2000 CarswellOnt 4284
Ontario Superior Court of Justice

Nichols v. Keyzer

2000 CarswellOnt 4284, [2000] O.J. No. 4356, [2000] O.T.C. 794, 101 A.C.W.S. (3d) 169

Nancy Nichols, Dawn Marie Nichols, Kenneth Nichols and Samantha Nichols, by her Litigation Guardian Brian Nichols and Brian Nichols personally, Plaintiffs and John J. Keyzer, Defendant

Mandel J.

Heard: September 18 - October 12, 2000
Judgment: November 17, 2000
Docket: Doc. 96-CU-102361

Counsel: *David Richmon*, for Plaintiffs.
Mark Veneziano, for Defendant.

Subject: Public; Torts

Headnote

Health law --- Physicians and surgeons — Malpractice — Types of malpractice — Failure to diagnose

Plaintiff had four surgeries on right small finger after lacerating tendon at age 13 — Plaintiff ended up with chronic fixed flexion contracture with small finger bent into palm of hand — Plaintiff did not experience any functional problems with finger over next 20 years — Plaintiff began experiencing tingling and recurring pain in right hand and underside of forearm — Plaintiff was referred to plastic surgeon who informed plaintiff that straightening finger would relieve forearm pain — Surgeon did not investigate other possible causes or conduct tests with regard to forearm pain — Nerves were injured during surgery and plaintiff suffered extreme pain following surgery — Different surgeon diagnosed plaintiff's forearm pain and successfully treated pain by splinting — Plaintiff's small finger was amputated and pathology report disclosed nerve injury and traumatic neuroma related to surgery — Plaintiff brought action against surgeon for medical malpractice — Action allowed — Surgeon was negligent in coming to diagnosis — Surgeon was negligent in failing to disclose existence of alternative treatment which offered no risk to plaintiff — Surgeon's negligence materially contributed to pain and discomfort of plaintiff — Agreed upon damages were ordered.

Health law --- Physicians and surgeons — Relationship with patient — Consent to treatment — Disclosure of risk (informed consent) — General

Plaintiff had four surgeries on right small finger after lacerating tendon at age 13 — Plaintiff ended up with chronic fixed flexion contracture with small finger bent into palm of hand — Plaintiff did not experience any functional problems with finger over next 20 years — Plaintiff began experiencing tingling and recurring pain in right hand and underside of forearm — Plaintiff was referred to plastic surgeon who informed plaintiff that straightening finger would relieve forearm pain — Plaintiff was not told that possible resulting nerve injury could lead to permanent pain in finger leading to amputation — Nerves were injured during surgery and plaintiff suffered extreme pain following surgery — Plaintiff's small finger was amputated and pathology report disclosed nerve injury and traumatic neuroma related to surgery — Plaintiff brought action against surgeon for medical malpractice — Action allowed — Surgeon was negligent in failing to inform plaintiff of serious and increased risk of surgery — Surgeon's negligence materially contributed to pain and discomfort of plaintiff — Agreed upon damages were ordered.

Table of Authorities

Cases considered by *A. Mandel J.*:

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Bucknam v. Kostuik (1983), 44 O.R. (2d) 102, 3 D.L.R. (4th) 99 (Ont. H.C.) — referred to

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Canterbury v. Spence, 464 F.2d 772, 150 App. D.C. 263 (U.S. D.C. Cir. Ct. 1972) — applied
Ciarlariello v. Schacter, 15 C.C.L.T. (2d) 209, 151 N.R. 133, 62 O.A.C. 161, 100 D.L.R. (4th) 609, [1993] 2 S.C.R. 119 (S.C.C.) — applied
Haughian v. Paine, 40 C.C.L.T. 13, [1987] 4 W.W.R. 97, 55 Sask. R. 99, 37 D.L.R. (4th) 624 (Sask. C.A.) — referred to
Hollis v. Birch, (sub nom. *Hollis v. Dow Corning Corp.*) [1995] 4 S.C.R. 634, (sub nom. *Hollis v. Dow Corning Corp.*) 129 D.L.R. (4th) 609, (sub nom. *Hollis v. Dow Corning Corp.*) 190 N.R. 241, (sub nom. *Hollis v. Dow Corning Corp.*) 67 B.C.A.C. 1, (sub nom. *Hollis v. Dow Corning Corp.*) 111 W.A.C. 1, [1996] 2 W.W.R. 77, 14 B.C.L.R. (3d) 1, 27 C.C.L.T. (2d) 1, 26 B.L.R. (2d) 169 (S.C.C.) — applied
Layden v. Cope (1984), 28 C.C.L.T. 140, 52 A.R. 70 (Alta. Q.B.) — applied
Malette v. Shulman (1990), 2 C.C.L.T. (2d) 1, 72 O.R. (2d) 417, 67 D.L.R. (4th) 321, 37 O.A.C. 281 (Ont. C.A.) — applied
Rawlings v. Lindsay (1982), 20 C.C.L.T. 301 (B.C. S.C.) — referred to
Reibl v. Hughes, [1980] 2 S.C.R. 880, 114 D.L.R. (3d) 1, 14 C.C.L.T. 1, 33 N.R. 361 (S.C.C.) — applied
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Videto v. Kennedy (1981), 33 O.R. (2d) 497, 17 C.C.L.T. 307, 125 D.L.R. (3d) 127 (Ont. C.A.) — applied
White v. Turner (1981), 31 O.R. (2d) 773, 15 C.C.L.T. 81, 120 D.L.R. (3d) 269, 5 L. Med. Q. 119 (Ont. H.C.) — applied
White v. Turner (1982), 47 O.R. (2d) 764, 12 D.L.R. (4th) 319, 20 C.C.L.T. xxii (Ont. C.A.) — applied
Whitehouse v. Jordan (1980), [1981] 1 All E.R. 267, [1981] 1 W.L.R. 246 (U.K. H.L.) — applied
Wilson v. Swanson, [1956] S.C.R. 804, 5 D.L.R. (2d) 113 (S.C.C.) — applied
Wood v. Cobourg District General Hospital (1997), 1996 CarswellOnt 5514, 37 O.T.C. 241 (Ont. Gen. Div.) — applied

ACTION by plaintiff against surgeon for medical malpractice.

