IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Pellerin v. Balfour,*
2024 BCSC 2135

Date: 20241122
Docket: S121455
Registry: Kelowna

Between:

Nicole Laurette Pellerin

Plaintiff

And

Dr. Nicholas James Broadfoot Balfour, Dr. Nevin Victor de Korompay, and Interior Health Authority operating a public hospital under the name of Kelowna General Hospital

Defendants

Before: The Honourable Justice Girn

Reasons for Judgment

Counsel for the Plaintiff:	K.T. Grenier
Counsel for the Defendants, Dr. Nicholas James Broadfoot Balfour and Dr. Nevin Victor de Korompay:	R.M. Gagnon K. Furniss
Place and Dates of Trial:	Kelowna, B.C. December 4-8, 11-13 and 15, 2023 March 4, 2024
Written submissions received:	January 15, 2024
Place and Date of Judgment:	Kelowna, B.C. November 22, 2024

2024 BCSC 2135 (CanLII)

Table of Contents

INTRODUCTION 4
EVIDENTIARY ISSUES 5
Credibility and Reliability 5
Use of Medical Records and Standard Practice Evidence 8
THE PARTIES 9
Nicole Wray (née Pellerin) 9
Dr. Nicholas Balfour 13
OTHER WITNESSES 22
Erik Wray 22
Rene Pellerin 25
Cherie Emerick, LPN 26
Angela Sjoquist, RN 26
Amy Payne, RN 28
EXPERT EVIDENCE 28
Expert Opinion Evidence Tendered by Ms. Wray 29
Dr. Garry Feinstadt (Family Physician) 29
Dr. Ken Perrier (Family Physician) 34
Dr. William Siu (Radiologist) 35
Expert Opinion Evidence Tendered by the Defendant, Dr. Balfour 37
Dr. John Ward (Emergency Physician) 37
Evidence 37
Question of Objectivity 41
Dr. David Konkin (General Surgeon) 45
LEGAL FRAMEWORK 45
Negligence 45
Standard of Care 46
Misdiagnosis & Errors in Judgement 49
DISCUSSION 50
Initial Assessment 51
Diagnosis and Use of Judgement 53
Discharge Instructions 57
CAUSATION AND CONTRIBUTORY NEGLIGENCE 59

2024 BCSC 2135 (CanLII)

CONCLUSION 59

2024 BCSC 2135 (CanLII)

2024 BCSC 2135 (CanLII)

INTRODUCTION

[1] This matter concerns medical negligence alleged by the plaintiff, Nicole Wray (née Pellerin), against Dr. Nicholas Balfour, an emergency room physician. The claim against the other two defendants was dismissed by consent.

[2] The key issue that is in dispute is liability. If liability is found, contributory negligence is at issue. Damages have been agreed to between the parties.

[3] On November 30, 2016, Ms. Wray attended the emergency department ("ED") at Kelowna General Hospital ("KGH") with abdominal pain. She was attended by Dr. Balfour. Ms. Wray was assessed and an ultrasound was ordered, which showed a normal appendix. Given her past history with endometriosis, Ms. Wray was advised that her abdominal pain was likely due to a ruptured ovarian cyst. She was discharged later that day. She was given pain medication for seven days and told to follow up with her physician or return to clinic if the pain continued.

[4] Ms. Wray continued to have pain when she returned home. On December 4, 2016, she returned to the ED by ambulance where she was diagnosed with a punctured appendix and underwent surgery. She was discharged on December 11, 2016.

[5] Ms. Wray asserts that Dr. Balfour fell below the standard of care of an emergency room physician by failing to take an appropriate history and conduct an appropriate physical examination. She asserts that Dr. Balfour had an anchoring bias for diagnosing an ovarian cyst given her history of endometriosis. Ms. Wray also asserts that Dr. Balfour breached the standard of care due to inadequate record taking.

[6] Ms. Wray further asserts that Dr. Balfour failed to undertake further investigation, such as: ordering a CT scan; further lab tests including a CRP test; conducting a further assessment, including vital signs; or keeping her in hospital for further observation when she was still in severe pain and he had not ruled out appendicitis.

[7] It is alleged that Dr. Balfour discharged Ms. Wray prematurely with an inappropriate amount of pain medication and misleading discharge instructions and, specifically, failed to explain the importance of returning to the ED.

[8] Dr. Balfour admits that he owed Ms. Wray a duty of care but disputes that he fell below the standard of care in all areas asserted by Ms. Wray.

[9] In the event the court finds that Dr. Balfour breached the standard of care, the parties have agreed that causation is established if Ms. Wray proves, on a balance of probabilities that but for Dr. Balfour's breach, Ms. Wray would have been diagnosed with appendicitis on November 30, 2016 or kept in hospital on November 30, 2016 until the diagnosis was reached; or but for Dr. Balfour's breach with respect to his discharge instructions to Ms. Wray, she would have returned to the hospital on or before December 3, 2016.

[10] The parties have provided a great deal of material and detailed submissions, both oral and written, on the facts and the law they consider to be relevant. While I have considered all of their material, in these reasons I will not address each and every argument made by the parties but rather only focus on the facts and law that I consider to be most directly relevant to the decision.

EVIDENTIARY ISSUES

Credibility and Reliability

[11] I preface my discussion of each witness's evidence with an overview on credibility and reliability of witness testimony and circumstances which may impact the weight afforded to certain evidence.

[12] It is not disputed that the leading case of *Bradshaw v. Stenner*, 2010 BCSC 1398 sets out the law regarding the assessment of the credibility of witnesses:

> [186] Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to

2024 BCSC 2135 (CanLII)

> resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont. H.C.); *Faryna v. Chorny*, [1952] 2 D.L.R. [354] (B.C.C.A.) [*Faryna*]; *R. v. S. (R.D.*), [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Faryna* at para. 356).

[13] A sincere and credible witness is not necessarily a reliable one. Assessing reliability involves considering the witness's ability to accurately recall and recount the events. Memories of past events fade over time. The reliability of a witness's evidence of their invariable or standard practice must be considered in the context of the case as a whole. The length of time between relevant events and the trial is a factor that impacts negatively on reliability: *Williams v. Rosenstock*, 2020 ABQB 303 at paras. 15–16.

[14] Although intended to be for the benefit of a self represented litigant, I find the comments of Justice Kent in *Moinzadeh v. Loblaws Inc.*, 2021 BCSC 793 helpful in regards to resolving credibility disputes and making findings of fact:

> [13] A human being's perception and memory of events is fallible. Memories are fragmentary, suggestible, and malleable. They often contain amnesic gaps, information out of order, guesses, and incorrect details. They are subject to decay, interference, distortion, and constructive error. Witnesses in a trial usually do their best to provide accurate evidence about a sequence of events or the content of conversations, but there is a great deal of room for error and reconstruction, and conflicting testimony is commonplace.
>
> [14] The primary role of a trial judge is to make findings of fact, i.e. to determine what happened in any given case, and to apply the law to those facts in order to generate the appropriate legal result. Findings of fact are based on admissible evidence presented to the court. As in this case, that evidence can include testimony under oath from witnesses respecting their actions and observations, as well as documents or other material marked as exhibits. The role of the trial judge is to appropriately weigh all of this evidence and to determine which alleged facts have been proved in accordance with the applicable standard of proof – in civil cases, on a balance of probabilities.
>
> [15] The assessment of a witness's oral testimony necessarily entails an assessment of credibility. The role of the court is not usually reduced to

2024 BCSC 2135 (CanLII)

> simply choosing between two or more versions of events, and it is not an all-or-nothing process. In determining facts, i.e. making findings as to what actually occurred in any given case, the court is free to reject some aspects of a witness's evidence while accepting others and, indeed, to assign different weight to different parts of the witness's evidence.
>
> [16] Accepting all or part of the testimony of any witness involves an assessment of credibility (truthfulness/honesty) and reliability (accuracy) of both the witness and the evidence. That in turn involves consideration of many different factors including:
>
> - consistency of the witness's account of events;
> - consistency with other admissible evidence from witnesses, documents, or other physical objects;
> - whether the evidence is reliably corroborated or contradicted by other evidence;
> - the witness's ability to reliably recall and communicate details;
> - the demeanour of the witness and whether the questions are answered in a frank and forthright fashion without evasion, speculation, or exaggeration; and
> - the inherent plausibility of the evidence and its consistency with the probabilities affecting the case as a whole.

[15] A negative inference can be drawn when a physician's record-keeping is lacking: *Pinch (Guardian ad litem of) v. Morwood*, 2016 BCSC 938 at paras. 113–114 [*Pinch*]; *Leckie v. Chaiton*, 2021 ONSC 7770 at paras. 29–30.

[16] In order to make factual findings in this case, I must consider the weight to be given to the evidence of various fact and expert witnesses, most of whom had little to no direct recollection or knowledge of the key events in question.

[17] Ms. Wray testified that her recollection of her attendance at the emergency room on November 30th is hazy and she was unable to recall key facts.

[18] The nurses who dealt with Ms. Wray have no independent recollection of their interactions with her. They rely on their charting and usual practice. Similarly, Dr. Balfour also has no recollection of treating Ms. Wray. He also relies extensively on the charting and his usual practice.

2024 BCSC 2135 (CanLII)

[19] As such, my assessment of the evidence includes the credibility and reliability of the witnesses' evidence, as well the reliability of medical records as evidence of facts and evidence of the usual or standard practice.

Use of Medical Records and Standard Practice Evidence

[20] In medical negligence cases, medical practitioners often have no independent recollection of the facts. They rely on their interpretation of the medical charts and standard or usual practise to testify to what occurred. This is the case with Dr. Balfour, who acknowledged that he has no independent recollection of Ms. Wray or attending to her.

[21] Both parties rely on *Gilmore v. Love*, 2023 BCSC 1380 for guidance on what evidentiary use can be made of a professional's usual or standard practice. I see no reason not to adopt Justice Marzari's useful summary on this area at paras. 61—65:

> [61] All of the practitioner defendants rely upon evidence of their "standard" or "usual" practice to supplement the charting and their lack of direct recollection of the events of Abigail's labour and delivery.
>
> [62] It is well-established that the court may consider evidence of a medical practitioner's common or usual practice, and even give it significant weight. The usefulness and admissibility of such evidence was expressed in *Belknap v. Meakes,* 1989 CanLII 5268, 64 D.L.R. (4th) 452 (B.C.C.A.) as follows:
>
>> [39] If a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that surely is evidence and possibly convincing evidence that he did it in that way on the day in question.
>>
>> [40] *Wigmore: On Evidence*, vol. IA (Tillers, rev. 1983), states that there is no reason why habit should not be used as evidence either of negligent action or of careful action (para. 97), and that habit should be admissible as a substitute for present recollection. *Phipson on Evidence*, 13th ed. (1982), paras. 9-22, reaches a similar conclusion.
>
> [63] Even where there is medical charting evidence, but those charts contain no documentation of a particular act, "evidence of standard practice is admissible as evidence of what happened": *Wiebe v. Fraser Health Authority,* 2018 BCSC 1710 at para. 118. This court has also stated that: "the absence of a chart note will not deprive a health

2024 BCSC 2135 (CanLII)

practitioner of the ability to rely on his or her standard practice on a matter”: *Parhar v. Weaver,* 2021 BCSC 123 at para. 84.

[64] Finally, Justice Power summarized how evidence of standard practice can be used and weighed, with reference to the leading authorities, in *McKerr v. CML Healthcare Inc.,* 2012 BCSC 1712:

> [8] There are numerous examples in the case law of the use of usual practice evidence and examples where it has been preferred over independent recollection: *Belknap v. Meakes*, 1989 CanLII 5268 (BC CA), 64 D.L.R. (4th) 452, 1 C.C.L.T. (2d) 192 (B.C.C.A.); *Erbaturr v. Carruthers*, [1990] B.C.J. No. 772 (S.C.); *Friedsam (Guardian ad litem of) v. Ng*, 1993 CanLII 1129 (BC CA), [1994] 3 W.W.R. 294, 86 B.C.L.R. (2d) 335 (C.A.); and *Mirembe v. Tarshis*, [2002] O.T.C. 456 (S.C.J.). Ultimately, however, each case turns on an assessment of the totality of the evidence and on the evidence itself in determining what weight to give to usual practice evidence.

[65] The weight I give to the standard practice evidence of the various medical practitioners in this case depends on the substance of the evidence itself, including the extent to which it is persuasive evidence that something was likely done because it is consistently done by that practitioner in the same or similar circumstances.

THE PARTIES

Nicole Wray (née Pellerin)

[22] I wish to make it clear that I found Ms. Wray to be an honest witness who genuinely believes her testimony was entirely accurate. However, there were aspects of her evidence that are concerning in terms of the reliability of her testimony, both in terms of her memory and when comparing her evidence with the other witnesses and objective evidence. I will address this in more detail throughout these reasons.

[23] Ms. Wray is 41 years old and has worked as a care aid since 2007. She is currently employed at KGH. In November 2016, she was 34 years old. She is married to Erik Wray.

[24] Ms. Wray described herself as an active healthy person and was never overweight. She described how her work as a care aid is very physical and requires her to be on her feet all day.

