COURT FILE NO.: N/C/41/08

IN THE COURT OF QUEEN'S BENCH OF NEW BRUNSWICK

TRIAL DIVISION

JUDICIAL DISTRICT OF MIRAMICHI

COUR DU BANC DE LA REINE DU NOUVEAU-BRUNSWICK

DIVISON DE

CIRCONSCRIPTION JUDICIAIRE DE MIRAMICHI

BETWEEN:

ALBERT JOHN GAY, KIMBERLEY ANN DOYLE and JAMES BLISS WILSON

Plaintiffs,

- and -

REGIONAL HEALTH AUTHORITY 7, a corporation Incorporated under the laws of the Province of New Brunswick

First Defendant

- and -

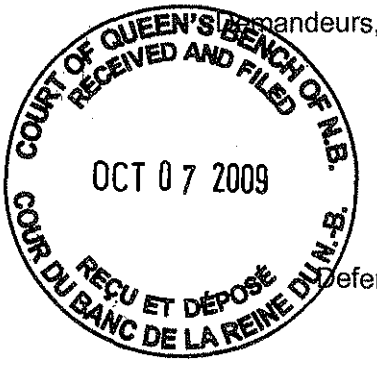
DR. RAJGOPAL S. MENON

Second Defendant

ENTRE:

Demandeurs,

-et-



Defendeurs.

-et-

Defendeurs.

NOTICE OF ACTION WITH STATEMENT OF CLAIM ATTACHED
(FORM 16A)

AVIS DE POURSUITE ACCOMPAGNE D'UN EXPOSE DE LA DEMANDE
(FORMULE 16A)

TO: The First Defendant
Regional Health Authority 7
500 Water Street
Miramichi, NB E1V 3G5

DESTINIAIRE:

AND TO: The Second Defendant
Dr. Rajopal Menon
Miramichi, NB E1V 5M9

DESTINIAIRE:

LEGAL PROCEEDINGS HAVE BEEN COMMENCED AGAINST YOU BY FILING THIS NOTICE OF ACTION WITH STATEMENT OF CLAIM ATTACHED

If you wish to defend these proceedings, either you or a New Brunswick lawyer acting on your behalf must prepare your Statement of Defence in the form prescribed by the Rules of the Court and serve it on the Plaintiffs or their lawyer at the address shown below and, with proof of such service, file it in this Court office together with the filing fee of $50.00:

(a) if you are served in New Brunswick, WITHIN 20 DAYS after service on you of this Notice of Action with Statement of Claim Attached or

(b) if you are served elsewhere in Canada or in the United States of America, WITHIN 40 DAYS after such service, or

(c) if you are served anywhere else, WITHIN 60 DAYS after such service.

PAR LE DEPOT DU PRESENT AVIS DE POURSUITE ACCOMPAGNE D'UN EXPOSE DE LA DEMAND, UNE POURSUITE JUDICIAIRE A ETE ENGAGEE CONTRE VOUS.

Si vous desirez presenter une defense dans cette instance, vous-meme ou un avocat du Nouveau-Brunswick charge de vous representer devrez rediger un expose de votre defense en la form prescrite par les Regles de procedure, le signifier au demandeur ou a son avocat a l'adresse indiquee ci-dessous et le deposer au greffe de cette Cour avec un droit de depot de 50$ et une preuve de sa signification:

(a) DANS LES 20 JOURS de la signification qui vous sera faite du present avis de poursuite accompagne d'un expose de la demande, si elle vous est faite au Nouveau-Brunswick ou

(b) DANS LES 40 JOURS de la signification, si elle vous est faite dans une autre region du Canada ou dans les Etats-Unis d' Amerique ou

(c) DANS LES 60 JOURS de la signification, si elle vous est faite ailleurs.

If you fail to do so, you may be deemed to have admitted any claim made against you, and without further notice to you, JUDGMENT MAY BE GIVEN AGAINST YOU IN YOUR ABSENCE.

Si vous omettez de le faire vous pourrez etre repute avoir admis toute demande formulee contre vous et, sans autre avis, JUGEMENT POURRA ETRE RENDU CONTRE VOUS EN VOTRE ABSENCE.

You are advised that:

Sachez que:

(a) You are entitled to issue documents and present evidence in the proceeding in English or French or both;

(a) vous avez le droit dans la present instance, d'emettre des documents et de presenter votre preuve en francais, en anglais ou dans les deux langues;

(b) the Plaintiffs intend to proceed in the English language; and

(b) le demandeur a l'intention d'utiliser la langue; et

(c) your Statement of Defence must indicate the language in which you intend to proceed.

(c) l'expose de votre defense doit indiquer la lange que vous avez l'intention d'utiliser.

THIS NOTICE is signed and sealed for the Court of Queen's Bench by M. Crippa, Clerk of the Court at Miramichi, New Brunswick, on the 13th day of October, 2009.

CET AVIS est sign et scelle au nom de la Cour de Banc de la Reine par greiffier de la Court a ce 200 .

