Court of Appeal for Saskatchewan **Citation: *Lorencz v Talukdar*, 2024 SKCA 105**
Docket: CACV4127 **Date: 2024-11-15**

Between:

Courtney Lee Lorencz, Tracy Lorencz and James Albert Lorencz

Appellants
(Plaintiffs)

And

Sneha Prabha Talukdar and Robert Bogden Babchuk

Respondents
(Defendants)

Before:	Leurer C.J.S., Schwann and Drennan JJ.A.
Disposition:	Appeal dismissed
Written reasons by:	The Honourable Chief Justice Robert W. Leurer
In concurrence:	The Honourable Justice Lian M. Schwann The Honourable Justice Jillyne M. Drennan
On appeal from:	2022 SKKB 258, Regina
Appeal heard:	May 13, 2024
Counsel:	Reginald Watson, K.C. and Ryan Kitzul for the Appellants David Thera, K.C. and Richika Bodani for the Respondents

Leurer C.J.S.

I. INTRODUCTION

[1] On January 23, 2005, James Lorencz suffered a massive heart attack, leading to his death several weeks later. His widow, Tracy Lorencz, and his children, Courtney Lee Lorencz and James Albert Lorencz [family], attributed his death to the negligence of Dr. Robert Babchuk and Dr. Sneha Prabha Talukdar, whom Mr. Lorencz had seen in 2004, and they sued for damages. After a trial, a Court of King's Bench judge dismissed the family's claim: *Lorencz v Talukdar*, 2022 SKKB 258 [*Trial Decision*].

[2] The family appeals only the dismissal of the claim against Dr. Talukdar. In connection with that part of the family's claim, the judge determined that Dr. Talukdar had breached the duty of care she owed Mr. Lorencz because she had not referred him to a cardiologist after seeing him twice in the months prior to his heart attack. However, the judge also found that Dr. Talukdar's negligence had not caused Mr. Lorencz's death because he was "unable to conclude on a balance of probabilities that Mr. Lorencz would have been able to see the specialist, have the necessary investigations completed, and arrive at the necessary medical opinions [to prevent his death] prior to his cardiac event on January 23, 2005" (*Trial Decision* at para 114).

[3] The family invites this Court to conclude that the judge erred in various ways in making his causation finding. However, I see no basis to interfere with the *Trial Decision*. The family's appeal must, therefore, be dismissed.

II. BACKGROUND

A. Mr. Lorencz's medical attendances and death

[4] In 2004, Mr. Lorencz was 49 years old. He was described by the judge as "what might be considered obese by medical standards". He also smoked a pack of cigarettes a day and had done so for many years and "had a family history of cardiac disease and high cholesterol" (*Trial Decision* at para 9).

[5] The judge noted that Mr. Lorencz was "not a regular attender at the doctor's office" (at para 8). When Mr. Lorencz had a need to see a doctor, he went to Dr. Talukdar. Prior to 2004, the last occasion on which Mr. Lorencz had seen Dr. Talukdar was in March of 2000.

[6] On September 13, 2004, Mr. Lorencz attended the clinic at which Dr. Talukdar practiced. Dr. Talukdar was on vacation, so Mr. Lorencz was seen by Dr. Babchuk. According to the medical chart created by Dr. Babchuk at the time, "he learned that Mr. Lorencz's sister had passed away a few weeks prior to the visit and Mr. Lorencz could not relax, was agitated, had sweaty palms, night sweats, and muscle twitching. Dr. Babchuk concluded his note with the word 'etc.'" (*Trial Decision* at para 10). Dr. Babchuk did not undertake any physical examination of Mr. Lorencz or engage in any additional questioning of him. Based on what Mr. Lorencz told him, Dr. Babchuk diagnosed Mr. Lorencz as suffering from an anxiety condition and he prescribed the anti-anxiety medication Ativan. Dr. Babchuk also told Mr. Lorencz that he should return to see Dr. Talukdar in a few weeks.

[7] Mr. Lorencz completed the prescription for Ativan. When it was finished, he sought to refill the prescription. Dr. Talukdar arranged for Mr. Lorencz to reattend at her office. Dr. Talukdar's "concern was that Ativan was a highly addictive medication and, accordingly, Mr. Lorencz should be slowly taken off the drug and it should be replaced with a different medication, being Xanax" (at para 13). Mr. Lorencz ultimately saw Dr. Talukdar on two different occasions, November 29, 2004, and December 22, 2004.

[8] The judge summarized the November 29, 2004 attendance, as follows:

> [14] Mr. and Mrs. Lorencz attended together to Dr. Talukdar's clinic on November 29, 2004. He was seen by the physician at the end of the workday while his wife remained in the waiting room during his attendance. Dr. Talukdar completed the medical chart of her attendance with Mr. Lorencz. She indicated as follows on the chart:
>
> > Nov 29 2004
> > Still pain + anxiety attack
> > Taking Ativan 1 mg tid given by Dr. Babhuk
> > Seems worry (??), all anxiety/panic attack
> > Brother has depression
> > Feels Depressed
> > Try Ativan …
> > Advised dependency on Ativan

> [15] The wording is taken from Dr. Talukdar's handwriting and therefore may not be completely accurate. The first sentence after that date, however, appears to be accurate according to Dr. Talukdar and the positions taken by the parties in the action.
>
> [16] She did not make any further inquiries of him and she did not perform any type of physical examination. There was no evidence that she engaged in any further questioning of him during this attendance.
>
> [17] Dr. Talukdar accepted the diagnosis completed by Dr. Babchuk, that Mr. Lorencz was suffering from an anxiety condition. She supplemented that diagnosis by determining he was also suffering from depression. As indicated, she changed his medication to one which was, presumably, not as addictive as Ativan. She also provided [to Mr. Lorencz] a Burns Anxiety and Depression [Burns] checklist to have him complete and return it to her. He was to complete these forms at his home and then return them to the doctor for review.

[9] Later in the *Trial Decision*, the judge considered more specifically what information had been relayed to Dr. Talukdar by Mr. Lorencz. In connection with the reference in Dr. Talukdar's notes to "still pain", the judge recorded that Dr. Talukdar "was adamant in her testimony that this reference was not an assertion of chest pain as that would have definitely caused her to make further inquiries of the patient" (at para 61), although, to be clear, at no point in his reasons does the judge state that he accepts or rejects this testimony.

[10] By the time that Mr. Lorencz saw Dr. Talukdar on December 22, 2004, he had completed the Burns Anxiety and Depression checklists [Burns index forms] referred to in Dr. Talukdar's notes from November 29. The judge summarized the attendance on that day, as follows:

> [18] Dr. Talukdar then saw Mr. Lorencz for the final time on December 22, 2004. It is unclear how this appointment was made, but presumably had been arranged at the time of the previous visit. At that time, he attended on her to return the completed Burns evaluation sheets. Dr. Talukdar tallied the numbers for the test from the responses provided. The final scoring then allowed her to conclude he was suffering from both severe anxiety and moderate depression. She also advised him to return for a follow up and complete physical examination. The evidence indicates that the physical could not be booked for perhaps in excess of two months. There is no evidence that Mr. Lorencz completed that booking or engaged in any follow up, or took any steps in that regard.

[11] Again later in the *Trial Decision*, also in the context of discussing what information had been relayed to Dr. Talukdar by Mr. Lorencz, the judge offered the following additional comments regarding this second attendance:

> [64] The comments made in the previous section regarding an identification of pain in a patient apply equally here. Dr. Talukdar's notes quite clearly confirm that she was directly advised by the patient, Mr. Lorencz, that he told her he was still experiencing pain. While she is adamant that he did not refer to this as chest pain and she was adamant there was no indication of there being any indication of chest pain, the fact remains that he

> identified to the doctor that he was experiencing pain. Where that pain was located is not indicated in the chart note.
>
> [65] The material indicates further that Dr. Talukdar was indirectly advised by the patient through the Burns index forms that there was pain being experienced and there were other conditions evidencing potential cardiac concerns.

