

THE DUTY TO DIAGNOSE

By Bill McNally and Barb Cotton

When you are acting as plaintiff's counsel in a medical malpractice case, one of the grounds of liability you may want to investigate is a possible breach of the duty to diagnose, and the companion duty to refer, by the attending physician(s). The legal principles governing these duties are now well defined, and seemingly cast a broad net for potential liability.

The seminal text establishing the principles governing medical malpractice is that of Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors in Hospitals in Canada*¹ ("Picard"). This text is cited in numerous cases, primarily in its second edition.

Picard states in the third edition under the heading of "The Duty to Diagnose":²

"Having undertaken the care of a patient, a doctor is under a duty to make a diagnosis, and to advise the patient of it. If a doctor cannot come to a diagnosis, he or she has a duty to refer the patient to others who can. The duty to diagnose is not as onerous as it might seem. A doctor is not expected to be infallible, only to exercise reasonable care, skill and judgment in coming to a diagnosis. If this is done, the doctor will not be held liable even if the diagnosis is mistaken.

This is an area where the distinction between negligence and error of judgment ... is especially important. A mistaken diagnosis is not necessarily a negligent one, because despite the error, the doctor may have met the required standard of care. Perhaps the best statement of this appears in an English authority:³

"[N]o human being is infallible; and in the present state of science even the most eminent specialist may be at fault in detecting the true nature of a diseased condition. A practitioner can only be held liable in this respect if his diagnosis is so palpably wrong as to prove negligence, that is to say, if his mistake is of such a nature as to imply an absence of reasonable skill and care on his part, regard being had to the ordinary level of skill in the profession."

...

While it may be possible to identify some of the steps to be taken in exercising reasonable care and skill, determining whether a misdiagnosis is the result of breach of the standard or only an error of judgment is not easy. The difficulty flows from the important role played by medical judgment. As one Court put it, “Diagnosis is, above all, an exercise of the physician’s judgment based on his training, experience and, perhaps, intuition. . . .”

And further:⁴

“A doctor’s role in diagnosis cannot be just a passive one. Within reason, if appropriate tests are indicated they should be carried out and their results carefully reviewed, and if certain symptoms could be critical they should be canvassed.”

And further:⁵

“In summary, the duty to diagnose requires doctors to take a full history, use appropriate tests and consult or refer if necessary. They must take reasonable care to detect signs and symptoms and formulate a diagnosis using good judgment. They cannot act only on what they are told, nor ignore what they are told. Sophisticated tests and continuing knowledge of disease must be employed when appropriate. A doctor’s skill and judgment must be in step with that of colleagues but need not be in advance of theirs, and if this standard of care is not met in the particular circumstances the doctor will not be liable to a patient injured by a misdiagnosis. As with all errors of clinical judgment, a misdiagnosis is not necessarily negligent.”

And further under the heading of “The Duty to Refer” Picard states:⁶

“Recognizing that no person is infallible or the fountain of all knowledge and skill, the Supreme Court of Canada has said there is a duty upon a doctor in some circumstances to refer a patient to another doctor. The term “refer” may mean either that the doctor confer with a colleague and then carry on treatment personally, or that the patient is passed completely into the care of another doctor.

There is no absolute test to ascertain when a doctor should refer or consult, but the cases suggest that it is indicated when:

1. the doctor is unable to diagnose the patient’s condition;
2. the patient is not responding to the treatment being given;

3. the patient needs treatment which the doctor is not competent to give;
4. the doctor has a duty to guard against his or her own experience (e.g., the student doctor); or
5. the doctor could not continue to treat a patient (e.g., while on vacation).”

And further:⁷

“Referring doctors have the duty to take reasonable steps to ensure that all significant information in their possession, including their own findings, opinion and diagnosis (if any), is brought to the attention of the other doctor or facility ...”

