CITATION: Levac v. James, 2021 ONSC 5971
COURT FILE NO.: CV-14-511333-00CP
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ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:	
Anne Levac Plaintiff	*Paul Harte*, *Maria Damiano, and Giuseppe Michelucci*, for the Plaintiff
– AND –	
Stephen Rose James, Sue-Ellen Solger, Izabella Gerbec, Erin Kostuch, Anita Takyi-Prah, Joana Nunes, Elizabeth Hicken, Marissa Allin, Rachel Schrijver, Annie Michaud, Anna Nudel, Elena Polyakova, Raymund Tanalgo, Jefferd Felix, Jason Foster, Paolo Galvez, Glenn Francesco, Peter Rothbart and Rothbart Centre For Pain Care Ltd. Defendants	*Darryl Cruz, Erica Baron, Eric Pelligrino, and Patrick Gajos*, for the Defendant, Stephen Rose James *Voula Kotoulas*, for the Defendants, Sue-Ellen Solger, Izabella Gerbec, Erin Kostuch, Anita Takyi-Prah, Joana Nunes, Elizabeth Hicken, Rachel Schrijver, Annie Michaud, Anna Nudel, Elena Polyakova, Raymund Tanalgo, Jefferd Felix, Jason Foster, Paolo Galvez, Glenn Francesco *Ron Bohm*, for the Defendant, Marissa Allin
	HEARD: February 16-19, 22-26, March 1-5, 8-12, 15-19, June 28, 2021

E.M. MORGAN, J.

I. Overview of the case

[1] On November 30, 2012, officials from Toronto Public Health ("TPH") visited the Rothbart Centre For Pain Care Ltd. (the "Rothbart Centre") in North York, and advised the staff there that

three patients who had received epidural injections had reported suffering from infectious meningitis. All three patients had been treated at the Rothbart Centre by Dr. Stephen James, a U.S.-trained anesthesiologist and specialist in pain management.

[2] Infections of this nature following epidural injections are a rare occurrence. Assuming the use of proper aseptic technique, the expected rate of serious infection is less than 1:10,000. TPH, which at the time of its visit was aware of three cases, declared there to be an outbreak of infectious meningitis and ordered Dr. James to stop practicing pending the completion of the investigation. By the time the investigation was complete, some two dozen cases of meningitis had been discovered among Dr. James' patients over the nearly three years since he had commenced practicing at the Rothbart Centre.

[3] There is little doubt that there was a serious outbreak of meningitis at the Rothbart Centre during the class period from January 2010 to November 2012 (the "Class Period"), but that is not the question for this common issues trial. The central question here is whether any of the cases were caused by Dr. James' negligence or breach of fiduciary duty, and whether the other Defendants – specifically, the nursing staff that assisted Dr. James from time to time in performing epidural procedures – were contributing causal agents.

II. The issues

[4] As indicated, this is not a standard trial but rather is a class action common issues trial. The result, therefore, will be in the form of answers to the set of questions posed when the case was certified, and then further amended, under the *Class Proceedings Act*, SO 1992, c. 6 ("*CPA*"): *Levac v. James*, 2019 ONSC 5092. I would point out that although there are no specific findings with respect to any one patient, the answers to the common issues questions will apply to all class members. Strathy J. (as he then was) explained this approach in *578115 Ontario Inc v. Sears Canada Inc*., 2010 ONSC 4571, at para 40:

> With regard to the common issues, 'success for one member must mean success for all. All members of the class must benefit from the successful prosecution of the action, although not necessarily to the same extent.' That is, the answer to a question raised by a common issue for the plaintiff must be capable of extrapolation, in the same manner, to each member of the class.

[5] The Class has been defined as:

> All persons who received an epidural injection administered by Stephen Rose James at the Rothbart Centre for Pain Care Ltd. between January 1, 2010 through to November 30, 2012, and who subsequent to their treatment developed signs or

symptoms clinically compatible with bacterial meningitis, epidural abscess or cellulitis of a bacterial origin and/or bacteremia, or where such a person is deceased, the personal representative of the estate of the deceased person who developed a clinical infection; and

All living parents, grandparents, children, grandchildren, siblings, spouses and same sex partners (within the meaning of s. 61 of the *Family Law Act*) of infected patients, or where such a family member died after his or her related infected patient developed signs or symptoms of clinical infection, the personal representative of the deceased family member.

[6] Two subclasses have been defined as follows:

All persons who received an epidural injection administered by Dr. James at the Rothbart Centre between January 1, 2010 through to November 30, 2012, and who subsequent to their treatment at the Rothbart Centre developed a clinical infection, and who were infected by a strain of methicillin-sensitive *Staphylococcus aureus* matching the strain of methicillin-sensitive *Staphylococcus aureus* colonized on Dr. James during the Class Period as determined by pulsed-field gel electrophoresis, or where such a person is deceased, the personal representative of the estate of that deceased person (the 'Genetically Linked Patients'); and

All persons who received an epidural injection administered by Dr. James at the Rothbart Centre between January 1, 2010 and September 2, 2012, who subsequent to their treatment at the Rothbart Centre developed a clinical infection, or where such person is deceased, the personal representative of the estate of the deceased (the 'Presumptively Untimely Claims').

[7] The certified common issues to be determined are as follows:

NEGLIGENCE

Q# 1: Whether the Defendants owed a duty of care to the Class to take reasonable precautions to prevent the transmission of health care associated infections?

Q# 2: What was the standard of care applicable to each Defendant relating to their duty?

Q #3: Whether the Defendants breached the applicable standards?

CAUSATION

Q# 4: Was any breach sufficient to have caused or contributed to clinical infection in the infected patients?

Q# 5: Should an inference be drawn that any breach, in the absence of evidence to the contrary, caused or contributed to clinical infection in the infected patients?

Q# 6: Did any breach cause or contribute to clinical infection in the Genetically Linked Patients?

FIDUCIARY DUTY

Q# 7: Whether the putative fiduciary Defendants owed a fiduciary duty to the Class?

Q# 8: For those putative fiduciary Defendants found to owe a fiduciary duty, what was the nature of the fiduciary duty owed to the infected patients?

Q# 9: For those putative fiduciary Defendants found to owe a fiduciary duty, whether these Defendants, or any of them, breached their fiduciary duty?

Q# 10: Whether the fiduciary breaches, or any of them, caused or contributed to clinical infection in the infected patients?

LIMITATION PERIOD

Q# 11: Could the claims of the Presumptively Untimely Claims subclass have been discovered within the meaning of section 5 of the *Limitations Act* more than 2 years prior to September 9, 2014?

PUNITIVE DAMAGES

Q# 12: For the putative fiduciary Defendants, whether there is conduct sufficient to attract punitive damages, and if so, whether punitive damages should be awarded and in what amount?

III. The Toronto Public Health investigation

[8] On November 29, 2012, a case of meningitis in a patient who had recently received an epidural injection performed at the Rothbart Centre was reported to TPH. Danielle Steinman, the

Infection Control Manager for TPH, testified that TPH personnel connected this case with two other cases of meningitis reported in the previous months that were associated with the Rothbart Centre. Meningitis is an inflammation of the membranes surrounding the spinal cord and brain, caused by any of a bacterial, viral, or fungal infection. It is a serious condition and a reportable disease as specified under the *Health Protection and Promotion Act*, RSO 1990, c. H.7 (the "*HPPA*") and O. Reg 559/91.

[9] TPH considers that three or more cases of meningitis constitutes an "outbreak" – i.e. the occurrence of more cases than expected in a given area or among a specific group of people over a particular period. TPH personnel therefore commenced an investigation of the Rothbart Centre on November 30, 2012.

[10] The investigation went on until April 2013 and was headed by TPH's Director of Communicable Diseases, Dr. Barbara Yafee. A report was produced as required by the *HPPA* entitled "Toronto Public Health Final Summary: Investigation of Methicillin-sensitive Staphylococcus aureus (MSSA) infections associated with epidural steroid injections Rothbart Centre for Pain Care 4646 Dufferin Street, Unit #9, Toronto, Ontario". Three of the TPH investigators involved in the investigation testified at trial: Danielle Steinman, Dr. Allison Chris and Debra Hayden.

[11] Dr. Chris and Ms. Steinman attended at the Rothbart Centre during the afternoon of Friday, November 30, 2012 and confirmed that all three patients with reported cases of meningitis had received an epidural injection performed by Dr. James. They also confirmed that no Rothbart Centre patients other than those treated by Dr. James had reported similar infections. They then undertook a review of some of the practices in which Dr. James engaged with respect to infection prevention and control ("IPAC"). Dr. James advised Ms. Steinman that he was aware of the three patients that TPH had identified as suffering from meningitis infections: SK, MW, and TM.

[12] The TPH investigators did not witness Dr. James during the course of performing any treatment on a patient. Likewise, they did not observe his treatment room or his IPAC technique in action with a patient. Rather, they interviewed him and other Rothbart Centre personnel regarding IPAC and patient care and had Dr. James perform a mock epidural procedure in order for him demonstrate his approach to IPAC.

[13] As a result, while their observations explain how TPH analyzed the situation, and may also shed some light on the operation of the Rothbart Centre and on Dr. James' practice and methodology. However, the testimony of the TPH investigators does not amount to evidence of how Dr. James actually treated any one patient. In that respect it is hearsay and I will not take it into account unless confirmed by Dr. James himself or another reliable source.

[14] The TPH investigators also interviewed some of Dr. James' patients. However, this, too, provided little in the way of evidence as to how Dr. James approached IPAC matters. Epidural injections such as those administered by Dr. James are done behind the patient's back where it cannot be seen by the patient.

[15] Neither the Plaintiff, who testified at trial, nor any of the patients who were interviewed by TPH, was able to see how Dr. James sterilized his hands, whether and how he donned surgical gloves, where he rested his medical implements while performing the procedure, etc. Similarly, the nurses who assisted Dr. James were focused on their own duties and had some, but not necessarily a thorough ability to directly observe Dr. James throughout an entire procedure; additionally, there is no record of which nurse assisted with which patient, and so none of the nurses who testified are able to identify a specific instance of substandard patient care. As Dr. James' counsel points out, other than Dr. James' own description there is little direct evidence as to what, precisely, Dr. James did in terms of IPAC for any given patient.

IV. The Rothbart Centre

[16] The Rothbart Centre is a large facility with approximately 14-18 treatment rooms, a dedicated recovery room, a fluoroscopy suite, and 6-10 other rooms used for administration and purposes other than actual medical procedures. During the class period, there were 8-12 pain medicine physicians and 10-15 nurses practising at the Rothbart Centre from time to time, plus some 15-20 administrative staff members. During the same period, roughly 30,000 patient visits were recorded each year, with about 5,000 epidural injections administered to patients annually. Prior to Dr. James starting work there in 2010, the Rothbart Centre had no reported infections associated with an epidural injection.

[17] At the Rothbart Centre, Dr. James had a procedure room, Room 11, assigned to him where he treated patients and performed pain management procedures, including epidural injections. He confirmed in his own testimony that he was the only physician who used Room 11 for patient care. Some of Dr. James' epidural injections were done with image guidance using fluoroscopy – a type of medical imaging that shows on a monitor a continuous X-ray image of the subject. Procedures requiring this technique were performed in the Rothbart Centre's fluoroscopy suite which, unlike Room 11, was shared among all the physicians working there. The fluoroscopy suite was staffed with nurses specifically assigned to assist with fluoroscopy procedures.

