Citation: Grennan v. Reddoch and Whitehorse General Hospital
2002 YKCA 0017

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Docket: 00-YU452
00-YU453

COURT OF APPEAL FOR YUKON TERRITORY

BETWEEN:

SIMON EDWARD GRENNAN, ADMINISTRATOR OF THE ESTATE OF MARY-ANN GRENNAN, DECEASED

RESPONDENT
(Plaintiff)

AND:

DR. ALLON REDDOCH and WHITEHORSE GENERAL HOSPITAL

APPELLANTS
(Defendants)

Before: The Honourable Madam Justice Ryan
The Honourable Mr. Justice Braidwood
The Honourable Mr. Justice Hall

C.E. Hinkson, Q.C. and N.L. Trevethan	Counsel for the Appellant, Dr. Allon Reddoch
J.C. Grauer	Counsel for the Appellant, Whitehorse General Hospital
R.D. Gibbens	Counsel for the Respondent
Place and Dates of Hearing:	Vancouver, British Columbia 21-23 October 2002
Place and Date of Judgment:	Vancouver, British Columbia 13 December 2002

Written Reasons by:
The Honourable Mr. Justice Hall

Concurred in by:
The Honourable Madam Justice Ryan
The Honourable Mr. Justice Braidwood

Reasons for Judgment of the Honourable Mr. Justice Hall:

[1] This is an appeal from a trial judgment finding the defendant doctor and hospital negligent in the treatment of a patient and awarding damages to the administrator of the estate of the patient.

[2] On September 6, 1995, Simon Grennan, the plaintiff, who is the administrator of the estate of the late Mary-Ann Grennan, smoked some fish that he had caught. On the following day, September 7, 1995, Mr. Grennan ate some of the fish for lunch. His daughter and perhaps her boyfriend, George Miller, also ate some of the smoked fish that same day. There is some obscurity in the evidence as to whether Mr. Miller consumed any substantial amount of the fish and if he did, whether or not he became nauseated after eating it. Mr. Miller did not give evidence at the trial. We were advised by counsel that the reason for this was that he had died in an accident prior to trial. In any event, father and daughter both became ill in the early morning hours of Friday, September 8, 1995.

[3] As I interpret the evidence of Mr. Grennan, he became ill first and was sick and vomiting overnight after midnight on September 8. Early on the morning of that day, he felt that

he ought to seek medical attention and decided to go to the emergency department of the defendant, Whitehorse General Hospital. He was intending to enlist his daughter to drive him because he felt too unwell to drive but he then discovered that she too was demonstrating symptoms of nausea. Both were driven to hospital and were seen by Dr. Kanakowski at around 9 a.m. Mr. Grennan was given some pills for his condition but it is not clear as to whether his daughter was given any medication. The diagnosis made by Dr. Kanakowski was gastro-enteritis (an infectious or inflammatory condition which affects the stomach or intestines). This can be caused by eating spoiled food. Both father and daughter were advised they could return home. They were told to return if the symptoms did not clear up within a reasonable time.

[4] Mr. Grennan took his medication and felt there was some slight improvement in his condition during that day (Friday), but his daughter continued to be nauseated. She was brought back to the emergency department of the hospital around midnight on Friday, September 8. She told Dr. Galloway, who was the duty physician at this time, that she had been vomiting all day, that she was feeling quite weak and that she had abdominal cramps. The diagnosis continued to be gastro-enteritis. She was given some fluids intravenously at the

hospital and was sent home again in the early morning hours of September 9. On this occasion, her mother, Ms. Vance, had been enlisted by Mr. Grennan to assist in taking their daughter to the hospital because Mr. Grennan felt too unwell to assist his daughter. He said he was still ill and throwing up that evening. Mr. Grennan and Ms. Vance were separated, but apparently continued to be on amicable terms. Ms. Grennan normally resided in Whitehorse with her father.

[5] When it was determined by her parents that Ms. Grennan would have to return to the hospital on September 9, Ms. Vance got in touch with the defendant, Dr. Reddoch, who was the family physician. He had cared for Mary-Ann for many years. Ms. Vance told him about the problem stemming from eating the fish. She said that her husband, her daughter and Mr. Miller were all ill and they believed it was a result of eating the fish. She asked Dr. Reddoch to either come to the hospital to see her daughter or to arrange to have her admitted to the hospital because she did not appear to be improving. In response to the request, Dr. Reddoch phoned the hospital and spoke to someone there to ensure that Ms. Grennan would be treated when she arrived. He was not to be on duty that weekend and planned to be out of town.

[6] As noted above, after being given some fluid intravenously, Ms. Grennan was again discharged from hospital in the early morning hours of Saturday, September 9. She returned home to her father's house but she did not seem to be improving that day. On that day, the Saturday, Ms. Vance had to go to the funeral of Julia Roberts at Pelly which is quite some distance north of Whitehorse. Julia Roberts was the grandmother of Mary-Ann Grennan. Later, Ms. Vance got a call from her husband notifying her that their daughter was not improving and that he felt she would have to be admitted to hospital. Ms. Vance returned to Whitehorse. She went to the hospital to see her daughter who had been admitted late Saturday evening.

[7] When Ms. Grennan was admitted to hospital late on Saturday, she was seen by members of the nursing staff and by Dr. Alton who was then on duty. At that time, she reported that she was unable to keep down fluids, that her mouth and throat were dry and that she found it hard to swallow but she felt her nausea was a bit better. The diagnosis made by Dr. Alton continued to be gastro-enteritis. Ms. Grennan was given more fluids intravenously. Dr. Reddoch, as I noted, was off duty that weekend and was, in fact, out of Whitehorse at a cabin on the Saturday and for part of the Sunday. Thus, Ms.

Grennan came under the care of Dr. Alton, the on-duty physician at the hospital. In the admission note, Dr. Alton recorded that the vomiting and pain were subsiding but that the patient was unable to swallow and was only able to drink in small sips. She had been put on intravenous for fluid enhancement and it was noted by Dr. Alton on the following morning (Sunday) that her hydration status had returned to normal. She remained weak but had some improvement of the ability to swallow. Dr. Alton then assessed her neurological reflexes as normal.