[12] On January 21, 2005, after a period of exertion, Mr. Lorencz exhibited signs of confusion. He completed his regular daily activities the following day. In the early morning of January 23, 2005, Mr. Lorencz suffered a massive heart attack.

[13] Mr. Lorencz was taken to the hospital where the medical staff were able to revive him and revascularize the blood flow to his heart. However, the lack of oxygen he had experienced had caused significant brain damage and organ failure. He was initially placed on life support. On February 4, 2005, his family made what the judge described as the "incredibly difficult decision to stop life support efforts" (at para 6). Mr. Lorencz passed away the next day.

B. The trial

[14] The family sued both Dr. Talukdar and Dr. Babchuk, alleging that but for their negligence Mr. Lorencz's underlying heart condition would have been diagnosed and treated, preventing his heart attack.

[15] By the time the dispute was set down for trial, the parties had agreed that each of the defendants owed a duty of care to Mr. Lorencz in their capacity as his treating physician. They also agreed on damages if it were to be found that one or both doctors were liable. This left the judge to determine whether the defendants had breached the duty of care they each owed Mr. Lorencz and, if they had, if their negligence had caused Mr. Lorencz's death.

[16] The trial proceeded over four days in September of 2022. The judge heard evidence on behalf of the family from Ms. Lorencz and two experts. Dr. Hein De Klerk provided expert evidence pertaining to the standard of care expected of a family physician. Dr. Robert Iwanochko was qualified in the field of cardiology with expertise in the diagnosis and treatment of cardiac disease, and was tendered to offer opinion evidence on the questions of whether Mr. Lorencz's death could have been prevented by appropriate medical management.

[17] For the defendants, Dr. Talukdar and Dr. Babchuk each testified on their own behalf. They also called Dr. Roy Chernoff and Dr. Nawal Sharma. Dr. Chernoff was qualified to give opinion evidence in the field of family medicine. Dr. Sharma was tendered to provide testimony in the field of internal medicine with expertise in the diagnosis and treatment of cardiac disease. The scope of Dr. Sharma's opinion evidence included whether appropriate medical management was provided prior to Mr. Lorencz's death and whether his death could have been prevented by alternate medical management.

C. The *Trial Decision*

[18] After an introduction and an overview of the facts, the judge identified four issues as requiring his attention. The first two of these related to the information that had been conveyed to Dr. Babchuk and Dr. Talukdar when Mr. Lorencz attended their offices, as I have discussed.

[19] The third question the judge considered was whether the two doctors had met the standard of care expected of a reasonably prudent physician. A key part of the family's case at trial was Dr. De Klerk's opinion that physicians are required to complete what he referred to as a "differential diagnosis". The judge indicated that this meant, in part, Dr. Babchuk and Dr. Talukdar "were required to obtain information through both listening to the patient and asking pertinent questions based on that information received" (at para 76). Later, the judge described the standard of care as to require "the attending physician to engage in positive and negative questioning to elicit information upon which an informed diagnosis could be made" (at para 94). The judge summarized Dr. De Klerk's opinion on the standard of care question, as follows:

> [77] Based on the need to engage in a differential diagnosis, Dr. De Klerk held the opinion that each of the physicians here were professionally obligated to do more during each of their attendances on Mr. Lorencz. He held the view they were specifically obligated to ask questions spurred on by the presenting symptoms, and through questioning form a complete personal and family history. He concludes that if that differential diagnosis had been completed, the need for further testing with respect to cardiac disease would have been made clear. The conclusion is based on the risk factors which would have been disclosed during the positive and negative questioning. In the end result, according to him, the cardiac disease would have been found in time to complete the necessary surgery and Mr. Lorencz would not have suffered the massive heart attack which ultimately led to his death.

[20] Testifying for the two doctors, Dr. Chernoff was of the view that both physicians had met the applicable standard of care. The diagnosis by Dr. Babchuk of an anxiety state was said to be

appropriate given the information that had been relayed to him during the September 13 attendance. Similarly, according to Dr. Chernoff, a confirmation of that diagnosis by Dr. Talukdar was appropriate, given the understanding of the information relayed to her on the two occasions when she saw Mr. Lorencz in her office.

[21] Faced with these competing opinions, the judge concluded that the determinations made by the two testifying experts as to the applicable standard of care "is driven by the same starting point: what were the presenting symptoms or complaints of the patient when interviewed by the physician?" (at para 79).

[22] While the judge accepted, at least in a general way, Dr. De Klerk's evidence regarding the need for a differential diagnosis, he qualified this somewhat. In this regard, he introduced his discussion of the claim against Dr. Babchuk as follows:

> [84] If it is being suggested that a deferential [*sic*] diagnosis in all presenting cases requires the physician to obtain a complete history, ask complete questions and complete appropriate testing, I am unable to conclude that is what the law requires. The standard of care expected of physicians is to act reasonably in the circumstances and reasonably seek information relating to the presenting conditions. It does not require them to do everything and anything during that single visit in the office. In *Cardy v Trapp*, [2008] OJ No 4547 (QL) (Sup Ct) at para 37, the court stated as follows:
>
> > [37] It would be wrong to require a physician to practice to a standard that anticipated a worse case scenario as the risk and elevate the standard of practice accordingly. We know the standard of practice applied has a degree of risk. We know now that additional communication and checks could have prevented the delay in obtaining a diagnosis. But the court must be careful not to rely upon the perfect vision afforded by hindsight. See *Lapointe v. Hospital LeGardeur*, 1992 [SCJ No. 11, 28].

[23] The judge stated that the approach described in *Cardy v Trapp*, [2008] OJ No 4547 (Lexis) (Sup Ct J), "lends itself to the claim being advanced against Dr. Babchuk". He concluded that Dr. Babchuk was "provided with certain information by the patient and on the basis of that information he made a diagnosis". He added that "none of the experts called questioned Dr. Babchuk's diagnosis and, indeed, it appears this diagnosis may be accepted as appropriate in these circumstances" (at para 85). He went on to conclude that "hindsight is not a tool to be used in determining the appropriate standard of care" (at para 86). On these bases, he found that "Dr. Babchuk did not breach the applicable standard of care in these circumstances" and he dismissed the action against him (at para 87).

[24] Having made this determination, the judge considered if Dr. Talukdar had met the standard of care that was required of a family doctor in the circumstances that presented themselves to her at the time. In connection with this, the judge found that "Dr. Talukdar heard [from Mr. Lorencz] there was ongoing pain", but she "did nothing with that information and did not ask any further questions of the patient". He added that Dr. Talukdar "perhaps made an assumption of what the patient was referring to" but that the "expert evidence called makes it clear assumptions do not satisfy the standard of care and specific questioning is in order to deal with that which is relayed by the patient" (at para 94). The judge observed that, although Dr. Talukdar had been "told of the existence of pain, there is nothing on the medical chart to indicate any form of inquiry or discussion to flesh out what this reference meant" (at para 95). He also reviewed the details of the information contained on the Burns index forms and the absence of any inquiries of Mr. Lorencz by Dr. Talukdar to identify the nature of the pain that he had been experiencing. The judge concluded from all this that Dr. Talukdar had failed to meet the applicable standard of care:

> [100] Questions regarding the pain, the taking of a family history due to the experiencing of pain, the presenting condition of the patient as a reasonably heavy smoker who was considered medically to be obese, would have, according to the evidence at trial, been the result of that questioning. And, that result would have compelled the physician to refer this individual on for further testing or consultation with a cardiologist specialist.
>
> [101] As a result of all of the foregoing, I must conclude that Dr. Talukdar did not meet the standard of care expected of a reasonably prudent family physician carrying on her practice in Regina, Saskatchewan with respect to Mr. Lorencz.

[25] The judge next observed that a finding that Dr. Talukdar had been negligent was not sufficient to ground liability. He noted, additionally, that the "breach of the standard of care must be causally connected to the death to find liability" (at para 102). He identified that the family's theory on causation "takes essentially two forms: either the patient should have been referred for emergency examination, or there was sufficient time for him to have obtained an appointment with a cardiologist" (at para 103).