(clerk)

(greffier)

Court Seal

COURT OF QUEEN'S BENCH NEW BRUNSWICK COUR DU BANC DE LA REINE NOUVEAU-BRUNSWICK

Miramichi Court House
673 King George Highway
Miramichi, NB
E1V 1N6

(address of court office)

(adresse du greffe)

AMENDED STATEMENT OF CLAIM

The Parties

1. The proposed representative Plaintiff, Albert John Gay, resides in Tabusintac in the Province of New Brunswick and was born on January 4, 1945. ~~He brings this action on his own behalf, and on behalf of a class of similarly situated persons pursuant to the *Class Proceedings Act*, S.N.B. 2006, c. C-5.15, such class to be defined in the Plaintiff's application for class certification.~~

2. The proposed representative Plaintiff, Kimberley Ann Doyle, resides in Miramichi in the Province of New Brunswick and was born on September 29, 1963.

3. The proposed representative Plaintiff, James Bliss Wilson, resides in Napan in the Province of New Brunswick and was born on December 11, 1941.

4. The proposed representative Plaintiffs bring this action on their own behalf, and on behalf of a class of similarly situated persons pursuant to the *Class Proceedings Act*, S.N.B. 2006, c. C-5.15, such class to be defined in the Plaintiffs' application for class certification.

5. ~~2.~~ The First Defendant, Regional Health Authority 7, is a body corporate constituted pursuant to the *Regional Health Authorities Act,* S.N.B. 2002, c. R-5.05, to manage and control the operation of, and was at all materials times responsible for the operation, supervision and management of, the Miramichi Regional Hospital, Miramichi, Province of New Brunswick, its employees, agents and servants, including its laboratory staff and pathology staff (the "Hospital").

6. ~~3.~~ The First Defendant operates a pathology laboratory at the Hospital (the "Laboratory"). The Plaintiffs were ~~was a~~ patients who received surgical pathology services from the Laboratory. They ~~He~~ brings this action on their ~~his~~ own behalf, and on behalf of a proposed class of similarly situated persons.

7. The Second Defendant, Dr. Rajgopal S. Menon, resides in Miramichi, New Brunswick, and was at all material times, a salaried physician with privileges at the First Defendant Hospital, and was licensed with the College of Physicians and Surgeons of New Brunswick. He was purportedly credentialed on an annual basis by the Hospital, although such credentialing was incomplete and not in compliance with Hospital by-laws, as detailed below.

Material Facts

8. In 1993 it was decided to build the Miramichi Regional Hospital and to close the existing hospitals at Chatham and Newcastle. Mr. John Tucker, the administrator of the Newcastle Hospital, was tasked by the Department of Health to recruit staff for the new facility which was to open in 1995, including two pathologists.

9. Advertisements were made and the Second Defendant, Menon, was the only applicant. Menon was working as a locum tenant at the Saint John Regional Hospital in 1993 and had been turned down for a permanent staff pathologist position. Mr. Tucker contacted only one medical referee, a Dr. John MacKay, a pathologist and Director of Labs at the Saint John Regional Hospital. Dr. MacKay advised Mr. Tucker that the head of his pathology team at Saint John did not want Menon and to offer Menon a one year conditional contract. Dr. MacKay advised that Dr. Menon was too "slow", had poor turnaround time (TAT), and that he had left his pathology position in Fredericton under a cloud of suspicious circumstances.

10. Mr. Tucker failed to contact references made by Menon to his pathology experience at labs in Fredericton, Moncton, Campbellton, and the Netherlands.

11. Mr. Tucker sent the Menon application for staff privileges and the MacKay reference to the Credentials Committee chaired by Dr. Jeff Hans, a general practitioner. The other two members of the Committee were not pathologists. Dr. Hans phoned Menon's previous employment at Fredericton and the Netherlands, and received no negative feedback. As Menon's credentials and provisional license to practice pathology were in

order, the Credentials Committee appointed Menon for associate medical staff privileges on a one year contract dated September 24, 1993.

12. The by-laws, rules and regulations stipulated that the Credentials Committee may make recommendations which would be forwarded to the Medical Advisory Committee for approval and then forwarded to the Board for final approval. The Board would then instruct the CEO to inform the applicant on the success or failure of his or her application. None of these requirements were followed. Noticeably missing from Menon's application for staff privileges were the signatures of approval from the Chairman of the Medical Advisory Committee and the Board Secretary.

13. Contrary to the recommendation of the Credentials Committee and Menon's peer Dr. MacKay, and in breach of the by-laws, Mr. Tucker offered Menon open employment with no probationary period and no end/renewal date, the offer date being September 28, 1993. The by-laws clearly state that the medical staff shall nominate a candidate for chief of a department and the nominee shall be appointed by the Board of Trustees giving consideration to the recommendations of the Medical Advisory Committee. Mr. Tucker usurped the authority of the Credentials Committee, the Medical Advisory Committee, the Board of Trustees, and the medical staff and Mr. Tucker offered Menon the position of Director of Clinical Laboratory Services with Region 7 Hospital Corporation. This usurpation resulted in the First Defendant's sponsorship of Menon to the College of Physicians and Surgeons of New Brunswick, owing to Menon being a foreign graduate and provisional licensee.

