
CANADA / JUDGMENT

Baglot v. Fourie

2019 BCSC 122

COURT

Supreme Court of British Columbia

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2019 BCSC 122 Baglot v. Fourie

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Baglot v. Fourie,

2019 BCSC 122

Date: 20190131

Docket: S135657

Registry: Vancouver

Between:

Jeffrey Clarke Baglot

Plaintiff

And

Dr. Clasina E. Fourie

and John Doe

Defendants

Corrected Judgment: The paragraph numbering of the judgment was corrected from page 92 to page 96 on February 4, 2019.

Before: The Honourable Justice D. MacDonald

Reasons for Judgment

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Vancouver, B.C.

June 18-22, 25-29,

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Place and Date of Judgment:

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January 31, 2019

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Chronology of Events

- 1985: the year the plaintiff is born
- Kindergarten: father leaves the family
- Grade 5: involved in a motor vehicle accident
- Grade 7: expelled from school
- Grade 10: made the honour roll
- Grade 11: grades start to drop
- Grade 12: failed on his first attempt, but made the honour roll when he repeated grade 12
- Post-graduation: worked at Mystical Distributing
- 2004: began having stomach problems
- February 2005: attended the culinary arts program at Vancouver Community College
- April 2006: obtained his culinary arts certificate
- Spring 2006: worked at Café Crepe for 3 months
- Fall 2006: enrolled at University of the Fraser Valley ("UFV"), but had poor grades
- December 9, 2006: was admitted to Matsqui-Sumas-Abbotsford ("MSA") General Hospital with abdominal pain and nausea

- January 2007: enrolled at UFV again, but did not complete his courses
- 2009: got a part-time job at MEC for three months
- April 22, 2009: hospitalized for stomach pain at Vancouver General Hospital ("VGH"), underwent a laparoscopic procedure that removed some adhesions, and was diagnosed with Crohn's disease
- October 7, 2009: was admitted to Abbotsford Regional Hospital ("ARH") with abdominal pain and nausea
- November 10, 2009: was admitted to University of British Columbia Hospital ("UBC Hospital") with a bowel obstruction
- Summer 2010: moved back in with his mother due to his health
- September 2010: began working at Thrifty Foods as a baker
- January 22, 2011: admitted to ARH for stomach pain and stayed for three days
- March 2011: resigned from Thrifty Foods due to his health problems and applied for social assistance
- March 2011: Dr. Chatur, his treating gastroenterologist, recommends he go on a biologic to treat his Crohn's disease
- March 6, 2011: admitted to ARH to address a small bowel obstruction
- March 12-16, 2011: was in and out of ARH for abdominal pain and a possible small bowel obstruction; was given a prescription for Tylenol 3 and prednisone
- Prior to the ulcer, Mr. Baglot saw Dr. Yik and Dr. Chatur, both gastroenterologists. He was put on Imuran and prednisone for flare-ups.
- July 22, 2011: admitted to ARH for abdominal pain
- July 23, 2011: began taking ketorolac prescribed by Dr. Fourie
- July 25, 2011: underwent an ultrasound
- July 28, 2011: Dr. Fourie spoke with Dr. Chatur about the plaintiff's condition
- July 29, 2011: Dr. Fourie ordered a CT scan
- August 1, 2011: transferred to Royal Columbian Hospital ("RCH")
- August 2, 2011: Dr. Turner surgically repaired his perforated duodenal ulcer; Mr. Baglot began taking prescribed opioids to control his pain
- August 6, 2011: had his first internal bleed, which required emergency surgery
- August 25, 2011: Dr. Turner advised that he was to be discharged in four to five days
- August 29, 2011: had his second internal bleed, which resolved without surgery

- September 12, 2011: discharged from hospital
- October 2011: Dr. Chatur again advised him to treat his Crohn's disease with a biologic
- October 9, 2011: saw Dr. Garraway for pain complaints
- January 6, 2012: Dr. Chatur reiterated that he needed to get his medical therapy started for his Crohn's disease
- June 2013: travelled to Korea to see his sister
- March 11, 2014: he went on a biologic for the first time through a drug trial (AMG 181)
- August 1, 2014: Dr. Chatur prepared a consult for him to see a psychiatrist; the plaintiff did see a psychiatrist approximately five times between 2014 and 2016
- May 2016: admitted to VGH with an acute flare
- June 2016: went on Entyvio, a different biologic
- July 5, 2016: underwent a CT scan at VGH
- July 24, 2016: underwent a small bowel resection and right hemicolectomy surgery at VGH
- February 2017: involved in a motor vehicle accident
- Spring 2017: visited Portland
- January 2018: Dr. Chatur performed a colonoscopy
- June 18, 2018: first day of trial

Introduction

- [1] This is a complex medical malpractice action arising from a prescribing error by the defendant, Dr. Clasina Fourie, a general practitioner who works at Abbotsford Regional Hospital ("ARH").
- [2] The plaintiff, Jeffrey Clarke Baglot, was admitted to ARH on July 22, 2011, for symptoms relating to his Crohn's disease. Rather than improve over the course of the hospital treatment, the plaintiff's symptoms worsened. Mr. Baglot alleges that the decline occurred because the defendant prescribed a powerful non-steroidal anti-inflammatory drug ("NSAID") called ketorolac, also known as Toradol. The ketorolac caused a large duodenal ulcer (the "ulcer") that eventually perforated and required surgery to be repaired. A long hospitalization ensued (the "hospitalization").
- [3] The defendant admitted the prescription error and that it breached the applicable standard of care. She also admitted that the ketorolac caused a duodenal ulcer for which surgery was required and that the plaintiff ought to be compensated for this discrete injury.

- [4] The remaining issues in the case regard whether Dr. Fourie's negligence caused any further injuries and damages. I must determine which injuries, if any, resulted from the perforated ulcer, the surgery to repair the perforation, and the subsequent hospitalization.
- [5] The plaintiff's theory of the case is that the prescribing error and the resultant duodenal ulcer, surgery, and lengthy hospitalization left the plaintiff with scar tissue and chronic pain requiring high doses of opioids. This has increased his fatigue and has resulted in significant bowel problems for the plaintiff. Consequently, the plaintiff developed severe depression, post-traumatic stress disorder ("PTSD"), and visceral hypersensitivity, all of which have had a devastating impact on the plaintiff's life. He is currently totally disabled.
- [6] The defendant's theory of the case is that the plaintiff is entitled to damages resulting from the perforated ulcer, surgery, and hospitalization. The defendant takes the position that there have been no lasting injuries resulting from the defendant's breach of her standard of care. There is no causal connection between the perforated ulcer and the long-term course of the plaintiff's Crohn's disease and/or his psychiatric conditions. The defendant argues that the ulcer was an isolated event in the plaintiff's under-treated Crohn's disease and his history of injuries sustained in several motor vehicle accidents.

Evidence

- [7] The following is a summary of the evidence of each lay witness who testified at the trial. I set out their evidence in a general way, but leave certain details for discussion under the issues I address. In reaching my conclusions, I have considered the totality of the evidence.

Mr. Baglot

Social, Education, and Work History

- [8] Mr. Baglot is currently 33 years old and was 26 at the time of his admission to ARH on July 22, 2011.
- [9] Mr. Baglot testified that his father was mentally, and to some extent physically, abusive to him when he was a child. He testified that his father left the family when he was approximately six years old. His mother raised Mr. Baglot and his sister, although they occasionally stayed with their father. He did not enjoy seeing his father. Both he and his sister stopped seeing their father when they were grown.
- [10] Mr. Baglot testified that he had some interpersonal and behavioural difficulties in elementary school; he was bullied and he was eventually expelled in grade 7. Mr. Baglot was successful in school once he changed schools.
- [11] Mr. Baglot was a good student until grade 11. He participated in a summer science program while in high school and he travelled to China on an exchange program with his sister. He participated in the high school band and played a number of instruments. He received various awards and one bursary.

- [12] Mr. Baglot's marks dropped in grade 11 and he failed grade 12 on his first attempt. He missed 43 days of school in his grade 12 year. He completed grade 12 the following year and did well in the chef program. He retained a close relationship with the teacher who taught the chef program. Mr. Baglot was on the honour roll in grade 10 and in his second attempt at grade 12.
- [13] After graduating from high school, Mr. Baglot worked for a year at Mystical Distributing, a fireworks company. He continued to work at this company part-time over the next several years. He primarily worked during the high seasons. He also volunteered at a recreation centre. During this time, Mr. Baglot used his bike as his primary form of transportation and cycled everywhere.
- [14] In approximately 2004, Mr. Baglot began having intermittent stomach problems that became worse over time.
- [15] In February 2005, Mr. Baglot attended the Culinary Arts Program at Vancouver Community College ("VCC"). He obtained a culinary arts certificate in April 2006. After graduating from VCC, he worked as a cook at Café Crêpe for approximately three months in the spring of 2006. He quit Café Crêpe to attend a concert with his sister in the United States. He testified that he was disenchanted with working as a cook because it paid very little and was a labour job, and because chefs use speed and cocaine which he did not want to be around.
- [16] Mr. Baglot enrolled at the University of the Fraser Valley ("UFV") in the fall of 2006. His grades were poor. He again enrolled at UFV in January 2007 but did not complete his courses. He testified that he was having a hard time with stress, had stomach problems, and was depressed. He had to withdraw from UFV due to his health.
- [17] During this period, Mr. Baglot received approximately \$30,000 from a motor vehicle accident that occurred when he was in grade 5. This allowed him to travel.
- [18] Mr. Baglot did not work or go to school after withdrawing from UFV in early 2007 until he obtained a job at Mountain Equipment Co-op ("MEC") in 2009. He worked at MEC part-time for approximately three months. He testified that he had problems with his Crohn's disease when he worked at MEC and found the job stressful. His contract was not renewed.
- [19] Mr. Baglot began to work at Thrifty Foods as a baker in September 2010. He worked there until March 2011. Mr. Baglot took on some management duties due to the death of the assistant manager. He prepared his resume to apply for the manager's job. Unfortunately, he had to resign due to his Crohn's disease. He had pain, dizzy spells, and problems concentrating.

- [20] Between finishing high school and suffering the ulcer, Mr. Baglot traveled a fair bit, often to the United States. He met his former fiancée, Justa Phillips, in Portland, Oregon. Mr. Baglot lived for a short while in Vancouver and in Portland, and was very involved with the cycling community. He had many friends and participated in many cycling activities. He fixed bikes and volunteered in a program that fed homeless people. He participated in some competitions and won the Ben Hurt Chariot Race.
- [21] Mr. Baglot was engaged to Ms. Phillips for approximately one and a half years. Although he lived for a time in Portland, and she had visited Abbotsford, they had a long distance relationship for the most part. Prior to the ulcer, they had broken up several times. He testified that it was a volatile relationship.
- [22] In March 2011, Mr. Baglot applied for social assistance. His file was closed in May 2011 after he did not submit the necessary documentation. Dr. Donald Eddy, his family physician, completed a form on his behalf for the Ministry of Social Development. Under "employability", Dr. Eddy stated that Mr. Baglot was suffering from severe, constant Crohn's disease. He was on medical employment insurance prior to the hospitalization.
- [23] At trial, the defendant tendered Mr. Baglot's Canada Pension Plan statement of contributions. This document established that the most money Mr. Baglot made from employment was in the year after he graduated from high school, when he made just over \$9,000. In 2006, he made \$4,338 while working at Café Crêpe and in 2009, he made \$6,333 while working at MEC. In 2010, he made \$5,234 at Thrifty Foods.
- [24] Mr. Baglot testified he drinks alcohol. Between the ages of 19 to 23 he drank at parties. Throughout the rest of his 20s, he drank more but not when cycling. He testified that sometimes he drank two or three times per week, and then would go a week or two without drinking.
- [25] Mr. Baglot was hospitalized on two occasions due to incidents related to alcohol consumption. On one occasion he fell into a hood fan and cut his forehead. On another occasion he was in an altercation. In August 2011, he completed a CAGE questionnaire when he was at Royal Columbian Hospital ("RCH"). He answered in the affirmative to the questions "have you ever wanted to cut down" your alcohol consumption and "have you ever felt guilty about your drinking?" He answered no to the question "have you ever had a drink (or drug) to get you started in your day or to steady your nerves?"

Prior Medical History

- [26] Mr. Baglot was in a motor vehicle accident when he was in grade 5. As a result, he suffered from headaches of varying duration and intensity for many years. He testified that his headaches stopped in the past few months, are slowly getting better, and are no longer a daily worry for him. However, prior to the past few months he had headaches almost every day.

- [27] Mr. Baglot acknowledged having trouble with his stomach but testified that he was on no medication for his stomach prior to the surgery. Around 2004, he started getting stomach pain. He testified that he was able to largely control his stomach pain through his diet and by drinking Eaters Digest Tea.
- [28] Mr. Baglot testified, and the medical records confirmed, that he had periodic Crohn's flares and symptoms prior to the ulcer. He was admitted to ARH on December 9, 2006, with abdominal pain and nausea. His flares affected his ability to complete his second term at UFV. He was hospitalized in April 2009 for stomach pain and had a laparoscopic procedure to remove adhesions. It was at this point that he received a formal diagnosis of Crohn's disease. He was admitted to ARH again on October 7, 2009, with abdominal pain and nausea.
- [29] In cross-examination, Mr. Baglot agreed that the formal diagnosis of an incurable, lifelong disease was very upsetting to him.
- [30] Despite his Crohn's disease, Mr. Baglot maintained a high level of activity until mid-2010. He had a number of hospital visits, but they were brief and his symptoms were relieved with nasogastric ("NG") tubes. He was physically active and cycled everywhere. He testified that apart from periodic Crohn's flares, he was healthy.
- [31] During this period, Mr. Baglot suffered pain in his knees, shoulders, hips, and hands from a type of arthritis related to Crohn's disease. He testified that this pain affected his ability to walk, draw, hold small objects, and doodle at times.
- [32] Mr. Baglot's symptoms worsened and he moved in with his mother in or around the summer of 2010. He was becoming lethargic. In cross-examination, Mr. Baglot agreed that he used some corticosteroids to control his Crohn's disease prior to the ulcer. He used marijuana for pain relief in 2008. He acknowledged that he had taken Tylenol 3, which contains an opioid, after receiving a prescription for it on March 16, 2011. He also had morphine administered in hospital in March 2011. He testified that any use of painkillers prior to the ulcer was temporary and that his previous use was "a world of difference" from his current permanent reliance on opioids.
- [33] Prior to the ulcer, Mr. Baglot saw Dr. Yik and Dr. Chatur, both gastroenterologists. He was put on Imuran and prednisone for his flare-ups. Mr. Baglot's admissions to hospital intensified in 2011. For example, he was admitted to ARH on January 22, 2011, for stomach pain. He stayed three days. He returned to ARH on March 6, 2011 to address a small bowel obstruction related to his Crohn's. He stated his pain was severe. He was in and out of the hospital between March 12 and March 16, 2011, again for his Crohn's disease.
- [34] Although his doctors recommended going on a biologic medication ("biologic") to control his Crohn's disease, Mr. Baglot did not do so prior to his ulcer. He testified that it crossed his mind to go on a biologic prior to 2011, but he was told that it was a major risk because it would cut off part of his immune system. He understood that there are always trade offs and risks with going on medication, but he believed this medication was not worth the risk.

Abbotsford Regional Hospital

- [35] On July 22, 2011, when he attended ARH, Mr. Baglot's stomach was distended and hard. He testified that it felt like he had blockages similar to the ones he had experienced previously. He told the emergency room staff that his abdominal pain was a "9-10", meaning it was severe on the pain scale. Mr. Baglot testified that he felt sick and weak. He understood that he would have to stay overnight as he usually stayed one to three days when was admitted to hospital. He thought the doctors would be able to help because he had attended Vancouver General Hospital ("VGH") and RCH in the past for similar stomach pain and had been treated without issue.
- [36] Dr. Fourie, a general practitioner, was the physician who was primarily responsible for Mr. Baglot while he was at ARH. He was not given an NG tube. He testified that while he was sick going in, he continually got worse until he was delirious. He could barely talk to his mother. He testified that he repeatedly asked to see a specialist, which he had always done in other hospitals. He felt that the staff at ARH was not prepared for his situation.
- [37] Mr. Baglot testified that at first he wanted to trust Dr. Fourie, but he did not feel safe at ARH. He found Dr. Fourie to be "snippy" and "rude". He testified, "I felt like I was going to die in that place I really thought I was going to die there. I really legitimately thought that if I didn't go somewhere else, I would die "
- [38] Mr. Baglot admitted in cross-examination that anytime he was in the hospital he worried about his sickness. In cross-examination, he stated that prior to meeting Dr. Fourie on July 22, 2011, he thought he was going to die.
- [39] On July 25, 2011, Mr. Baglot underwent an ultrasound examination of his abdomen. Although he had been asking to be transferred, Mr. Baglot chose to wait until after the ultrasound results came back to ultimately determine whether to transfer to a different hospital. The examination revealed that there was no free fluid and no abscesses present.
- [40] Mr. Baglot's condition was "spiralling down." Dr. Chatur confirmed that Dr. Fourie discussed Mr. Baglot's condition with her on July 28, 2011. On July 29, 2011, Dr. Fourie ordered a computed tomography ("CT") scan which showed evidence of Crohn's disease, but no evidence of a perforated ulcer or abscess.

Royal Columbian Hospital

- [41] Mr. Baglot was transferred to RCH on August 1, 2011. Mr. Baglot testified that he felt really sick, dizzy, and weak. By this point he could not really walk and needed to use a commode by the bed.

- [42] The physicians at RCH investigated and identified a perforated duodenal ulcer. The ulcer was repaired by Dr. Turner, a general surgeon, on August 2, 2011. Mr. Baglot awoke from surgery and found an incision from his pelvis to his sternum. He was attached to multiple tubes and bags. He originally thought he was going to have a colostomy bag, but after a week he realized this would not be necessary.
- [43] On August 6, 2011, Mr. Baglot noticed "coffee ground-like" blood in his stool. This was evidence of a bleed (the "first bleed"). He confirmed that the physicians told him that the cause of the bleed was unknown, but that it could have been caused by his underlying Crohn's disease.
- [44] Mr. Baglot was given high doses of opioids during his lengthy hospital stay and was on a low dose of heparin, an antiplatelet agent. He testified that since the August 2, 2011 surgery, he has consistently been on prescribed opioids to control his pain.
- [45] On August 25, 2011, Dr. Turner advised Mr. Baglot that the repair of the perforation looked good and that there was a plan to discharge him from the hospital in four to five days. Unfortunately, on August 29, 2011, Mr. Baglot experienced another bleed (the "second bleed"). He was transferred to ICU. After performing a scope, the physicians thought the bleed was due to a Dieulafoy lesion in his stomach. The bleed resolved without surgical intervention.
- [46] Mr. Baglot testified regarding the second bleed. He said it was awful. He had four or more IVs in him to give him blood. They were cold pack blood transfusions, resulting in him being extremely cold. He was having eye problems related to low blood pressure. He was terrified. He was "out of it" and was very weak. He thought he was going to die. "My body was shutting down." He testified that the doctors seemed scared.
- [47] The experience surrounding the second bleed was very traumatic for Mr. Baglot. He said, "my body was shutting down" and that he was "face to face with mortality." His mother kept telling him to stay awake. He thought that if he went to sleep he would not wake up, that he would die. Mr. Baglot managed to stay awake because he wanted to say goodbye to his sister, who was not there during this period. He really thought he was going to die. He testified that he was incredibly lucky he did not die.
- [48] After the second bleed Mr. Baglot was in ICU for a few days. Mr. Baglot was discharged from RCH on September 12, 2011, after having been in the hospital for a total of 53 days.

