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DATE: July 16, 2003

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:	)	
	)	
EDWARD VAN DYKE and DOROTHY VAN DYKE	)	RICHARD BOGOROCH LINDA WOLANSKI and TRISTA CHANDLER, for the Plaintiffs
Plaintiffs	)	
	)	
- and -	)	
	)	
	)	
THE GREY BRUCE REGIONAL HEALTH CENTRE, ALEXANDER MARSH. J. OSTRANDER. JOHN DOE, GREY-BRUCE HOME CARE PROGRAM and VON GREY-BRUCE BRANCH	)	JONATHAN LISUS and THOMAS SUTTON, for the Defendants. Dr. Marsh and Dr. Ostrander and HUGH BROWN and ANN MITCHELL for the Defendant VON GREY-BRUCE BRANCH
	)	
Defendants	)	
	)	
	)	**HEARD:** January 7-10, 13, 14, 15, 17, 20-24, 27-31. February 3, 17, March 24, 25, 2003.

REASONS FOR JUDGMENT

VAN MELLE. J.

[1] At trial, this case proceeded against Dr. Marsh and Dr. Ostrander and the Victorian Order of Nurses (VON). At the conclusion of the co-defendants' case, the VON brought a motion for a non-suit which was granted.

[2] In 1995 Edward Van Dyke was a reasonably healthy, fit 35 year old man. He was (and still is) married to Dorothy, with four children, Kyle, Karrie, Karlynn and Kristen, He resided In Hepworth, just outside of Owen Sound and worked as a shipper/receiver at the Beaver Lumber store (now Home Hardware) in Owen Sound. His life revolved around his family, work, church and friends.

[3] On the Victoria Day weekend in May of 1995. Mr. Van Dyke started having terrible headaches, facial pain and nausea. As a result of the severe pain in his head, Mr. Van Dyke went to the emergency department of the Wiarton Hospital. He was prescribed painkillers and oral Amoxil. Mr. Van Dyke's symptoms did not improve and he went to his family doctor. Dr. Jane Tucker on May 25,1995. She discontinued the Amoxil and prescribed oral Clarithromycin. She also ordered a series of x-rays from the Wiarton hospital,

[4] Initially, Mr. Van Dyke responded well to the oral Clarithromycin. However, soon after, his symptoms worsened dramatically. On June 2 he went back to Dr. Tucker. Dr. Tucker was immediately concerned and arranged for Mr. Van Dyke to be admitted to the Grey Bruce hospital. She also prescribed Gentamicin and Clindmycin to be taken intravenously and called in Dr. Alexander Marsh to assist.

[5] Dr. Marsh is an Otolaryngologist who has been practising as an ENT surgeon in Owen Sound since the fell of 1985. He received an undergraduate

medical degree from the University of Western Ontario in 1979. After completing a rotating internship at St Joseph's Health Centre in London, he entered a residency program in Otolaryngology.

[6] Mr. Van Dyke presented at the Grey-Bruce Regional Hearth Centre with a serious sinus infection, which was complicated by the fact that he had been in a serious car accident in 1979. In the car accident, he suffered multiple injuries, including a depressed skull fracture, a compound fracture of the frontal sinus, a flail chest injury, severe facial lacerations and a blunt trauma to the abdomen. Both the anterior and posterior walls of his frontal sinus were shattered into multiple fragments and the dura covering his brain was pierced, causing a leakage of cerebro-spinal fluid. The traumatized area was rebuilt using bony fragments, metal wires and tissue extracted from Mr. Van Dyke's thigh.

[7] Dr. Marsh first met Mr. Van Dyke on June 3, 1995. He concluded that Mr. Van Dyke was suffering from an infection of the soft tissue, involving the nerves in the area by inflammatory spread or compression, and that this was complicated by Mr. Van Dyke's medical history. Dr. Marsh also feared that Mr. Van Dyke might have osteomylitis. Dr. Marsh ordered a bone and gallum scan, Dr Marsh prescribed an aggressive course of antibiotics, and continued Mr. Van Dyke on Gentamicin, as originally prescribed by Dr. Tucker.

[8] On June 3,1995 Dr. Marsh reviewed a CT scan, which had been ordered by Dr.Tucker.

[9] On June 5,1995 the bone scan ordered by Dr. Marsh was carried out and on June 7, 1995 a report was filed on the chart. Also, as ordered by Dr. Marsh, a gallium scan was taken on June 8,1995.

[10] Mr. Van Dyke's condition improved steadily until June 10th but thereafter his condition deteriorated dramatically. Dr. Chatterson, an emergency physician who added intravenous Ceftazadine and continued Gentamicin, saw him on June 11th. Dr. Chatterson requested that Drs. Marsh and Ostrander consult on June 12. Dr. March ordered a further CT scan to assess the extent of Mr. Van Dyke's infection.

[11] Dr. Jack Ostrander was consulted to review the antibiotic therapy already prescribed, and first saw Mr. Van Dyke on June 12,1995. Dr. Ostrander is a general internist. He received his undergraduate medical degree in 1968 from the University of Western Ontario, after which he entered a five year program of internal medicine with one year of neurologic sub specialization. He has been in private practice in Owen Sound since 1974. In his consultative note, Dr Ostrander recorded the complications arising from Mr, Van Dyke's prior motor vehicle accident and the probable diagnosis of left peri-orbital cellulitis. Dr.

Ostrander concurred with the antibiotic therapy. In particular. Dr. Ostrander concurred in the prescribing of Gentamicin for Mr. Van Dyke.