The Alberta case of *Webb v. Motta*,⁸ a decision of Sullivan J. of the Alberta Court of Queen’s Bench, is illustrative of a case in which Picard is applied extensively. This case involved the negligent delivery of a baby in that the caecum was perforated during an emergency cesarean section. The perforation was not noticed by the obstetrician, leading to over fourteen further surgeries on the patient before discharge. For more than one year following the surgeries, the patient was unable to care for her child or do any of the physical activities she had done in the past.

In assessing whether the doctor was negligent Sullivan J. quoted extensively from Picard’s second edition.

In the result the doctor was held to be negligent for failure in his duty to diagnose and to utilize available aids in establishing a diagnosis.

The recent case of *Williams (Litigation Guardian of) v. Bowler*,⁹ a decision of G. Roccamo J. of the Ontario Superior Court of Justice dated August 4, 2005, is of much assistance in that it extensively reviews the governing principles. (Roccamo wrote the text *Medicine in the Litigation Process*.¹⁰)

In this case the plaintiff suffered serious brain damage caused by a ruptured aneurysm. Her family members and former spouse claimed damages against the family doctor, Dr. Bowler, for failing to consider a leaking aneurysm among the possible explanations for her condition in time to avert the subsequent rupture – thus for breach of the duty to diagnose.

Vicky Williams was a patient with a longstanding history of headaches and abdominal pain, for which she had surgery twice. Her care was complicated by chronic anxiety, psycho-social problems and prescription drug abuse. Her repeated attendances at hospital emergency departments and to Dr. Bowler's office for multiple complaints and seeking medications for pain control “. . . would have tested the intellectual stamina and diplomacy of any physician in properly evaluating and setting forth a controlled treatment program”.¹¹

One of the main submissions of the defence was that because the plaintiff was such a difficult patient the family doctor should be exonerated for his failure to diagnose.

The plaintiff's response to this defence submission was that, given the difficulties presented by this patient, the family doctor should have referred out to a specialist for consultation, which he did not do.

On March 16, 1993, Vicky Williams presented at Dr. Bowler's office complaining of headaches after hitting her head on a cement pillar in a barroom brawl the previous week. Dr. Bowler did not order an assessment but merely diagnosed post-traumatic headaches and prescribed a mild analgesic for pain relief. Ms. Williams then attended at the Trenton Memorial Hospital complaining of more severe headaches and nausea, vomiting and blurry vision and with a “wild-looking” presentation which was atypical of her usual neatly groomed appearance. She was admitted by Dr. Bowler to the hospital for assessment and treatment of intractable migraines and apparent dehydration. While in the hospital, he followed her case on a daily basis.

Due to the persistence of her headaches and fever and a questionable finding of neck stiffness, a symptom potentially indicative of an inflammatory process causing irritation to the meninges of the brain, Dr. Bowler elected to carry out a lumbar puncture on March 25, 1993 to assist in his

diagnosis. Following the puncture he observed the cerebral spinal fluid (CSF) to be slightly yellowish, a finding associated with a breakdown of red blood cells in the CSF, in contrast to its normally crystal clear appearance. Subsequent laboratory analysis determined the presence of red blood cells in the CSF, a finding which is diagnostic of subarachnoid hemorrhage (SAH).

It was accepted that the most frequent cause of SAH was head trauma in seventy percent of the cases. However, in almost thirty percent of cases, blood found in the subarachnoid space was caused by spontaneous and life-threatening conditions, the most frequent of which was due to a leaking or ruptured aneurysm. A small percentage of cases of spontaneous SAH could also be due to arteriovenous malformation, which was another life-threatening condition.

After further discussions with Vicky Williams on March 25, 1993, Dr. Bowler ascribed her complaints to viral meningitis, and attributed the presence of the red blood cells in the CSF to the head injury she had sustained in the barroom brawl.

At the date of her discharge from Trenton Memorial Hospital on March 31, 1993, Vicky Williams was observed to be somewhat improved. She was seen by Dr. Bowler on three further occasions subsequent to discharge.

