CITATION: Ibrahimova v. Cavanagh, 2025 ONSC 4808
COURT FILE NO.: CV-21-018
DATE: 20250822

ONTARIO
SUPERIOR COURT OF JUSTICE

BETWEEN:

TAMARA IBRAHIMOVA and OLEKSII GUBENKO

Plaintiffs

- and -

ANGELA DAWN CAVANAGH, SIVANESAN KALAICHANDRAN and DAVID JOHN ANTHONY PONESSE

Defendants

Barbara Legate, Alex Wolfe, and Luke Kilroy, for the Plaintiffs

Matthew Sammon, Madison Robins, and Evan Linn, for the Defendants

Heard: March 18-21, 24-28, 31, April 1-3, 7-11, 15-17, 22-25, 28-29 and May 12, 2025

REASONS FOR JUDGMENT

SPROAT J.

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I. INTRODUCTION AND OVERVIEW

[1] Tamara Ibrahimova trained as a veterinarian in Ukraine and came to Canada in 2016 on a work visa. She met Oleksii Gubenko that year, and they were married on January 4, 2019. As of May 1, 2019, Ms. Ibrahimova was 28 years old and 17 weeks pregnant.

[2] She went to the Kincardine hospital on May 3, and was seen by the defendant Dr. Cavanagh and discharged with a diagnosis of threatened miscarriage. (When I refer to a date, with no reference to the year, I am referring to 2019.) The plaintiffs agree that Dr. Cavanagh met the standard of care that day.

[3] Ms. Ibrahimova returned to the Kincardine hospital at 6:42 on May 4, and reported a “gush of fluid” from her vagina. She was again seen by Dr. Cavanagh, who again discharged her with the same diagnosis, although she recorded it as “threatened abortion”. The evidence that I will later review clearly establishes that a “gush of fluid” is a clear indication of a rupture of membranes.

[4] Ms. Ibrahimova went to the Goderich hospital and was seen by the defendant Dr. Kalaichandran on May 5 at 16:15. He diagnosed “second trimester bleeding” and made a semi-urgent referral to an obstetrician.

[5] Ms. Ibrahimova went to the Walkerton hospital on May 6 at 16:29 and was seen by the defendant Dr. Ponesse, who diagnosed her as having a “second trimester bleed”. He discharged her to return the following morning for an ultrasound examination and a further assessment in the emergency department.

[6] The plaintiffs allege that Dr. Cavanagh, Dr. Kalaichandran and Dr. Ponesse breached the standard of care by not diagnosing a rupture of membranes and not making an immediate referral to an obstetrician.

[7] On May 7, an ambulance took Ms. Ibrahimova to the Kincardine hospital at 2:37. She was in septic shock. She was airlifted to London Health Sciences Centre ("LHSC"), arriving at 7:35. The consequences of the septic shock included amputation of her left leg below the knee, partial amputation of her right foot, kidney failure leading to a transplant, stroke, compromised ability to use her right arm and seizures.

[8] The parties have agreed on the quantum of damages for non-pecuniary damages, past and future income loss, special damages, and all subrogated claims. The parties have not agreed on the quantum of damages in respect of the plaintiffs' claims for past and future care needs and housing modifications.

[9] The parties agreed that the oral or written examination for discovery questions and answers of a number of released defendants could be relied upon as if they had testified in court.

[10] In the course of my reasons, I may comment on the credibility and reliability of witnesses and make findings of fact. I do so to better focus what follows. In all such cases, I do so taking into account all reasons and findings that appear later in these reasons.

II. STANDARD OF CARE – LEGAL PRINCIPLES

[11] In *Hutterli et al v. Scott*, 2021 ONSC 1426, Nieckarz J. provided a helpful summary of the law:

> [32] Medical practitioners have a heavy and onerous legal responsibility to patients in their care. Having said this, the standards of care imposed by a court must be realistic and reasonable: *Tacknyk v. Lake of the Woods Clinic,* 1982 CarswellOnt 3858, [1982] O.J. No. 170, 17 A.C.W.S. (2d) 154 (C.A.), at para. 29.

> [33] Physicians are not held to a standard of perfection, but rather to a standard of reasonableness. A physician is expected to possess a reasonable degree of skill and knowledge and must exercise a reasonable degree of care in treating a patient. The physician is bound to exercise a degree of care and skill that is reasonably expected of a normal prudent practitioner of the same experience and standing: *Crits v. Sylvester*, 1956 CanLII 34 (ON CA), [1956] O.R. 132, [1956] O.J. No. 526, 1 D.L.R. (2nd) 502 (C.A.), at para. 13.
>
> [34] A bad outcome or incorrect diagnosis should not be taken by itself as evidence of negligence: *Crits v. Sylvester,* at para. 18.
>
> [35] A physician should not be judged by the result or from the benefit of hindsight. An assessment of the reasonableness of his decision must be made prospectively, based on what a reasonably prudent physician would have done had (s)he been presented with the information the physician had at the time: *Hillis v. Meineri,* 2017 ONSC 2845, at paras. 53 and 62; *Mackell v. Moulson,* 2001 BCSC 1705 (CanLII), at para. 81.
>
> [36] An error in judgment will not constitute negligence. The law requires reasonable care and not infallibility. The law recognizes that reasonable physicians, exercising a reasonable degree of skill and knowledge may still make mistakes: *Hillis v. Meineri,* at paras. 56 and 63.
>
> [37] Generally, conformity with a common practice will exonerate a physician of a complaint of negligence: *Crawford v. Penney,* 2003 CanLII 32636 (ON SC), at para. 227.

[12] In *Heikamp v. Renfrew Victoria Hospital et al*, 2022 ONSC 780, the defendant, Dr. Caza, was a family physician with a one-year specialty in anaesthesia. He worked as an emergency room physician one day per week. Muszynski J. held that Dr. Caza should be held to the standard of care expected of an emergency room physician.

[13] In *Ediger v. Johnston*, 2013 SCC 18, Rothstein and Moldaver JJ., for the Court, stated:

> [44] The problem with the standard of care, as interpreted by Dr. Johnston, is that it would be unresponsive to the risk in question and potential harm arising from it.

[14] In *Crawford v. Penney*, 2003 CanLII 32636 (Ont. S.C.), Power J. stated:

> [227] Generally, conformity with a common practice will exonerate a physician of a complaint of negligence. However, there are situations where the standard practice itself may be found to be negligent such as where the practice is fraught with obvious risks or, put another way, where a custom ignores the elementary dictates of caution. In *ter Neuzen v. Korn*, 1995 CanLII 72 (SCC), [1995] 3 S.C.R. 674 at 696-7, the late Sopinka J. said:
>
> > It is evident from the foregoing passage that while conformity with common practice will generally exonerate physicians of any complaint of negligence, there are certain situations where the standard practice itself may be found to be negligent. However, this will only be where the standard practice is 'fraught without obvious risks' such that anyone is capable of finding it negligent, without the necessity of judging matters requiring diagnostic or clinical expertise.

III. DID THE DEFENDANTS BREACH THE STANDARD OF CARE?

A. Introduction

[15] The non-expert evidence in relation to standard of care is fairly straightforward and is based primarily on hospital notes and records and the testimony of the defendants. I will, therefore, review the evidence relevant to each of the defendants. When I come to address causation, I will provide additional detail as to Ms. Ibrahimova's symptoms (what she reported), and signs (what the health care professionals observed).

B. Alleged Breach

[16] The allegation is that the defendants breached the standard of care by failing to diagnose Ms. Ibrahimova as having ruptured membranes and failing to immediately refer her to an obstetrician. It was common ground that the defendants had the ability to consult by telephone with an obstetrician at a tertiary hospital at any time of the day or night.

[17] Given that Ms. Ibrahimova was only 17 weeks pregnant and had not gone into labour, this rupture of membranes was referred to by some witnesses as “pPPROM”, meaning previable, prelabour, preterm rupture of membranes. When membranes are ruptured, it provides a pathway for bacteria to ascend from the perianal and vaginal areas and infect the uterus and the foetus. The defendants instead diagnosed Ms. Ibrahimova as having a threatened miscarriage, threatened abortion, or second trimester bleed, all of which are essentially the same diagnosis.

C. The Evidence

i. Dr. Cavanagh

[18] Dr. Cavanagh received her medical degree in 2015 and did a two-year residency program through Queen’s University in family medicine. She received her designation as a specialist in family medicine from the College of Family Physicians of Canada in January 2018. She does not have any designation or certification in emergency medicine. From January 2018 to May 2019, she had a family practice, and worked four to five emergency shifts per month.

[19] Dr. Cavanagh testified that she had general, but incomplete, memories of seeing Ms. Ibrahimova. She was referred to the emergency record for May 3. She first saw Ms. Ibrahimova at 17:00. She then, by telephone, consulted Dr. Backman, an obstetrician in Owen Sound. Dr. Backman advised her that a speculum exam was safe, and that she

should look for any active bleeding from the cervix. Dr. Backman advised not to do an internal examination, as that could cause further bleeding. Dr. Backman described to her that the management for a threatened abortion was to monitor for signs and symptoms of a miscarriage progressing; and to watch for signs of significant bleeding, significant pain, fever and chills, or signs of infection; and to advise the patient to come back to the emergency department if that was happening.

[20] Dr. Cavanagh diagnosed “threatened miscarriage”. She advised Ms. Ibrahimova to follow up with her midwife (in fact a nurse practitioner) the next week and to return if she had increased bleeding or pain or was otherwise concerned. Dr. Cavanagh testified that Ms. Ibrahimova indicated that it was very upsetting that she might lose the baby. The plaintiffs agree that Dr. Cavanagh met the standard of care on this day.

[21] On May 4, Ms. Ibrahimova returned to the Kincardine hospital at 6:42, and left at 7:52. The nurse’s note included, “…today woke up and had additional bleeding with large amount of clear fluid (enough to fill a pad)…”. Dr. Cavanagh’s notes included, “…gush of fluid – 6 a.m. today – small amount of blood.” Dr. Cavanagh indicated that Ms. Ibrahimova showed her a pad with straw coloured fluid, and her impression was that “it likely was amniotic fluid”.

[22] Her note indicates that she advised Ms. Ibrahimova that she may be having a miscarriage. Dr. Cavanagh testified, “I knew that she wanted to continue the pregnancy”. Dr. Cavanagh advised Ms. Ibrahimova to “watch and wait” and to return if she had cramping, increased bleeding, or was otherwise concerned. The final diagnosis was “threatened abortion”.

[23] Dr. Cavanagh testified that she did not consult an obstetrician that morning because she had already discussed with Dr. Backman the management of a threatened abortion in the second trimester. In her mind, there was nothing that would indicate the need for an obstetrical referral that day.

[24] In cross-examination, Dr. Cavanagh was referred to competencies for family practitioners according to the College of Family Physicians of Canada. This publication refers to a patient presenting with features of antenatal complication, and one example of a complication is premature rupture of membranes. Dr. Cavanagh agreed that one of the competencies she is required to have as a family physician is diagnosing premature rupture of membranes.

[25] Dr. Cavanagh agreed that it was important in a new or novel situation to consult resources that are reasonably available, such as a colleague or a specialist. Dr. Cavanagh agreed that she had a duty to recognize when she was outside of her personal limits of experience and expertise.

[26] Dr. Cavanagh agreed that she had never seen a threatened abortion involving rupture of membranes in the previable stage. She was asked whether that would make it appropriate to consult. She said that her understanding is that if there was a rupture of membranes before 20 weeks, it was simply considered to be part of a threatened abortion.

[27] Dr. Cavanagh agreed that the membrane protects a sterile uterine environment. If it ruptures, that opens the environment to the outside area, which is the vagina and perianus, areas known to have a lot of bacteria. She agreed that the risk associated with rupture of membranes is that bacteria can ascend and infect the amniotic fluid, the foetus, and eventually the mother. She agreed that a pregnant woman is more immunocompromised. She knew that infection of the uterus was a potentially lethal condition if not treated appropriately. She agreed that the physiology and risk of infection is the same at 20 weeks as it would be at 17 weeks. She knew that after 20 weeks, if there was a rupture of membranes, she should consult with an obstetrician.

[28] Dr. Cavanagh agreed that on May 4 she could have called the obstetrician on call at Owen Sound or at LHSC. If she had made a call and been instructed to treat the patient with antibiotics intravenously, she would have done so.

ii. Dr. Kalaichandran

[29] Dr. Kalaichandran obtained his medical degree from the University of Alberta in 2012. He then did a two-year residency in family medicine. This included rotations in emergency medicine and obstetrics. He was certified as a specialist in family medicine in 2014.

[30] He obtained a designation in emergency medicine from the Canadian College of Family Physicians in the fall of 2019. He did so by practicing emergency medicine for four years and writing the required exam. At the Goderich hospital, he split his time between emergency medicine and anaesthesia.

[31] On May 5, Ms. Ibrahimova went to the Goderich hospital. She arrived at 15:30 and left at 19:30. A nurse recorded, “On Saturday filled one pad (all day) with blood/yellow discharge. Since just spotting.” Dr. Kalaichandran did a vaginal swab, which was sent for analysis. He originally ordered a complete blood count (“CBC”) but, following the assessment, he did not think that was necessary because it did not seem that Ms. Ibrahimova had an active infection. She did not have any obvious uterine tenderness or a fever or infectious looking discharge. Dr. Kalaichandran did a sterile speculum examination to see if there was cervical motion tenderness which is a sign of infection.

[32] Dr. Kalaichandran made a diagnosis of “second trimester bleeding” and advised Ms. Ibrahimova to return if she had “fevers/chills/concerns”. From an emergency medicine point of view, he regarded a rupture of membranes as part and parcel of a threatened miscarriage.

[33] Dr. Kalaichandran arranged a follow-up with Dr. Moore, an obstetrician, to reassess the pregnancy. He checked off “semi-urgent” on the referral form. His expectation was that Ms. Ibrahimova would at least be triaged within 48 hours to determine when she needed to be seen. He also requested an outpatient ultrasound to reassess the pregnancy.

[34] In cross-examination, Dr. Kalaichandran:

a) Agreed that in May 2019 he understood that, unlike spontaneous abortions occurring at less than 12 weeks where the uterine contents are completely expelled, those over 12 weeks will most likely have retained products of conception and will require either medical or surgical intervention.

b) Agreed with a publication of the College of Family Physicians that refers to rupture of membranes as a complication of pregnancy, and agreed that a complication of pregnancy is not dealt with in the emergency department.

c) Agreed that a family physician was expected to be able to diagnose a rupture of membranes.

d) Agreed that he initially ordered a CBC because of a concern of infection.

e) Stated that he had done a digital examination after the sterile speculum examination and agreed that it is possible that a digital examination could introduce additional bacteria into the cervix.

f) Agreed that a “gush of fluid” would have to be considered amniotic fluid until proven otherwise.

g) Indicated that Ms. Ibrahimova was anxious about losing the baby.

iii. Dr. Ponesse

[35] Dr. Ponesse received his medical degree in 1964. He then did a one-year rotating internship at St. Michael’s Hospital and two months of extra obstetrical training. He has been practicing full time in family practice, emergency medicine and obstetrics since 1966, and he has been at the Walkerton hospital since 1986. As of 2019, he was working one 24-hour shift per week.

[36] On May 6, Ms. Ibrahimova went to the Walkerton hospital, arriving at 16:29 and leaving at 17:59. Before meeting Ms. Ibrahimova, Dr. Ponesse knew that she was

bleeding and pregnant. A nurse's note stated, "just want to know how to save baby". Her vital signs appeared to be normal. He took a history from her. He wrote that she had vaginal bleeding starting May 3, which persisted May 4, 5, and 6. She had some pain on May 3.

[37] Dr. Ponesse testified that he did a fundal assessment by pressing on Ms. Ibrahimova's abdomen, and there was no indication of pain. A point of care ultrasound indicated a foetal heartbeat, and there were no signs of pain or tenderness during the ultrasound. His assessment was that there was a viable foetus, and a mother who stated she wanted to do whatever she could to help the baby.

[38] Dr. Ponesse diagnosed "second trimester bleeding" and Ms. Ibrahimova was discharged home. Dr. Ponesse also made an order for an ultrasound to rule out an incompetent cervix. This is a cervix that opens many weeks before it is supposed to, which is a condition that can be treated. Ms. Ibrahimova was to get the ultrasound at 8:00 the next morning, and then speak to the doctor on call in the emergency department.

[39] Dr. Ponesse testified that he did not do an internal examination. He denied that Ms. Ibrahimova ever shouted out in pain. The plaintiffs testified that Dr. Ponesse did, in fact, do an internal examination. I need not resolve that issue, as it is not relevant to my analysis and conclusion.

iv. Dr. Backman

[40] Dr. Backman, a released defendant who Dr. Cavanagh had consulted, provided a written answer on examination for discovery which effectively underscores the distinction between threatened abortion, which Dr. Backman agreed on May 3 merited a wait and see approach, and a diagnosis of rupture of membranes, which merited a same day obstetric consultation:

> Question: Given that the patient returned the next morning, had you been consulted would you have recommended admission?
>
> Answer: If Dr. Backman had been consulted on May 4, her usual practice would have been to recommend that Ms. Ibrahimova be assessed by an OBGYN that day. Whether or not to admit the patient would be based on the results of that assessment.

D. The Expert Witnesses

v. Plaintiffs' Experts

Dr. Munkley

[41] Dr. Munkley graduated in medicine from the University of Toronto in 1978. He did a one-year internship in Montreal, and then began practicing emergency medicine. In 1985, he obtained a certificate of special competence in emergency medicine from the College of Family Physicians of Canada. He has published articles, including in the Annals of Emergency Medicine and The New England Journal of Medicine.

[42] Dr. Munkley was a full-time emergency physician for 35 years, practicing in a community setting. For the most part, he would be the only doctor in the emergency department at any one time. He would, however, have access to other specialists on call.

[43] Dr. Munkley's opinion was that Dr. Cavanagh met the standard of care on May 3, but not on May 4. The other defendants did not meet the standard of care.

[44] Dr. Munkley testified that a threatened abortion is characterized by bleeding in pregnancy and is very common in the first 13 weeks. Threatened abortion involves vaginal spotting or bleeding.

[45] Dr. Munkley testified that a gush of fluid, as reported to Dr. Cavanagh on May 4, is "pathognomonic" of a rupture of the membranes. This means it is a very specific

indication that the membranes have ruptured. The diagnosis of threatened abortion was, therefore, incorrect. The diagnosis should have been pPPROM.

[46] Dr. Munkley testified that the decision making around care for the foetus and the mother in the case of a premature rupture of the membranes prior to viability is extremely complex. It requires the expertise of an obstetrician. As such, the standard of care requires an emergency physician to immediately consult with an obstetrician. Dr. Munkley concluded that, for the same reasons, Dr. Kalaichandran breached the standard of care on May 5 and Dr. Ponesse breached the standard of care on May 6.