[8] On the afternoon of the Sunday, it is noted in the chart that Ms. Grennan was seen by a social worker. The social worker felt Ms. Grennan was depressed because of the recent death of her grandmother. Earlier that day, in a note made by a nursing staff member around 0700, it had been observed that when the nurse entered the room and the patient saw her she started to breathe deeply and almost hyperventilate. She was, however, able at that time to swallow an oral medication and she said that she was no longer suffering from any cramps or nausea. During the Sunday, she continued to be weak and appeared to be either unwilling or unable to swallow much in the way of fluids. On one occasion, she had to be assisted by two male nurses to get back into her bed after going to the

bathroom. She continued through the day to receive fluids intravenously.

[9] When Dr. Reddoch returned to Whitehorse on Sunday, September 10, he dropped into the hospital where he saw Ms. Grennan around 3 p.m. At this time, he reviewed the hospital charts. He did not undertake to examine Ms. Grennan, since she had been seen recently by Dr. Alton. He described his visit that day as being supportive of his patient. He billed the Medical Plan for his visit. He noted that on this occasion Ms. Grennan was pale but his impression of the information available to him was that she was improving. He was aware that her grandmother had recently died and he thought that might have caused the patient some emotional upset. Knowing her medical history as her family physician, he also suspected that she could have some anaemia. His anticipation was, as he noted on the chart, "discharge tomorrow on oral iron".

[10] That Sunday evening, Ms. Grennan's mother saw her at the hospital and felt she was still quite unwell. She raised her concerns with the nurse on duty and wondered if Dr. Reddoch could be consulted but that did not occur. In any event, it was requested that Dr. Alton assess the patient. Feeling that there might be a possible problem with tonsillitis, Dr. Alton

prescribed some medication which could be given either orally or intravenously. Since giving the drug intravenously could have some unpleasant side effects, it was decided that Ms. Grennan should try to take the drug orally. This was a lengthy process but it was eventually accomplished, as the nurse noted in the chart, with a great deal of encouragement by her mother, Ms. Vance.

[11] The nursing shift changed at 8:00 p.m. on the Sunday evening. Nurse MacDonald was the duty nurse on the ward from 8:00 p.m. Sunday evening to 8:00 a.m. Monday morning. That evening, her father spent some time with Mary-Ann in her room but he was still far from well and in the late evening he returned to his home. Nurse MacDonald who testified at the trial was somewhat puzzled by the condition of her patient. At times, she appeared to be quite sick and weak but there were few objective signs to clarify what the illness might be. In response to a question as to how she felt about the patient maintaining that she could not swallow, she said, "I was very perplexed, frustrated. I didn't understand it. You know, it just didn't make sense." Some notes that were made by Nurse MacDonald in the chart during her shift reflect her impressions at the time:

> 22:00 Laying in bed. Unwilling to drink/swallow. Unwilling to pull herself up in bed. Whining. States too weak to put a cup to her mouth. In fact when handed a med cup for swish & swallow of nystatin pt thought herself unable to hold it to her mouth but the writer insisted. Breathes normally when asleep but seems to hyperventilate & dramatize her illness when awake & has an audience. Father is @ the bedside @ present. IV 2/3-1/3 is infusion @ 75cc/h per pump. IV site healthy. Denies abd. cramping or nausea. No diarrhea. The writer attempted to look in pt's mouth but the pt is "too weak" to open her mouth wide enough to view. Assisted to commode by her dad.
>
> 24:30 Continues to dramatize illness. Father left & pt. fine – not hyperventilating or whining but her Mom came shortly thereafter & pt. began hyperventilating & whining again. Mouth care done& assisted upon bed. Dr. Alton called to speak with Mom & reassess pt. found to have tonsillitis.

[12] Ms. Vance stayed with her daughter overnight. In the early morning, she expressed concern to the nurse that her daughter seemed to be choking. At the urging of the mother, Nurse MacDonald contacted Dr. Reddoch around 7 a.m. Shortly thereafter, he attended at the hospital. Initially, the nurse had tried to contact Dr. Alton who was on duty in the hospital but she was busy on another case. When Dr. Reddoch examined Ms. Grennan's throat, he did not detect the existence of tonsillitis. Her symptoms including a lack of fever caused him to doubt that she was suffering from this particular condition. He concluded that her difficulty in swallowing

could be a condition referred to as "globus". This is a condition reflected by spasms in the throat giving a sensation of inability to swallow. He decided to prescribe the use of a "nebulizer," a face mask through which moist air can be pumped to moisturize the lips and mouth. He, as well, prescribed the medication Ativan as needed to attempt to relax her muscles. He said this about his impression of the patient that Monday morning:

> ... One of my concerns at the time was there had been a diagnosis of tonsillitis, but she didn't have a fever, and normally with tonsillitis there is a fever, and so I wanted to particularly review that. So what I did was examine the head and neck by having Mary-Ann open her mouth and to look in with the flashlight and a tongue depressor, to look at her tonsils. Actually Mary-Ann always had fairly large tonsils, not that they were infected, but that they were normally large, and at the time when I examined her, her throat and tonsils actually looked normal. I didn't see any evidence of infection.

[13] Dr. Reddoch also assessed her level of hydration by examining the colour and texture of her skin and he did a chest examination using a stethoscope. After concluding his examination of Ms. Grennan, the doctor left the hospital. He next saw his patient at the hospital between 5:00 p.m. and 6:00 p.m. that evening. As he was going into the hospital, he encountered Ms. Vance, who still continued to express concern about her daughter's condition. Dr. Reddoch assured her that

he would assess the situation. Nurse MacDonald had gone off shift at 8:00 a.m. and Mr. Macklon was the nurse who had been in charge during the day shift.

[14] The notes contained in the chart of that day disclose that although Ms. Grennan remained weak and continued to complain about a dry mouth, she was able to swallow some fluid. At 5 p.m., around the time Dr. Reddoch was at the hospital, it was noted in the chart that she was resting better and that her respirations were easy.

