

CANADA / JUDGMENT

Ali v. Abu-Laban

2025 BCSC 1157

COURT

Supreme Court of British Columbia

DECIDED

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2025 BCSC 1157 Ali v. Abu-Laban

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Ali v. Abu-Laban,

2025 BCSC 1157

Date: 20250620

Docket: S204879

Registry: Vancouver

Between:

Azim Ali

Plaintiff

And

Dr. Riyad Abu-Laban

Defendant

Before: The Honourable Justice Veenstra

Reasons for Judgment

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Place and Dates of Trial:

Vancouver, B.C.

December 2-6 and 9-11, 2024

Place and Date of Judgment:

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June 20, 2025

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Introduction

- [1] A carcinoid tumour was discovered in June 2018 in one of the lungs of the plaintiff, Mr. Ali, and removed in August 2018. Carcinoid tumours are typically slow-growing and Mr. Ali says that the tumour could have been detected based on the results of a chest x-ray taken in March 2014, when he was treated by the defendant, Dr. Abu-Laban, in the emergency room (the "E.R.") at Vancouver General Hospital ("VGH"). Specifically, the report of a radiologist who reviewed the x-ray after Mr. Ali had been discharged from the E.R. made specific note of a "nodular appearing region" in Mr. Ali's lung. Dr. Abu-Laban reviewed this report, but concluded that the radiologist's note was not inconsistent with his diagnosis of pneumonia, and that there was no need for any follow-up on his part.

- [2] Determination of this case is complicated by the time that has passed, given that key events occurred on March 31 2014, more than ten years prior to the trial. The defence witnesses had no actual recollection of the events, while Mr. Ali's recollection of details of the time was not great. Analysis is also complicated by the fact that the family physician identified by Mr. Ali when he was admitted to the E.R. had retired, and the records of Mr. Ali's March 2014 chest x-ray were not reviewed by anyone involved with his ongoing treatment until 2018.

Issues

- [3] The submissions of the parties address three major issues. This judgment deals with those issues, and the facts that relate specifically to each issue, in the following order:
- a) **Standard of Care:** did Dr. Abu-Laban meet the standard of care when he decided that no follow-up steps were necessary after he reviewed the radiologist's report;
 - b) **Causation:** was any failure of Dr. Abu-Laban to meet the standard of care a cause of any of Mr. Ali's claimed losses, and specifically:
 - i. Did any failure of Dr. Abu-Laban to meet the standard of care make any difference and, in particular, would Mr. Ali have obtained a second chest x-ray in 2014 had there been follow-up from Dr. Abu-Laban;
 - ii. Was the "nodular appearing region" identified by the radiologist in 2014 the tumour that was diagnosed in 2018, such that a repeat chest x-ray in 2014 (after resolution of the pneumonia) would have led to an earlier diagnosis of a carcinoid tumour;
 - iii. Did Mr. Ali suffer compensable mental injuries as a result of the delayed diagnosis of his carcinoid tumour;
 - iv. was Mr. Ali contributorily negligent, and if so how should losses be allocated to reflect such contributory negligence;
 - c) **Damages:** what award, if any, should be made in respect of non-pecuniary losses or past loss of earning capacity, and should any award be reduced as a result of a failure to mitigate.

Issue #1 - Standard of Care

Relevant Facts

- [4] Mr. Ali was 29 years old when he was taken by ambulance to the E.R. at VGH on March 31, 2014. He had a bad cough with phlegm as well as some chest pain.
- [5] Mr. Ali had smoked cigarettes regularly since he was about 14 years of age, and in March 2014, he was generally smoking half-a-pack each day. He would also generally smoke marijuana once a day as well.

- [6] Mr. Ali was initially assessed by a nurse, then registered by a clerk at the hospital who completed a "Face Sheet". That document includes spaces for the patient's name, the patient's personal health number, a "triage acuity" score assigned by the initial nurse, and the name of the patient's family physician (if available).
- [7] When asked by the E.R. clerk for the name of his family doctor, Mr. Ali gave the name of Dr. Cyril Chan. Unbeknownst to Mr. Ali at the time, Dr. Chan had retired in September 2012. With respect to this:
- a) Mr. Ali had, for a period of time, been seen by Dr. Peter Yong. Dr. Peter Yong's son joined his practice and, thereafter, Mr. Ali was seen by Dr. Brian Yong. Mr. Ali was not particularly happy with the way this was handled and did not feel he had a good connection with Dr. Brian Yong.
 - b) Dr. Chan was Mr. Ali's mother's doctor. At some point, Mr. Ali had had a conversation with Dr. Chan, in which Dr. Chan had indicated he would be willing to take Mr. Ali on as a patient. The evidence was vague as to when that occurred, although it was presumably prior to Dr. Chan deciding to retire. Mr. Ali said that he had seen Dr. Chan once.
 - c) Medical Services Plan records at trial, which dated back to early 2013, did not show any Medical Services Plan charges in 2013 or 2014 with respect to Mr. Ali being seen by Dr. Chan-- which is perhaps not surprising given that Dr. Chan retired in 2012.
- [8] Dr. Abu-Laban was one of about twelve doctors on duty in the E.R. at VGH on the morning of March 31, 2014.
- [9] At the time, the E.R. at VGH used a paper-based system for doctors to record patient interactions. The particular form used was called an "M14" form, and had spaces to include the time, the vital signs, the pertinent history, the results of any examination, investigations or findings, a diagnosis, the ultimate disposition, any discharge instructions, and the time of discharge. The form was completed in triplicate, with one copy to go to the hospital records file, one copy to go to the family doctor (if identified), and one copy available for research purposes.
- [10] At the trial in December 2024, Dr. Abu-Laban had no recollection of seeing Mr. Ali on March 31, 2014. His evidence was based on what he recorded on the M14 form and his standard practice at the time.
- [11] I begin with what was recorded in the M14 form. With respect to "History", Dr. Abu-Laban's note includes the following:
- 29 year old male smoker. Worsening cough with left lateral chest pain more than 3 days.
- [12] With respect to his observations on examination of Mr. Ali, Dr. Abu-Laban noted:
- Coughing with low grade fever. Air entry reduced left side. ? creps.

The note as to "creps" referenced crackling noises from the lungs that are often associated with pneumonia.

[13] There follows a note "CXR", which referenced a chest x-ray. With respect to the results of the x-ray, Dr. Abu-Laban recorded the following:

Infiltrate left base consistent with early pneumonia. Discussed with patient.

[14] Under "Discharge Instructions", the form notes that Mr. Ali was being prescribed an antibiotic (Biaxin) as well as Tylenol #3. It notes that Mr. Ali was to return to the emergency department if "worsens or concerns". It then says:

Else follow up with family physician in 7-10 days for repeat x-ray to confirm resolution and normal.

Just below is a further note: "* urged to stop smoking".

[15] Under "Final Diagnosis", the form notes:

1. Pneumonia left base
2. Coughing & pain secondary to pneumonia
3. Smoker à post resolution follow-up chest x-ray pending

[16] Mr. Ali's recollection of his time at the emergency department was vague in many ways, which is not surprising given the time that had passed. He did not recall speaking with the intake nurse or clerk, and said it was only when he saw the documents in this case that he realized that Dr. Chan's name had been recorded.

[17] Mr. Ali generally recalled being told that the x-ray showed fluid in his chest, which would be considered pneumonia, and that he would be given antibiotics. His understanding was that if the pneumonia went away, that was great, but if it did not, then he should get a further x-ray. At trial in December 2024, Mr. Ali did not recall being told to see his family doctor in "7-10 days", although he acknowledged that on his examination for discovery in February 2022, he did agree that he was told he should do so.

[18] When asked if the doctor spoke to him about stopping smoking, Mr. Ali's response was that "He could have, potentially", but he also said that he did not recall such a conversation. He also commented during his evidence that it was somewhat expected that a doctor would advise him to stop smoking.

[19] As noted, Dr. Abu-Laban had no recollection of his interaction with Mr. Ali. His evidence largely focused on interpreting some of the less legible handwriting and discussing his usual practice. His notes included a reference to "Discussed with patient". With respect to that, Dr. Abu-Laban explained that his standard practice upon receipt of the x-ray in a case like this would be to discuss the findings, the implications, the recommendations for management, and the appropriate follow-up with the patient.

- [20] Dr. Abu-Laban's evidence was that it was inconceivable that he would have told Mr. Ali that he only required an x-ray if he was not feeling better. His evidence was that his invariable practice in cases of pneumonia like this is to recommend a further doctor's visit within 7-10 days--without qualification.
- [21] With respect to his note of "*" urged to stop smoking", Dr. Abu-Laban explained that he often uses E.R. visits like these with smokers to communicate a public health message about the importance of stopping smoking. He sees such visits as teachable moments. He said that any such discussion would have included a reference to smoking being bad for you because it causes cancer. That said, he acknowledged that nothing he had seen in his dealings with Mr. Ali was indicative of anything cancerous.
- [22] Some of Dr. Abu-Laban's evidence in cross-examination took this question of cancer risk a bit further. He suggested that he "suspected" that cancer might also have come up in expressing the importance of a follow-up x-ray, but that he could not say for sure. He acknowledged that there was no reference in his notes to any discussion of cancer.
- [23] In cross-examination, Dr. Abu-Laban identified three reasons for recommending a follow-up x-ray. The first is to confirm that everything has resolved, the second is to confirm no complications arising from the pneumonia, and the third would be to confirm that there is no underlying reason for the pneumonia, such as a mass lesion or tumour. He agreed, however, that in his discussions with Mr. Ali, he would not have used language such as "mass lesion" or "tumour", and that the question of cancer would have only come up in the context of it being one of the risks of smoking.
- [24] The practice at the E.R. was for an x-ray like that taken of Mr. Ali's chest in March 2014 to be initially interpreted by the E.R. physician, but then later reviewed by a radiologist. This review occurs anywhere from several hours to several days later. A paper copy of the report of the radiologist is sent to the E.R. physician for review, a copy is placed in the hospital file, and a copy is sent to the patient's family doctor.
- [25] The copy of the radiology report sent to the E.R. physician is placed in what Dr. Abu-Laban referred to as a "cubby"--I gather that is a mailbox in the E.R. area of the hospital. Dr. Abu-Laban said that he would review such reports during shifts as he had time, and that he would also sometimes come to the E.R. outside of his regular shifts in order to catch up on this sort of paperwork. In that way, he would typically review such reports within a week after a patient encounter--at a time when he still has an actual recollection of that encounter.
- [26] The report includes a note at the bottom of the "Emergency Physician's Interpretation". In this case, Dr. Abu-Laban's interpretation is "Infiltrate left base, early pneumonia". Dr. Abu-Laban explained that this is something he entered himself electronically at the time he saw Mr. Ali or immediately thereafter.
- [27] The radiologist's comments on the report are as follows:

FINDINGS: Consolidation is present in the left lower lobe. Given the clinical history provided, this is most in keeping with pneumonia. However, along the superior aspect of the said changes, a nodular-appearing 2.7 cm region is seen. Therefore, a follow-up chest x-ray following appropriate treatment is recommended. If this density should persist, a low-dose CT scan is recommended at [VGH].

The remainder of the lungs, cardiopericardal silhouette and mediastinal contours are unremarkable. Mild elevation of the left hemi-diaphragm is seen. This may be related to a prominent loop of gas-filled bowel in the left upper abdomen.

No acute osseous or pleural abnormalities are seen.

- [28] Dr. Abu-Laban does not recall reviewing this report, but says that he would have done so in the ordinary course. His evidence was that, when he receives these reports, he looks for any major discrepancy or finding between his interpretation and the radiologist's interpretation, impacting the kind of advice that the patient should be given. If there is no discrepancy that impacts on either the diagnosis or the management plan, then his copy of the report is placed in a shredding bin. If there is such a discrepancy, he will generally keep the report in a file until his follow-up is complete. Follow-up could involve a call to the patient's family doctor or it could be a call directly to the patient.
- [29] It seems clear in this case that Dr. Abu-Laban did not do anything further as a result of receiving the radiologist's report. Although he has no actual recollection of what happened, Dr. Abu-Laban said that he sees the radiologist's report as, in essence, describing the nature of the infiltrate in more detail. He said that x-rays of infiltrate are often heterogeneous, and the radiologist's description of a shape in one area of that infiltrate is not inconsistent with it being infiltrate. He suggested it is not unusual for radiologists to be "more descriptive and explicit" in describing things like infiltrate. Dr. Abu-Laban said that he sees nothing in this report that would make him think he would have made efforts to follow up.
- [30] It was suggested in cross-examination that the radiologist here was identifying things that Dr. Abu-Laban did not identify in the report, and that this is reflected in the radiologist's use of the word "however". Dr. Abu-Laban denied this, saying that heterogeneity is not uncommon, and the radiologist in describing the heterogeneity in more detail is "going on in an effort to ensure that the standard follow-up x-rays are done". He was insistent that there was no discrepancy between the totality of his interpretation and what the radiologist advised and documented.
- [31] With respect to the radiologist's recommendation of a further chest x-ray, Dr. Abu-Laban said that he would have seen this as simply reflecting the general practice that a patient being treated for pneumonia is recommended to have a follow-up x-ray.
- [32] Mr. Ali's evidence was that if the doctor had told him there was something specific of concern on the x-ray--for example, that there was a nodule, or it looks like possibly cancer--he would definitely have gone to have a follow-up x-ray.

[33] VGH's medical records include a fax. The fax is not dated (other than an automated fax header reference to 2008, which is clearly incorrect). The fax is sent by someone identified only as "Anita", who appears to be monitoring correspondence with Dr. Cyril Chan's former office. The subject line of the fax references "Emerg report of Ali, Azim", and a "Date of treatment" of March 31, 2014. It states:

Please check patient's data - update the name of pt's current family doctor info. This report came to Dr. Cyril Chan. Dr. Chan has closed his practice in Sept 2012. Patient has not been Dr. Chan's patient for 1½ years and this report will not be followed up.

[34] Dr. Abu-Laban's evidence was that he did not see this fax, and that from what he can tell, VGH's medical records department simply filed the fax in the medical file related to Mr. Ali's E.R. visit on March 31, 2014. His evidence was that this would be in accordance with his understanding of that department's practice at the time--that they do not typically communicate back to the E.R. physicians.

[35] Mr. Ali's evidence is that he took the antibiotics that were prescribed and his coughing and chest issues improved.

[36] Mr. Ali had an appointment with Dr. Brian Yong on April 10, 2014. Mr. Ali acknowledged in cross-examination that he most likely became aware at some point between March 31 and April 10, 2014 that Dr. Chan had retired. It appears, however, that neither Mr. Ali nor Dr. Yong on his behalf requested that a copy of the E.R. records from March 31 be sent to Dr. Yong.