[47] In cross-examination, Dr. Munkley acknowledged that he only reviewed one article in order to prepare his initial report. This was because rupture of membranes is a clinical condition that is easily diagnosed.

[48] Dr. Munkley acknowledged that in his reports he made some comments that related to causation and not standard of care.

[49] Dr. Munkley agreed that a reference he cited to Tintinalli's Emergency Medicine Manual was contained in a chapter entitled "Maternal Emergencies After 20 Weeks of Pregnancy…".

[50] It was suggested that Dr. Munkley was contradictory in that his November 14, 2024 report referred to a Society of Obstetricians and Gynaecologists of Canada ("SOGC") guideline underscoring the complexity of management of pPPROM which is not managed by an emergency physician, while in his January 23, 2025 report he referred to the fact that "diagnosis and initial management" of patients with pPPROM was within the competencies of an emergency physician. Dr. Munkley disagreed that there was a contradiction, and this was not pursued further. In re-examination, Dr. Munkley explained that the initial management he was referring to was to call and follow the advice of an obstetrician.

Dr. Talan

[51] Dr. Talan received his medical degree at the University of Illinois in 1981. From 1984 to 1986, he did an emergency medicine residency at the UCLA Medical Centre in Los Angeles. Dr. Talan is board certified in both emergency medicine and infectious diseases.

[52] He has been a clinical professor of medicine at the David Geffen School of Medicine at UCLA since 1986. From 2014 to present, he has been Professor Emeritus. From 2009 to 2017, he had an appointment as an emergency physician at the Santa Ynez Valley Cottage Hospital, which is a small hospital that does not have specialists in the hospital. He has practiced emergency medicine for almost 40 years, and he has also taught it to medical students and emergency medicine residents.

[53] Dr. Talan has written extensively and describes his research focus as being at the intersection of emergency care and infectious disease. Dr. Talan has published and lectured extensively not only in the United States, but around the world.

[54] For about 20 years, he served on the editorial board of the journal Annals of Emergency Medicine, which he described as the most important medical journal in the world for the specialty of emergency medicine. The editorial board includes Canadian emergency physicians. The board reviews papers submitted from authors all around the world, including from Canada.

[55] In 2008, he was a reviewer for the Canadian Journal of Emergency Medicine. He has also been a reviewer for the New England Journal of Medicine in Emergency Medicine and Infectious Diseases.

[56] The defendants submitted that Dr. Talan should not be permitted to testify, as he was not qualified to give evidence on the standard of care applicable to the defendants, and because his report and testimony on the *voir dire* suggested bias and advocacy.

[57] I gave a bottom line ruling that Dr. Talan was qualified to provide expert evidence as to the standard of care of an emergency physician. In order to better focus my reasons on standard of care, I set out my reasons for finding that Dr. Talan was qualified to give evidence as to the standard of care, even though he was educated and practiced in the U.S., in Appendix 'A' hereto.

[58] In large measure, Dr. Talan's opinion mirrored that of Dr. Munkley. He referred to Ms. Ibrahimova's report of a "gush of fluid" early on the morning of May 4 as almost "synonymous" with a rupture of membranes. In his opinion, Dr. Cavanagh failed to meet the standard of care because:

a) She failed to diagnose rupture of membranes;

b) She failed to advise Ms. Ibrahimova that a rupture of membranes presented an increased risk of infection; and

c) She failed to consult an obstetrician.

[59] Dr. Talan was referred to a report by Dr. Booth, a defence expert, which stated that emergency physicians manage pregnancy cases at less than 20 weeks gestation. Dr. Talan testified that an emergency physician will manage anyone who comes to emergency in the sense of making a diagnosis, initiating treatment, and referring to a specialist if appropriate.

[60] Dr. Talan made the point that premature rupture of membranes is associated with "a much, much greater risk of sepsis" than a threatened abortion. There is also a very high risk that the foetus will not survive. To the mother, the risk is an ascending infection that affects the birth contents, placenta, uterus, and ultimately the whole body, leading to sepsis and septic shock which can be fatal.

[61] For the same reasons, Dr. Talan's opinion was that Dr. Kalaichandran breached the standard of care. Dr. Talan did not address whether Dr. Ponesse breached the

standard of care on May 6, because his opinion was that, by then, it was too late to avoid sepsis and septic shock.

[62] In cross-examination, Dr. Talan stated that he did not agree that a clinical guideline defines the standard of care. He testified that a guideline can inform the standard of care, but that there are myriad variations of patient presentations. Guidelines typically acknowledge that they cannot fully anticipate all situations.

[63] Dr. Talan agreed with the proposition that, if there are no clinical guidelines specifically addressing a problem or presentation, physicians must rely upon their education, training, and experience to make reasonable clinical judgments about diagnosis and appropriate treatments. He did not, however, agree with the converse. Even if there are clinical guidelines, doctors are still required to use their reasonable skill and knowledge to manage a patient.

[64] Dr. Talan agreed that reasonable doctors presented with the same information can sometimes disagree on a diagnosis and treatment. He also agreed that he was not aware of any clinical guidelines in emergency medicine as of May 2019 which specifically addressed a rupture of membranes in the second trimester before foetal viability.

[65] Mr. Sammon suggested that when Dr. Talan wrote his first report, he was relying upon his education, training, experience, and judgment to formulate his opinion, as opposed to a clinical guideline or emergency medicine textbook. Dr. Talan responded that what he has learned in emergency medicine textbooks informs his state of knowledge. The leading textbooks are Rosen and Tintinalli, and his opinions are informed by being familiar with those texts and teaching from them over many years.

[66] Mr. Sammon pointed out that, in responding to one of the defence reports, Dr. Talan referred to a chapter in Tintinalli entitled “Maternal Emergencies After 20 Weeks of Pregnancy…”. Mr. Sammon suggested that this chapter was not applicable to Ms.

Ibrahimova at 17 weeks gestation. Dr. Talan responded that the advice to obtain an obstetrical consultation in the event of a rupture of membranes would apply equally prior to 20 weeks.

[67] In re-examination, Dr. Talan was referred to an American College of Obstetrics and Gynaecology ("ACOG") Clinical Practice Update (July 2024) which recommended that a diagnosis of suspected intraamniotic infection could be made in the absence maternal fever when other associated clinical signs and symptoms are present. This update also noted that:

> …the absence of fever may delay or limit the initiation of appropriate therapeutic interventions. These interventions would include administering broad-spectrum antibiotics across all trimesters, as well as expeditiously managing the primary source of the infection, either by evacuating the uterus in a previable pregnancy or actively moving towards delivery when a pregnancy is viable.

Dr. Di Cecco

[68] Dr. Di Cecco is an obstetrician/gynaecologist at LHSC. He graduated in medicine in 1989 from the University of Toronto and then did a residence program in the department of obstetrics and gynaecology. He was qualified by the Royal College of Physicians and Surgeons of Canada in obstetrics and gynaecology in 1998. From 1999 to 2006, he was an assistant professor, and from 2006 to the present he has been an associate professor, at the Western University School of Medicine.

[69] He has never before been called to testify as an expert. He has provided one report in connection with litigation and been consulted on other matters that did not lead to a report.

[70] While Dr. Di Cecco did not give opinion evidence as to the standard of care of an emergency physician, he was qualified and gave evidence as to the interaction, referral, and consultation process between emergency physicians and obstetricians, and when

an obstetrician should have taken over the care of Ms. Ibrahimova. As such, it is helpful to now review his evidence in that regard as it is relevant to my analysis of the standard of care of an emergency physician.

[71] At LHSC there is always an on-call obstetrician available to see anyone that might come in through the emergency department. That obstetrician would also field calls from CritiCall, which is a service through which physicians can consult from anywhere in Ontario.

[72] Dr. Di Cecco reviewed the emergency record for May 4, including the reference to a gush of fluid. He testified that at 17 weeks with ruptured membranes this was no longer a threatened abortion. In his opinion, Ms. Ibrahimova should have been referred to an obstetrician on May 4. If consulted, he would have suggested that she be transferred to LHSC and admitted.

[73] Dr. Di Cecco was also referred to the fact that Dr. O'Toole, a defence expert, stated in a report that a consult with a maternal foetal medicine specialist in London would have taken several days, at which point the sepsis would have already occurred. Dr. Di Cecco disagreed that referrals for these types of consultations are triaged as urgent but not emergent. He testified that a simple phone call to the hospital, or through CritiCall, would have resulted in advice from an obstetrician.

[74] Dr. Di Cecco was referred to Dr. McMurray's opinion that management would not have changed, even if the pPPROM had been diagnosed. Dr. Di Cecco says with the diagnosis of pPPROM the prognosis had changed significantly. In this case, Ms. Ibrahimova was denied the opportunity to participate in the management of her condition because she did not have the requisite information. She was not in a position to make an informed decision to "wait and see".

vi. Defence Expert

Dr. McMurray

[75] Dr. McMurray received his medical degree in 1981 and thereafter did a rotating internship at Toronto East General Hospital. He obtained his designation as a specialist in family medicine in 1993 from the College of Family Physicians of Canada.

[76] Dr. McMurray had a family practice in Brockville from 1985 until 2018. As part of that practice, he worked in the emergency department of the local hospital and provided obstetric care. The Brockville hospital serves a population of approximately 90,000 people. From 1997 to 2012, he also served as an emergency physician at a hospital in Watertown, New York, which was a larger medical facility serving a population of approximately 200,000 people.

[77] Dr. McMurray served on the quality assurance committee of the College of Physicians and Surgeons from 1996 to 2005. From 2005 to 2022, he was an assessor for the quality assurance committee, which meant that he would interview physicians and assess their charts and practices and report back to the committee. He was involved in assessing both family practice physicians and emergency medicine physicians.

[78] Dr. McMurray has provided opinions on behalf of plaintiffs and defendants and has testified in two medical malpractice cases. In one case with respect to family practice, and in the other with respect to emergency medicine.

[79] I concluded that Dr. McMurray was qualified as an expert in emergency medicine and, as such, was qualified to give opinion evidence on whether the defendants met the standard of care.

[80] Dr. McMurray testified that a spontaneous septic abortion is a loss of pregnancy before 20 weeks. It would start as a threatened abortion and then proceed through a

series of medical developments that result in a demise of the foetus, usually in an expulsion of the foetus and the products of conception (not always completely), and the development of infection in the uterine cavity.

[81] In Dr. McMurray's opinion, on May 4 there was no reason to conduct another cervical examination or test the fluid with nitrazine paper, because it was self-evident that the gush was amniotic fluid. He also did not think that ordering a CBC was required because it would not change the management plan. He also disagreed with the suggestion that Dr. Cavanagh should have arranged a same day consultation with an obstetrician. He said the expected standard of care was to recommend a community follow-up with the patient's obstetrics provider.

[82] Dr. McMurray disagreed with the criticism that there was a misdiagnosis on May 4. In his view, threatened abortion is a continuum, and as long as there is a viable foetus, the condition is still, by definition, a threatened abortion. The fact that there has been premature rupture of membranes does not change the diagnosis.

[83] In cross-examination, Dr. McMurray was referred to his September 5, 2023 report in which he referred to this as a "desired pregnancy". He agreed that this simply meant a couple who planned to have a baby.

[84] In his December 13, 2024 report, however, Dr. McMurray explained his opinion that the standard of care had been met as follows:

> In the **highly desired pregnancy where the mother expresses a desire to do anything to help the pregnancy continue** [emphasis added], expectant management, as opposed to pregnancy termination, is the recommended treatment.

[85] In the same report, Dr. McMurray stated:

> Dr. Di Cecco states that Ms. Ibrahimova should have been referred to a neonatologist who would counsel her about the very grim prospect

> of reaching viability and that termination would be her option. It appears that he is suggesting that Ms. Ibrahimova should have been counselled to terminate a **much wanted** [emphasis added] pregnancy. This fails to recognize that **Ms. Ibrahimova expressed to her providers that she wanted to proceed with the pregnancy as long as there was any hope** [emphasis added], and that there was still a detectable fetal heartbeat even at the May 6, 2018 attendance. The probability of reaching viable age was low but it was not zero.

[86] Dr. McMurray also refers in the same report to the fact that "she repeatedly expressed her desire to continue the pregnancy as long as there was a possibility of continuing viability."

[87] Dr. McMurray testified that mechanical cervical dilators can be used if an obstetrician determines that a situation requires an immediate evacuation of the uterus.

E. Analysis and Conclusion

i. Credibility and Reliability of the Expert Witnesses

[88] The parties made duelling accusations that the opposing experts were biased advocates. I do not share that view. I find that Dr. Munkley, Dr. Talan and Dr. McMurray were all acting in good faith. I will begin by addressing the principal arguments advanced in relation to credibility and reliability.

[89] The defence submitted that Dr. Munkley's evidence was confusing, contradictory, devoid of any research, contained improper credibility findings and stepped outside of his area of expertise by commenting on causation. I will address a number of these criticisms.

[90] I do not agree that Dr. Munkley contradicted himself by indicating in his January 23, 2025 report that "initial management" of pPPROM was by an emergency physician. It is clear on a fair reading of all the evidence that the only "initial management"

contemplated by Dr. Munkley would be to refer to an obstetrician, or act in accordance with the direction of an obstetrician.

[91] Dr. Munkley had a less than perfect understanding of the distinction between standard of care evidence and causation evidence. This was the first time he had testified in court. I am satisfied that any passing references in his reports to causation do not evidence partiality and advocacy.

[92] Dr. Munkley's initial opinion may make only one reference to medical literature, but it was also quite simple and straightforward. In essence, it was that a rupture of membranes opens up a pathway for infection. This is a materially different risk than is posed by a threatened abortion. At 17 weeks gestation, the patient needs to decide between expectant management and termination. This requires an obstetrical consultation.

[93] Dr. Talan also testified as to causation. As I will explain, I do not need to rely upon his opinion as to the standard of care. I will, therefore, defer my discussion of his credibility and reliability to the causation section of my reasons.

[94] The plaintiffs submitted that Dr. McMurray was "transparently an advocate" and that he "conveniently chose" a timeline that supported the defendants' argument on causation.

[95] While, as I will explain, Dr. McMurray overstated Ms. Ibrahimova's desire to continue the pregnancy, I find he also testified in good faith. I would attribute this to be a product of the fact that experts, despite best efforts and often without realizing it, tend to develop an interest in supporting the side that called them.

ii. The Standard of Care

[96] Dr. McMurray testified that expectant management, sometimes referred to as "watch and wait", met the standard of care. This opinion was founded on the premise

that Ms. Ibrahimova wanted to continue the pregnancy. It is instructive to review the actual evidence in that regard.

[97] Dr. Cavanagh testified that on May 4, Ms. Ibrahimova was upset about possibly losing the baby. Dr. Kalaichandran testified that on May 5, Ms. Ibrahimova was anxious about losing the baby. The only reference to continuing the pregnancy in the medical records was a May 6 nurse's note, "Just want to know how to save baby."

[98] Dr. McMurray inflated Ms. Ibrahimova being anxious or upset about losing the baby and wanting to know how to save the baby to this being a "highly desired pregnancy where the mother expresses a desire to do anything to help the pregnancy continue". He also suggested that Ms. Ibrahimova "expressed to her providers that she wanted to proceed with the pregnancy as long as there was any hope".

[99] Stopping there, as a matter of common sense, these statements are next to meaningless. In a desired pregnancy, all women would make a similar statement. There is a world of difference between a statement made by a woman like Ms. Ibrahimova, who has been told there is a foetal heartbeat and would assume the pregnancy might proceed safely, as opposed to a woman counselled that the chance of the pregnancy proceeding to viability was slim; that there was a grave risk that the baby would be born with severe birth defects and there was increasing risk of infection to the woman. As I will later explain, I am satisfied to a high degree of probability that if Ms. Ibrahimova had been counselled as to the risks to herself and the foetus, she would have elected to terminate the pregnancy.

[100] The opinions expressed by Dr. McMurray, which are premised on Ms. Ibrahimova having decided to continue the pregnancy if there was any hope of viability, actually undercut his opinion as to the standard of care. Implicit is the acknowledgment that, to meet the standard of care, the physician must ascertain and be guided by the decision of the patient. This requires that the patient be advised of the likelihood of the pregnancy proceeding and the attendant risks. This advice was within the scope of

practice of an obstetrician, not an emergency physician. This conclusion is supported by the fact that none of the defendants made the slightest attempt to advise Ms. Ibrahimova of the prognosis and risks.

[101] The practical, and decidedly dangerous, implications of the standard of care posited by Dr. McMurray are as follows:

a) Ms. Ibrahimova throughout remained completely unaware that she had suffered a rupture of membranes, such that she and the foetus were at significantly increased risk of infection;

b) As a result, while Dr. Cavanagh's discharge instructions included to "follow up with midwife (in fact a nurse practitioner) next week", Ms. Ibrahimova and her nurse practitioner would not have any sense of urgency as to scheduling an appointment. In addition, it was left to the nurse practitioner to take note of the report of a "gush of fluid", diagnose the rupture of membranes and make a referral;

c) Dr. Kalaichandran simply made a "semi-urgent" referral to an obstetrician, which was faxed at 9:12 on May 6. He expected the obstetrician would at least triage the referral within 48 hours. The referral, in relevant part, simply stated that the patient had been seen in the Kincardine emergency department and she was being followed by a nurse practitioner. The request was that she be seen, as she was anxious regarding ongoing vaginal bleeding and discharge. There was no indication of rupture of membranes, and so no reason why the obstetrician would give this high priority;

d) While Dr. McMurray agreed that Ms. Ibrahimova had the right to make an informed decision between expectant management and termination of her pregnancy, the reality was that she would, at best, have seen the obstetrician, Dr. Moore, on or after May 8. As a result, Ms. Ibrahimova was effectively consigned to expectant care from 7:52 on May 4, when she was discharged home by Dr. Cavanagh to on or after May 8, when she would see Dr. Moore; and

e) There is a dangerous gap between the standard of care of emergency physicians suggested by Dr. McMurray and the expectations of

> obstetricians. Dr. Di Cecco's opinion was that Ms. Ibrahimova should be seen by an obstetrician on May 4, while Dr. McMurray's standard of care would have her seen by an obstetrician at the earliest on May 8, and perhaps days later.

[102] Dr. McMurray's standard of care does not require the defendants to diagnose rupture of membranes. Instead, it meets the standard of care to simply diagnose "threatened abortion" or "second trimester bleeding". This makes no sense. The evidence of Dr. Di Cecco was that an obstetrician would want to see a patient, at 17 weeks gestation with ruptured membranes, the same day. This is consistent with Dr. Backman's statement that if Dr. Cavanagh had contacted her again on May 4 with a diagnosis of rupture of membranes, she would have wanted to see Ms. Ibrahimova that day. In contrast, for threatened abortion or second trimester bleeding it was appropriate, as Dr. Backman recommended on May 3, to discharge Ms. Ibrahimova home with instructions to return if there were certain symptoms.