Post-Hospitalization

- [49] After his extended hospitalization, Mr. Baglot lived with his mother for a short period. Upon his partial recovery, he and Ms. Phillips moved in together in a Qualicum motel. He described still being weak and unable to walk any distance due to the pain. He testified that Ms. Phillips was frustrated he was not the same person. They argued over having children. He testified that he told her he did not want to have biological children because he has a

"genetic sickness". Mr. Baglot went to his sister Kim's place after one particular argument and when he returned to the motel, Ms. Phillips was gone. They broke up after approximately six weeks of living together.

- [50] Mr. Baglot testified that he has been on Entyvio, a biologic, for about a year and a half leading up to trial. The Entyvio is slow acting and he had to build up his usage. He testified that since being on Entyvio, his Crohn's is not flaring up.
- [51] Mr. Baglot testified that he has less joint pain and his hands do not cramp when he plays music any more. He has put on some weight, but is still totally exhausted most of the time. He is still in pain, which is often debilitating. He testified that if he goes shopping, or is busy for a couple of days, it takes him a week to recover.
- [52] Mr. Baglot testified that eating is painful and his sleep is erratic. He experiences dizziness and light-headedness, is often depressed, and has a difficult time dealing with stressful situations.
- [53] Mr. Baglot testified that his mother helps him with everything. This includes cooking, doing the dishes, driving him around, and doing his laundry.
- [54] Mr. Baglot was emotional and upset when testifying. Recently he has been in withdrawal because his doctors can no longer prescribe more than a certain amount of opioids, which is less than what he had been taking. He testified that it is not possible for him to manage his pain on the reduced medication. When he runs out, he resorts to alcohol and marijuana as substitutes before he can refill his prescription.

Friends and Family

- [55] Mr. Baglot's friend (Ms. Adriane Ackerman), sister (Ms. Kim Baglot), and mother (Ms. Linda Baglot) testified at trial. I have organized their evidence chronologically and thematically.

Childhood

- [56] Ms. Linda Baglot testified to the abuse of her former husband. She testified that he was volatile, physical, harsh, and critical. He would scream, yell, and hit the children. Ms. Baglot testified that her former husband was harsher on their son than on their daughter. He spanked Mr. Baglot and hurt his tailbone. The family suffered. They split up when Mr. Baglot was in kindergarten.
- [57] Ms. Kim Baglot testified that their father was volatile and emotionally abusive.
- [58] Both Ms. Linda Baglot and Ms. Kim Baglot testified regarding the difficulties Mr. Baglot had in elementary school. Ms. Kim Baglot testified that Mr. Baglot was bullied. She thought this was because he had glasses, was overweight, his parents were divorced, and he had manual dexterity issues. She also testified that he may have been bullied because they are Métis.

High School

- [59] Ms. Kim Baglot testified that in high school, Mr. Baglot was quite bright and was always passionate about something. He played with yo-yos, played sports, always played a musical instrument, and skateboarded. Ms. Linda Baglot testified that he volunteered at a First Nations' day camp.
- [60] Both his mother and sister testified that Mr. Baglot did well at courses he enjoyed and did not do well if he did not enjoy them. He did well in band and did especially well in culinary arts. He loved and was very passionate about food. He was very capable, but had to repeat grade 12. He chose to finish high school so he could take more culinary arts courses.

Pre-Hospitalization

- [61] Ms. Adriane Ackerman, Mr. Baglot's friend from Portland, met Mr. Baglot around 2007 or 2008 through the cycling community.
- [62] Ms. Ackerman described Mr. Baglot before the ulcer and hospitalization as sunny, effervescent, magnetic, and outgoing. She described him as personable, the life of the party, and a joy to be around. She testified that Mr. Baglot had a wry sense of humour, and loved cooking, music, candy, skateboarding, and biking.
- [63] Mr. Baglot sublet from Ms. Ackerman and her then-husband for several months in 2009 and 2010 while they traveled. There was some overlap, so they all lived in the house together for a period. Ms. Ackerman testified that Mr. Baglot socialized with friends at events held at their house and around the city. She recalled him as a casual drinker at parties but did not recall him using marijuana.
- [64] Ms. Ackerman noticed problems with Mr. Baglot beginning in 2010 when she and her then-husband returned from their trip and he continued to live with them. She testified that he was having stomach problems, was in pain, and was having adverse reactions to things he ate. He was frequently tired. He had some swelling in his ankles and at times was not able to skateboard or cycle. He was not as active as he had been prior to that time. The changes were observable, but he was not incapacitated.
- [65] Mr. Baglot returned to BC, but they continued to correspond by Gmail, GChats, and Facebook. Ms. Ackerman testified that although he tried to be upbeat, he complained of being fatigued, feeling ill, and having joint pain.
- [66] Ms. Kim Baglot described Mr. Baglot as an extremely active individual who was in excellent physical condition prior to the ulcer and hospitalization. They travelled extensively in the US together, including a cycling trip. They went to concerts in Portland, Seattle, and California while he was at VCC. They went to China on an exchange and went to Thailand in the summer of 2008.

- [67] Ms. Kim Baglot testified that she and Mr. Baglot looked for events that celebrated cycling. Mr. Baglot went to many bike festivals and competitions and helped plan one in Vancouver.
- [68] Ms. Kim Baglot testified about Mr. Baglot's job at Thrifty Foods, saying he was excited about the job and he loved baking. She testified that he assumed a lot of responsibility, particularly after the assistant manager passed away, and wanted it to be a stable job.
- [69] Ms. Kim Baglot had never seen Mr. Baglot take any pain medication before the hospitalization, except during his prior hospital visits which only lasted a few days. She stated that after a few days in the hospital, the pain would subside and he would be back to normal.
- [70] Ms. Linda Baglot testified that Mr. Baglot was very active after his graduation up until his Crohn's worsened, confirming Mr. Baglot's testimony regarding his employment history, extracurricular activity, and chef training.
- [71] Both his mother and sister testified that Mr. Baglot attempted college but had to withdraw in the second term because of his stomach problems. Ms. Linda Baglot did not remember the details. She described how at UFV he cycled to the college every day, so long as his condition allowed, and was involved with the student body.
- [72] Ms. Linda Baglot testified that when her son was diagnosed with Crohn's disease he was upset and became emotional. It took him a while to deal with it but then he got on with his life. He said it was not going to slow him down. Ms. Kim Baglot recalled him being happy prior to the ulcer and coping well.
- [73] Prior to the July 2011 hospital visit, Ms. Linda Baglot testified that there were long periods when Mr. Baglot was well. He was in the hospital several times but would go right back to work.
- [74] Ms. Linda Baglot agreed in cross-examination that Mr. Baglot had moved home prior to the 2011 hospitalization due to his health. She testified that when he lived with her, Mr. Baglot cooked and bought groceries which he transported home on public transit or on his bike. It was her understanding that he did not experience depression prior to July 2011.
- [75] Ms. Kim Baglot agreed in cross-examination that Mr. Baglot's Crohn's disease started in about 2004 and worsened in 2010 and 2011. Ms. Kim Baglot described the flare-ups Mr. Baglot was having in the spring of 2011 as worse than before. They affected his employment and he was home a lot. Mr. Baglot did embroidery in an effort to manage the flares. He was taking things a bit slower, but he was coping well emotionally. In terms of his mood, she described him as being quieter.

Hospitalization

- [76] Ms. Linda Baglot testified that in 2011 her son was about to see Dr. Chatur but he ended up in ARH instead. She recounted how she had to visit Mr. Baglot in ARH in the middle of the night because Mr. Baglot was distressed in the bathroom. She testified that when he got up to have a shower there was blood on Mr. Baglot's bed sheets. Ms. Linda Baglot testified that she requested he be transferred to VGH because she knew Dr. Chatur was there. She confirmed that Dr. Fourie offered Mr. Baglot an appointment with Dr. Vivian, the local gastroenterologist, but she refused on his behalf.
- [77] Ms. Linda Baglot testified that in ARH Mr. Baglot did not get an NG tube, even though she asked for one to be used. When questioned about the records stating that Mr. Baglot was upset about having an ultrasound, both Ms. Linda Baglot and Ms. Kim Baglot testified that he was upset because Dr. Fourie had told Mr. Baglot that he would need a colostomy bag. It was not until about a week into his stay at RCH that Mr. Baglot realized he would not need a colostomy bag for the rest of his life.
- [78] Ms. Kim Baglot testified that Mr. Baglot was in a lot of pain when he was transferred to RCH. He needed surgery. Ms. Kim Baglot testified how Mr. Baglot thought that he was in a war zone when he came out of the anaesthetic.
- [79] Ms. Linda Baglot testified about Mr. Baglot feeling helpless while in RCH. Dr. Turner came to them to explain the surgery. He said that they needed to be careful with Mr. Baglot for the next few days. There was a hole in his duodenum the size of two small thumbnails. She described Mr. Baglot as emaciated, fatigued and in pain at RCH. She was very emotional when testifying. She testified that in the first week or two after the surgery her son was in a lot of pain. He was very thin and she was very concerned. He looked like a skeleton. There were bags coming out of him, "big bone-like things" holding him together, he had many stitches, and he had a large scar.
- [80] Ms. Linda Baglot testified that the second bleed, which occurred on August 29, 2011, was very frightening. She testified that Mr. Baglot lost consciousness. The experience was so frightening that she got her daughter on the phone to talk to Mr. Baglot, hoping that it would stop him from lapsing into unconsciousness again.
- [81] Ms. Linda Baglot testified that Mr. Baglot remained in significant pain upon discharge from the hospital.

Post-Hospitalization

- [82] Ms. Ackerman testified that Mr. Baglot changed in the years following the ulcer and the hospitalization, but initially maintained positive online chats. For example, in 2012, he stated to her that he was on painkillers and was not in much pain, only that he had no energy. During this time he competed in a tall bike jousting match.

- [83] When Ms. Ackerman later saw Mr. Baglot, the difference in him was stark. He was noticeably depressed and had lost his cognitive abilities. She described him as being like a parent with dementia. He was "out of it." She was aware of the disorientation that comes with painkillers, but it was a step beyond what one might expect. She testified that he was no longer the vibrant, fun-loving man she had known.
- [84] Ms. Ackerman testified that Mr. Baglot's attitude online changed in the last several years. She described him as despondent and "zombie-like" the last time she saw him. She thought that life was really difficult for him.
- [85] Ms. Kim Baglot described Mr. Baglot as a shell of his former self. She testified about his ongoing pain, the negative changes in him, and his loss of many friends post-hospitalization.
- [86] After being discharged from RCH, Ms. Kim Baglot stated that Mr. Baglot was self-conscious about not having a belly button due to his large scar. He tried to do some of the things he had done prior to his hospitalization such as playing music and seeing friends, but it was very difficult. He could not walk far without getting exhausted, he was in a lot of pain, and he was severely impacted by his time in hospital.
- [87] Ms. Linda Baglot described her son since his discharge from RCH as having good days and bad days. On good days, he could walk around and enjoy life.
- [88] After Mr. Baglot returned home, he would often bring up events that occurred in the hospital. He would get very upset and cry. His mother and sister testified that he avoids the ARH, gets upset if they drive past the building or in its direction, and generally avoids hospitals, physicians, dentists, and other health professionals. Ms. Linda Baglot described sitting in their car for two hours before she could finally convince him to go into VGH for surgery in July 2016 to address a bowel obstruction.
- [89] Ms. Linda Baglot agreed in cross-examination that Mr. Baglot has been back to ARH twice since July 2011. He went once to see a dietitian and another time for an infection in his feet.
- [90] Ms. Kim Baglot testified that Mr. Baglot gained some weight, but not enough. He has not improved. Since the ulcer, he has been anxious and does not handle change well.
- [91] Ms. Kim Baglot testified that if they had conflict in the past, they resolved it without anger. Now Mr. Baglot gets incredibly upset, gets angry, cries, and is unable to deal with such conversations. Mostly he rests, naps, and plays music.
- [92] Ms. Kim Baglot testified that Mr. Baglot visited her twice in Korea post-hospitalization when she was working there as a teacher.

- [93] Ms. Kim Baglot testified that once Mr. Baglot started taking biologics, he was able to maintain better weight and get better colour. After starting Entyvio in 2016, Ms. Kim Baglot stated that Mr. Baglot seemed to manage his pain well. Although there were some good days and some not so good days, he was feeling better physically and could manage his pain with his medications. This ended when his pain medication was reduced.
- [94] Ms. Kim Baglot testified about the reduction of Mr. Baglot's opioids. She testified that when he runs out he gets shaky, itchy, angry, quick tempered, and is in significant pain. He sometimes gets chills and cold sweats.
- [95] With respect to marijuana use, both Ms. Linda Baglot and Ms. Kim Baglot recalled that it was discussed with Dr. Eddy to assist with his Crohn's disease. Ms. Kim Baglot testified that he uses an oil with chemical properties from marijuana for pain management. She testified that the oil does not get Mr. Baglot high, which he prefers as he wants to remain alert. Ms. Linda Baglot testified that she and her daughter pay for part of the marijuana. They spent \$2,550 on it last year.
- [96] Ms. Linda Baglot testified that as time has gone on, Mr. Baglot continued to be in significant pain, was depressed, and became cognitively compromised. He continues to live with her and is on high doses of opioids. He has no pain free days. He is unable to do many of the tasks of everyday living and requires supervision to accomplish anything.
- [97] Ms. Linda Baglot testified that her son has spoken of suicide since the 2011 surgery, when he realized he could not go back to the life he had and that all his days are painful. He says, "why do I have to do this the rest of my life?"
- [98] Ms. Linda Baglot testified that Mr. Baglot has no social life, unless she or her daughter take him out. Even if he really wants to go somewhere, hours of preparation are required to get him out of the house and to another location. He is very isolated.
- [99] Ms. Linda Baglot testified that caring for her son is a full-time job. She spends all her time making sure Mr. Baglot has his meals and medications. She cooks, does his laundry, cleans his dishes, and cleans the house. She makes sure he is okay when she leaves in the morning to go to work. She usually goes home at lunch. She goes home right after work. She changes his bed twice a week because sometimes he has accidents. She also takes care of his cats.
- [100] Ms. Kim Baglot testified to the same effect, saying that their mother takes care of all aspects of his daily living except his immediate hygiene and personal care. Their mother prepares his daily pills because Mr. Baglot is not able to deal with that maintenance. He takes supplements in addition to his medication, which their mother prepares as well. She makes sure he gets to his appointments and picks up pain medications for him.
- [101] Ms. Linda Baglot agreed in cross-examination that Mr. Baglot was in a lot of pain prior to his July 2016 bowel surgery and had not been taking care of himself.

- [102] Ms. Linda Baglot agreed that after the July 2016 surgery, when Mr. Baglot began taking Entyvio, he no longer reported pain in his back when he was hugged. He was in less pain even though he had just had surgery. Also, since he has been on Entyvio, his joint pain is not as bad.

Medical Experts

- [103] The following is a summary of the evidence of each expert witness whose reports were filed as exhibits at the trial and/or who testified at the trial. I set out their evidence in a general way but leave a number of details for discussion under the issues I address. In reaching my conclusions, I have considered the totality of the evidence.

Dr. Chatur

- [104] Dr. Nazira Chatur is Mr. Baglot's attending gastroenterologist. She has been seeing Mr. Baglot since 2009. Dr. Kwok Yik, another gastroenterologist, has also seen Mr. Baglot. Dr. Chatur provided a report for the plaintiff, dated October 5, 2017, and a supplemental report dated March 1, 2018.
- [105] Dr. Chatur is of the view that Mr. Baglot does not currently have active Crohn's disease and that his pain is largely due to adhesions he has as a result of past surgeries. She testified that prolonged hospital stays can lead to increased gastrointestinal inflammation, which can lead to visceral hypersensitivity.

Background

- [106] Dr. Chatur testified that she did not review the RCH chart in its entirety, but perused it before writing her report for the plaintiff. She did not state that she reviewed the ARH records in her written report, nor did she set out her underlying assumptions as she is a treating physician.
- [107] Dr. Chatur testified that she based her report principally on her clinical experience with Mr. Baglot. In addition, her evidence regarding physiological stress and compromise of mucosal health is based on her experience in treating patients in the intensive care unit ("ICU") and the post-surgical units at VGH.
- [108] Dr. Chatur testified that when she charts she tries her best to record all of the patients' symptoms as they are related to her. She tries to be complete and accurate. She sets out what she believes to be the most likely diagnosis based on her assessment at the time. She also sets out what she believes to be the best course of treatment for the patient.

Medical History

- [109] Dr. Chatur testified that after she saw Mr. Baglot in 2009, he saw Dr. Yik who started him on a course of prednisone. He was then switched over to Imuran and Entocort.

- [110] Dr. Chatur testified that Mr. Baglot had surgery for adhesion lysis following a bowel obstruction in 2009.
- [111] Dr. Chatur agreed that she recommended that Mr. Baglot go on a biologic in March 2011. This was to treat the Crohn's disease and to prevent further damage. She testified that biologics are medications that target certain molecules to dampen the effect of inflammation on the body.
- [112] Dr. Chatur was taken to records that stated Mr. Baglot was reluctant to embark on medical therapy for his Crohn's disease. She testified that this, in part, seemed to be driven by his mother who wondered why he would need to remain on indefinite therapy when it would not be curative. Dr. Chatur testified that it was not unusual for patients to want to know why they are on indefinite therapy, especially because such therapy can have significant side effects.
- [113] Dr. Chatur confirmed that she discussed Mr. Baglot's condition with Dr. Fourie on July 28, 2011. Dr. Chatur suggested a CT scan to make sure there was no abscess. She agreed that on the CT scan dated July 29, 2011, performed while Mr. Baglot was still at ARH, there was no evidence of perforation or abscess.
- [114] Dr. Chatur testified that in October 2011, she again advised Mr. Baglot that he should treat his Crohn's disease. However, she testified such treatment might need to be delayed post surgery to ensure there was no underlying infection. This is because it is dangerous to give an immunosuppressant to a patient who may have an underlying infection from surgery.
- [115] In cross-examination, Dr. Chatur agreed that Mr. Baglot was not in the ICU prior to the first bleed. This bleed was embolized in surgery and Mr. Baglot went to the internal medicine clinical teaching unit ("CTU"). He was not admitted to the ICU until after the second bleed.
- [116] Dr. Chatur explained that it was not just being in the ICU that would have been traumatic for Mr. Baglot; the entire course of having a perforated duodenal ulcer, being transferred emergently to RCH, and undergoing emergency surgery would be traumatic. She testified that a series of events, rather than one discrete event, would cause physiological stress.
- [117] Dr. Chatur testified that a perforation is a tear or disruption to the abdominal cavity. An ulcer occurs when the mucosa (lining) erodes to the point where it breaches all layers and opens into the abdominal cavity. With the perforation, bile and gastric juices leak into the abdominal cavity. This is dangerous because it disturbs the sterility of the abdominal cavity. A person can die from such a leakage.
- [118] Dr. Chatur testified that Mr. Baglot's perforated ulcer was in his upper small bowel, whereas his Crohn's disease is located in his terminal ileum. These are completely different areas of the gastrointestinal ("GI") tract. There has been no evidence of Crohn's disease in Mr. Baglot's upper GI tract.

[119] Mr. Baglot saw Dr. Garraway at RCH on October 9, 2011, for ongoing pain issues post-surgery. Dr. Garraway stated:

[Mr. Baglot had] a new right lower quadrant pain with nausea and vomiting yesterday. It appears that he has a thickened area of small bowel, which could represent a reactivation of some Crohn's as his prednisone has been tapered to almost off. This could also potentially be either infectious or due to postoperative changes. He has no abscesses seen, so it seems more likely, this could be related to his Crohn's disease.