[37] Dr. Yong's record of this visit took the form of handwritten notes. Those notes say:

S Went to ED (VGH) for pneumonia

Given Tylenol #3, Biaxi

Feeling better

Did x-ray there à pneumonia

O/E N S1/S2

Chest clear

A/P Pneumonia

CXR

- [38] Dr. Yong was a witness at trial. He had no specific independent recollection of his visit with Mr. Ali. He explained that the "S" means "subjective", and reflects what he was told by the patient. The "O/E" means either "objective" or "on examination", and reflects Dr. Yong's own observations. The "A/P" refers to assessment or diagnosis and plan. He explained that his note of "N S1/S2" means a normal cardiac and respiratory exam, and that "CXR" refers to chest x-ray.
- [39] Dr. Yong explained that the reference to CXR indicates that he ordered a chest x-ray for Mr. Ali. At the time, a chest x-ray would have been requested by completing a requisition in paper format within his office, which he would have handed to the patient directly. At the time, it was not his practice to keep a copy of such a requisition in his file.
- [40] Dr. Yong was asked whether he told Mr. Ali that the follow-up chest x-ray was optional. He said that he cannot say for sure, given that he has no actual recollection of this visit, but that was not something he would typically say. His evidence was that, generally speaking, if there is a diagnosis of pneumonia, you want a repeat x-ray in four to six weeks to ensure that there is resolution, and that if he prepares a requisition for an x-ray, it is not typically presented as optional.
- [41] Mr. Ali did not recall this visit with Dr. Yong, although he did agree that the comment attributed to him that he was "feeling better" reflects his general recollection that he was feeling better within a short time of the E.R. visit, and that he would have told Dr. Yong what he recalled from his visit to the E.R.
- [42] Mr. Ali did not have a repeat chest x-ray after seeing Dr. Yong. In fact, he did not have a further chest x-ray for over four years.
- [43] These are the significant facts related to questions of standard of care in this case. For context, however, I note that in June 2018, Mr. Ali was admitted to hospital as a result of hiccups that he could not get rid of. A chest x-ray at that time led to a CT scan of the chest, which showed a carcinoid tumour in the area of his lungs that had been identified by the radiologist in 2014 as having a "nodular-appearing 2.7 cm region". The evidence with respect to this tumour will be discussed in more detail in respect of the causation issue.

Expert Evidence

- [44] Three expert witnesses gave evidence with respect to the applicable standard of care--one called by Mr. Ali, and two called by Dr. Abu-Laban.

Dr. James Atkins

- [45] Dr. James Atkins prepared an Independent File Review report in April 2023 at the request of counsel for Mr. Ali. He has been a member of the College of Physicians and Surgeons of British Columbia since 1982, practicing primarily in Penticton, British Columbia. He

obtained a College of Family Practice certificate in Emergency Medicine in 2002. He initially performed a combination of family practice with on-call emergency room duty, then spent 20 years working full-time in the emergency room at Penticton Regional Hospital. He was Chief of Penticton's Department of Emergency Medicine from 2006 to 2008 and 2012 to 2013.

[46] Dr. Atkins was asked whether Dr. Abu-Laban should have followed up with Mr. Ali to advise him of the findings in the radiological report. His opinion was that (in part):

[] given the radiology findings of a 2.7 cm nodular region on the superior aspect of the area of consolidation/infiltrate and the base of the left lower lobe this would be a significant discrepancy from Dr. Abu-Laban's interpretation in the Emergency Department. It could be considered worrisome for malignancy. Therefore in my opinion the standard of care would be for Dr. Abu-Laban to attempt to make personally certain that Mr. Ali was getting follow-up.

[47] In terms of specifics, Dr. Atkins opined that:

[] a documented attempt to contact the patient either by telephone call or letter to inform him of the additional finding and emphasize the need for follow up would be the appropriate standard of care in this regard. In my opinion, this would be regardless of whether he was aware that Dr. Chan would not be following up.

[48] On cross-examination, Dr. Atkins agreed that the role of an E.R. physician is not to provide continuing care of a patient, and that is particularly true where a patient has a family doctor. He agreed that it would be rare for an E.R. physician to call a patient after discharge. However, he expressed the view that where concerning information comes to an E.R. physician after the patient has been discharged, where there is something that had not been diagnosed or seen or appreciated while the patient was in the E.R., there is an obligation to ensure that gets followed up on.

[49] It was put to Dr. Atkins that an E.R. physician would not call a patient to tell them something with the same advice you had already given them. His view in response was that if you see a suspicious finding that needs follow-up, you would call either the patient or their family doctor, or write a letter to them, to make sure.

[50] Dr. Atkins said that he regularly sees small nodules on chest x-rays, but that if it's a big one (he suggested larger than about 1 cm), he would want to follow it up.

[51] Dr. Atkins agreed that the radiologist did not specifically use the words "tumour" or "suspicious". However, Dr. Atkins' view was that the references to a nodular appearing region gave rise to concerns about the possibility of a tumour, and that is the implication of his words.

[52] Dr. Atkins agreed that Penticton's hospital is much smaller than VGH, but did not agree that the standard of practice on a matter such as this would be different. Dr. Atkins also agreed on cross-examination that lung cancer is more common in elderly smokers than in smokers of the age of Mr. Ali in 2014.

- [53] Dr. Atkins was cross-examined on the order in which he reviewed the documents that were sent to him. His evidence was that he reviewed the files from 2014, but that he did not review them in exactly the same order as Dr. Abu-Laban would have reviewed them. He agreed that Dr. Abu-Laban's initial review of the x-ray would have been done without access to the radiologist report. He said that, based on the information Dr. Abu-Laban had at the time of discharge, he agreed with Dr. Abu-Laban's diagnosis and advice at the time. He reiterated his view that the expectation is that an E.R. physician, who receives information of significance after seeing a patient, needs to make sure the patient is followed up on.
- [54] Finally, Dr. Atkins was cross-examined in respect of assumptions that were inherent in one of the questions he was asked to opine on, in particular, the suggestion that Dr. Abu-Laban knew at the time he reviewed the radiological report that Dr. Chan was retired and would not be seeing any documents. Dr. Atkins said that he was not sure that was actually the case, and agreed that the evidence in the transcript of Dr. Abu-Laban's examination for discovery that he was provided before finalizing his opinion (although after he had advised counsel that he had formed an opinion) was that Dr. Abu-Laban did not see the fax from Dr. Chan until 2020. He affirmed his view that, whether or not Dr. Abu-Laban understood things were being sent to a family doctor who would be in a position to act on them, Dr. Abu-Laban should have contacted either Mr. Ali or his family doctor with respect to the radiologist's report.

Dr. Eric Grafstein

- [55] Dr. Eric Grafstein prepared an opinion letter in July 2022 at the request of counsel for Dr. Abu-Laban. Dr. Grafstein has since 2012 been the Regional Head, Emergency Medicine for Vancouver Coastal Health, based at St. Paul's Hospital in Vancouver but also working at VGH where Dr. Abu-Laban worked at all material times. He is also a clinical professor in the Department of Emergency Medicine at the University of British Columbia. He completed a residency in emergency medicine in 1991 and holds an FRCPC designation in emergency medicine. He has engaged in extensive scholarly research, and has a particular interest in emergency room record-keeping. His curriculum vitae includes an extensive list of publications.
- [56] Dr. Grafstein confirmed in his evidence-in-chief that he was provided with the material documents one at a time, beginning with the M14 record, followed by the chest x-ray image from March 31, 2014. He was not told that the issue was delayed diagnosis until later in the process.
- [57] Dr. Grafstein was also provided with a three-page statement of assumed facts, which facts he assumed to be true. As part of s. 9 of the statement of assumed facts, Dr. Grafstein was instructed to assume that Dr. Abu-Laban:

[] advised the plaintiff to see his family physician in 7 to 10 days for assessment and to arrange a follow-up chest x-ray to ensure resolution of the pneumonia, that there were no complications of the pneumonia, and no underlying lesion such as a neoplasm that caused the pneumonia.

[58] Dr. Grafstein said that he assumed this to be true. When pressed on whether he assumed Dr. Abu-Laban specifically advised Mr. Ali about a lesion, Dr. Grafstein said "no"; and that what he actually assumed was that Dr. Abu-Laban advised Mr. Ali to get a chest x-ray in "7-10 days".

[59] The statement of assumed facts also included the following:

14. Dr. Louis' report was later delivered to Dr. Abu-Laban's mailbox. Dr. Abu-Laban reviewed the report. It was consistent with his interpretation of the x-ray and his discharge instructions. [Discovery of Dr. Abu-Laban, Q&A 68-72]

[60] On cross-examination, Dr. Grafstein confirmed that he relied on this fact and, in particular, that he assumed that the finding of the radiologist was consistent with Dr. Abu-Laban's interpretation of the x-ray.

[61] Dr. Grafstein opined that Dr. Abu-Laban met the standard of care of a reasonably prudent E.R. physician in providing medical care to Mr. Ali. After summarizing what happened while Mr. Ali was in the E.R., Dr. Grafstein went on to note that:

When Dr. Dr. Abu-Laban received the dictated report from Dr. Louis, he reviewed the results and noted that since his interpretation and advice to Mr. Ali was similar, he did not need to alter his management. He rightfully assumed that the family physician listed on the chart was the patient's family physician. He reasonably assumed that when he advised Mr. Ali to follow up, he would do so. Not only did Dr. Abu-Laban meet the standard of care but in many ways exceeded it. I do not believe that all emergency physicians would have told their patients to get a follow up x-ray or counseled them to stop smoking.

[62] Dr. Grafstein noted that pneumonia is a relatively common diagnosis, while carcinoid tumours are relatively rare. With respect to Dr. Abu-Laban's discharge instructions to Mr. Ali, Dr. Grafstein commented:

The standard of care did not require that Dr. Abu-Laban tell Mr. Ali that he needed a repeat x-ray to rule out the possibility that he might have a lung cancer. In fact, there are many other reasons for getting a repeat chest x-ray. The most common and compelling one would be to insure that the antibiotic treatment was effective. Since there are so many reasons that a repeat chest x-ray might not show resolution of the pneumonia, it would not be practical to describe all the potential reasons for treatment failure to the patient.

[63] With respect to the question of what further steps were required of Dr. Abu-Laban after he later received the radiologist report, Dr. Grafstein opined that (in part):

Dr. Abu-Laban dutifully reviewed the findings on the x-ray report by Dr. Louis and rightfully concluded that his interpretation was congruent with that of the radiologist and that no further change in his advice to the patient needed to occur. [SAF 14]. He rightly expected that if Mr. Ali were given instructions to follow up with his family doctor and obtain and a repeat x-ray, he would have done so.

[]

It would be reasonable for Dr. Abu-Laban to expect that the patient, Mr. Ali, would, of his own accord, heed his advice and arrange for a follow-up x-ray. It would also be reasonable for Dr. Abu-Laban to believe that Dr. Chan was Mr. Ali's family doctor and that he would receive a copy of the patient's chart and initiate follow-up if he did not hear from Mr. Ali.

[64] On cross-examination, it was put to Dr. Grafstein that the radiologist's comments about a nodular-appearing 2.7 cm region was not in keeping with a diagnosis of pneumonia. He expressed the view that if the radiologist was "very concerned", they would say something like "this looks like cancer, please get a CT scan". He sees the job of a radiologist as to be very sensitive and not to miss anything, but says that there is what he called a "code" between radiologists and other doctors. He views the "code" used by the radiologist in this case as more in the nature of "we don't know what this is, it could be something, it could be nothing".

[65] Dr. Grafstein further explained that an x-ray creates a two dimensional image of a three dimensional structure like a lung, which shows the various parts of the lung, including air, blood vessels, and tissues, in grey, white, and black. Thus, there are often overlays of shadows that form shapes, which makes them difficult to interpret.

[66] Dr. Grafstein agreed on cross-examination that patients in British Columbia are entitled to make decisions regarding their own health care and that, to do so, they are entitled to be provided with full and complete information.

[67] Finally, in response to a question from the Court, Dr. Grafstein commented that in 2014, there was no central repository of medical records with respect to a patient that a doctor like Dr. Yong could have accessed to obtain details of Mr. Ali's treatment at VGH. At the time, information was shared only through documents being faxed or mailed from one care-provider (e.g. VGH) to another (e.g. a family doctor). That system has since changed.

Dr. Anthony Fong

[68] The third expert with respect to standard of care was Dr. Anthony Fong, an emergency medicine physician who practices at St. Paul's and Mount Saint Joseph hospitals in Vancouver. Dr. Fong obtained his CFPC certificate in emergency medicine in 2014, and is a clinical assistant professor of emergency medicine at the University of British Columbia. He prepared an expert opinion letter in October 2024 at the request of counsel for Dr. Abu-Laban, which letter was in response to Dr. Atkins' report of April 2023.

[69] Dr. Fong was asked to address four specific questions:

- a) The reasonableness of an assumption referenced in Dr. Atkins' instructing letter, when Dr. Atkins was asked to assessed the standard of care "with reference to the fact that no other doctor other than himself would be seeing the radiological report"; and
- b) Whether Dr. Atkins was correct in opining that:
 - i. the radiologist's findings of a "2.7 cm nodular region" were a "significant discrepancy" from Dr. Abu-Laban's own interpretation of the x-ray image;
 - ii. Dr. Abu-Laban should have made personally certain that Mr. Ali was getting follow-up; and
 - iii. there should have been a documented attempt to contact the patient, regardless of whether Dr. Abu-Laban understood that a family doctor would be following up.

[70] With respect to the first question, Dr. Fong opined that it was reasonable for Dr. Abu-Laban to assume that Mr. Ali's family doctor would receive the radiologist's report and would be "aware of any follow-up issues".

[71] With respect to the second question, Dr. Fong distinguished the comments of the radiologist in this case from a situation where a radiologist makes a specific finding of a pulmonary nodule on a CT scan. He suggested that the latter situation gives rise to specific follow-up criteria and guidelines. However, comments about a nodular region do not give rise to a well-defined standard of care or guideline and, in such circumstances, "management is always context-specific". Dr. Fong noted that the only actual specific diagnosis made by the radiologist was pneumonia, and that even if a nodule was present, it could be something non-cancerous. He concluded that (in part):

[] for a clinically significant discrepancy between a radiology report and an emergency physician's initial impression to exist, the discrepancy has to cause a change in diagnosis, management or both. In this case, the radiology report made no difference in either diagnosis or management.

[72] With respect to the third issue, Dr. Fong expressed the view that since the recommendation that Mr. Ali see his family doctor in 7-10 days had not changed, and given that the radiology report did not give rise to a change in that recommendation, there was no need for Dr. Abu-Laban to follow up. He explained his view as follows:

Emergency physicians are constantly providing direct clinical care throughout their careers and it is not reasonable or possible to make personally certain that all patients have followed prescribed advice once discharged.

[73] With respect to the final question, Dr. Fong reiterated his view that the contents of the radiology report did not warrant a follow-up by Dr. Abu-Laban. He characterized the radiology report as "a differently[-]worded description of findings leading to the same diagnosis and management".

[74] On cross-examination, Dr. Fong was asked to (and did) confirm that he had relied on specific statements from the statement of assumed facts that he had been provided. One was from s. 9, it stated that Dr. Abu-Laban had:

[] advised the plaintiff to see his family physician in 7 to 10 days for assessment and to arrange a follow-up chest x-ray to ensure resolution of the pneumonia, that there were no complications of the pneumonia, and no underlying lesions such as a neoplasm that caused the pneumonia.

[75] The other was from s. 14; it instructed Dr. Fong to assume that the radiologist's report was "consistent with [Dr. Abu-Laban's] interpretation of the x-ray and his discharge instructions".

[76] Dr. Fong confirmed that he had relied on both of these assumptions. However, with respect to the assumption from s. 14, he volunteered (without being asked) that he also agreed with the assumption. When pressed, Dr. Fong was unable to recall whether he had discussed this assumption when meeting with counsel to prepare for his testimony. [The same question had been asked of Dr. Grafstein the previous day.]

[77] Dr. Fong was asked on cross-examination whether he accepted that patients are entitled to be provided full and complete information in order to make health care decisions. He responded that his view is that patients are "entitled to the relevant information that they need to make health care decisions".

Legal Context

[78] The basic legal principles that apply to questions of standard of care were not in dispute.

[79] A physician has a duty to conduct their practice in accordance with the conduct of a prudent and diligent physician in the same circumstances, based on the knowledge they ought reasonably to have at the time of the alleged negligence: *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674, 1995 CanLII 72 at paras. 33-34.