[15] Dr. Reddoch said that when he saw Ms. Grennan on the Monday morning, he felt that her respiration was fine and said that his plan when he departed the hospital that morning was that she ought to remain in hospital that day and try to take fluids orally and to have Ativan as required to help with the swallowing problem. He anticipated that next day she could be discharged from hospital. When he saw Ms. Grennan that evening and spoke to Nurse Macklon, he discerned nothing that led him to be particularly concerned. He described what happened when he saw her that evening:

> Q Now, would you have looked at the nursing entries that had been made on the chart since your visit in the morning?
> A Yes.
> Q Was there any basis, in your review of those nursing notes, for your concern?
> A No, things actually seemed to be quite good.

Q And did you provide new orders at that time?
A I did.
Q Did you go in and examine Mary-Ann before providing new orders?
A No, I –- I went into the room and just saw her in bed and just waved hello and that was it, so I didn't do an examination other than just visually seeing her.
Q Okay. And how did she appear to you on just a visual –
A Just comfortable, she was just sitting up in bed.
Q Did she acknowledge your wave?
A She smiled.
Q And, sorry, if we go back to page 10, you have orders from your afternoon visit?
A That's correct, at the bottom of the page.
Q What do they say?
A Sept. 11, 1995, Restart IV 2/3 and 1/3 at 100 CCs per hour. Ativan 1 milligram, sublingual, Q4H, PRN Sleep or anxiety.
Q Okay. Now, why did you restart the IV?
A At that point, she hadn't been drinking very much that was – during the day, and I was expecting that she was going to be sleeping overnight, and consequently, therefore, not drinking, and in order to keep her comfortable overnight, felt that the best bet was to use the IV that was already in place and to restart the fluid.
Q Is 100 CCs per hour a fast rate, a slow rate, a moderate rate?
A It's moderate.
Q And more Ativan, why was that?
A The order in the morning when I was in was for just one dose of Ativan. The order was one milligram sublingual now, but not a repeating order. It was just a one-time order. And from the nursing notes during the day, she seemed to be more comfortable than what had been reported the previous day, and, consequently, I felt that the Ativan was helping her, so I – in this order, it allows for the nurses to provide the medication if they felt that she need it. It's not a – it's not that she has it every four hours, as might happen with an antibiotic. It's if she needs it, it's available for her.

[16] At 8 p.m. that Monday evening, Nurse White came on duty for the overnight shift. During the early evening, Ms. Grennan's brother and her boyfriend were there with her but eventually sometime after 9 p.m. Nurse White asked them to leave as she felt that the patient needed rest. Ms. Grennan was given another pill of the Ativan medication.

[17] Shortly after 10 p.m., Nurse White noted in the chart that the patient, who was being assisted back to her bed by staff, "buckled at the knees and slid to floor stating she was too weak to walk. Very dramatic." At about 10:30 p.m., Nurse White decided that she would order an oxygen test to determine the blood oxygenation level of Ms. Grennan. This was not particularly routine, nor had it been directed by medical staff but it was something nurses could do of their own volition. Nurse White was alarmed when the nursing aide reported that she got a reading of between 84-88% because this is unacceptably low, especially in a young person. Nurse White rechecked the test. After having Ms. Grennan breathe deeply, she determined the blood oxygenation level was at 90%, a level that was described as being low normal by the expert, Ms. Farrow, who was called to testify about nursing practice.

[18] In light of the tragic situation that occurred with respect to Ms. Grennan within the next 45 minutes, it is material to consider the history of her blood oxygen level in the preceding 24 hours. In the early morning hours of Monday, September 11, Nurse MacDonald, puzzled by the condition of the patient, decided that she would take an oxygenation reading. This is apparently accomplished by putting a clip on the finger of the patient. Another nurse, Nurse Cowan, observed that this particular process is one that can have features of unreliability if, for instance, the measuring clip is not correctly affixed to the finger of the person being tested. When Nurse MacDonald did this test, she determined the reading was in the range of 95%. This is reckoned to be a normal range. Readings can apparently be lower for people with conditions like emphysema or asthma or in older people but, of course, this patient did not fit any of those profiles. Sometime around noon on the 11th, a nurse's aide repeated the procedure and reported to Nurse Macklon that she had obtained a reading of 90%. As noted, this is apparently considered to be within the bounds of normality but is also considered low in a healthy individual. Nurse Macklon proceeded to have another reading taken and he determined the correct figure was 97%, a figure that would be quite acceptable. However, perhaps unfortunately, the reading of 90% was noted on the

chart rather than the reading of 97%. Nurse Macklon indicated in his evidence that he made this note in order to draw this to the attention of someone, presumably medical staff, so that it would not be overlooked. He said he discussed this with Dr. Reddoch when he came in that afternoon around 5:30 p.m. It was agreed between the doctor and Nurse Macklon that there should be a test done again. Upon doing the test again at around 6:00 p.m., the reading was found to be 95%. The way in which the 90% reading was charted, possibly with a line drawn through it, may later have inadvertently been misleading to Nurse White. The reason that this is so is that when she got the 90% reading on rechecking late in the evening, she looked at the chart and perceived there had been an earlier 90% reading at noon that day. This may have led her to think that the earlier baseline was lower than in fact it was. This had some capacity to lead her to believe that there had been no particular decline in the status of the oxygenation of the patient's blood over the course of the preceding hours.

[19] Nurse White believed that the patient required rest. At about 10:45 p.m., she observed the patient. Ms. Grennan was found to be breathing satisfactorily and was drifting off to sleep. The nurse decided not to do any immediate recheck on the oxygenation level but to defer this for a short time.

When she instructed her assistant to do another oxygenation check shortly after 11:00 p.m., Ms. Grennan was found to be not breathing. Immediate resuscitation efforts were made. Despite resuscitation efforts being in one sense successful in that they preserved a measure of life and allowed the patient to go on living for several more months, the efforts were of only limited success. Because of the deprivation of oxygen to her brain, Ms. Grennan suffered irreversible brain damage. She was airlifted to Vancouver and although she was eventually able to breathe on her own again, she never recovered consciousness. She died from other complications in the spring of 1996.

