IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Hewer v. Cambridge,*
2025 BCSC 292

Date: 20250224
Docket: S185530
Registry: Vancouver

Between:

Douglas William Hewer

Plaintiff

And

Dr. Sean Liam Oscar Christopher Cambridge and Dr. John Doe

Defendants

Before: The Honourable Justice Wilson

Reasons for Judgment

The Plaintiff on his own behalf:	D.W. Hewer
Counsel for the Defendant, Dr. Sean Cambridge:	A. Turner M. Barber
Place and Date of Trial:	Vancouver, B.C. January 13 – 17, and 20, 2025
Place and Date of Judgment:	Vancouver, B.C. February 24, 2025

Introduction

[1] Mr. Douglas Hewer's claim against the defendant family physician, Dr. Sean Cambridge, is for medical malpractice.

[2] Mr. Hewer says that when he presented at Dr. Cambridge's office with a lump in his neck in March 2015, Dr. Cambridge should have sent him for a biopsy right away. Instead, Dr. Cambridge ordered ultrasounds and prescribed antibiotics before finally referring him to a surgeon. When Mr. Hewer finally had a biopsy some 13 months after his first report, he was found to have squamous cancer, and investigations through the BC Cancer Agency concluded that his cancer was at stage IV, which is an advanced stage.

[3] Mr. Hewer argues that had Dr. Cambridge sent him for a biopsy sooner, the cancer would not have spread, and he would not have needed to undertake such significant course of radiation and chemotherapy treatments. He had 35 radiation treatments and chemotherapy and had to use a feeding tube for a year. While in hospital he lost weight down to 85 pounds, 50 pounds less than his usual weight. He was only able to undergo two of the three planned chemotherapy treatments because he was vomiting constantly for two weeks after the second.

[4] Although the cancer in his neck has not returned, he says he has remaining symptoms from the treatment, including radiation fibrosis, loss of hearing, and lack of taste.

The parties

Mr. Douglas Hewer

[5] Mr. Hewer is presently 72 years-of-age and was 63 when he first went to see Dr. Cambridge with the lump on his neck. He was born in the Maritimes but grew up in Boston. He has lived in Chilliwack for the past several years, and has a 28-year-old daughter.

[6] Mr. Hewer has lived a varied and interesting life. He has lived in various parts of the world, including in the Himalayas for six years. He returned to Canada in the 1990's.

He has worked building motorcycles, as a music teacher, and a drug counsellor, and is interested in philosophy and a wide variety of other subjects. He was actively involved in the movement to legalize marijuana in Canada.

[7] In terms of medical history, he has experienced kidney issues including stones for many years. He contracted malaria while overseas and also had been diagnosed with Hepatitis C long before his cancer diagnosis that is the subject of this claim.

[8] Although the initial physical manifestation of his cancer was a lump in his neck, it was subsequently determined by his oncologists that the cancer had actually started at the back of his throat, known as oropharyngeal squamous cell carcinoma, and had metastasized to the lymph nodes in his neck. Although he had to undergo an aggressive course of radiation treatment supplemented by chemotherapy, the treatment was, fortunately, successful. He has had no recurrences.

[9] Unfortunately, he presently has bladder cancer, which is unrelated to his squamous cell carcinoma. He continues to undergo treatment for his bladder cancer.

[10] Although he previously had a lawyer, Mr. Hewer represented himself at the trial and did not want an adjournment to seek new counsel.

Dr. Sean Cambridge

[11] Dr. Cambridge was born in Guyana and received his medical training in South Africa. A South African medical degree is recognized in Canada and Dr. Cambridge was recruited to Canada, initially to work in Saskatchewan. He subsequently relocated to British Columbia. Once in Canada, a doctor from overseas such as Dr. Cambridge has five years to obtain his Licentiate of the Medical Council of Canada.

[12] The Licentiate, or LMCC, involves two examinations. The first examination, referred to as the LMCC1, must be taken within two years of licensing, and the LMCC2 must be completed within five years.

[13] Dr. Cambridge passed the LMCC1 exam on time, but was not able to complete the LMCC2 within the five-year deadline. The effect of having not completed the LMCC2

within time meant that he was no longer entitled to practice in British Columbia. At no time did he ever practice in the province without a license, however. Doctors from overseas are licensed during the five-year period by which they must complete the LMCC2.

[14] Dr. Cambridge has since returned to live in Guyana where he resides with his wife and family. Since he stopped practising in British Columbia, he completed the LMCC2 and therefore is now authorized to practice in Canada, even though he does not presently do so.

Legal principles of medical malpractice claims

[15] The general principles to be applied in a claim of medical negligence are no different than any other claim framed in negligence. In order to succeed, the plaintiff needs to establish: (a) that the defendant owed the plaintiff a duty of care; (b) that the defendant's conduct breached the applicable standard of care; (c) that the plaintiff sustained damage; and, (d) that the damage was caused, in fact and in law, by the defendant's breach: *Mustapha v. Culligan of Canada Ltd*., 2008 SCC 27 at para. 3.

[16] It is acknowledged that Dr. Cambridge owed a duty of care to Mr. Hewer.

[17] On the question of damages, there is also no doubt that Mr. Hewer underwent radiation treatment, accompanied by chemotherapy. While the treatment was by all accounts entirely successful, it was nonetheless an extremely unpleasant and uncomfortable experience, resulting in radiation fibrosis, diminished hearing, and a loss of his sense of taste. I accept that if Mr. Hewer's treatment regime could have been avoided, he would have a compensable loss.