14. Menon completed his contract with the Saint John Regional Hospital and came to the Chatham Hospital in January 1994. The Miramichi Regional Hospital was still under construction. He performed little or no pathology services at Chatham Hospital but acted in an advisory capacity in the new Miramichi Regional Hospital laboratory.

15. The Miramichi Regional Hospital opened for business in December 1995.

16. In April 1996, Dr. Larry Lacey was appointed as the second pathologist. On February 5, 1997, Dr. Lacey wrote Menon a letter copied to Dr. T. Venters, Vice President Medical

with the First Defendant. He accused Menon of mishandling several cases, two of which were directly affecting patients' care and safety. He accused Menon of resistance to quality assurance, i.e. double signatures on cancer cases and external consultations on difficult cases. He concluded by saying the pathology department had a reputation for bad turnaround times and for a significant number of disturbing errors. Dr. Lacey resigned April 1, 1997.

17. Dr. Venters reported Dr. Lacey's serious allegation against Menon to Mr. Tucker, CEO. Mr. Tucker did not react until 18 months later. The minutes of a meeting between Menon and Mr. Tucker are dated August 4, 1998. Discussed were complaints from the surgeons over the past year (both verbal and written) on delays of reporting, the medical staff perceptions of Menon's abilities and his absenteeism related to his private enterprises. The meeting ended with an assertion that if things did not improve then a three month notice of termination would be inevitable. Two days later, on August 6, 1998, a notice of termination was prepared to be effective in three months, on November 5, 1998. The letter of dismissal was not signed or delivered.

18. In July 1997, Dr. Darius Strzelczak replaced Dr. Lacey. Dr. Strzelczak noted over time the lack of quality control in the lab and Menon's resistance to change. He also noted his absenteeism and slow turnaround time. These failures of Menon were well known to administration, who decided to take no action until a August 4, 1998 meeting between Menon and Mr. John Tucker.

19. In May 1998, Dr. Venters resigned as Vice President Medical and was replaced by Dr. David Doucet pro temp. Dr. John MacKay, a senior pathologist with years of experience in lab management was appointed Vice President Medical in March 1999, and resigned this position two years later in May 2001. His resignation was coincident with the firing of the CEO, John Tucker, as a result of the fraudulent use of funds by administration in May 2001.

20. During Dr. MacKay's tenure, Dr. Strzelczak complained to Dr. MacKay four times about diagnostic errors of Menon. Nothing was done by administration. The administration was informed of the frequent complaints against Menon's poor turnaround time,

absenteeism, non-attendance at MAC committee meetings, poor attendance at staff meetings and resistance to quality assurance in the pathology lab.

21. Mr. James Wolstenholme, an experienced administrator, replaced Mr. Tucker as CEO in October 2001. He appointed Dr. Carl Hudson VP Medical early in 2002. Both administrators were well aware of Menon's competency issues.

22. On April 21, 2004 Mr. Wolstenholme removed Menon as Chief of Pathology some 10 years after Menon was appointed as a staff pathologist.

23. Mr. Wolstenholme and the VP Medical Dr. Hudson prepared a case to be presented to the Medical Advisory Committee to have Menon's staff privileges revoked, but Mr. Wolstenholme publicly disagreed with an unrelated health department policy and was terminated May 2004. He was replaced by Mr. Gary Foley as CEO.

24. Mr. Foley and Dr. Hudson prepared a complaint before the Medical Advisory Committee for termination of Menon's staff privileges. However, in August 2005 the Medical Advisory Committee did not think the evidence was strong enough to revoke Menon's privileges, and dismissed the complaint.

25. Dr. Hudson finally lodged a complaint against Menon with the College of Physicians and Surgeons when Dr. Strzelczak, the new Chief of Pathology, found three more cases of Menon's with significant errors in December 2006 and January 2007.

26. The complaint was heard by the College, which on February 6, 2007 suspended Menon's license to practice pending investigation. Menon was also under investigation by the College for two other complaints at the time from private individuals.

27. On February 6, 2007, Menon was terminated from staff at Miramichi Regional Hospital by the CEO Mr. Foley and the Vice President Medical Dr. Hudson.

28. The Plaintiffs say that from the first complaints of Dr. Lacey in February 1997 which called into question Menon's competency as a pathologist with issues of patient safety, to his final dismissal in February 2007, ten years had expired.

29. During that ten years the various CEOs and Vice Presidents Medical failed to act on the numerous complaints lodged against Menon, specifically Dr. Lacey's complaints to Mr. Tucker and the Vice President Medical Dr. Venters in 1997, and Dr. Strzelczak's four complaints to Vice President Medical Dr. MacKay in 1999-2001. The complaints of Dr. Lacey and Dr. Strzelczak directly raised issues of patient safety and care, and the competence of the First Defendant's staff pathologist Menon.