[20] After the patient was transported to St. Paul's Hospital in Vancouver from Whitehorse on September 11, 1995, she was treated with an anti-toxin for botulism poisoning. As well, her father was given the same treatment. After the respiratory arrest occurred on September 11, Dr. Reddoch had noted as possible diagnoses myasthenia gravis or botulism. It was discovered at St. Paul's Hospital that she was, in fact, suffering from botulism. Although within a couple of weeks, the patient had largely recovered from the symptoms of botulism, she never did recover consciousness because of the

severe brain damage suffered as a result of the respiratory failure of September 11.

[21] Thereafter, disciplinary proceedings against Dr. Reddoch were commenced by the Yukon Medical Council. As well, these civil proceedings were initiated against the treating physicians including Dr. Reddoch and the Whitehorse General Hospital. It was alleged the Hospital was vicariously liable for negligence alleged against the nursing staff. The action against some defendants was discontinued before trial.

[22] The trial came on for hearing in September of 2000 before Irving J., sitting as a judge of the Supreme Court of the Yukon Territory. On February 28, 2001, His Lordship delivered judgment finding liability against the appellants/defendants. He assigned fault as to 2/3 against Dr. Reddoch and as to 1/3 against Whitehorse General Hospital.

[23] Dr. Keyes, a neurologist testified on behalf of the defendant, Reddoch. This expert said that botulism is an extremely rare disease. It is difficult to diagnose and in this case was rendered even more difficult because Ms. Grennan displayed somewhat atypical symptoms. Dr. Keyes suggested that the initial diagnosis of gastro-enteritis was a reasonable one based on the patient history. He also opined that the globus diagnosis was reasonable given the history and

the clinical situation observed at the time this diagnosis was made. Prior to this case, there had never been a confirmed case of botulism identified in the Yukon. The condition has an incidence that is quite rare, occurring at an incidence of one out of a million people. The treatment of this disease consists of intensive care that may require mechanical ventilation if respiratory failure begins to develop and treatment with either anti-toxin or antibiotics. Recovery can often be a slow process. The terrible danger with botulism is that it has the capacity to affect what is termed the neuromuscular junction. With this dysfunction, bodily processes are impaired and severe consequences are inevitable. Ultimately, as occurred in this case, the neuromuscular junction between the nerves and the lungs will be affected. This shuts down the respiratory function with, of course, disastrous results. Dr. Keyes said that it was possible, although not particularly likely, that if the physicians had been advised of the change in her condition in the late hours of September 11, there might have been a reassessment. He went on to note, however, that the patient was observed at 22:45 hours by Nurse White to be resting with no particular abnormal respiratory status. Dr. Keyes suggested that even if the patient had been admitted to a large city hospital, the same clinical situation would likely have occurred.

[24] Two general practitioners filed reports suggesting that the defendant doctor had met the requisite standard of care. One was Dr. Esler, a physician with a practice in emergency medicine. He practiced in Delta. The other, Dr. Ralston was a general physician practicing in Campbell River, a smaller centre on Vancouver Island. Both of these physicians were of the opinion that Dr. Reddoch had acted within the proper professional standards to be expected of a physician in general practice.

[25] Dr. Assad, a physician with experience in emergency medicine gave evidence that Dr. Reddoch's care of the patient did not measure up to an appropriate standard. It was submitted by counsel for the appellant, Dr. Reddoch, at trial and on appeal, that this witness ought to have been found not qualified to give opinion evidence because his area of practice was sufficiently different from that of the defendant Reddoch. In my view, that consideration goes more to weight than to admissibility. I do not consider it was error to receive his evidence. There is, however, one disturbing feature of the report of Dr. Assad, namely, the following paragraph:

> As requested, I have made the assumptions listed in your June 28, 2000 letter. These assumptions are that Ms. Grennan was complaining of double vision

> from September 9, 1995 onwards and that she exhibited diminished or total loss of papillary light reflex from September 9, 1995 onwards.

[26] While the trial judge noted that the patient's father suggested in his evidence that his daughter was complaining of double vision on September 8 and that a drooping eyelid or double vision can be indicative of botulism, such symptoms, if they existed, were never reported to or observed by any of the medical personnel. The trial judge concluded the father could have been honestly mistaken about his recollection of this matter. I would note also that when Dr. Reddoch was examining the patient's throat on the morning of September 11, he would have been favourably situated to have observed any such symptoms, had they then existed. It appears to me that there is in the record no convincing evidence that any such symptoms were manifested by the patient. In light of this circumstance, a major assumption that underlies the report of Dr. Assad is without validity. In my view, this must considerably weaken the basis for his conclusions adverse to the defendant doctor.

[27] Dr. Assad was critical of Dr. Reddoch for failing to perform a more detailed examination of the patient and to consider a wider range of diagnoses. He felt that from what he viewed as the deteriorating condition of the patient on

September 11 that the diagnoses made by the physicians at Whitehorse General and, in particular, Dr. Reddoch, were insufficient. However, it must be noted that while the patient remained weak and experienced difficulty with swallowing, there were indications in the records that she appeared at times to be displaying signs of improvement. It was anticipated by the physicians including Dr. Reddoch that she would soon be sufficiently recovered to be discharged from hospital. The picture changed late on September 11. Dr. Reddoch testified that the decline observed by nurses in her blood oxygen status late on September 11 was a danger signal. He said this symptom should have prompted an immediate visit from a physician and a blood gas analysis. I have given a history above of the oxygenation observations concerning the patient.

[28] The trial judge accepted the argument made on behalf of the respondent that issue estoppel should apply in this case as regards issues determined against Dr. Reddoch in the prior disciplinary hearing by an Inquiry Committee of the Yukon Medical Council. It concluded that Dr. Reddoch had failed to perform adequate recording, failed to carry out adequate examinations of his patient and failed to record expected diagnoses or a suitable plan for the management of the

illness. Based on these adverse findings, the defendant was found guilty of unprofessional conduct. This verdict was appealed to the Yukon Supreme Court where the appeal was dismissed. On further appeal to this Court, the appeal was allowed, substantially on the basis that even if the care administered by the defendant was not up to the required standards, such conduct on the part of the doctor was not comprehended within the term "unprofessional conduct". Southin J.A. who gave the Reasons of the Court observed in coming to this conclusion that it could not be said that the actions of the doctor amounted to "unprofessional conduct". She did note that she was not in any way differing from the conclusions of the Medical Council or the committee as to what proper practice was in the circumstances of the case. In my view, the result and conclusions in that earlier case have no relevance to the issues we must address in the present appeal.

