SUPERIOR COURT OF JUSTICE

B E T W E E N :

NADINE SIMON and SHAWN SIMON
Plaintiffs,

- and -

JAN LUSIS
Defendant

---Before the HONOURABLE MR. JUSTICE JURIANSZ at 393 University Avenue, on October 20, 2000.

A P P E A R A N C E S :

R. Bogoroch, Esq.	Counsel for the Plaintiffs,
P. O'Hagan, Esq.	Counsel for the Defendant

T A B L E O F C O N T E N T S - V O L U M E I

October 20, 2000.

---Preliminary Discussions

R E A S O N S F O R J U D G M EN T

Juriansz, J. - Orally:

First, I will set out the basic facts.

Mrs. Nadine Simon was born September 29, 1966 in Newfoundland. She completed grade 11 in 1986; married in July of 1990; had a son in January of '89 and a daughter in July of '94.

In 1991, while living in New Brunswick and working on an assembly line, she injured her back and was never returned to work. She had unsuccessful back surgery in November of 1991, and ever since then has been on Workers' Compensation or Canada Pension Plan Disability Benefits.

Since then, she has suffered severe back Pain. In July of 1996, she was back living in Newfoundland and began to experience gastric symptoms. Her family doctor, Dr. Dennis, referred her to a gastroenterologist, Dr. Jenkins.

Dr. Jenkins visually confirmed that she was suffering from a gastric ulcer by using a gastroscope. The vast majority of gastric ulcers are caused either by a bacterium called

"H. Pylori" or by the use of NSAIDs. NSAIDs are a group of medications that include aspirin. Gastric ulcers that are caused by NSAIDs are treated by a drug named "Losec," which evidently is highly effective. Ulcers caused by H. Pylori are treated by triple therapy which is comprised of Losec and a combination of antibiotics.

Dr. Jenkins took a biopsy which indicated that Ms. Simon's ulcer was H. Pylori negative. Thus, it may be concluded Ms. Simon's ulcer was caused by the use of NSAIDs and the continued use of NSAIDs was extremely dangerous to her. If Ms. Simon stopped taking NSAIDs, it would be highly unlikely that the ulcer would recur after it had been appropriately treated.

On the other hand, if she continued to take NSAIDs, there was a high likelihood that the ulcer would come back or that it would begin to bleed or perforate. A bleeding or perforated ulcer is life threatening. Smoking is also not good for ulcers. Dr. Jenkins prescribed Losec for Ms. Simon and told her to stop smoking and to discontinue taking aspirin. He said that if she had backaches she should use Acetamaphene Nofen. This was at the end of November, 1996.

In March of 1997, Ms. Simon moved to Brampton, Ontario with her family. She came under the care of Dr. Lusis who has had a family practice in Brampton since 1976.

She first saw him on April 7, 1997 and remained a patient of his until July, 1998.

While on a trip to Newfoundland in

July, 1998, she vomited blood and was admitted to the hospital where she continued to bleed from a large gastric ulcer. She required blood transfusions and emergency surgery to remove the portion of her stomach contain the ulcer. Ms. Simon had been taking over-the-counter medication called "AC&C" which stands for Aspirin, Codeine, and Caffeine.

Ms. Simon claims that Dr. Lusis failed to exercise a reasonable standard in his care of her and had he done so she would not have had a recurrence of the ulcer, the complications of the ulcer, and the surgery to remove the portion of her stomach.

Ms. Simon claims that Dr. Lusis failed to give her any warning about the use of NSAIDs or an inadequate warning. She also claims that Dr. Lusis failed to refer her to a Gastroenterologist in a timely manner to ensure That her ulcer, whether had been documented in Newfoundland earlier had healed properly.

I will now turn to an assessment of the quality of the testimony.

The first witness was Nadine Simon.

There were minor and major inconsistencies between her testimony at trial and at her Examination for Discovery. She explained that she misunderstood some of the questions. She said her memory got worse after the surgery. Her health was not at its best during the times in question. She was weak and in pain. And at some of the times she was

focused on other concerns, such as the well-being of her children. But she did say that she was trying to tell the truth at discovery, and she did acknowledge that her recollection of events was fresher then.