[12] The CT scan of June 12,1995, Indicated an abscess in the peri-orbital region. Surgery carried out by Dr. Marsh on June 14. 1995 confirmed an abscess. The abscess was drained and a drain was inserted. Mr. Van Dyke was maintained on the antibiotic regimen, including Gentamicin.

[13] Mr. Van Dyke was discharged from the hospital on June 20, 1995. He was to continue therapy at home under the supervision of the VON.

[14] According to Mr. Van Dyke, sometime on June 30, 1995, Mr. Van Dyke experienced symptoms of dizziness. The VON learned of this on July 3 and Mr. Van Dyke was advised to contact Dr. Marsh immediately which he did. The Gentarnicin was stopped immediately.

[15| Although the Gentamicin was stopped on July 3, Mr. Van Dyke had already suffered a bilateral vestibular loss.

[16] It Is acknowledged by the parties that Mr. Van Dyke suffers from a bilateral loss of his vestibular apparatus as a result of Gentamicin toxicity.

[17] Gentamicin is an aminoglycoside, a potent antibiotic which carries the risk of significant toxicities, nephrotoxicity (damage to the kidneys) and ototoxicity (damage to the inner ear.)

[18] When Gentamicin is administered, it is taken up by hair cells in the ear, some of which are associated with hearing and some with vestibular function. When it accumulates, it begins to kill the hair cells, causing loss of either hearing or vestibular function, depending on which cells are killed. The longer the patient Is on the drug, the more accumulation there is and the greater the risk of injury.

[19] The Plaintiffs claim:

(i) that the Defendant doctors were negligent in continuing to prescribe Gentamicin after the surgery of June 14,1995;
(ii) that the Defendants were negligent In continuing to treat Mr. Van Dyke on the basis of a diagnosis of osteomylitis when virtually all of the evidence available to them pointed otherwise;
(iii) that the Defendants were negligent in failing to order daily monitoring by the VON;
(iv) that the Defendants were negligent in falling to keep proper medical records of their treatment of the Plaintiff and that the Defendants were negligent in failing to property Inform Mr. Van Dyke and his wife of the risk associated with the prolonged administration of Gentamicin and the availability of alternative drugs, particularly in the time period after the June 14 surgery.

[20] It Is the position of the Defendants that Edward Van Dyke presented with a complicated and rare presentation of a life threatening infection, complicated by his previous injury in 1979, which made the use of Gentamicin appropriate and necessary. The Defendants believed that the risk of osteomylitis was present at all times.

[21] The Plaintiffs take the position that the bone and gallium scans ruled out osteomylitis and that in any event, the Gentamicin should have been discontinued after the June 14th surgery when it became apparent that Mr. Van Dyke's condition was caused by an abscess. As well, a bone fragment removed during the surgery felled to disclose any evidence of osteomylitis.

EXPERT MEDICAL EVIDENCE

[22] Three medical experts testified on behalf of the Plaintiffs. They were; Dr. Jeremy Freedman, Dr. Arnold M. Noyek and Dr. Tony Mazzulli. All three are highly qualified In their respective fields.

[23] Dr. Freeman is an Otolaryngologist at Mount Sinai Hospital in Toronto. He is also a professor at the faculty of Medicine, Department of Otolaryngology University of Toronto.

[24] Dr. Noyek is also an Otolaryngologist at Mount Sinai Hospital and a professor at the University of Toronto. He has a special interest in radiology. He has authored many publications in his field as well as studied and lectured extensively in this area.

[25] Dr. Mazzulli is the Deputy Chief Microbiologist at the Toronto Medical Laboratories/Mount Sinai Hospital Microbiology Department. He is at the faculty of Medicine at the University of Toronto. He is the program director for the Infectious Diseases Subspecialty Fellowship Training Program.

[26] Both Dr. Freedman and Dr. Noyek agreed that the diagnosis of osteomylitis is "fraught with difficulties". During cross-examination Dr. Freeman agreed that the bone and gallium scans and the pathology report did not rule out osteomylitis.

[27] Dr. Noyek testified that bone and gallium scan results are entirely reliable in determining whether or not osteomylitis is present.

[28] Dr. Mazzulli was, for the most part, very critical of both Defendants. His evidence was inconsistent with the evidence given by the other experts who tested for the Plaintiffs. To the extent that it was inconsistent. I prefer the evidence of Dr. Freeman and Dr. Noyek.

[29] Two medical experts testified on behalf of the Defendants. Dr. North is an Otolaryngologist at Peel Memorial Hospital (now Sir William Osler Health Centre) in Brampton. He was the senior Otolaryngologist and chief of the Division of Otolaryngology from 1976 to 1996. His practice is similar to that of Dr. Marsh.

[30] Dr. Warren Wilkins is a general internist in Peterborough. He spends about 20 to 25 hours per week at his office and 30 to 40 hours per week at the Peterborough Regional Health Centre.

[31] Although both Drs. North and Wilkins were critical of the written record in this case, they concurred with the treatment provided by the Defendant doctors. They both testified that the concern throughout was the danger of osteomylitis.

PLAINTIFFS' CLAIMS OF NEGLIGENCE

(i) that the Defendant doctors were negligent in continuing to prescribe Gentamicin after the surgery of June 14, 1998

(a) The Plaintiffs submit that the Gentamicin should have been discontinued after the surgery on June 14, 1985 for the following reasons:
(b) The by-then known "failure" of the Gentamicin;
(c) The length of time Mr. Van Dyke had already been receiving Gentamicin;
(d) The fact that his condition improved dramatically after the surgery.