[103] Dr. McMurray's standard of care approves of Dr. Cavanagh not diagnosing rupture of membranes and leaving Ms. Ibrahimova's nurse practitioner to figure it out. It also approves of Dr. Kalaichandran making a semi-urgent referral to an obstetrician but making no mention of rupture of membranes, a diagnosis that would be important in triaging Ms. Ibrahimova. It also approves of Dr. Ponesse being unaware that Ms. Ibrahimova had ruptured membranes. His practice was to take his own patient history and not look at the patient's medical records that were available online, and Ms. Ibrahimova did not mention a gush of fluid to him.

[104] Both sides argued that the Tintinalli text supported their position. The text contains the following:

a) Chapter 98, "Ectopic Pregnancy and Emergencies in the First 20 Weeks of Pregnancy"; and

b) Chapter 100, "Maternal Emergencies After 20 Weeks of Pregnancy and in the Postpartum Period".

[105] In responding reports, both Dr. Munkley and Dr. Talan referenced chapter 100 in the Tintinalli text, which states:

> Premature labor or premature rupture of membranes requires obstetric consultation. If obstetric services are unavailable transfer the patient to a center where such services are available.

[106] In cross-examination, it was suggested that chapter 100 was only relevant after 20 weeks of pregnancy, and so would not assist an emergency physician attending Ms. Ibrahimova. All witnesses did agree that in terms of the risk of infection, there was no difference between 17- and 20-weeks gestation.

[107] Dr. Munkley and Dr. Talan took the position that chapter 100 was instructive and should have guided the defendants. Ms. Legate pointed out that Dr. Cavanagh consulted Dr. Backman on May 3 because of her concern of possible *vasa previa*, which is a medical emergency discussed in Tintinalli chapter 100, Emergencies after 20 Weeks, and is not discussed in chapter 98, Emergencies in the First 20 Weeks.

[108] I find what a reasonable emergency physician would take from Tintinalli as a matter of logic and common sense is that since rupture of membranes was a medical emergency requiring obstetrical care after 20 weeks, it was similarly an emergency at 17 weeks gestation.

[109] To paraphrase the Supreme Court of Canada in *Ediger*, the standard of care proposed by Dr. McMurray is not at all responsive to the risk presented by ruptured membranes and the potential harm to Ms. Ibrahimova and the foetus.

[110] The defendants all shared essentially the same view as to the applicable standard of care. This may simply reflect the fact, as a matter of human nature, they are motivated to suggest a standard that excuses or exonerates them.

[111] I do not regard the defendants as having adhered to a common or standard practice as referred to by Sopinka J. in *ter Neuzen*. In any event, I would find that the

practice of the defendants is so “fraught with obvious risks” such that conformity with the practice would not exonerate the defendants.

[112] I conclude that the standard of care required Dr. Cavanagh to consult, or refer Ms. Ibrahimova to, an obstetrician prior to 7:45 on May 4, being the time she was discharged from the hospital. This is on the basis that:

a) She should have diagnosed rupture of membranes and realized that, with the increased risk of infection, a referral to an obstetrician was required; AND

b) Knowing Ms. Ibrahimova presented with pPPROM, a rare condition she had never encountered, this was a new or novel presentation such that a referral to an obstetrician was required.

[113] It follows, that Dr. Kalaichandran and Dr. Ponesse similarly breached the standard of care.

[114] Given that there was an issue raised as to the ability of Dr. Talan to give an opinion on standard of care, I want to make clear that my conclusion on standard of care was reached without reliance upon the evidence of Dr. Talan. For the reasons stated, I prefer the evidence of Dr. Munkley to that of Dr. McMurray. I will, therefore, defer my consideration of Dr. Talan’s credibility and reliability to my reasons regarding causation.

IV. CAUSATION – LEGAL PRINCIPLES

[115] The parties agreed that the onus is on the plaintiffs to establish “but for” causation. In *Clements v. Clements*, 2012 SCC 32, Chief Justice McLachlin described this test as follows:

> [8] The test for showing causation is the “but for” test. The plaintiff must show on a balance of probabilities that “but for” the defendant’s negligent act, the injury would not have occurred. Inherent in the phrase “but for” is the requirement that

> the defendant's negligence was *necessary* to bring about the injury - - in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.
>
> [9] The "but for" causation test must be applied in a robust common sense fashion. There is no need for scientific evidence of the precise contribution the defendant's negligence made to the injury. See *Wilsher v. Essex Area Health Authority*, [1988] A.C. 1074 (H.L.), at p. 1090, *per* Lord Bridge; *Snell v. Farrell*, 1990 CanLII 70 (SCC), [1990] 2 S.C.R. 311.

[116] In *Goodman v. Viljoen*, 2012 ONCA 896, the Court further explained:

> [76] The robust and pragmatic approach describes the manner in which evidence is to be evaluated, not some special burden of proof: see *Aristorenas*, at para. 56. The robust and pragmatic approach takes into account the nature of the factual issues underlying the causation question and the kind of evidence that the parties are reasonably capable of producing on those issues. The approach acknowledges that the causation inquiry is essentially a practical one based on the entirety of the evidence and made with a view to determining whether the plaintiff has established causation on the balance of probabilities and not to a scientific certainty. Clearly, as counsel for the appellant urges, the robust and pragmatic approach does not countenance speculation or resort to common sense to determine issues that require expert knowledge. To resort to speculation or the misuse of common sense is to misapply the robust and pragmatic approach.

V. DID BREACHES OF THE STANDARD OF CARE CAUSE DAMAGE TO THE PLAINTIFFS?

A. Introduction

[117] I will first address the advice that Ms. Ibrahimova would have received had the standard of care been met and make a finding as to what she would have decided to do. I will then address whether the harm to her would have been avoided.

[118] I will highlight the areas in which Dr. Talan and Dr. Chagla diverge so that the reader has a full and balanced understanding of their evidence. As I will explain, however, my decision is based primarily upon the areas in which they agree.

B. When Would Ms. Ibrahimova Have Been Seen by an Obstetrician? What Would an Obstetrician Have Advised as to the Risks and Options? What Would Ms. Ibrahimova Have Done if Properly Advised of the Risks? What Would a Reasonable Person Have Done?

i. Plaintiffs' Expert

Dr. Di Cecco

[119] In addition to the qualifications I reviewed earlier, Dr. Di Cecco was also qualified to give expert evidence as to what an obstetrician would have done if Ms. Ibrahimova had been referred, and what the options were.

[120] Dr. Di Cecco testified that a generalist obstetrician could advise that it was unlikely that the pregnancy could proceed to 23 or 24 weeks. Further, the prognosis would include the likelihood of neonatal complications, which can include bleeding in the brain, intratesticular hemorrhaging, cardiac issues, bowel issues, and immature lung

development. The risk to the pregnant woman is infection potentially developing to life-threatening sepsis. The options would be to continue the pregnancy in the hope that it progresses to foetal viability, explaining the risks to the mother and the risk of infection of the foetus, or to terminate the pregnancy if the pregnant woman decided that the risks were too high to continue.

[121] Dr. Di Cecco testified that at LHSC, such a patient would be seen by a neonatologist or a maternal foetal medicine specialist. Whether Ms. Ibrahimova was seen by a generalist or specialist is immaterial. A specialist would simply be able to provide greater precision and accuracy as to the prognosis. On the evidence, I am satisfied that all that was relevant to Ms. Ibrahimova was a low likelihood of viability and significant risk of birth defects and a threat to her own health. That basic scenario would have allowed her to make a decision.

[122] Dr. Di Cecco was referred to the fact that Dr. O'Toole, who provided a defence opinion but did not testify at trial, said it is not usual for a referral to be made to an obstetrician before 20 weeks. Dr. Di Cecco says that is not relevant. The rupture of membranes is a complication of pregnancy and, therefore, an obstetrician would agree to be involved. In his experience, obstetricians see patients at any gestation stage.

[123] Dr. Di Cecco was asked what would happen if Ms. Ibrahimova had possible signs of infection and decided to terminate the pregnancy. He indicated that antibiotics would be used to try and "keep the infection at bay so that she can go ahead and evacuate the uterus".

[124] In cross-examination, Dr. Di Cecco was referred to an article in the British Medical Journal which identified that only 19% of the women with previable ruptures between 16 to 23 weeks opted for immediate termination. He agreed this was a high-quality journal. Dr. Di Cecco also agreed that from May 4 to May 6, Ms. Ibrahimova had the option of termination or expectant management.

ii. Evidence of Ms. Ibrahimova and Mr. Gubenko

[125] I am satisfied that, in giving her evidence, Ms. Ibrahimova was honest and made every effort to be accurate. Her ability to do so was compromised by the stroke and other injuries she suffered. It was also affected by the fact that she had numerous discussions with Mr. Gubenko as to what had occurred, so that it was difficult for her to distinguish between what she remembered and what Mr. Gubenko had told her.

[126] In a number of significant areas, Mr. Gubenko's evidence was incorrect. Examples include:

a) At discovery, he testified that Ms. Ibrahimova had bleeding most days from February 4 to March 6. He later corrected this and testified that there were only two or three days of bleeding during this time period.

b) At discovery, he testified that they saw a male doctor on May 3. He later corrected this to be a female doctor.

c) He testified that on May 4 he told the nurse that Ms. Ibrahimova had been screaming and crying and was in pain and cramping. A nurse's note, however, states "denies cramping or pain". Dr. Cavanagh's note states "no cramping or abdominal pain". I would accept the notes of these two health care professionals, making notes in the ordinary course of their profession, as being accurate.

d) He testified that he called an ambulance in March 2025 because he thought he might be having a stroke and said that his blurred vision and headache worsened until the ambulance attendants arrived. The ambulance call report, however, stated that on arrival his symptoms had resolved. I would prefer the record to the recollection of Mr. Gubenko.

[127] For these reasons, I approach with caution the testimony of the plaintiffs to the extent it conflicts with the written records or the testimony of other witnesses.

[128] Ms. Ibrahimova and Mr. Gubenko both testified that if they had been advised by Dr. Cavanagh at approximately 7:30 on May 4 to go to Owen Sound to see Dr.

Backman or go to LHSC, they would have done so immediately. This is supported by the fact that they were persistent in seeking, and consistent in following, medical advice. It also makes common sense that a young couple with issues in a first pregnancy would follow medical advice without delay. I, therefore, accept their evidence.

[129] Ms. Ibrahimova opted to be tested for the risk of a Down Syndrome child. She testified that she and her husband had discussed that if the result of that test was high-risk, they would terminate the pregnancy.

[130] Mr. Gubenko testified that prior to her pregnancy, and during her pregnancy, they had discussed that if there was a concern about Down Syndrome, or a similar health concern, they would terminate the pregnancy.

[131] Ms. Ibrahimova and Mr. Gubenko were in Canada on work visas with the ambition to stay in Canada. She wanted to continue her education in order to qualify as a veterinarian. They had relatively low paying jobs. I accept that there is evidence that from May 3 to May 6 she wanted to save the baby. This was, however, without the benefit of advice from an obstetrician as to the risks to herself and the foetus.

[132] In chief, she was clear she would have wanted to terminate if advised that it was unlikely that the baby could be born alive, and even if the baby did survive it would have significant disabilities. In addition, Ms. Ibrahimova would be at risk of infection that could result in sepsis. In cross-examination, she was asked if she wanted to save the baby if there was an unspecified risk, and she said that she didn’t know. Mr. Gubenko was, however, quite clear in his evidence that they had discussed and agreed to terminate if faced with a serious health risk. That was certainly his opinion, and that would have strongly influenced Ms. Ibrahimova.

iii. Analysis and Conclusion

[133] Dr. Di Cecco was the only obstetrician who testified. He was extremely well qualified. Nothing emerged in cross-examination to cause me to question his evidence. The defence did not seriously challenge his evidence in cross-examination. The defence instead submitted that what was most significant was what Dr. Di Cecco was not asked. I found Dr. Di Cecco to be both credible and reliable, and I accept his evidence.

[134] Dr. Cavanagh should have consulted an obstetrician prior to Ms. Ibrahimova leaving the Kincardine hospital at 7:52 on May 4. If that had occurred, there were two scenarios:

a) Ms. Ibrahimova would have been seen by an obstetrician in Owen Sound who, as I will explain, would have counselled her as to the options, which would have resulted in Ms. Ibrahimova proceeding immediately to LHSC; or

b) Ms. Ibrahimova would have been referred directly to LHSC.

[135] Both scenarios see Ms. Ibrahimova arriving at LHSC on the afternoon of May 4. If Ms. Ibrahimova had seen an obstetrician on May 4, she would have been advised that her membranes had ruptured; that she had lost amniotic fluid; that she was highly likely to lose the baby; that if the baby did survive it would likely have severe disabilities; and that she was at risk for an infection that could become severe or even become septic. She would have been given the option of terminating the pregnancy or being watched carefully for signs of infection.

[136] In reaching my conclusion, I place much more emphasis on Ms. Ibrahimova's personal circumstances than the fact that in the British Medical Journal study, only 19% of women opted for immediate termination. I accept Ms. Ibrahimova's evidence-in-chief that she would have elected to terminate, which was in response to a question that clearly identified the risks to foetal and maternal health in continuing the pregnancy. I also accept Mr. Gubenko's evidence on this point. I, therefore, find that if Ms.

Ibrahimova had been advised on May 4 of the risks to herself and the foetus, she would have decided to terminate the pregnancy. I am also satisfied that this would not have been a close call for the plaintiffs, who I find would have decided to terminate the pregnancy at the conclusion of the consultation on May 4. They would not have waited days, or even hours, to make that decision.

[137] As discussed in *Arndt v. Smith*, [1997] 2 S.C.R. 539, I must also consider whether a reasonable person in Ms. Ibrahimova's circumstances would likely have elected to terminate the pregnancy on May 4.

[138] I am satisfied on the basis of Ms. Ibrahimova's age, educational goals, uncertain status in Canada, limited financial resources, the low likelihood of the pregnancy progressing to viability, the significant risk of birth defects in that event, and the potentially grave risk to Ms. Ibrahimova's health, that a reasonable person in her circumstances would likely have elected to terminate the pregnancy on May 4.

C. Would Ms. Ibrahimova Have Suffered Harm if Antibiotics Had Been Administered and the Pregnancy Had Been Terminated?

i. Introduction

[139] The competing experts took somewhat different approaches, and their opinions on certain points conflicted. Dr. Talan's opinion was that there were clinical signs of uterine infection which was progressing on May 5 and 6. Dr. Chagla's opinion was that this was a relatively rare case in which the infection developed and progressed to sepsis over the approximately eight hours between when Ms. Ibrahimova left the Walkerton hospital and the time her husband called for an ambulance in the early morning hours of May 7.

[140] There was, however, agreement that, as a result of ruptured membranes, Ms. Ibrahimova was at considerable risk, and that she exhibited various signs and symptoms that could indicate infection.

[141] As I will explain, what is most important is how Ms. Ibrahimova's constellation of symptoms and signs would have impacted the urgency with which she was treated at LHSC. The central issue is when would Ms. Ibrahimova have had the dilation and evacuation procedure ("D&E"), not whether Ms. Ibrahimova met the diagnostic criteria for uterine infection prior to May 6 or whether, from the perspective of an infectious diseases expert, certain of her symptoms and signs should be discounted or disregarded as pointing to infection.

ii. Plaintiffs' Evidence and Expert

[142] Ms. Ibrahimova reported on her symptoms as recorded in the medical records. Ms. Ibrahimova had every interest in providing accurate information, and the health professionals had every interest in being accurate. To the extent she does not recollect matters, necessity and reliability are self-evident and I rely upon her statements as recorded at the time, as evidence of her condition.

[143] The triage nurse on May 5 recorded Ms. Ibrahimova has having reported a low-grade fever that day. Ms. Ibrahimova was an intelligent person with a science background, and I accept that she did have a low-grade fever.

[144] Dr. Talan testified for the plaintiffs on causation. Dr. Talan graduated from medical school in 1981. He did an infectious diseases fellowship from 1987 to 1989. Dr. Talan's CV contains a very extensive list of medical journals for which he has served as an editor or reviewer. These include journals devoted to infectious diseases and the New England Journal of Medicine. He has been the chair of, or speaker at, many national and international conferences on infectious diseases and emergency medicine. He has been a board-certified specialist in infectious diseases since 1990. He received

an award for the highest score on the certification examination. From 1990 to 2019, he was an attending physician in the Department of Medicine, Division of Infectious Diseases, Olive View – UCLA Medical Centre in Los Angeles. Throughout his career, he has focused on issues at the intersection of emergency medicine and infectious diseases.

[145] Dr. Talan's CV includes a number of entries specifically addressed to sepsis:

a) 1992 to 1995 – Septic Shock, Workup and Management, presented in Seattle, Chicago, Orlando, and Washington.

b) 1993 – Septic Shock: Critical Management, presented in San Diego.

c) 1995 – Sepsis: Understanding the Science and the Syndrome, presented in Orlando.

d) 2003 – Sepsis in the Emergency Department, presented in Spain.

e) 2003 to 2006 – Founder and Chairman of an Emergency Department Sepsis Education Program.

f) 2004 – Chairman, Emergency Department Sepsis meeting to plan consensus guideline for emergency department management of severe sepsis and septic shock.

g) 2004 – Conference Chairman at various cities, ED Infectious Disease Killers: From SARS to Sepsis, presented in New York, Seattle, and San Francisco.

h) 2013 – Conference Chairman, Sepsis: State of the Art in France.

i) 2006 to 2008 – Early Goal Directed Therapy at the Surviving Sepsis UCLA Nursing Conference.

j) 2009 – Lecture to the Infectious Diseases Association of California, Update on Sepsis Management.

k) 2009 – Surviving Sepsis Debate, presented in Chicago, San Diego, and Boston.

l) 2013 – Sepsis Risk Management, presented in San Francisco.

[146] Dr. Talan testified that on May 5 Dr. Kalaichandran noticed yellow discharge, which he described in an ultrasound request as, “worsening discharge large volume”. (In fact, the yellow discharge was noted to have been on May 4.) The colour yellow suggests purulent material or pus. Ms. Ibrahimova also had symptoms of fever and abdominal discomfort. These symptoms and the discharge indicate possible infection. If she had then been tested, he believes that her white blood count would have been abnormal.