[29] The learned trial judge based his adverse finding against the appellant, Dr. Reddoch, on two bases, one basis being issue estoppel, namely, that the adverse findings made by the Inquiry Committee of the Council should be accepted into these proceedings. He found also that even if those findings were not to be imported into these proceedings, that the evidence adduced at trial supported the conclusion that the defendant

doctor had been negligent in his care and treatment of his patient, Ms. Grennan.

ANALYSIS

[30] The first matter to be addressed is whether or not issue estoppel should be held to be applicable in the circumstances of this case. I note that this trial took place before the recent judgment of the Supreme Court of Canada in ***Danyluk v. Ainsworth Technologies Inc.*** [2001] S.C.J. No. 46, 2 S.C.R. 460. In that case, an employee had been involved in a dispute with an employer over unpaid commissions. The employee filed a complaint under the ***Employment Standards Act*** (of Ontario). In her complaint, she sought certain wage payments and the commissions. The wages were in a small amount and the commissions were in a large amount. The employer rejected the claim and took the position the employee had resigned from her employment. After what was found to be a somewhat flawed investigation, the Employment Standards Tribunal accepted the proposition that the employer owed her a small amount of wages but found that the employee was not entitled to be paid the commissions she claimed. The employee thereafter commenced a lawsuit seeking payment of the unpaid commissions. The employer moved to strike out the claim on the basis of issue estoppel. A motions judge accepted the argument advanced

concerning issue estoppel and the Ontario Court of Appeal affirmed this decision. On further appeal to the Supreme Court of Canada, the appeal was allowed on the basis that issue estoppel ought not to be applied in the circumstances of the case.

[31] The Supreme Court of Canada concluded that although the necessary preconditions of issue estoppel might have been met in the case, it would be nevertheless unfair in the particular circumstances to apply the doctrine of issue estoppel. Binnie J., giving the judgment of the Court, observed at para. 73:

> ... the purpose of the ESA is to provide a relatively quick and cheap means of resolving employment disputes. Putting excessive weight on the ESA decision in terms of issue estoppel would likely compel the parties in such cases to mount a full-scale trial-type offence and defence, thus tending to defeat the expeditious operation of the ESA scheme as a whole. This would undermine fulfilment of the purpose of the legislation.

[32] Binnie J. referred with approval to a judgment of this Court in ***British Columbia (Minister of Forests) v. Bugbusters Pest Management Inc.*** (1998), 50 B.C.L.R. (3d) 1. There, a decision made by a deputy chief forester concerning responsibility for a forest fire was found not to be governing in subsequent litigation on the basis of issue estoppel. In that litigation, responsibility for the cost of fighting the

fire was at issue. At p. 11, Finch J.A., (as he then was), noted:

> The doctrine of issue estoppel is designed as an implement of justice, and a protection against injustice. It inevitably calls upon the exercise of a judicial discretion to achieve fairness according to the circumstances of each case. In this case, it would be quite unfair to hold the Crown bound by the decision of the Deputy Chief Forester.

[33] In a recent case from the Yukon Territory Court of Appeal, ***Burchill v. Commissioner of the Yukon Territory***, [2002], Y.J. No. 19, one of the issues was whether a previous decision of an employment tribunal ought to be found to be dispositive in subsequent litigation between the parties. This was an employment law case. The court concluded that issue estoppel ought not to be applied. Saunders J.A. noted that to uncritically accept issue estoppel as being applicable had the potential to turn administrative proceedings into full blown hearings on allegations of cause contrary to sensible public policy. She referred to the judgment of the Supreme Court in the ***Danyluk*** case. In this case, I would sound the same cautionary note. It seems to me fundamentally undesirable in the majority of cases to import findings made in an administrative proceeding, where differing considerations and purposes are relevant, into a related civil proceeding before a court concerning damages for alleged

negligence or breach of duty. The scope of the proceedings and the resources employed may be significantly different.

[34] While I would not wish to put undue stress upon this point, I note that the proceedings before the Council were not of a final nature. That circumstance was noted to be a relevant but not conclusive factor in ***Bugbusters***, *supra*, and as well this serves to distinguish some of cases cited to us including ***Raison v. Fenwick*** (1981), 120 D.L.R. (3d) 622 (B.C.C.A.). In my view however, there are other more substantial considerations that militate against the application of the principles of issue estoppel or res judicata in circumstances like the present. To allow as governing the earlier findings of an administrative tribunal in proceedings involving possibly differing standards and levels of participation by the parties or their privies could have the capacity to work an injustice. Also, as was pointed out in ***Burchill***, *supra*, to allow such a principle to be invoked could result in an enormous expansion of the scope and cost of administrative proceedings. That would not be a useful development. Binnie J. in ***Danyluk***, *supra*, made reference to the following excerpt from the American Restatement of the Law, as being worthy of note. In ***Danyluk***,

this is cited as: American Restatement of the Law, Second: Judgments 2d (1982), vol. 2 s. 83(2)(c):

> procedural elements as may be necessary to constitute the proceeding a sufficient means of conclusively determining the matter in question, having regard for the magnitude and complexity of the matter in question, the urgency with which the matter must be resolved, and the opportunity of the parties to obtain evidence and formulate legal contentions.

[35] That excerpt highlights what I conceive to be a very salient consideration in these cases, namely, would it be appropriate to apply earlier conclusions having regard to the scope of the administrative proceedings, the resources, (legal or investigative), available and the salient issues being contested in such proceedings? While issue estoppel has a useful role to play in encouraging finality of proceedings and the achievement of economical justice, I should think it would be the exceptional case where it would be thought appropriate to adopt the previous conclusions of an administrative tribunal as being dispositive in a subsequent civil case. That exceptional case might occur where issues such as abuse of process arise for consideration. I consider that it was not appropriate for the trial judge in this case to rely on issue estoppel as a basis for an adverse finding against the

appellant Reddoch. In my view, it was error to adopt such an approach.