[18] When an epidural injection is performed as a pain management technique, medication is injected into the epidural space. The procedure is commonly performed in specialized pain clinics such as the Rothbart Centre. It involves injecting the medication directly into the space that surrounds the spinal cord and nerve roots – i.e. the space inside the bony spinal canal but outside the dura mater. The evidence is uncontroverted that if bacteria is introduced into the epidural space

the consequences can be catastrophic for the patient. Dr. James himself testified that serious infections associated with epidural injections can occur but are very rare; he was aware of data that puts the incidence of infection at 1:10,000.

[19] Dr. James also testified that during the Class Period, he performed roughly 25 epidural injections per week, or 1,300 per year. He was assisted from time to time in performing epidural injections by a nurse, including each of the Defendants, Erin Kostuch, Anita Takyi-Prah, Joana Nunes, Elizabeth Hicken, Marissa Allin, Rachel Schrijver, Annie Michaud, Anna Nudel, Elena Polyakova, Raymund Tanalgo, Jefferd Felix, Jason Foster, Paolo Galvez, and Glenn Francesco (collectively the "Nurses").

[20] There is no evidence as to which of the Nurses assisted with which patients. The Nurses assisting physicians in the procedure rooms, including Dr. James' Room 11, circulated throughout the Rothbart Centre during any given shift and were not assigned to a particular physician. They responded to a call bell system by which any physician could summons them for assistance. The physician recorded matters in the patients' files pertaining to the procedure being performed, while the Nurses took over the charting requirements once patient care was transferred to a different nurse in the recovery room.

[21] The Rothbart Centre's policies did not require any records of the nursing assistants to be recorded in patient files, although the doctor was free to do so. Dr. James did not note down any records of his nursing assistants. Accordingly, no Class member or patient of Dr. James can trace the cause of any infection to the conduct, negligent or otherwise, of any one of the Nurses.

[22] Dr. James himself testified that he never had any complaints about any of the Nurses that worked with him at the Rothbart Centre, and that from his point of view none of them were substandard in their nursing care or their IPAC techniques. He also agreed that in any given procedure he was the responsible physician, and that it was he, and not the various attending Nurses, who was ultimately responsible to ensure that appropriate steps were taken to avoid the transmission of infection to patients.

V. The Plaintiff's experience

[23] Ms. Anne Levac testified that she was referred to the Rothbart Centre in June 2012 for treatment of chronic lower back and right leg pain. On June 26, 2012, she was examined by Dr. James, who diagnosed her as having lumbar spondylosis with right L5 radicular pain. Dr. James proposed a treatment plan involving a series of injections, including lumbar epidural steroid injections, and he performed the first of those injections on her that same day. In all, Ms. Levac attended three appointments on June 26, 2012, July 25, 2012, and August 22, 2012.

[24] For the injection procedure, Ms. Levac recalls sitting on a gurney in Dr. James' procedure room – Room 11 – where, with the assistance of a nurse who she cannot identify, she was prepared for an epidural injection. Ms. Levack does not know exactly what Dr. James did since he was outside of her line of sight. She is also unable to say whether or not the nurse was wearing gloves or a mask before or during the procedure, since the nurse worked at all times from behind her back.

[25] After the procedure was complete, Ms. Levac was moved to the recovery room of the Rothbart Centre. She testified that each of her visits to Dr. James at the Rothbart Centre followed roughly the same sequence. In cross-examination, she reiterated that during the time Dr. James was preparing her and administering the injection she could not see what steps Dr. James or the nurse were taking to prevent infection because, as she put it, it was "all done behind me."

[26] Two weeks after Ms. Levac's last epidural injection in August 2012, she found herself unable to move and was eventually transported to a hospital by ambulance. Upon admission she was diagnosed as suffering from a serious infection in her spine. Bacterial blood cultures analyzed by the hospital were found to be positive for the bacteria *Staphylococcus aureu*s, or *Staph aureus*.

VI. TPH's review of prior patients

[27] Within a week of their initial visit to the Rothbart Centre, on December 3, 2012, TPH staff initiated what they called a "look-back" in an effort to determine if there were other patients recently treated by Dr. James with an epidural injection who had experienced an infection following their treatment. TPH selected a look-back period of four months, from August 1, 2012 to the date of their initial visit with Dr. James on November 30, 2012. Dr. James performed 408 epidural injections on 272 patients during this period.

[28] The TPH investigative report identified nine patients of Dr. James who developed an infection requiring hospitalization during the look-back period. This infection rate works out to 220 per 10,000 cases, or 220 times greater than the expected rate of infection for epidural injections of this type.

[29] Given this rate of occurrence, TPH deployed a number of analytic tools for identifying the source of the infections, all of which are described in its investigative report included in the evidentiary record. These included, first of all, an epidemiologic analysis of the hospital records of the infected patients. Eight of the nine identified infected patients had positive laboratory cultures for methicillin-sensitive *staphylococcus aureus* ("MSSA"), with no organism being cultured for the ninth patient. MSSA is a type of *staphylococcus aureus* ("*Staph aureus*") that is not resistant to the antibiotic methicillin.

[30] Ms. Steinman testified that *Staph aureus* is a relatively common organism colonizing people's nasal passages. She indicated that approximately 25% of health care workers are colonized with this bacterium at any time. And while it is generally harmless sitting on the surface of nasal membranes, the TPH report observes that introduction of this bacterium into deep tissue can cause infections and abscesses on nearby parts of the patient's anatomy.

[31] At the time of the time of the TPH investigation, samples of infected areas were still available to be tested for six of the infected patients. These specimens were tested at the Public Health Ontario Laboratory and were then sent to the National Microbiology Laboratory for pulse field gel electrophoresis ("PFGE") sub-typing. Ms. Steinman explained that PFGE is a bacterial typing method by which one can identify those strains of bacteria that are a genetic match.

[32] It turned out that all of the patient samples that were available for this type of testing were found by the PFGE sub-typing to be the same strain of S*taph aureus*. Using genomic sequencing techniques, this strain was identified as CC59. Dr. Neil Rau, an expert witness called by Dr. James, confirmed in cross-examination that CC59 is an extremely uncommon strain that is very rarely seen in North America.

[33] Dr. Rau stated that there was some evidence suggesting that CC59 is a particularly virulent strain of *Staph aureus*. It was also his evidence that there is no strain of *Staph aureus* that is known to infect patients when appropriate IPAC measures are employed.

[34] TPH also collected for biological testing specimens from seventeen members of the Rothbart Centre staff, including the Nurses, who potentially had contact with the infected patients. Five staff members were found to have positive cultures for S*taph aureus*, although when the cultures were sent for PFGE testing it turned out that none of the strains found on the Rothbart Centre staff members other than Dr. James matched the CC59 strain. Ms. Steinman testified that from TPH's point of view this effectively ruled out the Nurses as the source of infection.

[35] Specimens were also collected from Dr. James' fingernails, mouth, perineum, and an open sore on this thumb. Three of these samples came back from testing showing that they were positive for *Staph aureus*. Following that, PFGE testing of the samples taken from Dr. James revealed a match for the CC59 strain.

[36] In addition, TPH took thirteen environmental samples from Room 11, the treatment room where Dr. James administered most of his epidural injections. Samples taken from the countertop, the telephone, and the armrest on Dr. James' chair showed the presence of bacteria that matched the CC59 strain. Dr. Rau testified that this likely indicated that Dr. James was a chronic carrier of this strain of *Staph aureus*.

[37] For her part, Ms. Steinman explained that with these results TPH was able to conclude that, from a public health point of view, the source of the meningitis outbreak was the bacteria colonized on Dr. James. Ms. Steinman testified:

> Q. What's the significance of that finding to your investigation of the outbreak?
>
> A. Again, it shows that, that there's the source and the outcome. It shows that there is a direct tie, direct correlation or that he [Dr. James] is the source.

VII. Standard of Care

[38] In turning attention to the substantive legal dimensions of the trial, it is worth noting that the evidentiary and proof requirements of the common issues are not lessened merely because the matter is a class action. *In Quebec (Curateur public) v. Syndicat national des employes d L'Hopital St-Ferdinand*, [1996] 3 SCR 211, at paras 31-33, the Supreme Court of Canada explained:

> The basic principle of evidence in civil matters is that the party who wishes to exercise a right has the burden of proving the facts which support his or her claim…
>
> Thus, in the context of an action in civil liability brought in the form of a class action, the elements of fault, prejudice and causal connection must be established in respect of the members of the group, by the normal evidentiary rules.

[39] The Plaintiff bears the burden of proof in a negligence claim: *Wilkinson Estate v. Shannon* [1986] OJ No 625 (HCJ). The essential elements of negligence law are well known. They were reiterated in full by the Supreme Court of Canada in *Mustapha v. Culligan of Canada Ltd*., [2008] 2 SCR 114, at para 3:

> A successful action in negligence requires that the plaintiff demonstrate (1) that the defendant owed him a duty of care; (2) that the defendant's behaviour breached the standard of care; (3) that the plaintiff sustained damage; and (4) that the damage was caused, in fact and in law, by the defendant's breach.

[40] It is axiomatic that physicians owe their patients a duty of care and must adhere to the standard of care required of them by the medical profession under the circumstances. As with each of the elements of negligence law, the Plaintiff has the onus of establishing that a Defendant fell below the standard of care on a balance of probabilities: *Wilson v. Swanson*, [1956] SCR 804, at para 28. As the Court of Appeal put it in *Crits v. Sylvester*, [1956] SCJ No 71, aff'd [1956] SCR 991, at paras 13-14:

> 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.

[41] Dr. James and/or the Nurses that worked with Dr. James confirmed for the TPH investigators a number of deficiencies in the Rothbart Centre's general IPAC practices. Ms. Steinman testified that these included the cleaning of procedure room surfaces with a relatively weak disinfectant only once a week, not wiping down patient pillows at all unless visibly soiled, not wiping down gurneys between patients, never cleaning the pulse-oximeter used on every patient, and never cleaning the curtains partitioning the procedure rooms.

[42] Ms. Steinman testified that the TPH team also found a number of faults with Dr. James' own techniques, but, as indicated above, this was based on observing a mock procedure and not an actual procedure on a patient. Those observations therefore carry little to no evidentiary weight. The artificiality inherent in a mock procedure performed as part of an investigation does not allow one to draw meaningful conclusions from what is observed. If Dr. James forgot in the heat of a mock procedure before a group of TPH investigators to pinch the bridge of his facemask's nose, that does not mean that he did so every (or any) time he was with an actual patient.

[43] Not only is the court not to draw conclusions from the kind of second-hand account of Dr. James' practice reflected in the TPH observations of a mock procedure, it is not to draw inferences of wrongdoing from the fact of the Plaintiff's and Class members' injuries. To do so would be to engage in a type of analysis that has been rejected by Canadian courts. Perell J., in an earlier stage of this case, described the debunked analysis as "a retrospective inference of negligence that is an instance of the logical fallacy of *post hoc, ergo propter hoc* ('after this, therefore, because of this') and of the defunct doctrine of *res ipsa loquitur*, which was rejected by the Supreme Court of Canada in *Fontaine v. British Columbia (Official Administrator)*, [1998] 1 SCR 424, where the Court treated the doctrine as expired: *Levac v. James*, 2016 ONSC 7727, at para 105, rev'd on other grounds: 2017 ONCA 8.

