This is Exhibit 'A' of the affidavit of Gordon Henry Guyatt

Sworn before me at the City of Hamilton, in the Province of Ontario on August 25, 2009

A commissioner for oaths

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Mr. Andrew C. Dekany
1724 Queen Street West
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August 21, 2009

Dear Mr. Dekany:

Re: Nell Toussaint, d.o.b. July 14, 1969

This report represents my opinion regarding Nell Toussaint's past and present medical condition and the particular challenges she faces not having access to financial assistance to cover the cost of necessary health care. It is based on my review of Ms. Toussaint's extensive medical records, a conversation with her, and a physical examination I conducted.

Ms. Toussaint has a number of serious medical conditions one of which, diabetes, could become quickly life-threatening if not medically managed in an optimal fashion. She has had one episode of a life threatening illness aside from her diabetes in which she easily could have lost her life as a result of denial of care because of an inability to pay for it. She is currently receiving pro bono care from a number of physicians. Given her extremely precarious health status, it is my opinion that her well-being, and potentially

her life, are at risk given the uncertain nature of her medical care.

Ms. Toussaint is a 40-year-old single woman without children, originally from Grenada. A resident of Canada since 1999, Ms. Toussaint worked at a variety of temporary jobs including factory work, baby sitting, and cleaning between 1999 and 2006 when her health problems forced her to largely discontinue working.

Ms. Toussaint's health problems began in 1986 when she developed fibroids which were a source of chronic pain for her from that time until surgery which was undertaken in November 2008. She developed a second major health problem, adult onset Type 2 diabetes mellitus, in 1999. Since that time, she has been taking oral medication for her diabetes. In March 2009 she began to receive, in addition to oral medication, insulin.

In 2006 Ms. Toussaint developed an abscess on the right side, adjacent to the buttock and her right leg. The abscess required drainage and she was left with chronic pain and difficulty walking. In addition she developed chronic fatigue and decreased energy. It is at this time that Ms. Toussaint largely stopped working; although subsequently she did some cleaning and factory work in the latter part of 2007 and some volunteering in early 2008.

In November 2008, Ms. Toussaint underwent an operation for removal of more than 40 uterine fibroids. She remained in hospital approximately 10 days. When she was discharged she was severely anemic and the day after discharge required returning to the

emergency room to receive four units of blood.

On November 27, 2008, she presented to St. Michael's Hospital emergency room with uncontrolled hypertension. During a ten-day stay in hospital she was found to have nephrotic syndrome, a disorder in which the kidneys are damaged, causing them to leak large amounts of protein from the blood into the urine. The nephrotic syndrome may be a complication of her diabetes, or there may be another cause. A renal biopsy (which she has not had) would be required to establish that definitively. She was prescribed a number of antihypertensive medications that she was taking on discharge.

I spoke with Dr. Kamel, a nephrologist following Ms. Toussaint for her kidney problems. He informed me that his decision not to undertake a renal biopsy was based, in large part, on Ms. Toussaint's inability to pay should complications arise, or for the medication that might be indicated depending on the results of the renal biopsy. This is another example of Ms. Toussaint's care being directly affected by her inability to pay for her care.

At the end of February 2009 Ms. Toussaint developed increasing pain in her right leg. Her family doctor, Dr. Sharpe, sent her to the emergency room with a suspicion of deep venous thrombosis. Ms. Toussaint was asked to return the next day for a compression ultrasound. When she did so, the hospital personnel refused to carry out the ultrasound because Ms. Toussaint did not have OHIP and could not pay for the procedure. The day the ultrasound was declined, Ms. Toussaint developed left side pleuritic chest pain. Two days later she returned to the emergency room with her lawyer and investigation was

undertaken. This demonstrated a right subsegmental pulmonary embolus with elevated troponin. She was treated with heparin, hospitalized for 8 days, and discharged taking warfarin.

Pulmonary embolism is a life-threatening condition that can result in sudden death. The hospital's refusal to carry out an ultrasound could have proved fatal. To me, this highlights the precariousness of her access to health care.