2024 BCSC 2135 (CanLII)

[25] In terms of prior medical conditions, Ms. Wray has a history of endometriosis, resulting in painful menstrual cycles. In the three years prior to November 2016, Ms. Wray often had to call in sick to work, usually on the first day of her menstrual cycle. The pain from the endometriosis was localized in her uterus and it radiated to her sides. Ms. Wray also has a history of anxiety.

[26] She underwent a laparoscopic procedure in 2014, performed by Dr. Yoshida, which confirmed a diagnosis of endometriosis. After the surgery, she says that her menstrual cycle was no longer debilitating. Ms. Wray testified that she only took Tylenol for her endometriosis pain and did not take any opioid medication.

[27] After the surgery, the plaintiff developed a “water pocket”, which caused her pain and she had trouble walking and sleeping. On September 23, 2014, her roommate at the time brought her to the KGH ED, where she underwent an ultrasound and was advised that the water pocket would go away on its own in a few days. Ms. Wray recalls that the pain went away three or four days later.

[28] Turning to the events of November 30, 2016, Ms. Wray testified that she woke up early in the morning with pain in her entire abdomen. She had been in bed the day before with flu like symptoms including nausea and vomiting. She described the pain that morning as mind numbing. The pain extended from her sternum down to her pelvic floor, on both sides of her abdomen. This was a different pain than she had experienced with her endometriosis, which had been more localized.

[29] Unable to sleep, she and Mr. Wray decided to attend the ED. Ms. Wray recalls being in a lot of pain but was able to walk on her own. She also recalls being taken to the streaming area but does not recall having her vitals taken at triage.

[30] Ms. Wray recalls she laid on the floor because it was too uncomfortable to sit. Lying flat and straight relieved some pressure in her abdomen. She recalls being taken to the assessment bay five minutes after arriving. While laying on the assessment bed, Ms. Wray was crying out in pain. Ms. Wray testified that a nurse then administered her some morphine. Ms. Wray told the nurse that she does not

2024 BCSC 2135 (CanLII)

handle morphine well and preferred hydromorphone. Ms. Wray recalls that the nurse gave her a "side eye". Around this time Mr. Wray joined Ms. Wray in the assessment bay.

[31] Ms. Wray testified that Dr. Balfour came in to see her around at 7:00 a.m. She testified that her memory is hazy as it relates to this interaction. However, she does recall Dr. Balfour saying, "Well, when you're going through drug withdrawal, you tend to be in a bit of pain" (the "Drug Withdrawal Comment"). Ms. Wray testified that she did not respond to the Drug Withdrawal Comment because it was very shocking, and she was in so much pain and so much was going on.

[32] Ms. Wray vaguely remembers Dr. Balfour brushing her stomach during the initial assessment, but that he did not use a stethoscope. She also testified that Dr. Balfour did not do a pelvic examination. He did not ask Ms. Wray to move and she does not recall being asked about her pain. However, Ms. Wray stated later in her testimony that Dr. Balfour did ask where her pain was located, and she told him that it was everywhere in her abdomen. Ms. Wray recalls Dr. Balfour was not in the assessment bay for very long but estimates it was about ten minutes. She felt it was very quick and that the conversation was not extensive.

[33] In response to Dr. Balfour asking if her pain had changed at all, Ms. Wray recalls telling him that it had gone down since receiving the pain medication.

[34] After the initial assessment, Mr. Wray returned to the streaming area and then was taken for an ultrasound. Ms. Wray recalls the ultrasound technician saying "I can't see what's going on inside of you; there's too much fluid".

[35] Although a endovaginal ultrasound was performed, Ms. Wray testified that one was not performed. She says that if one had been performed, she would have remembered due to the invasive nature of the exam.

[36] When Ms. Wray returned to the streaming area after the ultrasound, her pain became more intense due to the pain medication wearing off. Although neither she nor Mr. Wray asked for more pain medication, Ms. Wray does recall a nurse coming

2024 BCSC 2135 (CanLII)

by at some point and administering more medication. Ms. Wray was hungry so Mr. Wray brought her a smoothie while they waited in the streaming area, but after a few sips a nurse stopped Ms. Wray from drinking it, stating that she may be sent for surgery.

[37] Ms. Wray was discharged by Dr. Balfour around 2:00 pm (the “Discharge”). Ms. Wray did not recall seeing Dr. Balfour before the Discharge. She only recalled when he called her into an assessment bay to give her a prescription and send her home. Ms. Wray walked slowly back to the assessment bay hunched over and she had difficulty getting onto the stretcher in the assessment bay. At that point, the pain medication had worn off and Ms. Wray was again experiencing intense pain.

[38] Ms. Wray recalls Dr. Balfour telling her the following:

> And that's when he told me, "It looks like it was a really large cyst from your endometriosis that burst. Here's a week's worth of Dilaudid. Come back in a week if you're still in pain." And he put the prescription on the bed and left.

[39] Ms. Wray does not recall Dr. Balfour doing a physical examination at this time, nor does she recall Dr. Balfour asking her any further questions about her pain. Ms. Wray does not recall Dr. Balfour asking about her past experiences with cysts or her admission to the ED in September 2014. Ms. Wray does not recall if Dr. Balfour asked her if she had a cyst before. Dr. Balfour did ask her to confirm whether she had endometriosis, which she confirmed. Dr. Balfour did not ask Ms. Wray if the pain she was experiencing was similar or different to the pain she had from her endometriosis, nor did he tell her that she may have appendicitis. Ms. Wray also testified that Dr. Balfour did not explain to her that she needed to watch for certain symptoms or that she should return to the ED if her symptoms got worse.

[40] After the discharge, Ms. Wray’s father, Mr. Pellerin, came to pick her up. After picking up her prescription from the pharmacy, Ms. Wray testified that her father dropped her off at home. She told him that the doctor advised her that it was a large cyst from her endometriosis that would go away and to come back in a week if she was still in pain.

2024 BCSC 2135 (CanLII)

[41] For the next few days, Ms. Wray stayed home. She had constant nausea and could not keep any food down and constantly felt like she needed to go to urinate or have a bowel movement or vomit but was unable to do so. She kept track of her temperature and did not develop a fever.

[42] On December 3, 2016, the day before she returned to the hospital, Ms. Wray recalls feeling better and was able to eat the dinner that Mr. Wray had prepared. However, the next morning she threw it all up and also noted that she had blood in her urine. At this point, Mr. Wray called 811 and spoke to a nurse.

[43] Ms. Wray testified that her parents and Mr. Wray had tried to convince her to go back to the hospital but she refused. She said that she did not go back primarily because Dr. Balfour had told her to follow up in a week and if she returned before then, they would think she was drug-seeking. Ms. Wray was embarrassed because the doctor and nurses made her feel as if she was there for something inconsequential and was wasting their time. She thought she would be dismissed again.

[44] Ms. Wray reluctantly agreed to return to the hospital after the 811 nurse called an ambulance. Upon arrival, she recalls that Dr. Yoshida examined her. She recalls him telling her that he was sure that her pain was not related to her reproductive system. Dr. Yoshida took her for an ultrasound and she recalls him consulting with someone else, perhaps another doctor. After that, Ms. Wray was told that they were going to do a CT scan to take a closer look.

[45] Ms. Wray recalls Dr. Sullivan, a general surgeon, told her that her appendix had swollen to the size of a grapefruit. Ms. Wray was admitted and stayed until December 11, 2016.

Dr. Nicholas Balfour

[46] Overall, I found Dr. Balfour to be a credible witness. While there were instances during his cross examination when he expressed frustration, in my view, this does not affect his credibility. I accept his evidence on his standard practice and

2024 BCSC 2135 (CanLII)

find that his evidence was internally consistent with the medical records including his charting.

[47] Dr. Balfour does not have any recollection of seeing Ms. Wray on November 30, 2016. Therefore, his evidence consists of his standard practice and his review of Ms. Wray's charts and tests.

[48] Dr. Balfour is an emergency medicine physician practicing in the ED at KGH.

[49] He obtained his medical degree in 1993. Dr. Balfour completed his residency focusing on critical care, emergency medicine, and anesthesia. In 1996, he completed a year of emergency medicine specific training at St. Paul's Hospital in Vancouver.

[50] He then began working as an emergency physician at Vernon Jubilee Hospital, where he later became the medical director for the ED. In 2000, he also began practicing part-time at KGH and then switched to a full-time position there. Until 2022, he was also the Executive Medical Director for Clinical Operations South and Transport for the Interior Health Authority, and was the ED Head and Medical Director at KGH from January 2016 to January 2017.

[51] Dr. Balfour provided details regarding how an emergency room operates and what patient care entails in an emergency room setting. He testified that the KGH is a tertiary hospital and the ED is a busy one, estimating that in 2016, between 225 to 250 patients came through the ED every day, and that approximately 150 of those patients would be in the streaming section.

[52] At KGH, there are four areas of the ED – main, minor treatment, streaming, and mental health. During slower times the emergency physician may cover all four areas. During busier times, a physician will often be assigned to one area.

[53] Dr. Balfour testified to the role of an emergency physician. He testified to the importance of an emergency physician exercising restraint in their diagnoses; it is often imprudent to provide a concrete diagnosis on an emergency visit, as it may

2024 BCSC 2135 (CanLII)

prove to be wrong or provide the patient with a false sense of security and inhibit them from returning to seek further care.

[54] The term “differential” was used often during this trial. Differential is a term physicians use when they take information, including the patient’s history, physical exam, and sometimes test results, to come up with a list of potential causes of their symptoms. They are usually ranked from most to least likely. Dr. Balfour explained that having a differential prevents the physician from anchoring on one diagnosis and missing other potentials.

[55] Regarding appendicitis, Dr. Balfour testified that he had diagnosed several hundred cases of appendicitis during his career up to 2016. He explained that when appendicitis is on the differential diagnosis, the standard process for assessing that patient is to monitor them.

[56] As a matter of standard practice, if Dr. Balfour suspects that a patient has appendicitis, he would order imaging to either rule it in or out. In 2016 the primary imaging tests to diagnose appendicitis was a CT, an MRI, or an ultrasound. A patient’s body habitus is a consideration when choosing an imaging type. Dr. Balfour testified that a CT scan on a very thin person without a lot of body fat can miss appendicitis. He also noted that for females in child rearing years, his first choice is an ultrasound because it does not expose the pelvis to ionizing radiation as a CT scan does.

[57] Dr. Balfour explained that if he sees a negative ultrasound and there is an alternate explanation for the patient’s symptoms, he will pursue that as a possibility. He would not order a CT scan to rule out appendicitis when a patient presents with abdominal pain. However, he noted that if the ultrasound could not visualize the appendix, he may discuss with the patient the risks and benefits of a CT scan given the concerns with over-prescribing CT scans.

[58] Dr. Balfour was asked about his standard practice when a patient comes in with abdominal pain. He stated:

2024 BCSC 2135 (CanLII)

> Well, I would, first of all, look at the patient. We always do ABCs to determine if they're stable, and then I would -- you know, in streaming, they would -- I would listen to their chest with my stethoscope because the abdomen extends from the chest to the pelvis. I would be listening for any sounds consistent with, you know, pneumonia or wheezing or any other things. I would listen to the heart and -- not only am I listening to heart sounds, but I'm also listening to the heart rate. If it's rapid, fast, feel the pulses.

2024 BCSC 2135 (CanLII)

[59] Dr. Balfour continued to describe his standard practice when he suspects appendicitis:

> So when someone comes in and I'm worried about acute appendicitis, I'm not going to just push hard on the right lower quadrant because that's cruel, and I don't like causing patients pain. And so I will likely percuss, which is to tap all four quadrants of the abdomen and see where that elicits pain. If that causes pain away from where I'm percussing in the right lower quadrant, that's interesting to me.
>
> That could imply that maybe there's some irritation of their peritoneum, which is the lining of the abdominal wall in the right lower quadrant.
>
> Once I determine that I'm not making them jump off the bed with percussion, I'll then move to what we call palpation, which is pushing deeper -- but again, push away from the site that's most uncomfortable because I'm trying to get the information I need without hurting the patient.
>
> And so then I will slowly move and, if it's not causing a lot of pain, finally get down to the right lower quadrant, and that's where -- you know, McBurney's point and you see if they're tender there.
>
> But appendixes don't read textbooks, patients don't read textbooks, and appendicitis can present in a myriad of different ways. It doesn't fit that classic.

[60] Dr. Balfour testified that in a female patient, a pelvic examination is part of his repertoire, however, his decision to conduct one depends on his assessment of its usefulness in the circumstances. Dr. Balfour testified that a pelvic exam does not provide any additional information when he is trying to rule out appendicitis. He also noted that a pelvic exam is an invasive procedure, and many physicians are now less inclined to conduct them as an automatic matter of course in patients who present with abdominal pain.

[61] Dr. Balfour testified that when he is assessing a patient, he does not typically consider the level of pain medication they have received. He noted that he has rarely

encountered a patient that has had so much medication that he could not assess them and that pain management typically enhances his assessment of a patient.

[62] Dr. Balfour testified that he came on shift at 6:00 a.m. on November 30, 2016 and was assigned to work in the main area of the ED, which is also when the night physician stopped taking on patients. Another physician assigned to the streaming area was scheduled to start at 7:00 a.m., and so Dr. Balfour was responsible for all ED areas before that time.