[44] That said, Dr. James himself confirmed a number of things in his own testimony that the TPH officials, along with expert witnesses at trial, identify as falling below the acceptable standard of IPAC. These include using the sterile glove packaging or wrapper as a sterile field for resting surgical implements during a procedure, and performing an injection in the caudal area of the spine without using an aseptic technique.

[45] None of the experts at trial testified that a non-aseptic technique met the standard of care for a caudal injection, and Dr. James could not identify a single text book or other piece of medical literature that suggested that was the case. Dr. Richard Doran, a pain management expert called by Dr. James, testified that all epidural injections, including caudal injections, require an aseptic technique. Dr. Catherine Smyth, a pain management expert called by the Plaintiff, stated in her testimony that the non-use of an aseptic technique when performing caudal epidural injections was "shocking".

[46] Dr. James' use of a glove wrapper for a sterile field was, he testified, a holdover from his medical training in Michigan where that was apparently a commonly utilized technique. He confirmed in his testimony that he used glove packaging rather than a sterile drape made for the purpose as a sterile field for all epidural injections in Room 11. Dr. James indicated that he was aware that the Rothbart Centre had a stock of 18" x 26" multi-layered and waterproof sterile drapes specifically for use as a sterile field, and in fact used those drapes as a sterile field when he performed procedures in the fluoroscopy suite. But at all times during the Class Period he continued to use the glove wrapper instead of using a specifically-designed sterile drape for the procedures he performed in Room 11.

[47] Dr. Smyth testified that the use of a glove wrapper for a sterile field was entirely unacceptable. She stated that the wrapper is "flimsy material" and that any tear would expose the contaminated counter underneath it, and any fluid spilled on the wrapper would render it unsterile. Dr. Jason Powell, a nursing expert called on behalf of Dr. James, testified that in his rather extensive experience with IPAC the use of a glove wrapper as a sterile field was patently substandard.

[48] A number of the Nurses who testified at trial identified yet further IPAC failings by Dr. James. Elena Polyakova testified that Dr. James would always draw his own medication rather than have a nursing assistant hold the medication while being drawn. This is both an IPAC concern as well as a safety hazard.

[49] Similarly, both Elizabeth Kostuch and Joana Nunes described Dr. James as sometimes working while he was congested, sniffling and able to breathe only through his mouth. Nurse Kostuch also testified that on one occasion she found a discarded mask on Dr. James' counter with yellow residue in it; at the time, she said, she had thought the residue was from either his mouth or nose. Another nurse, Glenn Francisco, recalled assisting Dr. James with both caudal and lumbar epidural injections in Room 11, and testified that Dr. James was wearing gloves but only sporadically wore a mask while performing the procedure.

[50] Counsel for the Plaintiff submit that the standards to which Dr. James was expected to adhere went beyond the hands-on treatment and IPAC standards required of epidural injections.

They also included standards of reportage, investigation, and remediation in respect of any reported infections. It is the Plaintiff's position that Dr. James fell below the professional standards expected of him in this regard as he took no action as he learned of the series of infections in his patients.

[51] In response, it is Dr. James' position that he did not fail his patients in this way. He testified that he did, in fact, report incidents of infection to the management of the Rothbart Centre, and specifically to the medical director, the Defendant, Dr. Peter Rothbart. In his testimony, Dr. James explained that he would have expected Dr. Rothbart, as medical director, to look after the issue. There is no written report by Dr. James to Dr. Rothbart regarding any infections in Dr. James' patients.

[52] Dr. Rothbart was unavailable to testify at trial due to his own serious, ongoing health problems. However, the transcript of his examination for discovery is in the record. At discovery, Dr. Rothbart deposed that he had no recollection of receiving any such report from Dr. James, either written or verbal. Certainly, there is no evidence of Dr. Rothbart doing anything in response to any reports of infections, and there is no reason to think that as medical director of the Rothbart Centre he would not take action if he were advised of such a problem. It would have been in his and in his clinic's interest to do so.

[53] Dr. Smyth testified that a physician who becomes aware of a potential infection associated with their epidural practice has a duty to report, investigate and remediate. This is not a controversial point among the experts that testified on both sides of the trial; no expert witness testified to the contrary. It is Dr. Smyth's view that Dr. James' response to his patients' infections was significantly sub-standard. She stated:

> A reasonable physician would have taken notice of a serious complication. They would have reported it within their practice to the medical director or quality control committee. They would have investigated it thoroughly to look for any remediable causes, excuse me, remediable causes that, that could be fixed and, and there should have been some changes that, that, that improved things for subsequent patients and reduced the risk for subsequent patients but he didn't do anything when he first learned of these infections.

[54] According to Dr. Smyth, there was an obligation on Dr. James to address patients' complications the same day or the day after he learned of them. She further explained in her testimony that the obligation to investigate and remediate is triggered upon learning of an infection, and that a physician need not wait until he or she is certain that the injection caused the patient's infection.

[55] The reporting obligation was codified in September 2010, in the Out-of-Hospital Premises ("OHP") Standards published by the College of Physicians and Surgeons. The OHP Standards form an exhibit in the trial record, and in cross-examination Dr. James confirmed that he was aware that the Rothbart Centre was an Out-of-Hospital Premises and was required to comply with the applicable standards.

[56] That said, Dr. James also made it clear that he had never read the OHP Standards either before or after several of his patients reported infections. The OHP Standards required him to monitor and report complications such as infections in writing to the medical director of the Rothbart Centre within 24 hours of learning of them. They also required him to identify the nurse who was assisting him with the infected patient's procedure and to provide an analysis in writing of the cause of the infection. The evidence is clear that Dr. James did not take any of these steps. Dr. James himself concedes that he did not, and the Rothbart Centre's documentary records confirm that Dr. James produced no reports of infections.

[57] In addition, the management and policies of the Rothbart Centre required Dr. James to report infections occurring with his patients. As already indicated, Dr. Rothbart was unable to testify at trial. However, at discovery he deposed that serious infections such as an epidural abscess or meningitis should have been reported to him as medical director. It was Dr. Rothbart's evidence that this was an expectation that he had conveyed to both physicians and nurses and of which he was sure that they were aware.

[58] Sue-Ellen Solger, the Nurse Manager of the Rothbart Centre, likewise confirmed in her testimony that a serious infection in a patient who had undergone an epidural injection by one of the physicians at the Centre, would be reported to the medical director. If there were a failure to report, the fault lay with the physician in failing to do so and not with the Rothbart Centre and its managerial policies.

[59] The patient records of eleven class members were adduced into evidence at trial and were put to Dr. James in cross-examination. He confirmed that he was aware of the infections suffered by each of them, either by having been advised by the patients themselves once they were diagnosed or by a subsequent treating doctor or hospital. It is unclear whether there were any others of which he was specifically aware, although there is some evidence that there were more. Ms. Solger, the Nurse Manager, testified that she personally advised Dr. James of a possible infection in at least one further patient of his who had called the Rothbart Centre after her treatment, but he testified that he did not recall being so advised.

[60] Matthew Moralis was the first of Dr. James' patients to incur a post-procedure infection. Although at one point in his testimony Dr. James claimed to have no memory of Mr. Moralis' infection, he also testified that in July 2010 he became aware of Mr. Moralis' diagnosis of infection

and that he took this news as an opportunity to reflect on his own practices and to contemplate what he could do to improve. Mr. Moralis was, in fact, a memorable person for Dr. James; he was a Canadian Armed Forces veteran who had suffered a back injury parachuting during the course of his military service. Dr. James stated that he began treating Mr. Moralis at just about the time he started working at the Rothbart Clinic and that he continued to treat him for a number of years.

[61] In all, Mr. Moralis underwent three epidural injections performed by Dr James in the caudal, or tailbone area of the spine. Mr. Moralis' chart at the Rothbart Centre shows that the procedures were done on June 15, 18 and 25, 2010. For each of those procedures, Dr. James testified that he used what he called a "clean" but non-aseptic technique. In other words, Dr. James did the injection without the assistance of a nurse (drawing the medications into the syringe himself) and without wearing a mask or sterile gloves.

[62] Dr. James conceded in cross-examination that on July 7, 2010, within two weeks of his third injection, Mr. Moralis informed him that he had been admitted to hospital with an infection in his spine and that he had been prescribed a six-week course of intravenous antibiotics. Dr. James indicated that Mr. Moralis told him that the laboratory results showed he had an abscess caused by S*taph aureus* infection.

[63] The evidence in Mr. Moralis' chart shows that Dr. James ordered a copy of Mr. Moralis' records from the hospital and that he reviewed the records and met with Mr. Moralis on August 9, 2010. Dr. James testified that he likely told Mr. Moralis that the epidural injection caused the infection. Dr. James also wrote to the Veterans Administration reporting that he had performed an epidural injection on Mr. Moralis and that Mr. Moralis was subsequently diagnosed as having an abscess that was likely associated with the injection.

[64] Dr. James testified that, contrary to his general assertions that he reported cases of infection to the medical director, he did not advise anyone at the Rothbart Centre of Mr. Moralis' infection. Rather, as he put it, he treated the incident as "an opportunity for self-reflection". This self-reflection, according to Dr. James himself, did not result in any changes in his IPAC or other methodology:

> Q. So my question was you decided, despite the knowledge you had about the nature, type, location and how this infection may have occurred, that you were going to do nothing about that at that time. That's just true, isn't it?
>
> A. I said I didn't change my practice.
>
> Q. You did nothing about it at that time, correct?
>
> A. Yes.

[65] Dr. James testified that he continued to perform caudal injections without wearing a mask or sterile gloves until he was told to stop doing so by TPH following their November 2012 visit. Indeed, at Mr. Moralis' next appointment, on August 9, 2010, Dr. James performed yet another caudal epidural injection using the same mask-less and glove-less technique. At the time, Mr. Moralis was still in the midst of his intravenous antibiotic treatment for the prior infection.

[66] Dr. James conceded in cross-examination that he was aware that he should not have administered an injection on that date due to the risk to a patient with an intravenous line in his arm. He explained that he nevertheless performed the further epidural injection because Mr. Moralis was complaining about having significant back pain.

[67] There is one patient of Dr. James – Anne Littleton – that died following a treatment that he performed at the Rothbart Centre. She passed away two weeks after Dr. James administered an epidural injection in the lumbar region of her spine on August 23, 2011.

[68] Two days after her lumbar epidural, on August 25, 2011, Ms. Littleton came in to see Dr. James. On that date, he noted in her chart that she had previously had an epidural injection and now had right lower stabbing pain, fever, chills, night sweats and lower bowel and bladder dysfunction. Dr. James conceded in cross-examination that these would have been signs of a serious condition. The records show that Dr. James sent Ms. Littleton to a hospital emergency department for an MRI to assess whether she had an epidural abscess infection.

[69] Ms. Littleton's file records reveal that six days after undergoing the procedure she called Dr. James and reported that she had swelling in her leg and was unable to walk due to an intolerable level of pain. Despite all this, Dr. James testified that he had no recollection of Ms. Littleton suffering any infection at all.

[70] On September 22, 2011, a hospital mental health worker documented in a contemporaneous medical note that she spoke with Dr. James and informed him of Ms. Littleton's death. For reasons which even Dr. James cannot explain, he made no note of this conversation and did not record it in Ms. Littleton's chart.