[26] Dr. Iwanochko had opined that, if the cardiovascular disease had been diagnosed before the heart attack, appropriate medical steps could have been taken to prevent the January cardiac event from occurring. The judge observed, however, that the question became "when could Mr. Lorencz have been examined" (at para 110). In short, the judge approached the issue of whether the family had established that Dr. Talukdar's negligence had caused his death by considering when, if she had met the applicable standard of care, Mr. Lorencz might have been

seen by a cardiologist and diagnosed with and treated for the underlying heart condition that precipitated his heart attack.

[27] Having framed the question in this way, the judge stated that the "test to be applied for determining causation in a medical malpractice claim is the but-for test" (at para 104). The judge referred to *Snell v Farrell*, [1990] 2 SCR 311 [*Snell*], *Hander v Kumar*, 2022 SKCA 33, 467 DLR (4th) 726 [*Hander*], and, later in his analysis, *The Estate of Carlo DeMarco v Dr. Martin*, 2019 ONSC 2788 [*DeMarco*], which in turn discussed *Aristorenas v Comcare Health Services* (2006), 274 DLR (4th) 304 (Ont CA), and *Clements v Clements*, 2012 SCC 32, [2012] 2 SCR 181 [*Clements*].

[28] Having set the stage in this way, the judge reiterated that, according to the evidence, had "Dr. Talukdar engaged in making a deferential [*sic*] diagnosis and determined to have Mr. Lorencz obtain a further medical consultation with a specialist, the options which might have been available in this regard would have been to make a referral on an emergent basis or to make a referral to a cardiologist for further consultation" (at para 106). He noted that the "evidence of each of Dr. Iwanochko and Dr. Sharma was that an emergent referral would only have been made if the patient was exhibiting serious and immediate symptoms during the attendance on the family physician". He then reviewed what those symptoms would include and concluded that there "is no evidence to suggest that any of these factors were present when Mr. Lorencz attended before Dr. Talukdar" (at para 107).

[29] The judge then stated that in "cases where such emergency conditions were not present, the patient would then be referred on a more routine basis" (at para 108). He reviewed the evidence and concluded that the "extent of the evidence at trial was that such a referral could take weeks or months in Saskatchewan" but that there "was no more precise evidence tendered to show exactly when a referral could have been had assuming Dr. Talukdar had started the wheels in motion for such referral at the time of even her first visit in December" (at para 113).

[30] Based on all of this, the judge found that he was not satisfied, on a balance of probabilities, that Mr. Lorencz would have been seen by a cardiologist and diagnosed and treated prior to his heart attack on January 23, 2005:

> [114] I am left with the rather imprecise estimate of such a referral taking weeks or months. Regrettably, on the basis of this evidence I am unable to conclude on a balance of probabilities that Mr. Lorencz would have been able to see the specialist, have the necessary investigations completed, and arrive at the necessary medical opinions prior to his cardiac event on January 23, 2005. I must determine that the plaintiffs have failed to establish such causation on a balance of probabilities. In the words of *DeMarco* at para 74: "... The plaintiff must prove on a balance of probabilities, that the outcome would have been avoided."
>
> [115] Even applying the robust and pragmatic approach encouraged by the Supreme Court of Canada, the trial court is not entitled to speculate on an outcome in the absence of evidence allowing for such a conclusion. For the court to conclude Mr. Lorencz would have been able to obtain a referral appointment to a cardiac specialist would be little more than speculation based on the evidence tendered at the trial of this matter.

[31] Finally, the judge considered other possible theories of causation but rejected each on the evidence. None of this latter analysis bears on the issues in this appeal.

III. ISSUES

[32] Although Dr. Babchuk is named in the style of cause of the family's notice of appeal, the family confirmed in their factum that they did not intend for him to be a party to this appeal. Therefore, I treat the appeal against the finding that Dr. Babchuk is not liable as abandoned.

[33] Dr. Talukdar has not appealed the finding that she did not meet the standard of care expected of a reasonably prudent family doctor. Thus, the only issue in this appeal is whether the judge erred in his conclusion that Dr. Talukdar's negligence did not cause Mr. Lorencz's death. In this regard, the family's many arguments can all be appropriately addressed by considering the following two questions:

(a) Did the judge apply the correct test for determining causation?

(b) Is the judge's finding that Dr. Talukdar's negligence did not cause Mr. Lorencz's death a product of a palpable and overriding error?

IV. ANALYSIS

A. The judge applied the correct legal test

1. Framing the issue

[34] The family agrees that it was proper for the judge to require them to establish, on a balance of probabilities, that but for Dr. Talukdar's negligence Mr. Lorencz would not have died. They could hardly do otherwise. In many cases, the Supreme Court of Canada has reiterated the "but for" test is generally applicable to the determination of cause-in-fact in all negligence cases. In *Clements*, the Court put it this way:

> [8] The test for showing causation is the "but for" test. The plaintiff must show on a balance of probabilities that "but for" the defendant's negligent act, the injury would not have occurred. Inherent in the phrase "but for" is the requirement that the defendant's negligence was *necessary* to bring about the injury — in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.
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> (Emphasis in original)

[35] This test applies in medical malpractice cases as much as any other claim in negligence: *Ediger v Johnston*, 2013 SCC 18 at paras 28 and 29, [2013] 2 SCR 98 [*Ediger*], and *Benhaim v St-Germain*, 2016 SCC 48 at para 45, [2016] 2 SCR 352 [*Benhaim*]. These, and other authorities, further describe the approach that triers of fact should take to the evidence in cases where causation is at issue. The general law in this area was summarized in *Stacey Estate v Lukenchuk*, 2020 SKCA 55, [2020] 8 WWR 668 [*Stacey Estate*], as follows:

> [79] In *Benhaim v. St-Germain*, 2016 SCC 48, [2016] 2 S.C.R. 352 [*Benhaim*], the Supreme Court confirmed that the ordinary rules of causation apply to medical negligence cases, meaning that the traditional "but for" test generally governs. However, citing *Snell*, the Court in *Benhaim* cautioned that the traditional principles should not be applied in "an overly rigid manner": at para 46. Because scientific causation and factual causation for legal purposes are two different things, causation need not be proven with scientific or medical certainty. Courts should, though, take a robust and pragmatic approach to the facts: *Benhaim* at paras 47 and 54. The Court in *Benhaim*, at paragraph 56, also cited with approval the comments of Gonthier J in *Lawson v Laferriere*, [1991] 1 S.C.R. 541 at 609, and *St.-Jean v Mercier*, 2002 SCC 15 at para 116, [2002] 1 S.C.R. 491, where he observed that in some negligent misdiagnosis cases, causation can be established "where a fault presents a clear danger and where such a danger materializes".

[36] Nonetheless, the family argues that the judge erred in law by misapplying the "but for" test. There were several wings to this argument, which I will address in order.