[120] Dr. Chatur responded that Dr. Garraway's impression may not necessarily be true. She testified that post-operative changes can be subtle enough that they may not show up on a CT scan. She testified that a CT scan is not that sensitive. A finer resolution test, such as a colonoscopy, may reveal that the thickened area noted on a CT scan was, in fact, not a thickened area of bowel.

[121] With respect to biologic medications, on January 6, 2012, Dr. Chatur stated, "I really think we need to get his medical therapy started, and I have informed him that unless he has all his pre-biologic investigations performed, I will not be seeing him as I really have nothing to add to his therapy." She testified that it is not unusual for young patients to resist treatment. It is a tough decision for them. She agreed that Mr. Baglot did not go on a biologic until March 11, 2014, almost three years after the prolonged hospitalization.

[122] Dr. Chatur testified that she saw Mr. Baglot on August 1, 2014. She prepared a consult for Dr. Howard, a psychiatrist. She indicated that Mr. Baglot had struggled with Crohn's disease which had been extremely debilitating for him. She felt that his mood problems, his stress, and his poor emotional well-being were having a big impact on him.

[123] Dr. Chatur testified that after seeing Dr. Howard, Mr. Baglot's mood was better and he was improving in January 2015. He was on a biologic at that time that was part of a clinical trial.

[124] At trial, Dr. Chatur noted that Mr. Baglot had been doing very well on the open label study drug, AMG 181, but he eventually failed the drug. This led to his hospital admission at VGH in May 2016 with an acute flare.

[125] Dr. Chatur testified that Mr. Baglot went on Entyvio, a biologic, in June 2016.

[126] A CT scan was done on July 5, 2016; it noted that Mr. Baglot had acute chronic changes involving a long segment of the distal ileum. He also had persistent small presacral abscess. At this stage, Mr. Baglot Crohn's disease was "penetrating." Dr. Chatur explained that this means the inflammation has affected all layers of the intestinal wall.

[127] Mr. Baglot had surgery on July 24, 2016, due to a small bowel obstruction. The operation performed was "Laparotomy with lysis of adhesions, right hemicolectomy with primary anastomosis and repair of incisional hernia." At this stage the Crohn's disease had strictured, with the mucosa turning "into like a scar." Dr. Chatur confirmed that the surgery was for Crohn's disease. In her consult to Dr. Eddy she stated, "unfortunately, he does have severe Crohn's disease and abdominal pain is a prominent symptom."

[128] Dr. Chatur states in her October 5, 2017 report that any abdominal surgery impacts Mr. Baglot's disease process adversely by putting him at risk for adhesions. Dr. Chatur explained how adhesions can result from any surgery. After surgery there is scarring, which leads to adhesions. Adhesions are part of the healing process and can cause pain when there is peristalsis, meaning when gas or stool move through the bowels. This pain would significantly impact Mr. Baglot's quality of life. This in turn would significantly impact his ability to work and undertake other aspects of a normal life. Dr. Chatur also stated, "Prolonged hospitalization with [a] complicated hospital course is also well known to cause psychological and emotional stress."

[129] In her October 5, 2017 report, Dr. Chatur also states:

[P]rolonged hospitalization as well as surgery would have impacted the mucosal health of the distal small bowel. Surgery causes physiological stress which could have further been compounded by prolonged hospitalization and an ICU stay. Thus, compromise of mucosal health could have, in turn, compounded any effect of Crohn's disease on the small bowel resulting in a bleed.

[130] In a March 1, 2018 clinical report, Dr. Chatur advised that in addition to his complicated surgery for the perforated duodenal ulcer, Mr. Baglot had surgery for adhesion lysis following a bowel obstruction in 2009.

Opinion on Current Condition

[131] Dr. Chatur stated that on March 1, 2018, Mr. Baglot was healthier than when she had seen him in the past. His weight had increased. She advised that Mr. Baglot has multiple surgical scars on his abdomen. He had a colonoscopy in January 2018, revealing:

him to be status post right hemicolectomy. There was minor ulceration [analogous to a break in skin surface] at the right hemicolectomy anastomosis [where the hookup of the small and large bowel is found]. Otherwise, mucosa was normal from neoterminal ileum to rectum. Anastomotic biopsies showed mild active inflammation that could have been either ischemic [restriction in blood supply to tissue] or NSAID induced (he does not take any NSAIDs). Neoterminal ileum, colonic and rectal biopsies were normal. All biopsies were negative for dysplasia.

[132] Dr. Chatur testified that these findings imply that Mr. Baglot does not currently have active Crohn's disease. She did not see any gross evidence of Crohn's disease. She noted, however, that he is still in pain.

- [133] Dr. Chatur agreed in cross-examination that Crohn's disease can cause disability, depending on the severity of the disease. When active, Crohn's disease causes symptoms including pain, cramping, diarrhea, appetite loss, the inability to eat, and vomiting. She agreed that abdominal pain can be associated with emotional suffering and disability. She also agreed that Crohn's disease causes microscopic damage over time.
- [134] In cross-examination, Dr. Chatur admitted that adhesions can result from small bowel Crohn's disease. She confirmed that Mr. Baglot had adhesions prior to the ulcer. She assumed those were a result of his Crohn's disease.
- [135] Dr. Chatur gave evidence that adhesions from his past surgeries may be causing Mr. Baglot's pain. Every time a surgery is performed, there is a risk of more scarring. She testified that he has had a number of surgeries and these will all lead to adhesions.
- [136] Dr. Chatur testified that there is significant data to support that perceived stress and major life events can put patients at risk of a flare from their inflammatory bowel disease. Dr. Chatur agreed in cross-examination that Crohn's disease can progress over time.
- [137] Dr. Chatur opined that a prolonged hospital stay can cause physiological changes in the body. This is due to compromised blood flow caused by hypotension. This means that the blood pressure goes down, risking inadequate blood flow. Blood flow is needed to deliver oxygenation and nutrients to the mucosa in the GI tract, otherwise the mucosa can start ulcerating and sloughing off, which compounds the effects of Crohn's disease.
- [138] Dr. Chatur agreed in cross-examination that there can be a strong association between gastrointestinal inflammation and the onset of visceral hypersensitivity. In such a case, the hypersensitivity may persist even after the complete resolution of the inflammation.
[confirmed]
- [139] Dr. Chatur testified that pain is one of the main manifestations of Crohn's disease, but she did not find any objective evidence of Crohn's on the recent colonoscopy and she has every reason to believe Mr. Baglot is responding to Entyvio.
- [140] Dr. Chatur testified that Mr. Baglot's current arthralgias, meaning his joint pain, is related to his February 2017 motor vehicle accident.

Dr. Somsouk

- [141] The plaintiff retained Dr. Ma Somsouk, a gastroenterologist and assistant professor at University of California, San Francisco. Dr. Somsouk is of the opinion that the defendant's ketorolac prescription may have exacerbated Mr. Baglot's Crohn's disease, leading to the first bleed.

- [142] Dr. Somsouk is of the opinion that the type of second bleed Mr. Baglot suffered is associated with chronic illness, hospitalization, and NSAIDs. He is of the opinion that Mr. Baglot may suffer from "dumping syndrome" due to a post-ulcer surgical procedure, and his diagnosed visceral hypersensitivity resulted from his emotional experience while hospitalized.
- [143] Dr. Somsouk testified that he did not perform any investigative tests of Mr. Baglot apart from a verbal history and a physical examination. He confirmed that the bulk of his opinion relies on the reports and the records provided to him. Mr. Baglot provided his views regarding what was traumatizing to him. Dr. Somsouk agreed in cross-examination that all of the social history provided by Mr. Baglot was contained within the other records before him.
- [144] Dr. Somsouk testified that Crohn's is an autoimmune disease in which the patient has an overactive immune system. The disease has a genetic predisposition and potentially has an environmental trigger.
- [145] Dr. Somsouk testified that there is no cure for Crohn's disease. There is therapy that can put patients in remission but they can have recurrent symptoms. biologic agents are becoming very effective at managing Crohn's disease overall. Dr. Somsouk admitted in cross-examination that pain from Crohn's disease can be debilitating and some patients never go into remission.
- [146] Dr. Somsouk testified that Crohn's disease can attack not only the bowels and intestines; the immune system can also attack the joints. Dr. Somsouk testified that individuals with Crohn's disease may have underlying fibrotic strictures or adhesions secondary to their disease. While not all pain is due to fibrotic strictures, there will be symptoms if they are present. If the disease is under control, or a diseased portion of the bowel has been resected, the individual would have less evidence of disease.
- [147] Dr. Somsouk testified that in 2009, "Mr. Baglot underwent lysis of adhesions," explaining that the surgeon went in to examine for scarring and then broke up the scars, the "adhesions."
- [148] Dr. Somsouk testified under cross-examination that inflammatory bowel disease can cause peritoneal inflammation. When asked whether subtle inflammation may exist even when standard disease activity is in remission, he responded that a small amount of disease activity was possible. He agreed that intestinal inflammation can affect the body's ability to move food through its digestive tract, which could secondarily induce visceral hypersensitivity.
- [149] At trial, Dr. Somsouk explained that some people develop visceral hypersensitivity, which is associated with anxiety and maybe with childhood events. In Mr. Baglot's case, he had an abusive, unfaithful father (not proven at trial), so he was predisposed to visceral hypersensitivity.

- [150] Dr. Somsouk concluded that Mr. Baglot does experience visceral hypersensitivity, which contributes to the debilitating nature of his symptoms. In his report, Dr. Somsouk opines that Mr. Baglot's visceral hypersensitivity "could have resulted from his emotional experience during the hospitalization." Dr. Somsouk testified regarding Mr. Baglot's reported fear of dying, anxiety, and helplessness during his hospitalization in 2011. Dr. Somsouk testified that in the first couple of days in the hospital, the notes indicate that Mr. Baglot was calmly sleeping and that he had his guitar with him. However, he did not improve and his pain got worse over the course of the hospitalization.
- [151] When questioned in cross-examination, Dr. Somsouk agreed that a patient with Crohn's disease can have visceral hypersensitivity even after the resolution of the inflammation (remission). He agreed there is an association between Crohn's and visceral hypersensitivity. He did not agree that there is a strong association between the two.
- [152] The surgery to repair Mr. Baglot's perforated ulcer included a tube duodenostomy, a tube cholecystostomy, and a gastrojejunostomy. Dr. Somsouk testified to what these procedures entail. The surgery involved closing off the opening between the stomach and the duodenum, patching over the perforation in the duodenum since the tissue was so damaged and inflamed that the doctors were unable to put sutures in it for fear that the tissue would "break apart easily." The physicians had rerouted his intestines so that his stomach contents would instead pass into his jejunum. As Dr. Somsouk explained, the gastrojejunostomy alters a person's original anatomy.
- [153] In terms of Mr. Baglot's 2016 surgery, Dr. Somsouk testified that he had surgery to remove 29 centimetres of his bowel. It was an "acute on chronic" change of the distal ileum that caused a small bowel obstruction. He testified that after surgery Mr. Baglot would have had a scar and that scars can cause pain. He explained that any time you violate the abdominal cavity, there will be inflammation and adhesions.
- [154] In terms of any association between NSAIDs and the worsening of Crohn's disease, Dr. Somsouk testified that there is not good evidence of such an association. However he explained in direct examination that a perforation is associated with inflammation and diversion of blood flow. The experts refer to this as a "systemic inflammatory response," like sepsis. This can worsen Crohn's disease because the blood may not be flowing as well to that part of the ileum. This would put the patient at an increased risk of experiencing a bleed from the Crohn's disease.
- [155] Lesions are thought to occur because there is a shift in terms of the blood flow. Dr. Somsouk agreed in cross-examination that a Dieulafoy lesion (what the physicians thought was a likely cause of the second bleed) is unlike a normal arterial tree. The branches of a Dieulafoy lesion progressively narrow. The blood no longer flows into the gastrointestinal circulation as well as it should and is diverted elsewhere. He explained that because these vessels do not prune as they come to the surface, they are predisposed to rupturing and bleeding at a large rate. Damage can occur to the surface of the stomach, the mucosa, or

the cells that make the mucosa.

- [156] Dr. Somsouk testified that Mr. Baglot essentially experienced sepsis systemic inflammation after having a bowel perforation. This is the type of risk factor that is associated with a Dieulafoy lesion. Dr. Somsouk testified that there are several risk factors for Dieulafoy lesions. The most common ones are an ICU stay, mechanical ventilation, trauma, burns, and sepsis. He testified that a trauma is often associated with significant blood loss and inflammation.
- [157] Dr. Somsouk wrote in his report that Mr. Baglot may have "dumping syndrome" as a result of a procedure he underwent due to his perforated ulcer. Dr. Somsouk testified that if the individual experiences pain many hours after they have eaten, it is less likely to be related to dumping syndrome or to upper GI pathology and is more likely caused by visceral hypersensitivity.
- [158] He agreed under cross-examination that given the length of time that Mr. Baglot has had Crohn's disease, it is likely that he has microscopic inflammation. He agreed that the resulting symptoms can contribute to visceral hypersensitivity.
- [159] Dr. Somsouk testified that as of April 22, 2018, Mr. Baglot's Crohn's disease is under good control.

Dr. Mann

- [160] The plaintiff retained Dr. Ranbir S. Mann, a general practitioner. Dr. Mann opined that Mr. Baglot's perforated ulcer caused pain and scarring. He further stated that Mr. Baglot "is likely to suffer substantial complications in the future because of this duodenal ulcer and perforation."
- [161] The defendant stressed that Dr. Mann did not interview or examine the plaintiff. This is also true of Dr. Fishman and Dr. Byrne, both gastroenterologists retained by the defendant.

Dr. Tarzwell

- [162] The plaintiff retained Dr. Robert Tarzwell, a psychiatrist who has a background in chronic pain and addiction medicine. Dr. Tarzwell opined that Mr. Baglot was not suffering from any psychiatric disorder prior to the ulcer, but diagnosed him as suffering from PTSD due to his experience in hospital. He is of the opinion that Mr. Baglot does not have substance use disorder, although he does exhibit some symptoms of the disorder. In his opinion, Mr. Baglot does not have a substance use disorder because he primarily uses opioids to control his persistent pain.
- [163] Dr. Tarzwell testified that Mr. Baglot had been troubled by an adverse childhood, but at the time of admission to ARH he showed normal adult function. He agreed that this information was important to his opinion.

- [164] Dr. Tarzwell opined that exposure to early childhood trauma significantly increases the risk of issues later in life. Mr. Baglot was abused by his father, his parents divorced, and he was in a motor vehicle accident when he was young.
- [165] Dr. Tarzwell is of the opinion that Mr. Baglot suffers from PTSD. The 5th revision of the Diagnostic and Statistical Manual of Mental Disorders ("DSM-V") stipulates, and Dr. Tarzwell agrees, that an individual has to have met all criteria to be diagnosed with PTSD. Dr. Tarzwell agreed that under criterion A, "exposure to actual or threatened death," the second bleed was Mr. Baglot's exposure event.
- [166] Dr. Tarzwell testified that whether or not the second bleed was causally related to other issues (such as the NSAID or the ulcer) is for his medical and surgical colleagues to determine. However, in his opinion, Mr. Baglot thought that the bleed was a result of a series of events and it was possible for him to form that belief. Dr. Tarzwell explained that Mr. Baglot felt that there was a direct link of causation between the way he was treated at ARH, the discovery of the ulcer which was initially not diagnosed, and the second bleed. The trigger was the second bleed in the context of his resentment regarding negligent care at ARH. He "sincerely believed he was going to die." Dr. Tarzwell testified that it is psychologically reasonable for Mr. Baglot to have linked the second bleed with what happened at ARH.
- [167] Dr. Tarzwell agreed that family history can increase the risk of alcohol abuse disorder, or any substance abuse disorder. He admitted in cross-examination that Mr. Baglot did not volunteer alcohol abuse disorder in his family even though his father had alcohol abuse issues.
- [168] Dr. Tarzwell agreed that marijuana use can explain lack of motivation and exhaustion. Dr. Tarzwell agreed Mr. Baglot's tobacco use is an example of using substances to cope with stress. He agreed that drinking two litres of cola per day could affect Mr. Baglot's sleep.
- [169] Dr. Tarzwell agreed in cross-examination that it would be of assistance for Mr. Baglot to be in the care of a psychiatrist. He testified that a team care multidisciplinary approach would be ideal. Dr. Tarzwell agreed that Mr. Baglot had seen a psychiatrist only four times. He agreed that Mr. Baglot had not received aggressive treatment for his psychiatric difficulties, and explained that his use of the term "aggressive" treatment in his report was from a pharmacological point of view. He hoped that if Mr. Baglot pursued treatment it would be of assistance.
- [170] Dr. Tarzwell agreed that alcohol can affect mood and anxiety. He agreed that severe abdominal pain, cold sweats, the sensation of crawling skin, and an increased number of bowel movements are classic opioid withdrawal symptoms. He also agreed that in order to meet the diagnosis of opioid use disorder, only two of the eleven criteria listed in the DSM-V need to be met. Dr. Tarzwell agreed that Mr. Baglot met two: tolerance and withdrawal.

- [171] Dr. Tarzwell opined that the DSM-V states for there to be opioid use disorder, "an individual prescribed analgesic opioids for pain relief at adequate dosing will use significantly more than prescribed and not only because of persistent pain." He testified that Mr. Baglot exhibits symptoms from opioid use disorder but those symptoms, in his opinion, relate to his chronic pain and therefore the substance use disorder does not apply. Dr. Tarzwell opined that pain is the fundamental driver of Mr. Baglot's use of substances.
- [172] Dr. Tarzwell explained that this is a difficult case with respect to what degree there is addiction versus sought relief from pain. Dr. Tarzwell agreed in cross-examination that Mr. Baglot reported that he uses substances to deal with stress. Dr. Tarzwell testified that poor coping skills are a risk factor for substance abuse disorder, not a cause.
- [173] Dr. Tarzwell agreed in cross-examination that individuals tend to minimize self-reporting of substance abuse. He did not specifically recall asking Mr. Baglot whether he felt the need to cut down on his drinking in 2011. He did not explore with him whether he felt guilty about his drinking prior to the hospitalization. He agreed that this would be important to know and would be relevant.
- [174] Dr. Tarzwell stated that there was some room for disagreement in the area of addiction. However, he is of the opinion that the real "elephant in the room" is Mr. Baglot's pain, which began to resurface when the opioid prescription was reduced. In his opinion, there was no evidence that Mr. Baglot recreationally used opioids. When it was put to him that the reason Mr. Baglot does not seek out opioids from illicit sources is because he is afraid to do so, he responded that this demonstrated Mr. Baglot appeared to appreciate salient, rational consequences which speaks against an opioid use disorder.
- [175] Dr. Tarzwell is of the opinion that Mr. Baglot's opioid use falls into the pain exception under the definition of substance use disorder.
- [176] Mr. Baglot frequently cannot participate in life because of pain and anxiety. Dr. Tarzwell opined that currently "he is almost afunctional."

Dr. Fishman

- [177] The defendant retained Dr. Martin Fishman, a gastroenterologist. Dr. Fishman opined that the second bleed was not related to the perforated ulcer, his hospitalization experience was not sufficiently traumatic to cause visceral hypersensitivity, he has not been diagnosed with dumping syndrome, and all of Mr. Baglot's post-hospitalization symptoms are due to his Crohn's disease.
- [178] Dr. Fishman believes there is a strong probability that Mr. Baglot's symptoms would not have been significantly different had he not had a perforated ulcer and the resultant surgery.

