

CANADA / JUDGMENT

Lee v. Black

2023 BCSC 1920

COURT

Supreme Court of British Columbia

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2023 BCSC 1920 Lee v. Black

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Lee v. Black,

2023 BCSC 1920

Date: 20231101

Docket: S1914672

Registry: Vancouver

Between:

Byung Kyu Lee

Plaintiff

And

Dr. Peter Colin Victor Black

Defendant

Before: The Honourable Justice Wedge

Reasons for Judgment

The Plaintiff, appearing in person:

B.K. Lee

Counsel for the Defendant:

A. Turner

M.A. McPhee

Place and Date of Trial:

Vancouver, B.C.

March 27-31, 2023

April 3-5, 2023

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Place and Date of Judgment:

Vancouver, B.C.

November 1, 2023

Table of Contents

I. Introduction.. 3

Nature of the Claim.. 3

Overview.. 3

II. Issues.. 5

III. Overview of Law on Medical Negligence.. 5

Standard of Care. 6

Causation.. 6

Informed Consent 6

The Remaining Issues. 8

IV. FACTS.. 8

Mr. Lee's condition before surgery. 8

Dr. Black. 9

Dr. Black's recommendation of surgery. 10

The Surgery. 12

Referral to an Expert in Urinary Incontinence: Dr. Alexander Kavanagh.. 14

Mr. Lee's conduct at the clinic. 18

Mr. Lee's medical care following his removal from VGH.. 20

The Expert Medical Opinion.. 21

Breach of Confidentiality. 24

V. DISCUSSION.. 25

Standard of Care. 25

Informed Consent 27

The Defamation Claim.. 30

VI. SUMMARY OF CONCLUSIONS.. 31

I. Introduction

Nature of the Claim

- [1] Byung Kyu Lee brought this claim in medical negligence against Dr. Peter Black, a urologist specializing in oncological surgery for prostate and renal cancer.

Overview

- [2] In 2016, Mr. Lee was diagnosed with high-grade prostate cancer which required urgent surgical intervention. Dr. Black first met Mr. Lee at the Vancouver Prostate Centre (the "VPC") at Vancouver General Hospital ("VGH"). Under Dr. Black's supervision, a history was taken and further investigations were conducted, resulting in Mr. Lee receiving a definitive diagnosis of high-risk prostate cancer.
- [3] At the time, Dr. Black was one of very few urologists who had received training in robotic prostatectomy, done by a form of laparoscopic surgery, which has become recognized as the preferred treatment for most prostate cancers. Dr. Black performed a robotic prostatectomy on Mr. Lee on June 23, 2016, to remove the prostate and thus eradicate the prostate cancer.
- [4] The surgery went well. No complications were noted. The cancerous prostate was successfully removed and there was no recurrence of the cancer.
- [5] Mr. Lee had experienced urinary incontinence prior to the surgery. He then experienced postoperative urinary incontinence, which is a common side effect of the surgery. However, the urinary incontinence persisted beyond the expected six- to twelve-month period, which is not usual, but is one of the recognized risks of treatment for prostate cancer.
- [6] After the surgery, Mr. Lee was followed and treated by Dr. Black for a considerable period of time with respect to postoperative healing and the cancer. Eventually, as a result of Mr. Lee's ongoing incontinence, Dr. Black referred him to a urologist, Dr. Kavanaugh, who specializes in urinary incontinence. Dr. Kavanaugh initiated various forms of treatment for Mr. Lee's incontinence, but the condition has not appreciably improved.

- [7] As time went by without improvement of the urinary incontinence following surgery, Mr. Lee became increasingly combative in his interactions with VPC staff. As a result, he was eventually referred to a physician at St. Paul's Hospital for ongoing treatment of his incontinence, and he was told he could no longer attend at VPC.
- [8] Mr. Lee believes his ongoing incontinence is the result of negligence on the part of Dr. Black in the performance of the surgery. He also alleges that Dr. Black failed to provide him with all necessary information concerning the risks of the surgery, such that Mr. Lee did not provide the necessary informed consent to the surgery. Further, he alleges that Dr. Black breached patient confidentiality by sending faxes containing information about his medical condition to other physicians involved in his care. Finally, Mr. Lee alleges that Dr. Black banned him from the VPC and defamed him in the process.
- [9] As a result, he initiated this action against Dr. Black.
- [10] Dr. Black says the robotic prostatectomy surgery was an appropriate choice of treatment for Mr. Lee and was performed to the requisite standard of care of a reasonable and competent urologic surgeon. Mr. Lee was fully aware of the risks and benefits prior to the surgery, and gave his informed consent to the surgery.
- [11] Postoperative urinary incontinence is a known complication affecting virtually all patients who undergo prostate surgery. Approximately 15% of patients have long-standing persistent urinary incontinence as a result of the surgery. Dr. Black and several staff members at his clinic testified that Mr. Lee's increasingly aggressive behavior in the months following the surgery left the medical staff with no alternative but to require Mr. Lee's removal from the clinic. Dr. Black denies defaming Mr. Lee in any way.

II. Issues

- [12] The following issues arise in this action brought by Mr. Lee:
- Did Dr. Black meet the standard of care of a reasonable and competent urologic surgeon?
 - If there was a breach of the standard of care, did the breach cause Mr. Lee's urinary incontinence?
 - If so, is Mr. Lee entitled to damages, and what is the measure of those damages?
 - Did Mr. Lee provide informed consent to the surgery?
 - Did Dr. Black breach patient confidentiality by disseminating medical information by fax concerning Mr. Lee's condition to other treating physicians?
 - Did Dr. Black defame Mr. Lee in the course of the various interactions between Mr. Lee and medical staff at the VPC?

III. Overview of Law on Medical Negligence

[13] In order to establish a cause of action in medical negligence, the onus is on the plaintiff to establish the following on a balance of probabilities:

- (a) a duty of care owed by the defendant to the plaintiff;
- (b) a breach of the standard of care established by law;
- (c) injury to the plaintiff; and
- (d) a causal connection in fact and law between the defendant's breach and the injury suffered and the damages claimed.

Etienne v. Remus, [1999] O.J. No. 3532 (Ont. S.C.J.) at para. 60.

[14] However carefully and expertly a surgical procedure may be performed, it is understood that a positive outcome cannot be guaranteed. There are risks inherent in virtually every surgery, and the mere proof of surgical injury will be insufficient, per se, to establish negligence on the part of the surgeon: Zacharias v. Schlagintweit, 2013 BCSC 667 at para. 66.

Standard of Care

[15] As the surgeon performing the prostatectomy, it is clear that Dr. Black owed Mr. Lee a duty of care. The crucial question is whether Mr. Lee has proven that Dr. Black failed to meet the appropriate standard of care. It is well-established law that a physician is expected to possess and use that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases: *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674 at 693.

