Citation: Dumesnil v Dr Jacob, 2024 MBCA 4
Date: 20240118
Docket: AI22-30-09733

IN THE COURT OF APPEAL OF MANITOBA

Coram: Madam Justice Freda M. Steel
Madam Justice Diana M. Cameron
Madam Justice Karen I. Simonsen

B E T W E E N :

DANIELLE MARIE-CLAIRE DUMESNIL	)	***M. D. Jodoin*** *and*
	)	***P. F. Reimer***
(Plaintiff) Appellant	)	*for the Appellant*
	)	
- and -	)	***H. D. Van Iderstine, K.C.*** *and*
	)	***A. J. Meyers***
DR. VATTAKATTUCHERRY CHANDY JACOB	)	*for the Respondent*
	)	
	)	***No appearance***
(Defendant) Respondent	)	*for Regional Health Authority Central Manitoba Inc.*
	)	
- and -	)	
	)	*Appeal heard:*
REGIONAL HEALTH AUTHORITY CENTRAL MANITOBA INC.	)	***May 10, 2023***
	)	
	)	*Judgment delivered:*
(Defendant)	)	***January 18, 2024***

On appeal from 2021 MBQB 240

SIMONSEN JA

[1] In this medical malpractice case, the plaintiff (Ms Dumesnil) appeals a judgment dismissing her claim against the defendant, Dr. Vattakattucherry Jacob (Dr. Jacob), for damages resulting from alleged negligent treatment that he provided. She asks that the judgment be set aside

and the claim allowed. (Her claim against the defendant, Regional Health Authority Central Manitoba Inc., was discontinued prior to trial.)

[2] Dr. Jacob is a general surgeon practising orthopedics at Boundary Trails Health Centre (Boundary Trails), located between the neighbouring smaller cities of Winkler and Morden, in southern Manitoba. In July 2006, he performed an open reduction and internal fixation (the surgery) on a fracture to Ms Dumesnil's left calcaneus—meaning heel bone—sustained as a result of a motor vehicle accident. He also provided post-operative care until September 22, 2006, when he performed a debridement procedure on the surgical wound (the September 22 procedure).

[3] Following September 22, 2006, Ms Dumesnil continued to be symptomatic for approximately 10 years, until Dr. Allan Hammond (Dr. Hammond), an orthopedic surgeon with subspecialties in trauma, and foot and ankle, performed surgery to remove bone and put the displaced peroneal tendons in her left foot back into their correct position in the peroneal groove.

[4] Ms Dumesnil alleged that her delayed recovery and resulting damages were caused by Dr. Jacob's negligence. Simply stated, she alleged that he failed to reduce her peroneal tendons into place during the surgery and that his actions caused her to develop an infection and an increased risk of arthritis.

[5] The trial judge described the applicable standard of care as that of "a general surgeon in a rural community based hospital practising in orthopaedics" (at para 114), and concluded that Dr. Jacob had met that standard. The trial judge also determined that Ms Dumesnil's complaints and

symptoms following the surgery were "directly attributable to the motor vehicle accident and the resulting injuries, not Dr. Jacob's repair of her calcaneus" (at para 251). Although the trial judge dismissed the claim, he nonetheless went on to provisionally assess damages.

[6] In his reasons for decision, the trial judge referred to and quoted extensively from a 2007 article reported in a medical journal about the treatment of calcaneal fractures, which was written by six orthopedic surgeons in Rome, Italy (the article).[1] The article had not been tendered by either party, referred to by any witness or brought to counsel's attention during the trial; the parties first learned of it when they read the trial judge's reasons.

[7] Ms Dumesnil appeals on the grounds that the trial judge erred by (1) referring to and relying on the article, (2) adopting the wrong standard of care, (3) determining that the standard of care had been met, (4) concluding that her complaints and symptoms were not caused by Dr. Jacob's negligence, and (5) with respect to the provisional assessment of damages, applying certain reductions for contingencies to her loss of income claim.

[8] For the reasons set out below, I would conclude that the trial judge made two material errors of law in defining the applicable standard of care; he erred by imposing a lower standard on the basis that Dr. Jacob was practising in a rural setting, and by not holding him to a standard close to that expected of an orthopedic surgeon with a subspecialty in trauma. I would, therefore, allow the appeal, set aside the judgment and order a new trial. Although not necessary to decide this appeal, I will also address the trial

[1] R Bondi et al, "Treatment of calcaneal fractures: the available evidence" (2007) 8 J Orthopaed Traumatol 36, DOI: <10.1007/s10195-007-0160-2>.

judge's reference to the article. And, while I also need not address provisional damages, this decision is not to be taken as an endorsement of that part of the trial judge's provisional damages assessment which has been appealed.

The Background

[9] On July 13, 2006, Ms Dumesnil suffered a comminuted intra-articular fracture of her left calcaneus in a motor vehicle accident. After being transported by ambulance to the hospital in Carman, Manitoba, she was transferred to Boundary Trails where she was referred to Dr. Jacob, who determined that she required the surgery to repair her fracture.

[10] Dr. Jacob performed the surgery on July 15, 2006, approximately 34 hours post-injury, on a non-emergent basis. Boundary Trails' records state that, immediately before Dr. Jacob began operating, there was swelling in Ms Dumesnil's left ankle, with edema noted to be "++".

[11] Dr. Jacob performed the surgery by making an incision in the ankle, inserting a metal plate and screws into the bone, and then closing the incision with sutures and staples. This was done to reduce (put the fractured pieces back into their anatomic position) and fix (secure the pieces in place) the fracture.

[12] Upon discharge on July 18, 2006, Dr. Jacob advised Ms Dumesnil to use a foot compression pump on her ankle to address swelling. He did not discharge her with a cast, but she was instructed to use crutches and be non-weight bearing. On July 28, 2006, he removed the sutures and staples. He then applied steri-strips and glue to the skin at the incision in an effort to keep the wound closed. He instructed Ms Dumesnil to clean the incision with

hydrogen peroxide daily, and to continue to use a foot pump because of swelling in her ankle.

[13] Ms Dumesnil next attended upon Dr. Jacob on August 18, 2006, and advised that the incision had not fully closed since the surgery; he noted no issues with healing or evidence of infection. Nor did any of the other medical practitioners whom she had seen since her discharge from the hospital.