[147] A May 5 urinalysis showed some evidence of leukocytes, which are white blood cells that can accompany an infection. Dr. Talan agreed that leukocytes are often found in the urine of a pregnant woman. He said that you do not, however, look at only one indicator, but also at “the company it keeps”. Dr. Talan referred to the fact that the rupture of membranes meant that Ms. Ibrahimova was at risk of infection. Further, a report of low-grade fever, abdominal discomfort, pain and tenderness, vaginal bleeding, yellow discharge, and leukocytes all indicated the possibility of infection.

[148] Dr. Talan’s opinion was that if Ms. Ibrahimova had terminated her pregnancy on May 4 or 5, antibiotics would have been prescribed and the source of infection removed by a D&E. In that event, she would have avoided septic shock and the consequent complications.

[149] Dr. Talan was referred to the defence expert report of Dr. Chagla that stated that there were no symptoms suggestive of an infection of the uterus or sepsis at the hospital visits May 3-6. Dr. Talan referred to the fact that fever, increasing vaginal discharge, and abdominal discomfort are all symptoms of infection. These symptoms also manifested themselves in a patient who had ruptured membranes, and so was vulnerable to infection. Dr. Talan testified that you cannot ignore the reported symptom of low-grade fever just because a temperature reading was normal.

[150] Dr. Talan also referred to there being objective evidence of infection – the volume of yellow discharge, and the fact that the discharge contained white blood cells which indicates there is purulent material or pus. These are objective signs of infection.

[151] Dr. Talan was referred to Dr. Chagla's opinion that testing and following the white blood cell count has not proven to be helpful in the absence of signs of infection. Dr. Talan said that it remains that white blood cells are a sign of infection and yellow discharge is also indicative of white blood cells, which are inflammatory and consistent with infection.

[152] In cross-examination, Dr. Talan agreed with Dr. Chagla that a uterine infection can develop rapidly over the course of a few hours. (In Dr. Chagla's opinion, the clinical signs developed between the Walkerton hospital visit that ended at 17:59 and approximately 2:08 on May 7 when the ambulance was called.) Dr. Talan did say, however, that it is more common for the infection to develop into sepsis over two to three days.

[153] Dr. Talan agreed that, as of May 2019, there were established clinical guidelines for the diagnosis of chorioamnionitis which is also referred to as intrauterine infection. For greater clarity, I will simply refer to intrauterine infection. The guidelines set out criteria to arrive at a presumptive diagnosis. The criteria were fever present with one or more indicators which included foetal tachycardia, maternal white blood count over 15,000, and purulent fluid confirmed visually to be coming from the cervix.

[154] Dr. Talan was also referred to an ACOG recommendation from August 2017 which states:

> Suspected intraamniotic infection is based on clinical criteria, which include maternal intrapartum fever and one or more of the following: maternal leukocytes, purulent cervical discharge or drainage, or foetal tachycardia.

[155] Dr. Talan agreed that Ms. Ibrahimova had three normal temperatures recorded at the hospital on May 4, 5 and 6. Dr. Talan pointed out, however, that Ms. Ibrahimova was not simply a pregnant woman with no verified fever. She was a woman with ruptured membranes who was extremely vulnerable to infection, and who had certain signs and symptoms. His opinion was also informed by the fact that Ms. Ibrahimova had "full blown" septic shock on May 7.

[156] Dr. Talan agreed that the reference to yellow discharge was on May 4, not May 5. Dr. Talan agreed that yellow discharge could be amniotic fluid. Dr. Talan agreed that leukocytes and vaginal discharge are common in pregnancy.

[157] Dr. Talan denied that he had engaged in circular reasoning. He said it was simple logic that the likelihood of a patient's low-grade fever having been caused by an infection increases if you know that the patient had ruptured membranes, and so was at increased risk of infection.

[158] Dr. Talan testified that the D&E would have to be performed by 2:00 on May 6 to avoid the septic shock. Dr. Talan also observed that bacteria was found in Ms. Ibrahimova's bloodstream, which meant that antibiotics were "very, very important" and could have been started on May 5.

[159] Dr. Talan was directed to the fact that Dr. Chagla had relied upon an article by Goodfellow and others in the British Medical Journal, which suggested that the rate of sepsis was similar in women who elected expectant management and those who elected immediate termination. He was then directed to Dr. Chagla's opinion that Ms. Ibrahimova's outcome may well have occurred even if she had an immediate termination of the pregnancy.

[160] Dr. Talan noted that this was not a randomized study. He also noted that the authors had stated "For women with previable PROM we are unable to make definitive recommendations regarding expectant management compared to immediate delivery."

Dr. Talan gave the example that individuals who were already exhibiting signs of infection might have been the ones who were most likely to opt for immediate termination, which would impact the results. Dr. Talan did agree that immediate termination of pregnancy does not always mitigate the risk of maternal sepsis. Dr. Talan also did not take issue with the statement in the article that pPPROM occurs in 0.1% of cases.

iii. Defence Expert

Dr. Chagla

[161] Dr. Chagla received his medical degree from Queen's University in 2009. He completed a Master of Sciences degree in Infectious Diseases from the London School of Hygiene and Tropical Medicine in 2012. He then completed a fellowship in infectious diseases at McMaster University in 2014. He has specialist designations in internal medicine and infectious diseases from the Royal College of Physicians and Surgeons of Canada.

[162] Since 2014, he has been an infectious disease and internal medicine consultant at St. Joseph's Health Care and Hamilton Health Sciences. He has been the Head of Service, Infectious Diseases at St. Joseph's since 2023. He is an associate professor in the Department of Medicine at McMaster University. From 2018 to 2021, he was the Chair of the Infectious Diseases section of the Ontario Medical Association.

[163] He has seen approximately ten septic abortion cases over his career. Sepsis and septic shock are, however, very common presentations, and he would see a few cases per week when he was on call.

[164] Dr. Chagla was qualified as an expert in infectious disease medicine to give evidence concerning causation.

[165] Much of Dr. Chagla's evidence was focused on when clinical signs of infection were evident. He described that intrauterine infection involves "the placental area that supports foetal development". Dr. Chagla described the "Triple i" criteria to diagnose intrauterine infection and opined that Ms. Ibrahimova did not meet those criteria.

[166] Dr. Chagla testified that he would not be involved in typical cases of intrauterine infection. It was then suggested to him that that was because obstetricians have developed protocols and antibiotic coverage that tends to do the job. He agreed.

[167] Dr. Chagla agreed that, given his opinion that there was no evidence of a clinical infection at the time, if Ms. Ibrahimova had a D&E on May 4, 5 or 6, according to a study he cited, there was a 90% probability that she would not proceed to sepsis.

[168] Dr. Chagla agreed that in one study, 18% of women who were found on postmortem review to have a uterine infection never developed a fever.

[169] In cross-examination, Dr. Chagla agreed that SOGC guideline 430 and ACOG guideline 217 note that a digital examination (such as Dr. Kalaichandran performed) increases the risk of infection. Dr. Chagla testified that the digital examination added a small theoretical risk, but that the time that the membranes were open was the bigger risk factor.

[170] In cross-examination, Dr. Chagla agreed that Ms. Ibrahimova had possible signs and symptoms of infection as follows:

a) White blood cells in the vaginal swab taken May 5 could be indicative of infection. The infection could be at the level of the vagina, cervix, or the uterus. He had never seen infection at the level of the vagina or cervix progress to sepsis, which would suggest that if there was infection, it was a uterine infection.

b) Leukocytes (white blood cells) were also detected in the May 5 urinalysis. The May 3 urinalysis had been negative for leukocytes.

c) A study indicated that only 21.9% of women with Ms. Ibrahimova's white blood cell count had no infection. Dr. Chagla agreed that uterine infection would be on the differential diagnosis for Ms. Ibrahimova.

d) Ms. Ibrahimova reported lower abdominal cramping on May 3, and on May 5 reported low-grade fever and abdominal discomfort. Dr. Chagla indicated that infection would be on the differential diagnosis to explain those symptoms.

e) Yellow discharge as recorded by the triage nurse.

f) Vaginal bleeding, which can be caused by infection.

g) Tachycardia, being a heart rate of 100 BPM or more. On May 5, Ms. Ibrahimova was triaged as having 100 BPM.

h) pPPROM itself could be a source of infection.

[171] In cross-examination, an excerpt from an UpToDate article that Dr. Chagla relied upon was put to him as follows:

> Patients with clinically symptomatic infection, even those who do not meet criteria for sepsis syndrome, require urgent surgical evacuation of the uterus. And you'd agree with that.
>
> A. Correct.
>
> Q. Even those who do not meet the criteria for sepsis syndrome, so you don't have to wait until the patient is septic, you'd agree that signs of infection would be a signal to have urgent surgical evacuation?
>
> A. In this article, yes.
>
> Q. And you would agree with this article that you cited?
>
> A. Yes, I agree.

[172] In Dr. Chagla's opinion, if Ms. Ibrahimova had a D&E performed prior to the May 6 16:29 attendance at the Walkerton hospital, she would have avoided sepsis and

septic shock. This was premised on his opinion that there had been no clinical signs of infection up to that attendance.

iv. Analysis and Conclusion

[173] I will begin by addressing the credibility and reliability of the expert witnesses.

[174] Mr. Sammon suggested that Dr. Talan's evidence demonstrated bias, partiality, and a "lack of care and attention". He submitted that Dr. Talan should not be qualified as an expert and, if qualified, his evidence should be given less weight. For example, he referred to the fact that:

a) 5%-10% of Dr. Talan's time is dedicated to litigation consultation, and it represented 20%-25% of his income as of 2019.

b) He has testified at deposition 200-300 times, and at trial approximately 65 times.

c) He did not read any literature, textbooks, or guidelines in formulating his initial report. Dr. Talan explained that this was because his opinion was based on his practicing and teaching from authoritative sources for over 40 years.

d) It was suggested that his initial report stated a bald conclusion that if Ms. Ibrahimova had been started on IV antibiotics as late as the May 5, 2019 visit, she would not have suffered septic shock. Dr. Talan responded that this opinion was based on his extensive experience in diagnosing and treating sepsis. He said he then did cite literature in commenting on the expert reports of others.

e) His report indicates that, "I have taken care of many patients such as Ms. Ibrahimova." It was suggested that this was a standard language he typically used and was an exaggeration. Mr. Sammon elicited that, in fact, he had seen few cases of PPROM, but hundreds of women who presented with a diagnosis of threatened abortion, a few with PPROM and many more with pre-term rupture of membranes (PROM).

f) Dr. Talan, in his report, used absolute terms such as “certain”, “impossible” and “inconceivable”.

[175] As his extensive CV demonstrates, Dr. Talan is highly qualified and regarded in emergency medicine and infectious diseases, as reflected in the nature and scope of his professional activities. For example, serving on the editorial boards or reviewing submissions for prestigious journals, or chairing or contributing to a large number of medical conferences in the U.S. and around the world.

[176] While Mr. Sammon characterized Dr. Talan’s compensation for medical-legal reports as “extravagant”, it is probably not far off what senior members of the legal profession charge on an hourly basis.

[177] I agree that it would have been preferable had Dr. Talan not included absolute terms in his report, but, in fairness, he also indicated in his reports that all his opinions were stated “to a reasonable degree of medical certainty”.

[178] In context, I interpret Dr. Talan’s reference to having seen “many patients such as Ms. Ibrahimova” to refer to threatened abortion and rupture of membranes. It was crystal clear from all the medical experts and the literature that pPPROM was extremely rare such that it would not make sense that even a biased expert would contest that fact.

[179] I, therefore, find that Dr. Talan was acting in good faith and did express his sincerely held opinions.

[180] Ms. Legate submitted that Dr. Chagla’s evidence was “replete” with advocacy, and that he exhibited “a pattern of minimizing or ignoring signs or symptoms of infection that did not support his theory…”

[181] I did not find it unusual that Dr. Chagla would have a strong opinion and, therefore, emphasize and repeat aspects of his evidence that supported that opinion.

Further, as I will explain, while Dr. Chagla disagreed with Dr. Talan as to when the infection began, he agreed that Ms. Ibrahimova reported symptoms and had signs of possible infection prior to attending the Walkerton hospital on May 6.

[182] A great deal of time and effort was devoted to the question of whether Ms. Ibrahimova's signs and symptoms met the criteria for a diagnosis of intrauterine infection prior to May 7. For the purpose of determining causation, however, the focus must be on what would have happened after Ms. Ibrahimova arrived at LHSC. In other words:

a) When would she have had the D&E; and

b) Would the procedure have avoided the septic shock and the consequent injuries that Ms. Ibrahimova suffered.

[183] The defendants submit that I should draw the adverse inference that the D&E would not have taken place in time to save Ms. Ibrahimova from injury due to the fact that Dr. Di Cecco was not questioned on this point. The defendants also submit that the absence of specific evidence as to how long it would have taken to schedule a D&E is fatal to establishing causation. As I will explain, I do not agree.

[184] The evidence is that a large tertiary hospital, such as LHSC, has specialists in the hospital or immediately available 24/7. I think it is also a matter of common sense and experience that large tertiary hospitals perform emergent procedures which must take priority, as well as non-emergent procedures which can be deferred without risk to patient safety.

[185] We know how quickly a D&E can be scheduled and performed at LHSC in the most urgent situation. Ms. Ibrahimova was airlifted to LHSC, arriving at 7:35 on May 7. The D&E began at 9:30. (I appreciate that the operative report indicates that the foetus was already halfway through the vagina so that dilation was not required.)

[186] As referred to in *Ediger*, the standard of care must always be responsive to the risks. I proceed on the basis that LHSC would have been responsive to the risk in terms of prioritizing the D&E for Ms. Ibrahimova. I now turn to those risks.

[187] Ms. Ibrahimova was an extremely high-risk patient. Dr. Chagla testified that:

a) A significant percentage of individuals with premature rupture go on to develop intrauterine infection. In one study 28% and, in another, 12%; and

b) While relatively rare, infection can develop over a few hours, leading to serious injury or death. In such cases, there is no time after signs emerge to effectively treat or prevent sepsis and its consequences.

[188] Dr. Di Cecco was referred to a defence expert report by Dr. O'Toole which suggested that, in the circumstances of Ms. Ibrahimova, a referral to a specialist would be regarded as urgent but not emergent. Dr. Di Cecco disagreed. (I note that Dr. Di Cecco had reviewed the reports of Dr. O'Toole and so would have understood that she equated "emergent" and "same day basis" in her December 11, 2024 report.)

[189] This is consistent with *Forde v. Inland Health Authority*, 2010 BCSC 91, which described a scale of increasing priority from elective to urgent to emergent. An emergent procedure is done "as soon as possible, usually on the same day or the next day": *Forde*, at para. 55. An urgent procedure, on the other hand, does not "have a definite time frame other than it should be done sooner than it would be done on an elective basis": *Forde*, at para. 57. See also *Latin v. Hospital for Sick Children*, 2007 CanLII 34 (Ont. S.C.).

[190] In the days following May 4, Ms. Ibrahimova was, in a sense, a ticking time bomb. She was vulnerable to an infection, which, as Dr. Chagla testified, could progress to septic shock in a few hours. It only makes sense that this condition would be treated as emergent.

[191] Dr. Chagla focused on whether Ms. Ibrahimova's signs and symptoms justified a diagnosis of intrauterine infection. In terms of causation, and specifically in terms of how quickly Ms. Ibrahimova would be taken for the D&E, the relevance is not whether she met a clinical diagnosis, but whether there were any signs or symptoms of possible infection present. In other words, if an obstetrician at LHSC observed any signs of possible infection, that would heighten the urgency of the situation. It would not make sense that the obstetrician would effectively ignore the signs and symptoms until such time that diagnostic criteria for intrauterine infection were met.

[192] As discussed, Dr. Chagla agreed that Ms. Ibrahimova's white blood cell count, leukocytes in her urine, abdominal cramping and discomfort, low-grade fever, tachycardia, vaginal bleeding and pPPROM could indicate possible infection. As to the significance of the yellow discharge, an obstetrician at LHSC is not going to pick up the phone to contact Dr. Kalaichandran to get a more detailed description of the yellow discharge, and then perhaps discount its significance. The obstetrician is going to proceed on the basis that yellow discharge could indicate infection.

[193] I take account of all of the explanations given by Dr. Chagla for why the signs and symptoms I have reviewed may not be related to infection. It remains, however, that these signs and symptoms would have heightened the sense of urgency to perform the D&E.

[194] Dr. Chagla cited an article by Dr. Prager and others entitled *Septic Abortion Clinical Presentation and Management*, which stated that:

> Patients with clinically symptomatic infection, even those who do not meet criteria for sepsis syndrome, require urgent surgical evacuation of the uterus.

[195] Dr. Di Cecco also testified that in the event of any signs of infection, antibiotics would be used to try to keep any infection "at bay". Dr. Talan agreed that if there were possible signs of infection, antibiotics would be administered.

[196] Given these signs and symptoms, and that according to both Dr. Talan and Dr. Chagla infection would be on the differential diagnosis, I find that Ms. Ibrahimova would have been started on antibiotics on May 4.

[197] I further find that since infection was on the differential diagnosis, this would be regarded as a situation requiring emergent (meaning same or next day) surgical evacuation of the uterus. This urgency would be viewed through the lens of an obstetrician and not a specialist in infectious diseases. Put differently, with ruptured membranes, the potential for lethal infection and a decision by the patient to terminate, it would not make sense that an obstetrician would consult an infectious diseases expert to opine on the constellation of signs and symptoms. The D&E had to occur, and patient safety would have dictated that it be performed without delay. Dr. McMurray testified that mechanical cervical dilators can be used if an obstetrician determines that a situation requires an immediate evacuation of the uterus.

[198] The defence submits that this case is nearly identical to *Salter v. Hirst*, 2010 ONSC 3440; 2011 ONCA 236. Salter was seen by Dr. Hirst in the emergency department on June 12, 2003 with “abdominal pain not yet diagnosed” and admitted to hospital. At 16:40 on June 14, he experienced leg numbness. Dr. Hirst transferred Salter to Southlake Hospital, where he arrived at 19:02 and was seen by Dr. Gupta, a vascular surgeon, at 19:50. Dr. Gupta ordered a CT scan but, before it could be completed, he diagnosed Salter as having an aortic dissection. Dr. Gupta was not capable of doing the surgery for that condition, and so decided that Salter should be transferred to Hamilton General Hospital, where surgery commenced at 2:22 and was completed at 4:25 on June 15. It turned out that Salter did not have an aortic dissection. Salter, in fact, had two rare conditions, and Dr. Gupta was capable of performing the required surgery for those conditions. The expert evidence at trial was that Dr. Gupta would have had to operate on Salter within six hours of the onset of numbness in his legs at 16:40 on June 14 to avoid the paraplegia he suffered. In other words, by 00:40 on June 15.