(e) The fact that all of the test results had come back negative for osteomylitis;

(f) There were known and acceptable alternative drugs available.

[32] The Defendants submit that following surgery, Drs. Marsh and Ostrander (and Dr. Tucker) considered discontinuing the Gentamicin but elected not to.

Their reasons for continuing Gentamicin were:

(a) as of the 16th of June, Mr. Van Dyke had been on antibiotics for almost a month, his therapy had failed three times resulting In a dangerous progression of his infection;

(b) this meant that he had an unusual or resistant organism In a closed space with poor blood supply and abnormal anatomy and preformed pathways to the brain;

(c) he had been on 5 antibiotics including Gentamicin;

(d) he was finally responding;

(e) due to his treatment prior to admission, a bug could not be cultured to further direct therapy;

(f) he had to be treated effectively;

(g) they could not know which drug of the three prescribed he was now responding to;

(h) the risk of introducing a new drug was too great; and

(i) there was a real and continuing concern about osteomylitis.

[33] I accept the Defendants' submission that it was appropriate to continue the use of Gentamicin in this time frame. However, I do not accept that Drs. Marsh and Ostrander or the treating team of physicians considered discontinuing

The Gentamicin, but elected not to. Nowhere is there any evidence that the Defendants made such a consideration. There are certainly, no notes in the medical records to support this submission.

[34] Although the Plaintiffs submit that Dr. Marsh disregarded the explicit statement In the pathology report that there was no evidence of osteomylitis, I accept his evidence that the moth eaten appearance of the bony fragments still caused him concern in this regard.

(ii) That the Defendants were negligent in continuing to treat Edward Van Dyke on the basis of a diagnosis of osteomylitis when virtually all of the evidence available to them pointed otherwise.

[35] There is no question that Mr. Van Dyke's condition was serious, being complicated by his previous injury, and was potentially life threatening. While Dr. Mazzulli took issue with the prescribing of Gentamicin right from the start, none of the other expert witnesses did. So I reject the evidence of Dr. Mazzulli on this point and I find that it was appropriate for Gentamicin to have been prescribed to Mr. Van Dyke on June 2,1995.

[36] Dr. Noyck, on behalf of the Plaintiffs, testified that the imaging and pathology reports ruled out osteomylitis. He relied solely on the reports of the doctors carrying out the investigations. Although they were available to him, he

did not review the scans themselves. As he is an Otolaryngologist with a subspecialty in radiology, he would have been uniquely qualified to interpret the scans. It certainly would have been of assistance to this Court had he done so.

[37] I do not accept the submission that virtually all of the evidence available to the Defendants pointed to a diagnosis a condition other than osteomylitis. The experts all agreed (with the exception of Dr. Mazzulli that the diagnosis of osteomylitis is a very difficult diagnosis to make. I find that the imaging and pathology reports did not clearly indicate an absence of osteomylitis.

(iii) that the Defendants were negligent in failing to order dally monitoring by the VON.

[38] Mr. Van Dyke was discharged home on June 20, 1995. He was assessed suitable for Home Care and was discharged home to continue therapy under the supervision of the VON. He was also to be under the care of Drs. Tucker and Marsh. A follow-up appointment with Dr. Marsh was arranged for June 23, 1995.

[39] Dr. Mazzulli, on behalf of the Plaintiffs, testified that a risk/benefit analysis should have been done when Mr. Van Dyke was being discharged home. I agree with Dr. Mazzulli in this regard. There is no indication in the record that a risk/benefit analysis was undertaken here.

[40] Dr. Marsh agreed that he needed to be satisfied that Mr. Van Dyke, at the time that he was discharged home, knew of the toxic side effects of Gentamicin and of the importance of reporting symptoms immediately. At no time did Dr. Marsh confirm that he had had discussions of this nature with Mr. Van Dyke.

[41] Dr. Marsh did not give the VON any special instructions to deal with Mr. Van Dyke and just expected that it would perform its usual job, which included medication and instruction with a view to having Mr. and Mrs. Van Dyke take over the administration of the drugs. The VON viewed the mandate as attempting to decrease, not increase its involvement.

[42] Dr. Marsh conceded that he could have ordered daily visits by the VON after Mr. Van Dyke had been discharged home.

(iv) that the Defendants were negligent in failing to keep proper medical records of their treatment of the Plaintiff and that the Defendants were negligent in failing to properly inform Mr. Van Dyke and his wife of the risk associated with the prolonged administration of Gentamicin and the availability of alternative drugs, particularly in the time period after the June 14th surgery.

[43] Dr. Marsh testified that he had ongoing discussions with Mr. Van Dyke about the risks and side effects of Gentamicin despite the fact that he kept no record of these discussions. Dr. Marsh during cross-examination admitted that he was under duty, by the law and by his professional code of conduct, to record the discussions he had with Mr. Van Dyke regarding Gentamicin

ototoxicity.

Although he recalled generally having had such discussions he could not recount specifically the content of those discussions, nor when these discussions might have taken place.

[44] I am satisfied on the evidence that there was a failure by Dr. Marsh to property document discussions with the "treating team of physicians" and with Mr. Van Dyke. Although the failure to keep proper records in this case does fall below the standard of care, the failure, in and of itself, does not constitute negligence here. However, as stated above. I am unable to accept that certain critical discussions took place with the other doctors and with Mr. Van Dyke when there is no written record of such discussions.