2. The judge did not require negligence to be the only cause of the death

[37] The family says that "but for" causation can be met "notwithstanding that the defendant's negligence was not the sole cause or primary cause of the injury", citing *Stacey Estate*. However, the judge did not suggest otherwise in his reasons. To the contrary, this very concept was recognized in the quote the judge reproduced from this Court's decision in *hanhandHander* (at para 104 of the *Trial Decision*), as follows:

> [40] The legal test for causation applicable to claims of medical negligence is the "but-for" test (*Benhaim v St. Germain*, 2016 SCC 48 at para 45, [2016] 2 SCR 352; see also *St. Jean v Mercier*, 2002 SCC 15, [2002] 1 SCR 491, and *Snell v Farrell*, [1990] 2 SCR 311). Under this test, the plaintiff bears the burden of showing that, but for the negligent act or omission of the defendant, the injury would not have occurred. This test recognizes that compensation for negligent conduct should only be made where there is a substantial connection between the injury and the defendant's conduct (*Resurfice Corp. v Hanke*, 2007 SCC 7 at paras 20-23, [2007] 1 SCR 333; *Clements v Clements*, 2012 SCC 32 at para 46, [2012] 2 SCR 181; *Ediger* [2013 SCC 18, [2013] 2 SCR 98] at para 28). *This does not mean that the defendant's negligence need be the sole cause of the plaintiff's injury in order for a claim to succeed. Causation will be made out under the but-for test if the defendant's negligence caused the whole of the injury, or if it contributed in some not insubstantial or immaterial way to the injury the plaintiff sustained* (*Stacey Estate v Lukenchuk*, 2020 SKCA 55 at para 78, [2020] 8 WWR 668; *Donleavy v Ultramar*, 2019 ONCA 687 at para 72, 60 CCLT (4th) 99).
>
> (Emphasis added)

3. The judge did not err by failing to discuss *Stacey Estate*

[38] In a related argument, the family criticizes the judge for failing to discuss *Stacey Estate* in his reasons despite the heavy reliance they placed upon that case in their post-trial brief of law. I am satisfied that the judge considered the guidance provided by *Stacey Estate*. It was, after all, referred to in the quotation from *Hander* that the judge reproduced in the *Trial Decision*.

[39] In any event, "it is not an error of law to fail to consider authorities" (*Kelly Panteluk Construction Ltd. v Lloyd's Underwriters*, 2024 SKCA 42 at para 48). Principles of *stare decisis* require courts to *apply* the legal principles that prior binding cases establish. Nonetheless, I am aware of no authority that would identify it to be a legal error for a judge to fail to *refer* to a precedential case. Therefore, I attach no consequence to the fact that the judge did not specifically cite to *Stacey Estate*. The important question for purposes of this appeal is whether he applied the guidance on the law that the binding cases provide, which I conclude he did, as I will next discuss.

4. The judge did not err in law by not finding causation based on the creation of risk

[40] The family asserts that the judge failed to apply the direction it says was given in *Stacey Estate* that "in some negligent misdiagnosis cases, causation can be established 'where a fault presents a clear danger and where such a danger materializes'" (*Stacey Estate* at para 79, quoting from *Laferrière v Lawson*, [1991] 1 SCR 541 at 609 [*Laferrière*]). The family submits in this regard that, because Dr. Talukdar had failed to sufficiently question Mr. Lorencz, she created a clear danger, which materialized, that he would suffer a heart attack because of his undiagnosed condition. In addition to relying on *Stacey Estate*, they refer to *Ruiz v Bouaziz*, 2001 BCCA 207, 150 BCAC 161 [*Ruiz*], *Paniccia Estate v Toal*, 2012 ABCA 397, [2013] 3 WWR 1 [*Paniccia Estate*], and *Saint John Regional Hospital v Comeau*, 2001 NBCA 113, 244 NBR (2d) 201 [*Comeau*], which are discussed in *Stacey Estate*. However, none of these cases assist the family.

[41] *Stacey Estate* itself concerned only the question as to whether the common law test for causation applied to a claim for damages under *The Fatal Accidents Act*, RSS 1978, c F-11 [*FAA*]. The Court's bottom-line conclusion was that the judge in that case had incorrectly concluded, in the context of answering a preliminary point of law, that "a claim cannot be brought against a defendant under the *FAA* unless the defendant's wrongful act, default or neglect is the *direct* cause of the deceased's death" (at para 97, emphasis in original). While *Stacey Estate* affirmed that common law principles of causation, summarized in the decision, apply to such a claim, the Court left the application of those principles to be determined at trial. Therefore, the Court was not deciding the question as to whether the material contribution test applied in the circumstances before it. As I will next discuss, *Stacey Estate* also did not purport to alter the well-established principles relating to the material contribution test, or causation more generally, that are laid out in the Supreme Court jurisprudence.

[42] *Laferrière*, which is the source of the statement of law the family relies upon in connection with this branch of their argument, concerned a case where a doctor failed to inform his patient of a cancerous condition and, subsequently, to follow up on the patient's health in the appropriate manner. It was held that the doctor's negligence did not cause the patient's death, but did give rise to other compensable loss, including the benefit of earlier treatment, which would have translated into a better quality of life despite her terminal condition. The Supreme Court in that case did not,

ultimately, dilute the requirement that but for causation be shown on a balance of probabilities. The passage from *Laferrière* that is referred to in *Stacey Estate* simply recognizes that the creation of a realized danger is a fact that can give rise to a presumption of causation. A more complete statement of the quote from *Laferrière* is as follows:

> The plaintiff is aided in establishing his or her case by presumptions (as provided by art. 1205 *C.C.L.C.*) and by such factual and statistical evidence as will aid the judge in appreciating what Moisan J. described properly as [TRANSLATION] "reasonable and prudent behaviour", "the natural order of things", "the sequence of cause and effect" and, generally, "the normal and ordinary course of events". The judge will want to pay especially close attention to the various causal properties of the doctor's fault as well as the particular character of the damage which has manifested itself. *In some cases, where a fault presents clear danger for the health and security of the patient and where such a danger materializes, it may be reasonable for a judge to presume the causal link between the fault and such damage, "unless there is a demonstration or a strong indication to the contrary*" (*Morin v. Blais*, *supra*, at p. 580, *per* Beetz J.). *If, after all has been considered, the judge is not satisfied that the fault has, on his or her assessment of the balance of probabilities, caused any actual damage to the patient, recovery should be denied. To do otherwise would be to subject doctors to an exceptional regime of civil responsibility*.
>
> (at 607–608, emphasis added)

[43] Prior to *Laferrière*, in *Snell*, Sopinka J. warned against finding causation on the basis simply that a defendant has "created a risk that the injury which occurred would occur" (at 326). In more recent decisions, the Supreme Court has cautioned against allowing the "but for" test for causation to be diluted in instances where there is a single alleged tortfeasor. This body of case law was thoroughly reviewed by the Supreme Court in *Clements* and again in *Benhaim*.

[44] In *Clements*, McLachlin C.J. limited the application of the material contribution test to circumstances where two preconditions exist. First, there must be multiple tortfeasors. Second, the material contribution test may only be employed "where (a) the plaintiff has established that her loss would not have occurred 'but for' the negligence of two or more tortfeasors, each possibly in fact responsible for the loss; and (b) the plaintiff, through no fault of her own, is unable to show that any one of the possible tortfeasors in fact was the necessary or 'but for' cause of her injury, because each can point to one another as the possible 'but for' cause of the injury, defeating a finding of causation on a balance of probabilities against anyone" (at para 46(2)).

[45] In *Benhaim*, Wagner J., as he then was, speaking for the majority, rejected an approach that would trigger a rebuttable legal inference adverse to a tortfeasor based on negligently created

causal uncertainty. He said that shifting "the consequences of causal uncertainty in this manner risks turning defendant professionals into insurers" (at para 68).

[46] The judge displayed his correct understanding of these principles by his references to *DeMarco*, which accurately summarized the law as articulated in *Clements* and *Benhaim*. In this regard, the judge reproduced the following passage from that decision (at para 111 of the *Trial Decision*):

> [68] The test of causation is the "but for" test. The "but for" test is a factual inquiry, and applies to single and multi-cause injuries. The plaintiffs must demonstrate, on a balance of probabilities, that "but for" the defendant's conduct, the plaintiffs would not have suffered the injury or loss. In other words, the defendant's negligence was necessary to bring about the harm.
>
> [69] Where the "but for" test is unworkable, courts have adopted a material contribution test to determine causation. This test is an exception to the "but for" test and is only to be used in special circumstances as follows:
>
> > (a) where the plaintiff establishes that the loss would not have occurred "but for" the negligence of two or more tortfeasors, each possibly in fact responsible for the loss; and
> >
> > (b) where the plaintiff through no fault of their own, is unable to show that any one of the possible tortfeasors in fact was the necessary or "but for" cause of the injury, because each can point to one another as the possible "but for" cause of the injury, defeating a finding of causation on a balance of probabilities against anyone.
>
> [70] These are not the circumstances of this case as there is only one potential tortfeasor — Dr. Martin. As such, causation in this case must be established according to the "but for" test.