[199] While the jury found Dr. Hirst liable for damages, the trial judge granted a motion to set aside the jury verdict and dismissed the action on the basis that there was no evidence that could establish causation. While there was evidence that Dr. Gupta had an available operating room, the trial judge found the following gaps in the causation evidence:

a) What would a CT scan have shown;

b) Would Dr. Gupta, based on the CT scan, have been able to make the correct diagnosis, or would he have transferred Salter to Hamilton; and

c) Would surgery have been conducted based upon the CT scan.

[200] The Court of Appeal dismissed an appeal, stating:

> It was within the power of the appellants to lead evidence from Drs. Gupta and Lossing regarding what likely would have happened if Dr. Hirst decided to transfer Mr. Salter sooner, how an earlier diagnosis likely would have been made and led to surgery within the six-hour window of opportunity. They did not do this.

[201] The case of Ms. Ibrahimova is quite different than *Salter*. My findings are that she would have arrived at LHSC on May 4. There was no uncertainty about diagnosis. She clearly had ruptured membranes, and I have found that she would have elected immediate termination. The gap relied upon by the defence is that there was no direct evidence with respect to how quickly the D&E would be performed at LHSC.

[202] The defence submits that, in the absence of such direct evidence, I should draw an adverse inference. I do not agree. In *R. v. Ellis*, 2013 ONCA 9, Watt J. explained:

> [45] In some instances, a *trier* of fact may draw, and be instructed about its authority to draw, an adverse inference from the failure of a party to call a witness or produce other evidence. This "adverse inference" principle derives from ordinary logic and experience. The principle is not intended to punish a party who

> exercises its right not to call a witness by imposing an "adverse inference" that a trial judge, aware of the explanation for the decision, considers wholly unjustified: Jolivet, at para. 24.
>
> [46] The cases seem to fall into two groups. In the first, an adverse inference may be drawn against a party for failure to produce a witness reasonably assumed to be favourably disposed to that party. In the second, the inference may be drawn against a party who has exclusive control over a material witness, but fails to produce him or her, without regard to any possible favourable disposition of the witness towards the party: McCormick on Evidence, 6th ed., vol. 2 (St. Paul, MN: Thomson/West, 2006), at para. 264.
>
> [47] The "adverse inference" principle applies in criminal cases, but with due regard for the division of responsibilities between the Crown and defence: Jolivet, at para. 26. The principle is also subject to conditions, among them the right of the party against whom the adverse inference is sought to provide an explanation for the failure to call a witness: Jolivet, at para. 26; Wigmore on Evidence, vol. 2 (Chadbourn Rev., 1979), at para. 290. [page650]
>
> [48] The "adverse inference" principle is rooted in the soil of ordinary logic and experience. As a consequence, the inference can only be drawn where there is no plausible reason for nonproduction, in other words, where it would be natural for the party to produce the evidence if the facts exposable by the witness had been favourable: R. v. Lapensee (2009), 99 O.R. (3d) 501, [2009] O.J. No. 3745, 2009 ONCA 646, at para. 42; R. v. Rooke, 1988 CanLII 2946 (BC CA), [1988] B.C.J. No. 104, 40 C.C.C. (3d) 484 (C.A.), at pp. 512-13 C.C.C.

[203] A witness from LHSC would not be favourably disposed to the plaintiffs or under their control. In addition, as I will explain, there is evidence that supports the inference that a D&E would have been performed on May 5 and that is a “plausible reason” for not calling additional evidence in that regard. The defendants’ counsel certainly have ready access to LHSC physicians and information as to its practices and procedures. If there existed a knockout blow to the plaintiffs’ case in the form of direct evidence from LHSC that the D&E could not have been performed on May 5, I expect they would have

delivered the blow and not sat back to rely on argument as to what inferences should be drawn.

[204] I accept that there must be evidence from which a reasonable inference can be drawn as to when the D&E would have taken place. There is evidence that:

a) In the most urgent cases, LHSC can schedule a D&E within two hours.

b) As a matter or common sense, and consistent with the standard of care being responsive to risk, urgent or emergent surgeries would be prioritized over elective surgeries.

c) Ms. Ibrahimova's ruptured membranes put her at significant risk of developing intrauterine infection which can be lethal.

d) Ms. Ibrahimova's condition, which included signs and symptoms of possible infection, would have heightened the urgency.

e) Ms. Ibrahimova's condition was regarded by Dr. Di Cecco as emergent, in the sense of requiring same or next day intervention.

f) The LHSC physicians would have taken steps responsive to the grave risk that Ms. Ibrahimova was exposed to.

[205] Applying the "but for" causation test in a robust common-sense fashion, as mandated by the Supreme Court of Canada in *Clements*, I infer and find that Ms. Ibrahimova would have had the D&E on May 5. Dr. Chagla and Dr. Talan agreed, and I find, that if Ms. Ibrahimova had been administered antibiotics and had a D&E on May 5, she would not have progressed to sepsis and septic shock.

[206] In conclusion, Dr. Cavanagh breached the standard of care, and her negligence caused the damages suffered by Ms. Ibrahimova.

[207] Dr. Kalaichandran and Dr. Ponesse also breached the standard of care. Dr. Talan testified that Ms. Ibrahimova required a D&E by 2:00 on May 6 to avoid injury. Even if Dr. Kalaichandran had immediately consulted an obstetrician when he saw Ms.

Ibrahimova on the afternoon of May 5, she would not have had a D&E in time. As such, Dr. Kalaichandran is not liable for damages. The same logic applies to Dr. Ponesse who saw Ms. Ibrahimova on May 6.

VI. DAMAGES

A. Legal Principles

[208] In *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 SCR 229, Dickson J., for the Court, stated:

> In theory, a claim for the cost of future care is a pecuniary claim for the amount which may reasonably be expected to be expended in putting the injured party in the position he would have been in if he had not sustained the injury. Obviously, a plaintiff who has been gravely and permanently impaired can never be put in the position he would have been in if the tort had not been committed. To this extent, *restitutio in integrum* is not possible. Money is a barren substitute for health and personal happiness, but to the extent within reason that money can be used to sustain or improve the mental or physical health of the injured person, it may properly form part of a claim. (emphasis in original)
>
> Contrary to the view expressed in the Appellate Division of Alberta, there is no duty to mitigate, in the sense of being forced to accept less than real loss. There is a duty to be reasonable. There cannot be "complete" or "perfect" compensation. An award must be moderate and fair to both parties. Clearly, compensation must not be determined on the basis of sympathy, or compassion for the plight of the injured person. (at pp. 242-243)
>
> […]
>
> It is clear that a plaintiff cannot recover for the expense of providing for basic necessities as part of the cost of future care while still recovering fully for prospective loss of earnings. Without the accident, expenses for such items as food, clothing

> and accommodation would have been paid for out of earnings. They are not an additional type of expense occasioned by the accident. (at p. 250)

B. Introduction

[209] Jordan Roovers, a certified life care planner, testified for the plaintiffs. He incorporated in his plan, input from the following:

a) Dr. Susan Pigott, a neuropsychologist;

b) Kay Sellars, an occupational therapist;

c) Judie Hill, a physiotherapist;

d) Lisa Jadd, a speech and language pathologist;

e) Jeffrey Baum, an expert in housing design and costs;

f) Dr. Sanders, a treating orthopedic surgeon; and

g) Dr. Gofton, a treating neurologist who prepared a report and testified at trial.

[210] Angela Fleming, an occupational therapist and certified life care planner, and Amanda Roa, an occupational therapist at Parkwood Hospital, testified for the defendants.

[211] Ms. Roa treated Ms. Ibrahimova at the Parkwood Hospital and was subpoenaed by the defence. In cross-examination, she indicated that she discussed with Ms. Robins the types of questions she would be asked, and “it was sort of what we were doing today…”. It is, therefore, not clear as to what extent, if any, Ms. Roa made reference to any personal health information. The plaintiffs submitted that since Ms. Ibrahimova had not consented, this communication was unauthorized, and so contravened the *Personal Health Information Protection Act*, 2004. The plaintiffs asked that I make a finding in this

regard, as this raises an important issue of general application. I decline to address this issue. Resolving this issue is not relevant to my decision and, in fairness, would require a hearing to address properly. Further, if this issue arises in other cases, it could effectively be determined on a pre-trial motion.

[212] As housing is a discrete issue and there is little dispute as to the housing suitable for Ms. Ibrahimova, I will review the expert evidence in that regard when I come to my analysis.

[213] The parties agreed that s. 116.1 of the *Courts of Justice Act* is applicable. As such, at stage one I am to determine the one-time and annual costs for goods and services that are reasonable and necessary. The parties will then return at stage two, at which time the form of the annuity contract and other related issues will be determined.

C. Ms. Ibrahimova's Condition and Prognosis

i. Ms. Ibrahimova

[214] Ms. Ibrahimova testified through a translator. She explained that, as a result of her stroke, her ability to speak English has declined. She cannot use a fork, spoon, or pen with her right hand. She uses both hands to hold a cup. She is able to do dusting and tidy up.

[215] In August 2019, Ms. Ibrahimova had a partial amputation of her left foot, and in October 2021, a below left knee amputation. She puts her ankle foot orthotic ("AFO") on her right foot to provide stability. She is then able to put on her prosthesis. Her right foot slants down and, while standing, her heel does not touch the ground. If she walks too far, the skin rubs against her prosthesis which causes pain. When this happens, she will take Tylenol extra strength or lie down. She suffers phantom pain two or three times per week, for which she takes Tylenol. She also has pain in her scalp one or two times per week as a result of a bone flap that was removed.

[216] Ms. Ibrahimova explained that most days she feels tired and depressed. She is afraid of seizures and falling down. Before her daughter Evelina was born, she would stay at home and read comics and play video games. Now she is able to sit on the sofa and play with Evelina for an hour or so. She cannot lift Evelina who now weighs ten kg.

[217] Ms. Ibrahimova testified that she has lost her driver's licence due to her injuries more than once. She now has her licence, but is afraid to drive, and only drives short distances on quiet streets.

[218] As a result of a seizure on July 1, 2023, Ms. Ibrahimova was prescribed anti-seizure medication which she will have to take for the rest of her life. She sees Dr. Gofton every six months for seizure related concerns.

[219] Following her kidney transplant in 2021, Ms. Ibrahimova was prescribed a high dose of prednisone which has caused swelling. She was also prescribed an anti-rejection drug which suppresses her immune system. She has her creatinine levels checked every two months.

[220] In cross-examination, Ms. Ibrahimova testified that:

a) After her left below knee amputation, she spent about one month at Parkwood Hospital in a rehabilitation program.

b) The Parkwood discharge summary dated March 21, 2022 indicated that she was independent in dressing, toileting, bed-chair-toilet-car transfers, bathroom and kitchen mobility, meal preparation and light housekeeping.

c) She has had one fall since her discharge from Parkwood.

d) She will sometimes drive herself to buy groceries and select light items which she is able to load into the car, and Mr. Gubenko unloads at home.

e) She told Mr. Roovers that she would drive herself to and from London if that was absolutely necessary. It was, however, unclear if she in fact ever did this drive herself after May 2019.

ii. Mr. Gubenko

[221] Mr. Gubenko testified that:

a) Ms. Ibrahimova can walk one or two blocks and walk or stand for about ten minutes.

b) He helps her get dressed and put on her AFO and prosthesis.

c) It takes Ms. Ibrahimova 30-40 minutes to have a shower.

d) He monitors Ms. Ibrahimova to make sure that she drinks enough water, eats the right food, and takes her medications.

e) He is almost totally responsible for caring for Evelina.

[222] In cross-examination, Mr. Gubenko was referred to an August 28, 2023 assessment of Ms. Ibrahimova by Angela Fleming. Mr. Gubenko agreed that it correctly described that he would go to work early in the morning and that Ms. Ibrahimova would get up, take her medication, brush her teeth, wash, and dress herself. Mr. Gubenko indicated that he would prepare her prosthesis and put it close to the bed, and that she dressed in a long t-shirt. She would shower after he came home at night.

iii. Dr. Pigott

[223] Dr. Susan Pigott received her Ph.D. in clinical psychology in 1990 and specializes in neuropsychology. She was qualified as an expert in neuropsychology, including the assessment of patient needs, prognosis, care needs, rehabilitation, and epilepsy. For many years, she worked at LHSC and also carried on a private practice focused on the rehabilitation of individuals with moderate to severe brain injuries. From 1997 to the present, she has been an adjunct professor in clinical psychology at

Western University. She has provided expert opinions for plaintiffs and defendants and devotes approximately 50% of her time to legal matters.

[224] The defence challenged the admissibility of evidence from Dr. Pigott and, after I ruled she was qualified, the defence challenged the weight to be given to her evidence, on the following grounds:

a) Using an interpreter, she administered standardized United States developed tests, but did not ascertain from the test developers that the tests were appropriate for Russian or Ukrainian speakers.

b) The test results are compared to U.S. populations, and Dr. Pigott does not know if the normative population would take into account that Ms. Ibrahimova was a Russian and Ukrainian speaker, and cultural factors.

c) She relied upon the translator to translate the test questions and answers.

d) A literal translation of a test may not be possible, as there may not be an exact equivalence between words in both languages.

[225] Dr. Pigott agreed that neuropsychological testing is linguistically and culturally specific, but that it was still appropriate to administer the tests. It was necessary, however, to apply clinical judgment and be cautious in interpreting the results. She also looked for patterns of strength and weakness across the tests she administered. Dr. Pigott indicated the translator came from a well-regarded firm that she had used in the past, and that LHSC had used.

[226] Dr. Pigott also explained that since Ms. Ibrahimova spoke some English, it was possible to confirm whether she was understanding what was required. By the time she tested, Ms. Ibrahimova had been in Canada for seven years, which would lessen the likelihood that cultural factors would affect test results. Her clinical judgment was that the testing results were valid.

[227] I concluded that Dr. Pigott's evidence was admissible. The defence concerns were ameliorated by the fact that Ms. Ibrahimova had some facility in English and had been living in Canada. Dr. Pigott's clinical judgment, which I accept, was that the test results had substantial validity despite the language and cultural issues.

[228] Dr. Pigott testified that Ms. Ibrahimova had sustained two strokes to the left frontal lobe of her brain. This is the area involved in executive function like planning and problem solving. Dr. Pigott noted that the testing occurred in a quiet environment, and that in the community Ms. Ibrahimova would have to deal with noise and distractions.

[229] Dr. Pigott's opinion was that Ms. Ibrahimova had weaknesses in executive functioning and problem solving; a moderate level of anxiety; and a severe level of depression. In her opinion, these were all related to her injuries. Dr. Pigott testified, giving as an example, that she would expect Ms. Ibrahimova to have difficulty processing and retaining medical information.

[230] Dr. Pigott's opinion was that, without rehabilitation, Ms, Ibrahimova's prognosis was "dire" and that she would continue to be housebound and dependant on others. She recommended intensive treatment by occupational, rehabilitation, and speech therapists, as well as a clinical psychologist having experience with brain injuries. Dr. Pigott described this as an aggressive attempt to increase her independence. These treatments would give Ms. Ibrahimova the opportunity to participate in the real world and be less dependant on others. While Ms. Ibrahimova will never make any further recovery of brain function, this would allow her to function better in the community.

[231] In cross-examination, Dr. Pigott acknowledged that she did not ask Ms. Ibrahimova about a typical day, her social and community activities. She did obtain related information from other medical experts and records.

[232] Dr. Pigott was referred to a psychiatric assessment that found no signs or symptoms of depression, and to a note in October 2024 indicating no signs of

postpartum depression. Dr. Pigott responded that when she assessed Ms. Ibrahimova she was not doing well.

[233] Dr. Pigott acknowledged that the College of Psychologists website currently lists one active neuropsychologist who provides services in Ukrainian and Russian and five more who provide services in Russian. Dr. Pigott agreed with a number of propositions in an article respecting the challenges of assessing an individual using a translator.

[234] Dr. Pigott acknowledged that on tests of intellectual functioning, Ms. Ibrahimova had scattered results and that it was possible translation issues could have contributed to this. In her clinical judgment, however, Ms. Ibrahimova's responses did not appear to be impacted by language or culture. Dr. Pigott also agreed that, prior to trial, she had refused to provide her raw data from the testing based upon a mistaken, but at one time common, understanding that such data can only be shared with another psychologist.

[235] Dr. Pigott maintained her opinion that Ms. Ibrahimova would have difficulty with most activities of daily living that require intact language, memory, and executive functioning.

iv. Dr. Gofton

[236] Dr. Gofton is a neurologist who has been treating Ms. Ibrahimova since January 20. Her March 6, 2025 report was filed, which included the following:

> The last documented seizure with loss of consciousness was in July 2023. The anti-seizure medication (levetiracetam) dose had to be increased at this time.
>
> Ms. Ibrahimova is now taking the maximum dose of levetiracetam that she can tolerate without side effects. The levetiracetam has been prescribed specifically because it has a low risk of drug-drug interactions with Ms. Ibrahimova's other required medications (i.e. anti-rejection medications for the kidney transplant). However, levetiracetam's side effects include dizziness, and problems with

> balance as well as mood. The dose she is on can be associated with anxiety and depression. It is renally cleared, which would be a concern if there are changes in kidney function and serum blood levels are checked when indicated.
>
> Ms. Ibrahimova will require life-long treatment with anti-seizure medication. The fact that she has not had a seizure in the last 18 months does not mean she will not have seizures in the future. Unfortunately, Ms. Ibrahimova's seizures with associated loss of consciousness come on without warning. Her anxiety in relation to that is common for persons with a seizure disorder given that seizures may occur at any time, without warning and may result in injury and rarely with sudden unexpected death in epilepsy (SUDEP).
>
> Many factors could precipitate a seizure by lowering the seizure threshold. Examples could include hormonal changes, changes in anti-seizure medication levels related to pregnancy, other systemic illness, certain antibiotics. Further, requiring surgery and having general anesthesia may also temporarily impact the seizure threshold and predispose to seizure.

[237] In cross-examination, Dr. Gofton testified:

a) Ms. Ibrahimova did not report anxiety or depression that could be attributed to her medication;

b) Ms. Ibrahimova did have a seizure July 1, 2023, and was seen at the Kincardine hospital. The seizure was attributed to a urinary tract infection and her dose of anti-seizure medication was increased;

c) Ms. Ibrahimova had a repeat seizure and returned to the hospital on July 1, 2023;

d) Persons with epilepsy may have a generalized feeling that something is off prior to a seizure, or may have specific symptoms that indicate the onset of a seizure; and

e) At monthly visits in January, June and September 2024, Ms. Ibrahimova did not report any side effects from medication.

v. Kay Sellars

[238] Ms. Sellars is an occupational therapist who predominantly works with patients with acquired brain injuries. She has experience with complex injury presentations, meaning clients with multiple physical and/or mental health issues.

[239] In civil cases she has prepared over 20 reports, all for plaintiffs. She also prepares accident benefit reports for injured persons. Reports are 10-15% of her practice.