I have made due allowance for the effect of time on any witness's memory. I would be very surprised if any normal human being could remember the dates on which one visited the doctor some years ago and the details of the conversations with the doctor. Even where one remembers what was said, one may well be unable to remember reliably at what visit it was said. On occasion in her testimony Ms. Simon attempted To place a particular visit to Dr. Lusis' office By reference to other important events in her Life, such as her son's diagnosis with a Particular condition or the Christmas season. The imprecision of her memory in such matters does not detract from her credibility.

However, there were some pertinent discrepancies between her testimony and what she said at discovery. At trial, she testified she did not take aspirin after Dr. Jenkins warned her not to. At discovery, she said she continued to take aspirin until May, 1998, even though she knew Dr. Jenkins had told her not to and that it was not good for her ulcer. At trial, she testified she started taking AC&C in Newfoundland after Dr. Jenkins warned her not to take aspirin. At discovery she had said she started taking AC&C in May of 1998. She did not

explain these discrepancies to my satisfaction.

Further clouding her testimony is Dr. Jenkins's report dated November 22, 1996 which states she was taking "ASA Compound" at the time of his treatment of her. Dr. Brankston, the plaintiff's expert witness, was unhesitating in his testimony that ASA compound was a synonym for AC&C.

As well, Ms. Simon did not seem able to reliably recount her symptoms in testimony. after a careful examination-in-chief about the symptoms she suffered and reported to Dr. Lusis and toward the end of a through cross-examination she added serious symptoms that she suffered and allegedly reported to Dr. Lusis, which she had not mentioned earlier in her testimony. She seemed surprised at defendant's counsel's reaction to these new bits of information. This made evident to me that her testimony must be assessed carefully since she may not be relied upon to recount her symptoms and those she reported to Dr. Lusis accurately.

Ms. Simon is the main plaintiff in the case and has a great interest in the outcome of the litigation, and this must be remembered in assessing her testimony.

In sum, I was not convinced that Ms. Simon was always trying to tell the truth nor that she was always able to shed light on the truth.

Dr. Lusis also has a great interest in

the outcome of the litigation. He gave his testimony deliberately and had the demeanour of trying to tell the truth. There was some inconsistencies between his testimony at trial and on discovery. I am satisfied that these were due to his bad handwriting, which even he had difficulty reading and the fact that he had a photocopy of his notes at discovery and the original at trial.

However, Dr. Lusis has a very busy practice. He saw some 450 people a month. It would be very surprising if he were able to recall the details of the communications with a particular patient and his treatment of that patient. It was evident to me that Dr. Lusis had very little direct recollection of his treatment of Ms. Simon. He testified about what he usually does and what he expects he probably did. However, what Dr. Lusis usually does is not the issue before me. I am concerned about what he did in this case.

His testimony of his treatment of Ms. Simon and the communications between them was based, in large part, on his notes. Therefore, Dr. Lusis' credibility and reliability depends in large measure on the credibility depends In large measure on the credibility and Reliability of his notes.

As interpreted by him, Dr. Lusis' notes, up to June 9, 1997 do not indicate that Ms. Simon made any complaints to him of the specific Usual symptoms of ulcers. He prescribed 60 tablets of Losec on May 1 as part of triple

therapy. That's some 30 day supply. His note of June 9, 1997 simply indicates he prescribed Losec, 100 tablets, at one a day. He does not record any symptoms or complaints reported by Ms. Simon. I consider it improbable in the extreme that Dr. Lusis made no inquiry of Ms. Simon about her symptoms on June 9, and that she Did not report any symptoms to him. Yet, his Notes record nothing in this regard.