30. The Plaintiffs say that Menon's frequent absenteeism from work, his frequent misdiagnoses, his poor turnaround time, his failure to set up or participate in any quality assurance programs in pathology, and his frequent non-attendance at staff meetings and the MAC, are all reasons for suspension or termination of staff privileges for reason of non-compliance to the staff bylaws and regulations.

31. Only after the College of Physicians and Surgeons started an investigation did the administration of the First Defendant start their own investigation. In July 2007 the hospital retained Dr. Vernon Bowes to do a quality assurance review of pathology. He recommended Menon not be given hospital privileges.

32. It was after the suspension of Menon in February 2007, that Regional Health Authority 7 retained pathologist Dr. Rosemary Henderson to conduct a review of Menon's work. Eleven months after the suspension, this independent audit was conducted between December of 2007 and January of 2008 and examined 227 cases of prostate and breast cancer biopsies from 2004-2005. This independent review found significant discrepancies in eighteen percent of the cases and that six percent were misdiagnosed, necessitating 39 addendum reports.

33. In forty-one of the 227 examined cases there was discovered either a miscalculation of the stage of the cancer, an incomplete protocol, or an incomplete examination.

34. Nine of the 227 cases revealed cases of undetected cancer, a finding contrary to the original diagnosis these patients would have received.

35. The First Defendant decided not to advise patients or the public of the retesting and the suspected deficiencies in Menon's work. The Plaintiffs and Class Members learned of

the retesting through the news media in February 2008, causing consternation, mental distress, and concern among patients as to whether they had received appropriate therapy, and in particular, that they might have undiagnosed cancer.

36. In late March 2008, it became known that the First Defendant would provide approximately 23,000-24,000 patient specimens reported by Menon during his employment with the First Defendant to a reviewing laboratory in Ottawa, Ontario. These included biopsies and surgical resection specimens. By December 2008, independent pathologists determined that 5,286 or 22% had a complete or partial change in findings. 370 cases had a complete change in findings, and 101 involved cancer.

37. News of the intended review of the 23,000-24,000 specimens was publicized, causing consternation, mental distress and concern among patients who knew or suspected that the interpretation of their specimens and therefore the correctness of their diagnosis and treatment, including diagnosis and treatment of cancer, were in question.

38. The Plaintiffs say that the actions of the First Defendant were too little and too late, and they should not have hired Menon at all, or if hired they should have discharged him or conditioned, suspended or supervised his privileges at an early date.

~~4. Regional Health Authority 7 employed Dr. Rajgopal S. Menon as a pathologist at the Miramichi Regional Hospital since 1994. Between 1995 and 2007, Dr. Menon was responsible for the diagnostic testing of approximately 24,000 pathology samples for patients who received services in the Miramichi region.~~

~~5. The Defendant's Chief Executive Officer, John Tucker, caused the Defendant to hire Dr. Menon against the advice of Vice President of Medical Services, Dr. John Mackay.~~

~~6. Dr. Menon was appointed to Chief of the Hospital's Pathology Department in 2002. When this position came up for renewal in 2005, the Board of the Hospital declined to reappoint Dr. Menon, citing certain complaints that had been filed against Dr. Menon. The Board elected to appoint the Hospital's only other pathologist, Dr. Dariusz Strzelczak.~~

7. Upon his appointment, Dr. Strzelczak scrutinized Dr. Menon's work. Dr. Strzelczak discovered at least five cases that were handled improperly by Dr. Menon. These five cases were reported to Dr. Carl Hudson, the Vice President of Medical Services at the Hospital.

8. On January 29, 2007, Dr. Hudson filed a complaint with the College of Physicians and Surgeons of New Brunswick (the "College").

9. At the time of receiving Dr. Hudson's letter, the College was already dealing with two separate unresolved complaints with respect to the deficient practice of Dr. Menon. On April 3, 2006, it received a complaint from the family of a deceased Miramichi resident alleging that Dr. Menon unnecessarily delayed the diagnosis and treatment of a cancerous tumor. On August 8, 2006, the Board further received a complaint from the daughter of another deceased Miramichi resident alleging delays and errors in an autopsy conducted by Dr. Menon. These complaints brought into question the accuracy of Dr. Menon's interpretation of pathology specimens.

10. Upon a review of the complaints, the College suspended Dr. Menon's license on February 7, 2007. It was found that his continued practice presented a significant risk to the health and welfare of his patients.

11. It was after this suspension that Regional Health Authority 7 retained pathologist Dr. Rosemary Henderson to conduct a review of Dr. Menon's work. Eleven months after the suspension, this independent audit was conducted between December of 2007 and January of 2008 and examined 227 cases of prostate and breast cancer biopsies from 2004-2005. *This independent review found significant discrepancies in eighteen percent* of the cases and that six percent were misdiagnosed.