***A. Mandel J.*:**

Reasons for Judgment

1 This is a medical malpractice action.

2 The parties have agreed as to the quantum of damages. The issue to be decided is that of liability.

3 At the beginning of the trial, the parties on consent filed exhibits and agreed that they need not be proved and that notwithstanding that the exhibits and what is therein contained or any part thereof are not referred to by any witness or counsel during the examinations or submissions that the court can rely on and base its judgment on what is contained in the exhibits and any part thereof. Included in the exhibits filed on consent were the reports of experts who also gave *viva voce* evidence. Again, such procedure was expressly agreed to by the parties.

Overview

4 The plaintiff Nancy Nichols (hereafter called "Nancy") is presently 43 years old. She has a grade nine education and presently cleans homes being employed by Molly Maid.

5 Nancy is ambidextrous. Although she is left hand dominant she does most things with her right hand.

6 When she was 13 years old she had lacerated a tendon in her right small finger. Over the years she had four surgeries with respect to such finger. The last of which was in 1974. The operations were not successful and she ended up with a chronic fixed flexion contracture whereby her small finger was bent into the palm of her right hand

7 From 1974 to 1994 she was "able to get along fine, despite the contracture" (Exhibit 1 Tab 2 page 15 letter of Dr. Rapson to the defendant). As Nancy testified, she experienced no functional problem with the finger in her work; her household chores; in any activities in her daily living and in raising her children. The only difficulties she had were first her finger getting caught on doorknob and secondly her need to wear mitts instead of gloves. In October 1993 she was a dietary aid at a nursing home. Her job consisted of preparing trays with drinks and meals; setting up the dining room; lifting trays and serving the meals; cleaning up the dining room; and washing dishes.

8 She left such employment in June or July 1994 because she had a lot of pain in her right hand. Her hand was giving away and although she was not dropping things at the job; she was at home. She also had forearm pain from just below her right elbow to the wrist and into her hand. The pain was along the underside of her arm. Such pain was not constant in 1994. She also had tingling in the hand closest to the "outside" thereof "where the baby finger was".

9 She did not seek treatment in 1994 because she felt that the pain, tingling and giving away of the hand would go away on its own. However, it did not.

10 In January 1995 she got a job as a telemarketer whereby she telephoned people canvassing them to clean the ducts in their homes. However, she had problem with using the phone for the pain in her arm became worse and constant and her hand was giving out. As she stated the pain increased when using the phone she rested on her elbow.

11 She consulted her family doctor, Valerie Rapson, on February 20, 1995. The doctor's note states:

> She has also had for a number eyars [*sic*] a fixed flexion deformity of the R. baby finger. She also had four operations on this. She had recently gone back to work at a telemarketing job. Despite being L. handed, she does most things with her right hand and this is an obstructive thing. She is having forearm pain as a result and she feels this is detracting from future employment.
>
> I am sending her to Dr. Keyzer for this.

12 From 1974 until the summer of 1994 Nancy experienced no functional problem with the finger and hand in her work; her household chores; in any activities in her daily living; and in raising her children. The only difficulties she had were first her finger getting caught on doorknobs and secondly her need to wear mitts instead of gloves.

13 An appointment was made for Dr. Keyzer to see the plaintiff on March 28, 1995.

14 Dr. Keyzer is a plastic surgeon and has been such since 1963. He obtained his medical training in Holland and immigrated to Canada. He obtained his licence to practice medicine in Canada in 1965. Since 1971 he became involved in traumatic surgery involving the face and hands and he testified that he dealt with fingers like the plaintiff's about six times a year before he saw the plaintiff.

15 He also testified that he treated patients with cubital tunnel syndrome ("C.T.S.") four to five times a year. Before he saw the plaintiff, such patients with C.T.S. were referred to him by the family doctor or a neurologist who made the diagnosis. It is to be noted that Dr. Keyzer did not make the diagnosis. The doctor also testified that it was not in "the scope of" his practice to examine and assess the etiology of forearm pain with which the plaintiff attended upon him on July 25, 1995, being post operation when she complained bitterly of forearm pain of which more hereafter.

16 Dr. Rapson, the family doctor of the plaintiff, wrote to the defendant on February 23, 1995. Her letter is short and reads:

> Thank you for seeing this 37 year old woman who has a chronic fixed flexion contracture of the baby finger on the R hand. She apparently had a laceration to a tendon as a child, and because of ongoing pain underwent surgeries to improve this. However, she ended up with a contracture instead. She has had four operations on this with no success.
>
> For the most part she has been able to get along fine, despite the contracture. Recent she has had pain in the forearm, affecting her ability to use that hand, especially with respect to employment. Nancy is actually left hand dominant, but does most things with her right hand.
>
> I ask that you see her for assessment of the contracture, and possible release. She is otherwise well, but is a smoker. She has had a tubal pregnancy in the past along with subsequent in vitro fertilization. She has had a remote appendectomy.
>
> Thank you for seeing her. I look forward to your assessment.

17 It is to be noted that the family doctor asks Dr. Keyzer to see the plaintiff "for assessment of the contracture and possible release".

18 During submissions counsel for the defendant conceded that as the defendant was a specialist he was obliged to assess the complaints of the plaintiff to come to his own decision as to a diagnosis and treatment and not to rely on the diagnosis and treatment indicated in the referral letter. In my view, such concession was properly made. I do not accept the testimony of Dr. McCain that the referral doctor, the family physician, was "the captain of the ship".

19 Dr. Keyzer read the referral letter immediately before he saw the plaintiff on March 28, 1995.

20 The plaintiff told the defendant of her medical history with regard to her finger; the symptoms of her forearm pain (from her elbow to wrist; the tingling; the hand giving out) and the intensity of the pain depended on what she did that day, *viz*, the moving or flexing of the arm or the resting of the arm on her elbow whilst talking on the telephone increased the pain. I accept the testimony of the plaintiff.

21 The defendant viewed the matter in the context of flexion contracture, *viz*, the straightening of the finger would relieve the pain and as he stated it was not important to find out how long she had forearm pain. He wrongly assumed that the hand had not been useful from age 13 on. He conducted no tests with regard to the forearm pain as, for example, the simple test of tapping the elbow. He did not investigate other possible causes. As he stated, his diagnosis was possible and he did not rule out anything else. He further testified that he was trained to diagnose C.T.S. However, as hereinbefore stated such diagnosis was performed by referring doctors and it was not in the scope of his practice to do so.