[18] This case therefore turns on the second and fourth aspects of the test as set out in *Mustapha* above:

a) Did Dr. Cambridge's conduct breach the standard of care?

b) If yes, did Mr. Hewer suffer a loss caused by Dr. Cambridge's breach?

[19] Only if both questions are answered in the affirmative would the court need to assess Mr. Hewer's damages.

[20] For the reasons that follow, Mr. Hewer's claim is dismissed.

[21] I conclude that Mr. Hewer has not proven that Dr. Cambridge breached the standard of care when he prescribed antibiotics and ordered ultrasound imaging while monitoring the lump in Mr. Hewer's neck, as opposed to sending him for a biopsy straight away, as Mr. Hewer argues he should have done.

[22] Moreover, even if Mr. Hewer had been sent for a biopsy immediately, the course of treatment would have been no different because his cancer would already have been considered to be at stage IV. As such, he would not have avoided what was undoubtedly an extremely unpleasant and debilitating course of treatment that left him with residual consequences, even if he had received an earlier diagnosis.

Facts

[23] These are my findings of fact.

[24] The vast majority of the facts in this case are not disputed, and as will become apparent, the majority of the factual disputes are not critical or material to the outcome in this case.

[25] Mr. Hewer's first encounter with Dr. Cambridge occurred on March 20, 2013. Dr. Cambridge conducted what is referred to as a meet and greet. Mr. Hewer reported that he had fully recovered from Hepatitis C and had concerns about kidney stones. Dr. Cambridge was unwilling to accept Mr. Hewer as a patient, but agreed to see him for emergency issues. Dr. Cambridge ordered some blood tests, the results of which were normal.

[26] The following year, on June 23, 2014, Mr. Hewer went to see Dr. Cambridge reporting kidney pain and advising that he believed his Hepatitis C treatment had affected his kidneys. Dr. Cambridge ordered blood work, a urine test and a renal ultrasound. Mr. Hewer completed the blood and urine tests, and both were normal.

[27] Mr. Hewer returned to see Dr. Cambridge nine months later, on March 23, 2015. Mr. Hewer presented to Dr. Cambridge with a number of issues, including kidney stones. Material to this claim, he also complained of a swelling in his neck. Dr. Cambridge conducted a physical examination and determined that the swelling was mildly red, slightly inflamed, and was semi-hard on palpation. Dr. Cambridge recorded that Mr. Hewer also reported that he was tasting pus in his mouth. Based on Dr. Cambridge's physical examination, and Mr. Hewer's reported symptomology, Dr. Cambridge thought the swelling looked like an infection. He prescribed a course of antibiotics for seven days. He wanted to see Mr. Hewer in one week to reassess, and also ordered blood work to check on Mr. Hewer's kidneys.

[28] Mr. Hewer returned to the clinic on April 28, 2015. Dr. Sia-Venugopal, a locum, saw Mr. Hewer. He complained of a swollen gland and reported slight discomfort. Mr. Hewer reported that there had been no changes in size. Dr. Sia-Venugopal ordered an ultrasound of Mr. Hewer's neck, which was conducted on June 15, 2015.

[29] The ultrasound report from a radiologist indicated:

> . . . an enlarged lymph node measuring 44 x 19 x 20 mm. This is seen as a lobulated hypoechoic focus with a thin fatty hilum. There were adjacent couple of smaller similar lymph nodes/nodules seen measuring 18 x 15 mm and 22 x 10 mm. These may be reactive lymph nodes. The adjacent right submandibular as well as the right parotid gland were normal.

[30] The radiologist who reviewed the ultrasound also noted that the appearance of the lymph node was non-specific and may have been a reactive lymph node, which would require further workup if there was further enlargement or if Mr. Hewer had constitutional symptoms. A reactive lymph node in this context means that the lymph node is enlarged in response to, or as a reaction to, some other condition, such as an infection or cancer. Dr. Cambridge reviewed the ultrasound results with Mr. Hewer and gave him a further course of antibiotics.

[31] The fact that there were three enlarged lymph nodes found on the ultrasound of June 2015 will become significant when the issue of causation is discussed later in these reasons.

[32] Mr. Hewer returned to see Dr. Cambridge on July 9, 2015, for follow up. Dr. Cambridge conducted a physical examination and noted that the lymph nodes were not as warm, not as red, and seemed to be responding to treatment to the extent that they seemed smaller in size. Based on Dr. Cambridge's observation that Mr. Hewer was responsive to treatment, he extended the antibiotics for a further seven days. Dr. Cambridge's clinical note indicates that Mr. Hewer's lymph nodes had "significantly decreased". Mr. Hewer denies that he ever told Dr. Cambridge this, and he also denies that his lymph nodes ever decreased in size, let alone decreased significantly. At the same visit, Mr. Hewer expressed concern about parasites and malaria, and Dr. Cambridge referred him for blood and stool tests which were conducted later in July 2015.

[33] On August 5, 2015, Dr. Cambridge saw Mr. Hewer for follow-up regarding the blood and stool tests for parasites. Dr. Cambridge also checked Mr. Hewer's neck and noted that the swelling was still present. Even though the lymph nodes had not increased in size and Mr. Hewer had no constitutional symptoms, Dr. Cambridge decided that further investigation was warranted. He referred Mr. Hewer to be assessed by an ear, nose and throat (ENT) specialist, Dr. Kloppers. In the referral note, Dr. Cambridge indicated that Mr. Hewer presented with an enlarged right lymph node at the side of his neck and that the enlarged lymph node was both visible and palpable. Dr. Cambridge noted that the lymph node had remained for three to four months, despite showing some positive response to antibiotics.