On April 19, 1993, at the age of 39, Vicky Williams suffered a major subarachnoid hemorrhage due to a rupture of a berry aneurysm on the middle cerebral artery, which resulted in serious injury to the brain.

The heart of the plaintiff's claim was that Dr. Bowler did not meet the standard of care in that he was obliged to include in his differential diagnosis of Vicky Williams a spontaneous subarachnoid hemorrhage due to an aneurysm once he found the red blood cells in the CSF following the lumbar puncture. Further, such a finding mandated a referral of Vicky Williams to a tertiary centre for neurological assessment and treatment in order to rule out potentially life-threatening causes of the hemorrhage, which Dr. Bowler failed to do. The plaintiff submitted that, had such a referral been made, the aneurysm would have been detected and surgically treated in order to avert the catastrophic brain injury.

In defence it was argued that there was merely an unfortunate error in clinical judgment by Dr. Bowler in interpreting the results of the lumbar puncture as consistent with the traumatic head injury and in electing not to refer her for neurological assessment. Further, “. . . in assessing whether Dr. Bowler met the standard of care, it is necessary to consider the context of the entire clinical situation: that Vicky Williams was a diagnostic challenge in the very best of hands given her lengthy history of multiple medical problems, including chronic headaches”.¹²

Roccamo J. reviewed the governing legal principles extensively in his decision, the main principles of which can be summarized as follows:

- Every medical practitioner must bring to the task the reasonable degree of care and skill of a normal prudent practitioner of the same experience. To succeed in an action for medical negligence, the onus is on the plaintiff to show that the defendant has breached the standard of care of a reasonable and prudent physician of the same experience and standing having regard to all of the circumstances of the case:

“The legal principles involved are plain enough but it is not always easy to apply them to particular circumstances. Every medical practitioner must bring to his task a reasonable degree of care. He is bound to exercise that degree of care and skill which could reasonably be expected of a normal prudent practitioner of the same experience and standing, and if he holds himself out as a specialist, a higher degree of skill is required of him than of one who does not profess to be so qualified by special training and ability.

*Crits v. Sylvester*¹³

*ter Neuzen v. Korn*¹⁴

- The specific facts of each case are an essential component for the determination of liability. The standard of care must be determined having regard to the particular circumstances of each case.

- In assessing if the standard of care has been met and in analyzing the evidence before it, the Court may, in the exercise of its discretion, accept and prefer the evidence of the treating doctor's interpretation of his or her own notes to the interpretation of an expert.
- If the physician's care is supported by competent professional opinion, the approved practice will not in all instances be shielded, particularly if the common practice is clearly negligent. Professor Fleming observed in *The Law of Torts*¹⁵ that conformity of general practice usually dispels a charge of negligence, but then he added:¹⁶

“All the same, even a common practice may itself be condemned as negligent if fraught with obvious risks . . .”

Along similar lines, Sopinka J. in *ter Neuzen* stated that:

“It is evident from the foregoing passage that while conformity with common practice will generally exonerate physicians of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be where the standard practice is “fraught with obvious risk” such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical experience.”¹⁷

- Ultimately, the applicable standard of care is determined by the trier of fact having regard for all of the expert testimony.
- The conduct of a physician must be judged in light of the knowledge that should have been reasonably within his/her possession at the time. A physician cannot be judged in hindsight.
- The avoidance of retrospective analysis is especially important in cases of medical negligence.

- It has long been recognized that a physician's honest and intelligent exercise of judgment will satisfy the standard of care. The Supreme Court of Canada has recently held:

“What must be asked is whether that act or omission would be acceptable behavior for a reasonably prudent and diligent professional in the same circumstances. The erroneous approach runs the risk of focusing on the result rather than the means. Professionals have an obligation of means, not an obligation of result.”