[47] I read nothing in *Stacey Estate* that would purport to alter or qualify these principles in a way that would make the material contribution test applicable to the matter at hand. Also, I find none of the other cases cited by the family in relation to this wing of their argument assist their position.

[48] In *Ruiz*, a surgeon was found to be negligent for failing to properly inquire into a patient's medical history before performing gallbladder surgery. In particular, the doctor failed to ask if the patient had questions relative to her health history that bore on the risk of post-surgical complications. After surgery, the patient developed complications that fell within the scope of that risk. Ultimately, the patient suffered liver failure and died. The patient's survivors brought a claim against the doctor. A trial judge's finding that the surgery had caused or contributed to the patient's death was upheld by the British Columbia Court of Appeal. One of the questions that confronted

the Court was whether there was evidence to support the trial judge's finding that the surgery had caused or contributed to the death of the patient (see paras 38–42).

[49] In their factum, the family points to the statement made in *Stacey Estate* about *Ruiz* that "[b]ecause the death resulted from something that fell within the ambit of foreseeable risk stemming from the defendant's negligence, that negligence was properly found to have 'caused or contributed to' the death on a 'but for' basis" (*Stacey Estate* at para 81). However, I do not interpret *Stacey Estate* as purporting to alter the direction given by the Supreme Court in relation to the placement of risk of harm in the proof of causation. To the contrary, *Stacey Estate* explicitly endorses the view that "before resorting to material contribution, 'it is necessary to establish that fault or negligence caused the event and that there is more than one negligent actor, but that it is impossible for the plaintiff to tease out whose negligence was a 'but for' cause' (*Stacey Estate* at para 76, quoting *Donleavy v Ultarmar Ltd.*, 2019 ONCA 687 at para 69).

[50] In *Paniccia Estate* a doctor's negligence was found to have delayed the identification and treatment of the deceased's diffuse gastric cancer. Even though a proper diagnosis would not, on a balance of probabilities, have led to a cure, the trial judge determined that the doctor's negligence substantially shortened the deceased's life, which amounted to an injury upon which a claim was properly advanced under Alberta's *Fatal Accidents Act*, RSA 2000, c F-8. This Court, in *Stacey Estate*, found two things in *Paniccia Estate* to be significant. The first was that the "relationship between the doctor's alleged negligence and the progression of the deceased's cancer was 'obvious and direct' (at para 84). The second was that, although the patient would have died in any event, based on the evidence "if Mr. Paniccia had received non-negligent treatment, his life would have been extended by six months" (at para 85). It was this shortened lifespan which gave rise to the compensable claim, because "a death accelerated is a death caused" (at para 86).

[51] *Stacey Estate* describes *Comeau* as providing an "example of a situation where medical negligence was found to have a causal connection to a person's death, even though death resulted from a natural condition" (at para 88). In that case, the deceased had gone to a hospital in the evening complaining of severe chest pain. After being seen by two doctors he was diagnosed with irritative bronchitis and sent home. He died the next day from a ruptured aneurysm. This Court quoted several passages from *Comeau* including that the "finding by the trial judge of a causal

relationship between the failure to keep Mr. Comeau under observation and his untimely death was based on two critical conclusions based on the expert evidence of Dr. Rosaire Vaillancourt that: (1) had Mr. Comeau not been discharged, the presence of the aneurysm would have been discovered in the morning; and (2) he would have undergone a successful aortic surgery and gone on to live a full life" (at para 90, quoting from *Comeau* at para 72).

[52] To sum up, I see nothing in *Stacey Estate*, or the many cases it discusses, that alters the general principles that I have discussed, which are also those that were identified and applied by the judge in the *Trial Decision*.

5. Other alleged errors of law

[53] The family alleges, in their notice of appeal, that the judge erred in law in four other ways. These include that the judge (a) conflated the tests for factual and legal causation and failed to appropriately consider legal causation, (b) failed to appreciate the difference between inference and speculation under the "but for" test for factual causation, (c) erred in law "by failing to appropriately consider or appreciate that any lack of evidence respecting the signs and symptoms of Mr. Lorencz's advanced cardiac disease and any unknowns respecting the urgency of a referral in the circumstances were caused by Dr. Talukdar's breach of the standard of care", and (d) failed "to appropriately apply a robust, pragmatic, and common sense approach to the evidence in determining factual causation". These allegations are each reproduced in the family's factum.

[54] The family did not develop any argument in connection with allegations (a) and (b). Accordingly, I see no need to consider them further in these reasons.

[55] As should be evident from my summary of the *Trial Decision*, it is replete with discussion by the judge of the evidence before him as to the signs and symptoms that might have prompted a referral to a cardiologist or a hospital emergency ward. Given that the judge addressed the issue, to the extent that allegation (c) describes an error, it is appropriately considered in the context of the family's challenge to the judge's finding of fact that no causation has been shown. I will discuss this issue in the next section of these reasons.

[56] This leaves for consideration only allegation (d), that is, that the judge erred in law by failing to "appropriately apply a robust, pragmatic, and common sense approach to the evidence

in determining factual causation". The judge was clearly aware of the direction from the Supreme Court that he take this sort of approach to assessing if the evidence established causation on a balance of probabilities. In this regard, he reproduced the passage from *Snell* that contains this direction (at para 105, quoting *Snell* at para 34). The test is referred to four times in the passages from *DeMarco* that the judge reproduced in his reasons (at para 111). Most decisively, the judge introduced his conclusion on the causation issue by emphasizing that "*[e]ven applying the robust and pragmatic approach encouraged by the Supreme Court of Canada*, the trial court is not entitled to speculate on an outcome in the absence of evidence allowing for such a conclusion" (at para 115, emphasis added). This leaves me with no doubt that the judge was not only aware of, but that he applied the robust, pragmatic and common sense approach to the evidence in determining causation.

[57] The family's argument, therefore, reduces to the suggestion that the judge's analysis was not *sufficiently* robust and pragmatic, as demanded by the authorities. For example, they write in their factum that the judge "ignored the Emergency Room option and focused on treatment and diagnosis options in the community only". However, a plain reading of the *Trial Decision* discloses that the judge did not *ignore* the evidence that the family led relating to applicable medical protocols or the availability of emergency care. To the contrary, as I have already reviewed, he carefully examined all the theories advanced by the family to establish causation and explained why he was not convinced on a balance of probabilities that any were made out on the evidence. Based on all this, as I see it, the suggestion that the judge failed to "appropriately apply a robust, pragmatic, and common sense approach to the evidence in determining factual causation" is not rooted in an identifiable error of law. Rather, it amounts to an assertion that the judge erred in his fact-finding. As with allegation (c), I will address this issue in the next section of these reasons.

6. Conclusion regarding alleged errors of law

[58] The judge did not err in law in his application of the "but for" test for establishing causation in this case.

B. The judge's factual finding on causation is not the product of palpable and overriding error

[59] Because the finding that Dr. Talukdar's negligence did not cause Mr. Lorencz's death is one of fact, this Court can interfere with that finding only if it is the product of palpable and overriding error (*H.L. v Canada (Attorney General)*, 2005 SCC 25 at para 63, [2005] 1 SCR 401, *Ediger* at para 29, and *Benhaim* at para 36). An error is palpable if it is one that can be "plainly seen", "plainly identified", or is "obvious"; an error is overriding if it "goes to the very core of the outcome of the case" (see *Benhaim* at para 38, and *R v Kruk*, 2024 SCC 7 at para 97, 433 CCC (3d) 301, both of which refer to *R v South Yukon Forest Corp.*, 2012 FCA 165 at para 46, 4 BLR (5th) 31).