- [179] Dr. Fishman opined that Mr. Baglot was suffering from ongoing incompletely treated Crohn's disease with recurrent small bowel obstruction prior to his July 22, 2011 admission to ARH. Prednisone would not be expected to have completely healed his inflamed intestinal mucosa and it was probable that Mr. Baglot had active Crohn's disease at the time of his July 2011 admission.
- [180] Dr. Fishman commented on Mr. Baglot's second bleed in his upper GI tract. The impression of the endoscopist was that the bleeding may have been from an invisible Dieulafoy lesion. It was no longer bleeding at the time of the endoscopy. In Dr. Fishman's opinion, such a lesion would not have been related to Mr. Baglot's Crohn's disease, the perforated ulcer, or to the surgery.
- [181] In relation to Dr. Somsouk's report, Dr. Fishman opined that his comments regarding bleeding from the Dieulafoy lesion are generally correct. The cause of these lesions is not known. He admitted that NSAIDs have sometimes been associated with these bleeds and Dieulafoy lesions may bleed on occasion in the context of a hospitalization.
- [182] Dr. Somsouk was of the opinion that Mr. Baglot's visceral hypersensitivity could have resulted from his emotional experience during the hospitalization. In his experience, Dr. Fishman testified that the bleeding is typically a brief event that stops on its own and is not catastrophic. He has treated thousands of patients with GI bleeding and thousands of patients with visceral hypersensitivity. Dr. Fishman found it difficult to believe that Mr. Baglot's bleeding would have been sufficiently traumatic to cause visceral hypersensitivity. He disagreed with the statement in Dr. Chatur's report regarding the impact prolonged hospitalization can have on a patient.
- [183] Dr. Fishman gave evidence that the amplified sensation of pain visceral hypersensitivity is often thought to cause arises from neurochemical changes in the nervous system. In some patients, this may be brought about by a severe or sustained deep-seated emotional trauma, such as sexual abuse. He stated that most patients with visceral hypersensitivity have sustained some form of abuse, emotional, physical or sexual, often on an ongoing or prolonged basis.
- [184] Dr. Fishman gave evidence that a diagnosis of visceral hypersensitivity is not made unless no other cause for symptoms can be identified that would adequately explain the symptoms. In Mr. Baglot's case, the presence of active Crohn's disease is sufficient to explain his symptoms. He opined that the balance of probability favours Crohn's disease as the principal and primary cause for Mr. Baglot's ongoing illness following his hospitalization.
- [185] Dr. Fishman opined that there is no evidence that Mr. Baglot has been diagnosed with or treated for dumping syndrome.

Dr. Byrne

- [186] Dr. Michael Byrne, a gastroenterologist, testified for the defendant. His report is dated March 16, 2018. Dr. Byrne is of the opinion that neither of the two bleeds was related to the perforated ulcer. Mr. Baglot's ongoing medical symptoms are due to his poorly controlled and aggressive Crohn's disease, and dumping syndrome is not the dominant cause of his symptoms. He further opines that while visceral hypersensitivity may play a role in Mr. Baglot's pain complaints, his Crohn's disease is the primary cause.
- [187] Dr. Byrne reviewed Mr. Baglot's medical history. Following his surgery in April 2009, Mr. Baglot saw Dr. Yik, who prescribed steroids as well as Azathioprine. He followed up with Mr. Baglot in September 2010, when Mr. Baglot had been on the prescriptions for several weeks. Mr. Baglot was feeling quite a lot better with no further pain and was passing formed stools. Dr. Yik believed that the symptoms of Crohn's disease had reoccurred and were mildly active. He believed Mr. Baglot might need to consider going on a biologic to treat his Crohn's disease.
- [188] Dr. Byrne believed that Dr. Yik's review, including suggesting a biologic, does not suggest a mildly active disease in 2009. Dr. Byrne's opinion was that Mr. Baglot was symptomatic of what turned out to be Crohn's disease from around 2004 or 2005, up to July 2011, when he was admitted to ARH.
- [189] Dr. Byrne addressed the prolonged hospitalization. He opined that the first bleed appeared to be directly related to Mr. Baglot's Crohn's disease of the small bowel. What the physicians assumed was a gastric Dieulafoy lesion on August 29, 2011, did not appear to have been coming from the area of the previous duodenal perforation. Dr. Byrne opined that neither the first nor the second bleed was caused by the perforated ulcer.
- [190] Dr. Byrne opined that despite having two surgeries and trying several medications, including biologics, Mr. Baglot continues to struggle with Crohn's disease.
- [191] Dr. Byrne notes that Mr. Baglot was somewhat resistant to advancing his therapy to biologic treatment. It was clear from a review of his clinical course up to the time of the perforated duodenal ulcer that his Crohn's disease was going to continue to cause him problems and require more extensive treatment. Mr. Baglot's clinical course and investigative findings subsequent to September 2011, are all consistent with his small bowel Crohn's disease. He notes that the overall recent pattern seems better with his adjusted drug therapy and his two surgeries for small bowel disease compared to several years ago.
- [192] Dr. Byrne agreed in cross-examination that the differential diagnosis did not stop at Crohn's disease and that he has to "keep an open mind." However, he testified that all the reports "pointed very strongly and clearly to poorly controlled Crohn's, quite aggressive Crohn's disease."

- [193] In response to Dr. Somsouk's report, Dr. Byrne stated in his report that recent studies and reviews have found no clear causal link between Dieulafoy lesions and the use of NSAIDs. It is a commonly held opinion that there may be an association between Dieulafoy lesions and diseases such as cardiac disorders, hypertension, renal failure, and alcohol abuse. There is no significant evidence that hospitalization increases the risk of Dieulafoy lesion formation.
- [194] Dr. Byrne agreed in cross-examination that he respects Dr. Chatur's opinion. Dr. Byrne was taken to a peer-reviewed journal regarding Dieulafoy lesions. He agreed with the statement that NSAIDs adversely affect the bowel and that they can cause bleeds. He agreed that NSAIDs can cause bleeding and can hamper clotting. He agreed that anti-platelet agents are significantly associated with Dieulafoy lesions in the study. He agreed that antiplatelet agents are a type of anticoagulant. He agreed with the proposition that although there is no direct evidence that Dieulafoy lesions are caused by NSAIDs, aspirin, or Coumadin (an anticoagulant), use of these medications have been reported in more than 50% of Dieulafoy lesion patients. He testified that Mr. Baglot was on low-dose heparin, an anticoagulant akin to Coumadin.
- [195] Dr. Byrne testified that Mr. Baglot potentially had ischemia (inadequate blood supply) from the surgery. He also opined that malnutrition can limit the regeneration of the mucosal cells and can affect mucosal integrity.
- [196] In terms of visceral hypersensitivity, Dr. Byrne thinks it is possible that visceral hypersensitivity, secondary to the traumatic events of 2011, could play a role in Mr. Baglot's ongoing symptoms. However, the clinical, endoscopic, radiological, and medication history prior to the surgery in 2011, and subsequent to the surgery, is overwhelmingly in favour of underlying aggressive Crohn's disease of the small bowel being the dominant cause of Mr. Baglot's ongoing health issues.

Dr. Hall

- [197] The defendant retained Dr. Lacrosha Hall, a psychiatrist. Dr. Hall wrote a report dated March 23, 2018. Dr. Hall is of the opinion that Mr. Baglot has alcohol, cannabis, and opiate use disorders, and substance-induced mood disorder, but does not have PTSD. Dr. Hall opined that these substance use disorders are more likely than not due to Mr. Baglot's poor coping skills and propensity to abuse substances, as opposed to his perforated ulcer.
- [198] Dr. Hall agreed in cross-examination that a person can become addicted within a week or two. She testified that Mr. Baglot is a vague historian.

- [199] Dr. Hall opined that Mr. Baglot takes opioids to manage his stress and anxiety; he is not taking opioids only for pain control. She also believes his pain, anxiety, and depression are related to his chronic substance abuse rather than the duodenal ulcer. It will not be possible to know if there are other causes of his pain until his substance use disorder is adequately treated. This is because substance use can mimic psychiatric disorders.
- [200] Dr. Hall testified that to be diagnosed with the mood disorder PTSD, the individual would need to have suffered from trauma. She testified that his experience in the hospital would not amount to the type of trauma that would result in PTSD. She agreed in cross-examination that she did not know how traumatic the hospitalization was for Mr. Baglot. She also agreed in cross-examination that fear of death is an important predictor of PTSD.
- [201] Dr. Hall opined that Mr. Baglot did not meet other criteria for PTSD such as intrusion symptoms avoidance associated with distress. She reiterated that PTSD could not be accurately diagnosed unless he remained substance-free for at least one month.
- [202] Dr. Hall recommended that Mr. Baglot seek treatment from a pain management specialist, a drug and alcohol counsellor, and a physician who treats addiction.

Occupational Therapy and Vocational Rehabilitation Experts

Stephanie Kaczmarek

- [203] Ms. Kaczmarek, an occupational therapist, was retained by the plaintiff. She wrote a report dated March 19, 2018.
- [204] Ms. Kaczmarek partially based her report on the assumption that Mr. Baglot was working full-time and had no functional restrictions prior to his hospitalization. Mr. Baglot reported this information to Ms. Kaczmarek. The evidence suggests otherwise, which I have taken into account in reviewing Ms. Kaczmarek's report.
- [205] Ms. Kaczmarek's opinion is limited by her reliance on the American Time Use Survey which does not provide data for single males with a chronic illness who live with their mothers.

Functional Capacity Evaluation

- [206] Ms. Kaczmarek performed a functional capacity evaluation of Mr. Baglot on January 16, 2018. In her report, she determined that he was presently unable to be competitively employable. A functional home assessment was meant to take place as well, but it did not as Mr. Baglot's mother was reticent to have her at their house.
- [207] While Mr. Baglot was not able to participate in all of the scheduled tests due to his pain-related challenges, Ms. Kaczmarek concluded that Mr. Baglot had no "physical limitations specific to range of motion, reaching, kneeling, bending, or strength." However, she determined that he had "significantly decreased tolerance for light physical activity, including standing and walking", needed to be near a bathroom at all times, and he

reported constant pain. Although this was not formally assessed, she noted his reported pain, anxiety, and depression "further contribut[ed] to his present inability to be competitively employable."

Cost of Future Care Recommendations

[208] Ms. Kaczmarek's cost of future care recommendations are discussed in the damages section of this judgment.

Tania Percy

[209] Ms. Percy, an occupational therapist, was retained by the defendant. She wrote a report dated March 23, 2018 and a supplemental report dated May 3, 2018.

Functional Capacity Evaluation

[210] Ms. Percy assessed Mr. Baglot on January 31 and February 28, 2018. In her report, she observed that Mr. Baglot was a poor historian and "tended to use catastrophic language and graphic descriptions of his surgery and aftermath." Similar to Ms. Kaczmarek, she determined that Mr. Baglot did not have specific physical impairments, but required extensive breaks and was unable to fully complete the testing.

[211] Ms. Percy concluded that Mr. Baglot would benefit from "psychological and behavioral support at this time to minimize isolation and promote engagement in a broader range of activities."

Cost of Future Care Response

[212] In her report dated May 3, 2018, Ms. Percy responded to Ms. Kaczmarek's cost of future care report. Ms. Percy considered the medical opinions under two scenarios: one wherein she accepts the defence experts' opinions (scenario A), and another where she accepts the plaintiff experts' opinions (scenario B).

[213] Under scenario A, she concludes that no specific care recommendations are appropriate in relation to the alleged medical negligence.

[214] Under scenario B, she makes the following points in response to Ms. Kaczmarek's report:

- a) Ms. Kaczmarek "overstated Mr. Baglot's health and capacity to engage in recreation and employment in the period leading up to [the hospitalization]."
- b) The prognosis for Crohn's disease regardless of the alleged medical negligence needs to be considered in determining cost of future care for household assistance. It must be determined whether he actually would have been capable of all household responsibilities but for the incident.

- c) The American Time Use Surveys Ms. Kaczmarek used to determine recommended hours for household assistance have some shortcomings.

[215] Ms. Percy's cost of future care recommendations are discussed in the damages section of this judgment.

Niall Trainor

[216] The plaintiff retained Mr. Trainor, a vocational consultant. Mr. Trainor testified that Mr. Baglot did not remember many details during their interaction, forcing Mr. Trainor to rely on the underlying records.

[217] Mr. Trainor performed a vocational rehabilitation assessment of Mr. Baglot on January 11, 2018. In his report, Mr. Trainor provided a report dated March 20, 2018, he determined vocational rehabilitation does not have "much to offer Mr. Baglot at this time", since he needs to significantly improve his "work hardiness prior to attempting a job search." If Mr. Baglot were to make significant gains in his work capacity, Mr. Trainor concluded he would need assistance to find sympathetic employers who would accommodate the challenges that accompany his Crohn's disease. He would likely have to make concessions to secure employment, which might include concessions on wages, hours, benefits, job security, and work environment.

[218] He opined, "[post-hospitalization] it is unlikely Mr. Baglot would be able to sustain attendance at any workplace and perform even sedentary work on a regular and reliable basis because of his persistent pain symptoms and reported functional impairment." He determined that Mr. Baglot's reported goal of becoming a culinary arts teacher was not realistic, pre- or post-incident. Mr. Trainor noted that protracted unemployment such as Mr. Baglot's can become a "self-fulfilling prophecy", with the discouraged worker abandoning the job search believing it to be futile. He recommended volunteer work and/or other initiatives moving forward.

Avita Sharma

[219] The defendant retained Ms. Sharma, a vocational consultant. Ms. Sharma prepared her report dated March 19, 2018 based on the referral and documentation provided to her. Although she did not meet with Mr. Baglot, she found him, on the basis of the records, to be competitively unemployable prior to the hospitalization. She based this on his inability to secure and sustain employment. She noted that his longest length of time at a job, after Mystical Distributing, was approximately three months. She opined that his work history did not demonstrate consistent or long-term employment.

[220] Ms. Sharma concluded that Mr. Baglot is not competitively employable now or in the future, nor was he competitively employable prior to the incident. Although beyond her expertise, she determined that the perforated duodenal ulcer caused him no impairment to his work capacity. His issues with employability prior to the incident included

psychological dysfunction, involvement in motor vehicle accidents, and sporadic work experience with short-term, intermittent placements. Although I think she overstates his pre-injury employability, I agree that he had a sporadic work history.

- [221] Ms. Sharma recommended a "structured type of employment re-activation plan", involving volunteer work and community inclusion, to increase his tolerance for work. Ms. Sharma noted his "perceived disability mind-set", chronic pain condition, and psychological issues as significant barriers to employment, along with the accommodations he will need for his Crohn's disease. Ms. Sharma said that Mr. Baglot is not necessarily permanently unemployable and may be currently capable of greater activity tolerances than he perceives.

Economist Experts

Robert Carson

- [222] Mr. Robert Carson, an economist retained by the plaintiff, wrote a report dated March 21, 2018. Mr. Carson agreed that Mr. Baglot's earnings history is below average, which his report does not reflect.

Future Loss of Income

- [223] In his future loss of income report, Mr. Carson provided some multiplier tables to assist in assessing Mr. Baglot's future loss of income.
- [224] In table 1, he illustrated his use of multipliers. In table 2, he provided the estimates of average earnings in 2016 for BC men with high school diplomas working full time. For men aged 25 to 34, the average annual earnings were \$54,453. In table 3, he provided the estimates of average earnings in 2011 for BC men employed as chefs or cooks full time. For chefs with trade certificates, it was \$46,500. For chefs with high school diplomas, it was \$38,285. For cooks with trade certificates, it was \$42,273. For cooks with high school diplomas, it was \$30,440.
- [225] Mr. Carson provided that earnings should be reduced by 14.5% under a risk model and by 11% under a choice model, meaning "the combination of risks and choice reduce the earnings of high school graduate males who are able and inclined to work at age 33 to 70, by about 25%." He agreed in cross-examination that a risk and choice based contingency of 25% does not reflect a situation where the individual could not work due to a chronic illness. Employers' contributions to non-wage benefits add approximately 10% to the value of wage compensation in his opinion.

Cost of Future Care

[226] In his cost of future care report, Mr. Carson provides the net present values of future costs adjusted for the probability of survival in table 1. He concludes this value to be \$30,442 at a cost of \$1,000 per year. Mr. Carson did not consider specific proposed costs of future care in making his report.

Douglas Hildebrand

[227] The plaintiff retained the economist Mr. Hildebrand. In his report dated April 26, 2018, Mr. Hildebrand responded to Mr. Carson's income loss multipliers and employment earnings report. Mr. Hildebrand provides his opinion on the methods and figures Mr. Carson used, commenting that they reached nearly identical income multipliers.

[228] Mr. Hildebrand opined that because the plaintiff was a below average worker prior to the incident, average earnings figures are likely not applicable to him. He provided figures with no contingencies in his first table. In a second table, he provided economic multipliers with a 32% reduction for labour market contingencies over the course of the working life of a British Columbian man with a high school diploma or equivalency certificate.

Factual Findings

[229] I must determine which injuries Mr. Baglot has in order to determine which of them, if any, are due to the defendant's negligence. Mr. Baglot submits that because of Dr. Fourie's admitted prescribing error and his consequent perforated ulcer, he sustained two internal bleeds; had a traumatic 53-day hospitalization; developed visceral hypersensitivity, dumping syndrome, and PTSD; and lives in constant pain. The defendant submits that none of Mr. Baglot's medical issues following his perforated ulcer and associated treatment are causally related to the prescribing error. Rather his ongoing medical issues are related to his underlying Crohn's disease. If he has visceral hypersensitivity, it is unrelated to the ulcer and the hospitalization. The defendant further submits he has one or more substance use disorders, again unrelated to the ulcer and hospitalization.

[230] If the plaintiff is partially or wholly correct, I must also determine what Mr. Baglot's future employment prospects are, and what they would have been but for the defendant's negligence, in order to effectively assess damages.

Background

[231] I find that Mr. Baglot had a physically, and to some extent emotionally, abusive father. He had some difficulties in elementary school from a behavioural perspective. In high school he was better adjusted. He was physically active and engaged in numerous extracurricular activities. He graduated from high school, although it took him an extra year to complete grade 12. He excelled in the culinary arts program.

- [232] I agree with Ms. Sharma and Mr. Trainor that Mr. Baglot's engagement with work was sporadic prior to the ulcer. He made little money and apart from the first year following high school, he did not maintain regular employment. Overall, Mr. Baglot's work history is less than impressive.
- [233] That said, Mr. Baglot was certainly socially engaged prior to the ulcer. I find that Mr. Baglot had many friends and was involved in the cycling community. He used his bike as his primary mode of transportation. He was very active in this community, participating in events and competitions, and voluntarily repairing bikes for others. He and Ms. Phillips were engaged. He was in excellent shape prior to late 2010 and prior to the hospitalization he remained outgoing and positive.
- [234] There is some evidence that Mr. Baglot, at least on occasion, drank heavily in his early 20s. On two occasions, Mr. Baglot was hospitalized due to incidents related to alcohol consumption.

Pre-Hospitalization

- [235] In approximately 2004, Mr. Baglot began having problems with his stomach. The records and testimony establish periodic Crohn's disease flares and symptoms during this early period.
- [236] I find that although he was not diagnosed until 2009, Mr. Baglot began suffering from Crohn's disease in 2004 or 2005. Starting in 2006, he had periodic episodes for which he attended emergency rooms. He was typically discharged within a few days. During this time Mr. Baglot was attending UFV. He completed his first term in the fall of 2006, although his marks were poor. He attempted a second term but was forced to withdraw due to his Crohn's disease.
- [237] In April 2009, Mr. Baglot was admitted to UBC Hospital for a bowel obstruction. This resulted in a surgeon performing a laparoscopic procedure to remove scar tissue. It was at this point that Mr. Baglot was officially diagnosed with Crohn's disease. Despite this setback, the plaintiff maintained a high level of activity up until late 2010. His symptoms worsened at that point, which included him suffering from a form of arthritis related to the Crohn's disease. Consequently, Mr. Baglot's joints were sore and, at times, he became lethargic.
- [238] I find that Mr. Baglot did not handle stress well. For example, he found his part-time job at MEC in 2007 particularly stressful, in part due to the escalation of his Crohn's disease.
- [239] I find that Mr. Baglot was an active and, apart from not performing regular work, an engaged member of society up to the end of 2010. His Crohn's disease and related health problems got progressively worse after that point.