I consider it improbable that Dr. Lusis Would prescribe a three-month supply of Losec without her reporting any specific symptoms to him. In fact, Dr. Lusis said that on June 9 he was in the treatment phase as the diagnosis had been established. He must have had some basis for making a diagnosis. I do not accept that his receiving Dr, Dennis' file provided the basis for an actual diagnosis without any continuing symptoms.

Dr. Stern, one of the defendant's experts, testified that triple therapy could be prescribed to an asymptomatic person who had a past history of an ulcer but the Losec was for a current condition. He did indicate that Losec could be given for conditions other than an ulcer, but as I understood it Dr. Lusis did not diagnose any other condition, and I understood him to refer to the diagnosis of an ulcer having been established.

Considering all of this, it is clear to me that Dr. Lusis is a poor note taker.
He admitted in testimony that his notes of June

9,1997 were not adequate. Ironically, it is a large part of his defence that his notes are incomplete and do not reflect all of his advice to Ms. Simon. Thus, in determining the issues in this case, I must be cautious in relying on Dr. Lusis' notes as it is clear to me he omitted important detail from them.

Dr. Joseph Connon was called by the Defendant and was recognized as an expert to Give opinion on the diagnosis and appropriate Care and treatment of ulcers, and the referral Practices between family practitioners and gastroenterologists. He was a gastroenterologist of great experience and considerable stature.

Counsel for the plaintiff suggested that eh showed some partiality to the defendant by taking the initiative to offer the unsolicited information that there are 917 aspirin-containing preparations in Canada. It is true that Dr. Connon was not asked directly for this information. However, when I consider his testimony as a whole, I am satisfied that Dr. Connon did not show any partiality.

In my view, he took the initiative to Offer this information in an effort to help the Court understand the difficulty of explaining to Patients precisely what medications they should avoid.

I not he had earlier said there were about a dozen different kinds of NSAIDs if which aspirin is one. It was my impression that the

917 preparations he referred to would include all brands, all sizes of bottles, all dosages, all compound preparations, and that one could infer that all 917 preparations would indicate that they contained aspirin on their labels.

The only limitation I would keep in mind in my application of Dr. Connon's evidence is that it must be understood in the context of the terms of his qualification as an expert witness in this case. Otherwise, I accepted everything Dr. Connon had to say.

Dr. Edwin Brankston was called by the plaintiff and qualified as an expert to provide opinion on the standard of care of family practitioners in Ontario from 1997 to the Present. He has provided opinions to the College of Physicians and Surgeons regarding the standard of care in discipline manners, and has provided opinions and appeared as a witness for the Canadian Medical Protective Association, and for plaintiffs. He is an experienced family practitioner in Oshawa.

I found him exceedingly credible. But there are two matters which I must keep in mind in relying on his testimony:

First, on medical matters, where his testimony conflicts with that of Dr. Connon, I prefer the testimony of Dr. Connon. Dr. Brankston himself indicated that on medical matters he would defer to a gastroenterologist.

Second, I must keep in mind that the standard of care expected of a medical

practitioner is that degree of care and skill which can reasonably be expected of a normal prudent practitioner of the same experience and standing. A medical practitioner need exercise only reasonable degree of skill, and knowledge, and care, not an ideal degree.

Counsel for the defendants submitted that Dr. Brankston's suggestion that Dr. Lusis should have provided Ms. Simon with a list of medications that contained aspirin and NSAIDs is frought with difficulties. He said that the effectiveness of such a list would be limited as new medications came on the market and that the list would soon become outdated. He said questions would arise as to how often if at all a doctor had a duty to update the list and what sort of notice should be given to patients when the list changed. Questions of liability would arise, he said, if the list were not complete at the time it was given or at some later time. I will keep this in mind.

The defendant called Dr. Sol Stern, a family practitioner in Oakville, as an expert who was qualified to offer an opinion on the standard of care of family practitioners in Ontario in the years 1997 and 1998. He is an experienced family physician who has been involved in continuing medical education. He has prepared opinions for the Canadian Medical Protective Association and for plaintiffs. I found Dr. Stern's testimony helpful, but in my view there were occasions when he took a

perspective that was uneven between the parties.