[36] The outcome of this case was tragic. A young person has died, a devastating blow to her parents. However, it must always be remembered that events looked at in hindsight usually disclose a much clearer perspective than was apparent at a time when the outcome of events was unknown and uncertain. As Bull J.A. noted in the case of ***Child v. Vancouver General Hospital*** (1968), 67 W.W.R. 169, affirmed [1970] SCR 477: "... it is all too easy to approach the question of fault in light of the event which has happened..." Here, unknown and unsuspected until too late, this young patient was suffering from a potentially lethal condition that was, as Dr. Keyes observed, a rare presentation of a rare disease. Unfortunately, not only was it a rare disease, it was also one with potentially fatal consequences.

[37] The defendant doctor was found culpable by the trial judge because it was felt that he ought to have done further investigations, considered further alternatives and perhaps consulted with specialists.

[38] Dr. Reddoch first came to see Ms.Grennan in the mid-afternoon of Sunday, September 10, 1995. She had already been assessed by a number of physicians at Whitehorse General

Hospital and had been generally under the care of Dr. Alton and nursing staff since her admission to the hospital late on Saturday, September 9. In light of what was then known of the history by Dr. Alton, gastro-enteritis coupled with dehydration seemed a reasonable diagnosis. Steps were taken by medical staff to address the dehydration and electrolytic imbalance of the patient. The nurse who was on duty on the ward that Saturday night and Sunday morning noted that the patient was able to swallow some medication. Sounding a theme that was to later reoccur in the charting, this nurse perceived a tendency on the part of Ms. Grennan "to dramatize her symptoms". It was observed that when the patient was alone, she tended to be quiet but she appeared to respond in a somewhat dramatic fashion as soon as a person came to the room. She was observed to then breathe deeply and almost hyperventilate. When the day shift nurse on Sunday noted that the patient was weak, was having difficulty swallowing and was tending to flop about on the bed in a somewhat rag doll condition, Dr. Alton was called. She ordered tests which did not disclose anything abnormal. Later on that day, Dr. Alton felt that the hydration status of the patient had returned to normal. Although the patient continued to feel weak it was noted that there was some improvement in her swallowing ability. Dr. Alton expressed the view at this time that

neurologically the patient seemed to be fine. In mid-afternoon, a social worker saw the patient. She felt that Ms. Grennan was probably somewhat depressed because of the death of her grandmother. That was the situation that was extant when Dr. Reddoch first saw Ms. Grennan in the hospital in the mid-afternoon of Sunday, September 10. Based on his perusal of the charts, and his conversation with the patient, and considering the circumstances that her grandmother had recently died, he saw no reason to differ from the opinion of Dr. Alton. He tentatively concluded that it was likely she could be discharged from hospital the next day. He intended to prescribe oral iron for her after discharge. From his knowledge as her family physician of her earlier history, he felt she could possibly be suffering some anaemia.

[39] It is not apparent that there was at this time any necessity for any particular further examination by Dr. Reddoch or indeed what the utility of that would have been. The patient continued to be in hospital under the care of the nurses and physicians including Dr. Alton. Dr. Alton was again on duty that night.

[40] Around midnight, Nurse MacDonald, the duty nurse, noted again the pattern of the patient being much more demonstrative when others were present. Around 1:00 a.m., after Dr. Alton

had been summoned by the nurse to again check the patient, the doctor ordered a medication for tonsillitis. Dr. Reddoch noted in his evidence that Ms. Grennan had always had large tonsils and that may have been a factor in this diagnosis by Dr. Alton. Later, Dr. Alton gave a further order for codeine medication to treat the sore throat of the patient.

[41] Early next morning, the patient's mother indicated to the nurse that her daughter seemed to be having trouble swallowing and breathing. Because Dr. Alton was not available, being on another case, Dr. Reddoch was called at home. He came and performed an examination of the patient. Not finding tonsillitis to be a likely diagnosis in light of her condition, including an absence of fever, he discontinued the medications ordered by Dr. Alton. He prescribed Ativan to help the patient relax her throat muscles. Around noon, when Nurse Macklon checked the patient, he found she was able to swallow a few sips of water. He did not note any particular problems with breathing or the condition of her tonsils. As I earlier noted, an oxymetry test was initially read as 90% but on re-examination, it was found to be 97% which is normal. When Dr. Reddoch attended again at 5:30 p.m., the nurse discussed the case with him, including the oxygen readings. Dr. Reddoch suggested it would be wise to take another

reading. This test was recorded as 95%, again a normal reading. Dr. Reddoch ordered the IV to be restarted and prescribed Ativan as required to relax the patient. The doctor felt that because Ms. Grennan had had little rest in the previous 24 hours and had experienced considerable visitation from family and friends, it would be perhaps helpful if she could get adequate rest. Dr. Reddoch was not contacted again by any personnel at the hospital until the patient was found not to be breathing just after 11 p.m. on the Monday night.

[42] In the leading case of ***ter Neuzen v. Korn***, [1995] 3 S.C.R. 674, Sopinka J. noted at p. 693:

> It is well settled that physicians have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances.

[43] He went on to say at para. 34:

> It is also particularly important to emphasize, in the context of this case, that the conduct of physicians must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence.

[44] This point was emphasized by this Court in ***Lapointe v Hôpital Le Gardeur***, [1992] 1 S.C.R. 351, at 362-63:

> ... courts should be careful not to rely upon the perfect vision afforded by hindsight. In order to evaluate a particular exercise of judgment fairly, the doctor's limited ability to foresee future events when determining a course of conduct must be borne in mind. Otherwise, the doctor will not be assessed according to the norms of the average doctor of reasonable ability in the same circumstances, but rather will be held accountable for mistakes that are apparent only after the fact.

[45] As the respondent points out, this is not a case of two alternate methods of treatment that may be viewed as equally valid by segments of the profession. That was the kind of case under consideration, for example, in the case of ***Brimacombe v. Mathews*** (2001), 87 B.C.L.R. (3d) 75 a recent decision of this court referred to by counsel. The issue in this case was whether or not Dr. Reddoch acted appropriately in his assessment and treatment of Ms. Grennan. I note that Dr. Keyes said in his report:

> It is ... my opinion, that even if this patient had been admitted to a large city hospital at the start of her illness, exactly the same clinical situation would likely have developed with this patient. Finally, it is my opinion, that even if these steps had been taken it is not at all clear that this patient's clinical outcome would have been different given the rapid and severe progression of the respiratory failure that occurred in this patient.