ARH

- [240] The evidence established that when Mr. Baglot arrived at ARH, he assumed he would be in for several days and then be released, consistent with his previous visits. Instead, Mr. Baglot's condition worsened. He and his family were unhappy with the care he received. They asked that Mr. Baglot be transferred to VGH where Dr. Chatur, his treating gastroenterologist, had hospital privileges.
- [241] I accept Mr. Baglot's testimony that Dr. Fourie told him that he would need a colostomy bag for the rest of his life, creating significant stress for Mr. Baglot. The evidence also established that on or about July 29, 2011, when Mr. Baglot was "spiralling down", Dr. Fourie advised him to have a blood transfusion and told him that if his iron levels got worse he could "go into heart failure or things like that."
- [242] There is a conflict in the evidence as to when Mr. Baglot began to feel that he was going to die. Unfortunately as noted by both Mr. Trainor and Ms. Percy, Mr. Baglot was not always an accurate historian. The defendant points out that Mr. Baglot testified in cross-examination that he feared for his life from day one of his admission. This does not accord with other parts of Mr. Baglot's testimony. It is also inconsistent with testimony from other witnesses that at the beginning of his stay at ARH, Mr. Baglot was calm and quietly played his guitar, only becoming more agitated as the days progressed and he failed to improve. I accept that Mr. Baglot began to fear that he was going to die towards the end of his stay at ARH, which was when his condition had clearly worsened in the last days of July 2011.

RCH

- [243] On August 1, 2011, Mr. Baglot was transferred to RCH and on August 2, 2011, he underwent surgery for a 2.5 centimetre perforated ulcer. I accept that the surgery performed was major and involved the surgeon operating on multiple parts of his GI tract to patch seriously damaged tissue and reroute his original anatomy. When he awoke, he found an incision from his pelvis to his sternum and he was attached to multiple tubes and bags. I accept that he originally thought he was going to have a permanent colostomy bag, but after a week he realized this would not be necessary in the long term.
- [244] Several days later, on August 6, 2011, Mr. Baglot suffered his first internal bleed, which was treated surgically and was successfully embolized. On August 25, 2011, Dr. Turner advised him that he was healing well and would be released in four to five days.
- [245] Unfortunately, on August 29, 2011, Mr. Baglot suffered a second bleed, which was traumatic for him and his mother. I accept that Mr. Baglot believed his body was shutting down, that he was "face to face" with mortality, and that if he went to sleep he would not wake up.

Post-Hospitalization

- [246] I accept the testimony of Mr. Baglot and his family that he has never been the same since he was discharged from RCH. He has had some periods where he was well enough to travel, including to Portland to visit Ms. Ackerman and to visit his sister. Dr. Chatur testified that after seeing Dr. Howard, Mr. Baglot's mood was better and he was improving in January 2015. He was on a biologic at that time that was part of a clinical trial. She commented to Dr. Eddy that Mr. Baglot looked remarkably well compared to all the times she had seen him in the past. She also advised that Mr. Baglot would be travelling to Korea to see his sister.
- [247] Nevertheless, since the ulcer, he is largely in pain, dependent on opioids, depressed, and struggles to keep on weight. He has lost friends, is isolated, has problems managing his time, and cannot deal with change. He needs assistance with all daily living activities, with the exception of his personal hygiene. His mother provides this assistance and his sister helps when she is in town.
- [248] I am satisfied that despite his severe Crohn's disease and repeated suggestions from Dr. Chatur, Mr. Baglot initially resisted treatment. He eventually tried a biologic through a clinical trial in 2014, approximately three years after Dr. Chatur first recommended he go on one. Although he responded well at first, eventually the drug failed. In July 2016, four months after he stopped the open label drug, Mr. Baglot presented at VGH with an acute flare of Crohn's disease. The imaging showed disease of significant pathology, revealing stricturing of the small bowel that required surgical resection. Following the surgery Mr. Baglot was treated with a different biologic, Entyvio, to reduce the Crohn's symptoms. Although Mr. Baglot has responded well to this treatment, there is no guarantee that it will continue to control his Crohn's disease into the future.
- [249] Despite this recent improvement, Mr. Baglot continues to be totally disabled and housebound. He suffers from pain, fatigue, has mood problems, and regularly takes significant doses of opioids.

Adhesions

- [250] Dr. Chatur stated in direct examination, "I would say that the main part of his disease that is causing his pain is likely the adhesions that have been a result of his surgeries." I accept that the adhesions are significantly contributing to Mr. Baglot's pain.

Visceral Hypersensitivity

- [251] Mr. Baglot experiences multiple gastrointestinal symptoms, certainly beyond the objective evidence regarding his Crohn's disease. As stated by Dr. Somsouk:

Mr. Baglot experiences visceral hypersensitivity, which is characterized by an exaggerated response to painful and non-painful stimuli within the inner organs. It is thought that traumatic events can cause sensitization, and traumatic experiences have been associated and may explain patient symptoms who report visceral hypersensitivity. For Mr. Baglot, he described fear of death, anxiety, trauma, and helplessness during the July 2011 hospitalization at Abbotsford. Currently, he experiences multiple gastrointestinal symptoms including dumping syndrome, constipation and diarrhea, and Crohn's disease, but the debilitating nature of the symptoms is more likely than not due to visceral hypersensitivity.

[252] I accept Dr. Somsouk's opinion that the debilitating nature of Mr. Baglot's symptoms "is more likely than not due to visceral hypersensitivity," and find that Mr. Baglot suffers from the condition. This is partly because there was no evidence that Mr. Baglot suffered from visceral hypersensitivity prior to the hospitalization.

[253] There was evidence that Mr. Baglot was abused as a child, was bullied and harassed in school, and suffered from some anxiety. As Dr. Somsouk testified, visceral hypersensitivity is associated with anxiety and childhood events. Dr. Tarzwell opined that exposure to early childhood trauma significantly increases the risk of issues later in life. Dr. Fishman agreed that most patients with visceral hypersensitivity have sustained some form of abuse, emotional, physical or sexual, often on an ongoing or prolonged basis and suffered from some anxiety. Dr. Chatur agreed he has visceral hypersensitivity. Moreover, Dr. Byrne acknowledged that visceral hypersensitivity could play a role in Mr. Baglot's ongoing symptoms.

Dumping Syndrome

[254] There is insufficient evidence to support the conclusion that Mr. Baglot suffers from dumping syndrome. Although Mr. Baglot's general practitioner requested that this be investigated, Dr. Chatur saw no evidence of the syndrome. It is not in her clinical notes. Dr. Byrne and Dr. Fishman also testified that there was little evidence to support dumping syndrome. Dr. Somsouk testified that because Mr. Baglot's pain occurs many hours after he has eaten, it is not likely to be due to dumping syndrome. Based on these expert reports, and my review of the evidence, I find that Mr. Baglot does not suffer from dumping syndrome.

PTSD

[255] Dr. Hall, the defendant's expert psychiatrist, opined that Mr. Baglot has substance/ medication induced depressive disorder among other conditions, while Dr. Tarzwell, the plaintiff's expert psychiatrist, opined that Mr. Baglot has PTSD. Dr. Tarzwell testified that the trigger for his PTSD was the second bleed at RCH, taken in context with the plaintiff's belief that the bleed was directly due to neglectful treatment at ARH. Both experts agreed that Mr. Baglot is suffering significant symptoms related to his psychological issues and that he did not have any diagnosed psychological disorders prior to the hospitalization.

- [256] The DSM-V stipulates, and Dr. Tarzwell agreed, that an individual has to have met all criteria, from A through G, to have the diagnosis. Dr. Tarzwell was of the opinion that Mr. Baglot meets all of the criteria.
- [257] Dr. Hall challenged that proposition. She testified that Mr. Baglot did not meet three of the required criteria: he did not endorse any intrusion symptoms (criterion B), he did not engage in avoidance associated with distress (criterion C), and he did not have negative alterations in cognition or mood (criterion D).
- [258] I prefer Dr. Tarzwell's evidence to Dr. Hall's, as his written report is detailed as to exactly why he thinks Mr. Baglot meets all of the criteria for a PTSD diagnosis. Although Dr. Hall states that she did carefully consider the diagnosis, she wrote only one paragraph regarding potential PTSD and did not elaborate on why she thought he did not meet three of the criteria. In cross-examination she testified that she did not consider his fear of dying during the hospitalization because he did not meet all the criteria for PTSD and because his substance abuse trumps other possible diagnoses.
- [259] The symptoms Dr. Tarzwell based his diagnosis on are supported by the evidence. For example, Mr. Baglot testified to regularly having painful memories of the hospitalization, which Dr. Tarzwell opined are intrusion symptoms (criterion B). Mr. Baglot, Ms. Kim Baglot, and Ms. Linda Baglot all testified that the plaintiff is intensely averse to attending at ARH and does not even like driving by it, which Dr. Tarzwell opined is avoidance associated with distress (criterion C). Mr. Baglot, his family members, and Ms. Ackerman all testified to the plaintiff's drastic shift in mood following the hospitalization, which Mr. Baglot also relayed to Dr. Tarzwell. Dr. Tarzwell acknowledged that since the plaintiff's negative alterations in cognition and mood are so prominent, it would be understandable to diagnose him as simply having major depressive disorder. However, he found that they satisfied criterion D, and concluded that he instead had PTSD.
- [260] Based upon my review of the evidence, I find that Mr. Baglot suffers from PTSD. This does not rule out that Mr. Baglot may also suffer from other psychological conditions, such as depression or anxiety, but making findings as to Mr. Baglot's exact psychological picture is not necessary. I am satisfied that the bulk of his mental health issues relate to his PTSD and that he had no diagnosed psychological disorders prior to the hospitalization.

Opioid Use

- [261] It is clear that Mr. Baglot is dependent on opioids, based on the evidence from him, his family members, and the experts. I find that his consistent opioid use began directly following the surgery on August 2, 2011.
- [262] Dr. Hall was strongly of the opinion that Mr. Baglot is addicted to opioids and his addiction stems from his earlier abusive use of alcohol in his 20s. Dr. Tarzwell did not agree that Mr. Baglot is addicted to opioids. He explained that according to the DSM-V:

Opioid use disorder includes signs and symptoms that reflect compulsive prolonged self-administration, use for no legitimate medical purpose, or if another medical condition is present that requires opioid treatment, that are used in doses greatly in excess of the amount needed for that medical condition.

Dr. Tarzwell is of the view that Mr. Baglot is using opioids appropriately to manage legitimate pain.

[263] I agree that Mr. Baglot had a propensity to abuse alcohol in his early 20s. However, I am of the view that Dr. Hall overstated Mr. Baglot's prior alcohol use, stating that he had a history of previous alcohol treatment. This is not true.

[264] While Mr. Baglot did abuse alcohol, based on the evidence I do not believe that this abuse rose to the level of an alcohol use disorder. Mr. Baglot was a functioning member of society, and his friends and family did not see his alcohol use as problematic. Unfortunately, many young individuals abuse alcohol. Most of these individuals do not become alcoholics or addicted to drugs in later life. In any event, it is not necessary for me to determine whether his opioid use constitutes an addiction or whether it is purely for pain management in order for me to assess the defendant's liability.

Future Employment

[265] Mr. Baglot is totally disabled at this time. There is no prospect that he will be employable in the foreseeable future.

[266] His sister and mother suggested that he wanted to be a schoolteacher, or at least a baker in line with the work he was doing at Thrifty Foods. I find that they both overstated his career prospects. Whether or not Mr. Baglot was competitively employable prior to the hospitalization, as Ms. Sharma opined, I agree that he was not heading in the direction of a promising career. His employment record was unimpressive. He did not show interest in any long-term career, including his chosen path in food services.

[267] I accept that Mr. Baglot was relatively young at the time of the injury and that due to a settlement from a prior motor vehicle accident, he may not have had much incentive to work. However, most young people are starting to develop career plans by the age of 26. He was showing no such inclination, apart from continuing to work in some fashion in the food industry, albeit sporadically.

[268] Based on the above factors, I do not believe that he would have become a teacher. I find that he may well have had ongoing work in the food industry, likely on a part-time basis, when his Crohn's disease did not prevent him from working.

The Legal Framework

Medical Malpractice Claims

[269] To succeed in a medical malpractice claim grounded in negligence, a plaintiff must prove that:

- a) the physician owed a duty of care to the plaintiff;
- b) the physician breached the standard of care expected in the circumstances;
- c) the plaintiff suffered harm; and
- d) the physician's breach caused the plaintiff's damages resulting from that harm.

Medina (Litigation guardian of) v. Wong, 2018 BCSC 292 at paras. 84-85; see also Ediger (Guardian ad litem of) v. Johnston, 2013 SCC 18 [Ediger - SCC] at para. 24.

[270] All these elements are essential. Here, Dr. Fourie does not dispute that she owed Mr. Baglot a duty of care and that she breached the standard of care. The contentious issues are the extent of the harm caused by that breach and the damages that flow from that harm.

Causation

[271] The generally accepted test for causation is the "but for" test. The plaintiff bears the onus of proving, on a balance of probabilities, that but for the defendant's negligent act or omission, the injury would not have occurred: *Athey v. Leonati*, [1996] 3 S.C.R. 458 [Athey] and *Blackwater v. Plint*, 2005 SCC 58. Put simply, causation is found if the injury would not have occurred without the defendant's negligence: *Ediger - SCC* at para. 28.

[272] Courts have recognized that plaintiffs can encounter practical difficulties in proving causation under the but for test in medical malpractice cases. In the seminal decision of *Snell v. Farrell*, [1990] 2 S.C.R. 311 [Snell], the Supreme Court of Canada set out the test for causation at 324, the hallmark of which is "a robust and pragmatic approach to the facts to enable an inference of negligence to be drawn even though medical or scientific expertise cannot arrive at a definitive conclusion." The causation test does not demand scientific precision and should not be applied too rigidly. While proof of causation will inevitably require expert evidence, common sense applies: *Athey* at 467.

[273] There is a difference between medical and legal causation. In *Snell* at para. 34, the Court articulated this point as follows:

It is not therefore essential that the medical experts provide a firm opinion supporting the plaintiff's theory of causation. Medical experts ordinarily determine causation in terms of certainties whereas a lesser standard is demanded by the law

- [274] A trial judge can find causation in circumstances where the precise mechanism leading to injury cannot be known with certainty: *Ediger* - SCC at para. 39. The Supreme Court of Canada described this principle in *Clements v. Clements*, 2012 SCC 32 [Clements] at para. 10: "[e]vidence connecting the breach of duty to the injury suffered may permit the judge, depending on the circumstances, to infer that the defendant's negligence probably caused the loss."
- [275] The court can reach a common sense inference of causation even when the parties have both adduced expert evidence. The British Columbia Court of Appeal in *Ediger (Guardian ad litem of) v. Johnston*, 2011 BCCA 253, held that a court cannot draw a common sense inference where there is expert evidence on causation adduced. The Supreme Court of Canada disagreed. The court held that the trial judge appropriately followed Snell by drawing a common sense inference despite the fact that the defendant called expert evidence:
- [36] The Court of Appeal's reasons also suggest that it understood the trial judge to have improperly relied on *Snell v. Farrell*, [1990] 2 S.C.R. 311, in order to draw an "inference of causation" (paras. 83-85). *Snell* stands for the proposition that the plaintiff in medical malpractice cases - as in any other case - assumes the burden of proving causation on a balance of the probabilities (*ibid.*, at pp. 329-30). Sopinka J. observed that this standard of proof does not require scientific certainty (*ibid.*, at p. 328); *Clements*, at para. 9. The trier of fact may, upon weighing the evidence, draw an inference against a defendant who does not introduce sufficient evidence contrary to that which supports the plaintiff's theory of causation. In determining whether the defendant has introduced sufficient evidence, the trier of fact should take into account the relative position of each party to adduce evidence (*Snell*, at p. 330).
- [276] This point was illustrated in *Goodman v. Viljoen*, 2012 ONCA 896 [Goodman], leave to appeal ref'd [2013] S.C.C.A. No. 63, where the court did not have the benefit of any scientific studies establishing causation between the breach of the standard of care and the precise injury. Despite this, the Court of Appeal held that the judge correctly found causation on the totality of the evidence. Based on the medical experts, who testified regarding their clinical experience, the trial judge was able to infer causation: see paras. 44-46 and 57-74.
- [277] The classic but for test is flexible. Although it must be applied with caution, causation may be inferred by reference to a temporal sequence of events: *Ediger* - SCC at paras. 39-40. As set out by Justice Ballance in *Chen v. Ross*, 2014 BCSC 374 [Chen], aff'd 2015 BCCA 250:
- [295] The court is called upon to exercise caution in inferring legal causation by exclusive or substantial reference to a temporal sequence of events: *Madill v. Sithivong*, 2012 BCCA 62 at para. 20; *White v. Stonestreet*, 2006 BCSC 801 at paras. 74-75. However, the judicial insistence of caution does not signify judicial thinking that temporal reasoning is an illegitimate analysis or a branch of logic to be seldom invoked.

- [278] Chief Justice McLachlin, as she then was, summarized the less onerous material contribution test developed in *Resurface Corp. v. Hanke*, 2007 SCC 7, in *Clements* at para. 46. This test may be used when it is impossible for the plaintiff to prove the defendant's negligence caused the plaintiff's injuries under the but for test. The material contribution test is exceptional and has limited applicability. I agree with the defendant that, to date, it has been used when there are multiple defendants and the plaintiff finds it difficult or impossible to determine which party caused his or her injuries under the but for approach. The but for test remains the primary test for determining causation in medical malpractice cases.
- [279] The plaintiff argued that where there is more than one cause of an injury, resulting in a non-divisible injury, the plaintiff need only show that the negligence contributed to the injury beyond the de minimis range: *Farrant v. Laktin*, 2011 BCCA 336 [Farrant] at paras. 9, 50-51; and *Chen* at para. 291.
- [280] I agree that the plaintiff is not required to prove that the defendant's negligence was the sole cause of his injuries. This is articulated by the Supreme Court of Canada in *Athey* at 467:

It is not now necessary, nor has it ever been, for 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. To borrow an example from Professor Fleming (*The Law of Torts* (8th ed. 1992) at p. 193), a "fire ignited in a wastepaper basket is . . . caused not only by the dropping of a lighted match, but also by the presence of combustible material and oxygen, a failure of the cleaner to empty the basket and so forth". As long as a defendant is part of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury. There is no basis for a reduction of liability because of the existence of other preconditions: defendants remain liable for all injuries caused or contributed to by their negligence.

[Emphasis in original.]

- [281] The plaintiff must establish a substantial connection between the tortious conduct and the injury: *Farrant* at para. 11. However, the robust and pragmatic approach under the but for test allows for there to be more than one cause of an injury. As long as the defendant caused or contributed to the injury in a material way (i.e., beyond the de minimis range), the defendant is liable: *Chappell v. Loyie*, 2016 BCSC 1722 at para. 5.
- [282] When a plaintiff makes a claim for emotional injury, there is no requirement that they provide evidence of a specific psychiatric diagnosis before damages are awarded: *Saadati v. Moorhead*, 2017 SCC 28 [Saadati] at para. 31; and *Riley v. Ritsco*, 2018 BCCA 366 [Riley]. Individuals have a duty to take reasonable care to avoid causing foreseeable mental injury. The focus is on the symptoms, not the label to attach to them.