Dr. Stern had read the Examinations for Discovery of both Ms. Simon and Dr. Lusis. Ms. Simon had said in her discovery that Dr. Lusis had not counseled her to not take aspirin, and Dr. Lusis had suggested that he did. Dr. Stern resolved this conflict in favour of Dr. Lusis and offered his opinion testimony on the basis that such advice had been given.

It is true that Dr. Brankston presumed that such advice had not been given, but Dr. Brankston resolved the conflict by relying on a principle. He said that the standard of care required doctors to document in their notes all important advice given to a patient, and since the advice about NSAID use was not documented in Dr. Lusis' notes, he presumed the advice was not given. In fact, for the purposes of his opinion, Dr. Brankston assumed that all the facts were consonant with Dr. Lusis' clinical notes, even though those notes do not indicate many of the complaints Ms. Simon claimed that she made to him in the discovery transcript Dr. Brankston had been provided with.

The basis on which Dr. Stern resolved the conflict in favour of Dr. Lusis was not apparent to me.

If I have a concern that Dr. Brankston suggested standard of care may be coloured by the ideal, I have the opposite concern that there seemed to be no limit to the understanding that Dr. Stern advocated should be extended to

doctors, because they are busy and cannot write forever.

One of the purposes of notes, according to Dr. Stern, was for the physician's own recollection, so that he or she can't treatment the patient properly. It seems to me that the standard proposed by Dr. Brankston, that is that all important discussions with the patient be Documented, is necessary to achieve this purpose. A family practitioner who sees over 400 patients each month and may not see a particular patient for several months will not likely remember what were the important discussions with the patient on earlier visits. Unless such matters are noted in the patient's file, the physician may erroneously assume that advice was given or that a discussion took place at an earlier visit, and then may fail to offer the advice or engage in the discussion with the patient on a subsequent visit.

As between Dr. Brankston and Dr. Stern, I found Dr. Brankston's testimony regarding the standard of care to be more helpful, though Dr. Stern's testimony and perspective was also of value.

Turning now to the issues:

The main issue in this case is whether Dr. Lusis counseled Ms. Simon against the use of aspirin and NSAIDs. Both the experts called by the defendant predicated their opinions on the assumption that he had done so. The defendant conceded in argument that if Dr. Lusis failed to

give such counseling it would follow that he failed to meet the appropriate standard of care.

Dr. Connon emphasized the importance of Such a warning because of the great danger to a patient's health by the continued use of NSAIDs. Dr. Connon described the content of what he saw to be appropriate counseling regarding the use of NSAIDS. He was not in favour of providing patients with a list. He said: "It's much better to say to the patient, 'Look, aspirin and NSAIDs, for you, are dangerous. You should only use Tylenol. If you use anything else, speak to the pharmacist and ask him: Is there aspirin; is there an NSAID in this compound?"

Counsel for the defendant relied on the following statement found in the decision of the Ontario Court of Appeal in Crits v. Sylvester [1956] O.R. 132,where after setting out the statement of appropriate standard of care, Mr. Justice Shroeder added the following principle: "And if he holds himself out as a specialist, the higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability".

Counsel for the defendant argued that Dr. Connon was a specialist, and that a family practitioner could only be held to a lower standard than that espoused by Dr. Cannon. The principle from the Crits decision, in my mind, can only be understood in reference to a particular procedure. In performing a technical medical procedure such as a gastroscopy, or in

determining what was the appropriate medical treatment of an ulcer, a gastroenterologist would be held to a higher standard than a family practitioner.

However, the procedure in question here is the counseling and educating a patient. In my view, in regard to this procedure, the family practitioner holds himself or herself out as looking after the patient's general medical interest in an ongoing relationship and in Acting as an intermediary between the patient and the technical specialist. In my view, Dr. Connon was not qualified to testify as to the appropriate standard of care to be exercised by a family practitioner in counseling a patient against using NSAIDs.

I prefer the testimony of Doctors Stern and Brankston on the appropriate standard to be exercised by a family practitioner.