22 The defendant informed the plaintiff that the straightening of the finger would relieve the forearm pain. He further informed her that the risk of such surgery was a possibility of nerve injury leading to temporary loss of sensation, which is sometimes permanent. He did not tell her that such nerve injury would lead to permanent pain in her finger, which may lead in turn to amputation of the finger. As the defendant stated, a possible risk of surgery is traumatic neuroma, which may be so painful that amputation of the finger is performed and that where surgery is performed a number of times on the finger the occurrence of such a risk increases.

23 The doctor then made his diagnosis and wrote to the family doctor on March 28, 1995. Although the family doctor referred the plaintiff to the defendant "for assessment of the contracture and possible release", and although the defendant wrote to the family doctor that the forearm pain "may well be related to flexor tendon fixations", the surgery that was performed was not a release of the tendons. Rather, he writes:

> I have discussed the several treatment options with Nancy. First of all, I would feel that any further attempt at getting tendon motion in that finger is doomed to fail and I do not consider this a valid option. However, soft tissue release most likely with z-plasties but possibly with a small skin graft to the volar aspect of the proximal phalanx should relieve some of the problem. I would then suggest completely dividing any flexor tendon or scarred flexor

> tendons and fusing the PIP joint in a position of function which is approximately twenty-five to thirty degrees of flexion. With a normal range of movement of her MCP joint, this should give her a very useful and useable finger. Whether or not anything may have to be done to the DIP joint remains to be seen and would definitely then require a second procedure.
>
> I have discussed this with Nancy and also discussed the final option of amputation of the little finger which she already had been offered and had refused.
>
> Nancy has asked me to make appropriate arrangements and I hope that if she needs and Physiotherapy post operatively that you will be able to arrange that at the RVH.
>
> Thanking you for your kind referral and hoping that this course of action meets with your approval.

24 It is common ground that flexor tendons were neither released nor divided. The reason being that no flexor tendons could be found. This is understandable having regard to the four operations that the plaintiff had undergone, the last being in 1974 as aforesaid.

25 The plaintiff signed a consent to "release flexion contracture digit five and fusion right digit five proximal intraphalangeal joint".

26 The operation was performed. During the course thereof the nerves were injured. The risk of traumatic neuroma occurred leading to a permanent painful finger.

27 On July 25th the plaintiff attended upon the defendant complaining "bitterly about pain in her forearm". The defendant wrote to the referring doctor as follows:

> Nancy presented today, now about two months since her surgery. She has done extremely well and the little finger has healed completely, the fusion is solid and the finger is in good position.
>
> However Nancy is still complaining bitterly about pain in her forearm, usually on the volar aspect but on occasion on the dorsum as well and extending up to the shoulder which I feel bear really no relationship at all to the hand injury and the surgeries to the little finger.
>
> I would suggest that you arrange for occupational therapy at the Royal Victoria Hospital in an attempt to improve this but I really feel that this is not related to either of the previous surgeries or to the little finger itself.

28 When the letter was brought to his attention, the defendant stated that the letter was in error in that the word "still" in the second paragraph should have been "now". I do not accept such testimony. Not only does it appear to me to be lame rationalization but also the defendant admitted that having regard to such forearm complaint his diagnosis that the forearm pain that the plaintiff complained of on her first visit would be relieved by the straightening of the finger was not correct. Having regard to such admission the reasonable and fair conclusion is that the use of the word "still" was not an error, and referred to the pain that the plaintiff originally complained of to the defendant on March 28th.

29 It is to be noted that the defendant in his letter to the referring doctor makes no mention of his incorrect diagnosis. Rather he states that the forearm pain is "not related to either of the previous surgeries or to the little finger itself".

30 The defendant does not examine or investigate or make any tests with respect to such pain. Nor does he make any diagnosis. As he explained it was not "in the scope of his practice to do so". Rather he refers the matter to the family doctor to arrange for physiotherapy.

31 In that regard I accept the testimony of the plaintiff that she sought medical help not to straighten her finger as the hand was not dysfunctional as aforesaid; rather such help was sought to relieve her forearm pain.

32 The plaintiff was referred by her family doctor to another plastic surgeon (Dr. McKee). Her report to the family doctor sets out her diagnosis:

> In reading the notes, this right little finger certainly struggled following the last operation. There is evidence that there is nerve recovery on the ulnar digital nerve with two tinels, one distal to the PIP and one in the pulp. As the one in the pulp grows more distally, she will probably have increased sensation and hopefully less of the bazaar sensations. Right now she gives this side of her finger 7/10.
>
> I tried to convey to her there was reason for optimism and that this is coming along and she should be doing lots of sensory reeducation to help her brain adjust to the altered sensation of the recovering nerve.
>
> I also pointed out to her that she tends to hold the finger extended at the MCP joint and abducted and that this holding in this position would provide some forearm discomfort. I encouraged her to do the intrinsic exercises of waving bye-bye and pretending she has cards or coins between her fingers like a card shark, also pulling her fingers together and separating them with all of the MCPs and IPs straight.

33 It is seen from the last paragraph of her letter as set out above that she attributes the "forearm discomfort" to the manner in which the straightened finger is held by the plaintiff this notwithstanding that the defendant felt that the forearm pain was not related "to the little finger itself" and that his diagnosis was incorrect *viz*, that the forearm pain arose from the dysfunctional use of the hand and that the straightening of the finger would make the hand functional and relieve the forearm pain. However, as I have stated, the defendant did not state that his diagnosis was incorrect in his letter to the referring doctor.

34 The plaintiff then consulted her former family doctor (Dr. Shrott), who referred her to Dr. Binhammer a surgeon at hand and microvascular surgery of Sunnybrook Health Science Centre of the University of Toronto.

35 Dr. Binhammer reported to Dr. Shrott on December 6, 1995. Such report states, *inter alia*:

> I explained to Mrs. Nichols that it is difficult to determine the etiology of her original forearm pain especially in view of the fact that she certainly has ulnar nerve irritation and/or compression. It is possible that an injury to the ulnar nerve at the level of her digital nerve of her small finger has produced the symptoms that she has related to the positive Tinel's. It is also possible that she originally had a cubital tunnel syndrome and still does.
>
> We will try and determine whether there is severe enough cubital tunnel to document on EMG a problem. Additionally we will obtain an X ray.

36 The plaintiff presented Dr. Binhammer with two distinct problems being the forearm pain (possible C.T.S.) and the excruciating pain in her right baby finger. The diagnosis was a difficult one as the pain would overlap from the two sources.