[45] During cross-examination the following exchange took place:

> **Q. Dr. Marsh, I have a few more areas I want to cover with you. You mentioned before at length that you had ongoing discussions with Mr. Van Dyke about the risks of ototoxicity and about Gentamicin. Do you remember saying that?**
>
> **A.** Over the course of his stay in hospital, yes, I spoke – no, I spoke to him about it initially when I first saw him and then, as we were doing blood levels and so on, I explained to him in the context of, as adjustments that were made by myself or by Drs. Tucker or Ostrander that was why we were adjusting the doses was to follow the levels.
>
> **Q. I was asking you, though, about your discussions, not about adjusting the levels.**
>
> **A.** No, no, I'm saying that's in the context that I was talking to him in that context each time that the levels were done and as I was visiting him.
>
> **…**
>
> **Q. What days did you have those discussions with him?**
>
> **A.** Well, I saw him every day, I can't give you a specific word for word transcript of what days and what exactly the conversation was. As I said, the general tenor was that, "you're on a drug that has toxic"
>
> **…**
>
> **Q. I want to understand the parameters of the duty that you say you had to Mr. Van Dyke. Did it involve educating him and counselling him?**
>
> **A.** Well, in my mind, discussing it with him and indicating to him the concerns about the toxicity and why we're doing the blood levels I would see as doing that.

Q. All right. So it's your position that you educated and counselled him about the risks of ototoxicity in the choice of Gentamicin?
A. I felt I gave him adequate information, yes.

[46] From Dr. Marsh's testimony I formed the opinion that although he may have had ongoing discussions with Mr. Van Dyke, those discussions centred-around the reason as to why same levels were being taken. Serum level monitoring shows whether the Gentamicin level is within the peak and trough therapeutic ranges. Serum level monitoring ensures that the kidneys are functioning property, nephrotoxicity being one of the other side effects.

[47] There was nothing in the medical record or in the evidence to support a finding that Dr. Marsh discharged his duty to adequately inform Mr. Van Dyke about the risk of ototoxicity and the symptoms. There was nothing to suggest that it had been brought home to Mr. Van Dyke that if he experienced any of those symptoms he was to report it to medical personnel immediately.

[48] It appears that Dr. Marsh's view was that the risk of ototoxicity was minimal when serum levels were within the therapeutic ranges. He acknowledged that ototoxicity might occur notwithstanding such serum levels, but only on an idiosyncratic or idiopathic basis, and that while such levels were not an absolute guarantee that ototoxicity would not develop, they were an assurance that it should not happen.

[49] The expert evidence supported the view that the risk of ototoxicity increased significantly with the use of Gentamicin. This is because ototoxicity is caused by an accumulation, of the toxic drug within the circulation or fluid system of the inner ear. The longer the patient is on the drug, the more accumulation there is and the greater the risk of Injury.

[50] Dr. Freeman testified that the standard texts and manuals regarding the administration of antibiotics clearly stated that the use of Gentamicin should not exceed 10 to 14 days.

[51] Dr. Mazzulli testified that it was generally said that the risks of toxicity increased significantly after 7 to 10 days use of Gentamicin.

[62] Dr. Ostrander agreed that the medical literature indicates that here is a large increase in the risk of ototoxicity after 14 days use of Gentamicin.

[53] Dr. Wilkins agreed that the risk of ototoxicity Increases substantially after 14 days and that that risk was known to the medical profession In 1995.

[54] Dr. Marsh did not share this view and testified that the risk increased only incrementally with continued use. I reject Dr. Marsh's evidence on this point and I accept the evidence of the experts. I find that Dr. Marsh should have known that the risk of ototoxicity increases substantially, at least after 14 days. As a result there was a duty on Dr. Marsh to monitor Mr. Van Dyke on an ongoing basis and to continue to press home the symptoms of ototoxicity,

which include blurring of vision, dizziness, imbalance, or they could be non-specific.

[55] There was no dispute that there was a need for careful monitoring of patients receiving Gentamicin.

[56] Dr. North said that there was a need to be able to stop the administration of Gentamicin promptly if there was a manifestation of symptoms of ototoxicity and that everyone (doctors and patient) needed to be vigilant.

[57] The case of *Elofson v. Davis* (1997). 144 D.LR. (4th) 143, (Alberta Court of Queen's Bench) (cited by Jenkins J. In *McGeoch v. Arciszewski*, [1999] O. J. No. 4148) dealt with a case in which a general practitioner in a rural area prescribed Gentamicin to a patient who had a urinary tract infection. At page 151 of the decision (paragraph 31) Binder J. said:

> **31 Gentamicin, being toxic, had two side effects, one causing potential damage to the kidneys (nephrotoxicity), and the other ausing potential damage (ototoxicity) to the balance apparatus or fuction (vestibular) originating in the inner ear.**
>
> **32 It therefore is important when administering Gentamicin to a patient, to:**
> **(a) clinically be aware and on the lookout for any visual signs of Gentamicin impairment, such as dizziness, difficulty in walking, imbalance, hearing, ringing in the ears (tinnitus) fluttering or to-and-frow oscillation of the eyese (nystagmus); and**
> **(b) monitor kidney function to ensure tha the kidneys areperforming sufficiently to filter and excrete the Gentamicin into the bladder so that it can in turn be ecreted or passed out of the body, before it causes any damage or harm to the kidneys, or the balancing function, or apparatus, originating in the inner ear (the "Balance System").**

[58] In *ter Neuzen V. Korn* (1995), 127 D.L.R. (4th) 577, S.C.C. at para. 33 the Supreme Court of Canada said:

> **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. In the case of a specialist, such as a gynaecologist and obstetrician, the doctor's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field. A specialist, such as the respondent who holds himself out as possessing a special degree of skill and knowledge, must exercise the degree of skill of an average specialist in his field.**

[59] Here Dr. Marsh, an Otolaryngologist who had been practising in this area of medicine since 1985, was aware of the necessity of ongoing monitoring regaining kidney function but did not monitor appropriately for ototoxicity. By not monitoring appropriate for ototoxicity and by not emphasizing to Mr. Van Dyke the necessity for ongoing vigilance In regard to the symptoms of ototoxicity Dr. Marsh fell below the acceptable standard of care.