[63] Dr. Balfour testified that given his standard practice, he is "a hundred percent certain" that, he would have looked at Ms. Wray's records before attending to her. This would have shown him: the reason she was attending the ED; her symptoms as noted by the intake nurse, which included vomiting, nausea, and abdominal pain without diarrhea; her vitals; her medical history, including endometriosis; and her prior hospital visits and surgical procedures.

[64] He testified that he would have specifically been looking for information regarding her endometriosis, since that could explain some of her symptoms. He testified that he also would have reviewed her prior bloodwork.

[65] His charting shows that Ms. Wray was asked about her travel history, recent changes in diet and her history of endometriosis. He noted that the endometriosis pain was associated with her menstrual cycle.

[66] Dr. Balfour testified that his notation of "O/E" indicates that he did a physical exam. He testified that his standard physical exam depends on the presentation and complexity of the patient.

[67] Dr. Balfour's charting reveals that he palpated the right lower quadrant and that it was tender. He did not detect rebound pain and Ms. Wray's pain was localized to the right lower quadrant, but he did not elicit signs of peritoneal irritation that are commonly associated with the term "rebound". He testified that even if a nurse had detected rebound pain and notified him of this, it would not have changed his assessment of Ms. Wray.

2024 BCSC 2135 (CanLII)

[68] Dr. Balfour did not perform a pelvic exam on Ms. Wray because an ultrasound would provide a lot more information. Dr. Balfour testified that nothing in a pelvic exam would help him rule out whether Ms. Wray may have appendicitis or not.

[69] Dr. Balfour testified that based on the charting he concluded that Ms. Wray had an acute process going on that could be related to her prior endometriosis, or it could be gynecological in nature in terms of an ovarian cyst. However, appendicitis was on the differential. He would have wanted to rule out serious issues such as a twisted ovary or appendicitis. Accordingly, Dr. Balfour ordered an ultrasound because it would allow him to see the gynecological structures as well as the appendix.

[70] Once the patient has had their ultrasound, Dr. Balfour testified that his standard practice is to review the results before discharging them. He would review the results on the “PACS monitors”, which are connected to the diagnostic imaging database. He noted that if one emergency physician signs into a PACS monitor, the system stays open for other emergency physicians to view diagnostic imaging results. In this case, Dr. Balfour testified that he would have seen the preliminary report written by the ultrasound technologist (the “Ultrasound Worksheet”).

[71] Dr. Balfour testified that his standard practice is to look at the Ultrasound Worksheet. He testified that in this case, he would have wanted to know more about the free fluid with debris that was described on the Ultrasound Worksheet. Dr. Balfour stated that he would have called the radiologist to ask him to look at the films and discuss the case. The records show that Dr. Balfour did access the PACS monitor to see Ms. Wray’s ultrasound records. The records also show that another physician, Dr. Reed accessed the images. Dr. Balfour testified that James Reed was the overnight physician the night prior and the implication is that he stayed logged into the computer, so any physician using the computer that day would be listed as James Reed. Dr. Balfour testified that he was accessing the PACS system ‘as James Reed’.

[72] In direct, Dr. Balfour provided an assessment of the Ultrasound Worksheet:

2024 BCSC 2135 (CanLII)

> Well, I would look at the -- just briefly scan down what the technologist was seeing.
>
> Looking at the ovaries, there's no signs of enlargement or a problem there.
>
> I noticed that there was free fluid in the adnexa -- free fluid with debris in the adnexa. The adnexa are the lower far corners of the pelvis.
>
> I then notice that there's a – a kidney that measures 9.8 centimetres, a kidney that measures 10.4. But interestingly, there's also free fluid adjacent to RK, to right kidney. So there's fluid in the adnexa, but there's also fluid adjacent to the right kidney.
>
> I then would scan down and I see the comments are, "Appendix 4.4 millimetres - N", for normal. The rest of the abdominal examination -- ABD is abdomen. "- NAD", no acuity detected. So in other words, they didn't find anything other concerning -- like, if he'd saw an impacted stone in the gallbladder, for example.
>
> And then they say, "Moderate amount of fluid debris", and then they comment on what the pregnancy status is of the patient, beta HCG negative. White cell count 10.1.
>
> So at this point, having had this information, I would have used our Vocera system or I may have picked up the phone and phoned my radiologist because there's something here.
>
> There is more free fluid than we would consider just normal physiologic fluid, and I would want to know about that and I would want confirmation about the attendance.

2024 BCSC 2135 (CanLII)

[73] The records from the PACS monitor reveal that the ultrasound images were accessed at 11:34 a.m. on November 30, 2016 by Dr. Balfour (using Dr. Reed’s sign in). At 11:36 a.m., Dr. de Korompay, the radiologist on shift that day, accessed the images. Dr. Balfour testified that this indicates to him that he likely looked at the images, read the Ultrasound Worksheet, and called Dr. de Korompay, the radiologist, to discuss his visual interpretation, as was his standard practice.

[74] Dr. Balfour testified that he likely asked about the free fluid and asked whether it could be explained by possibilities such as a ruptured ectopic cyst or ruptured ovarian cyst. He testified that he would have confirmed that the appendix was indeed visualized and that it was normal. He would have concluded the call with the understanding that there was no sonographic evidence of appendicitis and that the patient had free fluid in the pelvis, which had been seen on previous ultrasounds.

[75] In my view, the charting supports that Dr. Balfour reviewed the Ultrasound Worksheet. Dr. Balfour charted “US →FF”, meaning ultrasound and free fluid. He also charted that that the ovary seen was normal, the appendix was negative, and that Ms. Wray was not pregnant.

2024 BCSC 2135 (CanLII)

[76] While Dr. Balfour’s charting does not indicate that he spoke to the radiologist, he testified that this does not mean that he did not do so. He was certain that he would have talked to Dr. de Korompay about the ultrasound before deciding to discharge Ms. Wray. He stated that he was “willing to bet his career on it because I would never send a patient home without knowing what the ultrasound showed when I’m trying to rule out appendicitis. That would make me incompetent”.

[77] In his examination for discovery, Dr. de Korompay stated that he has no independent knowledge of the event and has no documentation to confirm a discussion with Dr. Balfour.

[78] Dr. Balfour testified as to his standard practice once tests are back: He stated:

> A: So at this point, if I’m to follow my standard practice – because, again, I have no recollection – I would have either asked the nurse to have the patient placed back in the exam room, or I would have come for them myself and found a place where we could talk -usually in an exam room in private.
>
> And I would first of all, ask them how they’re doing, get an assessment, then I would tell them about the results of their study. I’d say, well, what we have so far is – this is your bloodwork. Your white cell count’s up slightly, but that’s very non-specific, and it can be explained by a number of factors, including appendicitis. I was worried this could represent appendicitis, but your ultrasound was able to identify the appendix, and the radiologist said there’s no sonographic evidence of appendicitis. So weighing that information with everything else and recognizing there are more things in the right lower quadrant than just the appendix, that we need to consider other possibilities. I would then give discharge instructions.
>
> ….
>
> A: I’ve written, “Pelvic pain NYD” –not yet diagnosed --? Ruptured ovarian cyst”
>
> Q: What would you have told Ms. Wray about your final diagnosis?

> A: Okay. So at this point I would say based on the test and information we have at this moment, it does not appear to be an acute appendicitis, but that can be a very challenging diagnosis to make.
>
> It's also possible that your pain could be from a ruptured ovarian cyst because we know that fluid can be very irritating to the abdominal cavity and cause pain, such as the pain you're experiencing. And that's certainly a possibility.
>
> The good news is we did not find any other concerning findings in our tests, including any evidence of a twisted ovary or any other things we need to be worried about at this visit.
>
> And for now, the goal will be to ensure that you're comfortable and come up with an appropriate discharge plan.

[79] When asked whether he would have told Ms. Wray that he did not know what her issue was, Dr. Balfour stated:

> A: Particularly when I consider appendicitis as being in the differential, I –I specifically flag that. I say, look, there's –we have done the tests that we can do, and so far, everything is suggesting that's not what this is. And at this point, I accept the ultrasound diagnosis. Appendicitis – and then I say this – I say, I've actually been here long enough and I've been around long enough to know that you never say never in medicine. There's always a possibility, and so we need to keep that in mind going forward. And this is where I say that I expect one of three things to happen here. One, if we're correct and this is for a ruptured cyst, your pain was maximal at onset. It should, it presumable should get better within the next 24-48 hours. And if it does, that's good. We treated your pain. I'm not sure – you know, I may have brought up the endometriosis component with her. I don't know of course because I don't recollect.
>
> But when I see patients with endometriosis, I also acknowledge that can cause pain, and that can be very difficult to diagnose, but we have an established diagnosis proven laparoscopically, so that is certainly possible that your pain is coming from this endometriosis.
>
> Could this be an early appendicitis? Certainly. And so if your pain gets worse or if you're vomiting or having fever, you need to come back. I say we never close. We're open 24 hours and I would want you to return.
>
> If on the other hand in one to two days, if your pain is still of the intensity that it is now and clearly not getting better but clearly not getting worse, you should still be seen. But in that case it may be appropriate to be seen by your primary care physician or at a walk-in clinic – or see us, because, again, we're always here and we never close. Those are my standard discharge instructions.

[80] In cross examination, it was put to Dr. Balfour that he did not advise Ms. Wray that he was uncertain about the cause of her abdominal pain, he stated:

2024 BCSC 2135 (CanLII)

> A: Again, I don't recall this instance, but I know my practice and I know what I say to my patients when I discharge them. And I'm a hundred percent confident in my mind – and that's what makes me sleep at night, that I gave the appropriate discharge instruction because I do it every time.

[81] Dr. Balfour agrees that that he did not chart his discharge instructions in full, but rather charted that they spoke about analgesia, followed by "FUFP", meaning follow up with family physician. Dr. Balfour also charted "RTC", which he stated was his shorthand for "return to clinic if increased signs and symptoms".

[82] While Dr. Balfour agreed that he may have told her that her pain may be in response to a burst cyst, he explained that he would not have anchored it on just that explanation. Dr. Balfour testified that he would have also included that appendicitis is also a possibility given that it was on the differential.

[83] Prior to discharging Ms. Wray, Dr. Balfour has no recollection as to whether he did a physical examination on her. He testified that re-examinations on discharge are not standard practice.

OTHER WITNESSES

Erik Wray

[84] Erik Wray is Ms. Wray's husband and was her boyfriend on November 30, 2016. Mr. Wray testified in a credible, forthright manner. Neither his credibility nor the reliability of his evidence was impugned on cross-examination. I generally accept his evidence. However, I do note that Mr. Wray was not able to precisely recall everything that was said during his interactions with Dr. Balfour and Ms. Wray on November 30, 2016.

[85] Mr. Wray and Ms. Wray met while working together at a seniors care home. Mr. Wray is a licenced practical nurse and has been so since 2012. He described Ms. Wray's health as generally being good but was aware that she had a history of endometriosis which caused her to have cramps during her menstrual cycle. She did not have a history of drug or alcohol abuse.

2024 BCSC 2135 (CanLII)

[86] Mr. Wray testified that leading up to the event, Ms. Wray was not feeling well. They thought maybe, based on her symptoms, she had the flu or a cold.

[87] Mr. Wray testified that on November 30, 2016, Ms. Wray woke up at approximately 4:30 a.m. and complained of excruciating abdominal pain. As a result, they decided to go to the hospital. Mr. Wray stated that Ms. Wray could not stand up straight and when they arrived at the ED, he had to help her get out of the vehicle.

[88] Mr. Wray stated that while waiting in the streaming section. Ms. Wray was visibly crying out, squirming in her chair, and holding her abdomen.

[89] Mr. Wray recalled that the pain medication given to Ms. Wray by hospital staff helped temporarily but did not last.

[90] Mr. Wray testified that at some point Ms. Wray was moved to an assessment bay and he had to help her to get there. He was present when Dr. Balfour arrived. Dr. Balfour asked Ms. Wray where the pain was located. Mr. Wray recalls Ms. Wray lifting her top to show her abdomen to the doctor and she was crying out in pain and told the doctor that the pain was all over her entire abdomen. He does not recall whether the doctor used his stethoscope during the assessment, which he recalls lasted maybe a minute and the physical examination lasted just seconds. However, in cross examination, Mr. Wray acknowledged that he could not be certain that Dr. Balfour's assessment only lasted one minute as he did not time it. Nor could he say what exactly Dr. Balfour did in terms of the physical examination of Ms. Wray.

[91] Mr. Wray testified that he recalled Ms. Wray being asked to sit up, but she was unable to do so. Further, he recalled Dr. Balfour asking Ms. Wray if she used opioids, to which she replied "no".

[92] Mr. Wray does not recall Dr. Balfour discussing with them what was going on or what the next steps would be. Mr. Wray agreed on cross examination that he could not say for certain whether Dr. Balfour did or did not ask a certain question, or did or did not do a certain physical maneuver.