*St-Jean v. Mercier*¹⁸

- It is trite law that medical professionals could not be held liable for mere errors of judgment, which are distinguishable from professional fault. An error in judgment does not amount to negligence where the physician appropriately exercises critical judgment.
- Whether or not the physician was negligent or simply exercising error in judgment will be determined on a case by case basis having regard to the particular facts in each case.
- While it is now trite law to observe that an honest and intelligent albeit erroneous exercise of judgment will not result in a finding of negligence, the converse may be true:

“. . . The mere fact that the doctor's error involves the exercise of judgment does not necessarily shield the doctor from liability. If the error is one which a reasonable doctor would not have made in similar circumstances, liability will be imposed. An error of judgment is not necessarily negligence, but it may be, depending upon the circumstances.

E.I. Picard and G.B. Robertson, *Legal Liability of Doctors and Hospitals in Canada*¹⁹

- In exercising sufficient care and skill in making a diagnosis, the physician should avail him or herself of available resources, including up-to-date texts, articles and works in that particular field. This is especially important where a doctor makes a differential diagnosis. There is an absolute need for the physician to ensure that sufficient tests and detailed investigations have been conducted before ruling out one disease over another.

*Hughes v. Cooper Estate*²⁰

*Bergen Estate v. Sturgeon General Hospital District No. 100*²¹

- In the seminal Ontario case of *Wade v. Nayernouri*²² it was stated:

“In my opinion the cases have established that an erroneous diagnosis does not alone determine the physician’s liability. If the physician, as an aid to diagnosis, does not avail himself of the scientific means and facilities open to him for the collection of the best factual data upon which to arrive at his diagnosis, does not accurately obtain the patient’s history, does not avail himself in this particular case of the need for referral to a neurologist, does not perform the stiff-neck test and the lumbar punctive test, the net result is not an error in judgment but constitutes negligence.”

- In circumstances where the patient’s condition is potentially life-threatening, a short delay of only a few hours in consulting or referring to a specialist has been found to constitute negligence.
- A finding of negligence may result in circumstances where a physician falls prey to “tunnel vision” and continually adheres to an incorrect diagnosis, particularly in the case of new signs or symptoms consistent with a life-threatening condition.

*Bergen Estate v. Sturgeon General Hospital District No. 100*²³

- Where treatment records demonstrated that a physician was confused about a diagnosis and did not come to a decisive diagnosis that accounted for all of the plaintiff’s symptoms, a doctor who adhered to an incorrect diagnosis was found to depart from the requisite standard of care.

- Failure to consider alternate diagnoses in a timely fashion before summoning expert help may well amount to negligence in circumstances where the consequences to the patient from misdiagnosis were enormous.
- Even where a family physician diagnoses his patient with a condition with respect to which he has provided treatment in the past, and where there is initial improvement, a court may find a doctor negligent in failing to reconsider the initial diagnosis.
- Even where an initial diagnosis is found to be reasonable, the fact that a patient does not improve as expected has been found to require reconsideration of a diagnosis and consultation with a specialist.
- While the decisions made by a doctor in the diagnosis and treatment of the patient may, when considered in isolation from others, not amount to negligence, cumulatively they may reflect a want of skill such as to fall below a reasonable standard of care.
- In dealing with a potentially life-threatening condition, a higher standard is imposed on the physician to take appropriate care in diagnosing and treating the patient. The degree of care required in law is commensurate with the potential danger to the patient.

When coming to his conclusions Roccamo J. commenced by noting that Dr. Bowler had “... remained vigilant to his patient’s needs and did not dismiss Vicky Williams’ complaints as those of a drug-seeker”.²⁴

Roccamo J. then found that Dr. Bowler had met and “arguably exceeded” the standard of care up to his performance of the lumbar puncture on March 25, 1993.