Dr. Stern said, 'It isn't enough just to tell the patient not to take aspirin.' He agreed it was reasonable to explain what NSAIDs are, and to give the patient a list of common NSAIDs. He said that the patient should be educated. The physician should teach the patient and make sure he or she understands. He agreed that tie constraints and pressures should not interfere with the physician's role to educate the patient. He also said that chronic pain patients often require counseling. They often suffer psychological distress and

require counseling for both physical and psychological aspects to make sure they take appropriate medication.

Dr. Brankston said that Dr. Lusis should have formulated a more rigorous treatment plan for the management of Ms. Simon's back pain. He noted that she had lumbar back surgery and a chronic back problem. She had known gastric ulcer. He said Dr. Lusis should have ensured she was well educated regarding how to properly manage her back pain. She could have been given Misaprostol, a gastro-protective medication that would have protected her stomach against medications which included aspirin or NSAIDs.

Dr. Lusis' testimony regarding the advice he gave Ms. Simon at the first examination, which was April 7, 1997 is as follows:

A: "The subject of smoking would surely have been raised. I, on a routine basis, advised against smoking at such a physical and, of course, especially so in this case with the association of an ulcer. I would have given general advice about an ulcer, discouraging the use of aspirin or NSAIDs. I would have given advice to consult me if there were a change of symptoms.

Q. Doctor, can you give us more detail about the standard or typical advice you would have given concerning the warning not to use NSAIDs

and what types of language would you use?

A. I usually mention aspirin with NSAIDs, even though essentially aspirin is a type of NSAID, but not everyone appreciates that distinction. I might mention that NSAIDs are arthritis medication. That have helps identify them for people."

A little bit further down: "I typically ask the patient what medication they are taking, and sometimes I specifically – well mostly, I specifically ask if there are any others because sometimes people exclude those that are not prescribed. And some women indeed exclude the birth control pill".

Further on he indicates that if Ms. Simon had told him that she was using AC&C he would have advised her not to.

He said he was familiar with AC&C and knew it contained aspirin, and if he had been told she was using AC&C he would have written it down. My findings are as follows:

First I do not believe Ms. Simon told Dr. Lusis she was using AC&C. Ms. Simon has told several versions of her use of AC&C and aspirin. I found some of Ms. Simon's testimony did not accord with reasonable likelihood. She was repeatedly vague about the dosage of AC&C and aspirin that she had taking. She said One a day, or two a day, or a couple a week. I regard this testimony as implausible because I expect that someone who's suffering the excruciating and constant back pain which Ms. Simon described and

was using medication for it would take much more medication and more frequently. I strongly suspect that Ms. Simon has not been frank with us either about the amount of AC&C and aspirin she took or the periods during which she took it.

Dr. Jenkins in his report indicated that Ms. Simon was using an ASA compound in the fall of 1996 before he treated her. And Dr. Brankston testified that ASA Compound was a synonym for AC&C. Dr. Brankston suspected that Ms. Simon was using AC&C before she saw Dr. Jenkins, even though at her examination for discovery, which Dr. Brankston read, she said she began to use it in May of 1998. Dr. Connon indicated there are a small number of patients who continue to use aspirin or NSAIDs surreptitiously after being counseled not to. I make no finding, but I suspect that Ms. Simon is such a patient.

I find Ms. Simon's testimony that she told Dr. Lusis that she was using AC&C and April 7, 1997 implausible. She testified she told Dr. Lusis she had stomach pain and was taking Pepcid and Maalox for it. She said she told him she had been diagnosed with the gastric ulcer and had severe back problems. She said she told him she was taking AC&C and the occasional Tylenol for her chronic back pain. She said, "He asked what it was, and I told him I assumed it was Tylenol'. His clinical not for April 7 indicates "Tylenol off and on".

I do not understand why she would tell him she was taking AC&C and the occasional Tylenol if she thought AC&C was Tylenol. Moreover, the expert witness testified that any family practitioner would know what AC&C is. And Ms. Simon's version has a family practitioner asking her what it was.