2024 BCSC 2135 (CanLII)

[93] Mr. Wray testified that before the doctor left the assessment bay, he suggested that “sometimes these are symptoms that people can go through when they’re withdrawing from narcotics”. Mr. Wray testified that he and Ms. Wray seemed surprised by the remark but did not say anything.

[94] Mr. Wray then helped Ms. Wray back into a chair in the streaming section. He recalls that they were not given any instructions or told what plans were being made for her, whether it be discharge or something else. Mr. Wray testified that Ms. Wray received more medication for her pain.

[95] Mr. Wray needed to go to work that morning and before he left the ED he brought back a smoothie because Ms. Wray was hungry. When he returned he saw that she was no longer crying out in pain but was still somewhat restless. The nurse did not allow Ms. Wray to have the smoothie because there was a possibility that she may be going in for surgery. Mr. Wray then left for work.

[96] Mr. Wray was not there when Ms. Wray went for her ultrasound although he was aware that it was going to happen. He was also not present when she was discharged from the hospital.

[97] When he returned home that evening, Ms. Wray was at home. She advised Mr. Wray that she had an ultrasound but that there was too much fluid inside her abdomen to be able to see the results. She told Mr. Wray that she was advised that it was most likely a cyst and she was given a prescription for Dilaudid and was told to follow up with her family doctor in seven days.

[98] He observed that Ms. Wray was still restless and could not sleep in their bed. She decided to sleep on the sofa bed in the living room.

[99] Mr. Wray testified that over the next five days, Ms. Wray continued to show the same symptoms and was only comfortable lying on her right side in a fetal position. She continued to take Dilaudid for the pain which became increasingly more frequent than she wanted.

2024 BCSC 2135 (CanLII)

[100] Mr. Wray says that during this period Ms. Wray did not eat food at all. Every time she attempted to do so she would vomit. He also recalls her vaginally bleeding when she went to the bathroom. She was regularly taking her temperature and did not have a fever.

[101] On December 3, 2016, Mr. Wray noted that Ms. Wray was starting to feel better. She was able to walk around and to eat her dinner that night. He was surprised that she had an appetite and was able to eat.

[102] Mr. Wray testified that the following day, Ms. Wray's symptoms changed dramatically. He felt he needed some guidance on what to do, so he called 811 and spoke to a registered nurse.

[103] Mr. Wray testified that Ms. Wray was very reluctant to return to the hospital despite his repeated suggestions to do so prior to December 4, 2016. Mr. Wray stated that Ms. Wray did not want to return because she felt she was not going to receive any care if she went back.

[104] The registered nurse on the line called an ambulance for Mr. Wray. Even then, Ms. Wray was reluctant to go to the hospital. Mr. Wray testified that she kept saying that she would not receive any help there. Mr. Wray and paramedics were eventually able to convince her to go to the hospital.

Rene Pellerin

[105] Rene Pellerin is Ms. Wray's father. Although his evidence was limited, I found Mr. Pellerin to be a sincere, forthright and genuine witness.

[106] Mr. Pellerin testified that he was asked to pick up Ms. Wray from the hospital on November 30, 2016. He was not aware that she had been in the ED that day.

[107] Mr. Pellerin testified that when he arrived, he was shocked at seeing Ms. Wray's condition. He stated she was "not good"; she was hunched over, protective of her abdomen and had no colour in her face. He had never seen her appear that way in the past.

2024 BCSC 2135 (CanLII)

[108] Mr. Pellerin recalls Ms. Wray telling him that “they felt like it was a cyst that ruptured”.

[109] Although Mr. Pellerin repeatedly asked Ms. Wray to go to his house so that he could monitor her, she refused and wanted to be alone. Mr. Pellerin found this unusual because Ms. Wray usually liked to be with her family.

[110] After Mr. Pellerin dropped off Ms. Wray at her home, he followed up with her during the days after. She wouldn’t take any visitors.

Cherie Emerick, LPN

[111] Nurse Emerick is a licenced practical nurse. In 2016, she was working in the medical float pool at KGH. She testified that she attended to Ms. Wray on the date in question. Nurse Emerick noted that she seldom worked in the ED.

[112] Upon reviewing Ms. Wray’s medical chart from that day, Nurse Emerick confirmed that at 7:45 a.m., she charted Ms. Wray’s vitals and that Ms. Wray reported a 2/10 pain. Nurse Emrick conducted an abdominal assessment by pressing down gently on the abdomen. She noted that Ms. Wray’s pain was in the right lower quadrant on palpation, and that there was rebound pain.

[113] In cross examination, Nurse Emerick agreed that she would try to chart every time she reported to another health care provider. Nurse Emerick testified that there is no indication on Ms. Wray’s chart that her finding of rebound pain was brought to the attention of Dr. Balfour. Nurse Emerick testified that if she had advised Dr. Balfour of that finding, it would have been charted.

[114] Nurse Emerick testified that there is no indication on the chart that she was concerned Ms. Wray was drug-seeking.

Angela Sjoquist, RN

[115] Nurse Sjoquist is a registered nurse. She began working in the ED at KGH in 2010 after graduating from nursing school.

2024 BCSC 2135 (CanLII)

[116] Nurse Sjoquist testified to the general procedures of receiving patients in the ED at KGH. She noted that when patients arrive to the ED, they are assessed right inside the front doors at the triage area. Vitals are taken, the Emergency Assessment & Triage Record form starts getting filled out, and then the patient goes to “admitting”. If the patient is ambulatory, they are sent to the streaming area after admitting.

[117] Nurse Sjoquist was the triage nurse who would have first seen Ms. Wray arrived at the ED at 5:21a.m. Although she did not have an independent recollection of attending to Ms. Wray, she confirmed her handwritten notes on the Emergency Outpatient Record for November 30, 2016 pertaining to Ms. Wray.

[118] Nurse Sjoquist performed a secondary assessment of Ms. Wray. She charted that Ms. Wray was yelling out and moaning and looked pale. Nurse Sjoquist testified that Ms. Wray’s pain was a 10/10. She gave Ms. Wray an IV, and administered morphine in an effort to get Ms. Wray comfortable. Nurse Sjoquist monitored her closely while administering the morphine, including a frequent monitoring and charting of her vital signs. She gave a second dose of morphine within 10 minutes of the first does because Ms. Wray’s pain level was still high at 8/10. She noted that by 6:39 a.m., Ms. Wray’s pain went down to 1/10. This was approximately 20 minutes before the assessment by Dr. Balfour.

[119] Nurse Sjoquist believes the medication orders came from the night physician before Ms. Wray was actually seen by Dr. Balfour. In her experience at the KGH ED, there was nothing extraordinary about the amount of morphine that she gave Ms. Wray.

[120] Nurse Sjoquist was asked about the issue of patients seeking drugs. She testified that she had experienced patients coming in seeking drugs and that it was a common occurrence. When asked what patients do to try to obtain drugs, she stated that they will display a lot of pain, yelling or laying on the floor, or other behaviours, including hurting themselves.

2024 BCSC 2135 (CanLII)

[121] With respect to Ms. Wray, Nurse Sjoquist had no recollection of whether she thought Ms. Wray may have been drug-seeking on November 30, 2016 and she did not chart this fact. However, on cross-examination Nurse Sjoquist stated that she would not chart if she thought a patient was drug seeking.

2024 BCSC 2135 (CanLII)

Amy Payne, RN

[122] Nurse Payne has been a registered nurse since 2002. She joined the ED in early 2016 and was on shift when Ms. Wray arrived on November 30th. Nurse Payne also did not have an independent recollection of her dealings with Ms. Wray and also relied on her notes she made on the Emergency Outpatient Record for Ms. Wray.

[123] According to her notes, she assessed Ms. Wray at 8:45 a.m. and noted that, because Ms. Wray was complaining of pain, she administered 4mg of morphine along with 4mg of Zofran. She also charted that Ms. Wray was going for an ultrasound at 10:15 a.m. and was filling her bladder.

[124] Nurse Payne testified that based on the chart, it does not appear that Ms. Wray was reassessed by a nurse or given further analgesics after 8:45 a.m**.**

[125] Nurse Payne was asked on cross examination about whether there was anything in the chart to indicate that the patient was drug-seeking. She stated that, based on the chart, there does not seem to be.

EXPERT EVIDENCE

[126] An expert’s opinion is not conclusive. To be admissible, the opinion must be relevant and necessary, and its probative value must outweigh its prejudicial effect. The necessity criterion requires that the opinion provide scientific or technical information that is likely to be outside the court’s experience and knowledge. It will not meet that threshold if, on the proven facts, the court can form its own conclusions without help: *R v Mohan* , [1994] 2 S.C.R. 9, 1994 CanLII 80 (S.C.C.).

[127] In *Malette v. Shulman*, 63 OR (2d) 243 at para. 68, the Court outlined four factors for assessing expert testimony regarding standard of care:

> 1. The relevance of their training, experience and specialty to the medical issues before the court;
>
> 2. Any reason for the witness to be less than impartial;
>
> 3. Whether the standard of care propounded reflects the standard of the great majority of medical practitioners in the field in question; and
>
> 4. Whether the testimony appears credible and persuasive compared and contrasted with the other expert testimony at trial.

[128] While an assessment of the opinion of experts is necessary, the standard of care is not established by what a colleague, or even an expert, would do in their own practice: *Hillis v. Meineri*, 2017 ONSC 2845 at paras. 68–70. The expert opinion is one component of the totality of the evidence that must be considered.

Expert Opinion Evidence Tendered by Ms. Wray

[129] Ms. Wray called three experts, Dr. Garry Feinstadt and Dr. Ken Perrier, family physicians and Dr. William Siu, a radiologist.

Dr. Garry Feinstadt (Family Physician)

[130] Dr. Feinstadt is a family physician and was tendered as an expert in family and emergency medicine, qualified to provide opinion evidence on the standard of care of an emergency physician in the assessment, diagnosis, treatment, and discharge of patients with acute abdominal pain and suspected appendicitis.

[131] Dr. Feinstadt's medical career spans over 50 years, including working on the active staff at Vancouver General Hospital for almost 40 years and teaching medical students for family practice. Dr. Feinstadt does not have a specialization in emergency medicine.

[132] In 2006, Dr. Feinstadt returned to rural and remote medicine and has worked on a locum basis in EDs of rural community hospitals, including in Clearwater and Merritt, British Columbia. He estimates that on the weekend, the ED in Clearwater sees about 25 patients per day, and the ED in Merritt can see about 50 patients in

2024 BCSC 2135 (CanLII)

24 hours. Dr. Feinstadt agreed that he does not have experience working in the ED of a large tertiary hospital such as KGH.

[133] In his 50 years of practice, Dr. Feinstadt has diagnosed approximately 100 cases of acute appendicitis.

2024 BCSC 2135 (CanLII)

[134] Dr. Feinstadt wrote a report, dated September 18, 2023, in which he opines that Dr. Balfour breached the standard of care of a reasonable and prudent physician for several reasons.

[135] Firstly, Dr. Feinstadt opines that Dr. Balfour failed to conduct an appropriate history and physical examination. In his report, Dr. Feinstadt writes:

> An emergency room physician must obtain a clear description of the pain. In his original history, Dr. Balfour does not mention the pain, let alone provide an appropriate description of its characteristics. There are many mnemonics for abdominal pain, which have been devised to assist the physician. The following mnemonic, Lots Of Pain is just one:
>
> - Location
> - Onset
> - Type
> - Severity
> - Other locations (radiation)
> - Factors (aggravating/alleviating)
> - Progression
> - Associated Symptoms
> - Insight (what do they think it is)
> - Need relief (what have they taken)
>
> While the experienced emergency physician may not require an actual mnemonic, the above represents the approach to abdominal pain and the factors to be assessed and documented when dealing with abdominal pain. Dr. Balfour's documented history addressed very few of the above noted factors. Failure to address the features of the pain in a systematic and comprehensive fashion can obscure the actual diagnosis and, in my opinion, represents a breach of the standard of care of the reasonable and prudent physician.

[136] Secondly, Dr. Feinstadt opines that Dr. Balfour’s physical examination fell below the standard of care. He states that Dr. Balfour failed to: perform tests for peritoneal irritation; examine for antalgic gait; properly examine the patient, including

examining the four quadrants or flanks; and refer to guarding, rigidity, or bowel sounds.

[137] In cross examination, Dr. Feinstadt acknowledged that his assessment is based on Dr. Balfour's charting. He acknowledged that he could not be certain that Dr. Balfour did not consider all the factors listed in the mnemonic "Lots of Pain" and simply failed to chart them. Dr. Feinstadt further acknowledged that he does not know exactly what happened.

[138] Dr. Feinstadt also agreed that appendicitis is hard to diagnose and can mimic several other conditions, including gallbladder problems, urinary tract infections or pelvic inflammatory disease. Therefore, an assessment of whether or not a patient has appendicitis requires clinical evaluation and imaging, with the emphasis being on clinical evaluation.

[139] Dr. Feinstadt testified that there are certain diagnostic systems which, when all factors are present, can render a definitive diagnosis of appendicitis. One such system is called the Alvarado system. It gives points for signs of anorexia – meaning loss of appetite – nausea and vomiting, abdominal pain, abdominal pain radiating to the right lower quadrant, tenderness, rebound, elevated white blood cell count, and an elevated absolute neutrophil count known as a "left shift".