[240] Ms. Sellars was qualified as an expert in occupational therapy ("OT"), including the assessment of functional abilities and care and housing needs. She reviewed the medical records and then met Ms. Ibrahimova virtually, and later in person in Kincardine.

[241] Ms. Sellars administered cognitive screening assessments, and then had Ms. Ibrahimova show her around the apartment and demonstrate activities such as bed and bath transfers. For the most part, they conversed in English and sometimes Ms. Ibrahimova would resort to Google Translate.

[242] Ms. Ibrahimova reported issues with pain, walking and lifting. She struggled with finding words and memory. She reported that her mood had been bad but was improved. She was fearful of suffering further illness or injury.

[243] I will not review all of the testing that Ms. Sellars did. She acknowledged that Dr. Pigott would have the greatest expertise in relation to psychological testing. Her testing indicated mild cognitive impairment with a low level of participation in the activities of daily life.

[244] Ms. Ibrahimova's left hand strength was above the 90th percentile and her right hand strength was below the 10th percentile. Ms. Ibrahimova was able to demonstrate various transfers. She could stand for a short time before it became painful.

[245] Ms. Sellars did a second assessment after Ms. Ibrahimova had a baby. Ms. Ibrahimova seemed worried and anxious. She could not hold the baby comfortably.

[246] Ms. Sellars was referred to certain items in the Exhibit M future care cost summary.

[247] Ms. Sellars recommended that Ms. Ibrahimova have 199 hours of OT in the first two years and thereafter 40 hours per year for life. From year three for life, there is a maintenance regime to monitor her status, address any life changes that have occurred, and review the use of assistive devices. Ms. Sellars described her as having a lot of areas that warranted OT treatment such as training with assistive devices, increased community integration and strategies to make tasks easier for her to perform. A rehabilitation therapist would assist in this regard under the direction of a regulated health professional.

[248] Ms. Sellars also recommended what were referred to as “transition treatments” beginning in year ten of 41 hours of time every eight years. This would be to deal with a discrete issue requiring active treatment such as recovery from surgery or recovering from a period of illness.

[249] Ms. Sellars also allocated 384 hours in years one and two, and ongoing 192 hours per year for a rehabilitation therapist that would work under the supervision of the regulated health care professionals. In years one and two, the therapist would be involved in helping Ms. Ibrahimova get out in the community, developing various skills such as meal preparation and improving her English. The time allocated includes indirect services such as the time the therapist communicates with other professionals.

[250] Ms. Sellars supported Ms. Ibrahimova’s need for a power wheelchair and a lightweight manual wheelchair to use as a back up, or when it would not be suitable to take her power wheelchair.

[251] Ms. Sellars indicated that the food preparation devices at 4.12-4.23 are to compensate for her right extremity weakness, and to ensure her safety. In her opinion, Ms. Ibrahimova will not be able to become fully independent with food preparation.

[252] Ms. Sellars endorsed the need for a smartphone and plan, Apple Watch with fall detection capability, computer, internet access, a gaming mouse, ergonomic desk and ergonomic or gaming chair. This was on the basis that Ms. Ibrahimova's primary leisure activity was gaming, she had limited use of her right hand. The Apple Watch was to provide an extra level of safety. The smartphone is her primary means of communication and organization. The computer is for gaming and for study, such as English courses. In her view, Ms. Ibrahimova needs these items while for others it may simply be a choice whether to have these items.

[253] Ms. Ibrahimova requires a power wheelchair because of her right extremity weakness.

[254] Ms. Sellars believes that Evelina has outgrown the need for the items at 4.61, 4.62, 4.64 and 4.66.

[255] Ms. Sellars endorsed the need for $1,000 per year for social/recreational programs, and a one time $5,000 vocational/avocational assessment to enhance her community integration. She endorsed the need for $5,000 per year for financial management on the basis of Ms. Ibrahimova's cognitive impairments and the fact that English was not her first language.

[256] Ms. Sellars endorsed housing needs as set out in the report of Mr. Baum, and housekeeping and home maintenance needs.

[257] In cross-examination, Ms. Sellars confirmed that in making her recommendations she did not assume that therapies or assistive devices would reduce the need for attendant care, as they had not yet been implemented and results verified.

[258] Ms. Ibrahimova was cross-examined as to certain testing she did, however, I will not review that in detail as Dr. Pigott had greater expertise in that area and performed more extensive testing. Ms. Sellars did confirm that Ms. Ibrahimova scored well on a test related to safety awareness.

[259] In Ms. Sellars' opinion, Ms. Ibrahimova should never go into the community without an attendant. Ms. Sellars opined that Ms. Ibrahimova needed 90 minutes a day assistance for meal planning and preparation because she did not know how therapy might enhance her abilities. Ms. Sellars allocated 120 minutes per week for laundry assistance, being the entire laundry for the family and not taking into account Ms. Ibrahimova's ability to do laundry in a modified home with assistive devices. Ms. Sellars acknowledged that there might be an overlap between the eight hours per week she allocated to mobility assistance and the eight hours per month allocated to personal shopping.

[260] Mr. Roovers calculated all of the direct care needs she identified as 3.2 hours per day. Ms. Sellars did not agree there was an overlap between a rehabilitation therapist assisting Ms. Ibrahimova to practice meal preparation and 90 minutes a day for an attendant to assist in meal planning and preparation.

[261] A hypothetical of a very compromised individual was then put to Ms. Sellars, and she agreed the individual would require as much or more supervisory care than Ms. Ibrahimova. It was then pointed out to Ms. Sellars that in a 2005 case, she had allocated only 90 minutes a day to attendant care. The arbitrator referred to Ms. Sellars as having been wilfully blind to relevant information and found that the individual required 24/7 care. In re-examination, Ms. Sellars was directed to the reasons in the 2005 case indicating that she was replaced by another occupational therapist who reduced the attendant care.

vi. Judie Hill

[262] Judie Hill received her degree in physical therapy in 1989. She has extensive experience in the assessment and treatment of individuals with acquired brain injuries and orthopaedic trauma, such as amputees. Ms. Hill was qualified to give expert evidence in physiotherapy including the assessment of Ms. Ibrahimova's functional abilities and rehabilitation and therapy needs.

[263] Ms. Hill reviewed Ms. Ibrahimova's medical records and conducted an in-home assessment on December 12, 2022. Ms. Hill testified that Ms. Ibrahimova reported pain and phantom pain in her lower left extremity; losing her balance two or three times a week; and requiring poles or support from her husband on uneven ground or to step over a curb. Ms. Ibrahimova reported being able to walk at a slow pace for about 30 minutes with a rest halfway through. Ms. Ibrahimova had difficulty maintaining her balance if she moved her head from side to side as you might do if you wanted to cross a road safely.

[264] She observed that Ms. Ibrahimova was able to transition from lying to sitting to standing. She relied heavily on a railing to use stairs. She had difficulty on inclines because her right foot does not bend adequately. On an index used to predict falls in older adults, a score of 22-24 would indicate a safe walker. Ms. Ibrahimova scored 9.

[265] Ms. Ibrahimova had weakness and limited range of motion in her right shoulder and hand. Her right hand grip strength was half of her left hand strength.

[266] She tested Ms. Ibrahimova on a scale related to balance and mobility while in the community. Typically, a person without any impairments would score 84-96. Ms. Ibrahimova scored 7. Ms. Hill did feel there would be improvement when Ms. Ibrahimova got her new "definitive" prosthesis and new AFO. Having said that, Ms. Hill explained that the key component of balance control is the ability to sense changes and movements at the foot and ankle and provide feedback to the brain. Given that Ms.

Ibrahimova has no left foot or ankle, and minimal ability to sense given that her right foot is partial and fixed in place, that would not improve.

[267] Ms. Hill recommended Ms. Ibrahimova have physiotherapy twice a week to maximize what she could do and minimize problems that may occur, and also specialized hand therapy. Ms. Ibrahimova should also exercise, preferably at a community gym-pool, as she would benefit from the social interaction. She would also benefit from exercise equipment at home.

[268] Ms. Hill also recommended a lightweight foldable walker, walking poles, leather or sturdy fabric shoes, and a wheelchair.

[269] Ms. Hill recommended that Ms. Ibrahimova have access to follow-ups with a physiotherapist every 6-12 months. She noted that Ms. Ibrahimova attends the amputee clinic every 6-12 months, and probably sees the prosthetist more frequently. Any issues or modifications or different mobility aids could require a physiotherapist to address. When a physiotherapy intervention is required, it typically takes about six weeks of treatment to address the issue.

[270] Ms. Hill also recommended a gym membership for life. Ms. Ibrahimova needs to remain active to prolong her ability to have a quality of life.

[271] In cross-examination, she was directed to Parkwood documentation which indicated that Ms. Ibrahimova reported being 100% confident in activities such as walking up and down stairs and getting in and out of a car. She had 90% confidence walking around the house and 80% confidence in walking in a crowded mall. Ms. Hill also agreed that on a Functional Independence Measure of activities of daily living, Ms. Ibrahimova scored as modified independence, meaning she used devices to assist her.

[272] Ms. Hill agreed that Ms. Ibrahimova showed a marked improvement while at Parkwood and further improvements after leaving Parkwood.

[273] Ms. Hill confirmed that if her recommendations were implemented, Ms. Ibrahimova would have some improvements in function. She did not recommend that Ms. Ibrahimova have an attendant with her at all times while out in the community.

vii. Lisa Jadd

[274] Lisa Jadd was qualified as an expert speech and language pathologist to provide evidence as to Ms. Ibrahimova's assessment, recommendations for treatment, and the cost of care. Ms. Jadd graduated with a master's degree in clinical science in 1985 and she became a member of the College of Audiologists and Speech-Language Pathologists when it was established in the late 1980s.

[275] She works primarily with persons who have brain injuries caused by a stroke affecting the frontal lobe. She reviewed medical records and expert reports and met Ms. Ibrahimova one time. Ms. Jadd explained that aphasia is a brain injury that affects the ability to comprehend and express language.

[276] Ms. Jadd administered a number of tests, but certain tests were not attempted due to the fact that English was a second language. Ms. Ibrahimova reported that she had difficulty with words and building sentences. She had difficulty remembering and was slow in understanding and expressing herself.

[277] She did an aphasia assessment, and Ms. Ibrahimova was at or above the 70th percentile for processing sentence length material. She did not test her on paragraph length due to her ability in English.

[278] Ms. Ibrahimova's primary weakness was oral expression. To formulate a sentence, she would repeatedly have to pause. Ms. Ibrahimova did quite well on reading out sentences and paragraphs. She comprehended simple things. Ms. Jadd did not test her on longer complicated material as English was not her first language.

viii. Dr. Sanders

[279] Dr. Sanders is the orthopedic surgeon who cared for Ms. Ibrahimova from May 27, 2019 to January 2022. He prepared two reports as a treating physician and was cross-examined in court.

[280] In his February 25, 2025 report, he explained that:

> Her heel and mid foot will gradually turn in and flex downwards. This will result in increasing pain, decreasing ambulation, and deformity that will lead to skin pressure changes and skin necrosis.
>
> […] It is my opinion that Ms. Ibrahimova will eventually require transtibial amputation to deal with pain deformity and skin necrosis.
>
> […] The vast majority of patients with dual below knee amputations are wheelchair ambulators in the community.

ix. Dr. Connaughton

[281] Dr. Connaughton is a treating nephrologist whose report was filed. Treatment of Ms. Ibrahimova's kidney transplant is required for life. This includes monitoring immunosuppression medications, managing cardiovascular risk factors including blood pressure control, and treating infectious, cardiovascular, and malignancy complications.

x. Dr. Young

[282] Dr. Young is a neurologist whose report was filed. In his opinion:

a) As most improvement occurs in the first year after a stroke, it is unlikely Ms. Ibrahimova's condition will improve significantly;

b) Ms. Ibrahimova's general health status has "likely peaked". "She is immunosuppressed, and will be susceptible to infections and possibly malignancies…"; and

c) “Her neurological and general physical reserve will likely diminish as she gets older, if she survives into her 60s and beyond.”

xi. Jordan Roovers

[283] Jordan Roovers was qualified as an expert in kinesiology, cost of care and life care planning. He has a B.Sc. in kinesiology, an MBA and he is a certified life care planner with 21 years of experience.

[284] Mr. Roovers met with Ms. Ibrahimova at her Kincardine apartment on January 19, 2023, and at her London condominium on June 20, 2023. He reviewed the medical records and reports which I have already reviewed. He inquired as to the pain she was experiencing and assessed her physical abilities and balance.

[285] Mr. Roovers elicited information from Ms. Ibrahimova that was generally consistent with how Ms. Ibrahimova described her condition in court. I have already explained that I view her as an honest witness, and so I accept her evidence as to her physical abilities, mental state, and challenges.

[286] Mr. Roovers was referred to Exhibit M, which was a future care cost summary that he prepared. I will make reference to the items and services as they are marked in Exhibit M.

[287] Mr. Roovers testified that he did not make a deduction for costs that are currently paid for by government programs such as the Ontario Drug Benefit (“ODB”) or the Assistive Devices Program (“ADP”) because there is no certainty that funding will be in place in the future. He calculated housekeeping and home maintenance costs to age 75 on the basis that, at that age, most people would incur those expenses in any event.

[288] Mr. Roovers stated that, even as a life care planner, he had difficulty making sense of all of the medical reports. He recommended that there be funding for case management services, which would include attending some medical appointments. He

estimated 15 hours every three months. This is because of the complexity of Ms. Ibrahimova's medical conditions, the need to ensure that she understands what she is being told and follows up appropriately, and the fact that there is no assurance that Mr. Gubenko would always be willing and able to fulfill this role. Case management is a lifelong need. Mr. Roovers added case management mileage costs, assuming the case manager would attend appointments within the City of London.

[289] With respect to OT, physiotherapy, speech and language services Mr. Roovers recommended an initial period of intensive therapy over two years, followed by a reduced level of service from year three for life. These services would be supported by a rehabilitation support worker who would help implement the treatment goals of the health professionals. That would include going out in the community and engaging in activities. The initial therapy would be three-hour sessions twice per week over a 48-week year, plus four hours a month for the rehabilitation therapist to consult with the professionals and do planning.

[290] Mr. Roovers was asked to comment on Ms. Fleming's recommendation of $7,200 for OT services for one year, followed by a $14,400 allotment for the rest of her life. In his opinion, this is inadequate to meet Ms. Ibrahimova's needs considering that her physical condition and mobility will decline over time, and she will require a right lower extremity amputation at some point. That would be followed by a maintenance level of therapy which, for example, would assist Ms. Ibrahimova with changes in her mobility. Mr. Roovers also endorsed Ms. Sellars recommendation that there be five blocks of 41 hours every eight years to address transition periods that will arise, such as a move to a new home or changed living circumstances.

[291] Mr. Roovers also endorsed Ms. Hill's recommendations for physiotherapy, being 78 one-hour sessions in year one, followed by three hours consultation from year two for life, and six hours of treatment every 2.5 years from year two for life. Mr. Roovers

also endorsed the need for one-time hand therapy at a cost of $8,800. Mr. Roovers also endorsed the need for case management services.

[292] At 3.1-3.11, Mr. Roovers based his costing on the medication being taken by Ms. Ibrahimova at the time.

[293] With respect to assistive devices, Mr. Roovers endorsed the prosthetic and related devices at 4.1-4.7, and the footwear, walker, manual wheelchair and walking poles at 4.8-4.11.

[294] I don't propose to address items 4.12-4.49 and 4.56-4.66 individually. The issue is whether they are items that one would expect to purchase in any event, or whether they are required due to Ms. Ibrahimova's injuries.

[295] Item 4.50 is a power wheelchair every six years from year eight for life. 4.51-4.55 relate to needs as and when Ms. Ibrahimova has a right leg below knee amputation. Costing is provided for primary right prosthesis, water/back up prosthesis every three years for life, socket replacements every 1.5 years for life and stump socks.

[296] Item 4.48 is a stationary bicycle/elliptical trainer at $2,500 every 15 years. Mr. Roovers endorsed this expense even though a separate $1,000 per year provision was made for social/recreational programs such as a gym membership. He explained that this would allow her to exercise on "bad" days when the weather or her condition led her to remain at home.

[297] Mr. Roovers indicated that he did not initially include 4.56-4.58 smartphone and plan, computer and internet access, but did so later based on Ms. Sellars' indication that these were vital devices pursuing rehabilitation goals such as ESL training.

[298] Mr. Roovers endorsed $5,000 per year for financial management on the basis that Ms. Ibrahimova would need advice as to how to allocate funding to meet her various needs.

[299] With respect to transportation, Mr. Roovers described one scenario which provided for $40,000 in vehicle modifications every 15 years from year eight for life, and $3,000 for driver assessment and rehabilitation in year eight to accustom Ms. Ibrahimova to the modified vehicle, and a mileage allowance for attending medical and injury related appointments and activities. The second scenario was to provide funding for taxi service. Mr. Roovers indicated that, in light of the fact Ms. Ibrahimova would need a right extremity amputation, and be primarily reliant on a wheelchair, his strong recommendation was for the modified vehicle.

[300] With respect to attendant care, Mr. Roovers did not endorse Ms. Sellars' recommendation that she would require 24-hour assistance. He indicated that the best-case scenario is that she would require attendant care 12 hours per day, but that as her condition deteriorated, such as after a right leg amputation, the worst-case scenario would be for 24 hour a day care.

[301] Mr. Roovers referred to a report by Dr. Ross to support his opinion that, given her right arm limitations are permanent and will worsen over time, the difficulty Ms. Ibrahimova will encounter, such as doing transfers, will increase over time.

[302] With respect to housing, Mr. Roovers endorsed Mr. Baum's opinion as to her needs and the reasonableness of his assumption that, at age 65, she would downsize to a different home that would require modification.

[303] With respect to housekeeping and home maintenance, Mr. Roovers endorsed $15 per week for grocery delivery, 40 hours of handyperson tasks and 25% of the total costs of lawn and garden care, snow removal, and seasonal clean-ups on the basis that she and her husband would likely have done some of this work.

[304] In cross-examination, Mr. Roovers agreed that the article *Tenets of Life Planning* by Paul Deutsch and *Standards of Practice for Life Care Planners* are foundational documents for life care planners. Mr. Roovers agreed that it would be inappropriate to

make a recommendation and then proceed on the basis that the recommendation would not be successful. It is appropriate to assume the probability that a recommendation will be successful.

[305] Mr. Roovers agreed that part of his recommendation that translator assistance be provided for only five years was that Ms. Ibrahimova would have intensive ESL programming. This also took into account that she would have a case manager.

[306] Mr. Roovers also agreed:

a) That independence is a fundamental value that should be promoted in a life care plan; and

b) A life care plan should only include costs made necessary by the onset of a disability.