[60] Given that Dr. Marsh was the physician actually treating Mr. Van Dyke, while Dr. Ostrander was called in only to consult on the antibiotic regime, I find that only Dr. Marsh, not Dr. Ostrander, was negligent in falling to property monitor Mr. Van Dyke for symptoms of ototoxicity.

[61] I accept Mr. and Mrs. Van Dyke's evidence that Mr, Van Dyke first started experiencing symptoms on June 30. 1985. Mr. Van Dyke was very specific in recalling that his feelings of dizziness and imbalance started while he and his wife were at swimming lessons with their children the Friday of the July 1 holiday weekend.

[62] Mr. Van Dyke testified that he was walking with his younger daughter Kristen on the pier by the swimming lessons, when he started to "wobble". He described the sensation like being drunk. He says that he told his wife right away, that she called Dr. Tucker only to reach an answering machine which said Dr. Tucker was out of the office until Monday.

[63] Had Mr. and Mrs. Van Dyke been aware of the necessity of reporting these symptoms right away so that the discontinuation of Gentamicin could be considered, I find that they would have done so.

[64] Dr. Marsh testified that he was away from his office for the July long weekend in 1995. He testified though that he had left a phone number where he could be reached with Dr. Tucker. As well, Dr. Marsh testified that Mr. and Mrs. Van Dyke could have reached a nurse at the VON. Given that Mr. Van Dyke had been on Gentamicin for almost a month at this time, it would have been preferable for Dr. Mash to have left a phone number with Mr. and Mrs. Van Dyke, however, I accept that if Mr. and Mrs. Van Dyke had been aware of the necessity to call someone right away, they would have and could have called the VON. However, based on the evidence, I am satisfied that they were not aware of the importance of the symptoms Mr. Van Dyke was experiencing.

[65] In conclusion I find that that Dr. Marsh's behaviour in this regard was a breach of the standard of care. This beach of the standard of care caused Mr. Van Dyke's injury and Mr. Van Dyke has suffered damages as a result

DAMAGES

NON-PECUNIARY GENERAL DAMAGES

[66] The Supreme Court of Canada, in the cases known as the trilogy, namely, *Andrews v. Grand & Toy Alberta Ltd.,* [1978] 2 S.C.R. 229, *Arnold v. Tono*, [1978] 2 S.C.R. 287 and *Thomson v. Prince George School District No. 57*, [1978] 2 S.C.R. 267 has set the cap on non-pecuniary damages at $100,000.00 which, according to the Plaintiff's expert, Mr. Segal, Is $290,000.00 in today's dollars.

[67] Mr. Van Dyke suffered a bilateral vestibular loss and his life has been altered as a result He suffers from dizziness, headaches, and blurred vision and has difficulty walking in the snow or on uneven ground. He is unable to drive. As a result of these limitations he is not able to work at the job he had when he first became iII. As well, it is my belief from the evidence, that he is unemployable. He is not suited by education nor physical ability to perform any work for remuneration.

[68] It was clear from the evidence given by Mr. Van Dyke at trial that his job was very important to him. Mr. Van Dyke left school in grade 11 and joined the workforce at that time. He has been consistently employed since that time, except when he was recuperating from a motor vehicle accident in 1979 and a knee injury in 1985. In 1995 he was employed at Beaver Lumber in Owen Sound as a shipper/receiver where he had been since 1987. His employer testified that he was an excellent employee.

[69] He was also actively involved with Ms. family. He played pick-up hockey in the winter, baseball and soccer with his children in the summer and went snowmobiling, tobogganing and skating with his children.

[70] Prior to suffering bilateral vestibular loss Mr. Van Dyke was able to work and lead a full and active life. He is no longer able to participate in the activities that meant so much to him prior to the injury.

[71] I assess general damages for Mr. Van Dyke at $100,000.00. His quality of life has been greatly affected and will continue to be so affected in the future.

[72] The Plaintiffs seek $35,000.00 to $50,000.00 for Dorothy Van Dyke's *Family Law Act* claim. The Defendants take the position that any *Family Law Act* claim is minimal.

[73] Dorothy Van Dyke's life has changed significantly as well. As a result of Mr. Van Dyke's injury and his inability to drive, it became her responsibility to take the children to all of their activities. She must also monitor her husband's activities. It is now up to her to make sure that the family is running smoothly,

[74] On the other hand, Mr. and Mrs. Van Dyke continue to have a strong relationship between themselves and with their children. As well, once this lawsuit is finished some of the stressors on Mrs. Van Dyke will be eliminated. For example, Mr. Van Dyke will have funds available to him to obtain transportation independent of his wife. She will not have to be his primary source of transportation.

[75] Dorothy Van Dyke's *Family Law Act* claim is valued at $20,000.00.

PECUNIARY LOSS

Part and Future Low of Income

[76] The Plaintiff's position is that Mr. Van Dyke is unable to perform the duties of his previous employment with Beaver Lumber.