[46] Dr. Esler, in his report, observed as follows:

> Her management was as expected given the clinical situation and met the standard of care in all respects. Unfortunately, she fell victim to a rare and lethal disease before the diagnosis could reasonably have been made in the circumstances. It is difficult for me to conceive that her management or outcome would have been different in the hands of any similarly qualified physician.

[47] It was said in ***ter Neuzen****, supra,* that conformity with general practice or what others in the same profession consider sufficient or appropriate will usually exonerate a professional from an allegation of negligence. The Court went on to observe, however, that where a common practice is fraught with danger, a judge or a jury may find the practice negligent, despite its acceptance by members of the profession. An instance of this was the case of ***Anderson v. Chasney*** [1949] 4 D.L.R. 71 (Man. C.A.), affirmed [1950] 4 D.L.R. 223 (S.C.C.). There, a doctor performing surgery on a child's throat, had failed to ensure that proper precautions were put in place to ensure that a sponge was not left in the throat after the operation. The patient died of suffocation. It was observed in that case that ways to obviate such a danger would have been to utilize sponges that had tape or strings attached and, as well, to have a nurse present to keep count of the number of sponges used. These sorts of precautions have about them more of the elements of general care and caution than any particular medical standard. It was

held in that case, which was not concerned with any difficult or uncertain questions concerning medical practice or treatment, that in a case where the issue was simply whether obvious and simple precautions should have been taken, such issues could properly be determined by a jury or a judge. In such a case, the opinion of other physicians will have less relevance for the trier of fact.

[48] In my opinion, the present case is the sort of case where lay persons would not be readily able to assess the adequacy or appropriateness of the medical services rendered and therefore the opinions of other qualified physicians would be necessary to address the issue. In the instant case, the learned trial judge appears to have considered that the opinion of Dr. Keyes furnished a basis for finding the appellant doctor negligent. I find it difficult to interpret the evidence of Dr. Keyes as in any sense critical of Dr. Reddoch or as suggesting that more could or should have been done by way of examination, diagnosis or consultation. The two physicians whose practice profiles most closely resembled that of the defendant doctor, Drs. Esler and Ralston, felt that the standard of care demonstrated by Dr. Reddoch was entirely appropriate and up to normal professional standards for a family physician. The trial judge appears to have

placed little if any weight upon these opinions. With regard to the opinion of Dr. Assad, it seems to me that the force of his evidence was seriously weakened by the misassumption as to the presence of ocular symptoms of the patient that might have been indicative of a neurological problem leading to a possible diagnosis of botulism. Although Dr. Assad appeared to indicate in his evidence that more should have been done by the defendant doctor in the way of examination and consideration of differential diagnoses, the hospital charts, the reports of the nurses and the diagnoses by previously treating physicians at the hospital, do not, in my opinion, lend support to these suggestions of Dr. Assad. It must also be observed that while I would not accede to the submission that his evidence was not admissible, there is force in the submission of counsel for Dr. Reddoch that the profile of his practice is more divergent from that of the defendant than were the practice profiles of Drs. Esler and Ralston. The opinions of the latter are entitled, in my view, to substantial weight. I consider the learned trial judge fell into error in misinterpreting the evidence of Dr. Keyes and in failing to give due consideration to the opinions of Drs. Esler and Ralston. It appears to me that, with respect, the learned trial judge here fell into the type of error in approach identified both in ***Lapointe*** and in ***Brimacombe***,

namely, reviewing the events of September 10 and 11, 1995 with the considerable benefit of hindsight and failing to have sufficient regard to the actual situation then faced by the appellant doctor. This was not an obvious potential emergency case like some of the obstetric cases or a case of a type of surgery fraught with danger. It was a case of what all the treating doctors at the hospital perceived to be a case of gastro-enteritis that ought to resolve itself within a reasonable time. Dr. Reddoch felt that there could also be in operation factors such as possible anaemia and emotional upset but he had no particular cause to suspect the patient was in grave peril from a rare and lethal disease such as botulism.

[49] It bears repeating that the neurologist, Dr. Keyes, observed that this was a rare presentation of a very rare disease, one that probably very few practitioners would ever see in the course of their entire career. Although Dr. Assad in his evidence and the trial judge observed that this doctor was not being faulted for failure to diagnose botulism, there appears to be a pervading theme in the case that he should have appreciated that the patient was suffering from a serious illness. While she may have not been recovering as quickly as expected, it seems to me that there was no particular basis for Dr. Reddoch to have, in the circumstances, done anything

additional by way of examination, diagnosis or consultation than he did. Because the majority of the experts who testified felt that his conduct in the treatment of this patient was within appropriate parameters and was not negligent and having regard to the issue that was before the court, I consider that the learned trial judge erred in failing to pay due regard to the opinions of the defendant's medical peers. In my respectful view, on a careful assessment of all the evidence, it was not demonstrated by the plaintiff that the defendant doctor was negligent in his care of Ms. Grennan. In my opinion, the proper verdict in this case would have been a dismissal of the case against this appellant.

[50] The learned trial judge found that with respect to liability, the doctor should be held responsible for a greater degree of fault than the defendant hospital. He apportioned responsibility for 2/3 of the fault to Dr. Reddoch and 1/3 of the fault to the hospital. This latter finding was based on the vicarious liability of the hospital for the actions of Nurse White. As I interpret the Reasons of the trial judge, the substantial basis upon which he determined that a portion of fault should be attributed to Nurse White was her conduct subsequent to the 10:30 p.m. blood oxygen reading of 84-88%. I have, earlier in these Reasons, given the history of

oxygenation readings of Ms. Grennan. With regard to an important factual matter, it should be noted that the blood oxygen reading of 84-88% was the initial test reading but the duty nurse on rechecking determined the correct reading was 90%. This oxygen level was described by Nurse Farrell, the expert called on behalf of the hospital, as indicating a level considered to be low normal. Nurse White did not ignore this reading. She promptly did a respiratory assessment and as a result concluded that the patient was demonstrating normal respiration. It was her decision to continue to monitor the patient and, if it appeared that there was a problem, to contact a physician. It was her intention, within a short interval, to perform another blood oxygen test on the patient. When she gave instructions for this to be done, just after 11:00 p.m., the patient was discovered not to be breathing. While she had the opportunity to do a recheck at 10:45, when she observed the patient at this time, she found her resting quietly. Given that one of the objects Nurse White saw as desirable in the treatment of Ms. Grennan was that she should be given an opportunity to get proper rest, her decision to let her fall asleep was not unreasonable. When she checked on the patient at 10:45 p.m., she felt the patient was breathing properly. The nurse planned to further monitor the patient for a time and report to the physician should oxygen

saturation levels be determined to be at an unsatisfactory level.