[71] Again, Dr. James did nothing in the wake of this patient's serious infection and subsequent death, although he agreed in cross-examination that it would have been important to get information on how and why she had died. The evidence establishes that Dr. James never followed follow up with either the hospital where Ms. Littleton died or with Ms. Littleton's family, and that he never requested her hospital records in order to determine what had gone wrong and how it could be remediated in the future.

[72] Ms. Littleton's hospital records are in evidence. They show that had Dr. James followed up with even a cursory investigation he would have learned that the hospital records document that

Ms. Littleton died as a result of sepsis due to complications of a lumbar spine absces, and that *Staph aureus* was drained from her epidural abscess. This infectious abscess, the hospital records show, resulted from a lumbar spine injection that only he had performed on her.

[73] The Rothbart Centre records provide evidence that Dr. James performed a lumbar epidural injection on patient Melanie Riopel on October 5, 2011, barely two weeks after Ms. Littleton's death. Those records also show that two weeks later, on October 21, 2011, he learned that Ms. Riopel had also developed an infection. Dr. James testified that this time he spoke to his Rothbart Centre colleagues, Drs. Rolbin, Brown, and Rozen, in relation to this infection.

[74] There is no documentation of any such conversation about Ms. Riopel's (or any other of Dr. James' patients') infection in any of the Rothbart Centre files in evidence. Dr. Rolbin has since passed away, but Dr. Brown and Dr. Rozen are still very much alive and are apparently still working. Dr. Brown is James' long-time close friend and Dr. Rozen was Dr. James' colleague and mentor at the Rothbart Centre. Despite their close association with Dr. James and their availability, he did not call either of them to testify and to corroborate his statement that he verbally reported Ms. Riopel's infection to them.

[75] In my view, the failure to call either Dr. Brown or Dr. Rozen casts serious doubt on Dr. James' credibility in stating that he reported Ms. Riopel's case to them. I draw the inference that in fact he did not do so: see *R. v. Ahmadi*, 2010 ONCA 639, at para 10. Dr. James himself acknowledged that he did not inform the medical director, Dr. Rothbart, of Ms. Riopel's infection. As already indicated, it would in any case have been the medical director, and not two friends and colleagues, that would have been the required avenue of reportage in accordance with the OHP Standards and the applicable professional standard of care.

[76] Dr. Smyth's evidence was that Dr. James had an ongoing duty to report infections to the medical director, and that discussing the matter with a colleague, while advisable, would not be sufficient. Dr. James agreed in cross-examination that as this was the latest in a series of serious infections incurred by his epidural injection patients, he should have spoken with the medical director and explored whether there were deficiencies existing or improvements that could be made with respect to his IPAC.

[77] Six months after Ms. Riopel's infection, Dr. James became aware of an infection in another of his patients, Perry Crippen. Mr. Crippen was diagnosed with an epidural abscess by Dr. Neil Rau, who, in an unusual turn of events, would later testify as Dr. James' expert – a role that by all appearances is against the interests of his patient. In any case, Dr. James could not say if he spoke to anyone in the Rothbart Centre about this third or fourth case of serious infection in his patients. Nothing in the Rothbart Centre records suggests that he reported Mr. Crippen's infection to anyone.

[78] Dr. James testified that his lack of reportage was due to the fact that he thought the incidents of infection in his patients were within the standard probability of infections occurring. This, however, is directly contrary to his testimony that he knew that infections associated with epidural injections typically occur at a rate of 1:10,000. Four cases within the space of eight months should have been a serious wakeup call for Dr. James, but he testified that it was not.

[79] As with his other patients who reported post-injection infections, Dr. James testified that he again "took a moment, an opportunity to like, reflect on my practice." However, he took no meaningful action in attempting to address the ongoing occurrences of infections in his practice.

[80] Dr. James' own expert witness, Dr. Rau, testified that a doctor would be expected to take reasonable investigative and preventative steps once he or she had more infections than expected. Despite this applicable standard of care, Dr. James took no steps to prevent infection or to change his IPAC practices in any way, even after learning of a number of infections suffered by his patients following their treatments by him.

[81] Dr. James conceded in cross-examination that by the fall of 2012 he was aware of multiple infections that closely followed epidural injection procedures that he had performed. On September 5, 2012, he learned of the infection suffered by the Plaintiff, Anne Levac. Medical records in evidence show that shortly thereafter, on October 1, 2012, he learned of another patient, Patricia Tanaka, suffering an infection. Then, on October 30, 2012, he learned that patient Sandra Kacho was infected, and a few days after that he learned about an infection in patient TM. A review of the Rothbart Centre records also show that the following month, in November 2012, he learned of infections in two more patients, identified as MW and ED.

[82] It was Dr. James' evidence that he took steps in response to the escalating number of serious infections during this period. He testified that he had a meeting with Dr. Rothbart sometime in September 2012. He also stated that during this time he "shadowed" several of his colleagues to study their IPAC methods, that he requested that the Rothbart Centre's supplier of Betadine antiseptic be changed, and that he requested changes to nursing supplies and PPE at the Rothbart Centre. He also testified that in mid-November 2012, he got the Rothbart Centre to change from using Betadine to using Chlorohexidine, a more potent antiseptic used for swabbing an injection site.

[83] While all of these requested changes would certainly have been helpful, there is no evidence from any other source corroborating that any of the requests were actually made or acted upon. In fact, there is evidence from other witnesses that directly contradicts Dr. James' evidence regarding the changes he claims to have recommended and made.

[84] Nurse-manager Sue-Ellen Solger did recall one meeting during this time with Dr. Rothbart and Dr. James in which she participated, but she testified that the meeting was not about infections

or a review of IPAC. Rather, it was about several incidents of so-called "wet taps" that Dr. James had administered – i.e. puncturing of the dura and resulting leakage of spinal fluid during an epidural injection. In his examination for discovery, Dr. Rothbart deposed that this was the only issue Dr. James brought to his attention in relation to his practice. He also stated that the first time he learned of infections in Dr. James' patients was on November 30, 2012, when TPH personnel arrived at the Rothbart Centre.

[85] Dr. James agreed that he was trained in medical school to document all significant conversations in a patient's medical chart and to date, timestamp, and sign such entries. Yet there is no notation in any file or patient chart reporting, for example, Ms. Levac's infection. There is no documentation of any meeting about infections occurring with Dr James' patients at the Rothbart Clinic or any other evidence to corroborate Dr. James' account of having taken steps to address the problem. Plaintiff's counsel submits, and I agree, that given that the Rothbart Centre had never had any other serious infection associated with an epidural injection procedure, it is highly likely that there would have been serious action taken by Dr. Rothbart and Nurse Solger had any of these serious infections been brought to their attention the way that Dr. James says that they were.

[86] Dr. Rothbart specially deposed that had he become aware of a case of meningitis or abscess in relation to an injection performed at the Rothbart Centre, he would have acted in a way consistent with his obligations as medical director:

> I would have interviewed the doctor. I would have met with the doctor together with – first interview the doctor and then meet with the doctor and the patient to find out exactly what had happened. I would report him to the College of Physicians and Surgeons of Ontario.

[87] When Dr. Rothbart ultimately learned about the series of infections, he did have a discussion with Dr. James. At discovery, Dr. Rothbart indicated that he asked Dr. James why he had not informed him of the ongoing problems, and that in his view it was negligent not to do so. He deposed that in response Dr. James had no explanation, but that he apologized and said that he "wouldn't do it anymore".

[88] There is likewise nothing in the Rothbart Centre's records to support Dr. James' assertion that he had requested a change of the Betadine supplier. In fact, one of the Nurses who testified at trial, Izabella Gerbec, was the Rothbart Centre employee directly responsible for ordering medical supplies for the physicians' use. She testified that there were no requests for changes and no changes made in supplies for Betadine swabs during the time period preceding the November 2012 TPH investigation.

[89] Likewise, none of the Nurses who testified corroborated Dr. James' claim that he changed his policy prior to November 2012 and asked nurses to intensify their IPAC while assisting him with an epidural procedure. The Nurses all indicated that Dr. James always appeared to be satisfied with their performance and that he never told them to change any of the IPAC methodology. Indeed, Dr. James himself testified that he never had any issue with any of the Nurses or their IPAC while assisting him perform epidural injections.

[90] In much the same way, Nurse Gerbec did not recall Dr. James making any request of her to switch from Betadine to Chlorhexidine. The Rothbart Centre records show that the first order made for Chlorhexidine was in December 2012 – i.e. subsequent to the TPH investigation.

[91] When the supply order records were put to him in cross-examination, Dr. James said that he now remembers finding a small supply of Chlorhexidine in the Rothbart Centre's existing store of supplies, and that this must have sufficed until the following month. However, there is nothing in the record to corroborate that, and it seems unlikely that records would not show an existing supply or that other Rothbart Centre personnel more directly responsible for ordering and storage of supplies would not have had a similar recollection.

[92] Having heard Dr. James testify that he specifically requested a change from Betadine to Chlorhexidine, I find it difficult to conceive how it is that he now recalls not having to make such a request because he found an already existing supply of Chlorhexidine in storage. Dr. James' story about the changes he supposedly requested and made at the Rothbart Centre in the fall of 2012 is simply not credible. I find that Dr. James made no attempt to report, investigate, or remediate or to change any of his practices or procedures in response to learning of the series of patient infections.

[93] Plaintiff's expert, Dr. Smyth, was asked about Dr. James' responses to the patients whose infections he was informed about at the time. More specifically, she was asked whether if he had responded differently to those complications, he could have changed any of the patient outcomes. As discussed below under the heading of causation, Dr. Smyth opined that had Dr. James reported, investigated, and remediated as is expected of a physician learning of post-procedure infections in his patients, he likely would have prevented any or all of the infections that came after he first learned of Mr. Moralis' infection. The evidence establishes, however, that he did not do so.

VIII. The Nurses

[94] In addition to bringing this action against Dr. James, the Plaintiff has claimed against the medical director of the Rothbart Centre, Dr. Peter Rothbart, and against the Rothbart Centre itself. As indicated, Dr. Rothbart is in ill health and did not participate in the trial, and the Rothbart Centre

itself is in default. The other Defendants are the Nurses who worked at the Rothbart Centre during the relevant period of time. The Plaintiff alleges that the Nurses were negligent in the way that they worked in assisting Dr. James in his procedures – in particular in their IPAC practices – and that this substandard conduct caused harm to the class members. The Plaintiff also alleges that the Nurses, along with Dr. James, failed to report, investigate, and remediate incidents of infections in patients.

[95] The evidence about the Nurses' IPAC practices and their assistance of Dr. James is uniform across all of the Plaintiffs' witnesses. None of them knows what the Nurses did or did not do. As previously explained and as the Plaintiff testified, epidural injections take place literally behind a patient's back. Accordingly, the majority of the time that a nurse is in the same room as a patient, the nurse is out of the patient's line of vision. The Plaintiff, for example, testified that she thought the Nurses wore masks and gloves and cleaned the procedure room and equipment, but that she could not be sure of anything.

[96] As for Dr. James, he never raised any complaint or expressed any concern about nursing procedures at the Rothbart Centre. Likewise, none of the other Rothbart Centre physicians have expressed any concern or experienced any problems with nursing-related issues, including the Nurses' IPAC procedures.

[97] Most importantly, there are no records of which of the Nurses assisted Dr. James with which patient on which day. All of the Nurses worked on a rotating basis for all of the Rothbart Centre doctors. No other doctor at the Rothbart Centre experienced patients having post-injection infections, and there is no evidence that the Nurses did anything different for any of the other doctors than they did for Dr. James.