[140] In cross examination Dr. Feinstadt agreed that in this case, not all factors were present. For example, Ms. Wray did not have a fever, nor did she have a loss of appetite, given that she was in fact hungry at one point while in the ED and drank some of the smoothie brought to her by Mr. Wray.

[141] Dr. Feinstadt agreed that it is uncommon, but not unheard of, for appendicitis to present with a sudden onset of extreme pain and that pain associated with appendicitis has a gradual onset which migrates to the right lower quadrant. Dr. Feinstadt also agreed that patients with acute appendicitis may be loathe to move because of peritoneal irritation.

2024 BCSC 2135 (CanLII)

2024 BCSC 2135 (CanLII)

[142] Dr. Feinstadt agreed that while an elevated white blood cell count is commonly found with appendicitis, it is also commonly found with a lot of other conditions. Ms. Wray's white blood cell count was only slightly elevated.

[143] Dr. Feinstadt opines that the amount of morphine administered to Ms. Wray prior to her initial examination by Dr. Balfour would have probably been sufficient to render the patient incapable of providing an accurate history and would have obscured any physical findings such as rebound, guarding, and tenderness.

[144] However, in cross examination Dr. Feinstadt agreed that while it was common for surgeons to insist that patients not be medicated so that their condition could be properly assessed, that changed sometime in the 1990s and it became routine to provide sufficient analgesia to provide the patient with some comfort and relief without affecting the patient's ability to provide a good history and without obscuring the physical findings.

[145] Dr. Feinstadt also conceded that multiple studies have shown that by relieving a patient's pain, narcotic medication actually increased the accuracy of a physician's findings because the patient is better able to express their history.

[146] Dr. Feinstadt was taken to the product monograph for morphine, which he included with his report, and conceded that the amount of morphine Ms. Wray was given was in line with the starting dose as indicated on the product monograph:

> Q: So in fact, the amount of morphine that Ms. Wray received when she received 10 milligrams the morning of November 30th, 2016 is right in line with what the product monograph says could be a usual starting dose in adults. Do you agree that that's what this puts together?
>
> A: That is what that says.

[147] Although Dr. Feinstadt opines that Dr. Balfour's failure to perform a pelvic examination is a breach of the standard of care, he fails to explain why it was necessary given that Ms. Wray was going to have and ultimately had an endovaginal ultrasound. Dr. Feinstadt declined to answer whether an endovaginal ultrasound provides greater detail and clarity than a physical pelvic examination, but instead

reiterated that Tintinalli's Emergency Medicine textbook (Tintinalli's) and Up to Date (manual for emergency physicians) recommend that a pelvic examination be done.

[148] Dr. Feinstadt concludes in his report that the reasonable and prudent physician would have ordered further investigative testing such as CRP (c-reactive protein) and a CT scan, and would have kept the patient in hospital for further observation. In cross examination, Dr. Feinstadt agreed that a doctor does not need to perform every test in order to comply with the standard of care.

[149] Dr. Feinstadt agreed that a CRP is a sensitive but non-specific test that looks for inflammation or infection. It does not lead to a definite diagnosis. He agreed that an elevated CRP is consistent with any kind of peritoneal or intra-abdominal irritation, such as a ruptured ovarian cyst.

[150] Dr. Feinstadt agreed that with respect to imaging, the primary options to diagnose appendicitis are MRI, ultrasound, and CT, and that it is an emergency physician that decides which test to order.

[151] He agreed that while a CT scan has the best diagnostic accuracy for appendicitis, a CT scan also utilizes ionizing radiation, which carries a risk of malignancy with repeated CT scans. He agreed that there needs to be a very good indication for the use of CT in women of child-bearing age and in children. The more CT scans that a person has, the higher their risk of getting cancer.

[152] Dr. Feinstadt testified that where appendicitis is suspected on imaging, where it is suspected on clinical grounds, or where there is a discrepancy between the imaging and clinical grounds, a surgical consult is required.

[153] Finally, Dr. Feinstadt agreed that it was his opinion that in discharging Ms. Wray, Dr. Balfour did not fall below the standard of care so long as he provided appropriate follow up instructions. In his report, Dr. Feinstadt opines that the discharge should have included clear instructions to follow up in 12 hours and explicit instructions with respect to pain, fever, anorexia, and vomiting as adopted from Tintinalli's.

2024 BCSC 2135 (CanLII)

2024 BCSC 2135 (CanLII)

[154] Overall, while I found Dr. Feinstadt's evidence helpful, I find that much of his opinion retrospectively scrutinizes what Dr. Balfour should have or could have done according to what is described in medical textbooks. Moreover, Dr. Feinstadt made several concessions in cross-examination that supported Dr. Balfour and Dr. Ward's evidence. Where they differed in opinions, I place greater weight on the views of Drs. Ward and Siu.

Dr. Ken Perrier (Family Physician)

[155] Dr. Perrier is an experienced family physician. He has been Ms. Wray's physician since 2001. Dr. Perrier was tendered as an expert and qualified to provide opinion evidence in family medicine. Dr. Perrier was also tendered as a fact witness. He wrote a report dated September 30, 2022.

[156] Dr. Perrier provided a medical history of his treatment of Ms. Wray. In 2013, Ms. Wray had an ultrasound ordered due to right lower quadrant pain. The report revealed a possible complex cystic lesion within the right ovary. She also had complaints in February 2024, with the pain increasing in severity. Dr. Perrier referred Ms. Wray to Dr. Chai for possible endometriosis which was confirmed with testing. Dr. Chai reported that she suffered from chronic non-specific lower abdominal pain and cramping as well as right lower quadrant discomfort since 2011 and that some symptoms may be ovarian in nature.

[157] In 2015, Dr. Perrier saw Ms. Wray on a number of occasions for her endometriosis and pelvic pain. He recommended that Ms. Wray start intramuscular Depo-Provera for prevention of recurrent endometriosis. By 2016, Dr. Perrier noted that Ms. Wray had never started on the Depo-Provera.

[158] Dr. Perrier reviewed the charting of Ms. Wray's visit to the ED on November 30, 2016. Dr. Perrier testified that Dr. Balfour's workup of Ms. Wray on November 30, 2016 was thorough and appropriate. Dr. Perrier noted that Ms. Wray's investigations at the time of presentation were not significantly abnormal. He opines that the pelvic free fluid imaged on the ultrasound could be present in several clinical situations, including ruptured ovarian cysts or an early appendicitis. However,

Dr. Perrier testified that had Dr. Balfour assessed Ms. Wray when her pain was not masked by the medication, it is likely her exam would have been indicative of appendicitis.

[159] Dr. Perrier also assessed Ms. Wray's discharge:

> With her investigation results being very non-specific, her clinical examination becomes more important and in this case the analgesia given to Ms. Pellerin and her resultant marked reduction in pain prior to Dr. Balfour's clinical examination likely influenced his decision to discharge her home.

[160] I am unable to give any weight to these last parts of his opinion. Dr. Perrier is a family physician, and unlike Drs. Ward and Feinstadt, he has little experience practicing emergency medicine, including in a tertiary facility like KGH. He was not qualified to provide expert evidence in emergency medicine. His evidence is therefore limited to that of family medicine and his care of Ms. Wray.

Dr. William Siu (Radiologist)

[161] Dr. William Siu is a practicing radiologist and is on the medical staff at Royal Columbian Hospital and Eagle Ridge Hospital. He also works at a community clinic in Coquitlam. He was tendered as an expert in radiology qualified to provide opinion evidence in the field of radiology and the assessment of pelvic ultrasounds.

[162] Dr. Siu wrote a report, dated August 23, 2023, in which he opines that the diagnosis of appendicitis can be difficult, especially in the early stages when the symptoms and signs are vague and non-specific, as was the case with Ms. Wray.

[163] Specifically, Dr. Siu noted at p. 6 of his report:

> iii. In general, the diagnosis of appendicitis with ultrasound can be challenging, especially in a female. The appendix is a highly mobile and relatively small structure; thus, the appendix can be difficult to find due to its size and mobility and, in addition, it can be obscured (i.e., hidden) by other structures or can be mimicked by other loops of bowel in the right lower quadrant. In a female, ovarian or other gynecological pathologies, such as ruptured ovarian follicles/cysts or endometriosis, can produce similar non-specific symptoms, e.g., pain and tenderness and ultrasound findings, e.g., free fluid, as acute appendicitis.

2024 BCSC 2135 (CanLII)

[164] Dr. Siu noted that it is not uncommon for appendicitis to go undiagnosed on a patient's initial presentation. In the case of Ms. Wray, Dr. Siu stated there were three potential explanations to the appendicitis going undiagnosed:

> I agree that that is one of maybe three potential explanation (sic). So one possibility is that the appendicitis is so early that it hasn't swelled up, so the – 6 millimetre is usually our -- are considered within normal, anything less than six. So likes (sic) everything else in the body, there's a process -- you know, like a cancer when it first started is two cells. You can -- three cells, you can never detect
>
> it. You can only detect it when it gets to a certain size. So when the appendicitis starts, it may cause symptoms because, you know, it's -- it's starting to get inflamed, but it's still not inflamed enough to exceed that 6
>
> millimetre mark. So one of the possibility is that we're catching a very early appendicitis, and that is the appendix.
>
> …
>
> So this -- yes, the second -- the second -- the second potential -- wait. The second potential explanation is that that 4.4 millimetre loop of bowel is not the appendix but a loop of another bowel like a -- the -- this -- the last part of the small bowel is called the ileum, which also inserts into the cecum.
>
> So it could be that. Although most of the time, the ileum is a little bit more than 6 millimetre. Like, it would be more than 4.4 millimetre, but it is still possible.
>
> A third explanation is that that is the appendix and it's measuring a part of the appendix that's not yet inflamed. And there is more parts of the appendix that was not visible by the sonographer, and that portion of the appendix could have been inflamed, but the picture was taken a segment that was still normal looking.
>
> The appendix doesn't get all inflamed all at once. Quite often it's just a inflamed at the very tip which is very hard to find sometimes, and then it slowly kind of swells up, the -- the remainder of it. So it's -- there is potentially -- to me anyways, three different potential explanation for -- for this finding

[165] Dr. Siu also opined that pelvic free fluid is a non-specific finding that can be seen with endometriosis or from a rupture of a physiologic ovarian follicle/cyst.

[166] Dr. Siu testified that ultrasounds are better than CT scans at detecting appendicitis in people with very little body fat. He also opined that ultrasounds are the superior test for females because, quite commonly, the differential diagnosis for symptoms will include female organs such as the ovaries and uterus, and the CT is terrible at assessing those structures.

2024 BCSC 2135 (CanLII)

[167] Dr. Siu's report references an article which discusses certain issues ultrasounds present in diagnosing appendicitis. The contents of the article were not put to Dr. Siu or any of the experts in direct or cross examination. Dr. Siu's report, including the reference to the article, forms part of the totality of the evidence regarding the use of ultrasounds to visualize the appendix and diagnose appendicitis. I consider it along with the opinions and testimony of Dr. Feinstadt and Dr. Ward.

[168] This point in Dr. Siu's report supports similar points made over the course of this trial that an ultrasound can be an imperfect tool in diagnosing appendicitis. However, Dr. Siu's report ultimately does not challenge Dr. de Korompay's finding that the appendix was normal. Dr. Siu's report, including the article, do not disturb this fact, on which Dr. Balfour relied. Dr. Siu finds that Dr. de Korompay acted in accordance with the standard expected from a reasonable and prudent radiologist.

Expert Opinion Evidence Tendered by the Defendant, Dr. Balfour

[169] Dr. Balfour called two experts, Dr. John Ward, an emergency medicine specialist, and Dr. David Konkin, a general surgeon.

Dr. John Ward (Emergency Physician)

Evidence

[170] Dr. Ward is a specialist in emergency medicine and internal medicine and has been practicing for 27 years. Dr. Ward was tendered as an expert in emergency medicine and is qualified to provide opinion evidence on the standard of care of an emergency physician in the assessment, diagnosis, treatment, and discharge of patients with acute abdominal pain and suspected appendicitis in the ED.

[171] Dr. Ward currently practices emergency medicine at Providence Health Care (St. Paul's Hospital and Mt. St. Joseph's Hospital). Dr. Ward has been a clinical professor in the Department of Emergency Medicine at the University of British Columbia since 2015. In addition to his clinical work and teaching, Dr. Ward reviews patient complaints for the College of Physicians and Surgeons in British Columbia

2024 BCSC 2135 (CanLII)

which involves him reviewing the quality of care provided by physicians and assessing whether the physician met the standard of care.

[172] Dr. Ward estimates he has diagnosed several hundred cases of appendicitis over his career and investigated many more suspected cases.

[173] Dr. Ward comes with impressive qualifications. I found that Dr. Ward was prepared, articulate and helpful during his testimony. In my view, his report and testimony demonstrate his understanding of the role of an expert, which is to assist the Court, rather than to advocate for one party or another.

[174] In his report, Dr. Ward opines that Dr. Balfour's interpretation of Ms. Wray's presentation was reasonable and rational given the totality of the information available to him when he discharged her on November 30, 2016.