12. In forty-one of the 227 examined cases there was discovered either a miscalculation of the stage of the cancer, an incomplete protocol, or an incomplete examination.

13. Nine of the 227 cases revealed cases of undetected cancer, a finding contrary to the original diagnosis these patients would have received.

~~14. The Defendant decided not to advise patients or the public of the retesting and the suspected deficiencies in Dr. Menon's work. The Plaintiff and Class Members learned of the retesting through the news media in February 2008, causing consternation, mental distress, and concern among patients as to whether they had received appropriate therapy.~~

~~15. The Plaintiff says that the actions of the Defendant were too little and too late, and they should not have hired Dr. Menon at all, or if hired they should have discharged him or conditioned, suspended or supervised his privileges at an early date.~~

Representative Plaintiff – John Albert Gay

39. ~~16.~~ On March 17, 2004, at the Miramichi Regional Hospital, this ~~the~~ Plaintiff had a biopsy performed on a portion of his left forearm due to scarring and discolouration in the area of a skin graft. This ~~The~~ Plaintiff had a previous history of skin cancer scares. After the March 17, 2004 biopsy, this ~~the~~ Plaintiff was advised that the pathology test results on his left arm tissue sample were negative for cancer.

40. ~~17.~~ This ~~The~~ Plaintiff first learned that many results of pathology tests performed at the Miramichi Regional Hospital were being reviewed when he read an article in the local newspaper, the Miramichi Leader, on February 22, 2008.

41. ~~18.~~ On February 26, 2008 this ~~the~~ Plaintiff was contacted by Dr. Gerard Losier's office and was advised that the pathology tests on his left forearm tissue sample from the March 17, 2004 biopsy were being redone.

42. ~~19.~~ This ~~The~~ Plaintiff experienced panic when he was advised that his tests were being redone and fears that he may have cancer that was misdiagnosed.

43. ~~20.~~ Approximately ten years ago, this ~~the~~ Plaintiff had lumps and moles removed from under his upper arms, from his thighs and from his right hand. This ~~The~~ Plaintiff had three surgeries: one on his right hand, and one on his left shoulder and one on his thighs. Two of those surgeries were performed in Tracadie, New Brunswick, and one was performed in Bathurst, New Brunswick. After these surgeries, this ~~the~~ Plaintiff was advised that the

pathology tests came back benign. Since that time this ~~the~~ Plaintiff has worried about developing melanoma.

44. ~~21.~~ In August 2007, this ~~the~~ Plaintiff had ten biopsies taken from the area of his prostate and the results came back as non-cancerous. This ~~The~~ Plaintiff had his prostate "reamed out" or removed in October 2007. The pathology tests performed following the August 2007 prostate biopsies apparently were not performed by Menon. Nevertheless, this ~~the~~ Plaintiff also worries about whether he had cancer of the prostate.

45. ~~22. To date the Plaintiff has not received the results of the review of his pathology tests and continues to worry about the outcome of the review.~~ The Plaintiff can feel lumps under the skin in the area of the skin graft on his left forearm. The Plaintiff experiences hot sensations and swelling in the area of the skin graft on his left forearm.

46. ~~23~~ This Plaintiff no longer has trust and confidence in treatment received at the Miramichi Regional Hospital in particular and in the New Brunswick health care system in general.

Representative Plaintiff – Kimberley Ann Doyle

47. In 1998, at the Miramichi Regional Hospital, this Plaintiff had a biopsy performed on a tissue sample at approximately the time that she underwent a hysterectomy. At that time she was not advised that there were any concerns arising from the pathology tests performed on the tissue sample.

48. On March 4, 2008 this Plaintiff received a letter from Dr. Josef Hrncirik's office and was advised that the pathology tests on her tissue sample from the 1998 biopsy needed to be reviewed.

49. After receiving the letter from her physician, this Plaintiff worried that her hysterectomy procedure had not actually been necessary and she was also concerned that she might have undiagnosed ovarian cancer in her remaining ovary.

50. This Plaintiff continued to worry about the outcome of the review of her pathology tests and was very anxious about what the recheck may reveal until she received the results of the recheck in September 2008.

51. This Plaintiff no longer has trust and confidence in treatment received at the Miramichi Regional Hospital in particular and in the New Brunswick health care system in general.

Representative Plaintiff – James Bliss Wilson

52. This Plaintiff had pathology tests performed on 3 different occasions at the Miramichi Regional Hospital on tissue samples taken from his prostrate region.

53. The first set of biopsies were taken on January 8, 2004. At that time 6 samples were tested and the results indicated non-malignancy.

54. The second set of biopsies were taken on November 30, 2005. At that time a further 8 samples were tested and the results again indicated non-malignancy.

55. The third set of biopsies were taken on January 29, 2007. At that time 11 samples were tested and the results indicated that 3 samples were positive for adenocarcinoma and 4 samples were intraepithelial neoplasia, high grade.

56. In or about 2007 - 2008 Dr. Rosemary Henderson conducted a review of the pathology tests previously performed on this Plaintiff's first 2 sets of samples taken in 2004 and 2005. This Plaintiff was not advised by correspondence that this review was being carried out.