[77] Dr. Neville Doxey, a psychologist, conducted a psycho-vocational assessment of Mr. Van Dyke. Dr. Doxey testified that Mr. Van Dyke's total I.Q. score was 85, which is in the 16th percentile of the population. Dr. Doxey testified,

that Mr, Van Dyke's sole marketable asset would have been his ability to carry out physical work as opposed to his ability to perform clerical or professional-type work.

[78] Dr. Doxey testified that Mr. Van Dyke is competitively unemployable due to his inability, based on his test scores, to pursue physical, manual or clerical work. Even if Mr. Van Dyke has the capacity to perform a clerical job, he does not have the aptitude for this work.

[70] It was Dr. Doxey's opinion that Mr. Van Dyke would remain competitively unemployable for the rest of his life.

[80] Dr. Nedzelski testified on behalf of the Defendants. He is an Otolaryngologist at Sunnybrook and Women's College Health Science Centre. He is a professor and Chairman of the Department of Otolaryngologist. University of Toronto with a clinical and research interest related to the function of the inner ear.

[81] Dr. Nedzelski concluded that Mr. Van Dyke continues to have some peripheral vestibular function and made the following conclusions:

> **(a) Mr. Van Dyke's gait and Dr. Nedzelski's clinical findings, which were corroborated by Ms. Brown, suggest that Mr. Van Dyke continues to have <u>some peripheral vestibular function</u>;**

> **(b) It is Dr. Nedzelski's experience that adults who realize complete bilateral vestibular loss are much more handicapped than Mr. Van Dyke.**
>
> **(c) Mr. Van dyke would benefit from a formal vestibular rehabilitation program which could be done conjointly with a phased return to work over a four to six month period; and**
>
> **(d) he is confident that he, has a sense of what is and is not possible with regard to an individual's ability to work with bilateral peripheral loss and he was confident that Mr. Van Dyke is not completely disabled and that he could function in a structured environment where he will not be exposed to dangerous machinery, be required to climb ladders or be expected to drive an automobile such as a retail or desk-type job.**

[82] Dr. Nedzelski acknowledged, during cross-examination, that his opinion with respect to Mr. Van Dyke's employability was based only on the assessment of his balance, not his general aptitudes, I. Q. or skills.

[83] I accept that a person's employability is based on a number of factors, not solely physical ability to perform a certain function. There is no question that aptitude, I. Q. and skills are relevant. I therefore prefer the evidence of Dr. Doxey and find that Mr. Van Dyke is unemployable.

Part Loss of Income

[84] Murray Segal testified on behalf of the Plaintiffs and Professor James Pesando testified on behalf of the Defendants as to Mr. Van Dyke's past loss of

income. Both experts calculated Mr. Van Dyke's past loss of income to September 23, 2002 (the original trial date).

[85] Mr. Segal assumed the following annual salaries for Mr. Van Dyke.

(a) 1995 $26,520
(b) 1996 $27,075
(c) 1997 $27,629
(d) 1998 $28,184
(e) 1999 $28,808
(f) 2000 $29,744
(g) 2001 $30,517
(h) 2002 $30,975

[86] Mr. Segal calculated Mr. Van Dyke's past loss of income by adding together the amounts he would have lost and came up with a total of $207,815.

[87] Professor Pesando, on behalf of the Defendants, calculated the past loss of income to be $207,872.00. He found that Mr. Van Dyke's annual salaries, but for the Injury, would have been:

(a) 1998 $28,184
(b) 1999 $28,808
(c) 2000 $29,744

He therefore set the pre-injury earnings of Mr. Van Dyke equal to $30,923 per year in year 2002 dollars.

[88] Mr. Segal's calculations are based on the actual numbers supplied by Mr, Van Dyke's employers. I therefore accept the Plaintiffs' loss of income number as being $207,815.00 at September 23, 2002,

Future Lose of Income

[89] I accept that Mr. Van Dyke would still be employed at Beaver Lumber today but for his bilateral vestibular loss. The major difference between the calculations of Murray Segal and Professor Pesando is that Mr. Segal assumes that Mr. Van Dyke would have continued to work at Beaver Lumber until age 65, while Professor Pesando used the average retirement age of 62.

[90] Mr. Van Dyke testified, and I accept, that he would have worked until age 65, or longer if he was able. Beaver Lumber does not impose a mandatory retirement age and in fact, Mr. Van Dyke could have worked past 65 had he wanted to. I am satisfied that Mr. Van Dyke would have worked to age 65.

[91] Mr. Segal concluded that the present value of Mr. Van Dyke's future loss of income at September 23, 2002 was $506,408.00. He arrived at this conclusion by assuming that Mr. Van Dyke is subject to the average population mortality rates for males. He calculated the present values as of September 23, 2002 of annuities of $1,000 per year on the basis of those unadjusted average population mortality rates and various net rates of interest that could be used to compute the lump sum equivalents of Mr. Van Dyke's future loss of pre-

retirement income and of the reduction in his retirement pension from the Canada Pension Plan.

[92] Although Mr. Segal addressed the issue of the net rate of interest, to come to the calculation above, he applied the net rate of Interest at 2 ½ % per year. I see no reason to depart from the net rate of interest used in the *Rules of Civil Procedure*, I accept that I should follow the Ontario Court of Appeal In *Martin v. Listowel Memorial Hospital*, [2000] O. J. No. 4015 (CA) in that regard.

[93] I would ask Mr. Segal and Professor Pesando to recalculate the future wage loss for Mr, Van Dyke using 65 years as the retirement age and a discount rate of 2.5%.

[94] I will require submissions, including calculations, to determine the appropriate number at today's date.