[34] The referral was sent by fax on August 5, 2015, by Dr. Cambridge's medical office assistant, Jessica Sutherland (then Peters) who testified at the trial. On September 23, 2015, Dr. Kloppers's assistant called to advise that Dr. Kloppers was declining the referral and suggested that it would be better directed to Dr. Schwarz, a general surgeon practicing in Chilliwack. Ms. Sutherland redirected the referral to Dr. Schwarz on September 23, 2015.

[35] On November 25, 2015, Mr. Hewer had a second ultrasound of his neck. The report from the ultrasound radiologist indicated the following:

> Multiple mildly enlarged lymph nodes are again seen. The largest has a short axis diameter of 1.8 cm, previously 1.9 cm, likely within normal interobserver variability. The adjacent lymph nodes have short axis diameters of 1.4 and 1.0 cm, also similar to previous. The etiology of these lymph nodes is unknown, however, lack of growth since the previous exam favors a benign etiology, possibly reactive. Correlate clinically and recommend clinical follow-up.

[36] Dr. Cambridge met with Mr. Hewer on December 10, 2015, to review the results. According to Dr. Cambridge's clinical notes, "The patient is also [sic] indicated that it is significantly reduced in size to the point it is almost not noticeable". Again, Mr. Hewer denies that the lumps ever reduced in size and ever telling Dr. Cambridge this. Dr. Cambridge told Mr. Hewer that the ultrasound report from the radiologist suggested the lump in his neck was benign, and Dr. Cambridge recommended another ultrasound in three to six months.

[37] According to Mr. Hewer, he reattended for another appointment with Dr. Cambridge in late March or early April 2016, along with his friend Marjorie Murphy, to demand a biopsy. Dr. Cambridge's clinical notes do not include any appointments with Mr. Hewer after the December 10, 2015 appointment discussing the November 2015 ultrasound results with Mr. Hewer. Dr. Cambridge does not believe that Mr. Hewer ever returned in person to his clinic. This is another factual dispute that I will address below.

[38] On April 7, 2016, Ms. Sutherland resent the referral to Dr. Schwarz. Dr. Schwarz saw Mr. Hewer on April 27, 2016. Dr. Schwarz's consult report to Dr. Cambridge noted the mass had diminished in size, both by oral history and by ultrasound measurements, which suggested a benign etiology. However, because the mass was hard, Dr. Schwarz performed a biopsy and ordered a CT scan.

[39] The biopsy conducted by Dr. Schwarz on April 27, 2016, revealed squamous cell carcinoma. Dr. Schwarz advised that it was most certainly metastatic from an oropharyngeal source, and he referred Mr. Hewer to an ENT, Dr. Kloppers, to look for a primary source of the cancer. Dr. Schwarz also ordered a PET scan and referred Mr. Hewer to the BC Cancer Agency.

[40] Once Dr. Schwarz referred Mr. Hewer to the BC Cancer Agency for treatment following his diagnosis, Dr. Cambridge was no longer involved in Mr. Hewer's care, although he continued to receive copies of documents pertaining to his care.

Lay witnesses

[41] Mr. Hewer called three other witnesses in addition to himself: Ms. Majorie Murphy, Mr. Josh Fedoruk, and Ms. Jeanette Joynt.

[42] Ms. Murphy is a close friend of Mr. Hewer's. She was aware of the lump on Mr. Hewer's neck and became increasingly concerned because he had not been sent for a biopsy. She insisted on attending with Mr. Hewer at Dr. Cambridge's office in the spring of 2016 to demand that he get a biopsy.

[43] Ms. Murphy was of great assistance to Mr. Hewer as he went through his treatment regime and is familiar with the difficulties he experienced. She is aware of the effect the radiation and chemotherapy had on his health and she was concerned that he would not survive the treatment process. He had lost a significant amount of weight before he was finally given a feeding tube.

[44] Mr. Fedoruk had a lump on his neck and was referred by his dentist to an ENT specialist. He had surgery in 2022 that resolved his cancer issues entirely. The cancer was on his carotid gland.

[45] Ms. Joynt had an aunt who had throat cancer. She too was a patient of Dr. Cambridge. Her aunt went to the hospital and died a month later.

[46] The difficulty with this evidence, Mr. Fedoruk's good news story and Ms. Joynt's bad news story, is that neither assist the court in determining whether Dr. Cambridge's conduct fell below the required standard of care when dealing with Mr. Hewer. Mr. Fedoruk's cancer was of a different type than Mr. Hewer's, and I have no information at all about Ms. Joynt's aunt's cancer.

[47] The only other lay witness was Jessica Sutherland, who was previously a medical office assistant at Dr. Cambridge's office. Dr. Cambridge called her to testify.

[48] Ms. Sutherland's role as a medical office assistant included assisting in the administration of the doctor's office. Her role as it relates to this case was to make appointments with other service providers, send referrals and advise Mr. Hewer regarding upcoming appointments.

[49] Ms. Sutherland would record notes in the electronic medical chart. For example, there are entries made by Ms. Sutherland in which she would have advised Mr. Hewer of pending appointments for ultrasounds or other investigative procedures.

[50] Ms. Sutherland faxed the referral from Dr. Cambridge's office to the ENT, Dr. Kloppers. Ms. Sutherland received a telephone call from an assistant at Dr. Kloppers' office advising that Dr. Kloppers would not accept the referral and that he suggested Mr. Hewer be referred to Dr. Schwarz. As a result, Ms. Sutherland then redirected the referral to Dr. Schwarz. Her note indicates this was done on September 23, 2015.