[16] In *St-Jean v. Mercier*, 2002 SCC 15 at para. 53, the Supreme Court of Canada described the proper analysis:

The correct inquiry to be made in assessing whether a professional committed a fault is indeed to ask whether the defendant behaved as would a reasonably prudent and diligent fellow professional in the same circumstances [citation omitted]. To ask, as the principal question in the general inquiry, whether a specific positive act or an instance of omission constitutes a fault is to collapse the inquiry and may confuse the issue. What must be asked is whether that act or omission would be acceptable behaviour for a reasonably prudent and diligent professional in the same circumstances. The erroneous approach runs the risk of focusing on the result rather than the means. Professionals have an obligation of means, not an obligation of result.

[Underlining in original.]

Causation

[17] It is well-settled that after satisfying that burden, the plaintiff must establish a causal link between the defendant's alleged negligent conduct and the plaintiff's damages. The plaintiff must prove, on a balance of probabilities, through scientific or factual evidence, that his or her injuries were caused but for the established substandard conduct: *Ediger v. Johnston*, 2013 SCC 18.

Informed Consent

[18] A physician has an obligation to disclose "the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation." A material risk is one which carries serious consequences, and is a matter for the trier of fact: *Reibl v. Hughes*, [1980] 2 S.C.R. 880 at 884. A plaintiff must establish the following on a balance of probabilities to succeed in a claim for lack of informed consent:

- a) He or she was not fully informed of the nature of any material risk of a procedure and any special or unusual risks related to the procedure;
- b) A reasonable person in the plaintiff's position, properly informed, would not have proceeded with the procedure; and
- c) An undisclosed material or special or unusual risk actually materialized and caused the plaintiff's damage.

Allen v. Janjua, 2017 BCSC 2198 (in Chambers) at para. 88.

[19] The reasonable person in the place of the plaintiff must be taken to have similar beliefs and expectations. The evidence of the plaintiff as to the factors affecting his or her decision must be taken into account: *Arndt v. Smith*, [1997] 2 S.C.R. 539 at paras. 4, 9 and 14. The Court said this at para. 9:

Which aspects of the plaintiff's personal circumstances should be attributed to the reasonable person? There is no doubt that objectively ascertainable circumstances, such as a plaintiff's age, income, marital status, and other factors, should be taken into consideration. In my view this means that the "reasonable person" must be taken to possess the patient's reasonable beliefs, fears, desires and expectations.

[20] Physicians often have a pattern of practice; he or she may have a routine as to how informed consent is provided. There is value in a professional's evidence regarding standard practice, as observed by the Court of Appeal in *Belknap v. Meakes* (1989), 64 D.L.R. (4th) 452 at 465-466 (B.C.C.A.):

If a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that surely is evidence and possibly convincing evidence that he did it in that way on the day in question.

[21] More recently, our Court reiterated this principle. In *Chen v. Ross*, 2014 BCSC 374, at para. 288 the Court said:

Evidence of a physician's usual practice in relation to certain conduct may form a sufficient evidentiary base upon which the Court can make a finding of fact: *Friedsam (Guardian ad litem of) v. Ng*, (1993), 86 B.C.L.R. (2d) 335 (C.A.).

The Remaining Issues

[22] For the reasons that follow, it has not been necessary to canvass the law with respect to the other issues described above.

IV. FACTS

Mr. Lee's condition before surgery

[23] Mr. Lee, who was 74 years of age at the time of the surgery in 2016, had a history of urinary frequency as well as difficulty urinating. He testified at trial that he needed the washroom with increasing frequency, but also found it difficult to pass urine. His general practitioner, Dr. Yong, referred Mr. Lee to Dr. Goldenburg, a urologist at VPC. Dr. Yong had noticed a lump in Mr. Lee's prostate and, on testing, he had elevated prostate-specific antigen (PSA) which is usually indicative of prostate cancer.

[24] As time was of the essence given the elevated PSA, and Dr. Goldenburg was not available for several months, he asked his colleague at VPC, Dr. Black, to see Mr. Lee. Dr. Black was available to see Mr. Lee within a month. Their practices were similar; they both performed robotic prostatectomies and were among the very few urologists in the province trained to perform such surgery. Since 2007, Dr. Goldenburg has performed exclusively robotic prostatectomies, as they are considered the state-of-the-art surgery for prostate cancer.

[25] Mr. Lee testified that before seeing Dr. Black in 2016, he had been treated for multiple medical conditions. He had a history of coronary artery disease for which he underwent bypass surgery. He also had cataract surgery. Mr. Lee acknowledged that he had been previously diagnosed with possible mild cognitive dysfunction, chronic pain, and major depression with psychotic features. He had suffered from depression for many years, and since 1998 he had been admitted to hospital on numerous occasions for treatment of the depression as well as paranoid delusions and suicidal ideations. As recently as July 2015 he had seen Dr. Yong for anxiety, fatigue, depression and mild cognitive dysfunction.

[26] Mr. Lee confirmed that his brother living in Alberta had been diagnosed with prostate cancer sometime prior to 2015. His brother underwent a robotic prostatectomy in 2015. Mr. Lee testified that he knew his brother had suffered urinary incontinence for three to four months following the surgery.

- [27] Mr. Lee understood that he had been referred to Dr. Goldenburg by his general practitioner for suspicion of prostate cancer. He also understood that Dr. Goldenburg could not see him for several months, and for that reason he was to be seen by his colleague, Dr. Black.

Dr. Black

- [28] Dr. Black testified at trial. He is a full professor of medicine at the University of British Columbia (UBC). He completed his oncology residency and fellowship in Seattle when robotic surgery for prostate cancer had become available. He performed numerous surgeries using this surgical method during his fellowship. Dr. Black began working in British Columbia in 2008. He performs most of his surgeries at VGH. He works through the Prostate Cancer Centre, a research facility that brings together oncological and non-oncological research. Dr. Black is on the oncology side, along with Dr. Goldenburg and others.
- [29] Dr. Black and colleagues receive referrals from general practitioners. Patients are triaged according to their PSA levels, which indicate the degree to which the prostate cancer had advanced. The higher the level, the more urgently medical intervention is needed. When a referral comes in, the first appointment is booked. Dr. Black's Urology Fellow generally conducts the first examination, then meets with Dr. Black to discuss the findings, following which both doctors return to see the patient.
- [30] The referring general practitioner must be apprised of every step taken in the patient's treatment. That record of treatment is sent to the general practitioner by fax, the cover sheet of which is marked "confidential".
- [31] On February 23, 2016, (approximately three weeks after the referral) Dr. Black, along with a Urology Fellow, saw Mr. Lee at VPC. Dr. Black noted Mr. Lee's elevated PSA and urinary frequency. Mr. Lee had a positive family history for prostate cancer as his younger brother had undergone a radical prostatectomy for the same medical condition.
- [32] Dr. Black's Fellow took a history and noted that Mr. Lee had lower urinary tract symptoms with frequency during the day and even more frequency at night, along with postvoid dribble, which Mr. Lee said had worsened in the last six months. Upon physical examination, his prostate was noted to be small and firm with a questionable nodule. Referral notes from Dr. Yong stated that Mr. Lee also suffered from major depression. Dr. Black reviewed these findings and recommended a biopsy to confirm possible cancer. He discussed the risks related to the biopsy, after which Mr. Lee agreed to the recommendation.
- [33] The biopsy was performed on March 8, 2016, and the result indicated an invasive prostate cancer that required medical intervention as quickly as possible. Coincidentally, two weeks later Mr. Lee was the victim of an assault which was reported to police. Mr. Lee was kicked and struck in the face. His depression was exacerbated and Dr. Yong reported that he had suicidal ideation after the assault.