[95] The Plaintiffs seek a further 5% to allow for the expenses of investment guidance and management I am not allowing any amount in this regard. I adopt Mr. Justice Quinn's view in *Dybongco-Rimando Estate v. Jackiewicz*, [2001] 0. J. No. 3826 at paragraph 72:

> **The plaintiffs seek a management fee. Professor Carr suggests such a fee (fixed at 5% of damages for future loss of dependency income) so as to enable Raul to hire an investment counsellor for advice on the management of his damages award. Professor Pesando does not regard an investment management fee as necessary. One reason he advances is that such a fee is likely to be self-financing. I agree. A professional financial advisor should be able to obtain a rate of return (net of his or her fee) that is higher than Raul would experience if he invested on his own, without professional help. Otherwise, how could such an advisor stay in business?**

FUTURE CARE EXPENSES

[96] Mr. Van Dyke's future care costs were assessed by Carol Bierbrier, an occupational therapist, on behalf of the Plaintiffs and by Sandra Veilone on behalf of the Defendants. In their written submissions, the Defendants produced a schedule comparing the future care costs advanced by both parties:

		Plaintiffs	Defendants
(1)	**Meds and Assistive Devices (Annual)**		
	Paxil (Annual)	$671.60	$ -
	Cell Phone	$292.56	$ -
	Cell Phone (Licensing)	$55.20	$ -
	Grab Rail	$2.55	$2.25
	Total Meds and Ass. Devices (Annual)	**$1,021.91**	**$2.25**
(2)	**Professional Services (Initial Outlay)**		
	Ind. Counselling	$5,625.00	$4,680.00
	Trans. to Counselling	$1,406.00	$520.00
	Family Counselling	$3,420.00	$2,160.00
	Trans. to Fam. Councelling	$342.00	$168.00
	Occupational Therapy	$2,795.00	$2,795.00
	Total Pro. Services (Initial Outlay)	**$13,588.00**	**$10,323.00**
(3)	**Insurance Replacement (Annual)**		
	Premiums	$540.00	$ -
	Total Ins. Replacement (Annual)	**$540.00**	$ -
(4)	**Transportation (Annual)**		
	Taxis	$16,380.00	$5,060.00
	Total Transportation (Annual)	**$16,380.00**	**$5060.00**
(5)	**Avocational (Annual)**		
	Hobby Farm Costs	$2,000.00	$ -
	Total Avocational (Annual)	**$2,000.00**	$ -

(6)	**Housekeeping (Annual)**		
	Handyman	$1,250.00	$1,250.00
	Snow Removal	$180.00	$180.00
	Total Housekeeping (Annual)	**$1,430.00**	**$1,430.00**
(7)	**Vestibular Rehab (Initial Outlay)**		
	Travel and Lunch Costs	$ -	$1,820.00
	Total Vestibular Rehab (Initial Outlay)	**$ -**	**$1,820.00**
(8)	**Safety (Initial Outlay)**		
	Emergency Lighting	$ -	$5,750.00
	Total Safety (Initial Outlay)	**$ -**	**$5,750.00**
(9)	**Vocational Rehab (Initial Outlay)**		
	Vocational Counselling	$ -	$4,000.00
	Work Adjustment Training	$ -	$4,000.00
	Wage Subsidy for 8 Weeks	$ -	$4,000.00
	Total Vocational Rehab (Initial Outlay)	**$ -**	**$12,000.00**
	TOTAL ANNUAL COSTS	**$21,371.91**	**$6,492.55**
	TOTAL INITIAL OUTLAY	**$13,583.00**	**$29,893.00**

[97] I will deal with each item in the order set out above.

(1) Medications and Assistive Devices:

(a) Paxil: The only evidence to support Mr. Van Dyke's use of Paxil was his own testimony, which In this Instance Is not sufficient There was no medical evidence to support the use of Paxil or to indicate the dosage and the assertion that he will require Paxil for the rest of his life. I am therefore not allowing this claim.

(b) Cell Phone: I accept that a cell phone is necessary so that Mr. Van Dyke can summons assistance if necessary.

(c) Grab Rail: Both parties agree that a grab rail Is appropriate and that the annual cost would be $2.55.

(2) Professional Services:

(a) Individual Counselling: Everyone agrees that individual counselling would be beneficial to Mr. Van Dyke. The difference between the figures advanced by Ms. Bierbrier and those advanced by Ms. Veilone tie In the number of proposed visits. Ms. Bierbrier proposed 31.25 visits, while Ms. Veilone proposed 26. The number of visits and the cost put forward on behalf of the Plaintiffs is reasonable and I will allow $5,625.00 in this regard.

(b) Transportation to Counselling: Both parties agree with respect to the round trip cost of taxi fare. The difference between the experts relates solely to the total number of visits and a deduction to take Into account the fact that if Mr. Van Dyke Is working, he will already be In town for the appointment. I do not accept that Mr. Van Dyke will be working so I am allowing the amount shown by Ms. Bierbrier which is $1,406.00.

(c) Family Counselling: Both sides agree that family counselling would be helpful to Mr. Van Dyke. Again the parties disagree on the number of visits necessary. Ms. Bierbrier bases her calculation on averaging 12 to 26 sessions over the couple's lifetime and uses the median number of 19. Ms, Veilone suggests that a total of 12 session to reasonable. I agree with Ms. Veilone and accept the Defendants' submission that this Is appropriate because Mr. and Mrs. Van Dyke already participate in a discussion group at their local church and Mr. Van Dyke would be attending individual counselling sessions as well. I allow $2,160.00 for this Item.