[14] Ms Dumesnil testified that, after the August 18, 2006 appointment, she noticed yellow fluid discharging from her incision wound. On September 21, 2006, she saw Dr. Jacob about the fluid and he diagnosed her with "a non-healing ulcer". The following day, he performed the September 22 procedure, in which he did a nine-minute local irrigation and debridement of the ulcer at the site of the incision and reclosed the wound. This was intended to enhance healing. Antibiotics were not administered before or following that procedure.

[15] Shortly after the September 22 procedure, Ms Dumesnil noticed a foul odour emanating from her foot, and experienced fevers and increased purulent drainage from the site of the incision. On September 27, 2006, she attended at Health Sciences Centre in Winnipeg where Dr. John Embil (Dr. Embil), a physician with a speciality in infectious diseases, diagnosed her with an infection in her calcaneus, which he said had been present for at least two or more weeks. She underwent surgery by Dr. Bradley Pilkey (Dr. Pilkey), a Winnipeg orthopedic surgeon with subspecialties in trauma, and foot and ankle, to debride the infected tissue and bone (the September 29 procedure). In the September 29 procedure, Dr. Pilkey had to remove the plate and screws that were inserted during the surgery, in order to prevent the

infection from becoming worse. Ms Dumesnil saw Dr. Pilkey in follow-up, with her last visit being on October 7, 2008.

[16] Ms Dumesnil testified that, in the years following the surgery, she suffered considerable pain and discomfort in her left ankle, which caused limited mobility. She described having particular difficulty walking on uneven ground. However, she did not attend upon any physicians from July 2009 until early 2014.

[17] In February 2014, Ms Dumesnil reattended upon Dr. Pilkey with complaints of increased pain. Then in July 2014, she saw, for the purpose of this litigation, Dr. Alastair Younger (Dr. Younger), an orthopedic surgeon in Vancouver, British Columbia. Dr. Younger has subspecialties in foot and ankle, total joint arthroplasty and arthritis. He also practises in the area of trauma orthopedic surgery and, at trial, was qualified as an expert in that area. Dr. Younger assessed Ms Dumesnil's ankle and was of the opinion that the surgery had failed to adequately reduce her calcaneus. He concluded, based on a physical examination as confirmed by a CT scan done on July 30, 2014, that Ms Dumesnil's peroneal tendons had been left in a dislocated position following the surgery, as the inadequate reduction left no room for the tendons to move back into their proper place in the peroneal groove along the side of the calcaneus. The peroneal tendons run alongside the ankle and help control side to side motion.

[18] Dr. Younger also found that, as a result of the improper reduction of the calcaneus, Ms Dumesnil was suffering from arthritis in the subtalar joint (between the calcaneus and the talus) and calcaneocuboid joint (between the calcaneus and cuboid). He was of the opinion that the combination of the

dislocated tendons, malreduced calcaneus and subtalar arthritis was the cause of her current and ongoing discomfort. Dr. Younger recommended that she see Dr. Hammond, in Winnipeg.

[19] Ms Dumesnil saw Dr. Pilkey again in August 2014 and December 2014; at her attendances upon him in 2014, he noted mild to moderate arthritic changes. She did not advise him that she had seen Dr. Younger. She sought a second opinion and Dr. Pilkey referred her to Dr. Hammond.

[20] On February 25, 2015, Dr. Hammond determined, by palpation, that the peroneal tendons were out of place. He recommended that Ms Dumesnil undergo corrective surgery to restore the anatomy of her ankle and put her dislocated peroneal tendons back into their proper position.

[21] Dr. Hammond performed two surgeries on Ms Dumesnil's ankle. On July 3, 2015, he did endoscopic surgery to carve out bone from her ankle to relieve subtalar impingement. Then, on February 19, 2016, he performed an open surgery to remove more bone from the calcaneus in order to move the "grossly out of place" peroneal tendons back to their correct position in the peroneal groove.

[22] Following Dr. Hammond's procedure on February 19, 2016, all of Ms Dumesnil's symptoms were essentially alleviated.

[23] Despite Ms Dumesnil's symptoms between 2007 and February 2016, she continued to work in her pre-accident employment as a second assistant director in the film industry, which required her being on her feet for many hours per day.

The Particulars of the Alleged Negligence and the Expert Evidence

[24] At trial, Ms Dumesnil alleged a breach of the standard of care on the bases that Dr. Jacob did not properly reduce the calcaneus, with the result that the peroneal tendons could not be placed back into the peroneal groove, and that there was inadequate fixation.

[25] In addition, she alleged that there were three instances in which Dr. Jacob breached the standard of care relating to the risk of infection developing after the surgery:

(1) Failing to perform the surgery at the appropriate time, because the standard of care was to wait at least seven days after the initial fracture to allow swelling to subside—or to perform the surgery within 24 hours post-injury before swelling occurred;

(2) Failing to discharge her with a plaster cast, which constituted negligent wound care; and

(3) Removing the sutures and staples from the incision too soon after the surgery.

[26] Ms Dumesnil also alleged a breach of the standard of care in performing the September 22 procedure, asserting that Dr. Jacob should have swabbed for cultures of the soft tissue to test for infection; administered antibiotics; and performed a full debridement of the wound or, alternatively, avoided surgical intervention and applied wet dressing with antibiotic beads to the wound.

[27] In all, Ms Dumesnil contended Dr. Jacob failed to reduce her peroneal tendons into place during the surgery and that his actions caused her to develop an infection and an increased risk of arthritis. As a consequence, she suffered ongoing pain and disability.

[28] Ms Dumesnil called two experts to opine that the standard of care had been breached by Dr. Jacob—Dr. Younger and Dr. David Sanders (Dr. Sanders), an orthopedic surgeon practising in London, Ontario, who, too, has subspecialties in trauma, and foot and ankle. Ms Dumesnil's treating physicians, Drs. Embil, Pilkey and Hammond, also testified.

[29] Dr. Jacob relied on the expert opinion evidence of Dr. Mark MacLeod (Dr. MacLeod), an orthopedic surgeon with a subspecialty in trauma including foot and ankle, who also practises in London, Ontario, and Dr. Fred Aoki (Dr. Aoki), a Winnipeg internal medicine specialist, with subspecialties in infectious diseases and clinical pharmacology. Dr. MacLeod opined that Dr. Jacob had met the expected standard of care. Dr. Aoki's opinion was that Ms Dumesnil's infection developed between the September 22 procedure and the September 29 procedure.