[51] The referral was re-sent on April 7, 2016. Ms. Sutherland subsequently advised Mr. Hewer of his appointment with Dr. Schwarz.

Finding of disputed facts

[52] While most of the evidence in this case was not controversial, there are some factual disputes. I must therefore consider both the reliability and credibility of the witnesses.

[53] Credibility and reliability of witnesses are separate concepts. Credibility relates to honesty, whereas reliability relates to accuracy. A witness who is not credible on an issue cannot give reliable evidence on that issue; however, a credible witness may give unreliable evidence: *R. v. H.C.*, 2009 ONCA 56 at para. 41.

[54] In *Bradshaw v. Stenner,* 2010 BCSC 1398 at para. 186*,* this Court stated the following principles for evaluating the credibility of witnesses:

> Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides (*Raymond v. Bosanquet (Township)* (1919),

> 1919 CanLII 11 (SCC), 59 S.C.R. 452, 50 D.L.R. 560 (S.C.C.)). The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis*, [1926] 31 O.W.N. 202 (Ont.H.C.); *Faryna v. Chorny*, 1951 CanLII 252 (BC CA), [1952] 2 D.L.R. 354 (B.C.C.A.) [*Farnya*]; R. v. S.(R.D.), 1997 CanLII 324 (SCC), [1997] 3 S.C.R. 484 at para.128 (S.C.C.)). Ultimately, the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Faryna* at para. 356).

[55] The Court went on at para. 187 to set out an appropriate approach in order to determine whether to accept a witness' evidence:

> It has been suggested that a methodology to adopt is to first consider the testimony of a witness on a 'stand alone' basis, followed by an analysis of whether the witness' story is inherently believable. Then, if the witness testimony has survived relatively intact, the testimony should be evaluated based upon the consistency with other witnesses and with documentary evidence. The testimony of non-party, disinterested witnesses may provide a reliable yardstick for comparison. Finally, the court should determine which version of events is the most consistent with the "preponderance of probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions" (*Overseas Investments (1986) Ltd. v. Cornwall Developments Ltd.* (1993), 1993 CanLII 7140 (AB QB), 12 Alta. L.R. (3d) 298 at para. 13 (Alta. Q.B.)). I have found this approach useful.

[56] I accept that all of the witnesses at this trial testified to the best of their recollections, and that none of the witnesses made any attempts to mislead the Court. That said, there were certain aspects of the evidence where witnesses' versions of events either did not align or, alternatively, were specifically challenged by the other party.

[57] I conclude that Mr. Hewer gave his evidence as best he remembered, but that his recollection was at times faulty. Unsurprisingly, he was at times confused or mistaken about certain dates. For example, he was adamant during cross-examination that he had only undergone one PET scan while under the care of the BC Cancer Agency. It was apparent from the documents that there had in fact been two PET scans, and Mr. Hewer subsequently acknowledged that he was mistaken in his earlier testimony.

[58] Physicians often need to rely on their clinical records because they have no specific or independent recollection of events, especially when those events are relatively routine and happened a long time ago. In *Edmondson v. Payer*, 2011 BCSC 118, the Court discussed the purpose for which clinical records are admissible and affirmed that the *Evidence Act* makes clinical records "admissible to prove such things as a doctor's direct observations of the patient's medical condition, the results of tests performed or ordered by the doctor, and the medical advice given": at para. 26. At paras. 29 and 30, the Court said the following:

> [29] Portions of clinical records that report statements made by the plaintiff, including the plaintiff's description of symptoms, are therefore evidence of the fact the plaintiff made the recorded statements on those occasions. Where the recorded statements are inconsistent with the plaintiff's evidence at trial, they may be used in cross-examination to impeach the plaintiff's credibility.
>
> [30] Unlike prior inconsistent statements of an ordinary witness, which may only be used to impeach credibility, prior inconsistent statements of a party may also be treated as admissions and accepted for the truth of their content. However, there are important qualifications that apply to such statements in clinical records, whichever purpose they are being used for.

[59] I turn now to the factual disputes in this case.

[60] I will start with the notes in Dr. Cambridge's clinical records indicating a reduction in the size of Mr. Hewer's lymph nodes. Mr. Hewer disagreed with the notations in Dr. Cambridge's clinical records that indicated that the size of the lumps in his neck had diminished. He denied reporting that it was his belief that they had diminished, and he disagreed that he ever told Dr. Cambridge that they had diminished.

[61] The question of whether or not either Mr. Hewer or Dr. Cambridge subjectively believed that the lumps had shrunk is immaterial, because there were objective findings by way of the two ultrasound reports. The ultrasound of November 25, 2015, indicated no growth in size, consistent with a benign etiology. While it was the radiologist's view that the largest of the enlarged lymph nodes had a diameter of 1.8 mm, as opposed to 1.9 mm in the June ultrasound report, it was described by the radiologist in November as "likely within normal interobserver variability".

[62] Further, Dr. Schwarz's clinical note of April 27, 2016, states that Mr. Hewer "has had a right cervical mass since last spring. He says that it has become progressively smaller …", which corroborates that Mr. Hewer was informing his physicians that the growth had been decreasing in size. Regardless, the significant aspect of the evidence regarding the enlarged lymph nodes in Mr. Hewer's neck was not whether it was one-tenth of a millimetre smaller; rather, the key finding for the purposes of Mr. Hewer's ongoing treatment and management was that it had not grown larger.