[98] James Powell, the Senior Dean of the School of Health Sciences at Humber College, an expert on nursing standards, was called by to testify by Dr. James. It was Dr. Powell's view that if a nurse failed to wear mask or sterile glove while prepping a patient's skin for an epidural injection, it would be a failure to meet the standard of care. He explained that the particular policies of the clinic in this regard do not matter. Nurses are responsible for their own conduct and standards and must stay steadfast in adhering their profession's standards.

[99] Dr. Powell testified that he understood that some of the Nurses may not have worn either masks or gloves while assisting Dr. James in epidural injection procedures. It was also his understanding that no roster of Nurses' assignments was kept at the Rothbart Centre and that it was not possible to determine which of the Nurses worked when and in which procedure room. Accordingly, the most that Dr. Powell could conclude was that in general he cannot say that the Nurses all followed the IPAC standards expected of them, but that he cannot identify any specific instance of negligence by any specific one of the Nurses in any specific procedure.

[100] There is simply no evidence on which to conclude, and I find no reason to infer, that any one of the Nurses fell below the requisite standard of IPAC or other care in dealing with Class members. I would point out that TPH took swabs from all of the Nurses during their investigation of the Rothbart Centre in November-December 2012. Ms. Steinman testified that the lab results revealed that none of the Nurses were found to have been colonized by *Staph aureus* bacteria the way that Dr. James was.

[101] Accordingly, the best evidence available makes it impossible to determine which of the Nurses met the requisite standard of care and which, if any, fell below it and when. There is thus no evidentiary basis on which to conclude that any of the Nurses were negligent in respect of their IPAC practices or otherwise.

[102] Dr. Powell also raised a point about a nurse's duty to report, and questioned whether the Nurses had fulfilled their duties in this regard with respect to Dr. James. He testified that he would expect the doctor to correct any substandard practices of any nurse giving him assistance with a procedure, and *vice versa*. He explained that this was part of the policy requiring all regulated health professionals to speak up to correct substandard practices or procedures.

[103] That said, Dr. Powell also conceded that a licensed anesthesiologist such as Dr. James would know more about the procedure he was administering than would any of the Nurses. Although a physician might not be as expert in nursing care as an experienced nurse, it is not the case that IPAC is limited to nursing care. Dr. James conceded, and every expert who testified confirmed, that IPAC is a core competency of medical practice, and is an area in which an attending doctor such as Dr. James is expected to be entirely competent.

[104] I am not prepared to find that any of the Nurses breached their professional standards by failing to report any of Dr. James' aseptic or non-aseptic techniques. The evidence before me indicates that the Nurses met the standards expected of professional nursing care. Dr. James cannot offload his professional responsibilities by accusing the Nurses, who assisted him in accordance with standard procedures and with whose performance and IPAC he consistently expressed satisfied, of failing to notice that he himself did not meet the standards expected of a doctor.

[105] Finally, counsel for the Plaintiff submit that Ms. Solger, the Rothbart Centre's nurse manager for much of the Class Period, was remiss in her duty to report cases of infection of which she became aware. Specifically, they state that Ms. Solger was advised of three separate patient infections and that she failed in her duty to report them. Those incidents are described by Plaintiff's counsel as follows:

a) Dr. James' patient, Deborah Goodman, is said to have called the Rothbart Centre to report an infection in her elbow;
b) The evidence contains a note of a telephone message from someone at Oakville Trafalgar Hospital mentioning that another of Dr. James' patients, Perry Crippen, suffered an infection and that the patient would be speaking with Dr. James in the near future; and
c) The record contains another message, this time a fax, from the Niagara Infectious Disease Program to the Rothbard Centre regarding an infection suffered by Dr. James' patient, Saundra Kacho.

[106] I have serious doubts about the reliability of any of this evidence. In the first place, Ms. Solger has no recollection of these three instances. The telephone message, the faxed note, and the supposed conversation with a patient are cryptic at best. It is entirely unclear whether the terse, brief phone messages and fax are really reports of infections or just advisories that a patient is being seen elsewhere and will be in touch later with an actual report. None of these one-sentence or half-sentence communications are the kind of real report that would or should prompt someone into immediate action.

[107] Ms. Solger testified that the first she learned of any actual infections afflicting Dr. James' patients was in November 2012 when TPH surprised the Rothbart Centre with its visit and inspection. She was emphatic that she never knew of any infections in patients and that she and Dr. Rothbart never had any conversation about patients' infections with Dr. James or anyone else during the Class Period.

[108] When cross-examined about the three instances of infection that she is alleged to have known about, Ms. Solger indicated that had she learned of any infection suffered by any of the Rothbart Centre's patients, she would have immediately reported the matter to Dr. Rothbart. She was insistent that in that case she would have worked with him to report the infection to the relevant public health authorities. Ms. Solger stated with considerable credibility that she would have had no reason not to do so. As nurse manager she had an interest in ensuring that the Rothbart Centre fulfilled all of its professional obligations, and had no interest in doing otherwise.

[109] In her position at the Rothbart Centre, Ms. Solger may have received some indecipherable or incomplete messages about patients over the years, but none of the three messages she supposedly received amounted to a report of a patient infection on which she would be expected to act. I find that Ms. Solger never actually learned of any of the infections incurred by Dr. James' patients until informed of them by TPH in November 2012.

[110] Overall, the evidence against the Nurses is remarkably thin. In legal terms, it amounts to next to nothing. Perhaps the most extreme example of this is the case against the Defendant, Marissa Allin, who was represented separately at trial as she is apparently the only one of the

Nurses who is not insured. Ms. Allin's counsel asked each witness that spoke on the topic of nursing standards and the Nurses at the Rothbart Centre whether they had any knowledge of or evidence against Ms. Allin. Witness after witness, including those called by the Plaintiff and by Dr. James, confirmed that they have nothing to allege specifically against Ms. Allin and can identify no actionable conduct on her part.

[111] Ms. Allin was singled out as the subject of these questions because she was separately represented and her counsel, wisely, wanted to highlight the fact that there is not a shred of evidence against her. But these questions and answers reverberate beyond just Ms. Allin's case. In fact, the answers that Ms. Allin's counsel received can be extrapolated to each of the Nurses. None of the witnesses who testified at trial, and none of the patient charts or other documentary evidence, conveyed anything that could be characterized as evidence of actionable conduct by any one of the Nurses.

[112] The common issues trial has revealed no sustainable legal claim against any of the Nurses.

IX. Causation

[113] The law of negligence requires that where a defendant's substandard act must also be shown to have caused the harm alleged by a plaintiff. Counsel for Dr. James submits that causation is a crucial hurdle on which the Class's claim falters. They emphasize that if a physician's breach of the standard of care cannot be shown to have caused the injury on a balance of probabilities, the physician is not liable: see *Clements v. Clements*, 2012 SCC 32, at para 6. The burden of proof of causation remains with the Plaintiff: *Cheung v Samra*, 2018 ONSC 3480, at para 52, aff'd 2020 ONSC 4904 (Div Ct).

[114] As the Supreme Court of Canada described it in *Clements*, *supra*, at para 8:

> The test for showing causation is the 'but for' test. The plaintiff must show on a balance of probabilities that 'but for' the defendant's negligent act, the injury would not have occurred. Inherent in the phrase 'but for' is the requirement that the defendant's negligence was *necessary* to bring about the injury – in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.

[115] Having said that, the Supreme Court has also made it clear that the law does not put the Plaintiff to the test of establishing causation to the extent of absolute scientific certainty. Rather, the "but for" test is to be applied "in a robust common sense fashion": *Ibid.*, at para 9.

[116] In the present case, it is the Plaintiff, of course, who has the burden of demonstrating that Dr. James' substandard IPAC and/or his failure to investigate, report, and remediate caused her injuries. Plaintiff's counsel submit that in fulfilling that burden of proof there is no need for the Plaintiff to present scientific evidence of the precise way in which this negligence contributed to those injuries. They state that the question is more of a practical one in which "the trial judge may draw an inference where a medical expert would not, based on common sense and a consideration of all the circumstances": *Allen v. Mueller*, 2002 ABCA 195 at paras 18-19.

[117] The Supreme Court of Canada described the essence of the causation test in *Snell v. Farrell*, [1990] 2 SCR 311, where the applicable legal standard was distinguished from the typical medical standard:

> It is not therefore essential that the medical experts provide a firm opinion supporting the plaintiff's theory of causation. Medical experts ordinarily determine causation in terms of certainties whereas a lesser standard is demanded by the law. As pointed out in Louisell, *Medical Malpractice*, vol. 3, the phrase 'in your opinion with a reasonable degree of medical certainty,' which is the standard form of question to a medical expert, is often misunderstood. The author explains, at p. 25-57, that:
>
> > Many doctors do not understand the phrase ... as they usually deal in 'certainties' that are 100% sure, whereas "reasonable" certainties which the law requires need only be more probably so, i.e., 51%.

[118] In establishing causation on a balance of probabilities, the Defendant's conduct need not be shown to be the sole cause of the Plaintiff's injury, but rather must be shown to be a contributing cause: *Athey v. Leonati*, [1996] 3 SCR 458, at paras 13-17. The Supreme Court has also established that the causation requirement is satisfied where the Defendant is shown to have made a material contribution to risk of injury: *Resurfice Corp. v. Hanke*, [2007] 1 SCR 333, at paras 24-27. In circumstances where there are potentially multiple causes, liability can therefore be imposed not because the impugned conduct is definitively shown to have caused the injury but because the Defendant's conduct created or contributed to the risk that the injury would occur: *Clements*, *supra*, at para 15.

[119] Furthermore, the finder of fact "may draw reasonable inferences from the evidence even though there is no direct evidence on a particular point": *Mitusev v. General Motors*, 2014 ONSC 2342, at para 91. As trial judge, there is no reason that I cannot "draw factual conclusions of negligence based on circumstantial evidence" so long as I do not "infer negligence by assuming circumstantial evidence": *Levac*, *supra*, at para 157. As the Court of Appeal has put it in the context of a medical negligence claim: "[t]he onus is on the plaintiff to prove that negligence by the

defendant caused the plaintiff's injury. That onus may be satisfied by circumstantial evidence that allows an inference of negligence to be made, unless the defendant negates the inference with an explanation that is at least as consistent with no negligence as with negligence": *Hassen v. Anvari*, 2003 CanLII 1005, at para 9.

[120] The Supreme Court has also instructed that causation may be inferred from evidence, including from circumstantial evidence. This is so even where the record contains inconclusive or contrary expert evidence, provided that the inference takes into account all of the available evidence and is reasonable in the circumstances. Thus, for example, in analyzing a claim that exposure to carcinogens at a plaintiff's employment caused a plaintiff's cancer, the Court has indicated that evidence of "historical exposures followed by a statistically significant cluster of cases" can suffice to satisfy the causation requirement: *British Columbia (Workers' Compensation Appeal Tribunal) v. Fraser Health Authority*, [2016] 1 SCR 587, at para 38. Causation can therefore be discerned by inference from the statistical evidence.