[30] The experts agreed that the surgery Dr. Jacob performed on Ms Dumesnil is a difficult procedure. Drs. Sanders and Younger gave unchallenged evidence that it is usually done by orthopedic surgeons with a subspecialty in trauma, or foot and ankle. Dr. Pilkey testified that, in 2006, calcaneal fracture surgeries were performed in Winnipeg by him and other orthopedic trauma specialists.

[31] In dismissing the claim, the trial judge preferred the opinions of Dr. Jacob's experts to those of Ms Dumesnil's experts, and concluded that a breach of the applicable standard of care had not been proven.

The Standard of Review

[32] The applicable standard of review depends on the nature of the issue or question raised. The standard of review for questions of law is correctness. Questions of fact and mixed fact and law are reviewable on a standard of palpable and overriding error, unless the question of mixed fact and law involves an inextricable legal principle, in which case the standard of correctness applies (see *Housen v Nikolaisen*, 2002 SCC 33 at paras 8, 10, 36).

[33] The issue of whether the trial judge erred by adopting an incorrect standard of care raises a question of law reviewable on a standard of correctness (see Gerald B Robertson & Ellen I Picard, *Legal Liability of Doctors and Hospitals in Canada*, 5th ed (Toronto: Thomson Reuters, 2017) at 324; *Timlick v Heywood*, 2017 MBCA 7 at para 38 [*Timlick*]; and *St-Jean v Mercier*, 2002 SCC 15 at para 49).

Analysis

Standard of Care

[34] The foundational principles of the standard of care in a medical malpractice case were set out in *Crits v Sylvester* (1956), 1 DLR (2d) 502 (ONCA) [*Crits*] at 508, aff'd [1956] SCR 991:

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

[35] The applicable standard of care concerning specialists was also noted in the leading case of *ter Neuzen v Korn*, [1995] 3 SCR 674 [*ter Neuzen*] (at para 33):

> 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] S.C.R. 804, at p. 817, *Lapointe v. Hôpital Le Gardeur*, [1992] 1 S.C.R. 351, at p. 361, and *McCormick v. Marcotte*, [1972] S.C.R. 18.

[36] *ter Neuzen* further provides "that the conduct of physicians must be judged in the light of the knowledge that ought to have been reasonably possessed at the time of the alleged act of negligence" (at para 34).

[37] A legion of trial and appellate courts have adopted and cited the principles outlined in *Crits* and *ter Neuzen*, including this Court (see

Rutherford v Wiens, 2021 MBCA 84 at para 47 [*Rutherford*]; *Timlick* at paras 40-42; *Laing v Sekundiak*, 2015 MBCA 72 at para 68; *Jaglowska v Kreml et al*, 2003 MBCA 113 at para 57 [*Jaglowska*]; *Bachalo v Robson et al*, 1998 CanLII 28027 at para 33 (MBCA); and *Webster et al v Chapman et al*, 1997 CanLII 3108 at 8 (MBCA), leave to appeal to SCC refused, 26468 (4 June 1998)).

[38] As noted earlier, the trial judge determined the applicable standard of care when he stated that Dr. Jacob was "a general surgeon in a rural community based hospital practising in orthopaedics" (at para 114).

[39] Ms Dumesnil argues that, in so defining the standard of care, the trial judge erred by (1) concluding that a lower standard applied to a physician practising in a rural setting, and (2) failing to apply the standard of an orthopedic surgeon with a subspecialty in trauma. Ms Dumesnil contends that, despite Dr. Jacob's training being limited to that of a general surgeon, his extensive experience in orthopedics, including performing open reduction and internal fixation of calcaneal fractures, results in him being properly measured by the standard of a physician who ordinarily conducts such complex surgeries—an orthopedic surgeon with a subspecialty in trauma.

[40] Dr. Jacob says that, although the trial judge "could have used different language", he understood and applied the governing law, and correctly defined the standard of care. Dr. Jacob notes that the trial judge correctly stated the applicable law when he commented that the parties agreed "that a physician is expected to exercise the degree of skill and knowledge and degree of care which would reasonably be expected of a normal and prudent practitioner of the same standing" (at para 83). The trial judge

referred to *ter Neuzen* and this Court's decision in *Timlick*. He also quoted at length from *Campbell et al v Jones et al*, 2016 MBQB 10, in which a number of key principles were cited.

Rural/Community

[41] Ms Dumesnil asserts that the trial judge, by using the words "rural" and "community based", incorrectly injected into the standard of care the concept that Dr. Jacob should be measured by a lower standard than that expected of a similarly qualified physician practising in a large urban setting.

[42] With respect to the reference to "rural" in particular, Ms Dumesnil submits that, historically, the particular location where a physician practised was considered relevant in assessing the standard of care. This is sometimes referred to as the locality rule. However, she says that, with modern technology and communication and the standardization of medical practices, the standard for a rural physician is no longer lower unless the physician can show that because of geographic location, adequate facilities, equipment or staff were not available to them. According to Ms Dumesnil, the trial judge's reference to Dr. Jacob being "community based" (at para 114) also means that he adopted a lower standard of care than what would be required of a physician practising in a large urban setting, and is a further indication he improperly applied the locality rule.

[43] Ms Dumesnil's description of the locality rule is supported by the academic authority (see Lewis N Klar et al, *Remedies in Tort* vol 2 (Toronto: Thomson Reuters, 2023) (loose-leaf updated 2023, release 10) ch 18 at section 18:59; Allen M Linden et al, *Canadian Tort Law*, 12th ed (Toronto: LexisNexis, 2022) at 219; and Maria Damiano "The Continuing Evolution of

Standard of Care in Medical Malpractice" (2021) Ann Rev Civ 1 at 7-8, 21; Robertson & Picard at p 318). The academic authority indicates that, in the absence of deficient facilities, resources or support staff, geographic location, in and of itself, should not automatically lower the standard of care.

[44] Dr. Jacob does not dispute Ms Dumesnil's characterization of the locality rule or its inapplicability in this case. He does not suggest that there was any issue regarding lack of resources in his treatment of Ms Dumesnil; in fact, he says that, in certain respects, he had access to more resources than would have been available in a larger hospital.