[63] Mr. Hewer suggested that Dr. Cambridge had made changes to his clinical records after the fact with regard to the size of the lymph nodes. I reject this suggestion. Both Dr. Cambridge and Ms. Sutherland testified that it is not possible using the computerized records program to alter records, and that it would be apparent on the face of the record if this occurred. When a record is opened and entries are made, the name of the person entering the record and the date and time are automatically stamped onto the record.

[64] There are a couple of other factual disputes that arose. One was a clear contradiction in the evidence of the parties, namely whether Mr. Hewer reattended Dr. Cambridge's office in 2016. The other is the redirected referral to Dr. Schwarz.

[65] As for the former, Dr. Cambridge did not agree that Mr. Hewer ever attended at the clinic again after December 2015. He believes that there was no such attendance because he has no notes in his clinical records after December 12, 2015.

[66] By contrast, both Mr. Hewer and Ms. Murphy testified that Ms. Murphy attended with Mr. Hewer at Dr. Cambridge's office in order to demand a biopsy.

[67] I accept that Mr. Hewer attended at Dr. Cambridge's office with Ms. Murphy on or shortly before April 7, 2016. While both Dr. Cambridge and Ms. Sutherland seemed reluctant to countenance the possibility of an error in their records, no system is infallible. The three most likely possibilities to explain the lack of a note in the clinical records are as follows:

a) no notes were made of Mr. Hewer's appointment;

b) notes were made, but for some unknown reason they were recorded to an incorrect file; or

c) Mr. Hewer and Ms. Murphy went to Dr. Cambridge's office to demand action, even though he did not have an appointment.

[68] In all of the circumstances, I consider the latter to be the most likely.

[69] The second factual matter for which there is no obvious explanation is what became of the referral sent from Dr. Cambridge to Dr. Schwarz. According to Dr. Cambridge's office records, it was initially sent to Dr. Schwarz's office on September 23, 2015 and re-sent on April 7, 2016.

[70] However, Dr. Schwarz's consult note of April 27, 2016, addressed to Dr. Cambridge states the following in the opening paragraph:

> Thank you for asking me to see this very pleasant 64-year-old gentleman with a right neck mass. I see the consult was dated last August, but we received this just a couple of weeks ago.

[71] The wording of Dr. Schwarz's consult note would suggest that the first time Dr. Cambridge's office sent him the referral was in April 2016, and not in August or September 2015.

[72] Ms. Sutherland's evidence was that she sent the fax to Dr. Schwarz's office on September 23, 2015. Ms. Sutherland specifically noted in the office's electronic recordkeeping system, known as OSCAR, that Dr. Kloppers declined to see Mr. Hewer on September 23, 2015, that he recommended Dr. Schwarz, and that Ms. Sutherland redirected the referral to Dr. Schwarz on the same day. Ms. Sutherland explained that the office staff had an internal system of ensuring that faxes were actually transmitted. When a fax was sent, it was placed in a basket. The office fax machine generated transmission slips when faxes were sent, and the transmission slips would be paired with the outgoing faxes in the basket. If there was no transmission slip, the fax would be resent.

[73] It can be inferred from Dr. Schwarz's consult report that he did not see Mr. Hewer's referral until April 2016, even though the referral was dated August 2015, and according to Ms. Sutherland, was sent to Dr. Schwarz on September 23, 2015. The two possible explanations are that the referral was never actually sent from Dr. Cambridge's office even though Ms. Sutherland is confident that it had been, or that it was in fact sent to Dr. Schwarz's office but got lost or misplaced.

[74] I accept Ms. Sutherland's evidence of the usual practice, but again this does not ensure perfection. That said, and in the absence of any evidence from anyone at Dr. Schwarz's office, I accept Ms. Sutherland's evidence that the redirected referral was sent to Dr. Schwarz's office in September 2015.

[75] Ultimately, neither of these factual matters are critical to my decision. For reasons that I will explain later on the issue of causation, the uncontroverted evidence of Dr. Wu, Dr. Cambridge's oncologist, is that Mr. Hewer's cancer would have been classified as stage IV in June 2015, and therefore his treatment regimen would have been the same in June 2015 as it was in April 2016.

[76] As such, it would not have made a difference to Mr. Hewer’s treatment regimen whether or not Mr. Hewer attended at Dr. Cambridge’s office along with Ms. Murphy in March or April 2016, nor if the referral was first sent to Dr. Schwarz’s office in September 2015 as opposed to in April 2016.

Medical expert evidence

[77] Mr. Hewer did not tender any expert medical evidence.

[78] Dr. Cambridge called two medical experts, an oncologist Dr. Jonn Wu, and a general practitioner, Dr. Benjamin How.

Dr. Jonn Wu, radiation oncologist

[79] Dr. Wu is a physician and radiation oncologist at the BC Cancer Agency in Vancouver. Dr. Wu's qualifications and report were admitted without dispute. He is a clinical professor at the Faculty of Medicine at University of British Columbia, and

lectures in the faculties of Medicine and Dentistry. Dr. Wu's practice is focussed on tumours of the head and neck.

[80] Dr. Wu explained that cancer is a disease that occurs when some of the body's cells grow uncontrollably. The abnormal cells can cause damage to surrounding tissues and organs, including muscles, blood vessels and other parts of the body. Cancer cells can accumulate and become tumours.

[81] Mr. Hewer had squamous cell carcinoma, which Dr. Wu describes in his report as follows:

> Squamous cell carcinoma is a type of cancer that arises from squamous epithelial cells which cover the inside and outside of the surface of the neck and throat. Squamous cell carcinoma is the most common type of cancer in the throat.

[82] The word "epithelial" means pertaining to the skin.