[175] Similar to the evidence of the other experts, Dr. Ward also opines that diagnoses of appendicitis can be clinically challenging and that patients often present with generalized abdominal pain that, over the course of 12-24 hours, localizes to the right lower quadrant. He confirmed that the pain is associated with: fever; a loss of appetite, with or without vomiting; rebound tenderness in the right lower quadrant; and an elevation of the white blood cell count.

[176] He noted that in these circumstances, diagnosis is not difficult. However, patients do not always present with a full picture. Dr. Ward opines that before the advent of reliable diagnostic imaging, numerous physical maneuvers were used primarily to increase the accuracy of clinical evaluation. However, in current practice, such maneuvers serve primarily to determine whether to pursue diagnostic imaging.

[177] Dr. Ward testified that a standard abdominal exam would include looking at the abdomen to see if there is anything abnormal, listening for bowel sounds, and palpating the abdomen for tenderness. Dr. Balfour opines that given that Dr. Balfour arrived at a differential diagnosis that included appendicitis, he must have completed an appropriate bedside assessment.

2024 BCSC 2135 (CanLII)

[178] Dr. Ward observes that Dr. Balfour rightly considered appendicitis in his differential diagnosis. Given his clinical impression, arranging imaging was the expected course of action. Dr. Ward opines that Dr. Balfour's decision to order an ultrasound rather than a CT was reasonable and consistent with standard practice, considering the cumulative exposure to radiation associated with CT scans.

[179] Dr. Ward opines that when an ultrasound is negative, a diagnosis of appendicitis is extremely unlikely. Given that Dr. Balfour received a "negative" ultrasound – one showing a normal appendix – Dr. Ward opines that the conclusion that Ms. Wray did not have appendicitis was "reasonable and logical". Dr. Ward notes "the interpretation of an abdominal ultrasound to rule out appendicitis would be beyond the expertise of most emergency physicians and would be dependent on the opinion of a radiologist".

[180] Dr. Ward further opines that given the ultrasound report described a normal appendix and free fluid in the pelvis, the rupture of an ovarian cyst would be a very plausible and common explanation for Ms. Wray's symptoms, as would an exacerbation of her endometriosis. He notes that tenderness in the region of the appendix is the rule when the right ovary has ruptured and could also be seen with endometriosis.

[181] In cross examination, Dr. Ward explained that Ms. Wray's previous presentation on September 23, 2014 provided an alternate explanation for her presentation in the context of a normal appendix visualized on ultrasound. He testified that free fluid with debris, in the context of a normal appendix visualized on ultrasound, would make him suspicious that something had happened to the ovary, such as a ruptured cyst.

[182] Dr. Ward was asked whether a finding of moderate free fluid with debris and a finding of rebound pain, despite the normal appendix being visualized, would warrant further investigation. Dr. Ward testified that it would not. He expanded on this:

> Q: Doctor, if -- with a finding of moderate free fluid with debris, and if there was

2024 BCSC 2135 (CanLII)

rebound pain --

A*:* Mmhmm.

Q -- despite the reference to a normal appendix, would you agree that that requires some further investigation?

A: No. It's actually not uncommon to see rebound tenderness with a ruptured ovary (sic).

Q**:** Ruptured ovary or a ruptured cyst?

A*:* Oh, ruptured -- sorry, ruptured cyst.

[183] On the issue of a repeat assessment before discharge, Dr. Ward clarified that even if Dr. Balfour did not do one, that would not change his opinion that Dr. Balfour met the standard of care. Dr. Ward testified that the "fundamental issue in the whole case is that Dr. Balfour had received a definitive result from a study that we would rely on, telling him that it wasn't appendicitis". He would expect Dr. Balfour to go back to the patient and talk to them but a "physical examination was not likely to be more reliable than the ultrasound report that he had just received".

[184] On the issue of Dr. Balfour's discharge instructions, Dr. Ward opines that Dr. Balfour's treatment of Ms. Wray and subsequent decision to discharge her was in accordance with what he would expect of a competent emergency physician.

[185] Dr. Ward testified that if Dr. Balfour had told Ms. Wray to follow up with her family physician in seven days, with no further instructions, that would represent a breach of the standard of care. However, Dr. Ward testified that Dr. Balfour's chart states that he recommended that Ms. Wray see a family doctor and follow up with the clinic if her symptoms increased, so it was very unlikely that the follow up instructions were as Ms. Wray perceived them to be.

[186] In his testimony, Dr. Ward explained the difference between a sign and symptom. He described that a symptom is something experienced by a patient, whereas a sign is what the physician finds when they examine the patient. Dr. Ward testified that numerous studies have found that narcotic analgesics can mask the patient's symptoms of pain, but they do not mask the signs, and in fact, the sign becomes more specific and reliable with the use of analgesics.

2024 BCSC 2135 (CanLII)

2024 BCSC 2135 (CanLII)

Question of Objectivity

[187] Ms. Wray submits that very little weight should be given to the evidence set out in Dr. Ward's report due to lack of objectivity. In particular, she submits that it is clear that counsel had significant input into the changes that were made from his draft report to his final report.

[188] It is trite that expert witnesses have a common law and statutory duty to, when needed, assist the court by providing an independent and impartial opinion: *White Burgess Langille Inman v. Abbott and Haliburton Co., 2015 SCC 23* at para. 26 [*White Burgess*]; *Supreme Court Civil Rules*, R. 11-2(1).

[189] An expert's report or testimony can be challenged on the basis that it lacks objectivity because it is influenced by the counsel who retained them. However, the mere fact that counsel retained, instructed, and paid the expert does not alone undermine the expert's objectivity: *White Burgess* at para. 32.

[190] Lack of independence or impartiality can impact both the admissibility of the evidence and the weight given to it, even if it is deemed admissible: *White Burgess* at para. 40.

[191] In *Moore v Getahun,* 2015 ONCA 55, the Court reviewed the extent to which counsel could consult with an expert witness without raising concerns related to the independence of the expert. The Court stated unequivocally that consultation between counsel and experts is widely accepted, within certain limits, and is "necessary to ensure the efficient and orderly presentation of expert evidence and the timely, affordable and just resolution of claims": at para. 49.

[192] In *Moore*, the changes between the draft and final reports were deemed to be minor and mainly editorial. They did not alter the substance of the report or the expert's opinion. The Court stated that "expert witnesses need the assistance of lawyers in framing their reports in a way that is comprehensible and responsible to the pertinent legal issues in the case": para. 62.

[193] The Court in *Moore* went on to state the following:

> [63] Consultation and collaboration between counsel and expert witnesses is essential to ensure that the expert witness understands the duties reflected by rule 4.1.01 and contained in the Form 53 acknowledgment of expert's duty. Reviewing a draft report enables counsel to ensure that the report (i) complies with the Rules of Civil Procedure and the rules of evidence, (ii) addresses and is restricted to the relevant issues and (iii) is written in a manner and style that is accessible and comprehensible. Counsel need to ensure that the expert witness understands matters such as the difference between the legal burden of proof and scientific certainty, the need to clarify the facts and assumptions underlying the expert's opinion, the need to confine the report to matters within the expert witness's area of expertise and the need to avoid usurping the court's function as the ultimate arbiter of the issues.
>
> [64] Counsel play a crucial mediating role by explaining the legal issues to the expert witness and then by presenting complex expert evidence to the court. It is difficult to see how counsel could perform this role without engaging in communication with the expert as the report is being prepared.
>
> [65] Leaving the expert witness entirely to his or her own devices, or requiring all changes to be documented in a formalized written exchange, would result in increased delay and cost in a regime already struggling to deliver justice in a timely and efficient manner. Such a rule would encourage the hiring of "shadow experts" to advise counsel. There would be an incentive to jettison rather than edit and improve badly drafted reports, causing added cost and delay. Precluding consultation would also encourage the use of those expert witnesses who make a career of testifying in court and who are often perceived to be hired guns likely to offer partisan opinions, as these expert witnesses may require less guidance and preparation. In my respectful view, the changes suggested by the trial judge would not be in the interests of justice and would frustrate the timely and cost-effective adjudication of civil disputes.

[194] Where expert evidence has been admitted, a trial judge can still consider the expert's independence when "fully testing the weight that his evidence should properly attract": *R. v. Leclair*, 2021 BCSC 400 at para. 80. Cross-examination is a key procedural safeguard to assist the court in this regard: *Moore* at para. 61.

[195] In *Vancouver Community College v. Phillips Barratt*, 26 B.C.L.R. (2d) 296, 1988 CanLII 2827 (B.C.S.C.), Justice Finch assessed the proper weight to be given to an expert's evidence. In deciding to attribute no weight to the evidence, Justice Finch stated the following:

> [33] I in no way wish to condemn the practice of an expert's editing or rewriting his own reports prepared for submission in evidence or, for that

2024 BCSC 2135 (CanLII)

> matter, prepared solely for the advice of counsel or litigants. Nor do I wish to condemn the practice of counsel consulting with his experts in the pre-trial process while "reports" are in the course of preparation. It is, however, of the utmost importance in both the rewriting and consultation processes referred to that the expert's independence, objectivity and integrity not be compromised. I have no doubt that in many cases these ends are achieved, and counsel and experts alike respect the essential boundaries concerning the extent to which a lawyer may properly discuss the expert's work product as it develops towards its final form.
>
> [34] Regrettably, in this case, the boundaries were not observed. I will refer to some particular examples presently, but I cannot avoid saying that generally counsel participated far too much, and inappropriately, in the preparation of Atkins' reports. Atkins willingly permitted such participation by counsel and seriously compromised the objectivity of his opinions. Counsel suggested, and Atkins agreed to, many additions and deletions to his report. These suggestions went far beyond statements concerning factual hypotheses, their evidentiary foundation, the definition of issues, or other matters on which counsel might properly have advised or commented. Rather, the suggestions went to the substance of Atkins' opinions and the way in which they were expressed. The suggested changes were all one way. Any critical reference in Atkins' drafts to V.C.C., to its staff, to the Ministry of Education ("M.O.E."), or its staff, were removed. Criticisms of or complaints against P.B. were elaborated and multiplied. The result has been Ex. 12, and subsequent documents prepared by Atkins, that are hopelessly partisan and unfair. The reports and other documents he prepared have none of the objectivity or independence that the court looks for in reliable opinion evidence. They really amount to nothing more nor less than arguments advanced on V.C.C.'s behalf through the mouth of "an expert". Unlike convincing arguments, these are not based upon any honest, objective assessment of all of the evidence, nor upon factual hypotheses that are supported by other reliable evidence.

[196] On the other hand, in *R. v. Boule*, 2020 BCSC 1493, Justice Iyer found that the assistance counsel provided the expert on their draft report related to the form and not the substance of the report: at para. 23. While Justice Iyer was analyzing the overall admissibility of the expert's evidence, she did note that the admissibility of the evidence and the weight afforded to it were distinct questions: at para. 36.

[197] Counsel for Ms. Wray noted that there were several changes from Dr. Ward's draft report to his final report. Specifically, there was a deletion of: a "Case Summary"; commentary on tests and imaging used to diagnose appendicitis; a specific reference to Ms. Wray's low serum bicarbonate; a specific reference to

2024 BCSC 2135 (CanLII)

Dr. Balfour being unable to remember specifically what he said upon discharging Ms. Wray; and part of Dr. Ward's conclusion.

[198] Ms. Wray does not dispute the admissibility of Dr. Ward's report. However, her counsel argues that, given the evidence adduced in cross-examination, Dr. Ward acceded to requests by Dr. Balfour's counsel to alter certain portions of his report, the report should be given little weight.

[199] This was put to Dr. Ward in cross examination. He stated that he reviewed and edited his own report and consulted with counsel before finalizing his report. Dr. Ward provided three general bases for the impugned deletions. First, he relied on a statement of assumed facts in his final report that he did not in his draft, which removed the necessity of the "Case Summary" portion of his report. Second, he conducted his own editing of the report and made changes at various points, either for stylistic reasons or for concision. Third, he consulted with defendant counsel regarding the draft and took into account various notes, primarily that the report be as clear and concise as possible. Dr. Ward noted at various times in cross examination that he did not recall the reason for a specific change but noted that it was likely for one of the aforementioned reasons. He further stated in cross examination that he did not think the changes impacted his opinion in any way.

[200] Having reviewed the draft report and Dr. Ward's explanation for the changes, I am not satisfied that the revisions and any suggestions made by counsel went to the substance of Dr. Ward's opinion. The changes largely removed commentary that was secondary or tangential to Dr. Ward's opinion. The changes to portions that dealt directly with the live issues were editorial in nature and did not change the tenor of Dr. Ward's opinion. Dr. Ward's testimony under cross examination sufficiently explained the changes. The impugned changes between the draft and final report therefore will not negatively impact the weight that I attribute to Dr. Ward's evidence.

2024 BCSC 2135 (CanLII)

Dr. David Konkin (General Surgeon)

[201] Dr. Konkin is a general surgeon. He is the Regional Medical Director and Department Head of Surgery for the Fraser Health Authority and a clinical professor in the Department of Surgery, Division of General Surgery, at University of British Columbia.