[45] However, Dr. Jacob's position is that the locality rule was not applied by the trial judge. He maintains that by referring to "rural", the trial judge was simply stating a fact and not bringing that consideration into the standard of care. At the appeal hearing, his counsel also submitted that the trial judge's reference to "community based" meant that Dr. Jacob was a non-specialized orthopedic surgeon, as opposed to an orthopedic surgeon with a subspecialty practising in a tertiary care centre where there are highly specialized physicians, technology and support services. Dr. Jacob says that the standard of a non-specialized orthopedic surgeon was applied by the trial judge, and correctly so.

[46] When I consider the following additional statements in the trial judge's reasons for decision, I am persuaded that he did inject the concepts of "rural" and "community based" into the standard of care, thereby lowering the standard and going well beyond a statement of the facts:

(1) The trial judge described Dr. Jacob as "an experienced community surgeon" (at para 6);

(2) In outlining Ms Dumesnil's position, he stated: "[Ms Dumesnil] says that considering the law, and the circumstances of this case, the court should find Dr. Jacob's standard of care is that of specialist orthopedic trauma surgeon, not as argued by the defendants, with the qualifier as practising in a rural setting" (at para 91);

(3) In outlining Dr. Jacob's position, he stated (at paras 101, 106, 109):

> The defendants submit Dr. Jacob is a community orthopedic surgeon. [Ms Dumesnil's] expert opinions are deficient as:
>
> . . .
> (b) neither Dr. Younger nor Dr. Sanders practise in a community hospital;
> . . .
>
> Neither Dr. Sanders nor Dr. Younger practises in a rural setting.
>
> The defendants submit that Dr. Jacob's standard must be compared against an orthopedic surgeon practising in a rural community hospital.

(4) In his analysis, he wrote (at paras 239, 241):

> Although Dr. Jacob practises outside the City of Winnipeg, [Ms Dumesnil's] experts' assertions amount to speculation.
>
> . . . I also find Dr. Jacob, a rural surgeon with a subspecialty in orthopaedics, acted well within the standard of care for [the] surgery and he did not breach the standard of care expected of him.

[47] In fairness to the trial judge, counsel for Dr. Jacob made mention of "rural" during the trial. On cross-examination of Dr. Sanders, she asked, "you've never practised as an orthopedic surgeon in a rural community setting, correct?", to which he agreed. As well, in Dr. Jacob's written final

submission to the trial judge, there was repeated use of the word "rural" when describing the applicable standard of care. This was done without specifically responding to Ms Dumesnil's argument that the locality rule did not apply.

[48] The word "community" was used liberally throughout the trial by counsel for Dr. Jacob and by Dr. MacLeod, but I do not believe that a clear definition is provided in the evidence or the trial judge's reasons.

[49] While dictionary definitions typically describe "community" in terms of location or a group, hospitals and the medical profession have attributed particular characteristics to a "community hospital". In referring to community hospitals, many cases have drawn a distinction between such a hospital and a teaching/university hospital (see e.g. *Keith v Abraham*, 2011 ONSC 2 at para 250; and *Saint-Clair v Spiegel*, 2001 CarswellOnt 6192 at para 26 (SC)). Some cases also recognize that there are more resources at teaching/university or tertiary hospitals, which would include the wider availability of specialists and subspecialists (see *Baines v Abounaja*, 2023 ONSC 2078 at para 50; and *Timpano v Alexander*, 2008 CanLII 8270 at para 348 (ONSC), aff'd on other grounds, 2009 ONCA 863).

[50] So, as a broad statement, community hospitals may not offer the same services and specialists as larger tertiary hospitals. However, of course, the facts of an individual case may show that a so-called "community hospital" still offers some level of speciality/tertiary care. For example, in *Lalonde v Ontario (Commission de restructuration des services de santé*) 2001 CanLII 21164 (ONCA), a decision dealing with French language rights in hospitals, the Court wrote (at para 5):

> . . . As indicated, Montfort is a community hospital with approximately 196 beds in use. It provides primary health care services (i.e., care provided by a health care worker on a patient's first contact with the health care system, including emergency services), secondary care (i.e., care provided by a specialist health care professional, such as a general surgeon), and, according to the Commission's February 1997 report at p. 34, some tertiary level care (i.e., care that requires highly specialized skills, technology, and support services). In addition, Montfort provides intensive care, treatment and referral services, and outpatient or clinical activities. In addition to cardiology, surgery, orthopaedics and obstetrics, another of its principal inpatient programs was psychiatry.

[51] Based on the above review, the precise meaning of "community hospital" appears to be somewhat fluid. As well, while references are made in some cases to "community surgeon", there is, again, no firm definition. The underlying premise, however, seems to be that "community surgeons" may not be as equipped for difficult cases (see e.g. *Hicks v Belknap*, 2022 BCCA 292 at paras 12, 28; and *Powers v Powers*, 2006 ONCJ 600 at para 45).

[52] Although counsel for Dr. Jacob refers to the following exchanges from the cross-examination of Dr. Younger as providing support for the meaning of "community hospital" or "community surgeon" that Dr. Jacob has asserted, I find them to be of limited assistance:

> . . .
> Q And so if I understood your report that you provided, by 2006 and your -- that math, by 2006 there would have been about five to eight foot and ankle specialists in British Columbia?
>
> A That would be right, yes.
>
> Q And so again, there'd still be some community orthopaedic surgeons doing calcaneal -- excuse me, so there would -- there

would still have been some community orthopaedic surgeons repairing calcaneal fractures then in -- in or about 2006?

A I think that the -- at that point it would be mostly the orthopaedic trauma surgeons doing calcaneal fracture surgery. There was a study done by the orthopaedic fracture surgeons including those within British Columbia contributed to a randomized prospective study and that was done essentially by trauma surgeons. So there was a mixture but the -- in general the -- the calcaneal fractures would be sent to the larger centres but they could be done in the community but they were -- there was a lot of change in practice around that time.

. . .

Q And one of the reasons that you would train or want to have some general orthopaedic surgeons or community orthopaedic surgeons knowing the basics of calcaneal repairs is that sometimes calcaneal repair surgery is urgent, not just needs to be done but needs to be done immediately; would that be fair?

A Occasionally a calcaneal fracture requires immediate surgery. If it -- for example, if it's compound, if the fracture comes through the skin then that would be an indication for urgent surgery; that is correct.

. . .

[emphasis added]

[53] Dr. MacLeod's opinion as to whether Dr. Jacob had met the standard of care focused, indeed hinged, on the concept of a "community orthopedic surgeon" or a "community surgeon" who is doing orthopedic surgery, which he referenced repeatedly during his testimony. In terms of providing any definition as to what that meant, I consider the following extracts from his direct examination:

. . .