[121] Plaintiff's expert, infection control specialist Dr. Allison McGeer, testified that she did a thorough review of the results of the PFGE analysis conducted by the National Microbiology Laboratory on behalf of TPH. It was Dr. McGeer's view that it is highly significant that the bacteria sample taken from Dr. James matched the CC59 strain associated with the six of his infected patients for whom there were samples available:

> Q. What, if anything, does that tell you about the source of the infection in these patients?
>
> A. It tells you that the source of the infection in these patients was Dr. James and it is – because of what we know about the transmission and epidemiology of these infections, it tells you that it was likely directly from his colonized upper airway to the, the skin and subsequently the epidural space of these patients. So it is most likely to be a direct infection associated with the fact that he was colonized on and his practices were substandard.

[122] Another of the Plaintiff's experts, Dr. Michael Freeman, a professor of forensic epidemiology, testified that the correlation of the bacteria strain between the one that colonized Dr. James with the one that the laboratory tests identified in his patients confirms that Dr. James' aseptic technique was faulty and was the cause of the infections. In Dr. Freeman's words, "the only explanation for a post-ESI [epidural steroid injection] meningeal or epidural bacterial infection that is genetically matched to the provider who performed the ESI is lack of adequate IPAC. There is no known microorganism that can be transmitted from a provider to a patient if adequate IPAC has been followed."

[123] Dr. James produced no evidence that contradicted or cast serious doubt on this conclusion. His expert witnesses had no viable alternative theory for those patients for whom the laboratory results showed that they were infected with bacteria that genetically matched the bacteria that colonized Dr. James.

[124] This lack of contrary evidence, or any real contrary opinion is important. The courts have said that causation ought not be drawn by inference where the evidence points to two competing theories of causation: *Moore v. Castlegar & District Hospital* (1998), 49 BCLR (3d) 100, at para 11 (BCCA). As Sopinka J. said in *Snell*, *supra*, at para 32, "Whether an inference is or is not drawn is a matter of weighing evidence. The defendant runs the risk of an adverse inference in the absence of evidence to the contrary."

[125] Like the British Columbia Court of Appeal, "I do not understand *Snell* to stand for the proposition that…a tie means that the plaintiff succeeds*": C.P.M. (Guardian ad litem of) v. Martin*, 2006 BCCA 33, at para 39. Rather, an inference can be drawn here because the evidence of causation, while circumstantial, is overwhelming.

[126] As indicated, there are currently six patients whose infections were found by match the CC59 strain found on Dr. James. Three of those patients have opted out of the action, and the others form the Genetically Matched Subclass for the purposes of this class action. I have no hesitation in concluding that the members of the Genetically Matched Subclass suffered injuries caused by Dr. James. There is no other viable explanation – indeed, there is no explanation whatsoever in the evidentiary record – for the genetic match between the CC59 strain of Staph aureus infecting these patients and the CC59 strain of Staph aureus colonizing Dr. James.

[127] The rest of Dr. James' infected patients may or may not have been infected by the CC59 strain, but there were either no samples taken from them that could be tested or the tests to date are inconclusive. That does not mean, of course, that the subclass is closed. It may be that other Class members will be able to demonstrate a genetic match, although they will have to do so post-trial within the time parameters permitted by the action.

[128] For those Class members for whom there is no evidence that they have been infected by the specific CC59 strain of *Staph aureus*, Plaintiff's counsel seek to establish causation in a more novel way. In support, Plaintiff's counsel rely heavily on the evidence of their eepidemiology expert, Dr. Freeman. In Dr. Freeman's approach, one asks whether Dr. James' patients were under higher risk than the general population undergoing epidural spinal injections with different physicians in different clinics.

[129] Dr. Freeman starts with the understanding that some 20 of Dr. James' patients have suffered infections following an epidural procedure performed by him at the Rothbart Centre.

Using data from professionally credible published sources about frequency of infection, he compares the expected frequency of infection using proper IPAC technique with the frequency of infection experienced in Dr. James' practice.

[130] Dr. Freeman makes the point that infection rate for this type of procedure is a proxy for IPAC use: they go "hand and glove", as he put it in his testimony. Where IPAC is lacking or faulty one finds a high infection rate, and where IPAC is used and is properly done one finds a low infection rate. Since Dr. James has six patients infected with bacteria confirmed to be a DNA match to the rare CC59 strain that colonized Dr. James, it is certain that IPAC was faulty or, in the cause of caudal injections done by Dr. James, aseptic technique was not used at all.

[131] The professional literature reviewed by Dr. Freeman describes severe infections occurring in between 1 in 1,000 and 1 in 10,000 spinal injections. When one includes minor infections in the calculation, they occur with a frequency of 1%-2% of all procedures. But as Dr. Freeman points out, his opinion is directed toward what he calls "severe" infectious conditions such as meningitis. With this in mind, he concludes that in a practice such as that carried on by Dr. James one would ordinarily see an infection rate of 1 in 10,000.

[132] As part of his testimony, Dr. Freeman elaborated that most people have nasal colonization of *Staph aureus* – although not specifically the CC59 strain – at some point in their lives. There are persistent carriers, intermittent carriers, and non-carriers. Given Dr. James' test results and the time span of the genetically matched patients, Dr. Freeman concludes that he was a persistent carrier of the bacteria. Indeed, he explains that infecting numerous people over time with the same strand of *Staph aureus* is a way of identifying a persistent carrier.

[133] In any case, those Class members who cannot provide evidence of a genetic match to the strain of bacteria carried by Dr. James will have to rely on inference to prove the cause of their infection. Plaintiff's counsel submits that there is a common factual base for these inferences: the fact that by performing an epidural injection with substandard IPAC, Dr. James exposed each of then to a level of risk that is statistically much higher than for other patients undergoing the same procedure. There are currently 24 known infected patients, and Dr. James' infection rate was 9:10,000. Counsel calculates that this, in turn, equates to a relative risk of just under 69.0. In other words, patients of Dr. James had a nearly 69 times greater risk of developing a serious infection than pain clinic patients not exposed to Dr. James' substandard IPAC.

[134] In *Andersen v. St. Jude Medical, Inc.*, 2012 ONSC 3660, at para 553, Lax J. found that where the evidence at trial establishes that the breach in the standard of care more than doubles the risk of harm, causation has been established for the class "presumptively" – i.e. subject to proof to the contrary. Justice Lax explained the matter at some length in the context of the health risks related to use of Silzone heart valves, at paras 556-57:

> Where the epidemiological evidence demonstrates a risk ratio above 2.0, then individual causation has presumptively been proven on a balance of probabilities, absent evidence presented by the defendant to rebut the presumption. On the other hand, where the risk ratio is below 2.0, individual causation has presumptively been disproven, absent individualized evidence presented by the class member to rebut the presumption. That is, whether or not the risk ratio is above 2.0 determines upon whom the evidentiary responsibility falls in determining individual causation…
>
> I also note that the level of a risk ratio relative to 2.0 determines the *extent* of the evidentiary responsibility for the party on whom it lies. In other words, a class member faces a greater evidentiary hurdle where the risk ratio for the complication he/she suffered is 1.2, than when it is 1.8. Indeed, in the present case, a class member who suffered a complication for which the risk ratio is 1.2 (corresponding to a presumptive percentage chance of causation of 20/120 X 100 = 16.7%) would have a substantial evidentiary hurdle to overcome in order to persuade the trier of fact in his/her individual action that Silzone was more likely than not the causal factor driving his/her complication. Likewise, the defendant faces a greater hurdle where the risk ratio is 4.0, than where it is 2.2. Thus, the risk ratio for any given complication determines both the *direction* and the *extent* of the evidentiary responsibility when individual claims are brought forward.

[135] A similar analysis was undertaken in *Buchan v. Ortho Pharmaceutical (Canada) Ltd.* (1984), 46 OR (2d) 113, 123, aff'd (1986) 54 O.R. (2d) 92 (Ont CA), where epidemiological evidence was deployed to establish the risk-creating link between oral contraceptives and stroke. The general causation evidence that showed a greatly increased chance of stroke for those taking the pill was so strong at trial that R.E. Holland J., in a passage quoted with approval by the Court of Appeal, concluded that it was not necessary in the circumstances to establish specific causation:

> Based on a consideration of all of the evidence and weighing the evidence of the haematologists, epidemiologists and neurologists, I have come to the conclusion that Mrs. Buchan's use of oral contraceptives probably caused or, at the very least, materially contributed to her stroke. Although the exact mechanism by which the chemicals in oral contraceptives increase the tendency of blood to clot remains unknown, the fact of the matter is that there does appear to be this tendency, and a clear association between stroke and oral contraceptive use has been demonstrated.

[136] Thus, as the British Columbia Court of Appeal observed in *Stanway v. Wyeth Canada Inc.*, 2012 BCCA 260, at para 57, "if it were found that hormone therapy doubles the risk of developing breast cancer, the individual class members, depending on their individual circumstances, may

more readily prove specific causation." The same logic applies to the members of the Class in the case at bar.

[137] The IPAC technique employed by Dr. James more than doubled the risk of infection – indeed, it increased that risk by some 69-fold. While each Class member will have to demonstrate their right to a claim by showing that they partook of this common risk and suffered consequences, the inference that their injury was specifically caused by Dr. James' actions is statistically proven. As in *Andersen, supra* and *Buchan, supra*, the evidence before me demonstrates that the risk ratio of Dr. James' epidural injections is well above 2.0, thus presumptively proving causation for class members (subject, of course, to any evidence which might emerge in an individual case rebutting this presumption).

[138] As Plaintiff's counsel point out, the relative risk ratio of 69 converts to a finding that 98.5% of infections occurring among Dr. James' patients are attributable to substandard IPAC and would not otherwise have occurred. In fact, even accepting Dr. James' counsel's concerns about potential overinclusion in the number of patients suffering infections, Dr. James' infection rate adds up to 49:10,000, or a relative risk ratio of 49. This, in turn, translates into a finding that 97.9% of infections occurring amongst Dr. James' patients are attributable to substandard IPAC and would not otherwise have occurred.

[139] This evidence is so overwhelming that it cannot be ignored. Dr. James' own expert, Dr. Rau, was asked about this approach in the context of his (and Dr. James') former patient, Perry Crippen. As both an expert in the field and as a treating physician, Dr. Rau conceded that under the circumstances and given the statistical evidence of risk associated with substandard IPAC, a presumption of causation was both medically sound and a matter of common sense:

> Q. Yeah, so all I'm saying is in a case like this where you've got a known exposure, I'm just going to ask you to assume, okay, that they were substandard IPAC, all right. You, you're going to assume that it's related to the ESI 'cause that's most likely, subject to hearing some evidence to the contrary, is that fair?
>
> A. Yes.

[140] In addition, there is no evidence in the record that contradicts Dr. Smyth's view that Dr. James should have immediately assumed that his injection was the cause of any infection reported to him by his patient, Mr. Moralis. In Dr. Smyth's opinion, had Dr. James addressed the very first infection reported to him in the way that he was professionally obligated to do, he would have changed his aseptic techniques and thereby warded off the infections that afflicted his patients that followed Mr. Moralis. As she put it in her testimony at trial: "…if he appropriately addressed that first infection that he had, in patient Moralis, through proper reporting of the incident, proper

investigation of the incident, eliminating some issues, that he could have prevented the subsequent infections that occurred."

[141] Dr. James takes the position that since it was not clear precisely what caused Mr. Moralis' infection, his failure to report it and the subsequent infections suffered by his patients does not establish causation. All of the evidence, however, suggests that this is a misguided view. There had never been another case of infection from any other doctor at the Rothbart Centre, and Dr. Smyth's understanding that the very first report of an infection should have prompted an investigation and, ultimately, remediation, by Dr. James is in conformance with professional standards as promulgated by the College of Physicians and Surgeons.