Dr. Black's recommendation of surgery

- [34] On March 30, 2016, Dr. Black saw Mr. Lee for follow up at VPC. He reviewed the results of the biopsy, and told Mr. Lee he had confirmed prostate cancer which needed treatment as soon as possible. According to Dr. Black, he discussed the available treatment options: active surveillance, robotic assisted radical prostatectomy and radiation. In his opinion, robotic prostatectomy was the significantly preferable option. As it was performed by laparoscopy, it was minimally invasive. Dr. Black said he would not recommend either active surveillance or radiation. As was his invariable practice, he canvassed the risks, benefits and complications of each with Mr. Lee. In particular, he told Mr. Lee he would not recommend radiation therapy, which came with the risk of exacerbating Mr. Lee's urinary difficulties, as it could permanently affect the bladder and/or rectum. Urinary incontinence was a risk with a prostatectomy, as approximately 10% to 15% of patients developed persistent urinary incontinence post-surgery. As a rule, all patients experience such incontinence post-surgery, but in the vast majority of patients, it resolves itself in approximately six to twelve months.
- [35] Dr. Black testified that radiation carried other risks, including secondary cancer. He offered to refer Mr. Lee to a radiation oncologist for further consultation, but Mr. Lee decided to go with robotic prostatectomy. Dr. Black's consult notes state "He preferred surgery". Dr. Black recalled that Mr. Lee was very keen on the surgery as his brother had the same surgery and was pleased with the result.
- [36] Dr. Black estimated that the consult lasted about 30 minutes. He provided Mr. Lee with a printed guide to prostate cancer which gave an overview of the disease and an outline of the different treatment options. Mr. Lee chose the recommended prostatectomy option. His brother had spoken favourably about the procedure and its outcomes. Mr. Lee was given three different consent forms to sign, all of which described the risks of the surgery, and they were duly signed.
- [37] In light of the biopsy results, Dr. Black ordered a bone scan and CT scan for Mr. Lee to determine if the cancer had already spread beyond the prostate. Fortunately, it had not.
- [38] Mr. Lee remembered the consult differently. He testified that the risks and benefits of radiation were not explained to him, as Dr. Black said he did not think he was a good candidate for radiation, and focussed only on prostatectomy. Mr. Lee recalled signing only one consent form, which had small print and was not properly explained to him. He recalled that he met with an assistant by the name of Jennifer, to sign the form. He said that Jennifer did not explain the small print on the consent form.
- [39] In fact, the clinic records indicate that Mr. Lee met with another assistant, Betty Liao, and that he signed three consent forms, not just one, dealing with the different phases and procedures accompanying the surgery.

- [40] Dr. Black's booking clerk, Jaswinder Dahia, gave evidence at trial about the process for the completion of the consent forms. After meeting with Dr. Black, the patient then meets with a booking clerk and completes a medical questionnaire. Ms. Dahia then reviews the questionnaire and completes the consent to surgery form, the consent for blood transfusion, and the consent form for research, all of which are signed by the patient, who also receives the information booklet about prostate cancer and its treatment options. Following these steps, Ms. Dahia would put together the surgical booking package and send it to the Hospital for a booking date. Once the date for surgery is confirmed by the Hospital, she informs the patient. She followed this routine with Mr. Lee.
- [41] Ms. Dahia requested that Mr. Lee send her a list of his current medications, which he did. She informed him that his surgery date was June 23, 2016.

The Surgery

- [42] On June 23, 2016, Dr. Black performed the surgery at Vancouver General Hospital. The operative summary noted no complications during the surgery. Mr. Lee's prostate was completely removed. A catheter was implanted. The bladder was not removed.
- [43] Mr. Lee was discharged from hospital on June 24, 2016. Before discharge, medical staff had a detailed discussion with him about, among other things, the need to leave his catheter in place for 10 days. A nurse discussed his home care needs with him, and he was discharged in stable condition.
- [44] Three days later, on June 27, 2016, Mr. Lee attended VGH Emergency complaining of abdominal pain. He was examined and sent home.
- [45] On July 6, 2016, Mr. Lee's catheter was removed at VPC by an Oncology Fellow, although it is usually removed by a nurse. Mr. Lee was counselled about urinary incontinence he may experience once the catheter was removed. He was seen by a Dr. Chedgy for trial of voiding (TOV), a procedure to assess the ability to empty the bladder. They also discussed pain management. It appeared that Mr. Lee was not coping well with the post-surgical discomfort.
- [46] On July 8, Mr. Lee left a message requesting that Dr. Black call him about concerns with right flank pain. Dr. Black was away from the office so Dr. Chedgy spoke with Mr. Lee. The doctor was of the view that the pain was in keeping with his stage of postoperative recovery, as there had been no significant increase in pain which was controlled with Advil.
- [47] On July 12, Mr. Lee called the VPC asking to speak with Dr. Black as soon as possible. On July 15, Mr. Lee attended the VPC, where Dr. Black's office is located, without an appointment. He was upset that he had not heard about a pathology report. He was seen by a Dr. Johnson.