The experts said it was not possible for Dr. Lusis to be told she was taking AC&C and to write down Tylenol in his notes. I note that Ms. Simon did not offer any basis for why she assumed AC&C was Tylenol. I find it highly probable that she could have taken AC&C tablets several times a week for a long period of time, either months or years, and never once glance at the ingredients or the full name of the medication, even through inadvertence.

The April 7th, 1997 visit is the only time that Dr. Lusis suggests he counseled Ms. Simon about NSAIDs. One may note that at the time he did not know that she had an NSAID caused gastric ulcer. She may have had a duodenal ulcer. If one accepts Dr. Lusis' testimony abut the counseling he suggested he probably gave, it is my view that he still did not meet the standard indicated by any of the expert witnesses.

He did not tell the patient to ask the pharmacist if aspirin or NSAIDs were in medication before she took it, as suggested by Dr. Connon.

After saying he would have discouraged

the use of aspirin or NSAIDs, Dr. Lusis then said only that he might have mentioned NSAIDs. That is short of an evidentiary basis upon which I could find that he did. Moreover, if anything, what he says he probably said was likely to be confusing. The testimony established that aspirin and NSAIDs are found in many over-the-counter preparations. Advil and Motrin were two mentioned.

Dr. Stern said there were 10 to 15 common medications. I note this is a manageable number, but I refrain from finding Dr. Lusis fell below the standard by not providing Ms. Simon with a list of medications. I prefer Dr. Stern's general standard that the physician must educate the patient, must teach the patient, and must make sure the patient understands. In my view, Dr. Lusis did not meet that standard. By limiting the identification of NSAIDs to arthritis medications, a patient may believe that medication for back pain is permissible.

As noted, the advice, if it were given, was at the April 7, '97 visit. As Dr. Lusis did not know the ulcer was an NSAID caused gastric ulcer at that point, it may have been that he placed much less emphasis on the NSAID warning. But by June 9 Dr. Lusis knew that Ms. Simon had an NSAID caused gastric ulcer, and he had a medical report that stated that she used to take ASA Compound, AC&C, for her back pain. He knew she had a chronic back problem. According to the expert testimony I have accepted there was a

clear need for counseling at this point. The need was pressing and clear. But the only date Dr. Lusis suggested he gave any counseling was April 7. I accept the testimony of Dr. Brankston that Dr. Lusis should have recognized the risk that Ms. Simon might take an NSAID containing medication for her back pain. He should have given her much clearer and better counseling about NSAIDs, if he gave any, and he should have had a treatment plan for her back that involved using non-NSAID medication or in conjunction with a stomach protecting medication.

Dr. Lusis testified that in his treatment of Ms. Simon the issue of back pain came up, but it was never addressed as a principal discussion. He said: "It's likely true I never counseled her about back pain".

I find that Dr. Lusis failed to meet the standard of care in failing to counsel or adequately counsel Ms. Simon about the use of NSAIDs to reduce the likelihood she would use them. Contained in this is failing to have a treatment plan for her back pain with appropriate medications, as Dr. Brankston testified was required by the standard of care.

I accept Ms. Simon's testimony that she reported symptoms consistent with an ulcer to Dr. Lusis on June 9, 1997 and before, and that these symptoms were not recorded in his notes. As I said, she must have had some symptoms for his diagnosis that she had an ulcer and his

prescription of three months of Losec, a much longer course than Dr. Connon said was necessary.

I'm satisfied that Dr. Lusis failed to meet a reasonable standard of note taking by not recording whatever symptoms Ms. Simon indicated to him on June the 9th. He also failed to meet the standard of note taking if he gave her counseling about NSAIDs on April the 7th as he suggests and did not record it.