37 The EMG was normal but did not rule out C.T.S. The X-ray was necessary with regard to the underlying bone structure and nature of hardware in the finger that was operated on.

38 Dr. Binhammer diagnosed the forearm pain as C.T.S. and treated it conservatively by splinting. Such pain was gone in some four months.

39 This left the pain in the small finger. It was Dr. Binhammer's opinion that the nerve was injured in the surgery performed by the defendant. I accept such opinion.

40 The options were to desensitize the area by physiotherapy (conservative treatment) or amputate the finger.

41 Dr. Binhammer sent the plaintiff to therapy to desensitize the area. It was not successful and the pain was still there.

42 After several months the plaintiff decided to have the finger amputated. Dr. Binhammer performed the surgery on April 3, 1997. The pathology report of the amputated finger disclosed the nerve injury and traumatic neuroma. These were related to the surgery performed by the defendant.

Negligence

43 It is the position of the plaintiff that the defendant fell below the standard of care expected of a specialist.

44 It is well to keep in mind what the duty of a specialist is. Such duty is set out in *Wilson v. Swanson* (1956), 5 D.L.R. (2d) 113 (S.C.C.), at 124:

> The test of reasonable care applies in medical malpractice cases as in other cases of alleged negligence. As has been said in the United States, the medical man must possess and use, that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases, and it is the duty of a specialist such as the appellant, who holds himself out as possessing special skill and knowledge, to have and exercise the degree of skill of an average specialist in his field.

45 Furthermore, as the Ontario Court of Appeal has stated in *Tacknyk v. Lake of the Woods Clinic* (November 25, 1982), Cory J.A. (Ont. C.A.):

> It is now clear that the standard of care is a matter for the court and not for the medical experts although there view will be taken into consideration in setting the appropriate standard.

46 What then are such duties?

(a) Duty to diagnose

According to Rowbotham J. in *Layden v. Cope* (1984), 52 A.R. 70 (Alta. Q.B.), at 75-76:

> It is not sufficient in my view for a medical practitioner to say 'of the two or three probable diagnoses I have chosen diagnosis (A) or diagnosis (B) or (C).' It must be expected that the practitioner would choose diagnosis (A) over (B) or (C) because all the facts available to that practitioner and all of the methods available to check the accuracy of those facts and that diagnosis had been exercised with the result that diagnosis (A) remains as the most probable of all....
>
> In other words, every avenue of diagnosis should be explored before accepting the most probable of all. This need to explore alternatives would seem to me to be even more important in a situation when it becomes increasingly evident that the original diagnosis may have been incomplete and erroneous.

This duty and the steps to be taken in the exercise of such duty are described in *Scott (Crick) v. Mohan*, [1993] A.J. No. 592 (Alta. Q.B.) as follows:

> In making a diagnosis a doctor is required to obtain a thorough history, including the heeding of the patient's complaints during treatment, take appropriate tests, utilize the available scientific equipment facilities and tests; and consult and obtain professional referrals where necessary. All these should be examined to determine the quality of the diagnosis.
>
> All the medical practitioners who testified agreed the approach to diagnosis is a three step process. First, the doctor is required to make a differential diagnosis. This means he is required to consider all possibilities based on the history taken, the clinical exam performed and the test results obtained. From this step, the doctor is required to arrive at the second step of or presumptive or working diagnosis and design the treatment accordingly, unless a definitive diagnosis, the third step is obtained. Where there is a definitive

> diagnosis, the duty then arises to test specifically the ailment diagnosed with the best care and skill available in the circumstances.
>
> In the event a definitive diagnosis is not achieved, the doctor is required during the working diagnosis step to monitor the results of the treatments prescribed for the symptoms and complaints identified and to continue development of a history by clinical tests and examinations to determine if a definitive diagnosis can be obtained or return to the first step of differential diagnosis. Where treatment, ongoing history, clinical examination and tests do not support the working diagnosis there is a duty to reconsider the matter by further differential diagnosis or consultation and referral.

(b) Duty to discuss alternative options

In *Hollis v. Birch* (1995), 129 D.L.R. (4th) 609 (S.C.C.), at 656, Mr. Justice La Forest for the majority in the Supreme Court of Canada approved the following passage from *Canterbury v. Spence*, 464 F.2d 772 (U.S. D.C. Cir. Ct. 1972), at 780 :

> True consent to what happens to one's self is the informed exercise of a choice, and that entails an opportunity to evaluate knowledgeably the options available and the risks attendant upon each. The average patient has little or no understanding of the medical arts, and ordinarily has only his physician to whom he can look for enlightenment with which to reach an intelligent decision.

And see *Malette v. Shulman* (1990), 67 D.L.R. (4th) 321 (Ont. C.A.), at 326-8, *viz*:

> The doctrine of informed consent has developed in the law as the primary means of protecting a patient's right to control his or her medical treatment.
>
> Under the doctrine, no medical procedure may be undertaken without the patient's consent, obtained after the patient has been provided with sufficient information to evaluate the risks and benefits of the proposed treatment and other available options. The doctrine presupposes the patient's capacity to make a subjective treatment decision, based on her understanding of the necessary medical facts provided by the doctor and on her assessment of her own personal circumstances.
>
> . . . . .
>
> The right of self-determination, which underlies the doctrine of informed consent, also obviously encompasses the right to refuse medical treatment. A competent adult is generally entitled to reject a specific treatment or all treatment, or to select an alternative form of treatment, even if the decision may entail risks as serious as death and may appear mistaken in the eyes of the medical profession or of the community... The doctrine of informed consent is plainly intended to ensure the freedom of individuals to make choices concerning their medical care. For this freedom to be meaningful, people must have the right to make choices that accord with their own values, regardless of how unwise or foolish those choices may appear to others.

And further see *Van Mol (Guardian ad litem of) v. Ashmore* (1999), 168 D.L.R. (4th) 637 (B.C. C.A.); *Haughian v. Paine* (1987), 37 D.L.R. (4th) 624 (Sask. C.A.), at 644; *Seney v. Crooks* (1998), 166 D.L.R. (4th) 337 (Alta. C.A.). And see *Legal Liability of Doctors and Hospitals* (1996), (3d) edition at 163, *viz*:

> One exception to this trend is evident in cases where the doctor fails to inform the patient of alternatives to the treatment which is proposed. As we have seen, the doctor's duty of disclosure goes well beyond simply advising the patient of the risks involved in the treatment; the doctor must disclose all material information which a reasonable person in the patient's position would want to have, and this has been interpreted as including information about any available alternatives. Where the doctor is found to have been negligent in failing to disclose the existence of these alternatives, especially if they involve fewer risks to the patient, the decided cases indicate that the patient is much more likely to succeed in establishing causation.