He then stated:

“6) Dr. Bowler failed to consult the medical literature upon receiving the results of the lumbar puncture, nor took steps to consult any colleagues to review his subsequent course of action, notwithstanding the emphasis in his testimony and

that of all experts as to the complexity of Vicky Williams' history and the challenge she presented as a patient.”²⁵

And further:

“9) Following the lumbar punctures, Dr. Bowler's further investigation by a skull X-ray and brain scan did not confirm a traumatic SAH, nor rule out a spontaneous SAH.”²⁶

And further:

“15) On April 12, 1993, Dr. Bowler continued to question the diagnosis of post-traumatic headache and also questioned as well the possibility of vascular headaches. He admitted also thinking of other possibilities including vascular anomaly or aneurysm. He considered the complaint of blurred vision coupled with persistent headache cause enough to question a more sinister diagnosis such as aneurysm. He was not aware that she had made previous and similar complaints because, following the lumbar puncture, he failed to reconsider all relevant information including the nurses' notes throughout the hospital admission.

16) Despite his indecision, at no time did Dr. Bowler reconsider his preferred diagnosis of traumatic SAH. He therefore failed to explore the possibility that the SAH was spontaneous and due to aneurysm or arteriovenous malformation; he failed to associate Ms. Williams' complaints with a sentinel bleed which closed his mind to the potential risk of re-bleed of the aneurysm. He regrettably took comfort in the modest improvement in Ms. Williams' headaches, and the disappearance of her fever.”²⁷

Roccamo J. therefore concluded:

“In summary, these findings speak against any reasonably held belief or confidence in Dr. Bowler's preferred diagnosis of traumatic SAH. Taken alone, each lapse, error or omission on the part of Dr. Bowler may not constitute negligence, but rolled together the errors in judgment cumulatively amount to actionable negligence: . . .”²⁸

Adair (Litigation Administrator of) v. Hamilton Health Sciences Corp,²⁹ a decision of C.R. Harris J. of the Ontario Superior Court of Justice, is another recent decision³⁰ which discusses a “differential diagnosis” in more detail. C.R. Harris J. commenced by noting the definition of differential diagnosis as follows:

“The process of differential diagnosis, wherein possible medical perils are listed and eliminated by order of severity, is a universally accepted standard within the medical profession.”³¹

In this case the doctors and hospitals were sued for medical malpractice for failure to diagnose a small bowel obstruction. Later on in the judgment C.R. Harris J. expanded:³²

“. . . Differential diagnosis is the system of determining which of two or more diseases with similar symptoms is the one that a patient is suffering from, through a systematic comparison and contrast of the clinical findings. All experts at trial agree that this is the proper method of arriving at a diagnosis, leading to the conclusion that it is a universally accepted rule of medicine. Dr. Goldberg expanded on this definition by explaining that after the physician has identified the likely perils, those possible perils must be listed from the most serious to the least serious. The physician eliminates the peril that has the most severe consequences first. He summed this idea up in his expert testimony by asserting the simple maxim “worst first”.”

In this case the doctors were held to have failed to meet their standard of care in that they did not follow the systematic process of differential diagnosis:³³

“. . . Critically, several doctors prefer to deal with the most likely cause, rather than the most serious. The worst possible ailment was not eliminated from the list of differential alternatives first. The form of diagnosis used by the defendants remained focused on probability, whereas a proper differential diagnosis must also be informed by considerations of severity.”

It was held that the primary doctor had treated Mrs. Adair for constipation at first instance because it seemed the most likely cause of her difficulties. Then he felt that an ileus was more probable than an obstruction to her bowel, and disregarded the far more serious possibility of the obstruction.

C.R. Harris J. stated:³⁴

“A proper differential diagnosis that gave the most serious potential problem the priority it deserved would have saved valuable time and led to a proper treatment of Mrs. Adair’s condition. Failing to follow the process of differential diagnosis was a factor outside the *de minimus* range that materially contributed to the chain of causation that caused Mrs. Adair’s death.”