[80] In *ter Neuzen*, Justice Sopinka reviewed in some detail the question of standard practices. At para. 38, he commented that:

It is generally accepted that when a doctor acts in accordance with a recognized and respectable practice of the profession, he or she will not be found to be negligent. This is because courts do not ordinarily have the expertise to tell professionals that they are not behaving appropriately in their field. In a sense, the medical profession as a whole is assumed to have adopted procedures which are in the best interests of patients and are not inherently negligent.

[81] At para. 39, he quoted from Professor Fleming's text on *The Law of Torts* (7th ed., 1987):

Conformity with general practice, on the other hand, usually dispels a charge of negligence. It tends to show what others in the same "business" considered sufficient, that the defendant could not have learnt how to avoid the accident by the example of others, that most probably no other practical precautions could have been taken, and that the impact of an adverse judgment (especially in cases involving industry or a profession) will be industry-wide and thus assume the

function of a "test case". Finally, it underlines the need for caution against passing too cavalierly upon the conduct and decision of experts.

[Emphasis in original.]

[82] He concluded at para. 51 that:

I conclude from the foregoing that, as a general rule, where a procedure involves difficult or uncertain questions of medical treatment or complex, scientific or highly technical matters that are beyond the ordinary experience and understanding of a judge or jury, it will not be open to find a standard medical practice negligent. On the other hand, as an exception to the general rule, if a standard practice fails to adopt obvious and reasonable precautions which are readily apparent to the ordinary finder of fact, then it is no excuse for a practitioner to claim that he or she was merely conforming to such a negligent common practice.

[83] In *ter Neuzen* at para. 34, it was emphasized that a court should be careful not to rely upon "the perfect vision afforded by hindsight". As noted in *Williamson v. Wang*, 2024 BCSC 1227 at paras. 149-150:

[149] The mere fact of an unfortunate event or undesired consequence is insufficient to establish a breach of the standard of care. The Court of Appeal in *Carlsen v. Southerland*, 2006 BCCA 214, confirmed that the focus of the analysis must be on the precise manner in which the surgeon was alleged to have breached the standard of care, as opposed to inferring negligence based on the result: para. 15.

[150] Similarly, in *Siever v. Interior Health Authority*, 2021 BCSC 880, the Court cautioned against starting with a poor outcome and working backwards because this can have the effect of holding the physician to a standard of perfection: para. 102. I conclude that this is what Dr. Ezer has done in his report.

[84] The behaviour of a specialist is assessed in light of the degree and skill of an average specialist in that same field: *ter Neuzen* at para. 33.

[85] With specific respect to an emergency room physician, a useful summary is found in *Pinch (Litigation Guardian of) v. Morwood*, 2016 BCSC 938 at paras. 155-156, *aff'd* 2017 BCCA 234:

[155] More specific considerations within standard of care may apply in the emergency room. The emergency room creates a distinctive contextual setting (*Gemoto [v. Calgary Regional Health Authority]*, 2006 ABQB 740) at para. 24). In front line medicine, an emergency medicine specialist is expected to exercise a great deal of skill in history taking, examination, and instant diagnosis (*Smith v. Prieditis*, [1993] O.J. No. 899 at para. 33 (Ct. J. (Gen. Div.)), *aff'd* [1997] O.J. No. 1276 (C.A.)). The emergency room physician must apply differential diagnosis to determine whether the presenting complaint is a major problem or some other issue. The process is to give priority to the diagnosis with the most severe outcome, a "worst is first" approach (*Briante [v. Vancouver Island Health Authority]*, 2014 BCSC 1511 at para. 271). A process of diagnosis that focuses on the most likely explanation

is inconsistent with a proper differential diagnosis (Campbell [v. Roberts, 2014 ONSC 5922] at para. 100).

- [156] In the context of a "worst is first" approach to diagnosis, if a specific risk is foreseeable, the applicable standard of care is commensurate with the potential danger (Gemoto at para. 21; Williams (Litigation guardian of) v. Bowler, [2005] O.J. No. 3323 at paras. 250-251 (Sup. Ct.) (Williams)). If a potentially life-threatening condition is included in the differential diagnosis, it is urgent to either confirm it or to rule it out (Williams at para. 251).
- [86] With respect to the "worst is first" approach, counsel for Mr. Ali referenced the judgment in *Adair Estate v. Hamilton Health Sciences Corp.*, 2005 CanLII 18846, 32 C.C.L.T. (3d) 283 (O.N.S.C.) at paras. 116-117:
- [116] [] Differential diagnoses is the system of determining which of two or more diseases with similar symptoms is the one that a patient is suffering from, through a systematic comparison and contrast of the clinical findings. All experts at trial agreed that this is the proper method of arriving at a diagnosis, leading to the conclusion that it is a universally accepted rule of medicine. Dr. Goldberg expanded on this definition by explaining that after the physician has identified the likely perils, these possible perils must be listed from the most serious to the least serious. The physician eliminates the peril that has the most severe consequences first. He summed this idea up in his expert testimony by asserting the simple maxim "worst first".
- [117] Those who diagnosed Verna Adair did not follow the systematic process of differential diagnosis. Critically, several doctors preferred to deal with the most likely cause, rather than the most serious. The worst possible ailment was not eliminated from the list of differential alternatives first. The form of diagnosis used by the defendants remained focused on probability, whereas a proper differential diagnosis must also be informed by considerations of severity.

Positions of the Parties

- [87] Mr. Ali agrees that, during the ER encounter itself, Dr. Abu-Laban acted appropriately. The theory of Mr. Ali's case is that after discharge, and upon receiving the radiologist report, Dr. Abu-Laban should have taken steps to follow up with Mr. Ali to ensure he was aware of the findings of the radiologist.
- [88] Mr. Ali relies upon the opinion of Dr. Atkins that the radiology finding of a 2.7 cm nodular region on the superior aspect of the area of consolidation/infiltrate was in fact a significant discrepancy, something that could be considered worrisome, and something that should be communicated to the patient so that the patient could make an informed choice with respect to further follow-up.

- [89] Mr. Ali says that the role of the E.R. doctor is to rule out the worst possible diagnosis, that the radiologist properly identified a risk of something beyond pneumonia, and that Dr. Abu-Laban failed to identify that this was something he should be communicating to Mr. Ali. Mr. Ali submits that the radiologist report does indeed describe something different; that the radiologist's use of the word "however" is significant; and that a plain reading of the report is that pneumonia is a concern but there is something else (the nodular like region) seen.
- [90] Mr. Ali notes that there is nothing in the M14 report completed by Dr. Abu-Laban indicating any discussion or thought that the x-ray imaging might indicate anything beyond pneumonia. He submits that the obvious inference is that this is all that was discussed with Mr. Ali--other than a general discussion about the benefits of stopping smoking. He says that his decision not to get a follow-up x-ray after his pneumonia had cleared up reflects and was based on the information he was given by Dr. Abu-Laban.
- [91] Mr. Ali submits that the reports of Drs. Grafstein and Fong must be read in light of the assumption that each was instructed to make: that the radiologist report was consistent with Dr. Abu-Laban's interpretation of the x-ray and his discharge instructions. Mr. Ali submits that that instruction, in effect, assumes away the key issue in the case.
- [92] Dr. Abu-Laban submits that the decision as to what to do upon receipt of the radiologist's report required an exercise of clinical judgment. Dr. Abu-Laban says that the decision he made is supported by the opinions of Drs. Grafstein and Fong, and that those reports should be preferred over the report of Dr. Atkins.
- [93] Dr. Abu-Laban submits that Drs. Grafstein and Fong were provided information in stages, requiring them to come to an opinion first based on the M14 report and the x-ray image, then later being provided with further information. It is submitted that the fact that Dr. Atkins was provided with a full package of information all at once means that his report is tainted by "results-based reasoning".
- [94] Dr. Abu-Laban submits that his conduct must be viewed in light of his understanding at the time he reviewed the radiologist report, including that both his M14 report and the radiologist report would be sent to Mr. Ali's family doctor, who would review them with a second set of eyes. Dr. Abu-Laban submits that the role of an ER doctor is not to be involved in long-term care of a patient.
- [95] Dr. Abu-Laban points to one of the questions posed to Dr. Atkins, which implicitly asked him to assume that Dr. Abu-Laban was aware of Dr. Chan's retirement. Dr. Abu-Laban also points to Dr. Atkins' use of the words "nodular region" rather than "nodular-appearing 2.7 cm region".

- [96] Dr. Abu-Laban submits that to expect him to call a patient where the ultimate recommendation--to have a follow-up x-ray--is unchanged is inconsistent with the scope of care provided by emergency physicians. Dr. Abu-Laban argues that if the standard of care required every emergency physician receiving a radiology report to call a patient and describe the details of the report, an "already overburdened emergency medical system would be thrown into chaos".
- [97] Finally, Dr. Abu-Laban submits that even if Dr. Atkins' opinion represents one accepted school of thought on the standard of care required, the court should consider the opinions of Dr. Grafstein, Fong, and himself as representing another accepted school of thought. Dr. Abu-Laban submits that, where there are two accepted schools of thought, and a physician has acted in accordance with one of them, there is no breach of the standard of care.

Analysis

- [98] In my view, the radiologist's comments raised an issue of significance not previously recognized by Dr. Abu-Laban. I accept Dr. Atkins' opinion that the standard of care in light of the information in the report was for Dr. Abu-Laban to have followed up with either Mr. Ali or with Mr. Ali's family doctor.
- [99] In this case, the family doctor identified on the record, Dr. Chan, had retired some 20 months earlier. Had Dr. Abu-Laban attempted to contact Dr. Chan, he would have learned of this and would then presumably have attempted to contact Mr. Ali directly.
- [100] Even though it is clear that Dr. Abu-Laban did not know that Dr. Chan had retired, I do not see it as reasonable for him to have assumed that Dr. Chan would have reviewed the record, figured out what information and advice Dr. Abu-Laban had initially provided to Mr. Ali, and identified a gap that needed to be filled through communicating the risks implicit in the radiologist's identification of the nodular-appearing region. It was Dr. Abu-Laban who knew the advice provided to Mr. Ali, and it was up to him to ensure that any necessary additional information was brought to Mr. Ali's attention in an appropriate manner. Dr. Abu-Laban himself acknowledged that, if he had seen the radiologist's report as giving rise to a discrepancy, he would have contacted either the patient or the family doctor in order to highlight the discrepancy--he just did not think there was a discrepancy in this case.
- [101] It seems evident that all three of Drs. Atkins, Grafstein, and Fong had been provided assumptions that ultimately did not accord with the facts as they emerged at trial. However, it was clear from their cross-examinations that all three had reviewed the entirety of the materials provided to them before finalizing their opinions, and were opining based on substantially the same factual basis.

- [102] While I appreciate that, in some medical cases, there is a risk of results-based reasoning, I do not think that the order in which documents were provided to the experts made any substantive difference to their opinions in this case. All three experts had more or less the same materials before they provided their opinions.
- [103] In my view, Dr. Fong's opinion was influenced strongly by his view that patients are entitled to the information that a doctor deems "relevant" in any given case, rather than to be given information of significance so they can make their own decisions. In my view, his limited view of the information to be provided is inconsistent with the expectation in our medical system that patients have the right to make their own decisions based on all material information. In all of the circumstances of this case, it was important for Mr. Ali to have information as to significant risk factors so that he could make his own decisions as to additional tests that had been recommended to him.
- [104] I also have concern about Dr. Grafstein's explanation that there is a "code" used by radiologists, and that what was said in this case is not a coded message of something of significance. Nor do I accept Dr. Abu-Laban's explanation that this was just a case of a radiologist providing a more fulsome description of the heterogeneity of the area identified as pneumonia. The meaning of what the radiologist said is, in my view and, in the context of this case, clear from his use of the word "however". The language used is indicative of the radiologist identifying something that was of concern that potentially was above and beyond the pneumonia identified earlier in his report. This interpretation, in my view, reconciles precisely with Dr. Atkins' opinion. In my view, it flagged the possibility of a differential diagnosis more serious than the pneumonia that Mr. Ali was told he had.
- [105] I was also concerned about Dr. Grafstein expressing a view that Dr. Abu-Laban had gone above and beyond the usual standard by recommending a follow-up x-ray a few weeks after discharge from emergency. Dr. Abu-Laban, Dr. Yong, Dr. Atkins, and Dr. Gordon Cheung, a radiologist who practices in Ontario, all indicated that this was standard and expected practice.
- [106] I do not see this case as a matter of different clinical judgment. In my view, in order to properly respect the patient's right to the information needed to make a decision as to his own care, Mr. Ali should have been provided with the information identified by the radiologist. I accept the opinion of Dr. Atkins and conclude that Dr. Abu-Laban, in deciding not to follow up with either Mr. Ali or his family physician, did not meet the applicable standard of care.

Issue #2 - Causation

- [107] Some facts related to causation were not in dispute.

[108] In particular, it was common ground that had a carcinoid tumour been found in 2014, it would have been treated in the same manner (i.e., through surgical removal) as happened in 2018 when the tumour was discovered. It was also common ground that Mr. Ali's prognosis is good--there is no evidence that the cancer had spread or was not fully removed in 2018. These propositions arise from the expert report of Dr. Janessa Laskin, an oncologist, which I will discuss below, and which was not contested.

[109] Thus, there is no material difference between Mr. Ali's physical prognosis at the time of trial and what it would have been had a carcinoid tumour been discovered and surgically removed in 2014.

[110] I turn now to the positions of the parties on disputed causation questions.

Positions of the Parties

[111] Mr. Ali says that the "nodular-appearing 2.7 cm region" identified by the radiologist in 2014 is the carcinoid tumour that was removed in 2014. He relies on expert reports from Drs. Cheung and Mehta. Mr. Ali notes that there is no expert evidence challenging the conclusions of his two experts on this issue.

[112] Mr. Ali says that he suffered mental injuries that, but for Dr. Abu-Laban's negligence, he would not have suffered. He described an initial shock when he learned of the carcinoid tumour in 2018, but then went on to describe his reaction when he learned post-surgery in 2018 that the tumour had been present in 2014. He said that he was shattered to learn that the tumour had been growing inside him for at least four years, and that something could have been done about it in 2014. He said that he has lost all faith in the medical system and in doctors in particular. He said that he at times feels suicidal, that he had asked his wife to leave him (which she would not do), and that it was only his wife and his faith that have kept him going.

[113] Dr. Abu-Laban says that it has not been established that:

- a) even if Dr. Abu-Laban had contacted Mr. Ali in 2014, he would have obtained a repeat chest x-ray; and that
- b) even if Mr. Ali had obtained a repeat chest x-ray, that x-ray would have led to an earlier diagnosis of a carcinoid tumour.

[114] With respect to the first of these points, Dr. Abu-Laban acknowledges that Mr. Ali now says that he would have had the chest x-ray had he known there was a specific concern. However, Dr. Abu-Laban says that this evidence should not be accepted. Dr. Abu-Laban says that Mr. Ali had a long history of not making prudent choices involving following doctor's recommendations, including the fact that he engaged in smoking at all and also that he did not follow up on certain referrals made and treatments recommended by Dr. Brian Yong with respect to unrelated matters in 2013 and early 2014. Dr. Abu-Laban says that Mr. Ali's claims about what he would have done had Dr. Abu-Laban told him about the additional

comments in the radiologist's report are self-serving and unreliable, particularly in light of his past practices.

