THE 1986-1990 HEPATITIS C CLASS ACTION SETTLEMENT

IN THE MATTER OF AN APPEAL FROM THE DECISION OF THE ADMINISTRATOR DATED

DATE OF HEARING: July 11, 2006

IN ATTENDANCE:

CLAIMANT: Claimant #1000321

FOR THE ADMINISTRATOR: John Callaghan
Carol Miller

REFEREE: C. Michael Mitchell

BACKGROUND

1. This is an Ontario-based claimant, claim #100032.

2. The Claimant in this case is infected with Hepatitis C and asserts that she became infected as a result of a blood transfusion she received when she was treated in the Kingston General Hospital. While the original claim submissions contained a statement from a physician that the patient contracted Hepatitis C from a blood transfusion, it turned out that the statement was based entirely upon verbal information the physician received from the patient. The Claimant's medical records contain no record of a transfusion.

3. During the course of the hearings and a thorough review of the medical records, it was noted that the medical records reflected that the surgery was difficult. There was some indication of a blood loss of 250ccs, together with a screen and match for blood having been done prior to the surgery. The Claimant testified emphatically that she received a blood transfusion during the surgery.

4. The provisions of the Class Action Settlement prohibit an adjudicator from relying on the testimony of a claimant or a family member as the only evidence of a blood transfusion. Accordingly, because the medical records did not provide corroborating evidence of the Claimant's testimony, it was agreed that the hearing would be adjourned. On agreement, counsel for the Administrator wrote to three physicians setting out the circumstances of this matter and forwarding copies of the medical records to them. The physicians were specifically asked whether they had any recollection of whether blood was required or received during this surgery, whether the surgery in question would ordinarily require a blood transfusion, and to provide an explanation for their opinion as to whether a blood transfusion would or would not have been required for this type surgery, particularly given the circumstances of this particular surgery.

5. Dr. Jeremy Heaton performed the surgery and was assisted by Dr. John Pike, who at that time was a resident. The anesthetist was Dr. Brown.

6. In his response to the letter from counsel, Dr. Heaton confirmed that the patient did have surgery. She was diagnosed as having side pain that was likely due to more than active liver disease, and which indeed was a renal calculus – a kidney stone, that was partially obstructing her right kidney. He indicated that the surgery went well, resulting in the retrieval of the stone, although both endoscopic and open approaches to surgery had to be used. He indicated that while the surgery was technically demanding, there was no problem with blood loss, and that this surgery is usually not associated with significant blood loss or need for blood and that no transfusion was needed or given. On reviewing the file, he indicated he had no recall of a transfusion being needed or done, and there was no order to transfuse, no nursing note of transfusion, no inter-operative

order or record of transfusion, no post-operative order or record of transfusion, no record of units administered, and no summery on discharge of transfusion. He indicated that the operative note written and signed by him at the time was specific. Had transfusion been required, it would have been in response to a large blood loss of greater than 1,000 ml. He indicated that the estimate of loss of blood of 250 ml. was small and usually well tolerated. He indicated further that a transfusion would not have been required because there was no significant amount of blood lost. He indicated that while the surgery was endoscopic to start with, and the second phase of the surgery was "open" (performed through muscle splitting rather than through a muscle cutting technique), the risk of bleeding was small.

7. Dr. Heaton further indicated the stone was finally retrieved through directly opening the renal pelvis and only a small catheter was passed through the substance of the kidney for drainage. This again was not typically associated with a significant loss of blood. Indeed, he indicated the loss of blood was so small that no further hemoglobin determination was deemed necessary, given that the patient was a young person and that, in young people, the loss of this amount of blood would result in the hemoglobin being replaced spontaneously over the next few days. Finally, Dr. Heaton indicated that the screen order for blood was routine for a liver biopsy and did not indicate that a transfusion was being contemplated. The blood was never requested or issued. Moreover, the screen for the blood was done at another institution and not at the institution where the surgery was performed. He said that transferring blood between institutions would have required extensive and careful documentation, which was not present in the file.

8. Finally, Dr. Heaton noted that there were histories of prior transfusions in October, 1985, and many prior notations of a history of Hepatitis C in the file.

9. In his response to the letter, Dr. Pike confirmed that he was a urology resident at the time of the surgery. While he was evidently on the record on the file and had some involvement at the time, he did not recall any specifics about the patient, her hospitalization or subsequent care. He stated that he can find no indication in the record that the Claimant was ordered to have, or received, any blood transfusions. Dr. Pike indicated that while the requirements for blood transfusion had changed considerably since 1989, "open uretero-pyelolithotomy would not routinely require blood transfusion because of visual control of any local blood vessels intraoperatively. Even 15 years ago I think it unlikely that a blood transfusion would be considered in an otherwise healthy person with an intraoperative blood loss of 250cc, especially in light of a preoperative hemoglobin value greater than 100 G/L [which was noted in the medical records at page 229].

10. Apparently, Dr. Brown, the anesthetist, has retired and no response was received from him.

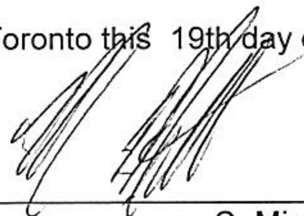
11. Following the receipt of the letters from Dr. Heaton and Dr. Pike, which were forwarded to the Claimant, the Claimant was asked how she wished to now proceed and whether she wished to have a further hearing. The Claimant indicated that she wanted a decision based on the material that had been provided to date.

DECISION

12. Having regard to all the evidence, there is nothing in the medical records to indicate that the Claimant received a blood transfusion in the relevant time period between 1986 and 1990. The Claimant clearly had a surgical procedure in 1989, and while she firmly believed, and testified extensively, that she had received a blood transfusion at that time, there is nothing in the file to corroborate that evidence. As noted, the terms of the Settlement Agreement prohibit an adjudicator from relying solely on the evidence of a Claimant or a family member with respect to the occurrence of a transfusion. Nonetheless, given some indication in the file that there may have been a loss of blood and that blood was ordered in anticipation of a procedure, an adjournment was granted so that the physicians in the case could be contacted to review the file and see if they had any recollection of a transfusion. It is clear from the replies received from the physicians, as set out above, that there was nothing in the nature of the procedure or the operation which typically would have required a blood transfusion, and nothing in the particular circumstances of the operation as shown by the medical notes and records that indicated that any transfusion took place. Rather, the evidence was to the contrary.

13. In the absence of any evidence that I am permitted to rely upon to find that there was a transfusion, the decision of the Administrator in this case is upheld.

DATED at Toronto this 19th day of July, 2010



C. Michael Mitchell
Referee