- [48] In his evidence at trial, Mr. Lee said he had no recollection of seeing Dr. Chedgy on July 6, 2016 or speaking with him on July 8. He also had no recollection of being seen by Dr. Johnson on July 15, 2016.
- [49] Dr. Black saw Mr. Lee on July 20, 2016, to follow up on Mr. Lee's complaints of pain. He examined Mr. Lee's abdomen and found it to be normal for one month post-surgery. He went over the pathology report with Mr. Lee. He also spoke with him about managing the incontinence and discussed various options should it persist beyond the expected six to twelve months.
- [50] On September 6, 2016, Dr. Black saw Mr. Lee to discuss his urinary incontinence and how to manage it. Dr. Black referred Mr. Lee to the Prostate Cancer Supportive Care (PCSC) program at the VPC, which included pelvic floor physiotherapy and counselling. Mr. Lee attended several physiotherapy sessions and was discharged on November 21, 2016. The discharge note stated that Mr. Lee's incontinence had improved significantly with the sessions.
- [51] At the September 6, 2016 appointment, Dr. Black advised Mr. Lee that another appointment would be scheduled for six months later, with a PSA test after three and six months, and office follow up after that. However, Mr. Lee sent a letter to Dr. Black asking for an earlier appointment to address his urinary incontinence. He told Dr. Black that the PCSC program was of no use, and wanted an examination of his bladder and other areas on which he had been operated.
- [52] Dr. Black testified that Mr. Lee became increasingly angry and demanding in the follow up meetings. He accused Dr. Black of having damaged his bladder during the surgery. Dr. Black tried to explain that the surgery had very little to do with the bladder, but Mr. Lee was convinced the surgery had somehow interfered with his bladder and that his ongoing incontinence was the result.
- [53] On December 29, 2016, Mr. Lee's PSA levels were reviewed, and found to be within the normal range. Dr. Black saw Mr. Lee again on February 1, 2017, well ahead of the time Mr. Lee was scheduled for follow up. Dr. Black performed a cystoscopy to rule out abnormalities to his anatomy, but his bladder appeared normal. He prescribed Mr. Lee a bladder overactivity medication. Mr. Lee's PSA levels were again reviewed on February 16, 2017 and found to be within the normal range. Based on these PSA results, Mr. Lee's prostate cancer had been successfully treated.

Referral to an Expert in Urinary Incontinence: Dr. Alexander Kavanagh

- [54] Dr. Black is a surgeon specializing in surgical cancer treatment, but he is not an expert in urinary incontinence. He continued to follow Mr. Lee regarding his prostate cancer, but decided that since Mr. Lee was still experiencing incontinence more than 12 months after his surgery, he would refer him for further treatment for his urinary incontinence to Dr. Alexander Kavanagh, a urologic surgeon specializing in the reconstruction of the urinary tract and treatment of urinary incontinence.
- [55] Dr. Kavanagh testified at the trial.
- [56] Dr. Kavanagh saw Mr. Lee on July 6, 2017 for a consultation and a further cystoscopy. He noted that Mr. Lee had a history of anxiety and depression, which he thought could be contributing to his urinary symptoms. He concluded that Mr. Lee was experiencing both urgency incontinence and stress incontinence. With urgency incontinence, the muscles controlling the urinary tract tighten before they should. Stress incontinence occurs when coughing or sneezing. The stress component may have been exacerbated by the prostate surgery, but could be treated with the implantation of an artificial urinary sphincter. The urgency component could be treated with medication. Dr. Kavanagh recommended that Mr. Lee undergo a urodynamic evaluation to determine his leakage type. Mr. Lee underwent this evaluation at the Bladder Care Centre at UBC later in July 2017.
- [57] The urodynamic testing results were reviewed on July 29, 2017, by another physician, Dr. Tran, who specialized in the same areas as Dr. Kavanagh. He determined that Mr. Lee suffered from both types of incontinence.
- [58] Dr. Black saw Mr. Lee on August 3, 2017 for a review of his PSA levels, which were undetectable. Dr. Black recalled that Mr. Lee was extremely angry. He would not accept that Dr. Black and Dr. Kavanagh were doing everything possible to assist him.
- [59] Dr. Kavanagh saw Mr. Lee on September 7, 2017. At that point in time, Dr. Kavanagh felt Mr. Lee's primary problem was urgency incontinence. He recommended treatment with a trial of a drug, solifenacin.
- [60] Mr. Lee contacted Dr. Kavanagh's office in November 2017 voicing ongoing concerns about his incontinence. Mr. Lee was convinced that the problem was with his bladder, and he wanted bladder surgery. Dr. Kavanagh reminded Mr. Lee that the urgency component was the primary concern and suggested that he continue with the recommended drug treatment before considering surgery, which would only assist with the more minor stress component. The surgery would entail the insertion of an artificial urinary sphincter in the bladder. Dr. Kavanagh also wrote to Dr. Yong recommending that a psychiatric assessment of Mr. Lee be conducted.

- [61] Mr. Lee wrote a letter to Dr. Kavanagh on November 23, 2017, saying he wished to proceed with bladder surgery even though he understood such surgery would likely be inconsequential. Dr. Kavanagh saw Mr. Lee on November 29, 2017. He told Mr. Lee the main problems were his markedly reduced bladder capacity and very early sensation causing urgency incontinence, and, secondarily, stress incontinence.
- [62] Mr. Lee also wrote a letter to Dr. Black in December 2017 complaining about his care. Dr. Black testified that there was nothing more he could do for Mr. Lee. His PSA was normal. A urinalysis, ordered to rule out an infection, had proved to be normal.
- [63] On January 17, 2018, Dr. Kavanagh saw Mr. Lee, who said he wanted to proceed with a surgical procedure to insert an artificial urinary sphincter. The surgery proceeded on May 3, 2018 but the sphincter was not activated at that time, presumably to give the bladder some time to adjust to the surgery. A few days later, on May 10, Mr. Lee was admitted to VGH with complaints of pain. His artificial urinary sphincter was revised. On July 10, 2018, Dr. Kavanagh saw Mr. Lee for follow up concerning the sphincter. At that time, Mr. Lee said he wanted the sphincter removed, as it was causing him too much pain. Although Dr. Kavanagh recommended that he keep the device in place for further observation, Mr. Lee insisted on its removal, which occurred on August 27, 2018.
- [64] Dr. Black had seen Mr. Lee on February 5, 2018 to review with him the latest PSA levels. Upon review, the prostate cancer was undetectable. He learned from Dr. Kavanagh that further testing confirmed that Mr. Lee had an unusually small bladder capable of holding only one third of normal volume of urine. Mr. Lee insisted that the surgery had somehow damaged his bladder. Dr. Black told him that was simply not possible given the type of surgery he had performed.
- [65] February 5, 2018 was the last time Mr. Lee was seen by Dr. Black. Multiple PSA tests confirmed that the cancer had been eradicated. Dr. Kavanagh was best positioned to deal with Mr. Lee's urinary incontinence.
- [66] Dr. Kavanagh continued to see Mr. Lee for the incontinence issue. On November 29, 2018, Dr. Kavanagh advised Dr. Yong by letter that Mr. Lee had a neurogenic bladder that lead to sudden onset urgency incontinence. Mr. Lee was prescribed another drug, Tovias, for the urgency incontinence, which seemed to lessen the incontinence.
- [67] Mr. Lee, still under Dr. Kavanagh's care, underwent a cystoscopy on April 11, 2019. His bladder appeared normal. Mr. Lee also received Botox injections for pain.
- [68] On May 25, 2019, Mr. Lee wrote to Dr. Black complaining about his urinary incontinence. Dr. Black wrote back to Mr. Lee a few days later to advise that as he was being followed by Dr. Kavanagh, and as a result of a complaint made against him by Mr. Lee to the College of Physicians and Surgeons, he would not be seeing Mr. Lee for any further follow up, but would refer him to another suitable physician should Mr. Lee want such a referral.