- [283] Lastly, I must consider the thin skull and the crumbling skull doctrines. The thin skull doctrine requires tortfeasors to take their victims as they find them. If the plaintiff has a pre-existing medical condition that was a contributory cause of the injury, the defendant remains 100% liable under the thin skull doctrine: *Athey* at 468. This is due to the "most basic principle of tort law" that "the plaintiff must be placed in the position he or she would have been in absent the defendant's negligence": *Athey* at 472.
- [284] The defendant is not liable for damages that were not caused by the injury: *Brewster v. Li*, 2013 BCSC 774 at para. 78, but that a defendant must take a plaintiff as they find them is the case even if the injury may be perceived as disproportionate to the tortious conduct. This is because damages flow from the tortious act: *The "Arpad"*, [1934] P. 189, 103 L.J.P. 129.
- [285] Under the crumbling skull doctrine, tortfeasors need not compensate the plaintiff for debilitating effects of a pre-existing condition which they would have experienced in any event: *Athey* at paras. 32-35.
- [286] In *Athey*, the Supreme Court of Canada outlined the crumbling skull doctrine:
- [35] The so-called "crumbling skull" rule simply recognizes that the pre-existing condition was inherent in the plaintiff's "original position". The defendant need not put the plaintiff in a position better than his or her original position. The defendant is liable for the injuries caused, even if they are extreme, but need not compensate the plaintiff for any debilitating effects of the pre-existing condition which the plaintiff would have experienced anyway. The defendant is liable for the additional damage but not the pre-existing damage: *Cooper-Stephenson*, supra, at pp. 779-780 and *John Munkman*, *Damages for Personal Injuries and Death* (9th ed. 1993), at pp. 39-40. Likewise, if there is a measurable risk that the pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligence, then this can be taken into account in reducing the overall award: *Graham v. Rourke*, supra; *Malec v. J. C. Hutton Proprietary Ltd.*, supra; *Cooper-Stephenson*, supra, at pp. 851-852. This is consistent with the general rule that the plaintiff must be returned to the position he would have been in, with all of its attendant risks and shortcomings, and not a better position.

[Emphasis in original.]

- [287] In terms of compensation, the Court of Appeal in *T.W.N.A. v. Canada* (Ministry of Indian Affairs), 2003 BCCA 670 [T.W.N.A.], held at para. 48 that "a weakness inherent in a plaintiff that might realistically cause or contribute to the loss claimed regardless of the tort is relevant to the assessment of damages." Such a "weakness" is a contingency to be accounted for in the award. It does not have to be proven to a certainty, but rather given weight according to its relative likelihood.

Remoteness

[288] If a medical practitioner knows, or ought to know, of a particular risk, the standard of care with respect to that risk is more demanding: *Ediger (Guardian ad litem of) v. Johnston*, 2009 BCSC 386 at para. 49 aff'd 2013 SCC 18.

[289] As set out by Schultes J. in *Bendzak v. Bohnet*, 2013 BCSC 435 [Bendzak]:

[46] For a risk to be foreseeable it is not required that it be more likely than not to occur or that there needs to be some particular degree of statistical probability attaching to it. In *Mustapha v. Culligan of Canada Ltd.*, 2008 SCC 27, at para. 13, Chief Justice McLachlin described the correct approach:

Much has been written on how probable or likely a harm needs to be in order to be considered reasonably foreseeable. The parties raise the question of whether a reasonably foreseeable harm is one whose occurrence is probable or merely possible. In my view, these terms are misleading. Any harm which has actually occurred is "possible"; it is therefore clear that possibility alone does not provide a meaningful standard for the application of reasonable foreseeability. The degree of probability that would satisfy the reasonable foreseeability requirement was described in *The Wagon Mound (No. 2)* as a "real risk", i.e. "one which would occur to the mind of a reasonable man in the position of the defendan[t] . . . and which he would not brush aside as far-fetched" (*Overseas Tankship (U.K.) Ltd. v. Miller Steamship Co. Pty.*, [1967] A.C. 617 (P.C.), at p. 643). [Emphasis in original.]

[47] It is also not necessary that the exact type of injury that occurred be foreseen. As Mr. Justice Dickson explained in *Assiniboine School Division No. 3 v. Hoffer* (1971), 21 D.L.R. (3d) 608 (Man. C.A.), at page 614:

It is enough to fix liability if one could foresee in a general way the sort of thing that happened. The extent of the damage and its manner of incidence may not be foreseeable if physical damage of the kind which in fact ensued is foreseeable.

[48] In *R. v. Côté*, [1976] 1 S.C.R. 595, at p. 604 Mr. Justice Dickson elaborated on this principle:

It is not necessary that one foresee the "precise concatenation of events"; it is enough to fix liability if one can foresee in a general way the class or character of injury which occurred.

[290] The thin skull doctrine is related to the issue of remoteness. As noted above, even if the plaintiff is injured to a greater degree than was foreseeable at the time of the breach, the defendant still must compensate the plaintiff for the resulting injuries. If the defendant caused harm beyond the de minimis range, the extent of the harm is irrelevant. The but for test will be satisfied.

Analysis

- [291] It is undisputed that Dr. Fourie owed Mr. Baglot a duty of care as his physician and that she breached the appropriate standard of care in prescribing ketorolac for his Crohn's disease. This breach caused Mr. Baglot's perforated ulcer, which required surgery.
- [292] The first question is: did Dr. Fourie's negligence cause Mr. Baglot's present condition, or would he have been totally disabled from his Crohn's disease even if Dr. Fourie had not incorrectly prescribed ketorolac? The second question is: if causation is found, was the risk of injury reasonably foreseeable such that Dr. Fourie should be held liable?
- [293] Mr. Baglot was a credible witness in that he testified to what he could remember, admitted when he could not, and agreed with certain statements put to him by the defendant even when they were not in his interest. He was emotionally distraught regarding what has happened to him. At times he came across, understandably, as angry. He needed frequent breaks due to pain.
- [294] My concern about his evidence is that his testimony was not always reliable because his memory is compromised. This is due to a combination of factors, including the passage of time and his opioid use. Mr. Baglot testified that his use of painkillers makes it difficult for him to remember details.
- [295] My decision with respect to causation is based primarily on expert testimony. The experts gave their evidence in a fair and impartial manner and understood their duty to the court. Where there was a weakness in their reports or testimony, I point this out when summarizing their evidence.

Causation

General

- [296] There are a number of different issues regarding causation. Since the defendant has admitted that the prescribing error caused the ulcer, the issue before me is the extent of injury resulting from the ulcer, the surgery to repair the perforated ulcer, and the effect of the lengthy hospitalization on Mr. Baglot. The defendant takes the position that the perforated ulcer is a discrete event and that the plaintiff would be in his current condition regardless of the injury. The plaintiff strongly disagrees.
- [297] Since there are a number of events which occurred, I will address each contested issue of causation in turn.

Crohn's Disease

- [298] All the medical experts agreed that Mr. Baglot was suffering from Crohn's disease prior to the hospitalization and that he continued to suffer from it after the hospitalization. Mr. Baglot was described by Dr. Byrne as being in a state of disease escalation in the months leading up to the hospitalization.
- [299] Dr. Byrne's medical report states that Mr. Baglot has no ongoing medical conditions as a result of the ulcer. Mr. Baglot's ongoing problems are instead attributable to his pre-existing small bowel Crohn's disease. Dr. Fishman opined that Mr. Baglot continued to have ongoing symptoms related to Crohn's disease following his September 2011 discharge. Extensive investigations such as the 2013 CT scan confirmed the diagnosis of Crohn's disease and showed no other cause. There is no evidence that any of his gastrointestinal symptoms were a result of his previous perforated duodenal ulcer.
- [300] Dr. Fishman opined that there was little evidence that the hospitalization and surgery had any significant effect on the course of Mr. Baglot's Crohn's disease. Dr. Fishman gave evidence that Mr. Baglot continued to have clinical symptoms of Crohn's disease more recently. He required a surgical resection in July 2016.
- [301] I note that Mr. Baglot's Crohn's disease was undertreated for many years. The evidence established that he did not agreed to try a biologic drug until March of 2014. It was not until June 2016 that he went on Entyvio, which has been more successful. His reluctance to try a biologic drug negatively affected his disease. However, there was testimony that Crohn's disease is pervasive and ongoing, even with biologic drug treatment. Consequently, although Entyvio is currently working for Mr. Baglot, it may not work to the same degree in the future.
- [302] Based on the above evidence, I agree with the testimony of Dr. Byrne and Dr. Fishman that the ulcer and hospitalization likely did not affect the trajectory of Mr. Baglot's Crohn's disease.

Malnourishment

- [303] Patients with Crohn's are likely to be chronically malnourished. Malnourishment can also occur in the context of lengthy hospitalizations. There was evidence that Mr. Baglot was suffering from malnutrition when he was at RCH. Based on the evidence before me, I cannot determine whether Mr. Baglot's malnourishment was a result of the lengthy hospitalization, his Crohn's disease, or both. Consequently, I do not attribute liability to Dr. Fourie for any malnourishment suffered by Mr. Baglot and I am unable to rely on malnourishment in my causation analysis regarding his two bleeds.

Cause of the First Bleed

- [304] Mr. Baglot remained in hospital to recover following his first surgery on August 2, 2011. Dr. Fishman testified that Mr. Baglot's 2.5 centimetre perforated ulcer was large and that it would take weeks to recover from such a perforation. There was testimony that Mr. Baglot's stomach lining would be compromised following the ketorolac prescription and surgery.
- [305] On August 6, 2011, Mr. Baglot had his first internal bleed, which required emergency surgery.
- [306] Dr. Byrne's evidence was that the first bleed was related to Mr. Baglot's poorly controlled small bowel Crohn's disease. He testified in cross-examination that the medication Mr. Baglot was on, the surgical intervention for the perforated ulcer, and the stress of the hospitalization could certainly add to the plaintiff's risk of suffering a bleed shortly after the ketorolac prescription. Dr. Byrne thought it was a fair statement that additional factors such as surgery and stress could put Mr. Baglot "over the edge."
- [307] Dr. Somsouk testified in cross-examination that the perforated ulcer and its complications "may have exacerbated" Mr. Baglot's underlying Crohn's disease, which then "could have contributed" to the first bleed. He explained in direct examination that a perforation is associated with inflammation and diversion of blood flow. The experts refer to this as a "systemic inflammatory response," like sepsis. This can worsen Crohn's disease because the blood may not be flowing as well to that part of the ileum. This would put the patient at an increased risk of experiencing a bleed from the Crohn's disease.
- [308] Noting that medical causation is a higher standard than legal causation, and the closeness in time between the perforated ulcer and the first bleed, I am satisfied on the balance of probabilities that Dr. Fourie's negligence caused the first bleed.

Cause of the Second Bleed

- [309] On August 29, 2011, Mr. Baglot was transferred to the ICU for a second bleed, an upper GI bleed. The doctors investigated but could not find its source. The treating physicians thought it was likely due to a Dieulafoy lesion in his stomach. The bleed resolved without surgical intervention, but it was very traumatic for Mr. Baglot.
- [310] Dr. Somsouk testified that the bleeding was likely from a Dieulafoy lesion, the cause of which is not well known. Dr. Somsouk testified that there are several risk factors for Dieulafoy lesions. The most common ones are an ICU stay, mechanical ventilation, trauma, burns, and sepsis. Dr. Somsouk opined that Dieulafoy lesions are associated with hospitalization and NSAID use.
- [311] Dr. Fishman stated the following in his response report:

The cause of Dieulafoy lesions is not known. Such lesions can bleed under many circumstances, but the reasons for bleeding are poorly understood, and such bleeding is highly unpredictable. Non-steroidal anti-inflammatory drug (NSAID) use has sometimes been associated, and on occasion, Dieulafoy lesions may bleed in the context of a hospitalization. However, it is important to note that no definitive cause-effect mechanism has been clearly established, and that neither the NSAID use nor the hospitalization is likely to have directly led to Mr. Baglot's bleeding event.

- [312] Both Dr. Fishman and Dr. Byrne testified that because the half-life of ketorolac is short, the second bleed was too remote to have been caused by the NSAID. Dr. Somsouk admitted that association between NSAIDs and bleeds is not strong. However, the powerful NSAID used in this case, ketorolac, resulted in a perforated ulcer. As noted above, Dr. Somsouk opined that a perforation is associated with inflammation and diversion of blood flow, which is a systemic inflammatory response similar to sepsis. This can worsen Crohn's disease, because the blood may not flow as well to parts of the GI tract. This would also put one at an increased risk of experiencing a bleed. Here, however, I must consider that Mr. Baglot was healing well prior to the second bleed.
- [313] Dr. Fishman noted that Mr. Baglot's Crohn's disease was not situated in the part of the GI tract where the second bleed occurred, the upper GI tract. Mr. Baglot had no upper gastric problems prior to the hospitalization.
- [314] The experts agreed that NSAIDs have dilatory effects on the digestive tract. As stated by Dr. Somsouk, ketorolac is one of the most potent NSAIDs.
- [315] Dr. Fishman testified that Dr. Somsouk's comments regarding Dieulafoy lesions are generally correct. He admitted that NSAIDs have sometimes been associated with these bleeds and, on occasion, Dieulafoy lesions may bleed in the context of a hospitalization.
- [316] Moreover, Mr. Baglot was on a low dose of heparin leading up to the second bleed. Heparin is an antiplatelet agent which can affect the mucosal cells. In cross-examination, Dr. Byrne agreed that Dieulafoy lesions are significantly associated with antiplatelet agents; they may be more common with comorbidities (multiple conditions/diseases). Dr. Fishman agreed that there is a risk of bleeding with the use of heparin.
- [317] Psychological stress has also been associated with bleeds. Certainly Mr. Baglot was under psychological stress while he was in the hospital.
- [318] The combination of the use of a particularly strong NSAID, the extended hospital stay and the resultant stress, and the administration of heparin, point to the reasonable inference that Dr. Fourie's negligence caused the second bleed. While not determinative, this finding is bolstered by the relatively close proximity in time between the ketorolac prescription and the second bleed. Although the ketorolac would no longer have been in Mr. Baglot's system by the date of the second bleed, Dr. Somsouk testified that Mr. Baglot essentially experienced sepsis systemic inflammation after having the perforated ulcer. Dr. Chatur testified that prolonged hospitalizations and surgery negatively impact mucosal health and

causes physiological changes in the body. Dr. Byrne testified that he has the utmost respect for the opinions of Dr. Chatur. Dr. Byrne also agreed in cross-examination that some inflammatory change in the abdominal cavity was possible following the ketorolac prescription.

- [319] I note that the causation test does not demand scientific precision and should not be applied too rigidly. Although expert evidence is necessary in complex medical malpractice cases, common sense applies: *Athey* at 467. A trial judge can find causation in circumstances where the precise mechanism leading to injury cannot be known with certainty: *Ediger - SCC* at para. 39.
- [320] I was presented with no evidence that Mr. Baglot has had another bleed in the years before or after his hospitalization despite his active Crohn's disease. Yet Mr. Baglot had two bleeds within one month of the surgery when Mr. Baglot was still in the hospital. This makes it more probable than not that the second bleed was caused by the prescription error and its sequelae. It fits with the temporal sequence of events: *Ediger - SCC; Chen*.
- [321] Although the exact cause of the second bleed cannot be identified with scientific certainty, I find it is more likely than not that the combination of the compromised lining of Mr. Baglot's stomach due to the dilatory effects of the NSAID, the surgery and the potential ischemia from the surgery, the prolonged hospitalization, the psychological stress due to the hospital stay, and the use of heparin caused the second bleed. I based this finding on the totality of the evidence: *Goodman*.
- [322] The court can reach a common sense inference of causation even when the parties have both adduced expert evidence: *Ediger - SCC* at para. 36. This is precisely what I have done here. I can think of no other way to explain the second bleed when Mr. Baglot had no previous upper gastric problems and no Crohn's disease in that part of his digestive tract. Although the exact mechanism for the second bleed cannot be identified, the logical inference is that it was caused by the breach of the standard of care of the defendant.
- [323] With regards to the defendant's argument that the second bleed was too remote from the defendant's prescribing error, I find that it was a "real risk", meaning "one which would occur to the mind of a reasonable man in the position of the defendan[t] . . . and which he would not brush aside as far-fetched": *Mustapha v. Culligan of Canada Ltd.*, 2008 SCC 27 at para. 13, citing *Overseas Tankship (U.K.) Ltd. v. Miller Steamship Co. Pty.*, [1967] A.C. 617 (P.C.), at p. 643).
- [324] The Supreme Court of Canada held in *R. v. Côté*, [1976] 1 S.C.R. 595, at 604, referred to in *Bendzak*, that the general character of the injury which occurred must be foreseeable, not the precise nature of the events that caused the injury. The second bleed was a real risk, one that a physician providing the requisite standard of care would have been aware of, given that Mr. Baglot was prescribed medication that was known to cause ulcers in patients with Crohn's disease. Ulcers can result in significant complications as it did here with the perforation.

Adhesions

- [325] Dr. Chatur pointed out that the 2018 colonoscopy she performed showed no objective evidence of Crohn's disease and she has every reason to believe that Mr. Baglot is responding to Entyvio. This finding led her to question what else could be causing his pain. She concluded that Mr. Baglot's ongoing pain is likely due to adhesions as a result of his surgeries.
- [326] Dr. Byrne admitted in cross-examination that there is a risk of adhesions every time an individual has surgery. The other medical experts agreed. Dr. Byrne testified that Dr. Chatur, as Mr. Baglot's treating physician, would be in the best position to comment on the current control of his Crohn's disease.
- [327] The defendant called evidence establishing that Mr. Baglot has had surgeries before and after the perforated ulcer repair surgery and the embolization for the first bleed, including the 2009 lysis of adhesions and the 2016 removal of approximately one foot of his colon.
- [328] The surgery Dr. Turner performed to repair Mr. Baglot's perforated ulcer was clearly major, requiring the surgeon to close off part of his GI tract, patch highly damaged tissue, and reroute his anatomy to redirect his stomach contents away from his duodenum.
- [329] Although major surgeries will generally cause larger adhesions, it is difficult to determine to what extent adhesions from surgery are causing Mr. Baglot's pain, and to what extent his Crohn's disease is causing him pain. However, I am satisfied that Mr. Baglot's Crohn's disease is well under control at this point and is not the central cause of his pain at this point in time.
- [330] Upon my review of the evidence, I am satisfied that the adhesions from the 2011 ulcer surgery are a contributing factor to Mr. Baglot's ongoing pain. Dr. Fourie is therefore liable as her prescription error led to the surgery. My finding is based on the experts' agreement that surgery always runs the risk of creating adhesions which can cause pain, and Dr. Chatur's testimony that adhesions are a likely cause of Mr. Baglot's pain since his Crohn's disease is not particularly active at this point. I accept the testimony of Dr. Chatur because she is Mr. Baglot's treating gastroenterologist and because she based her opinion on objective results from a colonoscopy she performed on Mr. Baglot in January 2018.

Visceral Hypersensitivity

- [331] Dr. Somsouk opined that visceral hypersensitivity is associated with trauma, anxiety, and childhood events. Mr. Baglot had an abusive father and difficult childhood, so he was predisposed to visceral hypersensitivity. Mr. Baglot described fear of death, anxiety, trauma, and helplessness during the hospitalization.

