose a major systemic bacterial infection, I find that during that period Dr. Zacharias acted appropriately given all the circumstances.

- [76] On all the evidence it is clear that Dr. Zacharias was conscientious in his care of the plaintiff. I have outlined it in detail. There is nothing to indicate that decisions he did make were not made with due consideration and there is nothing to indicate that he was neglectful in any way. He exercised at the very least, "ordinary care". Did he exercise "ordinary skill"?
- [77] I think it is fair to say that if all the information regarding the plaintiff's symptoms that she and her witnesses say were present were known to or observed by a treating physician by September 24th along with the test results, then such a physician of ordinary skill, exercising ordinary care might well have considered the possibility of a bacteremia, included it in his differential diagnosis, and would have done something about it. The most troubling dimension of the evidence is, of course, the blood tests. However, as I indicated above, I am not satisfied on the balance of probabilities that the defendant received as complete a picture from the plaintiff of her symptoms up to September 23rd as she now remembers giving to him. The key times are September 23rd and the point thereafter when he received the results of the blood tests of that day.
- [78] The plaintiff's condition according to Dr. Dvorak was rare and, unfortunately, very virulent or "aggressive". All six cases he has treated were very advanced by the time they came to him. The defendant cannot, of course, be judged on the basis of hindsight and an error in judgement alone is not enough to establish liability. I am satisfied that there was a reasonable basis for the clinical judgment Dr. Zacharias exercised on the basis of the information that the evidence has established he had before him. Accordingly, I am not satisfied that he was negligent in his treatment of the plaintiff.
- [79] The above is sufficient to dispose of the action. However, given the possibility of appellate review of this decision a few relatively brief observations in two areas are in order given that I had before me extensive evidence and submissions respecting them.
- [80] The first observation is for the most part in the nature of an alternative finding. Basically it is that the evidence has not established that the plaintiff's present condition in its entirety is linked causally to the alleged deficiency in Dr. Zacharias' care, that is, the failure to take further action sometime soon after September 23rd.
- [81] I note again the last two sentences in the passage from Dr. Gummeson's report set out above. Whether or not earlier treatment would have significantly changed the clinical outcome in terms of Ms. McClelland's long-term physical functioning and pain symptoms is unclear.
- [82] I note further the evidence of Dr. Dvorak cited above that the infection had likely been present in her lumbar spine "around two to three months" when he first saw her on November 2nd.
- [83] Given that evidence, it is difficult to say at what stage the infection and resulting damage would have been arrested if diagnosed and treated shortly after September 23rd. It is not enough to show that earlier treatment "might" have avoided the plaintiff's present condition.

[84] In *Cottrelle v. Gerrard* [2003] 233 D.L.R. (4th) 45, the Ontario Court of Appeal said at para. 25:

I agree with the appellant's submission that in an action for delayed medical diagnosis and treatment, a plaintiff must prove on a balance of probabilities that the delay caused or contributed to the unfavourable outcome. In other words, if, on a balance of probabilities, the plaintiff fails to prove that the unfavourable outcome would have been avoided with prompt diagnosis and treatment, then the plaintiff's claim must fail. It is not sufficient to prove that adequate diagnosis and treatment would have afforded a chance of avoiding the unfavourable outcome unless that chance surpasses the threshold of "more likely than not".

[85] It is clear on the evidence that the condition could not have been diagnosed until some damage had already occurred. It seems to me therefore that if Dr. Zacharias was found negligent, the court would likely have been faced with a "crumbling skull" scenario where part but not all of the plaintiff's present condition would be attributable to the failure to diagnose earlier, for example (only), at the stage of a disc infection but before significant damage to the adjacent vertebrae had occurred.

[86] The second observation is with respect to the claim for pecuniary damages. It is my opinion that in general it is not necessary and better not to assess damages after dismissing a claim. However, I have indicated above why it is preferable to offer at least some very brief comment in this regard.

[87] The plaintiff puts forward a claim for loss of earning capacity based on her business as a motivational speaker. However, the evidence was that up to the time of her illness, her business in that regard had been in a loss position and her calculations supporting her claim were based on what she hoped she would earn in the future. Up to the time of her incapacity, she had received only modest fees (with the exception of one \$1200 fee) but she expected that her fees and income would increase somewhat dramatically in the future. I cannot say that I am persuaded on a balance of probabilities that such an increase would have occurred, certainly not beyond the income that she has earned from the two positions she has held since her illness.

[88] I was advised that during the trial she resigned her most recent position because, she said, of the pain in her back. However, I would have had to hear more evidence before assessing damages on that basis.

[89] In the result, if I had had to assess an amount for loss of future earning capacity, it would have been a relatively modest amount on the basis of a "loss of opportunity" as in such cases as *Clark v. Kereiff* (1983) 43 B.C.L.R. 157 and *Freitag v. Davis* [1984] 6 W.W.R. 188 (B.C.C.A.).

[90] The claim is dismissed. Costs must follow the event.

"R.M.P. Paris, J."

The Honourable Mr. Justice R.M.P. Paris

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