I have considered whether these failures caused her any damage. Certainly, he gave her treatment on June the 9th appropriate for an ulcer. However, the failure to record her symptoms had the potential to affect his later treatment of her. Keeping in mind the first purpose of notes, as explained by Dr. Stern, is to enable the physician to treat a patient properly, then these notes do not ensure that Dr. Lusis , when he saw her in January of '98, would recollect the symptoms she had recorded on June the 9th, and consequently these notes would not achieve the purpose of ensuring the best treatment of Ms. Simon in January.

Furthermore, it seems it is Dr. Lusis' habit not to record when he gives an NSAID warning. If he did not give one on April the 7th, consequently on June 9 when he knew she had an NSAID caused ulcer, he may have erroneously believed he had already warned her, and as I noted he does not suggest that he gave her an NSAID warning on June 9 or any time afterwards.

I find that Dr. Lusis' failure to meet a

reasonable standard of note taking had the potential to cause damage to Ms. Simon.

Dr. Connon said there were two treatment options when a patient suspects an ulcer; and there are no red flag symptoms that suggest a bleeding or perforated ulcer. The first option was to treat the patient with Losec and the second option was to refer the patient to a gastroenterologist. There was no evidence that Ms. Simon exhibited any red flag symptoms before July, 1998 in Newfoundland. In fact, a blood test at the end of January 1998 showed that she had a normal level of hemoglobin. On June the 9th, 1997, Dr. Lusis treated her with Losec. On that occasion, he exercised option one.

The next formal appointment she made with him was in January of 1998, and at that time he referred her to a gastroenterologist, which is option two. In addition, he referred her to a urologist and a gynecologist.

Counsel for the plaintiff argued that Ms. Simon visited Dr. Lusis on October 21 when her son had an appointment with him, and that she reported symptoms to him on that occasion which he failed to note and failed to take into account in his treatment of her ulcer.

Ms. Simon said she saw Dr. Lusis when she was at his office with her children. She said that she "remembered one day that she was in excruciating pain, and I remember asking him is it - you know, there has to be a time this has to stop, you know. Is there anything I can

possibly do where it wouldn't be so aggravating"?

She was asked the following question:
"Q. You said pain. What complaints did you make to Dr. Lusis?
A. My bowel. I was totally constipated. There was no relief there. I was up all night urinating. I was up all night rocking myself. All I could eat was cereal, crackers, and milk."

Further in her testimony are additional references to pain, but no complaints of pain that are specific to the abdomen during this period. I do not accept that Ms. Simon told Dr. Lusis about not being able to eat on this occasion. And so I conclude that the October 21 visit is not helpful in resolving the issues in this case.

The evidence was that in Brampton there was a shortage of gastroenterologists at the time and long waits were necessary. After the referral in January, unfortunately, the appointment with the gastroenterologist could not be scheduled until May 5, 1998. Even more unfortunately, on April 28th, that gastroenterologist cancelled the appointment because he suddenly and unexpectedly closed his office. Dr. Lusis arranged a new appointment with Dr. Bellini which was scheduled for July 29.

Counsel for the plaintiff argued that in these circumstances the standard of care required Dr. Lusis to phone the new

gastroenterologist and explain what had happened and arrange a quicker appointment, or that Dr. Lusis should have referred Ms. Simon out of Brampton.

These were most unusual circumstances. I was not persuaded that there was an acknowledged procedure to be followed by a family physician in these circumstances. I note that in his referral letter to Dr. Bellini Dr. Lusis explained what had happened. A letter in my mind is as good as a phone call.

Dr. Bellini testified and said that because of the unfortunate circumstances he booked an earlier appointment for Ms. Simon than her medical status indicated. And he said that in the absence of red flag symptoms he could hot have seen her sooner. It is truly sad and unacceptable that a patient should have to wait so long to see a specialist. But I was not persuaded that the responsibility lay at the feet of Dr. Lusis.

This is a case in which the "but for" test of causation is not appropriate. The medical evidence was that the use of NSAIDs greatly increased the likelihood of recurrence of an NSAID ulcer and the risk of bleeding and perforation, not that it would. And, of course, whether an NSAID warning is given or not does not determine whether a patient will continue to use NSAIDs unknowingly or surreptitiously. And as Dr. Connon pointed out it is not known when Ms. Simon's ulcer recurred.