(d) Transportation to Family counselling: Given that I have allowed 12 visits and the transportation cost per visit Is $18.00 per visit, I am allowing $168.00.

(3) Insurance Replacement:

As t have already found that Mr. Van Dyke will not return to employment, I am allowing this item in the amount of $540.00 annually.

(4) Transportation:

The Defendants accept that Mr. Van Dyke can no longer legally drive. Ms. Bierbrier, on behalf of the Plaintiffs, suggested that it is reasonable for Mr. Van Dyke to receive a taxi allowance, worth $45.00 per day for 365 days per year, to allow for independent access to Owen Sound for shopping, socializing, vocational and avocational activities. She calculates the annual cost as $16,380.00. I accept the submission that Mr. Van Dyke should have $45.00 per day available to him as a taxi allowance. While he might not travel into Owen Sound every day, on some days he might go more than once.

However, I accept the Defendants' submission that as Mr. Van Dyke no longer owns and operates a vehicle the cost he would have incurred but for the incident, should be deducted. I accept the Defendants' submission that for Mr Van Dyke to drive 40 kilometres (to and from Owen Sound) 365 days per year equals 14,600 kilometres per year. Using the CAA statistics, the annual cost for Mr. Van Dyke would have been $8,000,00, which should be deducted from the $16,380.00 for a total of $8,380.00 annual cost I do not accept the Defendants' submission that I should deduct further amounts because of the reduced usage of Mrs. Van Dyke's vehicle. I find as well, that these trips to Owen Sound would be in addition to those required for counselling.

(5) Avocational:

I accept the Defendants' submission that there was no admissible evidence before the court with respect to the costs associated with the operation of the Van Dyke's hobby farm. No receipts were presented nor was there any viva voce evidence about the annual cost to operate the hobby farm.

(6) Housekeeping:

The parties agree that home maintenance is appropriate in the amount of $1,430.00 per year.

(7) Vestibular Rehabilitation:

I accept that vestibular rehabilitation Is appropriate and that the Initial cash outlay would be $1,820,00

(8) Emergency Lighting:

I accept that emergency lighting is appropriate and that the initial cash outlay would be $5750.00.

(9) Vocational Rehabilitation:

I do not accept that this is appropriate as ft Is not my view that vocational rehabilitation would be of assistance to Mr. Van Dyke.

[98] I summarize my findings as follows:

(1)	**Meds and Assistive Devices (Annual)**	
	Paxil (Annual)	
	Cell Phone	$292.56
	Cell Phone Licensing	
	Grab Rail	$2.55
	Total Meds and Ass. Devices (Annual)	**$295.11**
(2)	**Professional Services (Initial Outlay)**	
	Ind. Counselling	$5,625.00
	Trans. to Counselling	$1,406.00
	Family Counselling	$2160.00
	Trans. to Fam. Counselling.	$168.00
	Occupational Therapy	$2,795.00
	Total Pro. Services (Initial Outlay)	**$12,154.00**

(3)	**Insurance Replacement (Annual)**	
	Premiums	$540.00
	Total Ins. Replacement (Annual)	**$540.00**
(4)	**Transportation (Annual)**	
	Taxis	$8,380.00
	Total Transportation (Annual)	**$8,380.00**
(5)	**Avocational (Annual)**	
	Hobby Farm Costs	
	Total Avocational (Annual)	
(6)	**Housekeeping (Annual)**	
	Handyman	$1,250.00
	Snow Removal	$180.00
	Total Housekeeping (Annual)	**$1,430.00**
(7)	**Vestibular Rehab (Initial Outlay)**	
	Travel and Lunch Costs	$1,820.00
	Total Vestibular Rehab (Initial Outlay)	**$1,820.00**
(8)	**Safety (Initial Outlay)**	
	Emergency Lighting	$5,750.00
	Total Safety (Initial Outlay)	**$5,750.00**
(9)	**Vocational Rehab (Initial Outlay)**	
	Vocational Counselling	
	Work Adjustment Training	
	Wage Subsidy for 8 Weeks	
	Total Vocational Rehab (Initial Outlay)	
	Total Annual Costs	**$10,645.11**
	Total Initial Outlay	**$19,724.00**

PRESENT VALUE CALCULATIONS FOR FUTURE CARE COSTS

[99] Based on my award I invite the parties' experts to calculate the appropriate present value of the future care costs and the appropriate gross-up.

[100] OHIP: The parties have agreed that OHIP's subrogated interest totals $3,881.86.

TOTAL DAMAGES:

[101] I will reserve my findings on the total damages until I have received further Information from Mr. Segal and Professor Pesando.

COSTS:

[102] I will entertain brief (no more than six pages each, exclusive of Bills of Costs) written submissions as to costs. The Plaintiffs' submissions should be submitted within 30 days, the Defendants' (including the VON) within 45 days and any reply within 60 days of today's date.

[103] I am indebted to counsel for their assistance in this difficult matter. I am particularly grateful to the counsel for the Defendants for providing their submissions on disk from which I was able to produce the damages chart which is replicated herein.

VAN MELLE, J.

Released: July 16, 2003

COURT FILE NO.: O.S.1167/00
DATE: July 16. 2003

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

EDWARD VAN DYKE and DOROTHY VANDYKE

Plaintiffs

- and -

THE GREY BRUCE REGIONAL HEALTH CENTRE, ALEXANDER MARSH, J. OSTRANDER et al.

Defendants

REASONS FOR JUDGMENT

VAN MELLE. J.

Released: July 16, 2003