- [115] More generally, Dr. Abu-Laban attacks the credibility and reliability of Mr. Ali's evidence, arguing that on some points his evidence was different at trial than on examination for discovery, and that his evidence at times differs from the medical records. Dr. Abu-Laban relies on its cross-examination of Mr. Ali with respect to his various job applications, in which Mr. Ali acknowledged that he inaccurately reported the timing of some of his previous work and at times omitted work that he had done. Dr. Abu-Laban also notes that Mr. Ali acknowledged having been paid in cash at some of the more casual jobs he had early in his career, which Dr. Abu-Laban says impacts on his credibility.
- [116] With respect to whether a repeat x-ray in 2014 would have led to diagnosis of the carcinoid tumour, Dr. Abu-Laban says that the expert evidence does not establish that a carcinoid tumour was present in 2014 to be discovered. With respect to the plaintiff's expert reports from Drs. Cheung and Mehta, which I will discuss below, Dr. Abu-Laban says that:
- a) Dr. Cheung's conclusions are based on inferences drawn from the location of the tumour and the slow-growing nature of carcinoid tumours, but he has no specific qualification in oncology and his conclusions should be dismissed as speculative; and
 - b) Dr. Mehta's report is based on a mistaken interpretation of Dr. Cheung's report.
- [117] Dr. Abu-Laban further says that Mr. Ali's treatment and prognosis are no different than they would have been had a carcinoid tumour been discovered in 2014, and that the alleged mental injuries are not established on the evidence to have arisen from any delay in diagnosis (as opposed to arising from the cancer diagnosis itself) or, at best for Mr. Ali, should be considered "mere upset" and not sufficient to ground a legal claim.
- [118] Dr. Abu-Laban says that there is no expert evidence either confirming Mr. Ali's alleged psychological symptoms or connecting those symptoms to any delay in diagnosis. Dr. Abu-Laban acknowledges that expert evidence on this question is not, strictly speaking, required, but says that much of the evidence about times of upset focuses on the time that Mr. Ali initially learned of the cancer diagnosis. Dr. Abu-Laban notes that Mr. Ali never sought medical or psychological treatment for depression.
- [119] Dr. Abu-Laban also argues that Mr. Ali was contributorily negligent, given that he:
- a) Gave the name of Dr. Chan instead of Dr. Yong as his family doctor when he was admitted to hospital, and subsequently failed to notify the hospital that Dr. Chan had retired and that he would be seeing Dr. Brian Yong;
 - b) Failed to have the follow-up chest x-ray that was recommended not only by Dr. Abu-Laban but also by Dr. Brian Yong in the follow-up visit;

- c) Continued to smoke notwithstanding his appreciation that smoking was bad for his health, could cause lung cancer, and was likely connected to the coughing issues that led him to the emergency room on March 31, 2014.

[120] The parties' submissions give rise to four different questions that fit broadly under the rubric of causation:

- a) Whether a follow-up call from Dr. Abu-Laban would have made any difference with respect to Mr. Ali obtaining a repeat chest x-ray;
- b) Whether a repeat chest x-ray in 2014 would have led to an earlier diagnosis of Mr. Ali's carcinoid tumour;
- c) Whether the delayed diagnosis led to any injury to Mr. Ali; and
- d) Whether Mr. Ali's own negligence contributed to the delayed diagnosis.

Relevant Facts

[121] These issues require a more detailed consideration of Mr. Ali's background, as well as medical evidence with respect to the cancer he was ultimately diagnosed with.

[122] Mr. Ali grew up in Vancouver. He had an active, happy childhood, with activities including cycling, basketball, swimming, walking, and playing tennis. He began to smoke at around 14 years of age, and despite knowing it was bad for him and carried various risks including cancer, he continued to smoke until the day of his 2018 surgery. He was not particularly academically inclined, and left high school after Grade 11. He worked in a number of positions that were casual and included work as a labourer and as a dispatcher for a security firm. He met his wife shortly before his 21st birthday, and they married in late 2007--shortly before his 23rd birthday.

[123] In 2012, Mr. Ali obtained a Health Care Assistant diploma from Vancouver Community College. His evidence was that, at that time, he had hoped to get into nursing in the future, and thought that this diploma might be a step toward obtaining a licensed practical nurse designation. He acknowledged that he would have had to upgrade his high school credentials before moving forward.

[124] After completing this diploma, Mr. Ali began working in positions involving the care of individuals with mental, physical, or intellectual disabilities. He initially worked in a group home, then found positions providing care to private clients in 2012 and 2013.

Other Medical Matters in 2013 to 2014

[125] The evidence at trial canvassed two medical matters that were unrelated to Mr. Ali's lungs, but which were brought into evidence by Dr. Abu-Laban who seeks to have the court draw inferences as to what Mr. Ali would have done had there been follow-up from Dr. Abu-Laban.

- [126] The first relates to a planter's wart. Dr. Yong's medical charts indicated that Mr. Ali saw him for treatment of a planter's wart in February, March, May, and June 2013, and that in June 2013, Dr. Yong referred Mr. Ali to the VGH Skin Centre for "planter wart resistant to cryotherapy". Mr. Ali had a vague recollection of having Dr. Yong put freezing on a planter's wart, but did not recall being referred to the VGH Skin Centre.
- [127] There were handwritten notes on a document in Dr. Yong's file suggesting that someone in his office was advised by someone that Mr. Ali was a no-show for an appointment in September 2013. Dr. Yong said the notes were not his. Mr. Ali did not recall this.
- [128] Dr. Yong's file indicates that Mr. Ali saw Dr. Yong again in January 2014 with respect to problems with a planter's wart, and was referred again to the VGH Skin Centre. Once again, there was a handwritten note suggesting that someone in Dr. Yong's office was advised by someone that Mr. Ali was a no-show for an appointment in April 2014. The notes were not identified. Mr. Ali did not recall this.
- [129] The other records referenced in cross-examination relate to fertility issues. Mr. Ali agreed that in about late 2013, he and his wife had been referred to a fertility clinic for a work-up, where he saw a Dr. Anthony Cheung. Mr. Ali's evidence was that Dr. A. Cheung wanted him and his wife to do group counselling of some sort, but that he and his wife discussed and decided not to proceed. He said that they decided together that, if they were going to have children, it would happen, and that if it did not happen they were okay with that, but that they did not want to sit amongst other people that were having similar issues and have a group discussion.
- [130] Mr. Ali's wife said in her evidence that it was her idea that they not go for genetic counselling.
- [131] There was also an indication in Dr. Yong's records that Dr. A. Cheung believed that Mr. Ali had a particular genetic syndrome. Mr. Ali did not recall there being an actual diagnosis of this, and said that when he researched the syndrome, he found various characteristics associated with it that he definitely did not have and were not present within his family.

Cancer Diagnosis and Thereafter

- [132] As noted above, in about June 2018, Mr. Ali had his wisdom teeth removed and was sedated for that purpose. Afterward, he had hiccups for several days and, as a result, went to the emergency room at Mount Saint Joseph hospital. A chest x-ray taken on June 21, 2018 led to a recommendation for a CT scan, with the radiologist commenting:

There is a subtle opacity with partial convex borders in the left lung base, localizing to the inferior hilar window on the lateral view. Although this finding could represent scarring at the site of previous infection, an underlying parenchymal lesion remains to be excluded.

- [133] A CT scan on June 22, 2018 showed "a 4.1 x 3.0 x 3.0 cm smoothly circumscribed, oval left infrahilar mass which is heterogeneous in density, with both intermediate and low-density soft tissue components as well a 1.2 x 1.0 cm focus of coarse calcification inferiority", which was interpreted as most likely a carcinoid tumour.
- [134] Mr. Ali described receiving the news of this diagnosis by telephone at a family dinner, with his wife, his mother, and various other family members present. He recalled being told that carcinoid tumours were usually very slow growing, and that in order to get rid of it, he would have a significant amount of his lung cut out. Mr. Ali initially told his family members that the phone call was not significant, but when they insisted on knowing what was happening, he told them. The evidence from several of those present was that "everyone started crying" and it was a very sad moment.
- [135] Mr. Ali's brother-in-law, who was visiting for several months, described how Mr. Ali's behaviour changed after his diagnosis, and that he would get upset for no reason and put everything on himself.
- [136] Mr. Ali said that he initially understood that the surgery would likely be in October or November, but that about a week after the first call, he got a second call where he was told there was a risk of the tumour blocking his airway and so they would do the surgery more urgently. He said he asked about chemotherapy and was told that given the surgery was coming up quickly, they were not considering chemotherapy.
- [137] Mr. Ali said that his family began hiding his cigarettes from him, and that he was down to one or two cigarettes a day. He said that he had tried many times over the years to quit cigarettes, but found that it was "just so difficult" to do. He said he had his last cigarette just a short time before his surgery on August 22, 2018, and that he has not smoked since the surgery.
- [138] At some point in about September 2018, Mr. Ali had a follow-up appointment with the surgeon. He said that the surgeon told him that in his file was an x-ray and radiology report from 2014 that found something on his chest. He said:

God, I felt terrible. People say we have the best health care system in the world. And here I am in 2014, I go for pneumonia and they say oh, you know, that's all you have, you just have pneumonia, and take this medication, and if it goes away great, you know. And it goes away and yet somebody knows that I have cancer and I have a tumour and they don't tell me? It broke me. It really did. My trust in the health care system shattered, you know. Here I am, I want to be a nurse, I want to help other people, but my own team, I guess I would say that they were my own people, are not helping me. It's like they left me to die, you know.

Well, I went from being a person who easily trusted my superiors or people that were in a higher position than me in life to being someone who no longer can trust a system.

[139] He expressed concern that, if his hiccups had not led to the chest x-ray, then he could have died and nobody would have known about the tumour--given that in his religion, autopsies are not done. He expressed concern that his mother would have lost a son and his wife would have lost a husband, and described impacts on his social life:

I stopped talking to a lot of people, a lot of my friends. I stopped talking to my friends. I don't know who to tell, what to tell, how to tell, you know. I've gone through this trauma now. A lot of the folks I was talking to before my surgery I've given up on them. I think my one true friend that I have from childhood, his name's Richard, he's the only person that stuck with me until now. Even my uncle who I spend a lot of time, with my dad's youngest brother, I just don't want anybody in my life. It's hard. It's hard to express that because that wasn't me before. And I felt like a butterfly before if that's the right way to put it. I felt like a butterfly. Now I just feel like I'm a cocoon.

[140] When asked why he no longer wants to speak with people, he explained:

I'm not comfortable. I'm just not comfortable. I feel like I've -- the surgery has changed me. I'm stressed out. I've got some anxiety. I'm depressed all the time. I'm getting mad at people for no reason. I don't want to have people close to me and be getting angry with them. It's better just to keep them away.

[]

I told [my wife] to leave me because she's a young, beautiful woman and I think she could have found somebody good for herself and lived a good life. She decided to stay which is great. I'm very grateful by God that she stayed. I get mad at her for no reason. I'm a negative person now compared before *

Before, I made everybody laugh.

[141] Mr. Ali's wife also described ways in which he had changed. She described him as always being emotional, and ruminating over concerns that if he had not had the hiccups, his cancer might never have been found and he might have died. She said he does not like to share his feelings, gets upset easily, and does not want to go out and do anything. She said that she signed them up for a gym, but that Mr. Ali never wants to go. She said that he has shut out his friends, and that they no longer have people over to their house. She says that he occasionally expresses suicidal thoughts, which worries her greatly, and tries to push away those closest to him. She says that she tries to make Mr. Ali realize that they need to live their lives, but he continues to be always sad.

[142] Mr. Ali was on short-term disability prior to his surgery, which moved into long-term disability in late 2018. He said that he made inquiries about starting his way back to work in December 2018. His doctor initially discouraged it, but then agreed to recommend it provided that he could be given "light duties", which would include avoidance of any heavier physical work. Unfortunately, his employer was unable to accommodate him with light duties--Mr. Ali said he was told that the company had several employees already on

light duties, and could not handle any more. He ended up remaining on long-term disability until his benefits ran out in November 2021.

Expert Evidence

[143] Three expert witnesses gave evidence with respect to causation issues--two called by Mr. Ali, and one called by Dr. Abu-Laban.

Dr. Janessa Laskin

[144] Dr. Janessa Laskin is a medical oncologist who focuses on thoracic oncology. She conducted a records review at the request of counsel for Dr. Abu-Laban, and issued a report dated May 3, 2022.

[145] Dr. Laskin provided some helpful information with respect to the nature of Mr. Ali's cancer. She explained that "carcinoid" is a term generally applied to well-differentiated neuroendocrine tumours, generally operating in the digestive tract, lungs, or other less common sites. Carcinoids in the lung are relatively rare, representing 1 to 2% of all lung cancers, and behave differently than other, more common forms of lung cancer.

[146] Dr. Laskin also explained the differences between typical and atypical carcinoids. Typical carcinoids (the type Mr. Ali had) tend to grow more slowly and have a better overall prognosis than atypical carcinoids. The cause of lung carcinoids is still unclear, and the majority of typical lung carcinoids develop in patients who are never or current light smokers.

[147] Dr. Laskin further explained that surgical removal is the treatment of choice for lung carcinoids, with surgical removal to include an adequate margin of negative tissue around the cancer. However, for surgical approaches to succeed, the patient must have adequate pre-operative lung function to tolerate this procedure. Mr. Ali's pre-operative lung function was approximately 70% of normal, but that was sufficient for the surgery.

[148] Dr. Laskin noted the difference between the size of the tumour on the 2018 imaging and in the post-operative pathology report. This arose in a discussion of what "stage" the carcinoid was at when removed. She commented that it is "generally felt that surgical staging is more accurate than clinical staging for predicting outcome such as survival".

[149] Dr. Laskin was asked whether the treatment and prognosis would have been any different if the opacity identified on the March 2014 had been the same tumour. She explained that:

In 2014, if the reported "nodular-appearing 2.7 cm" region in the left lung was a carcinoid, then the treatment with surgery would have been the same because this is the standard approach for any carcinoid that is potentially surgically resectable.

A 2.7 nodule on CXR does not mean that the cancer itself measures 2.7 cm; however, even if it did measure 2.7 cm this would only slightly alter the stage to 1A (with a T1c cancer being >2 but <3 cm). If this were the case, technically the stage would have been slightly different but the

treatment and expected survival would have been the same. In the available literature with the reported survival rates at 5, 10 and 15 years there is no difference between these two stages of cancer. Therefore, I would not expect the treatment or excellent chance of long-term survival to be any different.

[150] On cross-examination, she was asked about the term "slightly different". She explained that her quoted comment should have referenced T1a (rather than T1c), and that the change in the tumour's size from 2014 to 2018 (if there was a tumour there in 2014) would have represented a change from stage 1a to stage 1b.

Dr. Gordon Cheung

[151] Dr. Gordon Cheung is a radiologist who practices in Ontario. He has subspecialties in neuroradiology and Medical Resonance Imaging. He prepared a Medicolegal File Review report on March 15, 2023 at the request of counsel for the plaintiff. His report reviewed the two chest x-rays of Mr. Ali (one from March 31, 2014 and one from June 21, 2018) and the CT thorax study and report done on June 22, 2018.

[152] Dr. Cheung noted in his report, and confirmed on cross-examination, that he reviewed the diagnostic imaging before reviewing any medical records. The notes referenced in the next three paragraphs reflect his comments from that initial review.

[153] With respect to the March 2014 chest x-ray, Dr. Cheung noted the area of general opacity reflecting consolidation from acute pneumonitis, then went on to say that:

In addition, the superior margin of the lesion shows a circumscribed convex margin measuring 2.7 cm, raising the possibility of an underlying mass lesion. A repeat chest x-ray in a few weeks is required after treatment. If there are any residual opacities, a followup CT chest can should be obtained.