Another major problem from which Ms. Toussaint suffers is decreased mobility and functional impairment resulting from weakness in the legs, particularly the right. Periodically, her right leg gives way completely and she falls. This problem began following her surgery in November and has been progressive. For the last few months she has required a cane to get about. She now cannot get up steps herself, but requires help from others. The problem has progressed to the point where she now has difficulty dressing the lower part of her body, particularly putting on pants.

The weakness is associated with neuropathic symptoms in the legs, particularly the right. These are characterized by pain and burning.

Ms. Toussaint also experiences dyspnea (shortness of breath) on exertion. I observed this when walking with her at quite a slow pace – her mobility being markedly impaired by the weakness in her right leg. She became extremely short of breath after walking about 100 meters and had to stop to catch her breath.

Family history reveals that a mother and brother have diabetes and her father has had colon cancer.

Current medications include multivitamins, rosuvastatin 40 mg. daily for her elevated cholesterol, metformin 500 mg. twice daily for her diabetes, insulin 47 units in the a.m. and 42 in the p.m., and Aliskiren, a medication to treat hypertension and to help decrease the amount of protein in the urine.

Examination revealed a chronically ill looking individual who was nevertheless cheerful. She walks slowly with a cane that supports her right leg. I have mentioned the dyspnea I observed after walking with her for approximately 100 meters.

Pulse rate was 74, respiratory rate 16 per minute at rest. I found 3+ pitting edema on the right and 2+ on the left. Cardiovascular exam revealed a II/VI systolic ejection murmur in the aortic area, non-radiating (a non-specific finding). Respiratory and abdominal examinations were unremarkable.

Neurological findings in the right lower extremity were striking with severe impairment of light touch and pinprick below the right knee and impairment in the right thigh as well. There was considerable weakness of the right lower extremity at the ankle and the knee, with some quadriceps wasting. There was also reduced light touch and pinprick in the left leg below the knee, though not nearly so marked as on the right. I also felt there was

some weakness of the left leg, but this was equivocal.

I did not examine her optic fundi, but noted on chart review that Ms. Toussaint has findings of diabetic retinopathy (damage to the retina as a result of diabetes, which can ultimately lead to blindness).

Laboratory abnormalities in the charts I reviewed included anemia, hyperlipidemia, mild renal dysfunction, nephrotic range proteinuria, and very elevated blood glucose and hemoglobin A1C.

In summary, Ms. Toussaint is a 40-year-old woman suffering from poorly controlled diabetes with complications of renal dysfunction, proteinuria, retinopathy and peripheral neuropathy. In addition to diabetic renal complications, she may well have primary renal disease, though the biopsy needed to determine this has not been carried out. Her neurological problems result in severe functional disability with marked reduction in mobility and impairment of basic activities such as dressing. Other problems include hyperlipidemia and hypertension.

It seems to me that there are two problems that require further investigation. The neurological findings in the right leg are, to me, difficult to explain solely on the basis of a diabetic neuropathy. In addition, the shortness of breath on exertion is not easily explained by any of the current diagnoses.

Ms. Toussaint has severe medical problems that markedly impair her quality of life, are likely to decrease her longevity, and could be life-threatening over the short term. She requires intensive medical management by highly skilled professionals, including medical subspecialists. Negotiating pro bono care by a number of such doctors is clearly extremely unsatisfactory and potentially dangerous. Delays resulting from lack of coverage and an inability to pay for the healthcare that she needs and the risk that she will not have access to necessary services creates serious risk to her health and may have life threatening consequences. For instance, I have conveyed to the physician now primarily responsible for Ms. Toussaint's care my concerns about her peripheral neuropathy and her exertional dyspnea, which I believe are significant problems. Dealing with these in an optimal fashion, or even perhaps in a satisfactory fashion, may involve additional specialist consultation. It is not clear to me that an indefinite number of consultants can be found who will be ready to provide pro bono care.

Sincerely,

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