- [69] Mr. Lee continued to be treated for the incontinence by Dr. Kavanagh, who ordered a further cystoscopy which Mr. Lee underwent on July 17, 2019. Mr. Lee was also given Botox injections. On August 27, 2019, Dr. Kavanagh saw Mr. Lee again, noting that the Botox injections had little effect on the incontinence. Mr. Lee wanted to know about the possibility of having his bladder removed, and that option was discussed.
- [70] Dr. Kavanagh, in his testimony, detailed chronologically his care of Mr. Lee. He said that Mr. Lee first raised the issue of surgical removal of his bladder in late 2018. At that point, Dr. Kavanagh told Mr. Lee he had done all he could for him, and was willing to refer him to another specialist. He explained that he was not discharging Mr. Lee from his care (and did not do so); he was just making a recommendation. He testified that he has seen thousands of patients for urinary incontinence, and not one of them ever asked to have his or her bladder removed. Dr. Kavanagh told Mr. Lee he did not recommend such removal and that, in any event, it was not surgery he performed in his practice.
- [71] When Dr. Kavanagh saw Mr. Lee in August 2019, the issue of the removal of his bladder was again raised by Mr. Lee. Once again, Dr. Kavanagh told Mr. Lee he would not recommend such surgery but would refer him to the appropriate physician if he wished to continue the discussion. Dr. Kavanagh said he did in fact refer Mr. Lee to another surgeon, who said he would not perform the surgery as Mr. Lee was not an appropriate candidate for it.
- [72] Dr. Kavanagh had also become increasingly aware of staff concerns about Mr. Lee's behavior at the office. He testified that the staff expressed concern about their safety and the ongoing stress that Mr. Lee was causing in their workplace. According to Dr. Kavanagh, it was very challenging to recruit and retain experienced medical office staff, and he was concerned Mr. Lee's behavior would result in the loss of staff. Several of the staff were refusing to interact with Mr. Lee.

Mr. Lee's conduct at the clinic

- [73] Mr. Lee had expressed his dissatisfaction with his medical care for some time, occasionally engaging in disruptive behavior at the offices of Dr. Kavanagh and Dr. Black. As early as July 28, 2017, office staff documented scenes Mr. Lee caused in Dr. Kavanagh's waiting room with rude behavior toward the staff and loud complaints about his care, demanding to see Dr. Kavanagh although he did not have an appointment.
- [74] Melanie Lam, employed to manage the front area of Dr. Black's offices where patients checked in for appointments, testified at the trial. She said that some time after his surgery for prostate cancer, Mr. Lee began phoning the clinic and engaged in conversations that she described as "difficult to manage". He then began coming into the office after the telephone calls, demanding to see Dr. Black without an appointment. He presented as upset and hostile, frequently shouting that he had to see Dr. Black. Ms. Lam testified that eventually she had to threaten Mr. Lee with calls to hospital security.

- [75] Ms. Lam said that Mr. Lee's behavior was frightening to herself and the rest of the staff in the office because he was often physically aggressive. She also had to deal with Mr. Lee's frequent visits to deliver abusive letters to Dr. Black.
- [76] Tracy Ferrier was the office manager for the Urology Group, responsible for hiring and managing staff, staff scheduling and other administrative matters. She testified at trial that she first became aware of Mr. Lee some months after his prostate cancer surgery performed by Dr. Black. Staff reported to her that Mr. Lee appeared to be upset about the results of his surgery, and would appear at the office demanding to see Dr. Black. He began coming to the clinic with more frequency. Often, said Ms. Ferrier, she would take him into her office to avoid disruption among the patients in the waiting room and the staff. However, after a particularly combative episode with Mr. Lee, she finally had to call hospital security to remove Mr. Lee.
- [77] Ms. Ferrier said she tried to avoid bringing such issues to the doctors in the clinic, but she finally took her concerns to the managing physician in August of 2019.
- [78] Mr. Lee's aggressive behavior escalated in August 2019, precipitated by a form letter he received from Dr. Black. On an annual basis, Dr. Black's office sent a form letter to all former and current patients on behalf of the Terry Fox Foundation, soliciting donations for cancer research on behalf of the Foundation. It is not clear whether Mr. Lee thought he had been specifically targeted by the solicitation or for some other reason took the letter as a personal affront. He testified that he was insulted by the letter because Dr. Black should have been inquiring about his medical condition instead of soliciting donations. He responded with a vitriolic letter to Dr. Black, calling him a "quack doctor" and a "f---ing God damned son of a bitch". He threatened revenge.
- [79] Dr. Ryan Patterson is the managing physician for the Urology Group at VGH, where physicians specializing in urology share office space. He testified that he received multiple complaints from office staff about Mr. Lee's behavior, which they described as disruptive and often frightening. He recalled that after tolerating the conduct for many months, the last straw was Mr. Lee's behavior following the Terry Fox Foundation letter. In early December of 2019, the clinic met as a group, and, after consulting with the Risk Management Team at VGH, took the decision to tell Mr. Lee that he could no longer attend their offices at VGH. Mr. Lee was told that going forward, he must attend at the urology clinic located at the University of British Columbia (UBC) and could no longer be seen at VGH.
- [80] Dr. Black testified that he did not "ban" Mr. Lee from VGH. It was Dr. Kavanagh, in consultation with the Risk Management team at VGH and staff at the clinic, who decided Mr. Lee could not continue to attend the clinic. Instead, arrangements were made to have Mr. Lee seen at UBC, where Dr. Kavanagh could continue with his follow up care. Both Dr. Black and Dr. Kavanagh testified that they wished to ensure that Mr. Lee continued to receive the appropriate medical care.