57. The pathology review showed that 1 sample from the biopsies taken in 2004 tested positive for adenocarcinoma and 2 samples from the biopsies taken in 2005 tested positive for adenocarcinoma. The pathology review of the 2005 samples further showed that this Plaintiff had cancer on both sides of his prostrate.

58. As a result of the incorrect diagnosis of the biopsies taken in 2004 and 2005, this Plaintiff did not receive any treatment for cancer of the prostrate, until it was eventually diagnosed on or after January 29, 2007.

59. This Plaintiff states that had his biopsies from 2004 and 2005 been correctly diagnosed, prostrate cancer would have been diagnosed at that time and he would have had surgery to remove his prostrate and he would not have required any further treatment.

60. As a result of the incorrect diagnosis of the 2004 and 2005 samples, this Plaintiff required 4 hormone needles, one every 3 months, over a 1 year period with the last injection occurring in November 2007. These treatments would not have been necessary if the biopsies performed in 2004 and 2005 had been correctly diagnosed.

61. This Plaintiff also had 2 brachytherapy treatments and 22 radiation treatments as a result of the incorrect diagnosis. These treatments also would not have been necessary if the biopsies performed in 2004 and 2005 had been correctly diagnosed.

62. As a result of the radiation treatments, this Plaintiff has subsequently had to have his urethera scraped due to urine flow obstruction. He was also required to use a foley catheter, has developed cystitis and takes medication every day to assist with urine flow. These problems would not have occurred if this Plaintiff's original biopsies had been correctly diagnosed.

63. This Plaintiff was shocked to learn that he had cancer and has had to endure painful and unnecessary procedures due to the incorrect diagnosis of his original biopsies.

64. This Plaintiff no longer has trust and confidence in treatment received at the Miramichi Regional Hospital in particular and in the New Brunswick health care system in general.

Fault or Negligence of First Defendant

65. ~~24.~~ The First Defendant is corporately liable to the Plaintiffs in tort of negligence. The First Defendant's conduct fell below the reasonable standard of care expected of it under the

circumstances and was corporate or systemic in nature. The particulars of the First Defendant's fault or negligence are that they:

(a) hired Dr. Menon against the advice of the Defendant's Vice President of Medical Services, Dr. John Mackay; ~~hired Menon against the advice of Menon's referee, the then Chief of Pathology at Saint John Regional Hospital, Dr. John Mackay~~

(b) performed an inadequate background check and minimized or ignored warnings and cautions from previous employers including the Saint John Hospital;

(c) improperly credentialed Menon before hiring and credentialed him inadequately and in violation of by-laws on a regular (at least yearly) basis thereafter;

(d) ignored the advice of the Credentials Committee to offer Menon a one year probationary contract only, and appointed him Director of Labs without the advice of the Committee;

(e) ~~(d)~~ chose to delay response or not respond to known and reported shortcomings in Dr. Menon's completion of pathology reports and the accuracy of his pathology reports;

(f) ~~(e)~~ chose to ignore or not to investigate inadequacies and inaccuracies and delays in pathology reports;

(g) ~~(f)~~ chose to ignore delays in work completion and conflicts of interest caused by absences to pursue private business interests;

(h) ~~(g)~~ chose not to monitor, not to investigate or not to adequately respond to diagnostic errors in Dr. Menon's pathology reports;

(i) ~~(h)~~ chose to continue with the contract with Dr. Menon or not to condition, suspend or supervise his privileges;

(j) ~~(i)~~ established and maintained an inadequate or no quality assurance program for pathology;

(k) ~~(j)~~ chose to establish an inadequate or no meaningful peer review program for pathology;

(l) ~~(k)~~ chose to ignore periodic mentoring of medical staff including pathology staff as a means of quality control and assurance;

(m) ~~(l)~~ established an inadequate or no standard operating procedures for pathology;

(n) ~~(m)~~ established an inadequate or no meaningful medical review committee of the hospital to supervise, control and discipline medical staff including pathology staff;

(o) ~~(n)~~ established an inadequate or no policy on minimal continuing education for medical staff including pathology staff;

(p) ~~(o)~~ chose to ignore concerns and complaints about inadequate or no meaningful communication between technical and pathology staff;

(q) ~~(p)~~ chose not to engage in external proficiency testing;

(r) ~~(q)~~ established an atmosphere that discouraged continuous quality improvement;

(s) ~~(r)~~ chose to have an inadequate or no meaningful policy on conflicts or potential conflicts caused by the pursuit of private business interests by staff including pathology staff;

(t) ~~(s)~~ established an inadequate or no meaningful policy to identify cases requiring remediation of staff including pathology staff, where other authorities such as the College declined to act;

(u) ~~(t)~~ ignored complaints about pathology staff's professional competency; and

(v) ~~(u)~~ credentialed a pathologist who was medically impaired and not competent.