[154] With respect to the 2018 chest x-ray, he commented that a "followup CT chest study is recommended" for evaluation of "two distinct lesions" that he identified and "to exclude underlying malignancy". He noted as well that the lesion identified above from 2014 "corresponds in configuration and location to the ovoid partially circumscribed infrahilar opacity seen on June 21, 2018, now increased in size".

[155] With respect to the 2018 CT imaging, he noted (in part):

[] an enhancing circumscribed solid left infrahilar ovoid mass measuring 4.1 x 3 cm. The lesion also shows small areas of non enhancement and an inferior calcification measuring 1.2 x 1.0 cm. There appears to be an endobronchial or partially endobronchial component. The mass is causing distortion and obstruction of the basal segmental bronchi, just distal to the left inferior lobar bronchus.

This mass corresponds to the ovoid partially circumscribed infrahilar opacity seen on the June 21, 2018, lateral chest x-ray. Retrospectively, this left infrahilar lesion was also seen on the initial chest x-ray, but smaller in size.

[156] In the section of his report titled "Discussion", Dr. Cheung commented that:

[] a retrospective review of the initial lateral chest x-ray from March 31, 2014 showed a partially circumscribed infrahilar opacity measuring approximately 2.9 x 2.1 cm. This lesion corresponds in configuration and location, albeit smaller, to the left infrahilar carcinoid tumour seen on the June 21, 2018 chest x-ray, approximately 4 x 2.7 cm in dimension. The tumour is confirmed by the chest CT study dated June 22, 2018.

[157] On cross-examination, Dr. Cheung confirmed that by using the term "retrospective review", he meant looking back to the 2014 imaging in light of what was shown in the 2018 imaging. He confirmed that, at the time of the initial chest x-ray in March 2014, there were a number of potential causes for the features that he noted.

[158] Dr. Cheung concluded that the carcinoid tumour identified in the lungs in 2018 was, more likely than not, present in March 2014, and explained as follows:

The diagnosis was a left infrahilar region 3.5 cm typical carcinoid tumour, which is a low grade malignant tumour that is slow growing.

A retrospective review of the March 31, 2014 lateral chest x-ray demonstrates a left infrahilar region opacity measuring 2.9 x 2.1 cm corresponding in location and configuration, albeit smaller, to the subsequently diagnosed carcinoid tumour.

[159] He also concluded that the tumour would, more likely than not, have been identified in 2014 had a CT scan had been done after March 31, 2014, explaining that:

- a) An infrahilar opacity measuring 2.9 x 2.1 cm is retrospectively identified on the March 31, 2014 lateral chest x-ray.
- b) This opacity is in the same location and has the same ovoid configuration, albeit smaller, than in 2018
- c) It is reasonable to assume that a slow-growing carcinoid tumour would be radiographically visible in 2014.
- d) Mr. Ali's pneumonia may be secondary to the carcinoid tumour, which is a common presentation of this endobronchial tumour.

[160] On cross-examination, Dr. Cheung confirmed that he is not an oncologist.

[161] Dr. Cheung was also asked about differences between the size of the tumour as shown on the 2018 imaging and as physically measured after its removal. He explained that it is not unusual that a tumour constrained by the body materials around it will change in size after its removal.

Dr. Varun Mehta

[162] Dr. Varun Mehta is a medical doctor with a specialty in internal medicine, who conducted a document review in July 2024 at the request of counsel for the plaintiff and issued a report dated August 28, 2024. Dr. Mehta has a subspecialty in addictions medicine. He agreed on cross-examination that oncology is a separate sub-specialty of internal medicine, and that he is not an oncologist. He also confirmed that he was provided and had reviewed Dr. Cheung's report.

[163] Dr. Mehta concluded that:

It is likely that the patient had a 2.7 cm carcinoid tumour in March 2014, as suggested by the X-ray performed at that time. However, without CT imaging, the exact size and location of the tumour cannot be confirmed.

Legal Context - The "But For" Test

[164] The legal test for causation was summarized in *Clements v. Clements*, 2012 SCC 32 at paras. 8-9:

[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.

[9] The "but for" causation test must be applied in a robust common sense fashion. There is no need for scientific evidence of the precise contribution the defendant's negligence made to the injury. []

[Citations omitted.]

[165] Causation need not be determined by scientific precision; it is essentially a practical question of fact which can best be answered by ordinary common sense: *Athey v. Leonati*, [1996] 3 S.C.R. 458, 1996 CanLII 183 at para. 16.

[166] The but for test does not require the plaintiff to establish that the defendant's negligence was the sole cause of the injury. There will frequently be a myriad of other background events which were necessary preconditions to the injury occurring: *Athey* at para. 17. As stated in *Blackwater v. Plint*, 2005 SCC 58 at para. 78:

Even though there may be several tortious and non-tortious causes of injury, so long as the defendant's act is a cause of the plaintiff's damage, the defendant is fully liable for that damage. The rules of damages then consider what the original position of the plaintiff would have been. The governing principle is that the defendant need not put the plaintiff in a better position than his original position and should not compensate the plaintiff for any damages he would have suffered anyway: *Athey*.

[167] As noted in *Athey* at para. 27:

[27] Hypothetical events (such as how the plaintiff's life would have proceeded without the tortious injury) or future events need not be proven on a balance of probabilities. Instead, they are simply given weight according to their relative likelihood [] A future or hypothetical possibility will be taken into consideration as long as it is a real and substantial possibility and not mere speculation.

[Citations omitted.]

[168] These principles were applied in the context of an alleged error of omission by a physician in *Sacks v. Ross*, 2017 ONCA 773 at paras. 46-48:

[46] Things are more complicated where the complaint is not about something the defendant did, but about something the defendant failed to do in breach of the standard of care. When what is in issue is not the defendant's act, but an omission, the trier of fact is required to attend to the fact situation as it existed in reality the moment before the defendant's breach of the standard of care, and then to imagine that the defendant took the action the standard of care obliged her to take, in order to determine whether her doing so would have prevented or reduced the injury. Even though this exercise is bounded significantly by the actual facts, it counts as "factual" because the task is to consider how the events would actually have unfolded had the defendant taken the action she was obliged to take.

[47] Regardless of whether the defendant's breach of the standard of care is an act or an omission, the trier of fact's cognitive process in determining causation has three basic steps. The first is to determine what likely happened in actuality. The second is to consider what would likely have happened had the defendant not breached the standard of care. The third step is to allocate fault among the negligent defendants.

[48] There are two possible outcomes to the trier of fact's imaginative reconstruction of reality at the second step. On the one hand, if the trier of fact draws the inference from the evidence that the plaintiff would likely have been injured in any event, regardless of what the defendant did or failed to do in breach of the standard of care, then the defendant did not cause the injury. On the other hand, if the trier of fact infers from the evidence that the plaintiff would not likely have been injured without the defendant's act or failure to act, then the "but for" test for causation is satisfied: but for the defendant's act or omission, the plaintiff would not have been injured. The defendant's fault, which justifies liability, has been established.

Legal Context - Mental Injury

- [169] In *Saadati v. Moorehead*, 2017 SCC 28, the Supreme Court of Canada rejected the notion that any claim for mental injury must be supported by diagnosis by an expert of a recognized psychiatric interest. As summarized by Justice Brown at paras. 36-37:
- [36] It follows that requiring claimants who allege one form of personal injury (mental) to prove that their condition meets the threshold of "recognizable psychiatric illness", while not imposing a corresponding requirement upon claimants alleging another form of personal injury (physical) to show that their condition carries a certain classificatory label, is inconsistent with prior statements of this Court, among others. It accords unequal -- that is, less -- protection to victims of mental injury. And it does so for no principled reason (Beever, at p. 410). I would not endorse it.
- [37] None of this is to suggest that mental injury is always as readily demonstrable as physical injury. While allegations of injury to muscular tissue may sometimes pose challenges to triers of fact, many physical conditions such as lacerations and broken bones are objectively verifiable. Mental injury, however, will often not be as readily apparent. Further, and as *Mustapha* makes clear, mental injury is not proven by the existence of mere psychological upset. While, therefore, tort law protects persons from negligent interference with their mental health, there is no legally cognizable right to happiness. Claimants must, therefore, show much more -- that the disturbance suffered by the claimant is "serious and prolonged and rise[s] above the ordinary annoyances, anxieties and fears" that come with living in civil society (*Mustapha [v. Culligan of Canada Ltd.]*, 2008 SCC 27] at para. 9). To be clear, this does not denote distinct legal treatment of mental injury relative to physical injury; rather, it goes to the prior legal question of what constitutes "mental injury". Ultimately, the claimant's task in establishing a mental injury is to show the requisite degree of disturbance (although not, as the respondents say, to show its classification as a recognized psychiatric illness).
- [38] Nor should any of this be taken as suggesting that expert evidence cannot assist in determining whether or not a mental injury has been shown. In assessing whether the claimant has succeeded, it will often be important to consider, for example, how seriously the claimant's cognitive functions and participation in daily activities were impaired, the length of such impairment and the nature and effect of any treatment (*Mulheron*, at p. 109). To the extent that claimants do not adduce relevant expert evidence to assist triers of fact in applying these and any other relevant considerations, they run a risk of being found to have fallen short. As Thomas J. observed in *van Soest [v. Residual Health Management Unit]*, [1999] NSCA 206] (at para. 103), "[c]ourts can be informed by the expert opinion of modern medical knowledge", "without needing to address the question whether the mental suffering is a recognisable psychiatric illness or not". To be clear, however: while relevant expert evidence will often be helpful in determining whether the claimant has proven a mental injury, it is not required as a matter of law. Where a psychiatric diagnosis is unavailable, it remains open to a trier of fact to find on other evidence adduced by the claimant that he or she has proven on a balance of probabilities the occurrence of mental injury. And, of

course, it also remains open to the defendant, in rebutting a claim, to call expert evidence establishing that the accident cannot have caused any mental injury, or at least any mental injury known to psychiatry. While, for the reasons I have given, the lack of a diagnosis cannot on its own be dispositive, it is something that the trier of fact can choose to weigh against evidence supporting the existence of a mental injury.

- [170] As noted above, Dr. Abu-Laban submits that in order to found a claim for psychological injury, the evidence must support something more than mere upset. He cites *Bothwell v. London Health Sciences Centre*, 2023 ONCA 323 at paras. 22-23 and 30-33:
- [22] Justice Brown soundly rejected the notion that, to prove mental injury, the claimant must prove that their condition meets the threshold of a recognizable psychiatric illness: Saadati, at paras. 29-36. Rather, he explained, recovery for mental injury in negligence depends on the claimant satisfying the ordinary duty of care analysis, which is whether: the defendant owed the claimant a duty of care to avoid the kind of loss alleged; the defendant breached that duty by failing to observe the applicable standard of care; the claimant sustained damage; and that damage was caused, in fact and in law, by the defendant's breach: at para. 13.
- [23] At para. 37 of Saadati, Brown J. set out the following propositions relating to what constitutes a compensable mental injury. Citing *Mustapha v. Culligan of Canada Ltd.*, 2008 SCC 27, [2008] 2 S.C.R. 114, he stated that "mental injury is not proven by the existence of mere psychological upset" (emphasis in original). Relying again on *Mustapha*, he said claimants must show that the disturbance suffered is "serious and prolonged and rises above the ordinary annoyances, anxieties and fears that come with living in civil society". He concluded by stating that "the claimant's task in establishing a mental injury is to show the requisite degree of disturbance".
- []
- [30] As noted above, Brown J. makes it clear at para. 37 of Saadati that a mental injury is not proven by the existence of mere psychological upset. Claimants must show that the disturbance they suffered is serious and prolonged and rises above the ordinary annoyances, anxieties, and fears that come with living in civil society. He concludes para. 37 by observing that the claimant's ultimate task is "to show the requisite degree of disturbance".
- [31] In para. 38, Brown J. describes how claimants are to show that requisite level of disturbance. He explains that in assessing whether the claimant has succeeded in showing a mental injury, it will often be important for the trier of fact to consider "how seriously the claimant's cognitive functions and participation in daily activities were impaired, the length of such impairment and the nature and effect of any treatment" (the "Saadati factors"). Later in para. 38, Brown J. describes the Saadati factors as "relevant considerations" for the trier of fact.

- [32] In my view, paras. 37 and 38 together are a clear direction that, in distinguishing mental injury from psychological upset, the trier of fact must consider not only the claimant's psychological upset but also how seriously the claimant's cognitive functions and participation in daily activities were impaired, the length of such impairment, and the nature and effect of any treatment sought and taken in relation to the psychological upset.
- [33] In short, Saadati instructs that it is insufficient for the trier of fact to find evidence of psychological upset, such as feelings of anger and frustration: the inquiry must include a consideration of the level of impairment that the claimant's particular feelings represent.
- [171] Dr. Abu-Laban also notes the case of *Levy v. Rubinstein*, 2022 ONSC 4547 at paras. 295-299, where Justice Sanfilippo concluded at paras. 295-299 that in that case (citing from para. 298):
- [] the evidence that established the psychological harm associated with the disease progression and resulting treatment is not, in my assessment, substantively different, or independent or distinguishable from the evidence that is said to support a claim for psychological harm due to delay in diagnosis.
- [172] Dr. Abu-Laban argues that much the same can be said in this case--that the anguish flowing from a cancer diagnosis is indistinguishable from the anguish arising from the fact that the diagnosis was delayed by four years.

Analysis - Causation Generally

- [173] I will deal first with questions of reliability and credibility, which are related but distinct concepts. As explained in *R. v. Morrissey*, 1995 CanLII 3498, 22 O.R. (3d) 514 (C.A.) at para. 35, cited in *United States v. Bennett*, 2014 BCCA 145 at para. 23:

Testimonial evidence can raise veracity and accuracy concerns. The former relate to the witness's sincerity, that is, his or her willingness to speak the truth as the witness believes it to be. The latter concerns relate to the actual accuracy of the witness's testimony. The accuracy of a witness's testimony involves considerations of the witness's ability to accurately observe, recall and recount the events in issue. When one is concerned with a witness's veracity, one speaks of the witness's credibility. When one is concerned with the accuracy of a witness's testimony, one speaks of the reliability of that testimony. Obviously a witness whose evidence on a point is not credible cannot give reliable evidence on that point. The evidence of a credible, that is, honest witness, may, however, still be unreliable.

- [174] In my view, in this case, many of the important questions fall to be decided on the basis of expert evidence. That said, there are some issues where consideration of the reliability of Mr. Ali's evidence is necessary. With respect to that, it is clear that Mr. Ali's evidence--particularly in relation to the events of 2014--is not particularly reliable. This is not surprising, as most witnesses would struggle to remember details of events over ten years in the past. Mr. Ali was not a reliable historian with respect to many of the details from 2014 and earlier, and his counsel did not argue that his evidence should be preferred where there

was clear and reliable evidence in the contemporaneous clinical records.