[307] Mr. Roovers agreed that at the time of his interview with Ms. Ibrahimova, she was independent in grooming, taking medication from a “dosette”, and taking her prosthesis and AFO on and off. He knew from Ms. Sellars’ report that she had a good level of awareness of safety concerns. He knew that after they moved to London, Mr. Gubenko returned to work so that Ms. Ibrahimova would be alone for eight or more hours a day. He was also referred to a note from Dr. Gofton that Ms. Ibrahimova attended the clinic on her own on September 9, 2024. He agreed that based on her evidence at trial, Ms. Ibrahimova had understood that Keppra was an anti-seizure medication she would need to take for the rest of her life at dosage levels determined by Dr. Gofton.

[308] Mr. Roovers endorsed the recommendation of Ms. Sellars for 3.2 hours a day direct attendant care, but not her recommendations for assistance with shopping and nurturing the baby. The 3.2 hours included 480 minutes per week of attendant care the community. This was based on Ms. Sellars’ assessment that Ms. Ibrahimova needed an attendant whenever she went out into the community. Mr. Roovers indicated that he did

not know this was the basis for her recommendation, but also observed that he would expect Ms. Ibrahimova to be out in the community for more than eight hours per week. Mr. Roovers agreed that in his opinion Ms. Ibrahimova did not require someone to attend her at all times in the community.

[309] Mr. Roovers did not agree with simply deleting the 480 minutes a week requirement. He believed she would sometimes need assistance while out in the community. For example, during bad weather or to traverse uneven terrain, and this need would certainly increase if she had a right leg amputation and needed to use a wheelchair.

[310] Mr. Roovers was asked about the 90 minutes per day attendant care related to meal planning and preparation. It was suggested that this did not assume the success of occupational and rehabilitation therapy coupled with the provision of an accessible kitchen and tools adapted for her use. Mr. Roovers partially agreed, but also made the point that he cannot simply assume that Mr. Gubenko will be available to assist her.

[311] Ms. Sellars recommended 120 minutes per week for laundry, being the total laundry needs for the family. Mr. Roovers agreed that, as a shared responsibility, only 60 minutes per week should be allocated to Ms. Ibrahimova. He also noted that Ms. Ibrahimova's mobility will decline, and she will ultimately be primarily using a wheelchair which will make her less capable.

[312] Mr. Roovers agreed that, if Ms. Ibrahimova had a rocker knife that would cut meat, she did not need 20 minutes a week assistance for feeding.

[313] Mr. Roovers maintained the position that Ms. Ibrahimova should have assistance with shower and bathing transfers, even though she would have an accessible shower and a water prosthesis.

[314] Mr. Roovers agreed that Ms. Ibrahimova's need for help with dressing would be small amounts of assistance at unpredictable times. To the extent Mr. Gubenko was providing this type of assistance, it would be at $22 per hour.

[315] In re-examination, Mr. Roovers was directed to evidence that Dr. Gofton gave that she prefers to have both Ms. Ibrahimova and Mr. Gubenko present for meetings. Mr. Roovers said that highlighted Ms. Ibrahimova's need for someone to help her understand medical instructions.

xii. Angela Fleming

[316] Angela Fleming testified for the defence. She has been a registered occupational therapist since 2000, and a certified life care planner since 2010. She is also authorized to prescribe the need for certain mobility devices under the ADP. 60-80% of her time is devoted to life care planning, about 80% of which are for defendants. Of her 80% defence work, 40-50% would be for the Canadian Medical Protective Association or the Health Insurance Reciprocal of Canada.

[317] I ruled that Ms. Fleming was qualified to give expert evidence as an occupational therapist and life care planner in relation to Ms. Ibrahimova's functional abilities, care needs, and future cost of care.

[318] In Ms. Fleming's opinion, Ms. Ibrahimova has the potential for further functional gains based on her own assessment and the reports of Ms. Jadd and Ms. Hill. She testified that a tenet of life care planning is to assume the relative success of interventions that are recommended. A life care plan should include only expenses or incremental expense required because of the injury.

[319] When Ms. Fleming did her assessment in August 2023, Mr. Gubenko worked 7:30 to 15:30 Monday to Friday and Ms. Ibrahimova was alone while he went to work. While she had an interpreter available, Ms. Ibrahimova would frequently answer

questions in English and correct the translator. Ms. Ibrahimova described that she would wake up at around 8:00, take her medication and then go back to sleep until about 10:00. She would prepare a simple meal, do hand exercises, and she would shower when Mr. Gubenko came home.

[320] Ms. Ibrahimova reported headaches two to three times per week and occasional blurry vision for 30 minutes after she wakes up. She had anxiety and a racing heart for which she took medication. She had some abdominal pain she attributed to her medications. She had lower back and kidney pain when out walking. She had pain and phantom pain in her lower extremities. Ms. Ibrahimova reported memory problems and difficulty in finding words, particularly in English. Ms. Ibrahimova had 36 kg of force using her left hand and 12 kg using her right hand. Most activities of daily living can be performed with 4 kg of force. Ms. Ibrahimova reported that she was independent in toilet, bed and chair transfers, but had Mr. Gubenko assist with bathing due to the need to step over the edge of the tub. Ms. Ibrahimova reported that she could negotiate three flights of stairs and that she could dress and undress and put her prosthesis on and take it off.

[321] Ms. Fleming administered the F-STAC test, which relates to activities of daily living which incorporates stressors and distractions. The test related to medication and cash management, safety, and grocery shopping. Ms. Ibrahimova achieved a high score on most of the test categories.

[322] Ms. Fleming also met Ms. Ibrahimova and Mr. Gubenko in December 2024. Ms. Ibrahimova had not had a seizure since July 2023 and, while anxious, was driving on less busy roads. Ms. Ibrahimova reported going to the hospital a few weeks before, feeling overwhelmed with Evelina crying and unwell. Her level of functioning was unchanged.

[323] For travel to medical appointments Ms. Fleming reasoned that Ms. Ibrahimova would see fewer specialists over time, and she believed funding seven trips per year at

a return cost of $40 plus a fund of $1,600 to address any extraordinary needs would be appropriate.

[324] Ms. Fleming allocated $6,000-$8,000 to cover mileage that a therapist might bill to her.

[325] Ms. Fleming allocated $0-$9,828 for extraordinary travel in the community. She believed that three to four taxi trips per week at $60 return was reasonable but, to some extent, those should be an offset for the non-extraordinary costs of transportation based on public transit costs.

[326] With respect to mobility aids and assistive devices, Ms. Fleming suggested Mr. Roovers' costs were excessive, and some items, such as a bathmat and shoelaces, were not extraordinary. She recommended a one-time payment of $500 and then $150 per year to replace any items for life.

[327] Ms. Fleming noted that adults typically incur costs for recreational activities. She disagreed with Mr. Roovers' recommendation of $1,000 for life. She instead suggested a one-time payment of $4,000-$6,000 so that Ms. Ibrahimova could try various activities to see what would be best for her, or to purchase modified equipment.

[328] Ms. Fleming referred to the fact that Ms. Ibrahimova receives the ODB because she is on the Ontario Disability Support Program ("ODSP").

[329] Ms. Fleming referred to the fact that Ontario residents are able to obtain funding for 75% of an essential prosthesis. Because Ms. Ibrahimova is on ODSP, she receives top-up funding.

[330] Ms. Fleming endorsed hand therapy at a one-time cost of $1,600. She did not agree with Mr. Roovers' recommendation for $2,500 every 15 years for home exercise equipment, given that she agreed that Ms. Ibrahimova should have $1,105 for life for a fitness facility membership.

[331] Ms. Fleming recommended initial intensive OT of 60 hours, supported by an occupational therapy assistant, plus funding for future OT of six 20-hour blocks of time.

[332] Ms. Fleming disagreed that Ms. Ibrahimova required ongoing case management but did endorse an initial 60 hours to help identify and organize clinicians.

[333] In Ms. Fleming's opinion, Ms. Ibrahimova would only need attendant care periodically when she did not feel well or had issues with her prosthesis. She, therefore, recommended an annual allocation of 40 hours which would cost $880, or $1,520 if through an agency. She also endorsed $5,200 per year for homemaking and housekeeping, and $1,484 for home maintenance if she moved out of a condominium. She also recommended an additional 14 hours per week of attendant care after Ms. Ibrahimova had a further amputation.

[334] In cross-examination, Ms. Fleming acknowledged that she based her life plan on the assumption that Mr. Gubenko was present and performing his current role.

[335] Ms. Fleming was referred to a report by Dr. Gofton, a treating physician, indicating that Ms. Ibrahimova was receiving the maximum dose of anti-seizure medication, and that her anti-rejection medication side effects include dizziness and problems with mood. These drugs can also be associated with anxiety and depression.

[336] Ms. Fleming agreed that Ms. Ibrahimova may have these problems for the rest of her life. There is the possibility of seizures in the future. Her seizures are associated with unconsciousness and can come on without warning. Ms. Fleming agreed that could provoke anxiety. Dr. Gofton also indicated that surgery and general anaesthesia would predispose Ms. Ibrahimova to seizures.

[337] Ms. Fleming agreed that Ms. Ibrahimova has no proprioception in her left leg and very limited in her right leg. Proprioception is the sense that provides feedback to the brain, such as whether your foot is on a flat surface or a tripping hazard.

[338] Ms. Fleming agreed that Ms. Ibrahimova would have more wear on her shoes than a person without her injuries.

[339] Ms. Fleming indicated that the cost of financial management is usually dealt with outside of a life care plan, but she agreed that Ms. Ibrahimova would require financial management services.

[340] Ms. Fleming said that she agreed with Ms. Hill's recommendation for physiotherapy, and she allocated $9,780 for initial services and thereafter $675 per year for life.

[341] Ms. Fleming was directed to amputee clinic questionnaires that Ms. Ibrahimova filled out on December 15, 2022 and June 15, 2023. She agreed that Ms. Ibrahimova's condition had declined significantly. In the first questionnaire, Ms. Ibrahimova indicated that she wore her prosthesis 12 hours per day and would get out of her home six to seven days per week. On the second questionnaire, she indicated she wore the prosthesis 10 hours per day and only left her home one to two days per week. She also indicated that she was using a wheelchair.

[342] Ms. Fleming acknowledged that her hourly rate for private home attendant care did not include any employer costs. She said there is a disability tax credit that may offset these items, but that would be for an economist to determine.

xiii. Amanda Roa

[343] Amanda Roa is an occupational therapist at Parkwood Hospital, who prepared a discharge summary after Ms. Ibrahimova's below left knee amputation. She confirmed that, at the conclusion of the Amputee Rehabilitation Program Ms. Ibrahimova attended from Monday to Friday from February 25 to March 18, 2022, she was assessed as independent with all Activities of Daily Living and most Instrumental Activities of Daily

Living. Ms. Ibrahimova did require assistance with activities such as laundry, groceries, and errands.

[344] Ms. Roa testified that she tested Ms. Ibrahimova's meal preparation abilities by watching her retrieve the ingredients and prepare a Greek salad. Ms. Roa did provide some cueing to ensure that Ms. Ibrahimova positioned her feet properly, and she helped clean up.

D. Analysis

i. Introduction

[345] The parties agreed on the costs of items marked in green on Exhibit M. Following argument, the parties provided a joint written submission on the costs of future care. This included Appendix 'A', which contained numbered headings that corresponded to Exhibit M. I agree that the items, services, amount, and frequencies marked in green are reasonable and necessary, and I will not make further reference to them. I am also mindful of the fact that I must take these items into account when considering the reasonableness and necessity of the other items and services.

ii. Finding as to Ms. Ibrahimova's Condition, Prognosis and Needs

[346] I will now make a number of findings, as that will inform my award under various heads of damage.

[347] As I will explain, I agree that Ms. Ibrahimova has very significant limitations currently, and that her prognosis is dire.

[348] The defence acknowledged that the plaintiffs' experts on damages, with the exception of Dr. Pigott and Ms. Sellars, "were generally reasonable and testified in accordance with their duties of impartiality".

[349] Dr. Pigott's opinion was that Ms. Ibrahimova had weaknesses in executive functioning and problem solving; a moderate level of anxiety; and a severe level of depression. The defence challenge the validity of her testing because tests were administered using a translator. I note, however, that Ms. Fleming also used a translator and noted that Ms. Ibrahimova would sometimes interject in English to correct the translator as she did when testifying in court. I accept Dr. Pigott's clinical judgment, based on her overall assessment of the test scores, that the test results were valid.

[350] Both sides sought to support and/or undermine the weight to be given to the evidence of Ms. Sellars and Ms. Fleming on the basis of comments made about their evidence by a judge or tribunal member in other cases. The circumstances are very different from *R. v. Hason*, 2024 ONCA 369, in which the Court had evidence that the expert himself had acknowledged improprieties in the preparation of his report. I cannot intelligibly determine the precise facts in the cases cited and come to any understanding of whether criticisms or commendations by the decision maker were valid.

[351] Ms. Ibrahimova has a daunting array of serious conditions impacting her physical and emotional health, including:

a) Dr. Gofton explained that Ms. Ibrahimova will need to take anti-seizure medication for the rest of her life and is already taking the maximum dose. The side effects of the medication are dizziness and problems with balance, and the dose she is on is associated with anxiety and depression.

b) Seizures can come on without warning and result in a loss of consciousness and, in rare cases, death. It is common for persons with a seizure disorder to have anxiety. Hormonal changes and having a general anaesthetic can predispose to seizure. Ms. Ibrahimova's July 1, 2023 seizures were attributed to a urinary tract infection.

c) Ms. Ibrahimova explained that most days she feels tired and depressed. She is afraid of seizures and falling down.

d) Dr. Connaughton, a nephrologist, advised that Ms. Ibrahimova will require lifelong monitoring for complications which include, but are not limited to, infectious, cardiovascular and malignancy related complications.

e) Dr. Young's report indicated that Ms. Ibrahimova is immunosuppressed and will be susceptible to infections and possible malignancies as a result of medication to inhibit rejection of the transplanted kidney.

f) Dr. Sanders indicated that Ms. Ibrahimova will suffer increasing pain and decreasing ambulation and will eventually require a right leg below knee amputation as a result of pain, deformity, and skin necrosis.

g) Dr. Pigott determined that Ms. Ibrahimova had weaknesses in executive functioning and problem solving, a moderate level of anxiety, and a severe level of depression.

h) On March 16, 2023, Ms. Ibrahimova went to a hospital emergency department. Her family doctor's record referred to this as a panic attack. Ms. Ibrahimova had a depressed mood, for which he prescribed an antidepressant.

i) The amputee clinic questionnaire that Ms. Ibrahimova filled out evidenced a decline in her condition from December 15, 2022 to June 15, 2023.

[352] I also take into account all of the positive evidence cited by the defence, including that Ms. Ibrahimova:

a) Drives on local, less busy streets;

b) Attends some medical appointments on her own;

c) Ambulates without aids in her condominium;

d) Can cook light meals, fold laundry, and do dishes;

e) Has not had a fall in over three years, and has not had a seizure for two years; and

f) Takes pride in being self-reliant.

[353] The defence placed considerable emphasis on the positive discharge summary Ms. Ibrahimova had at the conclusion of her Parkwood Hospital rehabilitation program in March 2022. This was, however, an assessment made at the end of a five day per week program, at which Ms. Ibrahimova received encouragement and support. She was assessed as independent in meal preparation on the basis of being able to retrieve ingredients from a refrigerator and assemble a Greek salad. That certainly would not represent the complexity of a typical dinner at home. In any event, my focus is on Ms. Ibrahimova's current mental and physical state and her prognosis.

[354] The weight of the evidence, however, indicates that Ms. Ibrahimova has a dire prognosis. I find that Ms. Ibrahimova will probably suffer an increasing series of health crises over the years. With all that she has endured and will face in the future, it is likely that she will also have significant mental health challenges to deal with.

[355] In cross-examination, Ms. Fleming acknowledged that she based her plan on the assumption that Mr. Gubenko would be there and continue to perform his current role. As I have described, Mr. Gubenko has made extraordinary contributions. It would, however, be unfair to simply award damages on the assumption he will always be ready, willing, and able to make these contributions. He could have his own mental and physical health challenges. It is no disrespect to take into account that many marriages do not last, and that the current circumstances would challenge any marriage. Ms. Ibrahimova's damage award should not, in effect, leave her vulnerable if Mr. Gubenko is not there to assist.

[356] In the event of conflict between the opinions of Mr. Roovers and Ms. Fleming, except as expressly noted, I accept the opinion of Mr. Roovers. He impressed me as reasonable and thorough, and he exercised independent judgment such as by disagreeing with Ms. Sellars as to the extent of the need for attendant care. Ms. Fleming's opinion was, in my view, flawed in important respects. She adopted an

unreasonably optimistic view of the prognosis for Ms. Ibrahimova and assumed that Mr. Gubenko would always be ready, willing, and able to provide services as he does now.

[357] Given my findings as to Ms. Ibrahimova's condition and prognosis, I find that the recommendations by Mr. Roovers are generally reasonable and necessary.

iii. Professional Services

[358] Given the impairments and challenges that Ms. Ibrahimova has, I am satisfied that case management and mileage as proposed by Mr. Roovers in 2.1 and 2.2 are appropriate.

[359] While one would certainly hope for the best, the evidence indicates that Ms. Ibrahimova is likely to face physical, mental, and emotional challenges and crises which are likely to worsen over time. I am satisfied that she requires the intensive initial therapy recommended by Mr. Roovers, as well as ongoing treatment for life as he recommends in 2.4-2.7. I do, however, conclude that the claims in 2.8 and 2.9 for transition treatment are duplicative and/or excessive.

[360] For the same reasons, I find that Ms. Ibrahimova requires the rehabilitation therapy recommended by Mr. Roovers in 2.10-2.13.

iv. Medications

[361] I am satisfied that the medications listed in 3.1 to 3.11 are all related to Ms. Ibrahimova's injuries and are reasonable and necessary. The parties agree that Ms. Ibrahimova's annual cost for medication is $10,873 and that a government plan pays for all by $438.96 of this amount. I conclude that Ms. Ibrahimova is entitled to damages based upon the full cost of her medication. In this regard, I rely upon *Lurtz v. Duchesne*, [2005] O.J. No. 354 (C.A.) at para. 25, and *MacLean v. Wallace*, [1999] O.J. No. 3220 (S.C.).

v. Assistive Devices

[362] I agree that it is preferable to list and cost items as Mr. Roovers did, as opposed to stipulating a fund from which Ms. Ibrahimova can pick and prioritize items as Ms. Fleming did. The fund approach makes it difficult to determine if the total amount is sufficient to fund all that is reasonable and necessary.

[363] The same reasoning as set out in relation to medications leads me to conclude that ADP and ODSP benefits should not be taken into account.