[202] Dr. Konkin opines in his initial report that the plaintiff’s appendix likely perforated around December 2 or 3, 2016.

[203] In his responsive report, Dr. Konkin responded to the opinions of Dr. Feinstadt and Dr. Perrier. Notably, Dr. Konkin does not agree with Dr. Feinstadt that a surgical consultation was warranted in this case. I note that, like Dr. Ward, Dr. Konkin also opines that an ultrasound was appropriate given Ms. Wray’s presentation, as it can look at the appendix but also gynecological causes of abdominal pain, including ovarian cysts. He concludes that a general surgery consultation was not warranted in this case.

LEGAL FRAMEWORK

Negligence

[204] To succeed in a negligence claim, the plaintiff must demonstrate the following elements:

a) the defendant owed the plaintiff a duty of care;

b) the defendant's behaviour breached the requisite standard of care;

c) the plaintiff sustained damage; and

d) the damage was caused, in fact and in law, by the defendant's breach.

See *Mustapha v. Culligan of Canada*, 2008 SCC 27 at para. 3; *Waterway Houseboats Ltd. v. British Columbia*, 2020 BCCA 378 at para. 198 [*Waterway*].

2024 BCSC 2135 (CanLII)

[205] In this case, as in most medical malpractice claims, it is accepted that the defendant owed the plaintiff a duty of care and that the plaintiff suffered damage: *Chasczewski v. 528089 Ontario Inc.*, 2012 ONCA 97 at para. 12. Accordingly, the case turns on the standard of care and whether Dr. Balfour failed to meet the required standard of care.

2024 BCSC 2135 (CanLII)

Standard of Care

[206] The standard of care required of a physician was set out in *Ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at 693, 1995 CanLII 72 [*Ter Neuzen*]:

> 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: see Wilson v. Swanson, 1956 CanLII 1 (SCC), [1956] S.C.R. 804, at p. 817, *Lapointe v. Hôpital Le Gardeur*, 1992 CanLII 119 (SCC), [1992] 1 S.C.R. 351, at p. 361, and *McCormick v. Marcotte*, 1971 CanLII 52 (SCC), [1972] S.C.R. 18.

[207] The standard of care required of a physician is not one of perfection or even of excellence, and not all errors will necessarily fall below a physician’s standard of care: *Carlsen v. Southerland*, 2006 BCCA 214 at paras. 13, 15; *Gilmore* at para. 234. To that end, the court must exercise caution to avoid holding a physician “to a standard of perfection by using a poor outcome or a low risk of injury to infer negligence”: *Siever v. Interior Health Authority*, 2021 BCSC 880 at para. 102 .

[208] The standard of care is assessed with reference to the time of the events in issue. A physician will not have failed to meet the standard if their treatment “corresponds to recognized medical science at the time, even if there are competing theories”: *Gilmore* at para. 232, citing *Ter Neuzen* at 695. Physicians “should not be held liable for errors of clinical judgment that are distinguishable from professional fault”: *Medina v. Wong*, 2018 BCSC 292 at para. 100 .

[209] In evaluating clinical judgment, the Court in *Medina* explained that “exercises of clinical judgment are decisions made by medical practitioners once they have considered all of the relevant information it is reasonably possible to obtain under the circumstances”: at para. 101.

2024 BCSC 2135 (CanLII)

[210] Recognizing that treatment requires an exercise of clinical judgment, “there will be cases where two reasonable physicians, acting reasonably, may disagree as to a course of action and diagnosis”: *Gilmore* at para. 237. In such cases, so long as the defendant follows one such reasonable course of action, they will not have failed to meet the required standard of care: *Gilmore* at paras. 237–238, citing *O’Connor v. Wambera*, 2018 BCSC 886 at paras. 50, 110–111.

[211] Further, any given error of judgment is not necessarily a negligent one. An error must be evaluated “relative to the conduct of a reasonable practitioner in similar circumstances”: *Medina* at para. 103.

[212] Courts must be cognizant of the dangers of hindsight analysis in determining and assessing the standard of care. To that end, in *O’Connor* at para. 107, Chief Justice Hinkson quoted Madam Justice L’Heureux-Dubé’s decision in *Lapointe v. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351 at 362–363:

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

[213] Ultimately, “doctors are to be judged by the standards at the time of the events, and not on the basis of what could only have been known with hindsight or with advances in medical knowledge”: *Gilmore* at para. 244.

[214] Where the defendant is an emergency room physician, further considerations may apply. As this Court noted in *Pinch*, “[t]he emergency room creates a distinctive

2024 BCSC 2135 (CanLII)

contextual setting". In that context, at paras. 155–156, the Court in *Pinch* set out the following principles:

a) "an emergency medicine specialist is expected to exercise a great deal of skill in history taking, examination, and instant diagnosis";

b) an "emergency room physician must apply differential diagnosis to determine whether the presenting complaint is a major problem or some other issue", and should accordingly "give priority to the diagnosis with the most severe outcome, a 'worst is first' approach";

c) "[a] process of diagnosis that focuses on the most likely explanation is inconsistent with a proper differential diagnosis";

d) "if a specific risk is foreseeable, the applicable standard of care is commensurate with the potential danger"; and

e) "[i]f a potentially life-threatening condition is included in the differential diagnosis, it is urgent to either confirm it or to rule it out".

[215] In assessing whether a physician has met the standard of care, the court may consider evidence of the physician's "common or usual practice, and even give it significant weight": *Gilmore* at para. 62. This can include medical charting evidence, and if charts do not contain documentation of a particular act, evidence of standard practice can still be admissible: *Gilmore* at para. 63, citing *Wiebe v. Fraser Health Authority,* 2018 BCSC 1710 at para. 118.

[216] Ms. Wray argues that the decision of *Bearden v. Lee*, [2003] O.J. No. 1261, is analogous to the case at hand. In that case, the Court found that the physician fell below the required standard of care, in part, because in that case, "written discharge instructions should have made it clear that follow-up was absolutely necessary, whether or not the abdominal pain simply persisted, and whether or not it increased": at para. 123.

2024 BCSC 2135 (CanLII)

Misdiagnosis & Errors in Judgement

[217] Ms. Wray acknowledges that doctors are not to be held to a standard of perfection and an error in judgment that does not fall below the standard of care is a defence to a misdiagnosis claim. She relies on *Adair Estate v. Hamilton Health Sciences Corp.*, [2005] O.J. No. 2180, a case that involved the misdiagnosis of a small bowel obstruction that resulted in the plaintiff's death. Justice Harris, at para. 121 of that decision, summarizes the distinction between an error in judgment that is negligent versus non-negligent:

> The defendants' rightfully point out that being incorrect on a judgment call does not form the basis of liability. But choosing a diagnostic thought process that is fundamentally flawed is not a judgment call; it is negligence. The process of making and acting on a differential diagnosis requires a specific consideration of the question of severity.

[218] Regarding reliance on probability and the importance of differentials when presented with symptoms that point to numerous potential diagnoses, Harris J. stated the following:

> [153] If doctors were to diagnose based on probability, rare and severe ailments would regularly be ignored in favour of common, non-life threatening alternatives. When faced with symptoms that point to two or more diseases, the universally acceptable system to use is a differential diagnosis that accounts for severity. Given the symptoms, the possibility of a bowel obstruction should reasonably have been at or near the top of the differential diagnoses list of risks. Dr. McDonagh's reliance on probability is a violation of a universally accepted diagnostic practice of the profession and is negligent.

[219] Dr. Balfour relies on this Court's commentary in *Medina:*

> [100] Medical practitioners should not be held liable for errors of clinical judgment that are distinguishable from professional fault: *Lapointe v. Hôpital Le Gardeur*, 1992 CanLII 119 (SCC), [1992] 1 S.C.R. 351 at 720.
>
> [101] Clinical judgment is not guesswork based on incomplete information. Exercises of clinical judgment are decisions made by medical practitioners once they have considered all of the relevant information it is reasonably possible to obtain under the circumstances. This includes the results of tests and consultations: *Campbell v. Roberts*, 2014 ONSC 5922 at para. 100.
>
> [102] This statement applies to both doctors and nurses, with the caveat that a nurse's discretion is more limited because they do not occupy the same diagnostic role as doctors and cannot depart from a doctor's instructions absent clear and obvious negligence or incompetence: *Tekano*

> *(Guardian ad litem of) v. Lions Gate Hospital* (1999), 16 B.C.T.C. 194 at paras. 109–110 (S.C.).
>
> [103] It is important to note that an error of judgment does not necessarily shield a medical practitioner from liability. The error must be assed relative to the conduct of a reasonable practitioner in similar circumstances. As stated in *Whitehouse v. Jordan*, [1981] 1 All E.R. 267 at 281 (H.L.):
>
>> Merely to describe something as an error of judgment tells us nothing about whether it is negligent or not . . . it depends on the nature of the error. If it is one that would not have been made by a reasonably competent [professional] professing to have the standard and type of skill that the defendant held [themselves] as having, and acting with ordinary care, then it is negligence. If, on the other hand, it is an error that a [professional], acting with ordinary care, might have made, then it is not negligence.

See also: *Brodeur (Litigation guardian of) v. Provincial Health Services Authority*, 2016 BCSC 968 at paras. 104–105.

DISCUSSION

[220] When assessing whether there has been a breach of the standard of care, I must exercise caution to avoid holding Dr. Balfour to a standard of perfection by using a poor outcome as a starting point and working backward. I must also keep in mind that an injured person is not required to disprove every conceivable non-negligent explanation for the injury: *Siever* at para. 102.

[221] I am also mindful of the oft cited comments of Madam Justice L'Heureux Dubé in *Lapointe* at 362–363:

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

[222] I have considered the expert evidence and the relevant facts that existed at the time of Dr. Balfour's examination, diagnosis, treatment and discharge of Ms. Wray to determine what a reasonable and prudent physician would do in like circumstances.

2024 BCSC 2135 (CanLII)

2024 BCSC 2135 (CanLII)

Initial Assessment

[223] Ms. Wray contends that Dr. Balfour fell below the standard of care of an emergency room physician by failing to take an appropriate history and conduct an appropriate physical examination, and further, doing so while her condition was obscured by pain medication. She also asserts that Dr. Balfour breached the standard of care due to inadequate record taking.

[224] Dr. Feinstadt listed a number of mnemonics for abdominal pain that he says are devised to assist a physician as described in Tintinalli's. He opines that Dr. Balfour's failure to address the features of pain in a systematic and comprehensive fashion represents a breach of the standard of care of the reasonable and prudent physician.

[225] I find that based on his standard practice, Dr. Balfour conducted an appropriate history and that his physical examination was also appropriate. This is supported by the objective evidence of what he recorded in his charting. Dr. Ward opines, which I accept, that because Dr. Balfour arrived at a differential that included appendicitis, his physical exam and assessment was appropriate.

[226] While Ms. Wray does not recall every detail of her interaction with Dr. Balfour, I accept her recollection that the initial examination by Dr. Balfour lasted about ten minutes.

[227] As well, while Dr. Balfour did not list each and every step of his physical examination, I am not satisfied that he failed to do an appropriate one. There is no obligation to include in a hospital chart a full transcript of each conversation with a patient. As noted by Dillon J. in *Pinch*, the lack of charting does not necessarily mean that procedures were not conducted, nor is the mere lack of charting *prima facie* evidence of negligence in the treatment.

[228] In fact, Dr. Feinstadt agreed that he cannot actually say that Dr. Balfour did not consider the factors listed in the mnemonic and simply did not chart them. I find that Dr. Balfour's history-taking and examination of Ms. Wray was commensurate

with the requisite standard of care. I do not agree that there was a failure to chart necessary information, or that the information recorded is ambiguous.

[229] Even if I were to accept that Dr. Balfour should have taken a more thorough history and physical examination as suggested by Dr. Feinstadt, the question then becomes where would that have taken Dr. Balfour? Based on Dr. Balfour’s own testimony and his charting, I accept that he would have likely ordered the same diagnostic testing, an ultrasound and not a CT scan. His primary concerns after taking Ms. Wray’s history and conducting a physical examination were an ovarian cyst, some other complication relating to her endometriosis, and appendicitis. This assessment would not have changed.

[230] Regarding Ms. Wray being over medicated, Dr. Feinstadt opined that the amount of morphine administered to Ms. Wray would have probably been sufficient to render the patient incapable of providing an accurate history and would have obscured any physical findings such as rebound, guarding, and tenderness.

[231] Neither Ms. Wray nor Mr. Wray testified that Ms. Wray was so medicated that she was not able to communicate with Dr. Balfour. Rather, Ms. Wray testified that there was “not a lot of extensive conversation”, but not that she was unable to communicate with him.

[232] I accept the opinion of Dr. Ward that narcotic analgesics do not mask signs, which is what the physician looks for when a patient is examined, and that the sign becomes more specific and reliable with the use of analgesics. I note that in cross examination Dr. Feinstadt conceded on this point as well.

[233] Nurse Sjoquist testified that in her experience of having worked in the ED since 2010, there was nothing extraordinary about the amount of morphine she gave to Ms. Wray. As well, Dr. Feinstadt conceded that the amount of morphine given to Ms. Wray was in line with the starting dose as indicated in the product monograph for morphine.