- [175] Apart from the time that has passed since the events in question, I see the circumstances surrounding the events as important. Mr. Ali was clearly in sufficient distress on the morning of March 31, 2014 that he had been taken to the emergency room by ambulance. It appears that he was seen by Dr. Abu-Laban fairly quickly, taken to the radiology department for an x-ray, and then seen again by Dr. Abu-Laban in quick succession, all while continuing to cope with the respiratory issues that had brought him to the emergency room. He was given a verbal report and verbal instructions, with no written follow-up other than a prescription, and no healthy family member present with him to assist with his comprehension and absorption of the information being communicated. In circumstances like these, some lack of clarity of recollection would typically be understandable even without the lengthy passage of time present in this case.
- [176] Much the same could be said about Mr. Ali's evidence about what he was told about the possibility of chemotherapy in 2018. Mr. Ali's evidence is that many of the key initial discussions he had with doctors in 2018 about his diagnosis were over the telephone. He understood that chemotherapy was not an option because surgery had to occur very quickly as the result of a risk that the tumour would block his airway, while the expert evidence is that surgical removal is the preferred response to a carcinoid tumour in the lung subject to concerns about the patient's remaining lung capacity. While there is clearly a distinction between these two rationales, the important message to someone in Mr. Ali's position is that chemotherapy was not recommended in the circumstances. Again, I do not see this as impacting on credibility as opposed to reliability.
- [177] For much the same reasoning, it was my view that the inconsistencies put to Mr. Ali as between his evidence on discovery and at trial reflect more on his reliability than his credibility.
- [178] The most concerning evidence with respect to credibility was what Mr. Ali said about inaccuracies on some of his job applications.
- [179] Overall, I approach Mr. Ali's evidence with some degree of caution, and consider carefully the extent to which it is supported by the evidence of other witnesses.
- [180] In the circumstances of this case, a key question with respect to causation is what Mr. Ali would have done if there had been follow-up from Dr. Abu-Laban to advise him of the results of the radiologist's report and, in particular, the presence of the "nodular-appearing region" of unknown cause. While Mr. Ali's evidence on this hypothetical issue is an important part of considering this issue, it is in no way determinative. Most people in Mr. Ali's situation, if asked after all was known, would honestly believe they would have been concerned about the prospect of this unexplained shape in their lung and ensured they did the follow-up x-ray. The task of the court in a case like this is to consider what would likely have happened given the available objective information, recognizing that hindsight is always 20/20.

- [181] I do not see the fact that Mr. Ali is a smoker as indicating that he is less likely to have reacted to a follow-up contact by Dr. Abu-Laban. Dr. Abu-Laban submits that this indicates a lack of care on the part of Mr. Ali about his own personal health, and that I should draw from that an inference that he still would not have had the follow-up chest x-ray. In my view, that approach fails to recognize the addictive nature of smoking. Mr. Ali presented as someone who tried to quit smoking numerous times prior to 2018 without success. In my view, it is equally consistent that someone who recognizes health hazards from smoking but struggles to quit would be extra sensitive to any information indicating an unknown condition in their lungs.
- [182] The evidence as to the planter's wart treatment was quite unsatisfactory--consisting primarily of hearsay notes from unidentified persons. While otherwise admissible evidence contained in clinical records may be admissible, the fact that a hearsay statement is recorded in a clinical note does not make it admissible. As well, Mr. Ali had no recollection of the circumstances of the wart treatment and what may or may not have led him not to follow up. And the nature of the genetic counselling that Mr. Ali and his wife did not participate in is such I would not draw any inference.
- [183] My assessment of the evidence overall is that Mr. Ali sought out medical treatment when he understood it to be important to do so. In my view, had Dr. Abu-Laban decided that the additional information identified in the radiologist's report needed to be communicated to Mr. Ali, he would have explained it in a plain language manner that emphasized that the shape identified by the radiologist might just be a manifestation of the pneumonia, but that it could also be attributable to some other unknown cause, which cause might or might not be serious, and that could only be determined by a follow-up x-ray after the pneumonia had cleared up. To the extent that Mr. Ali's understanding, after his visit to the emergency room, was that he only needed the follow-up x-ray if the pneumonia did not clear up, such a message delivered in more normal circumstances than what he was facing the morning of March 31, 2014 would have clearly dispelled that notion. It is my view that it is significantly more likely than not that any patient faced with information about such an unknown feature on the x-ray would have been motivated to ensure they had the follow-up x-ray.
- [184] I therefore accept Mr. Ali's evidence that, if there had been follow-up from Dr. Abu-Laban, he would have had a second chest x-ray in 2014.
- [185] The second causation issue identified by the parties' submissions is whether a repeat chest x-ray in 2014 would have led to an earlier diagnosis of Mr. Ali's carcinoid tumour.
- [186] The opinion of Dr. G. Cheung on this point was supported by the opinion of Dr. Mehta and was not contradicted by any defence expert. His opinion is based on the correspondence of location, configuration, and size--given the nature and growth pattern of a typical carcinoid tumour. I do not see these opinions as being outside of the scope of either of their expertise. I appreciate that neither one of these doctors has specialized training in oncology. While that might have been a factor to weigh if there was a different opinion

advanced by an oncologist, there was no competing opinion. Importantly, their comments about the nature and growth pattern of carcinoid tumours were the essentially the same as those of Dr. Laskin, who is an oncologist.

- [187] The third causation issue identified is whether Mr. Ali has established mental injuries arising from Dr. Abu-Laban's breach of the standard of care, with such mental injuries going beyond "mere upset".
- [188] With respect to this, Dr. Abu-Laban suggested that an adverse inference should be drawn from Mr. Ali's failure to call the surgeon who initially advised Mr. Ali about what was shown on the earlier x-ray report. It is not clear to me what useful and admissible information that surgeon would have had for the court. Mr. Ali has obtained reports from independent experts with no prior involvement in Mr. Ali's treatment who have provided opinion evidence as to the connection between the 2014 x-ray and Mr. Ali's carcinoid tumour. The surgeon's only other relevant evidence might have been his observation of Mr. Ali's reaction when first told about the earlier x-ray, but it is not clear to me that the initial reaction would necessarily be all that telling with respect to the impact that information had on Mr. Ali.
- [189] I have reviewed carefully Mr. Ali's evidence with respect to the impact on him of both the cancer diagnosis itself and what he subsequently learned about what was shown on the 2014 x-ray report. Distinguishing between them is not any easy matter, but is necessary as Mr. Ali would have been impacted by a cancer diagnosis regardless of when it occurred (in 2014 or in 2018). Given that his long-term prognosis is more or less the same as it would have been had a carcinoid tumour been diagnosed in 2014, the only injury for which he is to be compensated is the additional injury arising from the diagnosis not having been made in 2014.
- [190] Ultimately, I conclude that there was mental injury to Mr. Ali that goes beyond mere upset. I accept Mr. Ali's evidence that he feels betrayed by the health care system and is no longer considering that as a career goal, that his feelings of betrayal impact his ability to interact with others, and that he has experienced suicidal feelings that are more than fleeting. I accept that the symptoms of low mood he describes are more intense than they would have been had he been diagnosed in 2014. In my view, his evidence with respect to his post-2018 condition establishes mental injury attributable to Dr. Abu-Laban's breach of the standard of care that (to use the language of the cases) goes beyond mere upset.

Legal Context - Contributory Negligence and Apportionment

- [191] The applicable law, as summarized in Picard & Robertson, *Legal Liability of Doctors in Hospitals in Canada*, 4th ed. (Toronto: Thomson Carswell, 2007) at 368, was cited with approval in *Kahlon (Litigation Guardian of) v. Vancouver Coastal Healthy Authority*, 2009 BCSC 922 at para. 223:

Patients have certain duties and responsibilities when seeking medical treatment, including a duty to provide information, to follow instructions, and generally to act in their own best interests. In carrying out these duties they are expected to meet the standard of care of a reasonable patient. If they do not, and the breach of this standard is the factual and proximate cause of their injuries, they are contributorily negligent and their compensation will be reduced accordingly. Of course, if the injury is due exclusively to the patient's own negligence, the action will be dismissed. [Footnotes omitted.]

[192] The burden of proof is on the defendant on the issue of contributory negligence: Kahlon at para. 226.

[193] Mr. Kahlon had failed to schedule a follow-up CT scan recommended by his doctor. Justice J. Sigurdson noted at para. 245 that:

[245] The authorities recognize that a patient's failure to attend a follow-up appointment when he or she knows the importance of keeping the appointment will result in liability on the part of the patient []

[Citations omitted.]

Justice J. Sigurdson continued by referencing *Rupert v. Toth*, 2006 CanLII 6696 (O.N.S.C.) at para. 245 for the proposition that:

[] there is a duty on the part of the patient to participate fully and honestly in his or her own health care. See *Atack v. Castle*, [2003] O.J. No. 1943 (Ont. S.C.J.). This entails disclosing relevant information to his physicians and following the physician's clear instructions to him.

[194] Section 1 of the Negligence Act, R.S.B.C. 1996, c. 333 provides that:

- (1) If by the fault of 2 or more persons damage or loss is caused to one or more of them, the liability to make good the damage or loss is in proportion to the degree to which each person was at fault.
- (2) Despite subsection (1), if, having regard to all the circumstances of the case, it is not possible to establish different degrees of fault, the liability must be apportioned equally.
- (3) Nothing in this section operates to make a person liable for damage or loss to which the person's fault has not contributed.

[195] As noted by Justice Lambert in *Cempel v. Harrison Hot Springs Hotel Ltd.*, 1997 CanLII 2374 (C.A.), 43 B.C.L.R. (3d) 219:

[19] [] The Negligence Act requires that the apportionment must be made on the basis of "the degree to which each person was at fault". It does not say that the apportionment should be on the basis of the degree to which each person's fault caused the damage. So we are not assessing degrees of causation, we are assessing degrees of fault. In this context, "fault" means blameworthiness. So it is a gauge of the amount by which each proximate and effective causative agent fell short of the standard of care that was required of that person in

all the circumstances.

[]

[24] In the apportionment of fault there must be an assessment of the degree of the risk created by each of the parties, including a consideration of the effect and potential effect of occurrences within the risk, and including any increment in the risk brought about by their conduct after the initial risk was created. The fault should then be apportioned on the basis of the nature and extent of the departure from the respective standards of care of each of the parties. []

[196] In Kahlon, Justice J. Sigurdson at para. 260 applied a summary of factors applied in cases in assessing the relative blameworthiness from Heller v. Martens, 2002 ABCA 122 at para. 34, including:

1. The nature of the duty owed by the tortfeasor to the injured person ...
2. The number of acts of fault or negligence committed by a person at fault ...
3. The timing of the various negligent acts. For example, the party who first commits a negligent act will usually be more at fault than the party whose negligence comes as a result of the initial fault ...
4. The nature of the conduct held to amount to fault. For example, indifference to the results of the conduct may be more blameworthy ... Similarly, a deliberate departure from safety rules may be more blameworthy than an imperfect reaction to a crisis ...

Analysis - Contributory negligence

[197] As I noted above, Dr. Abu-Laban advances three matters said to constitute contributory negligence--those being that Mr. Ali:

- a) Gave the name of Dr. Chan instead of Dr. Yong as his family doctor when he was admitted to hospital, and subsequently failed to notify the hospital that Dr. Chan had retired and that he would be seeing Dr. Brian Yong;
- b) Failed to have the follow-up chest x-ray that was recommended not only by Dr. Abu-Laban but also by Dr. Brian Yong in the follow-up visit;
- c) Continued to smoke notwithstanding his appreciation that smoking was bad for his health, could cause lung cancer, and was likely connected to the coughing issues that led him to the emergency room on March 31, 2014.

[198] I will deal with the third matter first. Dr. Laskin's evidence was that the cause of lung carcinoids is still unclear, and the majority of typical lung carcinoids develop in patients who are never or current light smokers. In light of this, the evidence does not support a causal connection established between Mr. Ali's smoking and his carcinoid tumour. I conclude that this allegation of contributory negligence is not made out.

- [199] I reach a different conclusion with respect to the other two allegations.
- [200] In my view, Mr. Ali failed to carefully provide information as to his family physician when he first checked in and, more importantly, to obtain the follow-up x-ray recommended to him by both Dr. Abu-Laban and Dr. Yong.
- [201] It appears from Mr. Ali's evidence that he had intentions of making Dr. Chan his family physician. I infer as well that he did not know on March 31, 2014 that Dr. Chan had retired. There is no basis to think that he was attempting to mislead about who his family doctor was. Rather, I accept that at the time he was asked for this information, he was actively considering a change of family doctor, although he clearly had taken no recent steps to effect that, given his lack of knowledge of Dr. Chan's retirement.
- [202] In my view, it is important in assessing the blameworthiness of conduct to consider the circumstances in which Mr. Ali would have been asked for and given the name of his family doctor. He would have just been brought in to the emergency room by ambulance. It is not known whether he was ambulatory or being wheeled around in a wheelchair or stretcher. Given how he got to the emergency room, he was clearly in some distress. He was asked by one of the emergency room staff for several personal details. Given the available evidence, there is no way to know whether he was given any explanation as to why that information was sought, nor is there any explanation as to whether he asked any questions about it. In my view, this is not a circumstance in which it is appropriate to attach a great deal of blameworthiness to Mr. Ali. And while it perhaps goes to causation more than blameworthiness, I repeat here my observation in respect of Issue #1 that had Dr. Abu-Laban attempted to contact Dr. Chan, he would have learned of Dr. Chan's retirement and would then presumably have attempted to contact Mr. Ali.
- [203] The evidence indicates that Mr. Ali did eventually learn about Dr. Chan's retirement, and ended up seeing Dr. Yong in April 2014. Dr. Abu-Laban suggests that Mr. Ali should have realized at this time that he needed to contact VGH and advise them that his family doctor was actually Dr. Yong. I do not agree that is a reasonable expectation. There is no evidence indicating that Mr. Ali knew that Dr. Yong would not have access to any information he required about Mr. Ali's treatment, nor is there any indication that Dr. Yong advised Mr. Ali to ask VGH to send information to him.
- [204] In my view, Mr. Ali was also contributorily negligent in failing to obtain the follow-up x-ray that was recommended by Dr. Abu-Laban, and for which Dr. Yong gave him a requisition. In considering the blameworthiness of this failure, I note the comments of Justice J. Sigurdson in *Kahlon* at para. 269:
- [269] There is a duty on the part of a patient to participate fully and honestly in his own health care. This entails disclosing relevant information to physicians and following the physicians' clear instructions: *Rupert v. Toth*. A significant degree of fault must attach to Mr. Kahlon's failure to re-attend for the contrast scan and, to a somewhat lesser degree, to follow up with Dr. Khan. In my view, however, not every failure of a patient to follow up

appointments or testing equates to the same degree of fault. The patient's understanding of his condition and of the potential risks of not following up, and other steps he has taken, are relevant contextual factors in this regard.

[Emphasis added.]

[205] In the context of this case, Mr. Ali's conduct must be assessed in light of the circumstances surrounding his interactions with Dr. Abu-Laban, which I have already noted above. It is noteworthy that Mr. Ali was provided with a verbal report but nothing in writing when he was discharged. His evidence is that he understood that he had been diagnosed with pneumonia and that the pneumonia was expected to clear up after treatment with antibiotics. I accept that Mr. Ali understood that the follow-up x-ray was only required if the pneumonia did not clear up. At the same time, I accept that both Drs. Abu-Laban and Yong recommended an x-ray regardless of whether the pneumonia cleared up. It is not clear what sort of explanation was given of this recommendation and whether Mr. Ali was given any information about potential risks of not following up. While none of this excuses Mr. Ali's failure to listen more carefully and do a better job of understanding the doctors' recommendations, in my view, it attenuates the blameworthiness.

[206] In my view, giving due consideration to the two areas in which I have found Mr. Ali to have contributed to his loss, and the relative blameworthiness of his failures, I conclude that the circumstances of this case give rise to an unequal assessment of blameworthiness. I would apportion liability 70% to Dr. Abu-Laban and 30% to Mr. Ali.