The most that can be said is that she used NSAIDs at least form May of 1998; that the NSAID use greatly increased the likelihood that the ulcer would recur and bleed, and as it did; that there is a recognized duty on family practitioners to give an adequate warning against NSAID use to patients with an NSAID caused gastric ulcer and a duty to document that warning; That Dr. Lusis failed to give an adequate or any warning; and that he didn't document any warning that may have been given on April the 7th; that the lack of such documentation may have contributed to his not giving a warning on June 9; that his failure to document the visit of June 9 adequately may have had a negative impact on his subsequent treatment of Ms. Simon. I am satisfied that all of this increased the likelihood of the ulcer's recurrence and the development of complications.

I am satisfied that Dr. Lusis' negligence, which I have identified, materially contributed to the recurrence of the ulcer and its complications.

Turning to the assessment of damages. Ms. Simon no longer has any complaints of a gastric nature. Counsel described her damage under various headings;

First, a gross ugly scar with a bump. The testimony supported by photographs was that she has a scar from her breast bone down past her belly button. She said the scar bothers her because it is ugly, and that it hurts at times.

She testified that she keeps herself covered. She said she found it was hard when people ask, 'What happened to you?' She doesn't want to have to explain. There are cloths that she can't wear, including a bathing suit. She can't wear a one-piece bathing suit because the scar is raised and shows through. She said the scar was a "nasty reminder of all the suffering I have had".

Counsel said that she suffered pain and the actual operation, and was subjected to the risks of anesthetic, and that she had to undergo a period of convalescence. The operation is described in the medical reports. She indicated that after the operation she had bowel spasms. There was a period of time she was depressed and sought counseling. She saw the counselor about three times.

Counsel relied on the pain she has suffered in the period form June 25, 1998 to August, '99. Some of that has already been covered. He also relied on pain in the period from October of '97 when the Losec ran out to when she went to Newfoundland.

Counsel described her pain as multi-factorial. The pain that she described during the fall of 1997 in her testimony-in-chief I have reviewed carefully. Her testimony related primarily to her back. She made no isolated reference to abdominal pain. Certainly, during this period, she had pain from several sources, but I do not regard

her testimony as indicating the pain from the ulcer as the primary source or even an important source. There was expert testimony that gastric ulcers are not the most painful ones, and that analgesics often mask the pain from them.

On these facts, counsel for the plaintiff suggested the range of damages in the amount of $50,000 to $75,000. He recognized that this is not an exact science and that other cases are only of limited assistance. For example, in Koller v. Cokleugh, [1999], O.J. 4153, the plaintiff's scar was shorter than in this case, and the plaintiff was in her 60's.

Having considered all of the evidence, and the fact that Ms. Simon had young children, and that her illness and her stay in the hospital and her convalescence affected the relations with her children for some periods, I have decided that an amount of damages of $45,000 is appropriate.

I have also decided that Ms. Simon was contributorily negligent in the amount of 10 per cent for continuing to smoke against medical advice, knowing that it was not good for her ulcer, and for taking AC&C at least from May 1998 without reading the label on any of the occasions she had the bottle in her hand. This apportionment of negligence does not reflect my strong suspicion that Ms. Simon used AC&C from before she saw Dr. Jenkins, and that she continued to use it knowing it contained aspirin. If I made such a finding, her

contributory negligence would have been much greater.

Counsel have advised that they have come to agreement regarding the claim of the other plaintiff, Shawn Simon. He shall receive the amount of $1,000 subject to the finding of contributory negligence.

Judgment to go in accord with these reasons.

---Submissions on costs.

THE COURT: The plaintiff will have party and party costs as assessed.

The foregoing is certified to be a true and accurate Computer-Assisted Transcription (C.A.T.) of my shorthand notes, to the best of my skill, ability, and understanding.

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Patrizia Generali, Court Reporter