[142] The failure of Dr. James to adhere to these standards is another independent breach by Dr. James and an independent cause of injuries to his infected patients. Indeed, even Mr. Moralis appears to have suffered harm as a consequence of the failure to report, as this led to Dr. James engaging in subsequent treatments of Mr. Moralis and subsequent exposure of him to yet more risk of infection.

X. Fiduciary duty

[143] An analysis of the fiduciary duties owed by a physician to a patient can most fruitfully begin with the Justice LaForest's description of the history of this legal relationship, stated on behalf of a unanimous Supreme Court of Canada in *McInerney v. MacDonald*, [1992] 2 SCR 138:

> In *Kenny v. Lockwood*, [1932] O.R. 141 (C.A.), Hodgins J.A. stated, at p. 155, that the relationship between physician and patient is one in which 'trust and confidence' must be placed in the physician. This statement was referred to with approval by LeBel J. in *Henderson v. Johnston*, [1956] O.R. 789, who himself characterized the physician-patient relationship as 'fiduciary and confidential', and went on to say: 'It is the same relationship as that which exists in equity between a parent and his child, a man and his wife, an attorney and his client, a confessor and his penitent, and a guardian and his ward' (p. 799). Several academic writers have similarly defined the physician-patient relationship as a fiduciary or trust relationship; see, for example, E. I. Picard, *Legal Liability of Doctors and Hospitals in Canada* (2nd ed. 1984), at p. 3; A. Hopper, "The Medical Man's Fiduciary Duty" (1973), 7 *Law Teacher* 73; A. J. Meagher, P. J. Marr and R. A. Meagher, *Doctors and Hospitals: Legal Duties* (1991), at p. 2; M. V. Ellis, *Fiduciary Duties in Canada* (1988), at p. 10-1. I agree with this characterization.

[144] In keeping with this analysis, Justice McLachlin (as she then was) observed in *Norberg v. Wynrib*, [1992] 2 SCR 226, that "the most fundamental characteristic of the doctor-patient

relationship is its fiduciary nature". As the Court of Appeal has put it, "[t]he patient, a person with inferior power, trusts that the doctor, a person who has assumed superior power and responsibility, will exercise that power for the patient's good and only in the patient's best interests": *Gerula v. Flores*, 1995 CanLII 1096.

[145] It is now recognized that in the physician-patient relationship one party is, in effect, "at the mercy" of the other: *M. (K.) v. M. (H.)*, [1992] 3 SCR 6, at para. 73. That is, the doctor enjoys a discretionary power which can be exercised unilaterally to affect the patient's interest, and the patient has an undeniable vulnerability to the doctor's exercise of this discretionary power: *Frame v. Smith*, [1987]2 SCR 99. These inherent characteristics have placed the physician-patient relationship in the category of fiduciary *per se*: *Barker v. Barker*, 2020 ONSC 3746, at para. 1166, citing *Norberg*, at para 64. Once the doctor-patient relationship is established, it alone suffices to create fiduciary duties for the doctor.

[146] To succeed in an action for a breach of fiduciary duty, a plaintiff must establish: a) the existence of a fiduciary relationship; b) a fiduciary duty; and c) a breach of that fiduciary duty: *Avante Automobile (2017) Corporation v BMW Canada Inc*., 2018 ONSC 7406, at para 24. In the case at bar, Class members were in the very position in which medical patients typically find themselves – i.e. at the mercy of Dr. James' approach to IPAC and vulnerable to his decision to report (or rather to not report), investigate, and remediate his practice. As patients, the Class members had no knowledge of Dr. James' substandard approach to aseptic techniques, or of the other patients who had suffered infections following his administering of epidural injections and the consequent elevated risk of harm to which they were exposed.

[147] In his testimony at trial, Dr. James conceded that as a physician he had a duty to advise his patients of anything that could reasonably affect the risks of the procedures to which they were submitting. He also agreed in cross-examination that he was under an ongoing duty not to proceed with an epidural injection if he was aware of any circumstances or factors that would pose additional risk, and that he had a professional duty to monitor any adverse events in his practice, including infections in patients. He was also aware that he had an obligation to immediately report such infections to the medical director, Dr. Rothbart, and that he had a duty to take steps to identify the potential source of any infection suffered by a patient that was likely related to a procedure he performed.

[148] Plaintiff's counsel submit that Dr. James also had a fiduciary duty to learn of and apply the standards of practice for infection prevention in Ontario. In his testimony, Dr. James indicated that he was not aware of the College of Physicians and Surgeons' standards with respect to office infection control and of the prevailing OHP Standards for regulated Out-of-Hospital premises. In so failing to inform himself, he failed in his fiduciary duty to his patients, the Class members.

[149] Moreover, the evidence establishes that he did not report, investigate, and remediate his practice upon initially learning of Matthew Moralis' infection; this inaction was then augmented by Dr. James' decision to perform a follow-up epidural injection without a mask or sterile gloves at a time when Mr. Moralis was still receiving intravenous antibiotics as a result of an infection from his previous epidural injection. This conduct reflects disregard not only for Mr. Moralis' health and safety, but for the health and safety of patients subsequently treated by Dr. James who in turn suffered similar injuries. He neither reported this first infection nor did he change his practice by, for example, beginning to use an aseptic technique for caudal epidural injections or by using a proper sterile field rather than a glove wrapper for the implements he was using during an injection procedure.

[150] Not only did Dr. James not report Mr. Moralis' infection to Dr. Rothbart as required, he also did not inform subsequent patients of the increased risk of which he had become aware. In fact, the evidence is that he continued to advise patients who inquired about risk that there was essentially an infinitesimally small risk of infection – less than 1:10,000. This practice of misinforming patients continued throughout the Class Period, as did his failure to ensure that each of his patients reporting an infection was aware that he might be the source of their infection.

[151] In fact, in cross-examination Dr. James admitted misinforming at least one patient about the risks of infection associated with his practice even after TPH had conducted its investigation of the outbreak of infections associated with it:

> Q. Okay, can we agree on this? Nobody told you that you met the standard?
>
> A. That's correct. TPH did not make that determination.
>
> Q. Right. So rather than tell the client that, you actually deliberately told the client that, told you met the standard when that was not true, correct?
>
> A. Correct.

[152] Dr. James' inaction in the face of serious infections in his practice was one that disregarded the fundamental interests of his patients. In this respect, Dr. James' conduct matches the requirement that a breach of fiduciary duty be something more than negligence. Dr. James not only failed to properly advise his patients of the medical risks they faced in having him perform an epidural injection on them, but he actively obscured the risk in order to protect his reputation and to continue what the evidence shows had become a lucrative practice. In doing so, he engaged in an "abuse of power for an unprofessional end": *Arndt v. Smith*, [1997] 2 SCR 539, at para 38.

[153] Plaintiff's counsel submit that had Dr. James properly informed himself of the Ontario standards for infection prevention when applying for his license to practice in 2009, none of his patients would likely have been infected. The information that he overlooked would have helped ensure that his IPAC would be up to the standard required of him. Plaintiff's counsel further submit that had Dr. James reported Mr. Moralis' initial infection and taken appropriate action in the best interests of his patient and the class, either Dr. James himself would have changed his substandard practices or Dr. Rothbart would have ensured that the necessary changes were implemented.

[154] The evidence that Dr. James took none of these steps supports a conclusion that he put his own professional and personal interests above the welfare of Class members/patients. This inaction runs counter to the trust and confidence that his patients had placed in him, and amounts to a breach of the fiduciary duties that he owed to the Class members.

XI. Limitation period

[155] The Class as certified also contains a subclass of presumptively untimely claims, consisting of all those Class members whose claims arose at a time that would render them presumptively barred by the operation of the *Limitations Act*, 2002, SO 2002, c. 24, Sched. B, section 5(2). This includes the Class members' claims in negligence as well equitable claims of breach of fiduciary duty: *Boyce v. Toronto Police Services Board*, 2012 ONCA 230.

[156] All of the Class members' claims are, of course, subject to the discoverability principle embodied in section 5(1) of the *Limitations Act*. Under this principle, the issue of timeliness turns on whether the particular claim was or could have been discovered within the applicable two-year limitation period.

[157] Under section 5(1) of the *Limitations Act*, a plaintiff discovers a claim against a defendant on the earlier of:

> (a) the day on which the person with the claim first knew,
>
> (i) that the injury, loss or damage had occurred,
>
> (ii) that the injury, loss or damage was caused by or contributed to by an act or omission,
>
> (iii) that the act or omission was that of the person against whom the claim is made, and

(iv) that, having regard to the nature of the injury, loss or damage, a proceeding would be an appropriate means to seek to remedy it; and

(b) the day on which a reasonable person with the abilities and in the circumstances of the person with the claim first ought to have known of the matters referred to in clause (a).

[158] The matters referenced in section 5(1)(a) are to be considered cumulatively in order to ascertain when the claimant actually found out about the claim. That date is then compared with the section 5(1)(b) identification of the date on which a reasonable person would have found out about the claim, and the earlier of the two is the discovery date: *Clarke v. Sun Life Assurance Company*, 2020 ONCA 11. In the ordinary medical malpractice claim, the date that the patient learned of his or her injury is typically the discovery date, since the medical procedure the patient just underwent is self-evidently the source of the injury.

[159] In the case at bar, however, that conclusion could not be quite so readily drawn. That is, the underlying facts giving rise to the cause of action would not have been possible for a Class member to discover through the exercise of reasonable diligence. The substandard IPAC and problem with infections have come to light not because of any individual patient's diagnosis, but due to the exceptionally high rate of infection produced by Dr. James' practice.

[160] Since Dr. James did not report any of the infections, the infection rate remained undiscovered and undiscoverable until TPH conducted its investigation in November-December 2012. It is in that time frame that the cumulative factors in section 5(1)(a) culminate, and the reasonable diligence factor in section 5(1)(b) could have occurred no earlier than that.

[161] The Statement of Claim herein was issued in September 2014 – i.e. some 22 months after commencement of the TPH investigation of Dr. James and the Rothbart Centre. The claim is therefore within the two-year limitation period applicable under the *Limitations Act*. Plaintiff's counsel submit, and I agree, that Dr. James cannot rely on his own failure to report, repair, and remediate in order to provide himself with a limitation defence.

XII. Punitive damages

[162] It is a well-known proposition, but one that bears repeating, that punitive damages are a tool that is an exception to the usual rule that damages are designed to make a victim whole. Punitive damages are instead designed to denounce and deter exceptionally bad conduct. Rather than focusing on the harm caused to the Plaintiff and Class members, punitive damages apply where the Defendant has exhibited "a marked departure from ordinary standards of decent behaviour": *Whiten v. Pilot Insurance*, [2002] 1 SCR 595, at para. 36.

[163] Accordingly, the punitive damages question turns, in the first instance, on determining whether there is a rational connection between the Defendant's behaviour and a punitive award. That determination, in turn, involves identifying the impugned conduct as a "marked departure" from what was otherwise expected of a person in the Defendant's position: *Ibid*., at para 71. It does not suffice that the conduct was legally wrong or that it violated the Plaintiff's legal rights; rather, punitive damages are appropriate where the conduct calls out for particular condemnation and deterrence: *Smith v. Inco Limited*, 2010 ONSC 3790, at paras 331-2.