Issue #3 - Damages

Non-Pecuniary Loss

Positions of the Parties

[207] Mr. Ali seeks an award of non-pecuniary damages. He argues that he is no longer the same person he was before he learned of Dr. Abu-Laban's actions. He has no trust in the medical system, which has given him doubt of his own ability to work with people. He has lost trust in his friends and no longer socializes. He is frustrated, impatient, and loses his temper. He is suicidal and says that only his faith and the support of his wife have kept him going.

[208] Mr. Ali submits that an award of \$175,000 would be appropriate in respect of non-pecuniary damages, based on three prior authorities:

- a) Saadati v. Moorhead, 2014 BCSC 1365, rev'd 2015 BCCA 393, trial judgment restored 2017 SCC 28. Mr. Saadati was injured in a motor vehicle accident and was found to have suffered psychological injuries, including personality change and cognitive difficulties. He was awarded non-pecuniary damages of \$100,000, which is \$128,514 in 2024 dollars.

- b) *Hans v. Volvo Truck North America Inc.*, 2016 BCSC 1155, aff'd 2018 BCCA 410. The plaintiff was injured in a motor vehicle accident that did not result in serious physical injuries but the plaintiff's life was severely impacted by PTSD and major depression, which was chronic, severe and disabling. An award of \$265,000 in non-pecuniary damages (\$319,739 in 2024 dollars) was upheld on appeal.
- c) *Whatley v. Badshah*, 1991 CanLII 139 (BCSC). The plaintiff was in a motor vehicle accident that left him with diagnoses of PTSD, panic disorder, agoraphobia, depression, suicidal ideation, panic attacks, anxiety, depression, poor concentration and memory. He was awarded non-pecuniary damages of \$125,000 (\$243,674 in 2024 dollars).
- [209] Dr. Abu-Laban notes that any assessment of damages would have to reflect the fact that Mr. Ali had a carcinoid tumour that would have caused distress and would have had to be removed through surgery regardless of his interactions with Dr. Abu-Laban. Dr. Abu-Laban submits that, if Mr. Ali has a psychological injury at all, a substantial portion of that was inevitably related to the life-changing news that he had lung cancer--and not to any delay in diagnosis.
- [210] Dr. Abu-Laban submits that the Court should be skeptical of claims that Mr. Ali's mood was impaired due to the delay rather than the diagnosis itself. Dr. Abu-Laban submits that Mr. Ali was already distrustful of physicians. He also gave discovery evidence in 2022 that his mood had improved at one point.
- [211] Dr. Abu-Laban submits that the "crumbling skull" rule applies, by which the defendant is not required to compensate a plaintiff for debilitating effects of a pre-existing condition. Dr. Abu-Laban notes the approach taken in *Baglot v. Fourie*, 2019 BCSC 122 at paras. 361-366, in which Justice D. MacDonald noted at para. 366 that:
- [366] I find that the plaintiff's Crohn's disease was unaffected by the defendant's wrongful conduct. It is difficult to separate the effects of his Crohn's disease from the effects of the wrongful conduct in determining an appropriate award, since the plaintiff suffers from a complex combination of ailments. Instead of assessing damages for his compensable injuries alone, which is near impossible given how debilitated Mr. Baglot is, I will assess damages for the full extent of his disabilities. I will then reduce the plaintiff's award by 30% to account for the hardship he has and will face as a result of his disease rather than Dr. Fourie's negligence.
- [212] Dr. Abu-Laban also notes the approach taken in in other cases, in which the impact of a delayed diagnosis was assessed as a separate matter; specifically:
- a) *Laferriere v. Lawson*, [1991] 1 S.C.R. 541, Justice Gonthier re-considered the award of psychological damages in respect of the defendant doctor's failure to inform the plaintiff of a terminal condition. He awarded \$10,000 (\$19,400 in 2024 dollars), having noted that:

From 1975 until her death, she experienced the horrible rhythms of her disease and the regular and seemingly ineffectual treatments and medications in the knowledge that things might have been different had she known earlier and been treated earlier. Her chances may not have been sufficient for the law, but they were very real to her, no doubt. I think that it was also probable that the pain which she experienced as a result of the advancing disease was all the more distressing given that knowledge. While she was a person who was concerned with her health and prepared to seek the best medical evidence and abide by it, she was denied the opportunity and choice of doing so by reason of the appellant's failure to inform her. This led, for instance, to her continued use of contraception pills which she would have been advised against had her condition been known.

b) *Bohun v. Sennewald*, 2007 BCSC 269 at paras. 103-105, in which the defendant doctors were found negligent in failing to diagnose her breast cancer at an earlier date, and in undertaking a partial rather than a radical mastectomy when the breast cancer was eventually discovered. Justice Goepel noted at para. 99 that regardless of when the cancer was diagnosed, the plaintiff would have had to undergo chemotherapy and radiation. He also concluded that had the condition been diagnosed earlier, the plaintiff's chance of survival would have increased by 20%. As a result, he concluded that most aspects of the damages award would be discounted by a global contingency of 80%. Justice Goepel referenced authorities including *Laferriere*. At paras. 104-105, he concluded:

[104] In this case, in addition to pain and suffering and loss of expectation of life, Ms. Johnston has similarly had to live with the reality, that with proper diagnosis her cancer may not have recurred and she could have gone on to live a normal life. From the time of her diagnosis in January 2002, she has known that the results might have been different had she been treated earlier. As the disease has advanced and she faces the end of her life, this knowledge is all the more distressing.

[105] Non-pecuniary damages include compensation for loss of amenities, pain and suffering, and the expectation of life. While it is customary to set only one figure for all non-pecuniary loss, this case requires a somewhat different approach. I intend to divide the award for non-pecuniary damages into two components. For loss of amenities, pain and suffering and loss of expectation of life, I would award \$100,000. This award is subject to the 80% discount. In addition, I would award Ms. Johnston \$25,000 for the psychological injury she has suffered because of Dr. Segal's failure to properly diagnose her condition. This portion of the non-pecuniary award is independent of any contingency and not subject to deduction.

A \$25,000 award in 2007 would be equivalent to about \$36,000 in 2024.

- c) *Roshan-Moniri v. Dr. Herbert Y.C. Chang Inc*, 2022 BCSC 204. The plaintiff had seen her family physician eight times over a nine-month period for back issues. The plaintiff was eventually diagnosed with a mass in her back that would have been operable if diagnosed earlier. Justice Winteringham [as she then was] noted that the plaintiff's psychological and physical condition worsened as the months went on, and she spent five months not knowing what was happening to her. As explained at para. 215:

[215] This is a young woman whose life is to be measured in months, not years. To lose five months of what is to be a short life should be factored, at least to some extent, into the assessment of damages.

Ms. Roshan-Moniri was awarded non-pecuniary damages of \$125,000.

[213] Although referencing these authorities, Dr. Abu-Laban submits that all of these cases involved significantly more serious impacts. All of them involved diagnoses of matters that could have been better treated if discovered earlier. The first two involved cancer diagnoses that were life-threatening. The third involved physical injuries that could have been surgically repaired if diagnosed in a more timely manner. Dr. Abu-Laban submits that any award to Mr. Ali would be substantially less than any of these cases.

[214] Dr. Abu-Laban notes that Mr. Ali was not sick between 2014 and 2018, and that his cancer was treated within two or three months of diagnosis. His tumour did not metastasize, he has not had a recurrence, and he remains cancer-free with a positive prognosis.

Legal Context

[215] The principles guiding the assessment of non-pecuniary damages were summarized in *Stapley v. Hejslet*, 2006 BCCA 34, where Justice Kirkpatrick set out at para. 46 an inexhaustive list of factors that influence an award:

- (a) age of the plaintiff;
- (b) nature of the injury;
- (c) severity and duration of pain;
- (d) disability;
- (e) emotional suffering; and
- (f) loss or impairment of life;

[]

- (g) impairment of family, marital and social relationships;
- (h) impairment of physical and mental abilities;
- (i) loss of lifestyle; and

- (i) the plaintiff's stoicism (as a factor that should not, generally speaking, penalize the plaintiff)

Analysis

- [216] This is a difficult case in which to assess non-pecuniary losses, given that Mr. Ali would have experienced a significant amount of psychological upset from his diagnosis in any event. None of the cases cited by Mr. Ali reflect the need to attribute a part of a mental injury to a tortious cause. That said, they reflect awards that could potentially have been considered had the entirety of Mr. Ali's psychological symptoms been attributable to Dr. Abu-Laban, and thus provide helpful context.
- [217] Two of the defendant's cases, Baglot and Bohun, reflect different approaches to such circumstances. In Baglot, the court assessed an overall amount, then reduced it by a percentage to reflect losses that would have been suffered in any event, whereas in Bohun, the court assessed a specific amount for the delay in diagnosis.
- [218] I prefer the Bohun approach in the circumstances of this case. In my view, the greater part of Mr. Ali's psychological symptomatology would have been suffered in any event and it is more appropriate to separately assess the amount attributable to the tortious cause in this case.
- [219] In my view, considering Mr. Ali's young age as well as the nature of the psychological impacts, while recognizing that a significant part of his symptom burden would have been suffered in any event, I conclude that an appropriate award for non-pecuniary losses in all of the circumstances is \$40,000.

Past Loss of Earning Capacity

Positions of the Parties

- [220] Mr. Ali also seeks an award for past loss of earning capacity. He submits that the award should reflect the income he actually lost during his recovery in 2018, less what he would have lost had he had the surgery in 2014. Mr. Ali's income in the months prior to the surgery in 2018 (about \$2,800 a month) was significantly higher than it was in 2014 (about \$400 a month). He presents two calculations:
- The first is based on being off work for six months, which some evidence suggests may be a "typical" recovery time. Mr. Ali calculates the difference between six months of income at 2014 and 2018 rates as being \$14,300.
 - The second is based on Mr. Ali's actual time out of the work force of about 3.5 years. Using his actual income in 2015, 2016 and 2017 (the time he would have been off work if he had the surgery in mid-2014 and took 3.5 years to return to work), he calculates a difference of \$47,281.

[221] Dr. Abu-Laban submits that there are multiple problems with Mr. Ali's approach to past loss of earning capacity, including:

- a) Mr. Ali's income in 2014 was lower than in both 2013 and 2015, and reflects the variability of income of Mr. Ali, particularly given his history of changing employment regularly and working jobs for multiple employers - something that has continued since his surgery;
- b) His employment in 2018 at PosAbilities was tenuous, given his disciplinary issues with that employer;
- c) Given that Mr. Ali obtained employment at PosAbilities in 2016 through personal contacts, there is a reasonable likelihood that he would have obtained that employment in any event, even if he had surgery in 2014, and it is speculative to think there would have been any long term impact on his employment.

[222] Dr. Abu-Laban also submits that there is no connection on the evidence between the delay in Mr. Ali's treatment and any change in his employment capacity as a result of psychological impacts from any action or inaction on the part of Dr. Abu-Laban. Nor is there, in Dr. Abu-Laban's submission, any basis on the evidence to conclude that Mr. Ali's recovery took longer because of the psychological impacts of the delay in his treatment. Rather, any change in capacity was an inevitable result of having surgery to remove a carcinoid tumour.

[223] Overall, Dr. Abu-Laban submits that Mr. Ali's employment history is such that there is no real and substantial possibility that anything would have been different with an earlier diagnosis, and there is no basis for any claim for past loss of earning capacity

[224] Dr. Abu-Laban also submits that Mr. Ali failed to mitigate his loss, and specifically that to the extent Mr. Ali took longer than normal to return to work, that delay is attributable to his failure to follow required treatments, including attending all scheduled active rehabilitation sessions, failing to obtain counselling and take all medications, and failing to use a steroid-based inhaler that had been recommended. Dr. Abu-Laban submits that if Mr. Ali had followed all of these treatments, he might have been in a better position to return to work by the time of trial.

Relevant Facts - Prior to Surgery

[225] Mr. Ali's 2013 tax return indicates that he had earned a total of \$23,447. His largest source of income was a group home from which he earned just over \$16,000. His evidence was that he ultimately left that job because of difficulties with some of his co-workers. He also earned just over \$3,400 in income from a disabled person to whom he provided care on a private basis. The remaining approximately \$4,000 in income came from various casual employers involving labour-type work.

- [226] Mr. Ali's 2014 tax return indicated total income of \$4,777. None of his work in 2014 was care-related.
- [227] Mr. Ali's 2015 tax return indicated total income of \$16,875. The majority of this income came from care positions, including over \$9,000 in respect of a care aide position in a facility that provided care for individuals with long-term care needs. He eventually left that position because he found it was too busy and physically demanding.
- [228] Mr. Ali's 2016 income tax return indicated total income of \$18,382. Approximately half of this income came from a company that provided tents for movie companies and sometimes for weddings. Of the eight other employers, approximately three involved care-type positions.
- [229] In December 2016, Mr. Ali obtained a residential care aide position with a company known as PosAbilities that deals with people who have mental, physical, and intellectual disabilities. He was referred to this employer through a friend who worked there. PosAbilities is a unionized employer that runs about 25 group homes plus several community inclusion sites. Mr. Ali said that he enjoyed working with the people that needed care. His employment was for 27 hours a week, but Mr. Ali said that he was often given extra shifts which led to him working up to 40 hours some weeks.
- [230] Mr. Ali's 2017 tax return shows income of just over \$35,000, all of which came from PosAbilities.
- [231] Mr. Ali acknowledged that he had some issues with co-workers and supervisors. PosAbilities' employment file was canvassed at trial both with Mr. Ali and with Mr. Wierdsma, who was PosAbilities' Director of Human Resources. While Mr. Wierdsma had no direct dealings with Mr. Ali, he was able to give evidence with respect to PosAbilities' employment practices and confirmed that he would have been consulted with respect to some of the later human resources interactions that Mr. Ali had.
- [232] The PosAbilities documents include records of disciplinary meetings in March 2017 (keeping communications of a professional nature), September 2017 (leaving a person unattended for 20 to 30 minutes at a program), October 2017 (failing to report conduct of another staff member), November 2017 (telling a supplier not to bother recycling an old freezer that was to be hauled away), December 2017 (smoking in his vehicle while transporting a program participant), January 2018 (making inappropriate comments about or to another staff member), and April 2018 (making inappropriate comments about or to other staff). A letter dated April 13, 2018 advised Mr. Ali that he would be suspended for ten days without pay and warned that further incidents could result in termination of his employment. He was also transferred to a new facility so that he could have a fresh start.
- [233] Mr. Wierdsma confirmed that PosAbilities has a progressive discipline process, and that the next step in that process would have been termination should there have been further incidents of significance.

- [234] A further letter in PosAbilities' file is dated April 25, 2018 from Mr. Ali's family doctor, Dr. Grewal, asking that he be excused from work until May 14, 2018 due to medical illness.
- [235] An annual performance evaluation in PosAbilities' file, dated June 6, 2018, noted that Mr. Ali was now in a regular position at the new facility. Some of the evaluation categories had scores on a three point scale (for which 2 is "meeting expectations", and 1 is "below expectations") of 1.25 or 1.75.