Mr. Lee's medical care following his removal from VGH

- [81] Dr. Kavanagh saw Mr. Lee at UBC on December 3, 2019. He ordered a urodynamic evaluation of Mr. Lee's bladder, which indicated that his bladder was stable.
- [82] On December 4, Mr. Lee sent an abusive letter to Dr. Black accusing him of "banning" him from VGH.
- [83] On December 18, 2019, Dr. Kavanagh wrote to Dr. Yong to confirm that he could no longer provide care to Mr. Lee but had generated a referral to Dr. Henry Tran at St. Paul's Hospital for treatment of the urinary incontinence and follow up for prostate cancer surveillance. It was Dr. Kavanagh who informed Mr. Lee that he could not continue to receive care at VGH.
- [84] Dr. Black testified that Mr. Lee did not require further oncological care for his cancer, as he was three years postoperative and his PSA levels were consistently normal. Unfortunately, Mr. Lee was in the small minority of patients who continued to have urinary incontinence well beyond the expected period of time following surgery. Mr. Lee had an over-active bladder before the surgery, which is why Dr. Black had not recommended radiation therapy. Because the medical staff was committed to ensuring Mr. Lee continued to have the appropriate care for his incontinence, the referral to Dr. Tran at St. Paul's was made.

The Expert Medical Opinion

- [85] Mr. Lee did not provide any expert opinion evidence at trial.
- [86] Dr. Black filed reports authored by Dr. Howard Evans, a urologic surgeon who is also a Clinical Professor of Urology at the University of Alberta in Edmonton. Dr. Evans was presented at trial for cross-examination by Mr. Lee.
- [87] Dr. Evans has been a practicing urologist for 20 years. He completed a fellowship in minimally invasive surgery including advanced laparoscopic prostatectomy. Five years into his practice he completed extra training in robotic prostatectomy, and since that time he performs prostate cancer surgery exclusively via robotic prostatectomy. Dr. Evans generally performs between 30 and 40 such surgeries each year. He also focusses, among other conditions, on lower urinary tract infections.
- [88] Dr. Evans reviewed Mr. Lee's complete medical records for the period during which he was treated by Dr. Black and Dr. Kavanagh. I have summarized his opinion as follows.
- a) At the time Mr. Lee was first seen by Dr. Black in February of 2016, he had a significant elevation of his PSA and recent urinary frequency. He had lower urinary tract symptoms with urinary frequency during the day and four to five times at night, worsening over the previous six months. He also suffered from major depression.
 - b) The results of a prostate biopsy performed on March 8, 2016 confirmed that Mr. Lee suffered from high-risk prostate cancer and required surgery urgently.

- c) Dr. Black ordered all of the appropriate pre-and post-surgical tests and interventions. The choice of the robotic surgery itself was more than appropriate. It was the preferable method of surgery given Mr. Lee's disease parameters.
- d) Robotic prostatectomy has increasingly become the surgical choice for prostate cancer, because it is minimally invasive and as a result the postoperative recovery time is lessened. An even greater benefit is the visualization during the surgery to ensure more complete removal of the cancerous tissue. Numerous studies show that robotic surgery (versus open surgery) offers advantages to all patients. There is no case currently of prostate cancer where a surgeon would have to resort to an open procedure to obtain a better result than with a robotic procedure.
- e) With Mr. Lee's history of an overactive bladder prior to surgery, Dr. Black appropriately told Mr. Lee that radiation therapy was not recommended. Radiation therapy can exacerbate that condition and would be a sound reason to avoid such therapy. Given his age and health history, Mr. Lee was an excellent candidate for robotic surgery. Radiation could be an option, but by no means would it be the recommended treatment choice.
- f) Almost all patients will have urinary incontinence in the early postoperative phases. The majority will slowly regain their control over a period of months. A much smaller number will have significant urinary incontinence postoperatively which will need treatment in the form of an artificial urinary sphincter if the incontinence does not resolve on its own.
- g) In Mr. Lee's case, the surgery performed by Dr. Black was very much within the standard of care respecting robotic prostatectomy both at the time in 2016 and today. Mr. Lee had an excellent oncologic outcome with a still undetectable PSA in a patient who had a very high-risk disease. The surgery was successful.
- h) It is difficult to determine if or when a patient will recover his continence post-prostatectomy. Almost every patient will suffer incontinence immediately after surgery. Most urologists will encourage patients to perform pelvic floor exercises to try to expedite the return of continence. Dr. Black did so, and in fact referred Mr. Lee to a physiotherapy program specializing in this area of postoperative care. Some patients may recover continence within a number of weeks, whereas others may take months. Unfortunately, a subset of approximately 15% of patients will not recover continence on their own. Most urologists will not intervene with surgery until at least one year of attempting less invasive measures.
- i) In Mr. Lee's case, after an appropriate period of time following the prostatectomy, Dr. Kavanagh surgically inserted an artificial urinary sphincter. Mr. Lee could not tolerate the pain associated with the sphincter and wanted it removed before it was even activated. Because it was never activated, it was never given the chance to work. Had the sphincter been given a little more time to heal, and then been activated, Mr. Lee's incontinence would likely have been corrected.

- j) Dr. Black followed all guidelines in the same manner as any other competent urologist. He followed Mr. Lee closely after the surgery. He continually met with Mr. Lee concerning the ongoing incontinence. He set up appointments for Mr. Lee including physiotherapy and the referral to a specialist in urinary incontinence when all other methods failed. Dr. Black's follow up steps were both timely and appropriate.
 - k) In summary, the standard of care by Dr. Black was met both in terms of preoperative informed consent and the execution of the surgical procedure. Mr. Lee has had an excellent oncologic outcome in the face of a high-risk disease. Unfortunately, he suffered the known risk of postoperative incontinence; however, Dr. Black's follow up and treatment, including referral to a subspecialist for the urinary incontinence, also met the standard of care.
- [89] Mr. Lee submitted that he disagreed with much of Dr. Evans' opinion evidence, but he did not challenge it by calling any contradictory medical evidence as part of his case. Nor, in cross-examination of Dr. Evans, did Mr. Lee suggest Dr. Black could have done anything differently, except to give Mr. Lee the option of radiation therapy instead of recommending robotic surgery. Dr. Evans was steadfast in his evidence: radiation was not the recommended option for a patient of Mr. Lee's medical parameters, and posed a greater risk of urinary incontinence which Mr. Lee was already experiencing. On the contrary, said Dr. Evans, robotic prostatectomy was clearly the best treatment option for the high-risk cancer with which Mr. Lee had been diagnosed particularly in light of his medical history.

Breach of Confidentiality

- [90] On several occasions during the trial, Mr. Lee submitted that Dr. Black had breached his obligation of confidentiality by forwarding to Dr. Yong various reports concerning Mr. Lee's care at VPC. Mr. Lee's concern arose from his misunderstanding of the reason for the wording on the fax cover sheets, which routinely stated that the documents were "confidential". It was explained to Mr. Lee on a number of occasions that the reports were confidential in the sense that they were intended only for the recipient, in this case Dr. Yong. Dr. Black sent the reports to Dr. Yong in accordance with his obligation as Mr. Lee's surgeon to keep Dr. Yong, Mr. Lee's referring general practitioner, apprised of the treatment Mr. Lee was receiving for his prostate cancer. Mr. Lee could not accept, or continued to misunderstand, the significance of the fax cover sheets.
- [91] To be clear then, Dr. Black did not breach his obligation of confidentiality by sending Dr. Yong ongoing reports to keep him apprised of Mr. Lee's care at VPC.