[364] The dire prognosis faced by Ms. Ibrahimova leads me to conclude that most of the items recommended by Mr. Roovers are reasonable and necessary.

[365] Given Ms. Ibrahimova's condition and prognosis, I find that she requires the assistive devices as suggested by Mr. Roovers at 4.1, 4.3, 4.4, 4.8, 4.10 and 4.11. 4.8 footwear recognizes the extraordinary wear and tear that occurs. They all assist her in being out in the community. There will be many occasions in which 4.10, a manual wheelchair, will be more suitable than a larger, heavier power wheelchair.

[366] 4.12-4.35, 4.40-4.42, 4.44-4.47, 4.59-4.63, and 4.65 are mostly household items modified to meet Ms. Ibrahimova's needs. I agree they are reasonable and necessary, with the exception of 4.12, 4.17, 4.18, 4.24, and 4.25, which I regard as items most households would have.

[367] Ms. Ibrahimova's principal home leisure activity is gaming, and I agree that items 4.36-4.39 are reasonable and necessary to allow her to enjoy this activity. 4.43 is reasonable and necessary for safety.

[368] 4.48 stationary bicycle-elliptical trainer is reasonable and necessary to augment her exercise at a gym or for days she is not able to go to a gym.

[369] 4.49 earplugs are reasonable and necessary to allow Ms. Ibrahimova to rest and to focus on tasks without audible distractions.

[370] I agree that 4.50 power wheelchair will be reasonable and necessary in year eight, as recommended by Mr. Roovers. 4.51, 4.53 and 4.54 relate to the right leg prosthesis. I must, therefore, determine when that amputation is likely to occur. Dr. Sanders had advised that it be done around the same time as the left below knee amputation in October 2021. The plaintiffs were, however, opposed to proceeding. Dr. Sanders' report of February 25, 2025, as redacted pursuant to my order, indicates that Ms. Ibrahimova will eventually require the right below knee amputation, but does not indicate when. Ms. Ibrahimova is now 35 years old. The best I can do is make a rough and ready determination. If I assume a life expectancy to age 65, I would take the mid-point of that range, age 45, as when Ms. Ibrahimova would have the right below knee amputation.

[371] The plaintiffs also concede that 4.59, 4.61, and 4.66 are baby items that are no longer required. The plaintiffs also concede that 4.56, 4.57, and 4.58 are not extraordinary care expenses.

vi. Other Goods and Services

[372] I agree that given the nature and extent of Ms. Ibrahimova's injuries, she requires the 5.1 funding of $1,000 per year for life for social and recreational programs that will enhance her mental and physical health. I also agree that given her cognitive deficits, and the fact that English is not her first language, she requires the 5.2 $5,000 per year for financial management. The defence cites *Wilson v. Martinello*, (1995) 23 O.R. (3rd) 417 (Ont. C.A.), which held that a management fee to assist in investment was not required, as payments were predetermined and paid periodically by a life insurer. Our case is different. Ms. Ibrahimova will have a significant real estate asset. She will have to make decisions including how to fund different therapies and home repairs. She will also have to do tax planning and prepare and file tax returns.

vii. Transportation

[373] Ms. Ibrahimova will require a larger vehicle to accommodate transporting a power wheelchair and other assistive devices in year eight. She will also require modified controls after she has a below knee amputation on the right side. I accept as reasonable, Mr. Roovers' 6.1-6.3 recommendations. I accept 6.19 taxi expense as a proxy for mileage charges as proposed by the plaintiffs, which is less than claimed in Exhibit M.

viii. Vocational Assessment

[374] I agree with Mr. Roovers' 7.1 recommendation, as it is reasonable to assist Ms. Ibrahimova to obtain a vocation or avocation.

ix. Past Attendant *Care*

[375] Ms. Ibrahimova was in the hospital from May 7, 2019 to March 9, 2020. Mr. Gubenko claims that he provided 24/7 care during this period. He, therefore, claims compensation for 16 hours of attendant care per day, as his claim for lost income (presumably based on eight hours a day) has been agreed to.

[376] The position of the defendants is that Mr. Gubenko should not receive any compensation for the time Ms. Ibrahimova was in the hospital, citing *Matthews v. Hamilton Civic Hospital*, 2008 CanLII 52312 (Ont. S.C.):

> [187] Mr. Matthews lived for a total of 3788 days after his injury. For 670 of those days he was in the hospital due to infections and respiratory ailments associated with his condition. The plaintiffs' expert Dr. Wood acknowledged, the qualified hospital staff would not require the family's assistance in order to deliver appropriate care to Mr. Matthews. While I am satisfied that the family did provide some care to their father while he was in the hospital, I find that this was not reasonably necessary and it would have been provided by the hospital staff had the family members not chosen to not to do so.

[377] Given her cognitive and physical impairments and limited facility in English, it is difficult to conceive of a patient as needy and vulnerable as Ms. Ibrahimova. The medical records referred to in Schedule C to the plaintiffs' closing written submissions on damages demonstrate the extraordinary care and contribution by Mr. Gubenko during the period of hospitalization. I will provide only a few examples:

a) May 2019 – husband consistent presence at bedside, patient confused at times, husband quite involved in care;

b) June-July 2019 – husband at bedside, assists with transfers;

c) July 2019 – husband sleeps at bedside;

d) August 2019 – husband assists patient ambulating to washroom – husband is extremely vigilant, husband assists with majority of care and transfers;

e) September 2019 – spouse does most assistance with activities of daily living and transfers;

f) October 2019 – husband at bedside to assist with all care, husband doing dressing changes to feet;

g) November 2019 – husband took her to shower to wash her hair;

h) December 2019 – husband at bedside assisting with activities of daily living – husband instructed in how to do wound care;

i) January 2020 – spouse says prior to injury she could understand most basic English, but not verbalizing now;

j) February 2020 – husband provides additional care to her for many daily hours – husband stays 24/7 – husband will stay in London to be present for dialysis teaching; and

k) March 2020 – currently requires supervision with all functional mobility – always has someone with her when mobilizing – supervision on stairs.

[378] I am satisfied that *Matthews* is distinguishable. Mr. Gubenko made extraordinary efforts to meet Ms. Ibrahimova's needs. His availability to communicate with Ms. Ibrahimova in Ukrainian, and the hospital staff in English, was necessary and invaluable.

[379] I do, however, agree with the defence submissions that Mr. Gubenko is not entitled to be paid for time spent on his personal care and time spent on shared household tasks.

[380] The *Family Law Act* s. 61(2)(d) provides that Mr. Gubenko is entitled to a reasonable allowance for the value of nursing or other services that he provided to Ms. Ibrahimova. I find that a reasonable allowance for Mr. Gubenko would be $22 per hour, eight hours a day, from May 7, 2019 to March 9, 2020. I find the total amount reasonable, particularly when I factor in that Mr. Gubenko had the requisite facility in Ukrainian, and if the services had been provided by anyone else, it would have been extremely common for there to be premium rates for weekend/holiday work.

[381] With respect to March 10, 2020 to the present, Mr. Gubenko claims for eight hours a day of attendant care. I agree that the following excerpt from the plaintiffs' closing written submission fairly summarizes the evidence:

> 45. Upon discharge home in March 2020, Oleksii was tasked with completing personal care, housekeeping, case management, rehabilitation, transportation, mobility, wound care, and emotional support for his wife. He attended a two-week course to learn about Tamara's overnight hemodialysis. He managed her home dialysis for over 17 months until her kidney transplant occurred in July 2021. Tamara relied on Oleksii to be there overnight in case the machine malfunctioned.
>
> 46. Oleksii has taken Tamara to nearly all her outpatient appointments over the past six years. His presence is required to act as a translator and case manager due to her difficulties with language and comprehension. He missed countless days of work as a result and

> faced ridicule and turmoil from his coworkers and employer. He eventually changed careers to work as a construction labourer so that Tamara could live closer to her physicians in London.

[382] Mr. Gubenko made extraordinary efforts to assist Ms. Ibrahimova. I cannot, however, agree that he should, in effect, be compensated for every waking hour when he is not at work. I find that he should be compensated for five hours per day from March 10, 2020 to the present.

[383] These hours should be compensated at the rate of $22 per hour.

x. Future Attendant Care

[384] I do not agree that 24/7 attendant care, as recommended by Ms. Sellars, is reasonable or necessary.

[385] When Mr. Gubenko is working, Ms. Ibrahimova has been spending most of her time indoors. She has an extremely limited ability to care for Evelina, and her leisure activities are mostly reading and playing computer games. Her physical and, perhaps more importantly, her mental health would benefit by her spending time in the community. In my opinion, it is both reasonable and necessary for Ms. Ibrahimova to have eight hours of attendant care per day for life. This recognizes that Ms. Ibrahimova's needs will fluctuate over time. These hours should be compensated at the agency rate of $38 per hour, as it is unreasonable to think that Mr. Gubenko could provide this amount of care, or that he will always be available to provide such care.

xi. Household Modifications

[386] In *KY v. Bahler*, 2023 ABKB280, at paras. 3003-3005, the trial judge held that the defendants were not responsible for the entire cost of the plaintiff's future home. Rather, he found that the plaintiff would have likely lived in a 1200 square foot home had she not sustained injuries. Having accepted expert evidence that the plaintiff would require a

1500 square foot space due to her injuries, the defendants were responsible for the cost of the extra 300 square feet.

[387] The plaintiffs are both well educated, and both were hard working. They both had significant opportunities for advancement. They lived in a rural area and planned to have a family. I am satisfied that but for the injuries Ms. Ibrahimova suffered, they would have lived in a detached home. As such, I do not rely on the evidence concerning the possible purchase and modification of a condominium. The evidence establishes that Ms. Ibrahimova is extremely vulnerable and understandably anxious. That vulnerability will only increase as she ages and ultimately requires a below knee amputation.

[388] I am also satisfied that Ms. Ibrahimova, as a result of her injuries, requires a home with an extra room. This is based on the evidence that:

a) She would benefit from an area to exercise;

b) She requires an area to store items such as two wheelchairs and other assistive devices; and

c) Some additional space would no doubt be beneficial to her mental health, given that she spends a high percentage of her time indoors and that will likely increase over time.

[389] Jeffrey Baum gave expert evidence as to housing and the cost of necessary modifications. He graduated with an Honours Bachelor of Business Administration degree in 1984. In 1987 he founded a firm focused on consulting, design, and renovation of housing for persons with special needs. In the early 1990's, Lyndhurst Hospital, a rehabilitation centre, and Mount Sinai hospital designated his firm as a centre of expertise to provide reports in this area. He has been retained by both plaintiffs and defendants.

[390] Mr. Baum outlined features that Ms. Ibrahimova would require in a detached bungalow, such as a two-car garage, a primary and secondary exit with automatic door

operators and 36” wide doors, and an elevator to move from the garage up to the main floor and down to the basement, an ensuite bathroom, a zero-threshold shower, and rooms sized to allow her to move around the house in a wheelchair. All of his recommendations were reasonable, and I accept them. The mid-point of Mr. Baum’s cost estimate to renovate a bungalow to meet Ms. Ibrahimova’s needs is approximately $265,000.

[391] Mr. Borthwick, the defence expert on housing, was also well qualified. He qualified as a construction engineering technologist in the mid 1980s and founded Accessible Solutions Inc. in 1996. His company specializes in accessibility assessments and design accommodations for persons with disabilities. He has been retained by both plaintiffs and defendants.

[392] His opinion was that the cost to modify a detached residence to meet Ms. Ibrahimova’s needs would be in the range of approximately $139,000-$163,000. Most of the costs are not too far off Ms. Baum’s when you consider that Mr. Borthwick is recommending a stair lift that costs $5,000-$10,000, while Mr. Baum had recommended an elevator at a cost of $70,000-$80,000. Mr. Borthwick’s costing also did not include H.S.T., which Mr. Baum estimated at approximately $25,000-$30,000.

[393] Mr. Baum also testified that it was reasonable to assume that Ms. Ibrahimova would, as most people do, move at some point in the future. The same cost estimate in today’s dollars would apply to required modifications.

[394] Common sense and experience inform me that there is a very high probability that an individual will change residences multiple times in a lifetime. While I take into account that Ms. Ibrahimova, in a house modified at considerable expense, would be less likely to move than the average person, I find it probable that she will decide to move, and Mr. Baum’s suggestion that this would occur in 30-35 years is reasonable. Life circumstances change for many reasons, and this Court sees many family law cases in which parties have no alternative but to move.

[395] Mr. Baum pointed out that in his cost estimates Mr. Borthwick, who testified for the defence, did not include building permit, architectural technologist and project management fees, laundry appliances, and H.S.T.

[396] In cross-examination, Mr. Baum agreed that a lift costing $40,000-$50,000 would be appropriate if a house had only two levels, being a main floor and basement, instead of the elevator he recommended at a cost of $70,000-$80,000. He explained, however, that such a lift was not appropriate, as the elevator from the garage to the main floor constituted a third level. He also explained that building code requirements would not allow for a range from the garage to the main floor level.

[397] I prefer the evidence of Mr. Baum to that of Mr. Borthwick. I find that the elevator is the most appropriate solution for Ms. Ibrahimova, particularly given that the damage award is premised on her remaining in this house for on the order of 30 years. I, therefore, find that it is reasonable and necessary that Ms. Ibrahimova have:

a) A three-bedroom home at an incremental cost of $290,000.

b) Year one housing modifications in the amount of $265,000.

c) Year 30 housing modifications in an amount to pay for the same modifications that would have cost $265,000 in year one.

xii. Housekeeping – Home Maintenance

[398] I agree with Mr. Roovers' 10.1 recommendation which, in effect, compensates for Ms. Ibrahimova's contribution to normal housekeeping that she is no longer capable of. I do not find item 10.2 grocery delivery reasonable and necessary, as provision is made for Ms. Ibrahimova to spend some time in the community with an attendant, which would allow for grocery shopping. Ms. Fleming does not take issue with Mr. Roovers' recommendation of $1,484 for life for a handyperson, lawn and garden care, snow removal, and seasonal clean-up. She does, however, list that as a future consideration,

as Ms. Ibrahimova now lives in a condominium. I think it likely that Ms. Ibrahimova will move into a house in year one. As such, I find items 10.3-10.6 reasonable and necessary.

VII. CONCLUSION

[399] There are many heads of damages, and it is difficult to identify all of the findings that are required for the parties to proceed to stage two. I will, therefore, remain seized should the parties determine that there are any additional findings or clarifications required to proceed to stage two.

[400] I thank counsel for the professional and helpful manner in which they presented their cases.

_____

Sproat J.

Released: August 22, 2025

APPENDIX 'A'

[1] Mr. Sammon took the position that Dr. Talan could not give evidence as to how the U.S. standard of care compared to the Canadian or the Ontario standard of care, as it was not set out in his report. Ms. Legate took the position that Rule 53.03 only requires that the reasons for the medical opinion to be given.

[2] If the rule imposes a requirement that the expert report address the comparative standards of care, I would grant leave to allow Dr. Talan to testify in this regard. I do so because I see no prejudice to the defendants for the following reasons:

a) The defence knew it intended to object to Dr. Talan testifying to the standard of care, so had the opportunity to prepare to cross-examine on that, and to introduce defence evidence on the issue.

b) Both sides knew that various experts in this case relied upon U.S. standards and publications that support their position as to the standard of care.

c) As I will come to Dr. Booth, a defence expert on the standard of care, stated in her report that she regarded a U.S. publication as being authoritative and relied on by emergency physicians throughout North America.

d) Dr. Talan's CV contains a significant number of references to presentations in Canada and to the various Canadian journals and conferences that he has contributed to.

[3] I will now address the question of whether Dr. Talan should be permitted to testify as to the standard of care applicable in this case.

[4] The defendants cite *Grivicic v. Alberta Health Services*, 2017 ABCA 246, for the proposition that:

> [36] …the party hoping to use a foreign expert should produce evidence to the effect that the standards of care are the same or similar to those in Canada.

[5] The plaintiffs have another Ontario based emergency physician, Dr. Munkley, to testify as to the standard of care. The defendants have two experts as to standard of care. All of these experts are family physicians who obtained additional competence in emergency medicine through the College of Family Physicians of Canada ("the Canadian College").

[6] The Canadian College publishes a guide entitled "Preparing for the Examination of Added Competence in Emergency Medicine". It suggests two "general books" on emergency medicine, *Tintinalli's Emergency Medicine Manual*, which is a U.S. publication, and *Rosen's Emergency Medicine*, which Dr. Talan described as a U.S. publication with Canadian contributors.

[7] For exam preparation, there are four resources recommended by the Canadian College. One is co-authored by Dr. Tintinalli, and another is by Dr. Rivers and published by the Ohio American College of Emergency Physicians.

[8] Two journals are recommended by the Canadian College. The first being the Annals of Emergency Medicine. Dr. Talan was on the Editorial Board of that journal in 2002-2004 and has been an Associate Editor since 2004. That is a U.S. publication that has Canadian contributors.

[9] There are five "Online Resources" listed by the Canadian College, including the American College of Emergency Physicians, and "UpToDate" which is a U.S. organization which has contributors from outside the U.S.

[10] The Canadian College is, in effect, stating that for a physician to pass the examination required to be designated as having competence in emergency medicine,

she or he needs to apply the guidance offered by U.S. based emergency medicine publications.

[11] Dr. Booth, a defence expert on standard of care, stated in a December 13, 2024 letter:

> One final observation I wish to make is that Dr. Judith Tintinalli's "Emergency Medicine: A Comprehensive Study Guide" is a complete and highly regarded review text for emergency medicine. It is a "go to" reference for safe practice. I disagree with Dr. Munkley's statement that it is only a reference for undergraduate students. After twenty years as both an academic urban and rural emergency medicine physician, I see it used regularly by emergency physicians to guide sage and evidence based management across North America.

[12] There may be cases in which the standard of care is nuanced such that actual emergency department practice in rural Ontario would be helpful. This is, however, not such a case. The position of the plaintiffs is simple and straightforward, being that the standard of care of an emergency physician requires that the physician be able to diagnose pre-viability, pre-term premature rupture of the membranes (pPPROM), in which case, a referral to an obstetric specialist was required.

[13] Ms. Legate also cited Picard and Robertson, *Legal Liability of Doctors in Canada*, at p. 496:

> The mere fact that an expert practices in another jurisdiction does not in itself affect the admissibility or reliability of that witness's evidence. However, if the expert is not familiar with the available resources and the accepted practices in the defendant's community, this may diminish the weight which the court gives to the evidence.

[14] At the conclusion of the *voir dire,* I was satisfied that the United States standard of care was similar, if not identical, to the Canadian standard of care. That conclusion was supported by the evidence of various Canadian experts who testified at trial and who relied extensively upon United States publications as being authoritative as to the standard of care.