Q And so, if we flip back -- sorry. And why do you say that?

A So although Bohler's angle is -- it's certainly below normal. I think in the context of this reconstruction by a community orthopaedic surgeon or a community surgeon that is doing orthopaedic surgery, that that is an acceptable reduction.

. . .

Q So when you say "in this circumstance", what are you talking about?

A Well, I think the expectation for someone in my position would be different than the expectation for someone in Dr. Jacob's position. I'm a trained trauma surgeon and all I do now is orthopedic trauma and foot and ankle surgery. I would consider this to be a subspecialty expertise. And I think for a community surgeon performing this surgery, that this lies within the realm of acceptability in meeting the standard of care that would be accepted.

. . .

Q . . . And so, I'm wondering if you can provide -- what is your response to that criticism that's been raised by Dr. Sanders and Dr. Younger with respect to Dr. Jacob's training?

A I noted in my report that he had two years of training in orthopaedic surgery. He had taken specific courses relative to orthopaedic correction management, and specific to the foot and ankle. He had been performing these -- these procedures for a considerable period of time, and it's my understanding that he had been observing colleagues performing procedures. I think this level of training and experience is comparable to a community orthopedic surgeon.

. . .

[emphasis added]

[54] While I expect that Dr. MacLeod intended to indicate that there is a distinction to be drawn between a subspecialist, who limits their practice to a particular type of surgery (in this case foot and ankle, or trauma surgery), and a "community surgeon" or "community orthopedic surgeon", who

presumably undertakes additional types of surgery, his evidence on this point is not entirely clear. In any event and, importantly, when taken together with the focus on "rural", I am satisfied that the trial judge essentially conflated a "community" hospital or surgeon with a "rural" hospital or surgeon. That is, he considered what he described as "rural community based" (at para 114) to mean in a rural community—and that he thereby erred by relying on the locality rule. By so doing, he erred in law by imposing a lower standard of care on the basis that Dr. Jacob was practising in a rural setting.

[55] This error was material, indeed critical, to the outcome of the trial, because it affected the trial judge's assessment of the expert evidence. Specifically, it influenced him to prefer the opinion of Dr. MacLeod to those of Ms Dumesnil's experts. I will explain.

[56] Dr. Sanders did not use the words "rural" or "community" in describing the standard of care, and I have already set out the questioning of Dr. Younger about "community". While they both commented, to some extent, on how they, as subspecialists, would have treated a patient with this kind of fracture differently than Dr. Jacob, their opinions, considered in their totality, were that Dr. Jacob's treatment was substandard when measured by the standard of an orthopedic surgeon without subspecialty.

[57] Dr. Jacob submits that Ms Dumesnil's experts were both advocating for a higher and subspecialized standard to be applied. While that may be the case, their opinions were based on a much lower standard. Dr. Sanders called the reduction "mediocre", "not good" and having "fairly obvious" problems. He described the initial fixation as "poor", and the September 22 procedure as "extremely bizarre" and "off the charts in terms of its being abnormal."

[58] Dr. Younger, who is a professor of orthopedics at the University of British Columbia stated, in one of his reports, that the surgery "would not be of a standard that [he] would expect of an orthopedic graduate." During his testimony, he indicated that there were "a number of things [with Dr. Jacob's care] that don't necessarily work with the general principles that we teach our residents in orthopaedics about treating calcaneal fractures." He indicated that "[t]he fixation of this was not of a standard that [he] would have expected from an orthopaedic graduate" and that reducing the peroneal tendons into their correct position is the standard of open reduction for an orthopedic surgeon.

[59] Dr. MacLeod, who also made comments about how he would, in some respects, have treated Ms Dumesnil differently than Dr. Jacob, was very deliberate, in his answers, to measure Dr. Jacob's conduct by the standard of "a community orthopaedic surgeon or a community surgeon that is doing orthopedic surgery". Dr. MacLeod testified that he was not without criticisms of the surgery, and that the fixation, as well as the reduction as it related to restoration of what is called the Bohler's Angle, were "marginal". (Bohler's Angle is an anatomic feature of the ankle; the better its restoration, the better the outcome.) Dr. MacLeod further testified that there would be a different expectation for someone like him, but that for "a community surgeon", Dr. Jacob's performance of the surgery would be "within the realm of acceptability".

[60] As noted, I expect that Dr. MacLeod did not intend, by use of the word "community", to introduce the locality rule into the standard of care. However, I am persuaded that the trial judge did. This played a role in his accepting Dr. MacLeod's evidence on the basis that he spoke to a different

and lower standard of care than Ms Dumesnil's experts. In other words, I am satisfied that the trial judge's injection of the locality rule into the standard of care influenced him to accept Dr. MacLeod's opinion, which rested on the standard of a "community" orthopedic surgeon—as opposed to the opinions of Drs. Sanders and Younger, which simply spoke to the standard of an orthopedic surgeon.

Specialist/Subspecialist

[61] Ms Dumesnil also appeals on the basis that the trial judge erred by not applying the standard of care expected of an orthopedic surgeon with a subspecialty in trauma, as she had argued at trial. She notes Dr. Jacob's extensive experience, as well as his testimony that he was very confident of his abilities and that he was fully capable of performing this surgery for a calcaneal fracture.

[62] There is little question that specialists are expected to possess and exercise a higher degree of skill in their particular field than would be expected of a general practitioner. This would apply equally to the distinction between specialists and subspecialists. The question is the type of evidence that will support such a finding. Robertson & Picard offer the following basic indicia (at p 291):

> Evidence of education (degrees, certificates and memberships, publications and privileges) and training (internship, residency, research and special study) provides formal and relatively objective criteria for establishing specialization status. In general, the greater the education and training, the higher the standard expected. Evidence of extensive experience in a speciality will certainly raise the standard and may even be a substitute for some of the formal criteria just mentioned. Doctors may hold themselves out as a specialist either by formal certification, or by

> the more subtle means of gradually restricting their practice to a particular type of medical problem, patient, or treatment, or even by undertaking work which is normally done by a specialist. Once they do so, they will be expected to practice their profession at the standard of care required of the specialist.
> . . .
>
> [footnotes omitted]

[63] Many cases have confirmed that extensive experience can result in a higher standard of care (see *Tekano (Guardian Ad Litem) v Lions Gate Hospital*, 1999 CanLII 1578 at para 104 (BCSC); *Chesher v Monaghan*, 1999 CarswellOnt 1021 at para 7 (Div Ct); *Bastian v Mori*, 1990 CarswellBC 1213 at para 198 (SC); and *MacDonald v York County Hospital et al* (1973), 41 DLR (3d) 321 (ONCA), aff'd [1976] 2 SCR 825). While a general practitioner's experience may not raise the applicable standard of care, the evidence may support that conclusion. It will depend on the specific circumstances of the case.