There appears to be some authority that limits such duty to alternative options which offer some advantage and are reasonably likely to achieve a beneficial result. See *Bonnell v. Moddel* (February 5, 1987), Doc. 1399/82 (Ont. H.C.) and the trial judgment in *Bucknam v. Kostuik* (1983), 44 O.R. (2d) 102 (Ont. H.C.). However, in affirming the trial judgment in *Bucknam* the Court of Appeal (1986), 55 O.R. (2d) 187 (Ont. C.A.), at 188 stated:

> The trial judge refrained from deciding definitively whether the failure of the respondent to inform the appellant of the option of a single fusion was a breach of his duty to inform. It is not necessary for us to decide this issue because we think that the trial judge was right in his conclusion that, assuming that the respondent was in breach of his duty, there was no causal connection between the breach and the damages suffered by the appellant.

The learned authors of the text *Legal Liability of Doctors and Hospitals, supra*, in respect of such limitation state at page 130 and 131:

> To some extent the Ontario interpretation is both sensible and practical. In most clinical settings there will be alternative procedures which offer no prospect of therapeutic benefit to a particular patient and which would be entirely inappropriate to require the doctor to inform the patient of these. Since the doctor has no duty to perform or offer procedures which are medically futile for a particular patient, it would seem to follow that there is no requirement to advise the patient of their existence.

(c) Duty to inform the patient of the nature of the proposed operation, its gravity, and material risks and any special or unusual risks attendant upon the performance of the operation

In that regard it was stated in *Reibl v. Hughes*, [1980] 2 S.C.R. 880 (S.C.C.), at 892 :

> ...a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery. Although such failure relates to an informed choice of submitting to or refusing recommended and appropriate treatment, it arises as the breach of an anterior duty of due care, comparable in legal obligation of the duty of due care in carrying out the particular treatment to which the patient has consented. It is not a test of the validity of the consent.

And at pp. 884-5:

> In summary, the decided cases appear to indicate that, in obtaining the consent of a patient for the performance upon him of a surgical operation, a surgeon, generally, should answer any specific questions posed by the patient as to the risks involved and should, without being questioned, disclose to him the nature of the proposed operation, its gravity, and material risks and any special or unusual risk attendant upon the performance of the operation. However, having said that, it should be added that the scope of the duty of disclosure and whether or not it has been breached are matters which must be decided in relation to the circumstances of each particular case.

It is a matter for the trier of fact as to whether a particular risk is a material, special or unusual risk (*Videto v. Kennedy* (1981), 33 O.R. (2d) 497 (Ont. C.A.).

In *White v. Turner* (1981), 31 O.R. (2d) 773 (Ont. H.C.), affirmed (1982), 20 C.C.L.T. xxii (Ont. C.A.), Linden J. elaborated on the meaning to be attributed to and the distinction between the terms "material", "unusual" and "special" at p. 789:

> The meaning of 'material risks' and 'unusual or special risks' should now be considered. In my view, material risks are significant risks that pose a real threat to the patient's life, health or comfort. In considering whether a risk is material or immaterial, one must balance the severity of the potential result and the likelihood of its occurring. Even if there is only a small chance of serious injury or death, the risk

> may be considered material. On the other hand, if there is a significant chance of slight injury this too may be held to be material. As always in negligence law, what is a material risk will have to depend on the specific facts of each case.
>
> As for 'unusual or special risks', these are those that are not ordinary, common, everyday matters. These are risks that are somewhat extraordinary, uncommon and not encountered every day, but they are known to occur occasionally. Though rare occurrences, because of their unusual or special character, the Supreme Court has declared that they should be described to a reasonable patient, even though they may not be 'material'. There may, of course, be an overlap between 'material risks' and 'unusual or special risks'. If a special or unusual risk is quite dangerous and fairly frequently encountered, it could be classified as a material risk. But even if it is not very dangerous or common, an unusual or special risk must be disclosed. As was explained by Laskin C.J., even if a certain risk is a 'mere possibility which ordinarily need not be disclosed, yet if its occurrence carries serious consequences, as for example, paralysis or even death, it should be regarded as a material risk requiring disclosure.
>
> In *Rawlings v. Lindsay* (1982), 20 C.C.L.T. 301 (B.C. S.C.), Madam Justice McLachlin (as she then was) stated at p. 306:
>
> > The terminology of 'material', 'special', and 'unusual' risks has in the past given rise to confusion. However, a fair summary of the effect of those decisions, in my view, is that a medical person must disclose those risks to which a reasonable patient would be likely to attach significance in deciding whether or not to undergo the proposed treatment. In making this determination, the degree of probability of the risk and its seriousness are relevant factors. Thus an 'unusual' or improbable risk should be disclosed if its effects are serious. Conversely, a minor result should be disclosed if it is inherent in or a probable result of the process.

The Supreme Court of Canada in *Ciarlariello v. Schacter* (1993), 15 C.C.L.T. (2d) 209 (S.C.C.) has laid down the approach to be taken in deciding whether the risk is to be disclosed. Cory J. speaking for the court states at p. 222:

> In deciding whether a risk is material and therefore, one which should be explained to the patient, an objective approach should be taken. The crucial question in determining the issue is whether a reasonable person in the patient's position would want to know of the risk.

(d) The duty of the surgeon to his patient does not stop with the completion of the operation but is a continuing duty with respect to the complaint of the patient. (See, for example, *Tacknyk v. Lake of the Woods Clinic*, *supra*.)

47 The alleged negligence of the defendant arises in the pre-operation period and the post-operation period.

Pre-operation Period

48 As hereinbefore set forth, the defendant assumed that the hand had not been useful from the age of 13 on. This notwithstanding the letter of the referring doctor that she has been able to get along fine, despite the contracture. For some 24 years she could use the hand and the only problem she had was having her finger caught on doorknobs and having to wear mitts instead of gloves. The plaintiff consulted a doctor not to have her finger straightened but because of her forearm pain.