V. DISCUSSION

Standard of Care

[92] To succeed in his claim against Dr. Black for medical negligence, Mr. Lee must first prove that Dr. Black failed to meet the appropriate standard of care. It is well-established law that a physician is expected to possess and use that reasonable degree of learning and skill ordinarily possessed by practitioners in similar communities in similar cases (*ter Neuzen v. Korn* at 214). In this case, Mr. Lee must establish that Dr. Black did not meet the standard of care of a urologic surgeon practising in an urban centre in 2016 and 2017.

[93] In *St-Jean v. Mercier* at para. 53 the Court said the following:

. To ask, as the principal question in the general inquiry, whether a specific positive act or an instance of omission constitutes a fault is to collapse the inquiry and may confuse the issue. What must be asked is whether that act or omission would be acceptable behaviour for a reasonably prudent and diligent professional in the same circumstances. The erroneous approach runs the risk of focusing on the result rather than the means. Professionals have an obligation of means, not an obligation of result.

[94] In *Chen v. Ross* at para. 274, Justice Ballance stated:

There is no uniform standard of care governing all doctors. The applicable standard is related to the physician's education, experience, qualifications and the surrounding circumstances. Specialists are expected to exhibit a higher degree of skill in their field than are general practitioners with respect to treatment as well as diagnosis. The physician's conduct is evaluated objectively against a reasonable medical person who possesses and exercises the skill, knowledge, and judgment of the normal prudent practitioner of his or her special group, in the particular circumstances, at the material time [citations omitted].

[95] Dr. Black called expert medical evidence by a physician with the same qualifications practicing in a similar urban setting, Dr. Evans, who unequivocally opined that Dr. Black had met the appropriate standard of care with respect to diagnosis, surgical treatment, postoperative monitoring and follow up care. In my view, Dr. Evans' opinions were measured and fair, as was the evidence he gave at trial in response to questioning by Mr. Lee.

[96] I have concluded that the evidence overwhelmingly established that in his treatment of Mr. Lee, Dr. Black was a caring, competent and diligent surgeon in all aspects of Mr. Lee's care. Mr. Lee proved to be a difficult, angry and demanding patient, yet Dr. Black continued give Mr. Lee optimal care despite his abusive behavior. Dr. Black did so until Mr. Lee's conduct was so disruptive of the clinic that his medical colleagues and staff, along with the Risk Management Team at VGH, decided that he could no longer attend the clinic. That was not a decision taken by Dr. Black, but by the entire care team. Even then, Mr. Lee was offered follow up care at UBC by Dr. Kavanagh.

- [97] It bears repeating that the burden was on Mr. Lee to prove that Dr. Black did not meet the appropriate standard of care and to provide evidence sufficient to support that position. He did not provide the Court with any expert opinion evidence on the issue, nor did he advance any evidence other than his own testimony, which fell markedly short of successfully challenging any aspect of Dr. Black's medical care.
- [98] The clinical outcome of this case for Mr. Lee is unfortunate, but ongoing urinary incontinence was a known possible risk of the surgery. It was an even higher risk with the alternative treatment of radiation therapy. Mr. Lee's prostate cancer placed him at high risk of death had he not been treated by either robotic surgery or radiation. The medical evidence established that robotic surgery was not only the best option, but state of the art surgery which at the time of Mr. Lee's treatment could be performed only by a very few urologists in the province. The robotic surgery performed by Dr. Black was successful; Mr. Lee's prostate cancer was eradicated.
- [99] Further, Mr. Lee suffered urinary incontinence well in advance of the surgery.
- [100] In conclusion, I am satisfied that Dr. Black met the required standard of care in his treatment of Mr. Lee. Mr. Lee suffered from presurgical urinary incontinence. The surgery was completed without any complications. Mr. Lee's prostate cancer was successfully treated. There is no evidence to suggest that Mr. Lee would have had a better or different result if he had received radiation therapy instead of the surgery. His postoperative condition arose from the fact that he had cancer and required treatment for it. Unfortunately, he was one of 10% to 15% patients who suffer unresolved urinary incontinence following the surgery.
- [101] With no breach of the standard of care by Dr. Black, Mr. Lee's urinary incontinence could not have been caused by any negligent act on the part of Dr. Black. The matter should end there. For that reason, I will not address the issues of causation and damages. However, as the central complaint of Mr. Lee is that Dr. Black failed to obtain his informed consent for the robotic surgery, I will address that aspect of Mr. Lee's action as well.

Informed Consent

- [102] Central to Mr. Lee's action are the allegations that (i) Dr. Black failed to inform him of the material risks that are known to accompany robotic surgery; and (ii) Dr. Black failed to provide him with sufficient information about the risks and benefits of radiation therapy such that Mr. Lee was precluded from making an informed choice between radiation therapy and robotic surgery.
- [103] A physician has an obligation to disclose "the nature of the proposed operation, its gravity, any material risks and any special or unusual risks attendant upon the performance of the operation." A material risk is one carrying serious consequences, which is a matter for the trier of fact: *Reibl v. Hughes* at 884 and 894.

[104] As noted earlier in these Reasons, a plaintiff must establish certain factors to succeed in a claim for lack of informed consent. They are the following:

- i. The plaintiff was not fully informed of the nature of any material risk and any special or unusual risks related to the procedure;
- ii. A reasonable person in the plaintiff's position, properly informed, would not have proceeded with the procedure; and
- iii. undisclosed material or special or unusual risk actually materialized and caused the plaintiff damage.

[105] The test to determine whether the plaintiff would have undergone the surgery is based on a "modified objective analysis", which is described in *Reibl v. Hughes* at 899 as follows: "[W]hat the average prudent person, the reasonable person in the patient's particular position, would agree to or not agree to, if all material and special risks of going ahead with the surgery, or forgoing it, were made known to him." The opinion of the plaintiff on this question is of little assistance: "the plaintiff's evidence as to what he or she would have done, had the doctor given adequate warning, is of little value": *Arndt v. Smith* at para. 4.

[106] The modified aspect of this test was restated in *Arndt v. Smith* as follows: The reasonable person in the place of the plaintiff must be taken to have similar beliefs and expectations. The opinion of the plaintiff as to whether her or she would have agreed to the procedure is of little help as the plaintiff would invariably testify that the failure to warn was the determining factor. Instead, the evidence of the plaintiff as to the factors affecting that decision must be taken into account. Adopting a modified objective test eliminates from consideration those idiosyncratic or irrational fears that a patient may have.