- [332] Dr. Somsouk testified that a patient who has Crohn's disease can have visceral hypersensitivity even after their inflammation resolves. This appears to be the case with Mr. Baglot.
- [333] Dr. Fishman opined that visceral hypersensitivity is a diagnosis of exclusion, meaning that only if there is not another explanation for the pain would a physician look to visceral hypersensitivity as a possibility. Dr. Chatur, Mr. Baglot's treating physician, testified that his Crohn's disease is currently under control and yet he continues to be in significant pain. Consequently, there is a need to consider other sources of the pain, including visceral hypersensitivity.
- [334] The defendant argued that if Mr. Baglot has visceral hypersensitivity, it is not a result of Dr. Fourie's negligence. This is because the trauma, that Mr. Baglot feared dying at ARH, occurred prior to having contact with Dr. Fourie. In addition, the defendant took the position that any significant trauma only occurred at the time of the second bleed. Even then, Dr. Fishman did not think the second bleed was sufficiently catastrophic or traumatic to cause visceral hypersensitivity. He based this on having cared for thousands of patients with GI bleeding and thousands with visceral hypersensitivity. The plaintiff objected to this evidence, which he characterized as anecdotal.
- [335] I note that both Dr. Hall and Dr. Tarzwell testified that Mr. Baglot had no psychiatric disorder prior to the hospitalization. The treatment Mr. Baglot received at ARH resulted in psychological stress, as did the perforated ulcer.
- [336] I accept that Mr. Baglot thought he was going to die in hospital. In particular, I accept Mr. Baglot's testimony, along with that of his mother, as to his experience of significant trauma when the second bleed occurred. Mr. Baglot had already been in hospital for over a month, he had endured two emergency surgeries, and his health was significantly compromised. It is not surprising that when he had the second bleed he thought he was going to die.
- [337] I infer that the onset of Mr. Baglot's visceral hypersensitivity was more likely than not caused by a combination of his treatment at ARH, the perforated ulcer, the trauma related to the second bleed, and his extended hospitalization. The combination of these events was sufficiently traumatic to cause visceral hypersensitivity, which now makes his pain more acute than it would otherwise be.
- [338] I also note that the temporal sequence of events is relevant. Prior to the hospitalization, Mr. Baglot had no pain except during times of flares. While his flares were becoming more frequent, and therefore so did his pain, there was no evidence that he had visceral hypersensitivity prior to July 2011.
- [339] These findings make it more likely than not that Mr. Baglot developed visceral hypersensitivity as a result of the defendant's negligence.

Opioid Use

- [340] Mr. Baglot was prescribed opioids for pain for the perforated ulcer and the resultant surgery. Mr. Baglot has suffered from chronic pain requiring high doses of opioids since August 2, 2011. His opioid use has continued since he was discharged from the hospital. Mr. Baglot is consistently fatigued, although it is unclear if it is from the pain or the opioids.
- [341] As I have noted, there is a conflict in the evidence regarding Mr. Baglot's opioid use. The defendant argues that the plaintiff suffered from depression and alcohol abuse prior to July 2011. He also used opioids to treat his Crohn's disease prior to the hospitalization. Based on these factors, Dr. Fourie argues that the prescription error did not cause the plaintiff's ongoing reliance on opioids, which she characterizes as an addiction. The plaintiff argues that prior to the ulcer Mr. Baglot had been prescribed opioids only occasionally and always in the context of his hospital stays. Today he uses prescription opioids to treat his pain, and that his self-medicating behaviours are due to not being prescribed enough to sufficiently address his legitimate pain complaints.
- [342] Whether or not Mr. Baglot is addicted to opioids, he is dependent on them and has been since the hospitalization. His dependency likely stems from his visceral hypersensitivity, which is an exaggerated response to painful (and non-painful) stimuli within the inner organs, including adhesions he sustained during his surgery to repair the perforated ulcer. As I have already found, Mr. Baglot's visceral hypersensitivity is a direct result of the defendant's negligence.
- [343] Whether it is an addiction or simply to control pain does not matter: Mr. Baglot had no substance use disorder pre-hospitalization and there is a close temporal connection between the defendant's negligence and his consistent use of opioids.
- [344] I find that it is not necessary for me to make a definitive finding on whether Mr. Baglot is addicted or not, as I have found that he was not suffering from addiction issues prior to the hospitalization. This is not a situation where a plaintiff's pre-existing addiction was aggravated by the subject incident, as was the case in *Lewis v. Gibson*, 2018 BCSC 1713, a recent decision from this Court. Nor is it a situation where a plaintiff is continuing to use even though the pain from the subject incident is no longer present. His doctor continues to prescribe Mr. Baglot the medication Dr. Fourie alleges he is addicted to, and he presumably does so to support the plaintiff's pain management.
- [345] Mr. Baglot's current opioid use began directly after the surgery to repair his perforated ulcer, it has had a devastating impact on his well-being, and I find it would not have arisen but for the defendant's negligence. Any pain related to his Crohn's disease that he uses opioids to alleviate is not due to the defendant's negligence; this will be reflected in a reduction of his damage award.

PTSD

- [346] Mr. Baglot submits that he developed PTSD during his hospitalization, a condition from which he continues to suffer. Dr. Fourie argues that he does not have PTSD. Relying on Dr. Hall, the defendant argues that Mr. Baglot did not have an exposure event to satisfy criterion A to establish PTSD. According to the defendant, Mr. Baglot's exposure event to PTSD, were I to find he suffers from the condition, was the second bleed, for which she denies liability.
- [347] I have found that Mr. Baglot does have PTSD, as diagnosed by Dr. Tarzwell. In his report, Dr. Tarzwell opined that criterion A for the diagnosis, "exposure to actual or threatened death", was satisfied with Mr. Baglot's psychologically reasonable belief that he could have died during his hospitalization. I note that Dr. Hall did not dispute that if the plaintiff had an exposure event that would satisfy criterion A in her report.
- [348] Mr. Baglot developing PTSD in response to trauma suffered during a long hospitalization involving emergency surgeries is foreseeable, given that a prescription error was made that carried significant health consequences. I have found that Dr. Fourie's negligence caused the second bleed and that the event or events surrounding the second bleed were sufficiently traumatic to trigger PTSD. I therefore find Dr. Fourie liable for the damages suffered by the defendant due to his PTSD.

Summary

- [349] Mr. Baglot did not prove that Dr. Fourie's negligence resulted in dumping syndrome, as I found he does not suffer from the condition. Mr. Baglot proved causation on a balance of probabilities for the remaining injuries he claims, except his ongoing battle with Crohn's disease.
- [350] The lengthy hospitalization and the second bleed caused Mr. Baglot significant trauma. This in turn caused PTSD and visceral hypersensitivity, which intensify the pain now suffered by the plaintiff. The surgery also left the plaintiff with additional adhesions, which contribute to the plaintiff's pain. Mr. Baglot was prescribed opioids directly following the first surgery for the perforated ulcer. He continues to be reliant on opioids to manage his constellation of health issues.
- [351] The defendant's negligence has had a devastating impact on Mr. Baglot's life. Today Mr. Baglot is totally disabled, homebound, and isolated. Without the prescribing error, I find that it is more likely than not that Mr. Baglot would have continued to have Crohn's disease but that he would have worked and been a contributing member of society.

Mitigation

- [352] The defendant argues that the plaintiff acted unreasonably and did not mitigate his damages.

- [353] This court laid out the mitigation principle in *Gilbert v. Bottle*, 2011 BCSC 1389 at para. 202:
- [202] Once a plaintiff has established that the defendant is liable for causing his or her injuries, the burden of proof shifts to the defendant. To succeed on a mitigation defence, the defence must prove that the plaintiff acted unreasonably and reasonable conduct would have reduced or eliminated the loss. Whether the plaintiff acted reasonably is a factual question. Its answer depends on consideration of all of the surrounding circumstances
- [354] Mr. Baglot made some efforts, especially early on, to regain his former life following the hospitalization. However, when Mr. Baglot tried to bike and to skateboard after the injury he was unsuccessful. He was too exhausted. I find this to be reasonable and not a failure to mitigate, due to the physical and psychological toll the hospitalization took on Mr. Baglot.
- [355] However there are two areas where Mr. Baglot did not take steps to mitigate his damages. First, despite his mental health issues, which Dr. Chatur thought was contributing to his symptoms, Mr. Baglot did not pursue psychiatric care. He originally saw Dr. Antony, a psychiatrist, but cancelled the second appointment. He saw Dr. Howard, another psychiatrist, between January 26, 2015, and September 22, 2016. In 2015, Dr. Chatur recommended that he continue seeing Dr. Howard. Mr. Baglot did not continue this treatment despite the fact that Dr. Howard advised Mr. Baglot that they could communicate over FaceTime video chat as a possible accommodation.
- [356] Dr. Tarzwell agreed in cross-examination that it would be of assistance for Mr. Baglot to be in the care of a psychiatrist. He testified that a team care approach would be ideal. However, Mr. Baglot has not pursued the multidisciplinary approach to his psychiatric difficulties that Dr. Tarzwell believes is required or sought alternate help in years.
- [357] I find that Mr. Baglot likely would have had better outcomes, and perhaps would not be totally disabled, had he mitigated his losses by pursuing consistent psychiatric care.
- [358] Given my finding that the prescribing error did not change the course of Mr. Baglot's Crohn's disease, his failure to mitigate in this area is irrelevant.
- [359] I find that Mr. Baglot's award should be reduced by 10 percent due to his failure to mitigate with regard to his psychological challenges.

Damages

Motor Vehicle Accident

- [360] Mr. Baglot was involved in two motor vehicle accidents post-hospitalization. He suffered functional limitations as a result of the February 2017 accident. For example, his arthritis was affected, he had shoulder and back pain, his headaches increased, and he suffered from exhaustion and depression. These limitations are not the fault of Dr. Fourie and must be taken into account when assessing damages. I reduce his award by 5% to account for the injuries suffered in the motor vehicle accident.

Crumbling Skull

- [361] Dr. Fourie's negligence caused Mr. Baglot significant harm. However, a defendant need not compensate a plaintiff for debilitating effects of a pre-existing condition the plaintiff would have experienced in any event. Therefore, I must determine the extent of the harm attributable to Dr. Fourie, given Mr. Baglot's pre-existing Crohn's disease.
- [362] I agree with Dr. Fishman and Dr. Byrne that the prescription error, the surgery and the hospitalization likely did not have any material impact on the course of Mr. Baglot's Crohn's disease. I am persuaded that this is a case where the "crumbling skull" rule applies. Mr. Baglot was suffering from deteriorating health prior to the injury; his Crohn's disease was escalating in the months prior to the hospitalization.
- [363] Based on the evidence, I find that Mr. Baglot would have had ongoing symptoms and periods of time where he could not work due to his pre-existing Crohn's disease even without the wrongly prescribed ketorolac. For example, he had moved home to live with his mother and had quit his job due to trouble with his Crohn's disease in the five months prior to his hospitalization. Although he was in a much better position pre-hospitalization than he is now, Mr. Baglot's Crohn's disease had been getting worse since approximately mid-2010. Dr. Fourie's negligence simply triggered or hastened what was more likely than not the inevitable: *Mackie v. Wolfe* (1996), 41 Alta. L.R. (3d) 28 (C.A.). Even without Dr. Fourie's negligence, the medical evidence established that Mr. Baglot would likely experience bouts of Crohn's disease, interspersed with periods of remission.
- [364] Mr. Baglot's damages must be reduced to reflect his pre-existing Crohn's disease, otherwise he would be placed in a better position than his original position of a young man suffering from Crohn's disease. This would be contrary to the most basic principle of tort law: *Athey* at p. 472.
- [365] Dr. Fourie is only responsible to compensate Mr. Baglot for the harm she caused. She is only required to pay for the difference in eventualities resulting from her negligence, "discounting the separate effect of the pre-existing debilitating infirmity": Erik S. Knutsen, "Coping with Complex Causation Information in Personal Injury Cases" (2013) 41 *Advocates Q* 149 at 158. Due to the crumbling skull doctrine, Dr. Fourie is liable to pay for her negligent contribution minus the contribution of the Crohn's disease that Mr. Baglot would have suffered in any event.
- [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.

Thin Skull

[367] I find that Mr. Baglot had a "thin skull" with regard to developing visceral hypersensitivity due to the abuse he suffered during his childhood. He may also have been more susceptible to mood disorders such as depression, anxiety, and PTSD. Unlike his underlying Crohn's disease, there is no evidence to suggest that he would have suffered from these conditions but for the ulcer, the lengthy hospitalization and the second bleed. While Mr. Baglot's ongoing pain and the damages that flow from it may seem disproportionate to the original injury, Dr. Fourie must take Mr. Baglot as she found him.

Non-Pecuniary Damages

[368] Non-pecuniary damages are awarded to compensate the plaintiff for "pain, suffering, loss of enjoyment of life, and loss of amenities": *Trites v. Penner*, 2010 BCSC 882 at para. 188 [Trites]; and *Stapley v. Hejslet*, 2006 BCCA 34 [Stapley] at para. 46, leave to appeal ref'd [2006] S.C.C.A. No. 100. Non-pecuniary damages must be fair to all parties; fairness is measured against awards made in comparable cases. However, each case depends on its own unique facts: *Trites* at paras. 188-189.

[369] As set out in *Stapley* at para. 46, common factors that influence an award of non-pecuniary damages include:

- a) age of the plaintiff;
- b) nature of the injury;
- c) severity and duration of pain;
- d) disability;
- e) emotional suffering;
- 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
- j) the plaintiff's stoicism.

[370] The plaintiff relied on *Lindal v. Lindal* [1981] 2 S.C.R. 629 at 637, where Dickson J. (as he then was) stated that an award for non-pecuniary damages does not depend only on the seriousness of the injury, it also depends on the seriousness of the individual's loss:

the amount of an award for non-pecuniary damage should not depend alone upon the seriousness of the injury but upon its ability to ameliorate the condition of the victim considering his or her particular situation. It therefore will not follow that in considering what part of the maximum should be awarded the gravity of the injury alone will be determinative. An

appreciation of the individual's loss is the key and the "need for solace will not necessarily correlate with the seriousness of the injury" (Cooper-Stephenson and Saunders, *Personal Injury Damages in Canada* (1981), at p. 373). In dealing with an award of this nature it will be impossible to develop a "tariff". An award will vary in each case "to meet the specific circumstances of the individual case"

[371] At 639-640, the Supreme Court of Canada further held that:

The purpose of making the award is to substitute other amenities for those that have been lost, not to compensate for the loss of something with a money value. Since the primary function of the law of damages is compensation, it is reasonable that awards for non-pecuniary loss, which do not fulfill this function, should be moderate.

[372] One of the fundamental principles of tort law is that, to the extent a monetary award can accomplish it, a plaintiff should be placed in the same position he or she would have been in had the accident not occurred, not in a better position: *Parypa v. Wickware*, 1999 BCCA 88 at para. 29.

[373] The plaintiff suggests non-pecuniary damages in the range of \$265,000. The defendant argues that they should be assessed in the range of \$40,000 to \$60,000.

[374] Evidence was led by Mr. Baglot, his mother, his sister, and his good friend regarding his pre- and post-injury abilities. I have found that prior to the injury Mr. Baglot was an active young man, had some successes in high school, did well at VCC's chef program after he graduated, and travelled to China with his sister. He was employed, albeit intermittently, volunteered in his community, cycled everywhere, and travelled. These abilities were largely taken away from him following the defendant's prescribing error.

[375] Subsequent to the injury, despite trying, the plaintiff was unable to continue any of his athletic pursuits from which had derived so much pleasure. It is clear that prior to the accident the plaintiff was a functioning member of society. It is obvious that he lives with chronic pain and psychological issues. All his relationships have been negatively affected by the injury. He was engaged. While the injury may not be responsible for his break up with Ms. Phillips, given their previously volatile relationship, it has resulted in him not having the ability to find a lifetime partner. He is totally disabled, in constant pain, housebound, and isolated. He is not the same man he was before his hospitalization and he certainly cannot work.

[376] I have reviewed a number of cases regarding non-pecuniary losses. These cases differ regarding the age of the plaintiff, their pre-injury abilities, and their ability to enjoy life in the future. His pain and the opioids he takes to manage it have had a detrimental impact on his cognitive functions and his ability to participate in daily activities, and have increased his emotional suffering.

- [377] One case I found to be particularly instructive is *Scoates v. Dermott*, 2012 BCSC 485 [Scoates]. In *Scoates*, Justice N. Smith awarded \$250,000 in non-pecuniary damages to a paramedic in his thirties. This award is equivalent to approximately \$275,000 in today's dollars when adjusted for inflation. Prior to the accident the plaintiff had worked full-time as a paramedic, a job he loved, through which he defined himself, and which he would never be able to do again. The accident had a profound impact on his life, causing him "cognitive, emotional and personality difficulties."
- [378] Here the plaintiff did not have defined career like the plaintiff in *Scoates*. Yet he was a relatively young man at the time of the injury and now faces his adult life with chronic pain and total disability. The plaintiff's injuries have led to an inability to participate in the cycling community he so valued, social isolation, and a near total loss of autonomy. His injuries also pose challenges to his ability to derive purpose from meaningfully contributing to his community, be it through work, volunteering or otherwise.
- [379] In all the circumstances, I consider an appropriate award of non-pecuniary damages to be \$265,000. This amount recognizes the plaintiff's ongoing pain, loss of enjoyment of life, and the longevity of his claim.
- [380] In *T.W.N.A.*, at paras. 36-37, the Court of Appeal reduced damages to account for intervening events:
- [36] Unrelated intervening events must be taken into account in the same way as pre-existing conditions. If such an event would have affected the plaintiffs original position adversely in any event, the net loss attributable to the tort will not be as great and damages will be reduced proportionately (*Athey v. Leonati* at 31-32).
- [37] These principles of assessment apply equally to non-pecuniary damages and to damages for loss or impairment of earning capacity: see *Steenblok v. Funk* (1990), 46 B.C.L.R. (2d) 133 (C.A.) and *Rosvold v. Dunlop* (2001), 84 B.C.L.R. (3d) 158, 2001 BCCA 1, where this Court said:
- [9] Because damage awards are made as lump sums, an award for loss of future earning capacity must deal to some extent with the unknowable. The standard of proof to be applied when evaluating hypothetical events that may affect an award is simple probability, not the balance of probabilities: *Athey v. Leonati*, [1996] 3 S.C.R. 458. Possibilities and probabilities, chances, opportunities, and risks must all be considered, so long as they are a real and substantial possibility and not mere speculation. These possibilities are to be given weight according to the percentage chance they would have happened or will happen.
- [381] I have found that Mr. Baglot's pre-existing Crohn's disease would have occurred in any event. Because the crumbling skull doctrine applies, damages must reflect the trajectory of Mr. Baglot's degenerative condition and be reduced by 30%. Non-pecuniary damages must also be reduced 10% to reflect Mr. Baglot's failure to mitigate and 5% to account for the intervening 2017 motor vehicle accident. The motor vehicle accident affected his arthritis and increased his headaches. Reducing the non-pecuniary damages results in an award of

\$145,750, which I have rounded up to \$146,000.

Earning Capacity

[382] Where the court is satisfied that the plaintiff suffered injuries due to the defendant's negligence, the plaintiff is entitled to damages both for the wage loss they suffered from the date of injury to the beginning of the trial, and for the wage loss they will fail to earn in the future due to their injuries.

Past Wage Loss

[383] Compensation for past wage loss considers what the plaintiff likely would have earned, not what he could have earned, if the injury had not been sustained: *Rowe v. Bobell Express Ltd.*, 2005 BCCA 141 at para. 30.

[384] The plaintiff is entitled to past wage losses for work missed due to his injuries. His past wage loss is calculated up to June 17, 2018, the day before trial.

[385] Unfortunately, Mr. Baglot did not have a strong work history and was on medical employment insurance prior to the hospitalization. The evidence established that Mr. Baglot was sporadically employed in the years leading up to the injury. While he completed a culinary arts program at VCC he did not pursue a career as a chef or baker, although he did work at Thrifty Foods briefly. He enrolled in UFV in 2006 but received poor grades and withdrew in his second semester due to health issues. He later worked at MEC but found that job stressful and lasted only three months. His last employment was at Thrifty Foods. He started in September 2010 and worked for approximately three months. He took some time off for health-related reasons and stopped working there in March 2011, at which time he applied for social assistance. He did not receive social assistance because he did not submit the necessary documentation.