49 The defendant zeroed in on the flexion contracture. He made no tests nor examinations with regard to the forearm pain.

50 He was trained and aware of C.T.S. symptoms and the symptoms that Nancy evinced and complained of were C.T.S. symptoms, *viz*, pain from elbow to wrist; tingling along the outside of arm and hand to the small finger; the hand

giving away. Yet no examination nor tests were made by the defendant in regard thereto. As the defendant testified it was not within the scope of the practice.

51 Having zeroed in on the flexion contracture, it was his diagnosis that the forearm pain was secondary and that the straightening of the finger "should relieve some of the problem".

52 I find that the defendant was negligent in that:

(i) He did not explore every avenue of diagnosis before accepting the most probable of all. He did not make a differential diagnosis.

(ii) He was made aware of the forearm pain and of C.T.S. symptoms, yet he made no examinations nor tests nor determination in that regard. Such examination and tests were not within the scope of his practice. In such circumstances he should have referred the plaintiff to or consulted with a professional whose practice included such examination, tests and determination.

(iii) He did not provide the plaintiff with a possible alternative to relieve the forearm pain, especially as such possible alternative was a non-invasive and conservative treatment (*viz*, splinting which ultimately proved successful). If such treatment was not successful the plaintiff could always opt for surgery which was elective. Nor can it be said that such treatment was futile. It was reasonably likely to achieve a beneficial result and offered some advantage in that it was non-invasive.

(iv) He based his diagnosis in part on a wrong assumption that the hand had not been useful from age 13 on.

(v) He did not inform the plaintiff that a risk of the proposed surgery was nerve damage and traumatic neuroma resulting in permanent pain in the straightened finger which in turn may lead to amputation of the finger and that where surgery is performed a number of times on the finger that such a risk increases. All of which was known by the defendant. In that regard the plaintiff's main concern and for which she consulted the doctor was her forearm pain. The defendant had given her the option of amputating the finger to relieve the forearm pain. She refused such option. Having regard to the authorities hereinbefore cited, the risk posed a real threat to the plaintiff's comfort (*White v. Turner, supra*). Such risk increased with the number of surgeries on the finger and the surgery in question was the fifth one. It is then reasonable and fair to infer that the degree of probability was high. The risk was serious, *viz*, permanent pain leading to amputation of the finger (*Rawlings v. Lindsay, supra*). A reasonable person in the patient's position would want to know of the risk especially as the purpose of the consultation and surgery was to relieve the forearm pain and the risk of such surgery was permanent pain in the finger which in turn may lead to its amputation (*Ciarlariello v. Shacter, supra*). As I have stated the defendant testified that he gave the plaintiff the option of amputating the finger. The plaintiff refused. He was then aware that she did not want the finger amputated. He was also aware of the risks attendant upon the surgery, *viz*, nerve and vessel injury, traumatic neuroma resulting in permanent pain and ultimate amputation of the finger. The defendant knowing and being aware of the foregoing and not disclosing the risk was negligent. (See *Videto v. Kennedy, supra*, at 505.)

53 It is the position of the defendant that Drs. McCain and Douglas, the defendant's experts, agree that the diagnosis of the defendant was a reasonable and proper one and so did Dr. Binhammer, the plaintiff's expert, and that the defendant was not negligent in making such diagnosis. I do not accept such position.

54 Drs. McCain and Douglas arrived at their conclusions from the written documentation, *viz*, notes and records. Insofar as the consultation on March 28, 1995 between the plaintiff and the defendant is set forth in such documentation, it is sparse. There is no mention of forearm pain in the notes kept by the defendant and only a passing reference in the reporting letter to the family doctor. They did not have the benefit of the sworn testimony given by both the plaintiff and the defendant in court which, for example, included:

(i) The defendant's admission that:

(a) it was not within the scope of his practice to test, examine and determine forearm pain;

(b) he did no tests or examination with regard to the forearm pain;

(c) he was aware of what the symptoms of C.T.S. are;

(d) his diagnosis was wrong;

(e) he was aware that there was a risk of injury to the nerves and vessels and that such risk increases with the number of surgeries performed on the finger; that the proposed surgery was the fifth; that such injury could result in permanent pain in the finger which in turn would lead to amputation of the finger; and that the defendant never told the plaintiff of such risk;

(f) he wrongfully assumed that the hand was not useful since the age of 13;

(g) although the defendant stated that it was not within the scope of his practice to diagnose with regard to the forearm pain, in his letter to the family doctor post-operation on July 25 he suggests occupational therapy without testing, examining, determining and diagnosing with regard to such pain.

(ii) The plaintiff's testimony that she informed the defendant of pain from elbow to wrist, tingling from elbow to small finger and the hand giving out. All of which are C.S.T. symptoms.

Having regard to the foregoing, I do not accept the testimony of Drs. McCain and Douglas having regard to the admissions of the defendant and the testimony of the plaintiff as aforesaid, which I accept. And, as well, having regard to the authorities hereinbefore cited the diagnosis of the defendant was not a proper one.

Further, having regard to the foregoing, I do not accept the opinion of the defendant's experts that they would not have informed the plaintiff of the risk of amputation not only because it would scare the plaintiff but also because they have not heard of amputation of the finger ensuing from the surgery performed by the defendant. As I have stated, the defendant was aware that the plaintiff did not want the finger to be amputated and was aware that where five surgeries are performed on the finger the risk of injury to the nerves and vessels increases and may result in permanent pain leading to amputation of the finger. In such circumstances there was a duty to inform and the defendant was negligent (see *Videto v. Kennedy, supra*, at 505). Nor can it be said that the risk of amputation is remote having regard to the finger being operated on for the fifth time.

55 As for Dr. Binhammer's testimony, he also based his opinion on the written notes and record. He testified that there was not a proper diagnosis having regard to the passing reference to forearm pain in the March 28, 1995 letter of the defendant to the referring doctor. On cross-examination, he stated that if the defendant testified that he had made the diagnosis as to the proposed surgery that it would be a proper one. It is clear from the authorities hereinbefore cited that in arriving at the ultimate probable diagnosis, differential diagnosis with regard to the forearm pain is to be made, especially having regard to what I have found was what the plaintiff told the defendant and the defendant's admissions that the diagnosis was not a proper one. Dr. Binhammer was not present when the defendant testified and was thus unaware of those matters hereinbefore set forth with regard to such diagnoses. In that regard the report of Dr. Binhammer indicates that in effect differential diagnosis is to be made before the final probable diagnosis is made (see Exhibit 8).