2024 BCSC 2135 (CanLII)

[234] Based on the whole of the evidence, I find that Ms. Wray was not over medicated. She received the appropriate amount of morphine to relieve her pain and it did not affect her ability to communicate with Dr. Balfour. The morphine did not obscure the actual diagnosis. The evidence simply does not support this.

2024 BCSC 2135 (CanLII)

Diagnosis and Use of Judgement

[235] Ms. Wray argues that once Dr. Balfour learned her medical history of endometriosis, he had an anchoring bias for diagnosing an ruptured ovarian cyst as the cause of her symptoms and incorrectly diagnosed her.

[236] Dr. Balfour had both appendicitis and a ruptured ovarian cyst on the differential diagnosis as it related to Ms. Wray's abdominal pain. He also charted that her pelvic pain was not yet diagnosed.

[237] I accept that Dr. Balfour arrived at this conclusion based on Ms. Wray's past medical history including a history of endometriosis, his history taking and physical examination of Ms. Wray, as well as the results of the ultrasound imaging which included an endovaginal ultrasound.

[238] The following chart summarizes Ms. Wray's symptoms along with the symptoms associated with the diagnosis of a ruptured ovarian cyst and appendicitis:

Ms. Wray's Symptoms	**Ruptured Ovarian Cyst**	**Appendicitis**
Sudden onset	Sudden onset, usually maximal at onset and improves over time	Gradual onset
Pain all over abdomen from sternum to pelvic floor	Localized to right lower quadrant	Migrates to right lower quadrant
Yelling, squirming, could not settle	Made worse by movement, palpation	Made worse with movement
Nausea and vomiting	Associated with nausea and vomiting	Associated with nausea and vomiting
No rebound pain on Dr. Balfour's assessment	Causes rebound tenderness	Causes rebound tenderness
Ms. Balfour was hungry on November 30, 2016	-	Loss of appetite
No fever	-	Fever

Free fluid with debris	Free fluid with debris	No free fluid with debris until after appendix rupture

[239] As I have already noted, there is no dispute that doctors should not be held to a standard of perfection, and they are not required to come up with the correct diagnosis “right out of the gate”. However, I do agree with Ms. Wray that physicians have an obligation to follow a sound diagnostic thought process and to communicate it with the patient. Choosing a diagnostic thought process that is fundamentally flawed is not a judgment call, but rather negligence.

[240] Based on all of the evidence, I find that Ms. Wray presented with symptoms that were more closely aligned with a ruptured ovarian cyst than appendicitis. I also find that Dr. Balfour’s assessment that the abdominal pain was not yet diagnosed was a sound one.

[241] In reviewing the Ultrasound Worksheet, I accept that it confirmed a normal appendix.

[242] Dr. Balfour says he would have reviewed the Ultrasound Worksheet and then called the radiologist, Dr. de Korompay because of his concerns surrounding the free fluid. Based on the Patient Record Access Report, I accept that this conversation very likely occurred. I base this finding on Dr. Balfour’s standard practice, as well as the times that the PACs monitor was accessed by both Dr Balfour (under Dr. Reed’s name) and Dr. de Korompay. I accept Dr. Balfour’s evidence that he would have inquired whether the free fluid could be attributable to other causes, such as a ruptured ectopic cyst or ruptured ovarian cyst. I also accept Dr. Balfour’s evidence that he would have confirmed that the appendix was visualized and that it was normal and that there was no sonographic evidence of appendicitis.

[243] I note that Dr. Perrier also opined in his report that the ultrasound did not reveal an abnormal appendix even though there was some free fluid. He also opined that a small volume of free fluid may be present in several clinical situations, including ruptured ovarian cysts or an early appendicitis.

2024 BCSC 2135 (CanLII)

[244] Dr. Feinstadt also agreed that if the ultrasound is negative, that means a normal appendix has been seen. And in that situation, appendicitis is unlikely, with certain provisos.

[245] I accept without reservation, Dr. Ward's opinion that when an ultrasound is negative showing a normal appendix, a diagnosis of appendicitis is extremely unlikely. Dr. Ward further opines, which I accept, that free fluid with debris in the pelvis with a normal appendix would be a reasonable and plausible explanation for Ms. Wray's symptoms.

[246] In all of the circumstances, I find that Dr. Balfour's conclusion that Ms. Wray did not have appendicitis was reasonable and logical.

[247] Ms. Wray further asserts that Dr. Balfour failed to undertake further investigation, such as: ordering a CT scan; further lab tests, such as a CRP test; conducting a further assessment, including vital signs; or keeping her in hospital for further observation when she was still in severe pain and he had not ruled out appendicitis. She says this is supported by Dr. Feinstadt's opinion.

[248] It is accepted by all of the experts that diagnosing appendicitis can be difficult. Dr. Siu opined that it is especially difficult in the early stages when symptoms and signs are vague and non-specific, as was the case with Ms. Wray. He also noted that pelvic free fluid can also be seen with endometriosis or from a rupture of an ovarian cyst.

[249] Dr. Perrier agreed that medicine is not a perfect science and there is "certainly an art to the diagnostic process" and that medical diagnoses may be elusive and require some days, weeks, or months to investigate.

[250] I do not agree with Dr. Feinstadt's opinion that by not performing a pelvic exam as set out in Tintinalli's, Dr. Balfour breached the standard of care. A pelvic exam would not have provided any useful information to rule out appendicitis and therefore would not have changed Dr. Balfour's decision to order an ultrasound.

2024 BCSC 2135 (CanLII)

[251] With respect to Dr. Balfour not ordering a CT scan, I prefer the evidence of Drs. Ward and Siu over Dr. Feinstadt's. Dr. Ward opined that Dr. Balfour's decision to order an ultrasound instead of a CT scan was reasonable and consistent with standard practice considering the cumulative exposure to radiation that comes with a CT scan. Dr. Feinstadt himself noted that there needs to be a very good indication for the use of CT in women of child-bearing age and in children.

[252] Dr. Siu testified that ultrasounds are better than CT scans at detecting appendicitis in people with very little body fat. Dr. Balfour also made a similar comment. Dr. Siu further testified that ultrasounds are the superior test for females because quite commonly, the differential diagnosis for symptoms will include female organs such as the ovaries and uterus, and the CT is terrible at assessing those structures.

[253] I find that Dr. Balfour's decision to send Ms. Wray for an ultrasound to be sound and reasonable. I am not convinced that he should have chosen the CT scan route over the ultrasound route.

[254] Ms. Wray submits that Dr. Balfour should have ordered a CRP test prior to discharge, relying on Dr. Feinstadt's opinion. She argues that because a CRP test was done when she returned to the ED on December 4, 2016, one should have been ordered by Dr. Balfour. I am not persuaded by this argument. The CRP test was ordered on December 4, 2016 because Ms. Wray presented with different and increasing signs and symptoms than she did on November 30th. The attending physician was also aware that the diagnosis of a ruptured ovarian cyst was not correct. I also note that the attending physician did not initially include appendicitis in his differential diagnosis.

[255] I accept Dr. Ward's opinion that a finding of moderate free fluid with debris and a finding of rebound pain despite the normal appendix being visualized in an ultrasound, would not warrant further investigation. I also accept his opinion that it would not be uncommon to see rebound tenderness with a ruptured cyst. In my

2024 BCSC 2135 (CanLII)

view, the fact that Nurse Emrick noted rebound is not conclusive of Ms. Wray having appendicitis.

[256] Dr. Balfour contends, and I accept, that if the evidence establishes more than one recognised and accepted body of medical opinion, a physician is not negligent if they adhere to one accepted school of thought.

[257] I am persuaded that the opinions of Drs. Siu and Ward represent one accepted school of thought as to the acceptable standard of care by Dr. Balfour with respect to his decision to send Ms. Wray for an ultrasound rather than a CT scan and not pursue further investigations including a CRP. I therefore conclude that Dr. Balfour has met the requisite standard of care.

Discharge Instructions

[258] The parties agree that the only two witnesses that can testify as to whether Dr. Balfour breached the standard of care as it relates to discharge instructions are Dr. Balfour and Ms. Wray.

[259] Ms. Wray contends that Dr. Balfour discharged her prematurely with an inappropriate amount of pain medication and misleading discharge instructions and specifically failed to explain the importance of returning to the ED.

[260] As I noted earlier, the reliability of Ms. Wray's evidence is of concern. Much of her evidence regarding the visit to the ED on November 30, 2016 is hazy and she was not able to recall much of it. She could not recall getting a pelvic ultrasound or having bloodwork done. I also found some of her evidence to be inconsistent. For example, according to Ms. Wray she was not told that she may have appendicitis or that the ultrasound was ordered to determine if she had appendicitis. However, on December 5, 2016, according to the charting notes, Ms. Wray told the resident physician that on her November 30th visit for abdominal pain, "she had an ultrasound which showed a ruptured ovarian cyst and a normal appendix". I find this inconsistent because she would not have made reference to her appendix on

2024 BCSC 2135 (CanLII)

December 5th if there had not been a discussion on her November 30th visit of a possibility of appendicitis.

[261] In contrast to her evidence, Dr. Balfour's evidence is more consistent with the contemporaneous medical charting. His discharge instructions were that Ms. Wray had "pelvic pain NYD" and that he recommended Ms. Wray see her family doctor or return to the ED if her signs or symptoms increased. Given Ms. Wray's hazy recollection of the events and the inconsistencies between her evidence and the documentary records, I prefer Dr. Balfour's evidence on this point.

[262] Dr. Feinstadt's opinion is that Dr. Balfour did not fall below the standard of care in discharging Ms. Wray so long as he provided appropriate follow up instructions. Where his opinion differs from that of Dr. Ward's is that Dr. Feinstadt opines that the discharge should have included clear instructions to follow up in 12 hours and explicit instructions with respect to pain, fever, anorexia, and vomiting as adopted from Tintinalli's. I have two concerns with Dr. Feinstadt's opinion. Firstly, Dr. Feinstadt ignores the key issue in this case, which is that Dr. Balfour had received a definitive indication that told him it was not appendicitis when he made the decision to discharge Ms. Wray. Secondly, the standard of care is not defined by what is found in textbooks, guidelines or policies, although they may be relevant: *Gelowitz v. Revelstoke (City),* 2022 BCSC 46. The standard of care is established by expert evidence. Busy emergency room physicians simply cannot do everything by the book, especially an experienced physician like Dr. Balfour.

[263] I also note that in reviewing Ms. Wray's medical chart, Dr. Perrier was able to confirm that Dr. Balfour's charted shorthand indicates "return to clinic if symptoms worsen", and that this indicates that she should return to the ED if her clinical picture worsened.

[264] Dr. Ward's opinion, based on Dr. Balfour's charting, is that Dr. Balfour's treatment of Ms. Wray and subsequent decision to discharge her was in accordance with what he would expect from a competent emergency physician. On this issue, I accept the evidence of Dr. Ward over that of Dr. Feinstadt and I conclude that

2024 BCSC 2135 (CanLII)

Dr. Balfour did not breach the standard of care as it relates to his discharge instructions.

CAUSATION AND CONTRIBUTORY NEGLIGENCE

[265] Counsel have also made submissions on causation and contributory negligence. Presumably, the reason for making these alternative findings in negligence would be to avoid the need for a re-trial on the issue of causation and contributory negligence in the event of a successful appeal of my decision on liability, as explained in *Awan v. Canada (Attorney General)*, 2010 BCSC 942 at para. 75.

[266] The decision to make findings “in the alternative” is “in the discretion of the trial judge” and is “inherently, case specific”: *Recchia v. Co-operators Life Insurance Co.,* 2002 BCSC 712 at para. 63. I have considered the factors set out in *Caplan Builders Ltd. v. Royal Bank of Canada* (1988), 25 B.C.L.R. (2d) 335 (S.C.) at para. 7, aff’d [1989] B.C.W.L.D. 1737 (C.A.). In my view, my decision on the question of negligence is based on settled law and grounded in the evidence specific to this case. Accordingly, I exercise my discretion against proceeding to assess causation and contributory negligence in the alternative.

CONCLUSION

[267] There is no doubt that Ms. Wray suffered and continues to suffer. A misdiagnosis occurred. But that does not mean that Dr. Balfour was negligent.

[268] As Chief Justice Hinkson (as he then was) noted in *O’Connor*, “it is the role of this Court to assess the evidence through unbiased eyes, and to correctly apply the legal principles applicable to this jurisdiction”: at para. 290. I have done precisely that in this case.

[269] There were differing opinions from the experts presented by the parties. However, the opinion of one or even a group of medical experts about the appropriate medical standard will not necessarily equate to a finding of negligence.

2024 BCSC 2135 (CanLII)

[270] In all of the circumstances, while this was an unfortunate event for Ms. Wray, I find that there is an insufficient basis for a finding of liability against Dr. Balfour, and therefore dismiss Ms. Wray's claim.

[271] If either of the parties wishes to address the issue of costs, they may contact Supreme Court Scheduling within 21 days of these reasons to arrange to speak to the matter.

[272] I thank counsel for their exceptional advocacy and well-prepared submissions.

"Girn J."

2024 BCSC 2135 (CanLII)