[164] That said, punitive damages are not an all-or-nothing proposition. There are "marked departures" that are especially egregious, while there are others that demand condemnation and deterrence but on a more modest level. Further, it stands to reason that "if compensatory damages achieve objectives of retribution, deterrence and denunciation, punitive damages may not be warranted" at all: *Performance Industries v. Sylvan lake Golf and Tennis Club*, [2002] 1 SCR 678, at para. 87. As was said recently in *Cavanaugh v. Grenville Christian College*, 2020 ONSC 1133, at para 359, "It will be a question of degree."

[165] In *Whiten*, at para 113, the Supreme Court provided the following list of factors for evaluating the "blameworthiness" of a Defendant's conduct for the purposes of punitive damages:

a) whether the misconduct was planned and deliberate;

b) the intent and motive of the defendant;

c) whether the defendant persisted in the outrageous conduct over a lengthy period of time;

d) whether the defendant concealed or attempted to cover up its misconduct;

e) the defendant's awareness that what he or she was doing was wrong;

f) whether the defendant profited from its misconduct;

g) whether the interest violated by the misconduct was known to be deeply personal to the plaintiff…or a thing that was irreplaceable…

[166] In the present context, these factors must be analyzed with respect to Dr. James' actions alone. As already indicated, there are no grounds for a finding of liability, let alone for an award of punitive damages, against the Nurses.

[167] Furthermore, the punitive damages issue, like all of the common issues, must be considered on a class-wide basis. Like the other matters to be decided in a common issues trial, punitive

damages here is "not specific to any one victim but rather to the class of victims as a group": *Rumley v. British Columbia*, [2001] 3 SCR 184, at para 34. If punitive damages are to apply, Dr. James' IPAC and/or his failure to report, investigate, and remediate once learning of the infections associated with his practice must be seen as akin to a systemic wrong rather than an individualized one directed at a particular patient or victim: *Cavanaugh, supra*, at para 353.

[168] The Court of Appeal has stated that "when reviewing an award of punitive damages, the question the reviewing court must ask both with respect to entitlement as well as quantum is whether punitive damages serve a rational purpose": *CivicLife Inc. v. Canada (Attorney General)*, 2006 CanLII 20837, at para 66. In the context of a common issues trial, the prevailing rational purpose that one seeks in punitive damages – deterrence – meshes with the otherwise applicable class action goal of behaviour modification. It is well accepted that class proceedings are themselves designed to change or "inhibit misconduct by those who might ignore their obligations to the public": *Abdool v. Anaheim Management Ltd.* (1995), 21 OR (3d) 453 (Div Ct).

[169] To be clear, the goals of deterrence and behaviour modification are applicable with respect not only to the immediate defendant but to the industry or type of endeavor to which that defendant belongs. As the Supreme Court has observed, "class actions serve efficiency and justice by ensuring that *actual and potential wrongdoers* do not ignore their obligations to the public": *Western Canadian Shopping Centres Inc. v. Dutton*, [2001] 2 S.C.R. 534, at para 29 [emphasis added].

[170] Accordingly, the analysis "does not only look at the particular defendant but looks more broadly at similar defendants": *Pearson v. Inco Ltd., et al*, 2006 CanLII 913, at para. 88 (Ont CA). While Dr. James himself may now have changed his aseptic technique to comply with that required by the OHP Standards and mandated by the College of Physicians and Surgeons, the behaviour modification and punitive damages question does not end there. Rather, it raises a consideration of the impact of the impugned conduct and a punitive damages award on similarly situated health care professionals.

[171] Of particular concern with respect to punitive damages and deterrence is Dr. James' failure to report, investigate, and remediate the infections as he learned of them arising in his practice. His testimony demonstrated that he now understands the importance of using aseptic technique for caudal injections, properly donning a mask, using an appropriate sterile field for his medical implements, thorough hand hygiene, not wearing his scrubs in his commute to work, etc. These are matters personal to his own practices and there is no real need to make a further point to other physicians engaged in the same kind of medical practice. But having failed to take any action as the reports of infections came to him is precisely the type of conduct for which a deterrent message should be broadcast to the medical profession.

[172] The court's medium for that deterrent message is punitive damages. As noted by the Court of Appeal in *McBride Metal Fabricating Corp. v H & W Sales Co.* (2002), 59 OR (3d) 97, at para 30, the claim of breach of fiduciary duty can be addressed with deterrent remedies as a reflection of the "public concern about the maintenance of the integrity of fiduciary relationships". This is particularly the case with respect to doctor-patient relationships, where trust and confidence in the healthcare provider is essential to the success of the treatment and to the vulnerable patient's and the public's well-being: *Barker*, *supra*, at para 1187.

[173] Doctors must know that reporting infections is the first step in preventing further infections, and that a breach of the duty to report, investigate, and remediate issues like infection is as integral to the public's confidence in medical care as is the treatment of the patient's underlying condition. A compensatory remedy may well suffice in driving this message home to Dr. James, but it requires a punitive one to broadcast it to the medical profession and public at large.

[174] Accordingly, this case is an appropriate one for the imposition of punitive damages. As with compensatory damages for the Class members, fixing the amount of punitive damages does not form part of the certified common issues. Quantification is to be left for subsequent determination.

XIII. Answers to the Common Issues questions

[175] In accordance with the reasons set out above, the common issues questions are answered as follows:

> **NEGLIGENCE**
>
> Q #1: Whether the Defendants owed a duty of care to the Class to take reasonable precautions to prevent the transmission of health care associated infections?
>
> A: All of the Defendants, including Dr. James as well as the Nurses, owed a duty of care to the Class to take reasonable precautions to prevent the transmission of health care associated infections.
>
> Q #2: What was the standard of care applicable to each Defendant relating to their Duty?
>
> A: In order to conform with the standard of care expected of them, Dr. James and the Nurses were to use an aseptic technique for all epidural injections administered at the Rothbart Centre during the Class Period. They were also to advise the Medical Director within 24 hours of learning of any infection associated with an

epidural injection performed at the Rothbart Centre. As a licensed physician, Dr. James was also expected to investigate any potential infections and appropriately remediate any deficiencies found in his IPAC, in his practice more generally, or in the Rothbart Centre's practice.

Q #3: Whether the Defendants breached the Applicable Standards?

A: Dr. James breached the applicable standard of care in the first place by failing to consistently use an aseptic technique for epidural injections during the entire class period. He also breached the standard of care by failing to report Matthew Moralis' infection to the Medical Director of the Rothbart Centre on August 7, 2010 and subsequently failing to report all of his patients' infections that he learned about after that date, and he further breached the standard of care expected of him by failing to investigate and remediate the cause of the infections of which he was aware.

The evidence does not establish that the Nurses breached the applicable standard of care.

CAUSATION

Q #4: Was any Breach sufficient to have caused or contributed to Clinical Infection in the Infected Patients?

A: Dr. James' breaches of the standard of care were sufficient to cause clinical infection in his patients that suffered such infections.

Q #5: Should an inference be drawn that any Breach, in the absence of evidence to the contrary, caused or contributed to Clinical Infection in the Infected Patients?

A: An inference can and should be drawn that Dr. James' breaches of the standard of care in relation to his IPAC practices were the likely cause of the clinical infections suffered by class members, absent sufficient evidence to the contrary. In addition, an inference can and should be drawn that Dr. James' failure to report, investigate and remediate the infections that he learned about was the likely cause of any clinical infection suffered by Class Members after August 7, 2010, absent sufficient evidence to the contrary.

Q #6: Did any Breach cause or contribute to Clinical Infection in the Genetically Linked Patients?

A: The evidence establishes that Dr. James' breaches in the standard of care were the cause of clinical infection suffered by each of the members of the Genetically Linked Patients subclass. The Genetically Linked Patients subclass are entitled to a finding of liability.

FIDUCIARY DUTY

Q #7: Whether the Putative Fiduciary Defendants owed a fiduciary duty to the Class?

A: Dr. James owed a fiduciary duty to the class arising from the special relationship of trust and confidence between this doctor and the Class members – i.e. his patients.

Q #8: For those Putative Fiduciary Defendants found to owe a Fiduciary Duty, what was the nature of the fiduciary duty owed to the Infected Patients?

A: Dr. James' fiduciary duty to the Class required him to practice medicine in a manner that put his patients' interests ahead of his own, that kept the best interest of the Class in mind, and that maintained as his primary consideration the health and well-being of the Class members. This, in turn, required him to refrain from imposing on Class members unnecessary risk of harm.

Q #9: For those Putative Fiduciary Defendants found to owe a Fiduciary Duty, whether these Defendants, or any of them, breached their Fiduciary Duty?

A: Dr. James breached his fiduciary duties of loyalty, good faith, disclosure and avoidance of conflict of duty and self-interest that he owed to his patients, the Class members.

Q #10: Whether the Fiduciary Breaches, or any of them, caused or contributed to Clinical Infection in the Infected Patients?

A: Dr. James' breaches of fiduciary duty were the likely cause of clinical infection suffered by the Class members, absent sufficient evidence to the contrary.

In addition, the evidence establishes that Dr. James' breaches of fiduciary duty were the cause of the clinical infections suffered by the members of the Genetically Linked Patients subclass.

LIMITATION PERIOD

Q #11: Could the claims of the Presumptively Untimely Claims subclass have been discovered within the meaning of section 5 of the *Limitations Act* more than 2 years prior to September 9, 2014?

A: The claims of the Presumptively Untimely Claims subclass could not have been discovered within the meaning of section 5 of the *Limitations Act* more than two years prior to issuance of the Statement of Claim on September 9, 2014; no one in this subclass knew or ought reasonably to have known that Dr. James was aware of serious infections associated with his practice prior to November 2012, and such knowledge would have been necessary to discover a claim.

PUNITIVE DAMAGES

Q# 12: For the Putative Fiduciary Defendants, whether there is conduct sufficient to attract punitive damages, and if so, whether punitive damages should be awarded and in what amount?

A: Dr. James' failure to report, investigate, and remediate infections associated with his practice, and his continuing to perform epidural injections without having done so, and his failure to advise anyone – including the Medical Director of the Rothbart Centre and other patients – of an elevated infection rate among his patients and thereby misinforming them of the true risk of harm to which they were exposing themselves, attracts punitive damages in an amount to be determined.

XIV. Costs

[176] I would ask Plaintiff's counsel to send brief written submissions by email to all counsel and to my assistant within three weeks of today. I would likewise ask each set of Defendants' counsel to send equally brief submissions by email to all counsel and to my assistant within three weeks after receiving Plaintiff's counsel's submissions.

Released: September 15, 2021 Morgan J.

CITATION: Levac v. James, 2021 ONSC 5971
COURT FILE NO.: CV-14-511333-00CP
DATE: 20210915

ONTARIO

SUPERIOR COURT OF JUSTICE

BETWEEN:

Anne Levac

Plaintiff

– AND –

Stephen Rose James, Sue-Ellen Solger, Izabella Gerbec, Erin Kostuch, Anita Takyi-Prah, Joana Nunes, Elizabeth Hicken, Marissa Allin, Rachel Schrijver, Annie Michaud, Anna Nudel, Elena Polyakova, Raymund Tanalgo, Jefferd Felix, Jason Foster, Paolo Galvez, Glenn Francesco, Peter Rothbart and Rothbart Centre For Pain Care Ltd.

Defendants

REASONS FOR JUDGMENT

E.M. Morgan J.

Released: September 15, 2021