[64] In *Timlick*, this Court canvassed the principles regarding the impact of experience on a determination of the applicable standard of care (at para 43). However, those comments were *obiter* because the case was decided on the basis of this Court's view that, on the facts before it, there was no proper evidence to establish the correct standard of care against which to measure the defendant's conduct.

[65] With respect to Ms Dumesnil's argument that Dr. Jacob held himself out as a subspecialist or undertook work that is normally done by a subspecialist, she relies on *Wilson v Byrne*, 2004 CanLII 20532 (ONSC). In that case, the Court wrote (at para 20):

> . . . However, when a general practitioner holds himself out as a specialist, that is, by undertaking work that is normally done by a specialist, he too will be expected to practice at the standard of a specialist: see *McKeachie v. Alvarez* (1970), 17 D.L.R. (3d) 87 (B.C.S.C.). Evidence of extensive experience in a specialty, like surgery, raises the standard of care even further: see *Johnston v. Wellesley Hospital* (1970), 17 D.L.R. (3d) 139 at 141 (Ont. H.C.J.).

[66] I note that the decision in *Crits* and the previously quoted excerpt from Robertson & Picard quoted above (see para 62 herein) both indicate that holding oneself out as a specialist can demand a higher degree of skill (see *Crits* at para 13; see also *McCaffrey v Hague*, 1949 CanLII 208 at 295 (MBKB)). Of course, again, the application of the principle will turn on the facts (see e.g. *Crawford v Penney*, 2003 CanLII 32636 at para 258 (ONSC), aff'd 2004 CanLII 22314 (ONCA), leave to appeal to SCC refused, 30602 (27 January 2005)).

[67] Dr. Jacob's position is that he should be measured by the standard of a "community"—meaning unspecialized—orthopedic surgeon, as he had argued at trial. During submissions to this Court, his counsel acknowledged that he was effectively acting as an orthopedic trauma surgeon. She nonetheless maintained that the standard of an orthopedic surgeon with a subspecialty in trauma was not applicable due to Dr. Jacob's lack of formal training and designation as a subspecialist.

[68] That being said, Dr. Jacob does not rely on the notion that his conduct should be strictly measured by the standard associated with his education and designation. He does not suggest that he be held to the standard

of a general surgeon; instead, he accepts that the proper measure is that of an orthopedic surgeon.

[69] In terms of Dr. Jacob's background and experience, he was trained at the University of Manitoba in the early 1960's as a general surgeon, which included orthopedics. While training, he was chief resident in orthopedics at St. Boniface Hospital. There was no speciality program in orthopedics at that time. Before moving to Canada in 1960, he had taken a surgical speciality in India for six months that involved orthopedics, including ankle. And, prior to 2006, he had completed some courses in orthopedics, including calcaneal surgery. He testified that "[a]t least 50 percent" of his practice was in orthopedics. In addition, the evidence demonstrates that he performed approximately 460 orthopedic surgeries annually, which was on par with the average orthopedic surgeon.

[70] With respect to surgical repair of calcaneal fractures in particular, Dr. Jacob said that he had done seven such surgeries from July 2004 to July 2006—and that he had done about two or three each year from 1975 to 2006. To put this in perspective, the record contains evidence with respect to the number of calcaneal surgeries that are typically conducted each year. As a general observation, Dr. Hammond described calcaneal fractures as being "pretty rare". He also testified that, from 2003 to 2008, some calcaneal fractures were being fixed, where they had previously often been left to heal without surgery. Dr. Younger indicated that, extrapolating from statistics in British Columbia reported by him in 2014 and confirmed at trial, there would be about 25 calcaneal fractures treated by open reduction and fixation each year in Manitoba. With Dr. Jacob performing approximately three and a half per year in the two years prior to July 2006, he would have been doing a

significant portion of such surgeries in Manitoba. It is apparent that, despite Dr. Jacob's lack of formal education and training, he had very extensive experience in orthopedics, including calcaneal fracture surgery.

[71] In fact, counsel for Dr. Jacob stated at the appeal hearing that the problem with determining the standard of care in this case is that "there [was] nobody else like" Dr. Jacob and that there are "not many people like [him] in the Canadian context".

[72] Furthermore, Dr. Jacob was very confident of his abilities. He testified:

> . . .
> Q Now talking about calcaneal fractures generally, and not specifically to Ms. Dumesnil, was there any specific considerations or concerns you had about doing those surgeries in Boundary Trails?
>
> A No.
>
> Q Why was that?
>
> A I had enough experience in treating such fractures. I had sent one calcaneal fracture to Winnipeg, which was a compound fracture, sent to Dr. Melanie (phonetic), but this was a normal but badly injured calcaneal.
> . . .
>
> [emphasis added]

[73] And then:

> . . .
> Q Once you had done all of this, first of all, did you consider yourself to be a specialist orthopaedic surgeon?

A You know, I had enough training in orthopaedics, I am talking about the adult orthopaedics. I had the full training for the adult orthopaedics, not for the pediatric, but then one has to, up to the current knowledge and training and technical knowhow, as well as the technical ability to do it, along with the experience. So I felt I am good enough.

Q Did you have any concerns about proceeding with treating Ms. Dumesnil after having reviewed this?

A No.

Q Did you consider calling Dr. Pilkey or Dr. Huebert or Dr. Bellamy [whom he had testified were foot and ankle or trauma surgeons in Winnipeg in 2006]?

A No.

Q Why not?

A I thought I could do a good job. I have experience doing quite a number of them and had the training to do it.

. . .

[emphasis added]

[74] On cross-examination, there were these further exchanges:

. . .

Q Dr. Jacob, do you tell her that broken bones are normally treated by orthopedic surgeons as opposed to general surgeons?