66. ~~25.~~ The First Defendant is further negligent by its failing to advise the Plaintiffs and Class Members of their potential risk of illness at the earliest opportunity which at latest was February 2007, and thus, denying them the opportunity to seek early medical attention.

Vicarious Liability

67. ~~26.~~ The First Defendant is corporately and systemically liable. The First Defendant is also vicariously liable for all loss or damage caused by the Second Defendant Menon due to having sponsored to the College, credentialed, and maintained on medical staff, a pathologist who was not competent. ~~The Defendant is also vicariously liable for the acts or omissions of its employees and agents, as set out above. The representative Plaintiff specifically does not allege vicarious liability with respect to the acts or omissions of Dr. Menon. The negligence alleged with respect to medical professional involvement is entirely corporate and systemic.~~

Breach of Contract

68. ~~27.~~ The First Defendant has a contractual relationship for the provision of medical services to the Plaintiffs and other patients. A major or important part of the contractual relationship is to provide the Plaintiffs and Class Members with peace of mind and psychological benefit. An implied term of that contractual relationship is that the First Defendant would employ competent and properly trained and supervised personnel in its pathological processes, and that it would have a proper quality assurance program, proper controls, and ensure an appropriate level of expertise and specialization among the pathology medical staff charged with responsibility for interpretation of pathology testing, in the exercise of its contractual duties arising out of the testing, diagnosis and treatment of the Plaintiffs and Class Members. The First Defendant has breached this contractual duty.

69. ~~28.~~ Another implied term of the contractual relationship was that the First Defendant would promptly and appropriately notify the Plaintiffs and other patients of the discovery of testing errors and of the decision to embark on retesting of tissue samples, in a manner calculated to minimize the worry and concern that patients would feel.

70. ~~29.~~ One of the purposes of accurate and reliable pathology testing is to provide peace of mind to the patient. The nature of the contractual relationship is such that it was foreseeable and/or within the reasonable contemplation of the parties ~~contemplated~~ that the First Defendant's breaches of contractual duty set out herein would entail mental distress by the Plaintiffs and other patients.

Breach of Fiduciary Duty

71. ~~30.~~ The First Defendant stands in the position of fiduciary to the Plaintiffs and Class Members and has a duty of utmost good faith to be open and candid with the Plaintiffs and Class Members, and not to withhold information. The representative Plaintiffs repeat~~s~~ the foregoing and say~~s~~ that the First Defendant has violated duties of disclosure of a fiduciary nature, existing between the First Defendant and its patients. The First Defendant exercised its sole discretion in its decision not to tell the Plaintiffs and Class

Members in a timely manner of the potential diagnosis problems. In so doing, the First Defendant preferred its own interests to those of the Plaintiffs and Class Members. It did so in a manner that affects the interests of the Plaintiffs and Class Members by denying such persons knowledge of their medical conditions and the opportunity to seek early medical treatment. The Plaintiffs and other Class Members were peculiarly vulnerable and at the mercy of the First Defendant in the exercise of its sole discretion. The Plaintiffs and other Class Members had no way of knowing of the First Defendant's failure to ensure complete, accurate diagnostic testing but for the First Defendant informing them.

Equitable Fraud

72. ~~31.~~ Having regard to the fiduciary relationship between the First Defendant and the Plaintiffs and Class Members described above, the conduct of the First Defendant in failing to disclose to the Plaintiffs and Class Members the potential diagnostic ~~diagnosis~~ problems at the earliest opportunity was unconscionable and constituted equitable fraud committed against the Plaintiffs and Class Members.

Fault or Negligence of Second Defendant

73. The Plaintiffs say that the Second Defendant Menon had a duty to patients to maintain competency. Menon breached his duty to maintain competency in that he failed, chose not to or refused to:

(a) introduce quality assurance programs in anatomical pathology while he was Director of Labs including:

(i) obtaining second opinions on all malignancies with his fellow pathologists or subspecialists; and

(ii) participate in external proficiency programs;

(b) perform a reasonable turnaround time which resulted in delayed clinical management and severe mental distress and physical injury to the patients;

(c) undergo quality assurance initiated by the new Chief of Pathology (Dr. Strzelczak) in 2004 when he was dismissed as Chief of Pathology, despite frequent complaints of poor turnaround times, absenteeism and lack of consultation on malignancies;

(d) notify or minimized to the Chief of Pathology and record on his yearly application for renewal of active staff privileges to the Credentials Committee that he had health problems including cataracts which would interfere with his ability to properly gross specimens and use the microscope;

(e) participate in reviewing journals, continuing education, external examinations of professional tests or other external proficiency testing to ensure a level of competence expected by his patients;

(f) provide proper or any oversight with respect to standards of lab quality;

(g) produce additional slides to verify diagnoses;

(h) maintain necessary attendance and availability for essential pathology support service;

(i) properly or effectively communicate with subordinates, management or others;

(j) ensure collegiality within the pathology department

(k) follow appropriate protocols;

(l) in general, keep good and adequate records;

(m) keep his own agenda to invent a medical scanner separate from his work duties;

(n) properly use or put away slides used to further his own agenda;

(o) in general, did not possess the skill and knowledge expected by his patients necessary to meet the standard of a competent anatomical pathologist or of a competent Chief of Pathology.