[83] Squamous cell carcinomas can originate in any part of the body. Squamous cell carcinomas arising from the throat have a lower probability of spreading to other parts of the body, such as the lungs, liver or bone, then some other squamous cell carcinomas.

[84] Dr. Wu described the role of the BC Cancer Agency. The BC Cancer Agency is involved in treatment only once there has been a definitive diagnosis of cancer. A definitive diagnosis is generally obtained by way of biopsy. Once the cancer has been diagnosed, the cancer is staged, which is an assessment using a classification system that will be used to guide the management or treatment. It also serves to provide some idea of the patient's prognosis or of the aggressiveness of the cancer.

[85] Dr. Wu presented his evidence in a clear and concise manner. He was able to explain complex concepts in simple, understandable terms. He is very clearly highly skilled and qualified in his field.

[86] I accept Dr. Wu's evidence in its entirety.

Dr. Benjamin How, general practitioner

[87] Dr. Cambridge called Dr. How, family medicine physician, to opine on the standard of care for general practitioners.

[88] Dr. How has over 35 years of experience working as a family physician, providing care to a wide range of patients from infants to the very elderly. He previously provided obstetrical care and surgical assistance for 10 years. Dr. How is a member of the clinical faculty at the University of British Columbia and teaches first- and second- year medical students at his clinic. He is also an examiner for the Objective Structured Clinical Examination (OSCE) required of medical students at the end of each of their school year. Additionally, he is the medical advisor for an extended care nursing home and provides primary care for many of the residents.

[89] Dr. How explained that there are many potential causes for swelling in the neck, some serious and others less so. The serious causes include various cancers. According to Dr. How, the general practitioner must thoroughly assess the patient beginning with a physical examination. Further investigation would be based on the physical findings.

[90] Dr. How is a very experienced family physician who presented his evidence in clear and understandable terms.

[91] I also accept Dr. How's evidence in its entirety.

Standard of Care

[92] The law with respect to the standard of care of physicians is well settled. The Supreme Court of Canada outlined the test in *ter Neuzen v. Korn*, [1995] 3 S.C.R. 674, 1995 CanLII 72, at para. 33:

> [33] It is well settled that physicians have a duty to conduct their practice in accordance with the conduct of a prudent and diligent doctor in the same circumstances. In the case of a specialist, such as a gynaecologist and obstetrician, the doctor's behaviour must be assessed in light of the conduct of other ordinary specialists, who possess a reasonable level of knowledge, competence and skill expected of professionals in Canada, in that field. A specialist, such as the respondent, who holds himself out as possessing a

> special degree of skill and knowledge, must exercise the degree of skill of an average specialist in his field: see *Wilson v. Swanson*, 1956 CanLII 1 (SCC), [1956] S.C.R. 804, at p. 817, *Lapointe v. Hôpital Le Gardeur*, 1992 CanLII 119 (SCC), [1992] 1 S.C.R. 351, at p. 361, and *McCormick v. Marcotte*, 1971 CanLII 52 (SCC), [1972] S.C.R. 18.

[93] The standard of care involves consideration of a number of factors. In *Wilson v. Byrne*, 2004 CanLII 20532, 2004 CarswellOnt 2314 (S.C.J.), the Court identified three factors as informing what must be addressed in determining whether or not a physician has met the required standard:

> [19] Determining whether a doctor has met the standard of care of a "reasonable practitioner" requires consideration of: (i) the education, experience and qualifications of the doctor, (ii) the degree of risk involved in the procedure or treatment, and (iii) the equipment, facilities and other resources available: see Picard & Robertson, *Legal Liability of Doctors and Hospitals in Canada*, *supra* at 186.

[94] A doctor's education and qualifications are important because a specialist is expected to have a greater level of skill and knowledge than a generalist, such as a family physician: *ter Neuzen* at para. 33.

[95] The degree of risk associated with a procedure will inform the standard of care because the greater the risk, the higher the expectation will be that the doctor will endeavour to ensure that the risk be avoided.

Positions of the parties

[96] Mr. Hewer argues that Dr. Cambridge should have sent him for a biopsy when he first attended at Dr. Cambridge's office in March 2015, as opposed to getting prescriptions for antibiotics and referrals for ultrasounds. He says if Dr. Cambridge had referred him, his cancer would not have progressed to stage IV and as a result he would not have had to endure the treatment regime that followed in 2016 when he was finally diagnosed.

[97] Dr. Cambridge's position is that he met the standard of care required of him in his care of Mr. Hewer.

Discussion

[98] Mr. Hewer faced a significant challenge in this case because he did not have any expert medical evidence on the standard of care.

[99] The absence of expert evidence on behalf of Mr. Hewer is not necessarily fatal in a medical malpractice case because the breach by Dr. Cambridge may be so obvious that no expert evidence is needed. However, the challenge for the court in the absence of any evidence on the standard of care is while it may be a relatively straightforward matter for the court to entertain suggestions about what *could* have been done, it is much more difficult to reach conclusions about what *should* have been done. In the context of Mr. Hewer's cancer, one can always speculate with the benefit of hindsight about what could have been done to identify it sooner, but that is not the test. Physicians are not held to a standard of perfection.

[100] Turning now to the evidence I do have, Dr. How's report addressed the appropriate response by a general practitioner to Mr. Hewer's various presentations during Dr. Cambridge's care. I accept Dr. How's evidence in this regard.

[101] Dr. How agreed that the recommendation for an ultrasound on April 28, 2015, was appropriate. He also agreed that the fact the lump was no larger in size was consistent with it having reacted favourably to the antibiotics prescribed by Dr. Cambridge.