A I have to clarify here. I have the highest training in orthopedics, and I do more orthopedics than any orthopedic surgeon average, so I consider myself over 50 percent orthopedic surgeon. I do all the fractures. I go on the list on 2016, so my training, my experience, taking all into account, I was quite comfortable to treat her.

. . .

[75] The following exchange, where Dr. Jacob comments on his experience in relation to Dr. Huebert is also of interest:

> Q Okay, then let's -- let's talk about -- we haven't heard from Dr. Huebert, so in terms of Dr. Huebert, he was a fracture surgeon, trauma surgeon.
>
> A M-hm.
>
> Q Okay. And he had a subspeciality in foot and ankle.
>
> A That's what I understand.
>
> Q Right. So you knew of him and -- and you had a choice of referring [Ms Dumesnil] either to Dr. Huebert for care or doing the surgery yourself, fair enough?
>
> A Her doctor had the choice to refer to Winnipeg, the family doctor, when he referred to me. I could have sent somewhere else if I felt she would get better care somewhere else, but, you know, I had enough experience, more than Dr. Huebert at that time, though.
>
> . . .
>
> [emphasis added]

[76] Considering all of the above, and leaving aside the issue of "community" and "rural", I would conclude that, in the particular circumstances of this case, the trial judge erred by not adopting a standard of care close to that of an orthopedic surgeon with a subspecialty in trauma.

[77] This, too, had a significant impact on the trial judge's assessment of the expert evidence. Given the standard of care that he adopted, he did not deal with any of the experts' evidence about how they, as subspecialists, would have treated Ms Dumesnil. Moreover, his error was material because, had he considered some of that evidence, I am not convinced that the outcome

would necessarily have been the same. I appreciate that he discounted the evidence of Ms Dumesnil's experts for specific reasons, namely that "[s]ufficient errors were made by them in their reports such as the degree of swelling, failure to administer antibiotics when antibiotics were administered, or failure to control swelling when the foot pump deployed from soon after admission, through surgery, post-surgery and after discharge" (at para 252). However, he may well have taken a different view of their testimony had he considered it through the lens of the correct standard of care, particularly because there would have been no meaningful evidence to challenge their opinions. Dr. MacLeod touched upon what he would have done as a subspecialist but did not provide an opinion on that basis. In fact, he often commented that he would have handled things differently than Dr. Jacob.

[78] Therefore, the trial judge's error in failing to apply a standard of care close to that of an orthopedic surgeon with a subspecialty in trauma was also material to his conclusion that a breach of the standard of care had not been proven.

Materiality of Errors Regarding Standard of Care: Causation

[79] Whether the trial judge's errors regarding the standard of care were material to his ultimate decision to dismiss the claim also requires me to touch upon causation. That is, can his decision be upheld on the basis of a finding that Dr. Jacob's conduct, even if negligent, did not cause an adverse outcome to Ms Dumesnil?

[80] Accepting that the trial judge made such a finding, I am of the view that, because standard of care and causation are so closely connected in this

case, the finding was influenced by his conclusion that there was no breach of the standard of care. This is so despite there being evidence from the experts that this kind of injury often leads to long-term difficulties and that there may not be a resumption of pre-injury level of function, even with appropriate care.

[81] During submissions at the appeal hearing, counsel for Dr. Jacob indicated that standard of care and causation "are very linked in this case". This is not surprising as many cases have observed that the two are inextricably linked (see e.g. *Waterway Houseboats Ltd v British Columbia*, 2020 BCCA 378; and *Segal v Frimer*, 2001 BCSC 581 at para 22).

[82] The trial judge's analysis of whether there was a breach of the standard of care was very closely tied to an assessment of causation—so much so that, at times, he may have failed to independently assess whether the standard of care was met in connection with a particular treatment, but rather worked backwards to conclude that, because Dr. Jacob's actions did not contribute to an adverse outcome, he had met the standard of care (see paras 130, 150, 169, 233-34).

[83] Typically, standard of care is to be addressed first and causation thereafter—although there are exceptions where, in some cases, it can be necessary to first determine what happened, that is factual causation, to decide whether a defendant has breached the requisite standard of care (see *Armstrong v Royal Victoria Hospital*, 2019 ONCA 963, rev'd 2021 SCC 1; *Grass v Women's College Hospital*, 2001 CanLII 8526 (ONCA); and *Meringolo v Oshawa General Hospital*, 1991 CarswellOnt 1078 (CA), leave to appeal to SCC refused, 22409 (29 August 1991)). Considering causation before the standard of care usually constitutes a legal error because, in

principle, if the court finds that there was no breach of duty, the causation issue becomes moot (see *Rutherford*; Robertson & Picard at pp 353-54; *Shantry v Warbeck*, 2015 ONCA 395 at para 33; *Chasczewski v 528089 Ontario Inc (Whitby Ambulance Service)*, 2012 ONCA 97 at para 15; *Randall v Lakeridge Health Oshawa*, 2010 ONCA 537 at para 34; *Bafaro v Dowd*, 2010 ONCA 188 at para 34; *Harris v Beck*, 2009 PECA 8 at para 42; *McArdle (Estate of) v Cox*, 2003 ABCA 106 at para 25; and *Jaglowska* at para 92).

[84] In any event, making an error regarding the standard of care at the first part of the analysis sets the groundwork for what follows, and there can obviously be a negative, and rippling effect on considerations of causation—which is what occurred here.

[85] For the reasons outlined, I would conclude that the judgment cannot stand and I would allow the appeal.

The Article

[86] In light of my conclusions regarding the standard of care, I need not address the trial judge's reference to the article made at the outset of the part of his reasons headed "**STANDARD OF CARE**" (see para 81). I will nonetheless do so because it was a very serious error for him to have introduced this literature on his own, after the trial, without disclosing it to the parties before his decision was issued (see *Morrill v Morrill*, 2016 MBCA 66 at paras 31-36 [*Morrill*]; and *R v Bornyk*, 2015 BCCA 28 at paras 8-12 [*Bornyk*]). The only exception to this prohibition is for matters that are the proper subject of judicial notice, which is clearly not applicable.

[87] Dr. Jacob acknowledges the trial judge's error in conducting his own research and referring to the article. As stated in *Morrill* (at para 32):

> It has long been acknowledged that counsel for the parties are to have conduct of a trial, and it is counsel who must decide what is put before the judge. It is not for the judge to consult and rely upon outside or professional literature on his or her own motion and, even more so, introduce such material into a trial. To do so, as in this case, is an error and the practice followed by the trial judge in this case should be highly discouraged.