74. Menon owed patients the duty to maintain competence and the duty was owed in tort of negligence, in the law of fiduciary duties, and as an implied term of contract with the patients whose specimens he reported. It was within contemplation of Menon and the patients whose specimens he reported that a failure on his part to maintain competency leading to a general questioning of his surgical pathology diagnoses and the need to repeat or reread his tests, would cause mental distress to these patients.

Damages

75. ~~32.~~ As a result of the Defendants' ~~Defendant's~~ breaches of its obligations, the Plaintiffs and Class Members have suffered loss. Such loss was foreseeable by the Defendants. All loss arising from change or error in Menon's diagnoses attracts a remedy in damages, whether due to a breach by Menon of the applicable standard of care or not, on the basis that had the First Defendant not sponsored, credentialed and maintained a pathologist who was incompetent, and had Menon fulfilled his duty to maintain

competency, his individual errors, whether in breach of standard of not, would not have occurred.

76. ~~33.~~ Particulars of the loss or damage suffered by the Plaintiffs and Class Members include the following:

(a) pain, suffering, and loss of quality and enjoyment of life and loss of life expectancy;

(b) mental distress, frustration, anxiety, displeasure, vexation, tension, aggravation, upset, ~~and~~ inconvenience and all of a degree sufficient to warrant compensation;

(c) loss of faith and confidence in pathology and in the reliability of diagnostic testing in health care generally;

(d) past and future loss of income and earning capacity;

(e) past and future cost of care;

(f) loss of consortium and loss of guidance, care and companionship; and

(g) out-of-pocket expenses.

77. ~~34.~~ Particulars of the loss or damage suffered by Class Members, whether their initial pathological diagnosis was correct or not, include the following:

(a) pain, suffering, and loss of quality and enjoyment of life and loss of life expectancy;

(b) mental distress, frustration, anxiety, displeasure, vexation, tension, aggravation, upset and inconvenience;

(c) loss of faith and confidence in pathology and in the reliability of diagnostic testing in health care generally;

(d) past and future loss of income and earning capacity;

(e) past and future cost of care;

(f) loss of consortium and loss of guidance, care and companionship; and

(g) out-of-pocket expenses.

78. ~~35.~~ As well, as a result of the improper pathology processes performed at the Miramichi Regional Hospital and the failure of the Defendants to take proper and appropriate steps

to prevent or minimize the effects of these improper pathology processes, Class Members who are the wives, husbands, parents, children, brothers or sisters of deceased persons, have also suffered damages recognized pursuant to the *Fatal Accidents Act*, R.S.N.B., 1973, c. F-7. These damages include:

(a) Pecuniary losses resulting from the injury to such deceased persons, expenses incurred for the benefit of such deceased persons, travel expenses incurred in visiting such deceased persons during their treatment and recovery;

(b) A reasonable allowance for loss of income and the value of nursing, housekeeping and other services rendered to such deceased persons;

(c) An amount to compensate for the loss of companionship incurred and grief suffered; and

(d) Reasonable expenses of the funeral and disposal of the body of the deceased.

Aggravated Damages

79. ~~36.~~ The activities of the Defendants were carried out with reckless, callous and wanton disregard for the health, safety and pecuniary interests of the Plaintiffs and Class Members. The Defendants knowingly compromised the interests of the Plaintiffs and Class Members, solely for their ~~its~~ own purposes. Furthermore, once the First Defendant knew of Dr. Menon's history, the shortcomings in the turnaround time and in the procedures followed at the pathology lab at the Miramichi Regional Hospital and the resulting dangers to the physical and psychological health of the Plaintiffs and Class Members, the First Defendant failed to take remedial action and failed to advise the Plaintiffs and Class Members in a timely fashion, or fully, or at all.

80. ~~37.~~ The above described actions of the Defendants are independently actionable in negligence, in contract and for breach of fiduciary duty as pleaded herein and consequently, the Plaintiffs and Class Members are entitled to aggravated damages, commensurate with the Defendants' outrageous behaviour.

Relief Requested

81. ~~38.~~ The Plaintiffs claim the following relief:

(a) an order certifying the proceeding as a class proceeding on behalf of all patients whose pathology specimens were analyzed at the laboratory of the First Defendant between 1995 and 2007;

(b) general damages;

(c) special damages;

(d) aggravated damages;

(e) the costs of providing appropriate notice to Class Members and administrating this proposed class action for their benefit;

(f) interest pursuant to the provisions of the *Judicature Act*, R.S.N.B. 1973, c. J-2 and *Rules of Court*, N.B. Reg. 82-73; and

(g) such further and other relief as this Honourable Court deems just.

DATED at Halifax, in the Province of Nova Scotia, this 7th day of October, 2009.

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