The leading Alberta case on the duty to diagnose is the seminal decision of *Bergen Estate v. Sturgeon General Hospital District No. 100*,³⁵ a decision of Hope J. of the Alberta Court of Queen’s Bench. In this case the patient died and her estate sued the defendant hospital, the nurses and the doctors for negligence. It was held that the hospital was a modern, well-equipped hospital notwithstanding that it was in a rural setting. The patient died of appendicitis, but the doctors had diagnosed her with PID, pelvic inflammatory disease.

Hope J. gave some indications of what would provide a defence to the defendants, as follows:

- If they were required to make a snap decision because of the agony of the moment or a strict time constraint being forced upon them.
- If they were working in inadequate facilities or with below standard backup facilities.
- If it was an exotic or rare disease involved in the diagnosis, which made it very difficult to diagnose by reason of its rareness.

The decision then primarily found liability of the doctors for failure to “rule out” appendicitis, and thus inferentially to systematically apply a differential diagnosis. Hope J. stated:³⁶

“I would record at this point that the use of R.O. or the phrase “Rule Out” as used throughout the evidence is an expression to the effect that a disease or affliction – in this case appendicitis; is indicated or strongly suspected and that further

examinations, tests and observations must be carried out in order to negative that suspected diagnosis.”

One doctor was held liable for failure to ignore the signs that the patient was not improving, notwithstanding the course of treatment that he had prescribed (a frequent administration of Demerol). Other indicia of liability of the doctors were:

- They failed to order stool cultures or vaginal swabs or other steps whereby the type of bacterial infection might have been determined.
- They failed to give priority to rule out the life-threatening diagnosis.
- They failed to give adequate consideration to new developments such as “scant oozing on vaginal pain pad”, “increased need of the pain killer Demerol . . .”.
- They failed to move quickly and decisively by performing a laparotomy to prove or dispel the diagnosis of the life-threatening appendicitis.
- They failed to utilize all of the facilities readily available at the hospital.
- They failed to note that there was not a “marked improvement” after 48 hours from their prescribed treatment.
- They gave little or no attention to the nurses’ notes.

It was held that all of these amounted to more than an error of judgment.

Further, it was held that the doctors had developed “tunnel vision” and had zeroed in on a diagnosis to the exclusion of others. The physicians should have reassessed their patient constantly and always reassessed the diagnosis.

A more recent leading Alberta case on medical malpractice is *Lindahl Estate v. Olsen*,³⁷ a decision of Watson J. of the Alberta Court of Queen's Bench. In this case the estate of Lindahl sued Dr. Olsen, the family physician, and Dr. Hasinoff, another family physician, for negligence in failing to diagnose the colon cancer which led to his death.

Lindahl had a history of hemorrhoids, which caused bleeding, and which he suffered from chronically. When he attended at his family doctors they diagnosed him as suffering from these hemorrhoids, and did not refer him to specialists, which would have led to a diagnosis of colon cancer. It was held that Dr. Olsen, the primary family physician, was liable because he was too rapidly persuaded that Lindahl's symptoms were caused by the hemorrhoids without a proper basis. He should have referred Lindahl for further treating and testing, but discouraged him from doing so. His incomplete and inaccurate notes failed to give Dr. Hasinoff a full picture.

Much of the judgment deals with causation. Picard is cited for the governing principles regarding duty to diagnose and it is further stated that: "Doctors cannot be expected to be insurers of outcomes . . ." ³⁸

It is also noted that: "The contextual facts that influence a determination of the particular standard of care include the apparent degree of danger." ³⁹

Dr. Hasinoff was found not to have met the standard of care by failing to send Mr. Lindahl for a barium enema test but, as the colon cancer Mr. Lindahl was suffering from was very far advanced by the time of his failure, there was found not to be causation, and Dr. Hasinoff was therefore found not to be negligent.