[107] The Court in *Arndt* described the particular concerns of the plaintiff that ought to be considered (at para. 9):

Which aspects of the plaintiff's personal circumstances should be attributed to the reasonable person? There is no doubt that objectively ascertainable circumstances, such as the plaintiff's age, income, marital status, and other factors should be taken into consideration. In my view this means that the "reasonable person" who sets the standard for the objective test must be taken to possess the patient's reasonable beliefs, fears, desires and expectations. Further, the patient's expectations and concerns will usually be revealed by the questions posed. Certainly, they will indicate the specific concerns of the particular patient at the time consent was given to a proposed course of treatment.

[108] A physician may have a pattern of practice as to how he or she provides informed consent. In *Belknap v. Meakes* at 465-466, our Court of Appeal said the following: "If a person can say of something he regularly does in his professional life that he invariably does it in a certain way, that is surely evidence and possibly convincing evidence that he did it in that way on the day in question."

- [109] In *Chen v. Ross* at para. 288, the Court said: "Evidence of a physician's usual practice in relation to certain conduct may form a sufficient evidentiary base upon which the Court can make a finding of fact: [citation omitted]".
- [110] Dr. Black testified to his standard practice regarding discussions with patients about cancer, the treatments for cancer and the risks associated with such treatments. Further, he had Mr. Lee sign a consent to the robotic surgery which set out the risks of the surgery, which Dr. Black signed as well. Mr. Lee's recall concerning that process was poor. He recalled signing only one consent, which he said was in fine print that was not properly explained to him. He actually signed several consents. He recalled a particular staff person who assisted him with the consent, but in fact it was a different staff person.
- [111] Dr. Black also testified that he explained to Mr. Lee that because of his medical history, age and other factors, he would not recommend radiation therapy. Dr. Black's evidence was that he told Mr. Lee he could refer him to a radiology specialist to discuss that option, but that Mr. Lee declined. Mr. Lee did not challenge that evidence.
- [112] Dr. Black's opinion that radiation therapy was not a recommended treatment was supported by Dr. Evans, who opined that radiation would not be the preferred option for Mr. Lee, given his preoperative state from both a cancer and a functional standpoint. Rather, given Mr. Lee's age and medical history, he was an excellent candidate for robotic surgery. In his report, Dr. Evans described the risks related to radiation treatments which mirrored those explained by Dr. Black
- [113] Mr. Lee had high-risk prostate cancer, given his PSA levels. He expressed that he was frightened and wanted to fight it. His brother had robotic surgery with a positive outcome. Mr. Lee also knew that his brother suffered postoperative urinary incontinence and that it was a risk. Even if Dr. Black had not discussed the risks attendant upon robotic surgery as opposed to radiation therapy (which I do not accept), I am satisfied that the average prudent person possessing Mr. Lee's reasonable beliefs, fears and expectations would not have declined robotic surgery over radiation therapy.
- [114] In other words, I conclude that a reasonable person, fully informed, in Mr. Lee's position, would likely have proceeded as he did. He had a confirmed diagnosis of high-risk cancer. It was necessary to treat the cancer to prevent Mr. Lee's death. All of the treatment options came with potential complications that were relatively similar, but with Mr. Lee's preoperative urinary incontinence robotic surgery was the better option. With respect to the modified objective test, Mr. Lee did not lead any evidence to establish that a reasonable person in his position would have proceeded differently than he did.
- [115] For these reasons, I conclude that Mr. Lee has not established that Dr. Black failed to obtain his informed consent for the robotic surgery.

The Defamation Claim

- [116] To succeed in a defamation claim, a plaintiff must establish that (i) the impugned words were defamatory, that is, tend to lower the plaintiff's reputation in the eyes of a reasonable person; (ii) the words in fact refer to the plaintiff; and (iii) the words were "published", that is, they were communicated to at least one other person: *Grant v. Torstar Corp.*, 2009 SCC 61 at para. 28.
- [117] I have dismissed Mr. Lee's defamation claim, as it is without any basis in fact. Mr. Lee did not identify any specific defamatory words that could be attributed to Dr. Black. As I understand Mr. Lee's argument on this issue, he alleges Dr. Black provided false information about Mr. Lee's behavior to Risk Management, which prompted a representative of the team to write a letter about him which was then distributed by Dr. Black to his office staff and other VPC medical personnel which caused damage to Mr. Lee's reputation.
- [118] There is no evidence to suggest that Dr. Black provided false information to anyone. The evidence established that as a result of Mr. Lee's unacceptable and disruptive conduct at VGH, a decision was finally made collectively by medical staff, in consultation with the Risk Management Team, to advise Mr. Lee he could no longer attend the clinic at VGH. If a letter to that effect exists, it was not provided by Mr. Lee at trial. Mr. Lee did not identify any words or document attributed to Dr. Black that were alleged to be defamatory in nature. It was the clinic's managing physician, Dr. Patterson, who spearheaded the request that Mr. Lee cease to attend the clinic at VGH. That request was based on truthful facts concerning Mr. Lee's ongoing misconduct, to which Dr. Black, Dr. Kavanagh and several staff members testified at trial.
- [119] Mr. Lee also argued that Dr. Black defamed him by "banning" him from the clinic at VGH. As noted earlier, the evidence established that Dr. Black did not ban Mr. Lee. There was a collective decision that Mr. Lee could no longer attend the clinic because his conduct had proved to be intolerable. Mr. Lee did not articulate why his being told he could no longer attend the clinic was defamatory, much less defamation committed by Dr. Black. In any event, the reasons for the decision were well established in the evidence, and were true.

VI. SUMMARY OF CONCLUSIONS

[120] In summary, my conclusions are as follows:

- a) Dr. Black met the standard of care of a reasonable and competent urologic surgeon;
- b) Dr. Black did not breach his obligation of confidentiality by sending reports concerning Mr. Lee's care to his general practitioner;
- c) Dr. Black obtained Mr. Lee's informed consent to the robotic prostatectomy, adequately warning Mr. Lee of the risks associated with the surgery, and explaining why radiation treatment was not recommended;

- d) Alternatively, a reasonable person in Mr. Lee's position would have consented to proceed with the surgery if all material or special risks were known to him;
- e) Dr. Black did not defame Mr. Lee;
- f) In the result, Mr. Lee is not entitled to an award of damages under any of the headings sought.

[121] For all of these reasons, Mr. Lee's claims are dismissed.

[122] Unless the parties wish to address the issue of costs further, Dr. Black is entitled to his costs.

"The Honourable Justice C. Wedge"

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