[60] The family makes two principal arguments in their effort to show that the judge erred in his fact finding. The first is that he confused *differential* diagnosis with *deferential* diagnosis. The second is that he erred in his conclusion that there was no evidence to suggest that any risk factors necessitating a referral to an emergency department or an urgent referral to a cardiologist were present. I will consider these two arguments before addressing a collection of other points that the family raises in support of their submission that the judge erred in his fact finding.

1. Differential Diagnosis vs. Deferential Diagnosis

[61] As has been noted, a key part of the family's case at trial was Dr. De Klerk's expert opinion that physicians are required to complete what he referred to as a "differential diagnosis". The family argues that the judge confused a "differential diagnosis", which Dr. De Klerk opined that Dr. Talukdar should have performed, with a "deferential diagnosis". The basis for the family's submission in this regard is that, on seven occasions in the *Trial Decision*, the judge referred to the applicable standard of care as the performance of a "deferential diagnosis" (see paras 76, 84, 91, 93, 106, 113 and 116).

[62] In their factum, the family submits that the "differential diagnosis protocol is mainstream medicine, and a deferential diagnosis protocol is not". They further say that a "deferential diagnosis is dangerous" and "was contraindicated, as stated by both family physician experts, and using a deferential diagnosis in this case was plain wrong". Finally, the family asserts that this alleged error of confusing a differential diagnosis with a deferential one manifested itself because

"Dr. Talukdar had no plan, had the wrong diagnosis and ignored some of the important information that was available to her" and "was deferential to the initial diagnosis of Dr. Babchuk and did not engage in the differential diagnosis protocol".

[63] I accept that the judge's seven references to a "deferential diagnosis" in the *Trial Decision* are palpably wrong. However, I am unable to accept the family's argument that these mistakes amount to overriding error justifying appellate intervention. Instead, I am convinced that they are simple misstatements which are of no consequence to the judge's finding that causation was not made out, because they do not reflect a misapprehension by him of the evidence.

[64] In this regard, the first reference the judge made in the *Trial Decision* to a "deferential diagnosis" appears in paragraph 76, which states in full as follows:

> [76] Dr. De Klerk opined that both of the defendants failed to achieve the standard of care required of a family physician. He testified that the physicians were required to complete a *deferential diagnosis*. This means that they were required to obtain information through both listening to the patient and asking pertinent questions based on that information received. These questions, spurred by the manner in which the patient presents, would include family and personal history.
>
> (Emphasis added)

[65] As can be readily seen, in this paragraph the judge summarized what he understood Dr. De Klerk to mean when he "testified that the physicians were required to complete a deferential diagnosis". The judge said that this "means that they were required to obtain information through both listening to the patient and asking pertinent questions based on that information received". This is an accurate, albeit succinct, summary of what Dr. De Klerk said was required for a family doctor to undertake a *differential* diagnosis. Paragraph 76 therefore discloses that the judge was intending to root his references to "deferential diagnosis" to what Dr. De Klerk said about the standard of care required of a family physician, which is to undertake a *differential* diagnosis. Indeed, all the judge's later references to a "deferential diagnosis" were grounded in the direct or indirect evidence of Dr. De Klerk.

[66] Said another way, Dr. De Klerk testified as to what was required by a "differential diagnosis". He did not refer at all to a "deferential diagnosis". The judge displayed a correct understanding as to the substance of Dr. De Klerk's evidence, despite his several mistaken references to a "deferential diagnosis". All of the judge's other references to a "deferential

diagnosis" can be properly understood in the same way. I see no need to determine if the seven mistaken references to a "deferential diagnosis" are attributable to mistakes in transcription, an autocorrect feature of a word processing program or came about in some other way.

[67] In short, there is no merit to the submission that the judge misconstrued Dr. De Klerk's evidence respecting the need for a differential diagnosis in the circumstances of this case.

2. Evidence of risk factors

[68] In what I take to be the family's principal argument, they say that the judge committed a palpable and overriding error when he concluded there was no evidence to suggest that any risk factors were present when Dr. Talukdar examined Mr. Lorencz. The family points specifically to the following passage from the *Trial Decision* as demonstrating this error:

> [107] The evidence of each or [*sic*] Dr. Iwanochko and Dr. Sharma was that an emergent referral would only have been made if the patient was exhibiting serious and immediate symptoms during the attendance on the family physician. While Dr. Iwanochko identified there are a wide range of indicators for emergency or urgent cardio care, he outlined some of the important symptoms which would go into making an emergency referral. These included: chest pain or other worrisome symptoms, shortness of breath, heart racing, palpitations, and patient passing out. *There is no evidence to suggest that any of these factors were present when Mr. Lorencz attended before Dr. Talukdar*.
>
> (Emphasis added)

[69] The family emphasizes that on the Burns index forms Mr. Lorencz indicated that he had been experiencing pain. This form, of course, was before Dr. Talukdar when he attended her office on December 22, 2004. The family says that the report of pain, together with the presence of other risk factors, means that the judge's statement that there was "no evidence to suggest that any of these [risk] factors were present when Mr. Lorencz attended before Dr. Talukdar" is palpably wrong. They also say that the judge's conclusion that there was no evidence of the type of risk factors that would have triggered the need for emergency or urgent care is contradicted by his other findings, including that "Dr. Talukdar was indirectly advised by the patient through the Burns index forms that there was pain being experienced and there were other conditions evidencing potential cardiac concerns" (at para 65). The family's arguments under this head are closely aligned with their submission that the judge did not adopt a sufficiently robust approach to evaluating if the evidence established causation.

[70] The family's assertions demand that careful attention be given to precisely what information was on the Burns index forms. They also require that the judge's findings, in paragraph 107 and elsewhere in the *Trial Decision*, be closely scrutinized.

[71] In connection with the Burns index forms, it is important to note that Mr. Lorencz was asked, in the pertinent part of it, to use the checklist "to indicate how much each of the following 33 symptoms bothered you *in the past several days*" (emphasis added). This part of the forms was not, therefore, an inquiry into the symptoms that Mr. Lorencz was experiencing at the time he presented himself before Dr. Talukdar.

[72] The second thing of note about the forms is the precise question that provoked the answer the family most relies upon. The question inquired as to whether in the last several days Mr. Lorencz had been bothered by "Pain, pressure, or lightness in the chest". He was given four alternatives to answering this, and the other inquires, being "Not at all", "Somewhat", "Moderately" and "A Lot". Mr. Lorencz chose the second of these choices, "Somewhat", in response to this question.

[73] I turn then to the judge's findings in paragraph 107. The first three sentences of that paragraph summarize the evidence of Dr. Iwanochko and Dr. Sharma. The most important point to be made about these passages is that the judge accurately summarized the evidence of these two witnesses.

[74] In his testimony, Dr. Iwanochko identified two basic options that are open to a family doctor when a patient presents with risk factors that suggest the need for a cardiac examination. Again, these choices were a referral to a hospital or a referral to a cardiologist, which might be done on either an urgent or routine basis. He further explained how that decision might be made by a family doctor. More specifically, Dr. Iwanochko described how, if a patient displays critical symptoms, a referral would be made to a hospital emergency department and, if not, they would be referred to a cardiologist for an examination, to be seen either on an urgent or routine basis. Again, the latter choice would depend on what prompted the need for the referral. When asked about what criteria might make a referral urgent or routine Dr. Iwanochko gave the following more specific evidence regarding the type of factors that would go into the referral choices that a family doctor might make:

A Yeah. I mean, it depends what the problem is, right? So I mean, there's a wide range of things you're asked to see. Sometimes it could be management of difficult to control hypertension, where the blood pressure is under control, but it's just not adequate; that's not really urgent. They're already on treatment; they just need to be seen for adjustments.

I see a lot of patients -- genetic cardiac disorders; that's lifelong. None of that's critical. We see them as quickly as we can, but that's not urgent.

Patients with -- in the right age group with chest pain and worrisome symptoms, that's automatically urgent. So there's no way to put that into a checklist. It's not like a pre-flight checklist, it's just too complicated. We have to see each one and decide.