Another leading Alberta case on medical negligence is *Castillo v. Go*,⁴⁰ a decision of Kent J. of the Alberta Court of Queen's Bench.⁴¹ The case has little in the way of new governing legal principles, however, and in the result it seems that the plaintiff's action was dismissed because the trial judge found him to be a malingerer.

A leading Ontario case establishing the governing legal principles on medical malpractice is *Lurtz v. Duchesne*,⁴² a decision of Lalonde J. of the Ontario Superior Court of Justice.⁴³ In this case Lurtz was a 43 year old woman who was employed as a sales representative and in good health. Duchesne became Lurtz's family physician in 1989. She was a general practitioner. Duchesne treated Lurtz properly until September 22, 1993. On that date Lurtz's dentist informed her that her jaw had grown. He instructed her to inform her family physician so that she could conduct the appropriate tests. Lurtz met with Duchesne the same day, who thought that she might suffer from acromegaly. This is a chronic and debilitating disease caused by an excessive amount of growth hormone produced by a benign pituitary adenoma. The treatment is surgery to remove the adenoma. There is a greater chance of recovery if the tumor is less than one centimeter in diameter when it is removed.

Duchesne did not physically examine Lurtz. She did address external symptoms of the disease. She also did not conduct all the proper tests to diagnose acromegaly. She did not follow up with the dentist on the issue of jaw growth. She ruled out the presence of acromegaly.

Between 1994 and 1997 Lurtz was referred to many specialists for a variety of complaints. These included sharp pains in her head, acute right-sided headaches, difficulty in concentrating and light-headedness. She had joint pain and her muscles were weak. Duchesne ascribed all these problems to anxiety. She did not consider that there was an organic reason for the anxiety.

In May 1993 an ophthalmologist referred Lurtz to an internist who specialized in endocrinology after he noted her swelling eyelids. Hierlihy did not examine Lurtz thoroughly and did not take a careful history of her complaints. She therefore did not determine the cause of the complaints.

In April 1995 Lurtz went on long-term disability with her employer's group insurance plan, and was on disability until October 1997. Following this her employment was terminated in May of 1998. She gave birth to a son in April 1998, but was unable to care for him.

She was diagnosed with acromegaly in November 1998 and had surgery in February 1999 to remove the tumor. Her chronic headaches disappeared and the body swelling subsided, but she

was left with hard tissue which was irreversible. She continued to suffer pain in her joints, back and legs and her muscles were weak. She did not have additional surgery to remove the balance of the tumor because of the risks of brain damage or death.

Duschesne was held to be liable for 80 percent of Lurtz's damages. She breached the standard of care by failing to refer Lurtz to a more knowledgeable physician. Once she decided to test Lurtz she had a duty of care to do the testing properly. Her failure to do the proper test was negligence. She was also negligent when she did not follow up with the dentist. Hierlihy was also held to be negligent in that she failed to meet the standard of care when she failed to properly examine Lurtz.

In the result the Ontario Court of Appeal held that the appellant doctors had failed to establish that the trial judge committed a palpable and overriding error on their appeal of the damage award.

In *Segal v. Richmond Hospital*,⁴⁴ a decision of Allan J. of the British Columbia Supreme Court, the defendant Dr. Frimer, the surgeon on call in the Emergency Department of the Richmond Hospital at the time of attendance of Mr. Segal, applied for summary judgment dismissing the action. Segal had attended the Emergency Department complaining of abdominal pain and a doctor diagnosed him as having appendicitis and recommended surgery. Frimer discharged Segal, however, despite his continuing symptoms and allegedly without any further examination. Mr. Segal returned to the Emergency Department three days later complaining of abdominal pain and black stools. He was again discharged. On December 31, 1994, he again attended at the Emergency Department in very severe abdominal pain with an elevated white blood count. At this time he was admitted to hospital. On January 2, 1995, emergency surgery was performed which revealed he had a ruptured appendix and an adjacent large abscess.