Relevant Facts - Post-Surgery

- [236] Mr. Ali initially went on short-term disability in August 2018. His surgery was on August 22, 2018. He was discharged from hospital on August 29, 2018. It was in a follow-up appointment with his surgeon that he learned of the 2014 chest x-ray.
- [237] Mr. Ali recalls being told fairly soon after the surgery that it appeared that the cancer was gone, but that he would be monitored for the next ten years to make sure the cancer did not return.
- [238] As noted above, Mr. Ali was accepted for long-term disability benefits in late 2018, but made inquiries about starting a gradual return to work program in December 2018. He said that his doctor initially discouraged it, but then agreed to recommend it provided that he could be given "light duties", which would include avoidance of any heavier physical work. A form completed for the disability insurer in mid-December stated that "GRTW is appropriate" provided that there could be avoidance of heavy lifting.
- [239] Mr. Ali's 2018 tax return indicates income of \$19,652 from PosAbilities plus Employment Insurance ("EI") benefits of \$7,395.
- [240] Mr. Ali did not in fact return to work with PosAbilities. His evidence was that PosAbilities was unable to accommodate him with light duties--Mr. Ali said he was told that the company had several employees already on light duties, and could not handle any more. In July 2019, the disability insurer accepted his claim for ongoing benefits.
- [241] Various clinical records from Dr. Grewal, Mr. Ali's family doctor, were put in evidence. At a July 22, 2019 appointment, Dr. Grewal recorded complaints about breathing not improving, as well as discussion of home stressors. Mr. Ali reported that he was having issues with his relationship with his brother, and also that there were issues with flooding in their home and repairs not being completed by the landlord. At trial, Mr. Ali said that at the time, he was only able to do very short walks outside, he still had pain, and then he had the other stressors in his life as discussed with Dr. Grewal. He acknowledged that Dr. Grewal recorded that they had "discussed meds", which Mr. Ali declined, and that they had also discussed the possibility of him seeing a psychologist. Mr. Ali explained that he had had issues with medications he was given post-surgery that led to hallucinations and that one night he had hit his wife in his sleep, which he very much regretted. He said that after that, he decided that he would rather live through the pain than take medications that would

impact his mood.

[242] Mr. Ali acknowledged on discovery having said that he had a real hard time for about a year after his surgery, but that his mood then improved. His evidence at trial was that:

I think after my surgery for a solid year I was really, really down, very down. In that time period I had asked my wife to leave me and she didn't. She's a great woman, she stayed, and she made me fat. You know, I guess that was the down side of it. I don't know how to explain how bad of a situation I was in that year.

[243] Mr. Ali's 2019 income tax return indicated disability income of just over \$24,000.

[244] In January 2020, Mr. Ali's wife incorporated a company that performed evening janitorial services. The evidence was that Mr. Ali's wife and Mr. Ali's mother did some commercial cleaning work through this company. Mr. Ali would sometimes accompany them, but that he was unable to do much other than occasionally empty garbage containers. He was not paid for any work for this company.

[245] Various correspondence from the disability insurer in the summer of 2020 indicated that the insurer had concluded that Mr. Ali was still totally disabled, but that they would be looking into options to retrain him for other work.

[246] Documents from early 2021 indicated that Mr. Ali was part of an active rehabilitation program, but that he had missed about 10 of the 36 sessions that had been scheduled. His wife explained that he did not go when she was unable to drive him.

[247] On November 15, 2021, Mr. Wierdsma of PosAbilities wrote to Mr. Ali confirming that he had been informed by the disability insurer that

[] your LTD claim has ended as you have successfully completed vocational rehabilitation in preparation of finding alternative employment. As you will not be returning to [P]osAbilities your employment status with us has ended effective November 15, 2021. We thank you for your years of service with us and wish you the best of success in your new career.

[248] Mr. Ali's disability benefits came to an end in November 2021. His 2021 tax return showed total income of just over \$24,000 in disability benefits.

[249] In January 2022, Mr. Ali began a job at a company known as Earth's Own. He was not kept on at the end of his probationary period. His final day at work was May 2, 2022. He said that after this, he went on EI and spoke with WorkSafeBC where he was encouraged to take training in logistics, which he did.

[250] The parties' agreement statement of facts includes the following:

10. On March 4, 2022, Dr. Shaipanich recommended to Mr. Ali that he use 1 puff of his Ventolin inhaler as needed every 4 to 6 hours to see if it would improve his cough and symptoms.

11. On September 12, 2022, Mr. Ali advised Dr. Shaipanich that he had not been compliant in using his Ventolin inhaler.
12. On September 12, 2022, Dr. Shaipanich recommended to Mr. Ali that he take 1 puff of a Symbicort inhaler twice per day.
13. On September 12, 2022, Dr. Shaipanich provided Mr. Ali with three Symbicort inhaler samples to use over the next three months
14. On January 5, 2023, Mr. Ali reported to Dr. Shaipanich that his breathing had somewhat improved.
15. On January 5, 2023, Mr. Ali reported to Dr. Shaipanich that he had gained weight, started to snore at night, and was passing a lot of gas during the day and that he thought this was related to his use of Symbicort even though it had somewhat improved his breathing.

[251] With respect to the latter appointment, the clinical records from the SPH Pacific Lung Health Centre record the following for January 5, 2023:

I spoke to the patient today via tele health. His breathing has somewhat improved. However he indicated that he has gained a few lb his weight and 116 kilos now. He starts snoring at nighttime and has a lot of passing gas during the day. He think this is secondary to Symbicort steroid inhaler despite it has improved his breathing. He has discussed with his friend who is a nurse and also the another friend who is an RT and recommend him come off inhaled corticosteroid. I had long discussion with him that with the reactive airway disease with reversed stability seen on bronchodilator, he should be treated with long-acting beta 2 agonist and inhaled corticosteroid. However he believed that his friends and a RT who recommend him to come off inhaled corticosteroid are corrected. Therefore I believe that he should be on Symbicort 1 puff twice a day but given that he is quite concern of taking inhaled corticosteroid he will try to minimize use in inhaler and will use Ventolin p.r.n. as needed. I will speak to him again in follow-up in 3 months.

[252] Mr. Ali's evidence with respect to this note was that others he knew that were also taking Symbicort had the same symptoms, and that he found that the Ventolin puffer he was using was more helpful. He recalled that Dr. Shaipanich told him it was okay to use the puffer as needed, which is what he did.

[253] Mr. Ali's income tax returns indicate income received in 2022 and 2023 from S.U.C.C.E.S.S. This was not explained in evidence. His 2022 tax return indicates just over \$18,000 from Earth's Own, \$12,937 in EI benefits, \$2,552 from S.U.C.C.E.S.S., and \$553 from UPS.

[254] His income tax return for 2023 shows income of \$23,400 from S.U.C.C.E.S.S. and \$14,331 from Sandhar Trucking, which was work he found after completion of the logistics training. That work did not continue.

- [255] In early 2024, Mr. Ali obtained employment as a residential support worker in a group home, which he described as somewhat similar to the work he previously did with PosAbilities (although less physical). Later in 2024, he began working as well with Vancouver Coastal Health as a home support worker. Both of these positions are casual.
- [256] Mr. Ali says that his current goal is to upgrade his high school qualifications to the point that he can take training to become a social services worker. However, initial efforts in 2024 to complete his high school programming were not successful to the extent necessary to advance this goal.

Expert Evidence

- [257] Dr. Abu-Laban tendered two expert reports dealing with matters relating to Mr. Ali's employment capacity.
- [258] An independent medical examination report dated November 1, 2022 by Dr. Heather Finlayson, a physiatrist, diagnosed Mr. Ali with post-thoracotomy pain syndrome (intermittent and manageable with measures such as stretches and occasional pain medications) and respiratory symptoms. The respiratory symptoms include a chronic dry cough and shortness of breath on exertion. Dr. Finlayson recommended:
- a) Active rehabilitation - consistent participation in a supervised exercise program;
 - b) Pain medications.
- [259] She noted that Mr. Ali had missed 10 of 36 scheduled active rehabilitation sessions for a variety of different reasons, and that Mr. Ali reported inconsistent use of his home-based equipment. She suggested that "more consistent engagement in his active rehabilitation sessions and home exercise program would probably have resulted in an earlier improvement in his functional capacity and return to work".
- [260] Dr. Finlayson suggested that Mr. Ali would reasonably have required three to six months off work prior to returning to light duties, and that if he follows the recommended exercise regimen, he will likely be able to work including as a care aide so long as he is not required to lift and transfer patients without assistance.
- [261] Dr. Abu-Laban also tendered a vocational assessment report dated June 12, 2024 by Ms. Avita Sharma, a vocational rehabilitation consultant. The report reflected a battery of vocational tests taken in October, 2023, and a follow-up interview in November 2023. Ms. Sharma concluded that Mr. Ali is employable and has the capacity for employment. She suggested a range of different fields that the vocational testing indicated that he might pursue. She also concluded that he has the capacity to return to work as a care aide, subject to concerns about his ability to deal with patients who require lifting without mechanical aids.

Legal Context

- [262] The legal principles governing past loss of earning capacity were concisely summarized in *Lamarque v. Rouse*, 2023 BCCA 392 at paras. 29-30:
- [29] An award of damages for loss of past earning capacity compensates the claimant for the loss of the value of the work they would have, not could have, performed, but were unable to perform due to the accident-related injury. The standard of proof for past hypothetical events is: whether there is a "real and substantial possibility" that the events would occur. If the claimant establishes a real and substantial possibility, the court must then determine the measure of damages by assessing the likelihood of the event.
- [30] In many cases, a claimant's actual lost income will be the most reliable measure of a loss of earning capacity. However, there is no hard and fast rule that only loss of actual income is compensable. It must be remembered that it is not the actual lost income that is compensable, but the loss of capacity. An award of damages for past loss of earning capacity compensates a claimant for any pecuniary loss resulting in an inability to work, and evidence supporting such loss can take different forms. In *Ibbitson*, for example, the plaintiff, who worked in the forest industry, maintained his pre-accident level of income by working longer hours. Thus, he was found to have suffered a pecuniary disadvantage that was compensable through an award of damages for loss of earning capacity.
- [Citations omitted]
- [263] With respect to mitigation, the test was set out in *Chiu v. Chiu*, 2002 BCCA 618 at para. 57--
Dr. Abu-Laban must prove:
- a) that Mr. Ali acted unreasonably in eschewing the recommended treatment, and
 - b) the extent, if any, to which Mr. Ali's damages would have been reduced had he acted reasonably.
- [264] The onus is on the plaintiff to prove on a balance of probabilities that the plaintiff's injuries would have been reduced to some degree had they acted reasonably: *Haug v. Funk*, 2023 BCCA 110 at para. 61. Assessment of the extent of that reduction reflects a hypothetical.
- [265] The reasonableness of the plaintiff's mitigation efforts is assessed on a subjective/objective test, as explained in *Gill v. Lai*, 2019 BCCA 103 at para. 26:
- [26] In my view, under the subjective/objective test for the reasonableness of mitigation efforts, the trial judge was entitled to look to the respondent's personal circumstances to determine whether the course of action she took was reasonable. The subjective component of that test does allow a court to look beyond just whether the individual understood, appreciated, and was capable of following the advice given, and to look to their personal circumstances and ability to follow that advice. Further, the objective component of the test entitles the judge to look to what a reasonable person in that plaintiff's circumstances would do. []

Analysis

- [266] I agree with Dr. Abu-Laban that it would be inappropriate to use Mr. Ali's 2014 income alone as the basis for any assessment. Looking at his income before and after that year, I would assess his income earning capacity in 2014 as in the range of \$20,000 per annum.
- [267] I conclude that Mr. Ali did, over the next few years, expand his income-earning capacity. Given that his 2018 income was significantly impacted by his surgery that year, I would assess his income earning capacity at the time as in the range of \$35,000 (based largely on his 2017 income).
- [268] I accept that Mr. Ali's ongoing employment with PosAbilities was not a sure thing in 2018. There was a risk he might lose that job. However, I do not see that as substantially impacting my assessment of his 2018 earning capacity. In my view, the trend of Mr. Ali's employment as he moved into his 30s reflected increased maturity and an increasing ability to maintain employment. I do not accept that he was likely, if he was to lose that work, to suddenly be left in a position in which he could not obtain work at a comparable income level.
- [269] Both parties have made submissions with respect to the time required for Mr. Ali to return to work. Mr. Ali accounts for this as part of his calculation of the claim, presenting alternative claims based on a six-month recovery and a three-and-a-half year recovery. Dr. Abu-Laban, on the other hands, asserts that Mr. Ali's failure to recover more quickly reflects a failure to take the necessary actions to mitigate his loss. In my view, this is a matter more appropriately dealt with in the context of assessing the loss, rather than in reducing an amount that has been assessed.
- [270] Dr. Finlayson suggests that Mr. Ali could reasonably have been expected to return to work after three to six months on light duties. However, the evidence is that Mr. Ali explored the possibility of returning to light duties with PosAbilities and it was not available to him. In those circumstances, and given that he was for a time reasonably hoping to be able to return to his former employment, I see it as reasonable for him to have taken a longer time to return to work.
- [271] Dr. Abu-Laban argued that Mr. Ali unreasonably failed to use a steroid-based inhaler. The difficulty I have with the evidence on this issue is that it dates to late 2022 and early 2023, a time more than four years after surgery, and after Mr. Ali had rejoined the work force. As well, it appears from the documents that Mr. Ali was actively treating his issues with an inhaler. While it appears that Dr. Shaipanich would have preferred that Mr. Ali use a Symbicort inhaler, Mr. Ali had decided to use a Ventolin inhaler. I have no evidence as to the differences between a Symbicort and Ventolin inhaler and how and what (if any) difference there is would have affected Mr. Ali's ability to earn income.

- [272] Dr. Abu-Laban also made submissions based on Mr. Ali's failure to access psychological counselling. This relates to a discussion Mr. Ali had with Dr. Grewal in July 2019, at a time when there were issues with family relationships and home repairs. It is not clear to me how accessing counselling at the time would have impacted Mr. Ali's ability to earn income. Much the same would apply with respect to the general allegation of failure to take medications.
- [273] The final issue raised by Dr. Abu-Laban, and one to which I believe there is merit, is that Mr. Ali did not participate to an adequate degree in the active rehabilitation to which he was referred. This assertion is supported by the evidence of Dr. Finlayson, who stated that more consistent engagement with this programming would probably have resulted in an earlier improvement in his functional capacity and return to work. As well, Mr. Ali acknowledged in cross-examination that the records indicating he had missed 10 of 36 sessions by 2021 was probably accurate.
- [274] The result of all this is that I do not accept either that Mr. Ali should have returned to work after six months, or that it was reasonable for him to not return to work for 42 months.
- [275] I should say as well that I accept that Mr. Ali's low mood, which I have reviewed in my discussion of the award for non-pecuniary loss, plays a role in the time he took to return to work. However, for the reasons already discussed, it is my view that a significant part of his psychological burden related to the diagnosis of a carcinoid tumour itself, with that burden being somewhat intensified by additional strain arising from the delay in his cancer diagnosis.
- [276] This is not a case where an award for past loss of earning capacity can be calculated with precision. Accepting as a starting point that Mr. Ali's earning capacity had improved from about \$20,000 a year to about \$35,000 a year during the time period from 2014 to 2018, a difference of \$15,000, and considering all of the other factors at play, it is my view that an appropriate award would be \$25,000.

Conclusion

- [277] In my view, an appropriate award for non-pecuniary loss would be \$40,000, and an appropriate award for past loss of earning capacity would be \$25,000. The total amount of \$65,000, must be reduced by 30% to reflect Mr. Ali's contributory negligence.
- [278] Accordingly, I would award Mr. Ali damages of \$45,500.
- [279] If the parties are unable to resolve questions of costs, the party seeking costs should provide their submission to me in writing through Supreme Court Scheduling within 60 days of the date of this judgment. The other parties may reply within 30 days thereafter. I will advise whether I believe a hearing is necessary--although the parties are welcome to indicate in their submissions whether they believe a hearing would be appropriate.

[280] If the parties identify any mathematical errors, or if there is any issue that I have failed to deal with that was properly before me, or that arises from this judgment, then the parties may seek clarification or determination of those matters with the same schedule for submissions as in respect of costs.

"Veenstra J."

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