[51] Nurse Farrell was the only witness called on this aspect of the case to give expert evidence. While Dr. Reddoch said he would expect to be alerted if oxygen levels in the 80s were observed, he did not purport to be laying down standards of competence for nursing practice. No one else but Nurse Farrell commented on the appropriate standard of nursing care. In her report, Nurse Farrell opined that Nurse White took the actions that a reasonably competent nurse would do. In her report, she said *inter alia*:

> There was no medical diagnosis that completely explained the patient's varied symptoms. That is, there was nothing in the medical orders or notes to suggest that nurses needed to focus on a respiratory assessment for this patient. Therefore, the nursing assessment was broader than simply the respiratory component and included such aspects as physical mobility, bowel and bladder function, emotional state, and nutritional status. In completing their broad assessment, which included the respiratory status, the nurses demonstrated appropriate clinical judgement. In keeping with the medical diagnosis of dysphagia, the nurses appropriately monitored the patient's (a) upper airway, (b) breath sounds in the lungs, and (c) respiratory rate. These assessments consistently demonstrated clear lung fields and no evidence of aspiration or upper airway obstruction.
>
> I do not feel that there was anything in the patient's condition or hospital records that could have alerted the nurse to expect further sudden drop in oxygenation precipitating cardiac arrest within the 20 minutes between 2245 and 2305 while the

> patient was at rest in a semi-fowlers position. Although the patient had been given 1 mg of Ativan at 2200 on September 11, 1995, she had had 2 of the same doses previously (0800 and 1800 on September 11, 1995) with no adverse effect on her respiratory status. The nurse demonstrated appropriate clinical decision making by monitoring the patient's respiratory status, with oxygen saturation being only one component of respiratory status.
>
> Summary
>
> It is my opinion that the nursing care and treatment provided to Ms. Grennan on the evening of September 11, 1995 met acceptable standards of nursing practice in community hospitals.
>
> [emphasis added]

[52] What must not be lost sight of in this case is that all of the physicians involved to that time in the care of Ms. Grennan had provided diagnoses of the condition of the patient that, from the perspective of the nursing staff, were essentially benign in the sense that none suggested either an actual or potentially emergent situation. As observed earlier, this patient was not recovering as quickly as had first been thought likely. However, having regard to what illness the patient was believed to be suffering from and the history in the charts, there was nothing to alert treating nurses to imminent danger or to foreshadow the catastrophic outcome that occurred later that evening. Nurse White did not ignore the low blood oxygen reading. She did what the expert suggested was appropriate, namely, she proceeded to assess the

respiratory condition of her patient, Ms. Grennan. She planned to continue monitoring the oxygen content of the patient's blood and to notify a physician if she felt that was necessary. It is difficult to see that she was in any way neglectful of the care of her patient. She responded to the situation and decided on a course of action involving further observation and assessment. She was aware from the records of earlier readings of blood oxygen saturation being at 90% and 95%. She was aware of the fact that anything below 90% in a young patient required careful monitoring. It was her belief that this patient was in need of rest. Therefore, she elected not to disturb her at 10:45 when she appeared to be drifting off to sleep. There was nothing in the history or in the records made by her predecessors to suggest that this patient was suffering from a serious illness or that her respiratory function was at grave risk. It does not appear to me that it can fairly be said in this case that Nurse White was in any way neglectful of her patient or that she failed to comply with appropriate nursing standards on this evening. Again, as I observed in connection with the defendant doctor, hindsight casts a very different light on matters but the appropriate way to assess her actions is in the light of the situation as it reasonably appeared to her at the time. One must be careful, as Chief Justice McEachern observed in ***Brimacombe***,

supra, at para. 90, not to second-guess with the benefit of doubtful hindsight.

[53] The evidence adduced from the only expert who was called in the proceedings to give testimony concerning the standard of care expected of a nurse in these circumstances was supportive of the proposition that this nurse had not acted in a careless fashion or been neglectful of the well-being of her patient. In my respectful view, if the learned trial judge had paid due regard to all of the evidence including in particular the opinion of the witness, Nurse Farrell, he should have concluded that Nurse White was not negligent in her care of Ms. Grennan. Such a finding would mandate dismissal of the case against Whitehorse General Hospital. I consider that the appeal on this aspect of the case should be allowed and the case against the defendant hospital dismissed.

[54] In light of the conclusions I have reached above concerning liability, it is not necessary to address in any detail the issue of damages argued on the appeal and cross-appeal. However, I would not want it to be thought that by not dealing in any extended way with the matter, I am necessarily persuaded that the assessment of damages herein was correct. It seems to me there is considerable force in the argument advanced by the appellants that in the

circumstances of this case, namely, a young person likely to attain modest education qualifications and without a demonstrated history of earnings, that anything but a fairly modest award of damages could be sustained. However, I do not propose to consider this matter in any extensive fashion in light of the conclusions I have reached on liability issues.

[55] In the result, I would allow the appeals of Dr. Reddoch and Whitehorse General Hospital and dismiss the action as against both defendants. The appellants are entitled to costs since costs normally follow the event but in the circumstances of this tragic case, I should think the successful appellants might want to carefully consider their position on that matter.

“The Honourable Mr. Justice Hall”

I AGREE:

“The Honourable Madam Justice Ryan”

I AGREE:

“The Honourable Mr. Justice Braidwood”