[102] Dr. How's opinion was that it was appropriate for Dr. Cambridge to refer Mr. Hewer to an otolaryngologist (often referred to as an ENT, or ear nose and throat doctor) in August 2015 because by that time, the swelling had been apparent for over three months. When the otolaryngologist declined the initial referral, a redirection of the referral to a surgeon was also appropriate. Family physicians do not generally perform biopsies in their offices.

[103] Dr. How agreed that when the November 25, 2015 ultrasound came back indicating that the lymph nodes had not grown, it was reassuring and consistent with a benign etiology. Therefore, continued follow-up in three to six months was appropriate.

[104] Dr. How agreed it was appropriate to resend the referral to the surgeon on April 7, 2016. Dr. How explained that wait times in British Columbia often far exceed six or seven months, and while such a situation is obviously unacceptable, it is the reality of practice in British Columbia when there is a chronic shortage of doctors. He described waiting for the response to referrals to be one of the frustrations of general practice.

[105] Although he was not tendered as an expert on the standard of care for general practitioners in British Columbia, Dr. Wu also confirmed that the standard protocol as it relates to a lymph node is to order imaging by way of an ultrasound. On the facts here, it would have been reassuring that the November ultrasound showed no more enlarged lymph nodes than the June ultrasound, those that were present were no larger, and the architecture remained the same. This would be consistent with a low suspicion, and Dr. Wu would not have thought it necessary to order a biopsy at that time.

[106] During cross-examination, Dr. Wu disagreed that Mr. Hewer ought to have been sent for a biopsy upon the initial presentation in March 2015. Dr. Wu in his teaching capacity is involved in education of general practitioners regarding throat cancers. One of the signs of a throat cancer may be a palpable lymph node in the neck. However, many people have swelling lymph nodes in the neck and most of the reasons people might have a palpable lymph node is benign, such as an infection arising from a dental cavity, mumps, and other infections. Dr. Wu said it is important to keep watch on the lymph node and if it remains the same size or gets bigger, it is appropriate to get an ultrasound. The ultrasound will give information about the quantity, size and the internal structure of the lump. If a lymph node is malignant, it loses its usual architecture.

[107] In this case, there were two ultrasounds, one in June and one in November 2015. The lymph nodes remained the same or were smaller, and there was a comment in the radiology report indicating that the lymph node retained its normal architecture. Dr. Wu said that although it warranted monitoring, the fact that it was not getting bigger and looked normal would not have led him to necessarily get a biopsy. Dr. Wu’s evidence was wholly consistent with Dr. How’s evidence.

[108] When asked on cross-examination, Dr. Wu confirmed Dr. How's evidence that patients often wait for many months to be seen by a specialist in British Columbia.

[109] There were many possible causes for the swelling in Mr. Hewer's neck, many of which are benign. I conclude it was appropriate for Dr. Cambridge to first assess and treat Mr. Hewer's neck swelling to determine if it was an infection. Because the swelling remained after the course of antibiotics, it was appropriate to obtain an ultrasound, which Dr. Cambridge's locum ordered. Of note, at no time throughout the relevant period did Mr. Hewer complain of any pain associated with the swelling in his neck, nor did he have any constitutional symptoms such as fever, loss of energy, sleep issues, or weight loss.

[110] Although the lymph nodes had not increased in size, which is consistent with a benign etiology, I accept that it was reasonable and appropriate for Dr. Cambridge to refer Mr. Hewer to an ENT specialist on August 5, 2015. The lymph nodes remained swollen and had not abated for three to four months, even though they were seemingly no larger.

[111] Because the ENT declined the referral, it was then appropriate for Dr. Cambridge to re-direct the referral to a general surgeon on September 23, 2015. The follow up ultrasound conducted in November 2015 indicated that the lymph nodes were smaller, or at least were no larger, than before. This again supported the view that the lymph nodes were likely benign, as indicated by the radiologist. In the result, it was appropriate for Dr. Cambridge to plan to repeat the ultrasound in three to six months to determine if there was any growth while Mr. Hewer was waiting for his appointment with the general surgeon.

[112] In all of the circumstances, Mr. Hewer has not proven that Dr. Cambridge did not meet the standard of care in his treatment and care of Mr. Hewer. Moreover, I accept Dr. How's opinions and I conclude that Dr. Cambridge did meet the required standard of care expected of a general practitioner in British Columbia when treating a patient with Mr. Hewer's presentations.

Causation

[113] If a defendant is found not to have met the required standard of care, that does not, in and of itself, make that defendant liable for a plaintiff's injuries. A plaintiff must also establish a causal link between the doctor's negligence and the injury. The 'but for' test applies in medical malpractice cases, no different than other claims in negligence.

[114] The majority of the Supreme Court of Canada explained this in *Benhaim v. St-Germain*, 2016 SCC 48:

> [54] In sum, the Court held in *Snell* that "the plaintiff in medical malpractice cases — as in any other case — assumes the burden of proving causation on a balance of the probabilities": *Ediger*, at para. 36. Causation need not be proven with scientific or medical certainty, however. Instead, courts should take a "robust and pragmatic" approach to the facts, and may draw inferences of causation on the basis of "common sense": *Snell*, at pp. 330-31; *Clements*, at paras. 10 and 38. The trier of fact may draw an inference of causation even without "positive or scientific proof", if the defendant does not lead sufficient evidence to the contrary. If the defendant does adduce evidence to the contrary, then, in weighing that evidence, the trier of fact may take into account the relative ability of each party to produce evidence: *Ediger*, at para. 36.