56 I place little weight on the report of Dr. McKee, not only because there is no reference therein as to whether she examined, tested and determined the cause of the forearm pain, but also having regard to the short period between the time that Dr. McKee saw the plaintiff (October 3, 1995) and the time that Dr. Binhammer saw her (December 6, 1995); the testimony of the plaintiff as to her forearm pain; the diagnosis by Dr. Binhammer of C.T.S.; and the proper resolution thereof by the conservative treatment of splinting. Nor was Dr. McKee aware that the defendant was of the view that his original diagnosis that the contracture caused the forearm pain was incorrect. Dr. McKee read the notes (see her reporting letter) and concentrated on the little finger.

57 It is also the position of the defendant that according to Dr. Binhammer it was difficult to determine the original forearm pain. However, Dr. Binhammer in his report of December 9, 1998, invites the reader to draw an inference of C.T.S. as therein set out. In my view having regard to the testimony of the plaintiff, which I accept, as to what she told the defendant about her forearm pain and that such pain was eventually resolved by the conservative treatment of splinting, it is more than a reasonable and fair inference that the plaintiff had C.T.S. when she attended upon the defendant and I so find.

58 Nor do I accept the testimony of Dr. McCain that the diagnosis made by Dr. Binhammer was not more difficult but rather as difficult as that made by the defendant. The plaintiff presented herself to Dr. Binhammer with forearm pain and with permanent pain in her straightened finger. Such complaints overlapped but arose from two sources. Dr. Binhammer as a result of the manner in which he diagnosed the problems was able to resolve the forearm pain by the conservative treatment of splinting and the permanent pain in the finger by amputation. In contrast, the plaintiff presented herself to the defendant with only the complaint of forearm pain. There were not two sources of such pain, nor was there overlapping pain. The defendant neither tested nor examined the arm. The symptoms complained of were those which the defendant was trained to identify and were C.T.S. symptoms. I do not accept the position of the defendant that the diagnosis was a difficult one. It would not have been difficult if the defendant had examined the arm made tests and differential diagnosis before he arrived at a definitive diagnosis.

59 It was further the position of the defendant that he is not liable because at most the diagnosis was an error in judgment. In my view, the short answer to such position, which I do not accept, is found in the House of Lord's judgment in *Whitehouse v. Jordan* (1980), [1981] 1 All E.R. 267 (U.K. H.L.), at 276:

> Surprising though it is at this late stage in the development of the law of negligence, counsel for Mr. Jordan persisted in submitting that his client should be completely exculpated were the answer to question (b), 'Well, at the worst he was guilty of an error of clinical judgment'. My Lords, it is high time that the unacceptability of such an answer be fully exposed. To say that a surgeon committed an error of clinical judgment is wholly ambiguous, for, while some such errors may be completely consistent with the due exercise of professional skill, other acts or omissions in the course of exercising 'clinical judgment' may be so glaringly below proper standards as to make a finding of negligence inevitable....

As hereinbefore set forth I find that the defendant fell below proper standards.

Post-operative Period

60 On July 25, 1995, the plaintiff was still complaining of forearm pain. The defendant admitted that his diagnosis was wrong. He does not further examine, test, determine nor diagnose the source or treatment for such pain. As he admitted it was not within the scope of his practice to do so. He writes to the family doctor who is not a specialist, that such pain is "not related to either of the previous surgeries or to the little finger itself". Notwithstanding that he makes no tests, examinations, determination or diagnosis he suggests that the "family doctor arrange for occupational therapy". It is to be noted that he does not inform the family doctor that it was not in the scope of his practice to make diagnosis with respect to such pain, yet he suggests therapy be arranged for the plaintiff by the family doctor. It is further to be noted that he does not inform the family doctor that his original diagnosis was wrong. In my view and I find that he fell below the standard of a specialist in his field by suggesting a treatment (therapy) without testing, examining, determining and diagnosing with regard to the forearm pain. If as he states that it was not within the scope of his practice to do so, he fell below the standard by not consulting or referring the plaintiff to a colleague who did so. I do not accept the testimony of the defendant's experts that he did so by referring the plaintiff back to the family doctor. As I have stated, I do not accept Dr. McCain's testimony that the family doctor was the "captain of the ship". Furthermore, the plaintiff was not referred to the family doctor to determine the etiology of the pain. As hereinbefore set forth, the plaintiff was referred for therapy, a treatment that the defendant suggested without making a diagnosis which as he states was not within the scope of his practice.

Causation

61 Broadly speaking the defendant was negligent in coming to the diagnosis as he did as hereinbefore set forth and in failing to inform the plaintiff of the serious and increased risk of surgery being injury to the nerves and vessels, traumatic neuroma resulting in permanent pain in the finger, and the ultimate amputation thereof.

Diagnosis

62 The defendant admitted that his diagnosis (straightening of the finger to alleviate forearm pain) was wrong. Such wrong diagnosis arose from his negligence as hereinbefore set forth. The defendant was aware of the increased risk of injury to nerves and vessels in the finger having regard to the proposed surgery being the fifth surgery on the finger; such injury and traumatic neuroma resulted in permanent pain and led to the amputation of the finger. All of this occurred as a result of the negligent diagnosis of the defendant and I so find. In my view, the nexus is established whether one uses the "but for test" as submitted by the defendant or "the material contribution to the injury suffered by the plaintiff" and I so find. (See *Wood v. Cobourg District General Hospital*, [1997] O.J. No. 2676 (Ont. Gen. Div.)at paragraph 170 a case, *inter alia*, of wrong diagnosis.)

Failure to Inform the Plaintiff of Risks

63 On the issue of causation, the test to be applied is stated thusly in *Videto v. Kennedy, supra*, at p. 506:

> The question to be answered is, would a reasonable person in the respondent's position, on a balance of probabilities, have opted against the surgery if there had been proper disclosure, rather than undergoing it at the particular time?

64 The plaintiff did not want her finger to be amputated. The defendant was aware of this. The purpose of the consultation was to relieve forearm pain. The risks of the surgery were not remote and were serious having regard to the surgery being the fifth operation on the finger. The probability was greater than if this were the first surgery. The risk of injury to nerves and vessels, traumatic neuroma resulting in permanent pain in the small finger occurred. The pain was not only increased but became permanent and from a different source. Added to this is such pain could ultimately result in the amputation of the finger and the defendant was aware of this. I find that a reasonable person in the plaintiff's position on a balance of probabilities would have opted against the surgery if there had been proper disclosure rather than undergoing it at the particular time. The surgery was an elective one.