[386] On May 17, 2011, Dr. Eddy completed a form on behalf of Mr. Baglot for the Ministry of Social Development titled "Medical Report - Employability." Dr. Eddy stated the plaintiff's condition to be severe Crohn's disease. On June 24, 2011, Dr. Eddy recorded that Mr. Baglot was unable to work due to his Crohn's symptoms.

[387] Mr. Baglot applied for a disability tax credit in 2015. It was approved retroactive to 2004, meaning that Mr. Baglot may not have been able to work in any significant capacity long before the hospitalization.

[388] In her March 19, 2018 report, Ms. Sharma noted gaps in Mr. Baglot's work history before the hospitalization:

Mr. Baglot's pre-incident work history contains more gaps and inconsistencies than would be expected, even for a younger worker. Even after having completed one year of occupational training, he only worked briefly in one related job as a cook for a period of three months, which he left for reasons unrelated to work or his health. I understand that he had recurrent issues

relation to his Crohn's disease which required hospitalization and time for recovery. However, outside of those periods, I am unclear as to what Mr. Baglot's vocational goals were as it does not appear that he had any clear career direction or intentions in place after completing his culinary arts training in January 2006, more than five years prior to the subject medical incident.

[389] Since Mr. Baglot was young at the time he was injured, and because he had previously had a settlement from a previous motor vehicle accident that may have affected his work trajectory, I assume that Mr. Baglot would have worked as a cook with trade certificates on a part-time basis in the years following the hospitalization. I assume a wage of approximately \$15,000 for assessing his past income loss. I have reviewed and considered the economic expert reports in reaching this figure.

[390] I note that these assumptions are not mathematically perfect. However I believe this approach is a fair assessment of Mr. Baglot's past wage loss taking into account his poor work history but also that as he got older, and no longer had money from the motor vehicle accident settlement, he likely would have worked more.

[391] I therefore award Mr. Baglot loss of past wages between July 22, 2011 and June 17, 2018 in the gross amount of \$105,000. I must subtract 10% for his failure to mitigate and 30% for periods of unemployment due to his underlying Crohn's disease. I decline to reduce this further for the 2017 motor vehicle accident. This results in an award of \$63,000.

[392] I leave it to the parties to make the appropriate adjustments to reach the net figure.

Loss of Future Earning Capacity

[393] In determining a claim for loss of future earning capacity, the court must consider two questions (*Hoy v. Williams*, 2014 BCSC 234 at para. 153 [*Hoy*]). The first question is: has the plaintiff's earning capacity been impaired by his or her injuries? This is measured by whether there is sufficient evidence that there exists a real and substantial possibility of future income loss. If yes, the second question is: what compensation should be awarded for the resulting financial harm that will accrue over time?

[394] The law regarding loss of future earning capacity was further expanded upon in *Hoy*:

[153] The assessment of loss must be based on the evidence, and not an application of a purely mathematical calculation. The appropriate means of assessment will vary from case to case.

[154] The assessment of damages is a matter of judgment, not calculation.

[155] Insofar as possible, the plaintiff should be put in the position he or she would have been in but for the injuries caused by the defendant's negligence. The essential task of the Court is to compare the likely future of the plaintiff's working life if the accident had not happened with the plaintiff's likely future working life after the accident.

[Citations omitted.]

[395] In *Hoy*, Justice Kent explained there are two possible approaches when assessing loss of future earning capacity: the "earnings approach" from *Pallos v. Insurance Corp. of British Columbia* (1995), 100 B.C.L.R. (2d) 260 (C.A.) [Pallos], and the "capital asset approach" in *Brown v. Golaiy* (1985), 26 B.C.L.R. (3d) 353 (S.C.) [Brown], both of which are correct. The earnings approach is more useful when the loss is easily measurable: *Perren v. Lalari*, 2010 BCCA 140 [Perren] at para. 32. The capital asset approach is more appropriate where the loss is not measurable in a pecuniary way: *Perren* at para. 12.

[396] Justice Kent described the difference between the earnings approach and the capital asset approach as follows:

[157] The earnings approach involves a form of math-oriented methodology such as i) postulating a minimum annual income loss for the plaintiff's remaining years of work, multiplying the annual projected loss by the number of remaining years and calculating a present value or ii) awarding the plaintiff's entire annual income for a year or two.

[158] The capital asset approach involves considering factors such as i) whether the plaintiff has been rendered less capable overall of earning income from all types of employment; ii) whether the plaintiff is less marketable or attractive as a potential employee; iii) whether the plaintiff has lost the ability to take advantage of all job opportunities that might otherwise have been open; and iv) whether the plaintiff is less valuable to herself as a person capable of earning income in a competitive labour market.

[159] Though the capital asset approach is not a "mathematical calculation", the trial judge must still explain the factual basis of the award.

[Citations omitted.]

[397] Compensation is to be based on a real and substantial possibility, not on mere speculation. As Justice Kent stated in *Hoy*:

[141] Compensation for past loss of earning capacity is to be based on what the plaintiff would have, not could have, earned but for the injury that was sustained: *Rowe v. Bobell Express Ltd.*, 2005 BCCA 141 at para. 30; *M.B. v. British Columbia*, 2003 SCC 53 at para. 49. The burden of proof of actual past events is a balance of probabilities. An assessment of loss of both past and future earning capacity involves consideration of hypothetical events. The plaintiff is not required to prove these hypothetical events on a balance of probabilities. The future or hypothetical possibility will be taken into consideration as long as it is a real and substantial possibility and not mere speculation: *Athey v. Leonati* at para. 27; *Morlan v. Barrett*, 2012 BCCA 66 at para. 38.

[398] It is not necessary that the medical evidence specifically establish impairment of earning capacity. Such impairment must be established on the totality of the evidence: *Miscisco v. Small*, 2001 BCCA 576.

Has The Plaintiff's Earning Capacity Been Impaired by His Injuries?

- [399] As is often said by judges assessing future loss of income, this is an exercise akin to gazing into a crystal ball: *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229 [Andrews] at 251. This is certainly true in Mr. Baglot's case.
- [400] It is clear that Mr. Baglot's earning capacity has been impaired by his injuries. Mr. Baglot is currently totally disabled with no prospect of future employment. However, his work status prior to the hospitalization poses some challenges for assessing what that employment would have been.
- [401] One particular difficulty is that Mr. Baglot was a young man when he was injured. Another challenge is that, as Ms. Sharma opined, Mr. Baglot was not competitively employable before the hospitalization. Due to his underlying Crohn's disease, Mr. Baglot likely needed accommodations to remain employed even prior to the ulcer. His pensionable earnings in 2009 and 2010, the two years prior to the hospitalization, were \$6,333 and \$5,234 respectively. This reflects the fact that he was off work for significant periods due to his health as well as his poor work history.
- [402] The primary difference between before hospitalization and post-hospitalization is that today Mr. Baglot is no longer employable at all due to his current state of disability. This includes psychological difficulties that were not present prior to the hospitalization.
- [403] Mr. Baglot's future earnings are hard to predict given his young age and his lack of sustained employment. Since Mr. Baglot did not have a settled pattern of employment, I cannot determine his loss of future earning capacity with mathematical precision. Therefore the capital asset approach is appropriate for assessing his loss of future earning capacity: *Bearpark v. Lakhanpal*, 2013 BCSC 2082 [Bearpark]; and *Jurczak v. Mauro*, 2013 BCCA 507.
- [404] In *Bearpark*, Greyell J. held that capital asset approach was applicable to a plaintiff with no settled career choice who had explored a number of potential careers in relatively short stints.
- [405] I have taken into account the expert economist opinions of Mr. Carson and Mr. Hildebrand, as well as the functional capacity opinions that Mr. Baglot is today totally disabled in making my decision. I have considered Mr. Baglot's less than impressive work ethic prior to the injury, apart from his Crohn's related absences from work, along with the fact that he was only 26 years old when the incident occurred. He likely would have become more industrious with time.
- [406] Using the capital asset approach and having considered the projected earnings for less than full-time work as a cook or a baker, and an assumed retirement age of 65, I award Mr. Baglot \$800,000 for his loss of future earning capacity.

- [407] I have found that Mr. Baglot's pre-existing Crohn's disease would have occurred in any event and damages must be reduced accordingly. The loss of future earning capacity must also be reduced to reflect Mr. Baglot's failure to mitigate and to account for the intervening motor vehicle accident.
- [408] The amount of \$800,000 is therefore reduced by 10% for Mr. Baglot's failure to mitigate, 30% for his pre-existing and continuing Crohn's disease, and 5% for the 2017 motor vehicle accident. This results in an award of \$440,000.

In Trust Claim: Linda Baglot

- [409] The law on in trust claims is set out in *Dykeman v. Porohowski*, 2010 BCCA 36. Referring to its earlier decision in *Kroeker v. Jansen*, [1995] 6 W.W.R. 5 (B.C.C.A.), it confirmed that a plaintiff is entitled to receive compensation for the value of housekeeping services where these are carried out gratuitously by family members:
- [28] Since *Kroeker*, it has been settled law in this province that "housekeeping and other spousal services have economic value for which a claim by an injured party will lie even where those services are replaced gratuitously from within the family." In *Kroeker*, such recovery was allowed under the heading of 'loss of future ability to perform household tasks', but obviously, damages for loss of such ability prior to trial may also be properly claimed and recovered: see, e.g., *McTavish v. MacGillivray*, 2000 BCCA 164 at paras, 43, 51-7, per Huddart J.A.; *West v. Cotton* (1995) 10 B.C.L.R. (3d) 73 (C.A.) at para. 25; and *Campbell v. Banman* 2009 BCCA 484. The reasoning in *Kroeker* has been extended beyond "spousal" services to services rendered by other members of a family: see *Boren v. Vancouver Resource Society*, *Dufault*, *McTavish v. MacGillivray*; *Bystedt v. Hay*, all *supra*. Such awards are colloquially referred to as "in trust" even though it is the plaintiff who recovers them, and British Columbia courts do not generally impose trust terms in their orders, regarding the loss as that of the plaintiff: see *Feng v. Graham* (1988) 25 B.C.L.R. (2d) 116 (C.A.) at 9-10; *McTavish*, *supra*.
- [29] The majority in *Kroeker* was alive to the possibility that awards for gratuitous services by family members of plaintiffs could "unleash a flood of excessive claims" (*supra*, at para. 29) and for that reason, urged courts to be cautious in making such awards. In the words of Gibbs, J.A.:

... as the law has developed it would not be appropriate to deny to plaintiffs in this province a common law remedy available to plaintiffs in other provinces and in other common law jurisdictions. It will be the duty of trial judges and this Court to restrain awards for this type of claim to an amount of compensation commensurate with the loss. With respect to other heads of loss which are predicated upon the uncertain happening of future events measures have been devised to prevent the awards from being excessive. It would be reasonable to expect that a similar regime of reasonableness will develop in respect of the kind of claim at issue in this case. [At para. 19; emphasis added.]

- [410] The plaintiff claimed \$90,000 in trust. Ms. Linda Baglot provides many services to her son, but she also works full-time so these services are obviously not a full-time commitment. However, the services she provides are clearly well beyond what a parent would expect to provide for a grown child.
- [411] I recognize that trial judges must be restrained and reasonable in determining these awards. In these circumstances, I accept the plaintiff's claim of \$90,000, which I find to be modest. This award must be reduced by 30% for Mr. Baglot's Crohn's disease and 10% for his failure to mitigate. I decline to reduce the award due to the 2017 motor vehicle accident. This results in an award to Ms. Linda Baglot in the amount of \$54,000.

Cost of Future Care

- [412] A plaintiff is entitled to compensation for costs of future care for the harm caused by the defendant's negligence. These costs are based on what is reasonably necessary to restore the plaintiff to his pre-accident condition, according to the medical evidence to preserve and promote the plaintiff's physical and mental health: Gignac at paras. 29-30, citing Milina v. Bartsch (1985), 49 B.C.L.R. (2d) 33 (S.C.).
- [413] In Andrews, Dickson J., as he then was, discussed the rationale behind cost of future care awards at 241-242:

In theory a claim for the cost of future care is a pecuniary claim for the amount which may reasonably be expected to be expended in putting the injured party in the position he would have been in if he had not sustained the injury. Obviously, a plaintiff who has been gravely and permanently impaired can never be put in the position he would have been in if the tort had not been committed. To this extent, restitutio in integrum is not possible. Money is a barren substitute for health and personal happiness, but to the extent [sic] within reason that money can be used to sustain or improve the mental or physical health of the injured person it may properly form part of a claim.

[Emphasis in original.]

- [414] The Court of Appeal discussed what type of evidence is required for a future care claim in Gregory v. Insurance Company of British Columbia, 2011 BCCA 144:
- [39] I do not consider it necessary, in order for a plaintiff to successfully advance a future cost of care claim, that a physician testify to the medical necessity of each and every item of care that is claimed. But there must be some evidentiary link drawn between the physician's assessment of pain, disability, and recommended treatment and the care recommended by a qualified health care professional: Aberdeen at paras. 43, 63.

[415] Mr. Baglot seeks \$439,000 under this head of damages. This includes costs for cleaning services, personal attendants, gardening and home maintenance, prescription drugs, psychological counselling, vocational counselling, and occupational therapy. The plaintiff largely relies on the costs assessed by Ms. Kaczmarek, but seeks a higher overall award based on adjustments to some of the expert's figures.

[416] The defendant submits that the evidence does not justify the award Mr. Baglot seeks, based on his pre-existing chronic illness and Ms. Percy's expert report.

[417] Ms. Kaczmarek's cost of future care recommendations are as follows:

Medications

8 medications at various dosages and prices

Annual cost: \$3,552.10

Psychological Counselling

30 sessions at \$201.76 per session

Fixed cost: \$6,052.80

Occupational Therapy

30 sessions at \$105.67 per session

Fixed cost: \$5,036.77

10 sessions of the Progress Goal Attainment Program at \$1,866.67 total

Vocational Counselling

1 assessment at \$1,010.00

12 sessions at \$110.00 per session

Fixed cost: \$2,330.00

Household Assistance

Attendant care

95.81 hours per year at \$29.08 per hour

Annual cost: \$11,325.27

House cleaning

71.12 hours per year at \$33.75 per hour

Lawn/garden care

68.44 hours per year at \$51.75 per hour

Home maintenance

41.06 hours per year at \$63.25 per hour

Total fixed costs: \$13,419.57

Total annual costs: \$14,877.37

[418] Ms. Percy's responded with the following recommendations:

Medications

Must reduce cost for prescription dispensing fees

Annual cost: \$2,735.30

Psychological Counselling

Defers to the appropriate experts in psychology or psychiatry

To be determined

Occupational Therapy

16 to 20 sessions at \$112.00 per session plus 30% for travel time and mileage

Fixed cost: \$2,329.60 to \$2,912.00

Vocational Counselling

Ms. Percy disagrees that Mr. Baglot needs any

\$0

Household Assistance

Attendant care

3 hours per week combined at \$30.00 per hour

Annual cost: \$4,680.00 plus GST

House cleaning

Lawn/garden care

Dependent on where he lives; roughly 60 to 80 hours per year combined at \$35.00 to \$46.00 per hour

Annual cost: \$2,100.00 to \$3,680.00 plus GST

Home maintenance

Total fixed costs: \$2,329.60 to \$2,912.00 plus counselling

Total annual costs: \$9,515.30 to \$11,095.30 plus GST

- [419] This judgment has gone into significant detail regarding Mr. Baglot's conditions and the challenges he faces. For reasons I will not restate here, I accept that Mr. Baglot's injuries keep him from performing personal errands, daily chores, and otherwise contributing to household maintenance. I also accept that he is on costly prescription medication due to his injuries and that he would benefit from significant therapeutic support.
- [420] I give considerable weight to both expert reports in assessing costs of future care. Both Ms. Kaczmarek and Ms. Percy are qualified occupational therapists. They met with Mr. Baglot in creating their respective reports and explained in detail how they reached their conclusions.
- [421] Ms. Percy responded to Ms. Kaczmarek's figures, saying they were too high partly because she overstated the plaintiff's pre-incident abilities and did not consider that his condition would decline over time due to his pre-existing Crohn's disease. These concerns are taken into account by a reduction in my final award, rather than by reducing the base total of these costs.
- [422] Ms. Percy suggested Ms. Kaczmarek's projected medication costs were slightly too high because they overstated dispensing costs. However she acknowledged that these medication costs could rise if Mr. Baglot was put on different prescriptions. Ms. Percy declined to assess the appropriate value for psychological counselling, deferring to experts in that field. Ms. Percy agreed with Ms. Kaczmarek that the plaintiff would benefit from a progress goal attainment program and occupational therapy, although she suggested only 16-20 sessions rather than 30. Ms. Percy agreed with Ms. Kaczmarek that approximately three hours per week for home support and housekeeping was appropriate. For all of these future care categories, I accept Ms. Kaczmarek's figures, while noting they are fairly close to Ms. Percy's.
- [423] Ms. Percy opined that Mr. Baglot did not require compensation for future vocational counselling sessions, since he is at present unemployable and will have support from an occupational therapist and a psychological counsellor. I agree with Ms. Kaczmarek that it would be a disservice to Mr. Baglot to deprive him of this opportunity. If Mr. Baglot pursues psychological counselling and occupational therapy, his quality of life and abilities could improve such that vocational counselling would prove useful. Counselling could introduce him to volunteer opportunities or online courses. I accept Ms. Kaczmarek's recommendation that Mr. Baglot be awarded costs for vocational counselling.
- [424] Ms. Percy and Ms. Kaczmarek's figures are farthest apart for garden care and home maintenance. Ms. Kaczmarek suggests that Mr. Baglot will require professional services approximately 69 hours annually for garden maintenance and 41 hours annually for home maintenance. I disagree. Given Mr. Baglot's current status and his income prospects, I find it is unlikely that his living arrangements will require him personally to tend to a garden and perform home maintenance to this degree. I therefore award him these costs on the

high end of Ms. Percy's recommended figures, rather than Ms. Kaczmarek's.

- [425] I award the equivalent of \$12,600 annually to Mr. Baglot until he reaches the age of 70 for his costs of future care. Using Mr. Carson's multiplier of \$25,591, this totals \$323,000. I further award \$13,500 in "one time" costs for psychological counselling, vocational counselling, and occupational therapy. I was not persuaded these fixed costs amounted to \$30,000, as submitted by the plaintiff.
- [426] I must also reduce this award to account for Mr. Baglot's failure to mitigate, pre-existing condition, and the motor vehicle accident. This results in an award of \$185,000.
- [427] Mr. Baglot is in receipt of a disability tax credit. It was approved by the government from 2007 to 2020. The defendant pointed out that this credit would cover most if not all of his prescriptions. I assume he will continue to get this credit in the future as a person with disabilities.
- [428] I leave it to the parties to deduct from the cost of future care award any amounts covered by the disability tax credit for prescription medication, which I have assessed at \$3,552 annually.

Conclusion

- [429] I find that Mr. Baglot is entitled to the following damages for his injuries caused by the defendant's prescribing error:
- a) \$146,000 in non-pecuniary damages;
 - b) \$63,000 in past wage loss;
 - c) \$440,000 in loss of future earning capacity;
 - d) \$54,000 in trust for Ms. Linda Baglot; and
 - e) \$185,000 in costs of future care.
- [430] I leave it to the parties to make appropriate income tax adjustments to the past wage loss award and appropriate disability tax credit adjustments to the cost of future care award. If they cannot agree, they are at liberty to make submissions.
- [431] I award ordinary costs to the plaintiff, unless either party files an application to determine costs within 45 days of this judgment.

"The Honourable Madam Justice D. MacDonald"

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