And we also have to depend on the family doctor to tell us. Because they've got a lot more information about the patient than we do.

[75] Dr. Iwanochko was then invited to expand on this, and he gave the following additional evidence:

Q MR. THERA: Well, no. Here they are. Things like -- well, yeah. Can you -- you tell me. You said, "chest pain or worrisome symptoms." What type of worrisome symptoms might elevate something from routine to urgent?

A I mean, chest pain associated with shortness of breath, chest pain with palpitations, heart racing, patients who had actual syncope when they passed out, that becomes urgent. That kind of patient we would say, You should go to the Emergency.

So that would be different things. And you know, it depends on the patient's age, right? Patients who are in their 50s with chest pain and a family history, that's a higher risk patient than a 20-year-old with chest pain and no family history. That's a lower risk patient.

So there are lots of things that go into making this decision.

[76] Dr. Sharma's evidence on this point was similar to that of Dr. Iwanochko's:

Q And what, if any, type of symptoms might have led one to expect that he might have had advanced coronary artery disease or was at risk of a heart attack?

A Any complaint of any significant chest pain or especially the chest pain related to exertion, that could have been the red flag there.

Q Are there any other particular red flags that one would look for? Or that would lead one down that line?

A Yeah. So any symptoms which are related to physical activities, so exertion, like chest pain, shortness of breath, sweating, feeling lightheaded, or feeling extremely weak with minor physical activity, or episodes of passing out, palpitations. So those were some of the symptoms which will raise the suspicion for any cardiac underlying problem.

Q If Mr. Lorencz had attended at an emergency department one day prior to his January 23rd, 2005 cardiac event with symptoms of disorientation and confusion, how might that have affected the outcome or course of management?

A Yeah, that event was significant because that was associated with him doing the snow shoveling and he had felt that lightheaded and very weak. And so those symptoms were -- certainly, would have alerted that there is some cardiac event and further investigation should have been warranted at that time.

> Q Can you explain how mental symptoms like disorientation and confusion might be related to a cardiac event? Or coronary artery disease?
>
> A Yeah, so that is the lack of blood supply, ischemia, which is to the heart. Will think there is function temporarily and lose the cardiac output. So when we lose cardiac output, (INDISCERNIBLE). We lose supply in oxygen and brain is very sensitive so conscious level is the first one which gets affected. And with that one, disorientation and replete level of consciousness or unconsciousness, syncope symptoms do happen.
>
> So exertion related light-headedness is a serious symptom, indicating that cardiac output has decreased very likely because of the supply to the heart.
>
> Q If cardiac disease -- if coronary artery disease had been suspected by Dr. Talukdar or Dr. Babchuk and if that had resulted in a routine referral to a specialist such as yourself, what would be the pathway that it would follow, up to -- from the time of referral up to and including definitive treatment and diagnosis?
>
> A That depends on the suspicion on the part of the physician who sees the patient, based on his initial assessment. So if he strongly suspects, based on his assessment, that the patient has serious coronary artery disease or having active symptoms, that would be sent to the cardiologist on urgent basis. He won't go to emergency unless he has active chest pains at that time.

[77] Although the judge did not refer in paragraph 107 to the evidence given by Dr. De Klerk, that expert also testified to the factors that would go into a family doctor's referral decision. Ultimately, Dr. De Klerk linked the need for an emergency referral to the presence of cardiovascular symptoms on the day of the attendance. In this regard, Dr. De Klerk testified as follows:

> If he's asymptomatic in my office that day, I will make a referral -- a patient referral to internal medicine or cardiology for a stress test. If this patient had actual symptoms the day that he's in my office, I would actually pick up the phone and I would talk to one of those consultants to see him on a more urgent basis.

[78] Taken together, these passages well support the judge's summary of the risk factors that were identified in the evidence that should lead a family physician to refer a patient to a hospital emergency department or a cardiologist on an urgent basis. The question becomes whether the judge erred in his conclusion that on December 22, 2004, there was no evidence to suggest that any of these factors were present when Mr. Lorencz attended before Dr. Talukdar.

[79] At the outset, I would observe that while the judge found Ms. Lorencz to be a credible witness, he also concluded that her "present recounting [that her husband had complained to Dr. Babchuk about arm pain in September of 2004] is not, on a balance of probabilities, reliable" (at para 54). The judge based this conclusion on inconsistencies between Ms. Lorencz's trial testimony, on the one hand, and what she had reported in a complaint to the College of Physicians

and Surgeons and in her discovery evidence, on the other. He also based it on the absence of any mention of arm pain recorded in Dr. Babchuk's notes. This is important because it was the only direct testimony that suggested Mr. Lorencz had complained of active cardiac-related pain *at the time of a visit* to either Dr. Babchuk or Dr. Talukdar.

[80] I next reiterate that, while the judge observed in connection with Dr. Talukdar's first attendance she had written in her notes "still pain", he also recorded that Dr. Talukdar "was adamant in her testimony that this reference was not an assertion of chest pain as that would have definitely caused her to make further inquiries of the patient" (at para 61).

[81] It is further significant that, as I have noted, the answers given by Mr. Lorencz on the Burns index forms do not directly reveal whether he was experiencing pain on the day of his attendance before Dr. Talukdar. I reemphasize this fact because, while the judge found that Dr. Talukdar was negligent for not having engaged in a differential diagnosis, which would have led to a referral to a cardiologist, he was also very careful to link this finding to the information conveyed on the forms that "there was pain being experienced" – making no specific finding as to the type of pain – and the presence of "other conditions evidencing potential cardiac concerns" (at para 65). Again, I note that this was a limited finding only.

[82] Later in the *Trial Decision*, the judge rooted his conclusion that Dr. Talukdar had failed to meet the requisite standard of care on her failure to clarify what she was told by Mr. Lorencz about his pain. He emphasized that Dr. Talukdar had "been told of the existence of pain, [but] there is nothing on the medical chart to indicate any form of inquiry or discussion [by Dr. Talukdar] to flesh out what this reference meant" (at para 95).

[83] Similarly, in the context of his discussion of the standard of care, the judge specifically eschewed finding that the documents recorded that Mr. Lorencz was experiencing pain on the day of the attendance. Rather, the judge limited his findings to the conclusion that there were sufficient concerns present that he was confident that a referral of some sort to a cardiologist was required. In this regard, the judge wrote as follows:

> [97] The responses on the Burns index forms fall into the same category. They provided information from the patient. Whether or not they paint a picture of cardiovascular issues or concerns is not the inquiry to be made by the court. Rather, the inquiry is as to whether

> they provide information that compels a reasonable family physician to make further inquiries: to engage in the positive and negative questioning with the patient.
>
> [98] The information on these forms, according to the evidence tendered at trial, would alert a family physician to concerns regarding potential heart issues. Dr. Talukdar did not review any of this information and therefore did not consider it in any substantive way when arriving at her diagnosis. And yet, the whole point of using these forms was to better inform her in making her medical diagnosis, being anxiety and depression.
>
> [99] Returning again to her explanation, her seeming indication that the pain was reference to the earlier gastro difficulties cannot be supported by the evidence. There is no basis on the material to conclude this was, in fact, the pain to which the patient was referring. There is no indication that over the intervening three plus years that he had continued to experience this type of pain. But more importantly, as discussed, there was no inquiry from the physician to attempt to determine why the pain was being experienced.
>
> [100] Questions regarding the pain, the taking of a family history due to the experiencing of pain, the presenting condition of the patient as a reasonably heavy smoker who was considered medically to be obese, would have, according to the evidence at trial, been the result of that questioning. And, that result would have compelled the physician to refer this individual on for further testing or consultation with a cardiologist specialist.
>
> [101] As a result of all of the foregoing, I must conclude that Dr. Talukdar did not meet the standard of care expected of a reasonably prudent family physician carrying on her practice in Regina, Saskatchewan with respect to Mr. Lorencz.