65 It is the position of the defendant that the defendant's experts and the defendant never heard of a finger being amputated in such circumstances. Although the defendant stated that he never heard of a finger being amputated in such circumstances he was fully aware that and testified that permanent pain in the finger would ultimately lead to the amputation thereof. The answer to the defendant's submission which I do not accept is set forth in the decision of *Videto v. Kennedy* hereinbefore cited with regard to the negligence of the defendant, *viz*, he was aware that the finger would ultimately be amputated as a result of the permanent pain and he was therefore negligent in failing to disclose the risk. If he had so disclosed it, as I have found a reasonable person in the plaintiff's position on the balance of probabilities would have opted against the surgery.

66 In addition, as I have found, the defendant was negligent in failing to diagnose and disclose the existence of alternative treatment as splinting which involved no risk to the plaintiff. In such circumstances causation is established in that if the patient had such option of treatment, a reasonable person in the plaintiff's position on the balance of probabilities would have opted against the surgery. (See the cases in Note 380 at page 163 of *Legal Liability of Doctors and Hospital in Canada, supra*.)

67 Nor do I accept the defendant's submission that as the plaintiff ultimately agreed to the amputation of the finger that the defendant was neither negligent in failing to disclose the risk and a reasonable person in the position of the plaintiff would have opted for the surgery. The short answer to such submission is that as a result of the surgery performed by

the defendant the plaintiff was in constant and permanent pain with regard to the finger which she did not experience or have before the surgery. Such pain was not alleviated by therapy and the only solution was amputation. It is one thing to agree to amputation in such circumstances it is another to agree to amputation where if properly diagnosed the forearm pain could have been treated conservatively. Furthermore, it is a fair and reasonable inference to draw that such forearm pain was not as severe or as intensive as the subsequent constant and permanent pain in the finger for she refused to have the finger amputated in March 1995.

68 As I have found, the defendant was negligent on July 25, 1995. Such negligence materially contributed to the pain and discomfort of the plaintiff in that it delayed the ultimate resolution thereof.

Damages

69 The parties have agreed that if the defendant fell below the standard of care on March 28, 1995 and subsequently that the general and special damages of the plaintiff including P.J.I. is the sum of $37,500.00; and that if the defendant fell below the standard of care on July 25, 1995 and not prior thereto the general and special damages of the plaintiff including P.J.I. is the sum of $14,000.00.

70 Having regard to my findings that the defendant fell below the standard of care on March 28, 1995 and subsequently there will be judgment in favour of the plaintiff for $37,500.00.

71 The parties have agreed that the damages including P.J.I. of the following persons and institution are:

Dawn Marie Nichols	$1,250.00
Kenneth Nichols	1,250.00
Brian Nichols	1,250.00
Samantha Nichols	2,500.00
O.H.I.P.	6,250.00

72 There will be judgment in favour of the parties as set out in paragraph 70. As Samantha Nichols is a minor, the sum of $2,500.00 is to be paid into court to her credit.

73 Before leaving I would set forth why I do not accept the testimony of the defendant where it conflicts with my findings. He contradicted himself during his testimony. For example, he stated during examination in chief that on July 25 he felt that the forearm pain was related to the hand and with time might settle. However, such testimony conflicts with what he wrote to the family doctor on July 25, *viz*, "That it is not related to either of the previous surgeries or to the little finger itself". When this was brought to his attention he confirmed what he wrote and stated that his original diagnosis was incorrect (*viz*, the straightening of the finger would relieve the forearm pain) and that it was not in the scope of his practice to determine the etiology of such forearm pain. Furthermore, although he states that he was aware that the constant pain arising from the surgery would lead to amputation of the finger, yet he states that he never told this to the plaintiff because he never "saw it". This is incomprehensible especially as he was aware that the plaintiff did not want her finger amputated. He testified that he recommended surgery to release the flexor tendons which would release the pain. This was contradicted not only his reporting letter of March 28 to the family doctor but also in the operation notes. His explanation as to the word "still" should have been "now" in his letter of July 25 was lame for the reasons hereinbefore set forth especially as he admitted that his original diagnosis was wrong all as hereinbefore set forth. Having regard to the fair and reasonable inference to be drawn from such letter of July 25 I prefer the evidence of the plaintiff as to what occurred on March 28, especially as the defendant has seen a multitude of patients since March 28, 1995 and his notes of the consultation were very sparse. For example, he testified as to what was said having regard to the word "disc" simpliciter in his notes. Such notes did not specifically set forth what was said. Whereas the plaintiff was greatly effected by her malady and focused thereon. I found the plaintiff to be credible. He suggested treatment of such pain (therapy) on July 25th notwithstanding that he did not determine the etiology of such forearm pain. His testimony that he did not assume

that the hand was not useful since the age of 13, was contradicted by his testimony on his examination for discovery, *viz*, that he made the assumption that it was not useful from age 13 on. This notwithstanding that he had the referral letter of the family doctor which he stated he read immediately before he saw the plaintiff on March 28. Such letter states that the plaintiff was able to get along fine despite the contracture. Such wrong assumption formed part of his diagnosis. His testimony that the plaintiff mentioned the forearm pain but did not complain about it but rather complained of the flexor contracture is entirely inconsistent with the preponderance of the probabilities that rationally emerge out of all the evidence in the case, *viz*, the medical notes of the family doctor of the plaintiff's complaints as to the forearm pain; the referral letter of the family doctor that the plaintiff being able to get along fine despite the contracture; the wrong assumption by the defendant that she could not use the hand since the age of 13; and the testimony of the plaintiff that she sought medical help to relieve her forearm pain and not to straighten her finger. The foregoing are examples of why I do not accept the testimony of the defendant where it conflicts with my findings and are not all-inclusive.

74 As costs generally follow the result, the plaintiffs shall have party and party costs (except with regard to the amendments to the statement of claim obtained at trial and adjournment thereof) to be assessed unless I hear from the parties in writing within seven days of the release of these reasons. The defendant shall have party and party costs to be assessed with respect to such amendments, and adjournment.

Action allowed.

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