[88] I reinforce this fundamental and important point. Cases are to be decided on the evidence, and only the evidence. Outside sources are not to be consulted. We tell juries this. It applies equally to judges.

[89] That being said, the jurisprudence indicates that a judge's reference to professional literature not tendered in evidence, although a serious error, must "materially affect the outcome" to result in a new trial (*Morrill* at para 46; see also *Bornyk* at para 16).

[90] Ms Dumesnil claims that the extensive quotation from the article permeates the entirety of the trial judge's decision, as it demonstrates that he undertook self-directed research, rather than relying on the expert evidence tendered by the parties at trial.

[91] Dr. Jacob takes the position that the trial judge's reference to the article had no impact on his decision because the information about the nature and treatment of calcaneal fractures in the article was supported by virtually all of the experts who gave evidence at trial. Dr. Jacob notes that the excerpt from the article quoted by the trial judge makes no reference to the standard of care, but merely references the complexity of treating these fractures.

[92] Significantly, immediately prior to referring to the article, the trial judge stated: "In order to appreciate the standard of care in 2006 [citation omitted] the sometime conflicting comments made by the experts retained well after 2006 must be properly understood" (at para 81). He then quoted from the article, which was published in early 2007. I am satisfied that, by these comments, he was indicating that he would use the article to assist in determining the standard of care at the relevant time. As well, the article's statements that there was "no clear consensus . . . reached" (at p 36) regarding management of calcaneal fractures and "general disagreement on the most appropriate management of [calcaneal fractures], in particular for displaced intra-articular fractures" (at p 37) could tend to justify different approaches as being acceptable so as to diminish the criticisms of Dr. Jacob made by Ms Dumesnil's experts.

[93] Ultimately, although not necessary to decide in order to dispose of this appeal, I would be of the view that the trial judge relied on the article to assess the expert evidence, such that his error was material to his conclusion that Dr. Jacob had not breached the standard of care.

Remedy

[94] I now turn to the question of the appropriate remedy. In that regard, I find the comments of the Court in *Meyers v Moscovitz*, 2005 ABCA 114 [*Meyers*], leave to appeal to SCC refused, 30940 (27 October 2005) to be apt. In *Meyers*, also a medical malpractice case, the Court concluded that the trial judge had erred regarding the appropriate standard of care and in his causation analysis. The Court discussed in some detail why it was inappropriate to substitute its own decision for that of the trial judge. After noting that "the

evidence of the many experts was complex and, in part, conflicting" (*ibid* at para 10), it stated (at para 35):

> This Court decided to do so in ***Nova v. Guelph Engineering Co***. (1989), 100 A.R. 241 at 249 (Alta. C.A.), and both the majority decision and the dissent provide some guidance as to when that is appropriate. There are some significant differences between that case and this one. In this case, the credibility of the parties was determinative on an important issue. Here, scope of expertise of the various experts was not always carefully evaluated and the limitations of that expertise taken into account relative to the evidence accepted from each and the inferences drawn from that evidence. In a case such as this where causation is complex, where experts have different areas of expertise, and where the evidence of expert witnesses conflicts, an in-person rather than an on-paper assessment is better done by a trial judge: ***Nova***, *supra*, at 111, citing ***Joyce v. Yeomans***, [1981] 2 All E.R. 21 at 26-27 (C.A.). Counsel for the appellant argued that if this Court found a reviewable error, a new trial would be necessary.
>
> [underlining emphasis added; bold emphasis in original]

[95] Like in *Meyers*, it is not appropriate for this Court to decide the present claim, given the extensive, complex and sometimes conflicting expert opinion evidence.

[96] Furthermore, a new trial will be required where the necessary evidence or factual findings are not contained in the appellate record. In this regard, as I will explain, I have questions about the trial judge's key finding of fact as to when Ms Dumesnil's peroneal tendons first became displaced. In the trial judge's reasons for decision, he stated: "The court does not accept Dr. Hammond's evidence the peroneal tendons were dislocated from the time Dr. Jacob surgically repaired [Ms] Dumesnil's calcaneus" (at para 246). This is an important finding because of Dr. Younger's opinion as to the cause of

Ms Dumesnil's complaints and symptoms. He was of the view that her "infection and subsequent treatment likely delayed her recovery, but it may not have particularly changed her long-term outcome"; he opined that her ongoing problems were due to the quality of the reduction and the displacement of the peroneal tendons as a result of the surgery.

[97] The trial judge indicated that he made his finding as to when the peroneal tendons had become displaced on the basis that Dr. Pilkey had not observed that the peroneal tendons were "improperly seated" (*ibid*) when he performed the September 29 procedure. The trial judge also relied on the fact that no one, including Dr. Pilkey, who had seen Ms Dumesnil prior to July 2014 had noticed the problem with the peroneal tendons.

[98] I recognize that a trial judge need not address every piece of evidence. However, uncertainty is raised by the fact that, in analyzing when the peroneal tendons had become displaced, the trial judge did not address what appears to be disagreement between Dr. Younger and Dr. MacLeod regarding the post-surgical imaging. Dr. Younger testified that that imaging shows an unsatisfactory reduction leaving no room for the peroneal tendons to be reduced, while Dr. MacLeod's reports, in which he reviewed the imaging, seem to indicate no irregularity. As well, while it is true that Dr. Pilkey did not note that the peroneal tendons were displaced during the September 29 procedure or in the two years he followed up with Ms Dumesnil, the trial judge's analysis did not deal with the fact that Dr. Pilkey also did not observe same when he saw her in February 2014, August 2014 and December 2014, despite Dr. Younger diagnosing the problem in July 2014.

[99] All of which is to say that, given the assessments that must be made of complex medical evidence and of the credibility and reliability of expert opinion evidence, this Court cannot confidently decide this claim. That is best undertaken in the context of a trial. In my view, the interests of justice require a new trial. While further delay after this litigation has been outstanding for well over a decade, as well as the expense associated with a new trial, are undoubtedly regrettable, I would conclude that it is the appropriate remedy.

Conclusion

[100] For the foregoing reasons, I would allow the appeal, set aside the judgment and order a new trial. Ms Dumesnil shall have her costs on the appeal. With respect to entitlement to costs in the Court below, failing agreement, the parties are to file written argument, not to exceed 10 pages.

Simonsen JA

I agree: Steel JA

I agree: Cameron JA