Segal sued Frimer for negligence on the basis that he had failed to seriously consider the diagnosis of appendicitis, had failed to carry out a rectal examination, had failed to test the stool for blood and had failed to evaluate the abdominal ultrasound.

In the result the application for summary judgment by the doctor was dismissed. Allan J. stated:⁴⁵

“The evidence suggests that the doctors who treated Mr. Segal found him to be a difficult patient. Mr. Mackoff suggests that the early diagnosis of Mr. Segal’s pain as “functional” led to increasing difficulties as the doctors failed to recognize the life-threatening disease . . .”

On the specific point of the need to prescribe further tests etc., in addition to the seminal authority of *Bergen Estate*, the decision of *Mackell v. Moulson*,⁴⁶ a decision of Cullen J. of the British Columbia Supreme Court, states that:

“Although it would have taken inordinate skill, knowledge and judgment to have diagnosed endocarditis on the basis of the symptoms presented, it would have taken no more than ordinary skill, knowledge and judgment to have prescribed further tests.”

Thus it can be seen that the duty to diagnose is of broad coverage, and should be given serious consideration as a possible ground of liability.

ENDNOTES

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- 1 Ellen I. Picard and Gerald B. Robertson, *Legal Liability of Doctors in Hospitals in Canada* (3d)
2 (Scarborough, Ontario: Carswell, 1996)
3 At pp. 239-241
4 H.L. Nathan, *Medical Negligence* (London: Butterworths, 1957) at 57, referring to *Mitchell v. Dixon*,
5 [1914] App. D. 519 (S. Africa S.A.)
6 At p. 244
7 At pp. 245, 246
8 At p. 246
9 At p. 249
10 (1998), 233 A.R. 9; [1998] A.J. No. 1329
11 [2005] O.J. No. 3323
12 Giovanna Roccamo, *Medicine in the Litigation Process*, (Carswell, 1999)
13 At para. 5
14 At para. 18
15 (1956), 1 D.L.R. (2d) 502 at 508 (Ont. C.A.), affirmed [1956] S.C.R. 991
16 [1995] 3 S.C.R. 674; (1995), 127 D.L.R. (4th) 577 (S.C.C.) at 588-589
17 John G. Fleming, *The Law of Torts* (7th ed.) (Law Book Co., 1987)
18 At p. 109
19 At p. 591
20 [2002] 1 S.C.R. 491; (2001), 209 D.L.R. (4th) 513 at para. 53
21 *Supra* note 1 at 281
22 (1997), 36 C.C.L.T. (2d) 42; [1997] B.C.J. No. 1303 at para. 18
23 (1984), 52 A.R. 161; [1984] A.J. No. 2575 at para. 18
24 (1978), 2 L. Med. Q. 67; 1978 A.C.W.S.J. LEXIS 7977
25 (1984), 52 A.R. 161; [1984] A.J. No. 2575 at para. 18
26 At para. 504
27 At para. 538
28 *Ibid*
29 *Ibid*
30 At para. 539
31 [2005] O.J. No. 2180
32 April 25, 2005
33 At para. 2
34 At para. 116
35 At para. 117
36 At para. 120
37 (1984), 52 A.R. 161; [1984] A.J. No. 2575
38 At para. 15
39 (2004), 360 A.R. 310; [2004] A.J. No. 967; 2004 ABQB 639
40 At para. 76
41 At para. 93
42 [1999] A.J. No. 913; 1999 ABQB 591
43 Affirmed at (2003), 346 A.R. 118; [2003] A.J. No. 1224; 2003 ABCA 276
44 [2003] O.J. No. 1540
45 Varied on matters of the appropriate discount rate for the award at (2005), 194 O.A.C. 119; [2005] O.J. No.
46 354, but otherwise affirmed
[2001] B.C.J. No. 753; 2001 BCSC 581
At para. 24
[2001] B.C.J. No. 2553; 2001 BCSC 1705