[84] I have taken care to go over these findings, some of which I have previously reviewed, to be as clear as possible as to the precision of the judge's determinations. As I see it, there is no inconsistency between, on the one hand, the statement in paragraph 107 of the *Trial Decision* that there was no evidence to suggest that any of the factors that would trigger a need for a referral to a hospital emergency department or to a cardiologist on an urgent basis were present when Mr. Lorencz attended before Dr. Talukdar, and, on the other hand, the judge's other findings.

[85] The question remains if there is a plainly seen or obvious error in the judge's conclusion. Again, he held that there was no evidence to suggest that, on the day of the attendance before Dr. Talukdar, Mr. Lorencz was experiencing any of the symptoms that would trigger a need for an emergent referral. In connection with this, Ms. Lorencz testified quite clearly that Mr. Lorencz had not complained to her about chest pain at the time of these attendances. She also confirmed that symptoms of nausea and sweating that her husband was experiencing when he saw Dr. Babchuk in September were no longer present when Mr. Lorencz saw Dr. Talukdar in November and December.

[86] On the first of these points, Ms. Lorencz was questioned generally about the subject of the pain she claimed her husband was experiencing before he saw Dr. Talukdar:

> Q And Jim never complained to you about having chest pain, right?
>
> A Before the doctors appointment? No.
>
> Q Ever.
>
> A After -- after he seen Babchuk, I had asked him, but to come out and tell me, no, he wouldn't come and tell me that he had pains.
>
> Q Chest pain.
>
> A No.
>
> Q And you never saw evidence of Jim having chest pain.
>
> A No.
>
> Q Like, grab -- clutching at his chest or that sort of thing.
>
> A No.
>
> Q Or grabbing at his arm.
>
> A No. No.

[87] Ms. Lorencz was also at the clinic and with her husband before and after Dr. Talukdar's attendance of November 29, 2004. She saw no physical symptoms at all on that date:

> Q And of course, you said you went with Jim to Dr. Talukdar's office on November 29th of 2004, right?
>
> A Yes.
>
> Q And would you agree that Jim was not experiencing any physical symptoms or not talking about any physical symptoms, I guess, during the days and weeks prior to November 29th?
>
> A That's correct.
>
> …
>
> Q And you must have rode with Jim to Dr. Talukdar's office on November 29th, right?
>
> A Yes.
>
> Q And on the way there, Jim wasn't complaining of any pain or any other symptoms, right?
>
> A No.
>
> Q And didn't appear to be in pain.
>
> A No.
>
> Q And you didn't observe any other symptoms, right?
>
> A No.
>
> Q And same with on the way home?

A After the doctor's appointment, the only thing Jim and I talked about was what she has said and how he wished he would have never went on the drug.

Q Yeah, but on the way home, you didn't see him to be suddenly --

A No.

Q -- now in pain --

A No.

Q -- or anything like that, right?

A No.

Q And by the time you actually -- or by the time Jim actually saw Dr. Talukdar on November 29th, receptionist had gone home and he was the last patient still there, right?

A That's correct.

Q And you were with him, right?

A That's correct.

[88] Ms. Lorencz was not with her husband during the second appointment with Dr. Talukdar, but she testified that the symptoms she had described that Mr. Lorencz had earlier experienced were not present in the period between the first and second visits to Dr. Talukdar:

Q And then -- so we're at the end of November; is it fair to say that Jim did not have any new complaints or symptoms going into December?

A No.

Q Is it fair to say that the tapering seemed to go well?

A Yes.

Q In what way did it go well?

A Well, he didn't have any complications when I -- because he went off of it.

Q Yeah, like no return of -- of kind of a sweatiness or that sort of thing.

A No.

Q Or nausea, right?

A No.

…

Q But I'm sorry, I need you to answer that -- the question that I asked, which was, you know, again just backing up, I want to look at that time frame between the two visits to Dr. Talukdar between November 29th, 2004, and December 22nd, 2004, Jim didn't appear to be in complaint of or appear to be experiencing any symptoms of chest heaviness or tightness, right?

A Not that I could physically see, no.

Q And certainly, not chest pain, right?

A No, that's right.

Q Or arm pain, right?

A That's right.

Q And didn't have complaints that the -- that the sweatiness or nausea was returning.

A He didn't say -- he didn't say nothing to me unless I ask him the questions how he was feeling.

Q Yeah, but still didn't seem to be --

A I didn't physically see any any -- any of that, no.

[89] Bringing all of this together, based on the record, I see no palpable error in the judge's finding that there was no evidence that any of the factors that should have triggered an emergent referral were present when Mr. Lorencz attended before Dr. Talukdar.

3. Other arguments

[90] Lastly, I will consider a collection of other points that the family raises in support of their submission that the judge erred when he found that causation was not made out in the evidence.

[91] The judge clearly misspoke when he referred, at one juncture, to Dr. Talukdar's first attendance on Mr. Lorencz occurring in December (see para 113). Of course, the first visit was on November 29. Based on the judge's comprehensive consideration of what had occurred during the two attendances before Dr. Talukdar, and the multiple references to the correct date of these two visits, I see no basis to conclude that this misstatement affected his reasoning in any way. The error may be palpable, but it is not overriding.

[92] The family submits that the judge failed to consider, in the context of his discussion of causation, the evidence of Dr. De Klerk who opined that there should have been a referral to emergent care. I see no merit in this assertion. As I have reviewed, Dr. De Klerk had testified that if a patient was asymptomatic at the time of the appointment, he would only refer that patient to a cardiologist on a non-urgent basis. As outlined above, the judge accepted the evidence of Dr. Iwanochko and Dr. Sharma that the need for an emergent referral was dependant upon the presence of certain specific symptoms, which he found not to exist at the time Mr. Lorencz was attended upon by Dr. Talukdar. Given this conclusion, and Dr. De Klerk's own evidence about what he would do if a patient was asymptomatic on the day of the attendance, I see no basis for this Court to find error because the judge did not specifically evaluate Dr. De Klerk's opinion on this point.

[93] For the reasons that I have given in the previous section of this judgment, there is also no merit whatsoever to the family's assertion that the judge "overlooked, misconstrued" and "discarded" the option of a referral to a hospital emergency department, as is suggested in their factum. There would have been a slightly stronger basis for the family to have suggested that the judge did not sufficiently examine the evidence that a potential referral to a cardiologist might follow one of two courses, being either an urgent or non-urgent referral. Leaving aside the fact that the family did not directly make this submission, I reject it.

[94] As the judge pointed out, Dr. Sharma's evidence "was that a referral appointment to a cardiologist could take months, *in the absence of a need for an urgent attendance*" (at para 109, emphasis added). The judge's later statement that the "extent of the evidence at trial was that such a referral could take weeks or months in Saskatchewan" (at para 113) corresponds with the testimony of Dr. Sharma as to how long a referral would take, depending on whether that referral was made on an urgent or non-urgent basis. I would repeat, the judge's determination was that "to conclude Mr. Lorencz would have been able to obtain a referral appointment to a cardiac specialist would be little more than speculation based on the evidence tendered at the trial of this matter". He reached this conclusion, even though, as he said, he was "applying the robust and pragmatic approach encouraged by the Supreme Court of Canada" (at para 115). In the context of the judgment as a whole, this statement must be taken to encompass rejection of the idea that the circumstances existed for an urgent referral. In short, when the *Trial Decision* is taken as a whole, I am satisfied that the judge considered the possibility of both an urgent and non-urgent referral to a cardiologist before he reached his conclusion that the family had not established causation.

4. Conclusion regarding alleged errors in fact finding

[95] I see no basis to interfere with the judge's finding that, on a balance of probabilities, even if Dr. Talukdar had not been negligent Mr. Lorencz's death would not have been prevented.

V. OVERALL CONCLUSION

[96] The family's appeal against the dismissal of their claim against Dr. Talukdar must be dismissed, with costs in favour of Dr. Talukdar.

"Leurer C.J.S."
Leurer C.J.S.

I concur. "Schwann J.A."
Schwann J.A.

I concur. "Drennan J.A."
Drennan J.A.