[115] The 'but for' test remains the law, but the court may draw inferences based on human experience and common sense. In *Clements v. Clements*, 2012 SCC 32, the Court found the trial judge made an error by requiring scientific accident reconstruction evidence to establish what occurred in a motorcycle collision. The Court stated as follows at paras. 8 and 9:

> [8] The test for showing causation is the "but for" test. The plaintiff must show on a balance of probabilities that "but for" the defendant's negligent act, the injury would not have occurred. Inherent in the phrase "but for" is the requirement that the defendant's negligence was *necessary* to bring about the injury — in other words that the injury would not have occurred without the defendant's negligence. This is a factual inquiry. If the plaintiff does not establish this on a balance of probabilities, having regard to all the evidence, her action against the defendant fails.
>
> [9] The "but for" causation test must be applied in a robust common sense fashion. There is no need for scientific evidence of the precise contribution the defendant's negligence made to the injury. See *Wilsher v. Essex Area Health Authority*, [1998] A.C. 1074 (H.L.), at p. 1090, per Lord Bridge; *Snell v. Farrell,* [1990] 2. S.C.R. 311.

[116] In *Benhaim*, the Supreme Court of Canada concluded that inferences can be drawn regarding causation fact-finding, which are no different than in other fact-finding situations. As such, the "but for" test remains, and there is no reverse onus situation created in medical malpractice cases on the issue of causation.

[117] From a practical perspective, the analysis may be as simple as considering whether Mr. Hewer's treatment would have been different had his cancer been discovered earlier.

Positions of the parties

[118] Mr. Hewer says that if his cancer had been discovered earlier, he would not have had to undergo the same treatment regime which involved 35 radiation treatments, supplemented by two rounds of chemotherapy.

[119] Dr. Cambridge argues that even if the court finds his initial diagnosis and treatment of Mr. Hewer's neck swelling and failure to refer Mr. Hewer to a general surgeon sooner was a breach of the standard of care, that failure did not cause Mr. Hewer any loss.

[120] Obviously, Dr. Cambridge did not cause Mr. Hewer's cancer. As such, the analysis involves an assessment as to what Mr. Hewer's diagnosis and treatment would have been, had Dr. Cambridge referred him to a general surgeon for a biopsy earlier.

Discussion

[121] Dr. Cambridge's oncology witness, Dr. Wu, described how a cancer is staged, using a classification system. The classification of a patient's cancer will determine the appropriate treatment and management.

[122] The classification system for cancers of the head and neck, which is an internationally accepted standard, incorporates three factors. The classification system utilizes the TNM staging categories, which incorporates tumour characteristics (T), lymph nodes affected (N), and distant metastasis (M). These factors are incorporated

into an overall cancer staging, which ranges from stage I, which is the earliest stage, to stage IV, which is the most advanced stage.

[123] In the case of Mr. Hewer, although he presented with a lump in the neck, it was subsequently determined that the cancer had actually started at the base of his tongue.

[124] Dr. Wu explained that the primary treatment modalities for cancer in the head and neck are surgery, radiation therapy, and sometimes chemotherapy. In the case of head or neck cancers, the chemotherapy is generally administered at the same time as the radiation treatments in order to enhance the effects of the radiation therapy.

[125] In his report, Dr. Wu explains that physicians will try to minimize the number of modalities that are used. For example, if radiation therapy is going to be required, they would not undertake a surgical procedure as well unless it was necessary.

[126] As indicated earlier, Mr. Hewer had his biopsy in April 2016 and received his definitive cancer diagnosis shortly thereafter. He started his cancer treatments in June 2016, through the BC Cancer Agency.

[127] In Dr. Wu's opinion, Mr. Hewer's treatment would not have been any different had he been diagnosed with cancer in September 2015, or indeed in June 2015. The reason for his opinion in this regard is that based on the ultrasound that was conducted in June 2015, and also the ultrasound of November 2015, there were three enlarged lymph nodes of varying sizes that he can presume to be metastatic lymph nodes. Because there were multiple lymph nodes, the staging of Mr. Hewer's cancer according to the American Joint Committee on cancer staging system was stage IV.

[128] There are three categories of an N2 score, and Mr. Hewer's was an N2b, which is defined as metastasis in multiple lymph nodes, but none more than 6 cm at the greatest dimension. Dr. Wu stated the following in his report at page 13:

> If Mr. Hewer was seen by a surgeon in September 2015, diagnosed with cancer but the primary tumour was too small to be found (ie. Primary unknown), our standard of care at the BC Cancer Agency would have recommended chemotherapy and radiation due to the presence of multiple malignant lymph

> nodes (nodal stage cN2b). This was the same treatment that Mr. Hewer received in 2016.
>
> In summary, if Mr. Hewer was diagnosed and assessed by a surgeon or ENT specialist earlier than April 2016, we would have recommended the same treatment program ie. 7 weeks of daily radiation together with chemotherapy.

[129] Finally, Dr. Wu explained that there are various dosages of the radiation, with a high dose directed at a known tumour and a medium dose at areas that are suspicious. However, with cancer of the tongue, a low dose of radiation is generally applied to the entire neck area because experience shows that cancer that originates at the base of the tongue will normally spread to both sides. It may be too small to see on both sides, but even an area that does not have any visible signs of cancer will be treated with low-dose radiation.

[130] Dr. Wu's opinion was that even as of the June 2015 ultrasound, if it were known that the lymph nodes were malignant as opposed to benign, it would have been assessed as a stage IV cancer.

[131] It follows that Mr. Hewer's treatment regimen would have been the same had he been diagnosed in June 2015 (or indeed at any time later during 2015) as he subsequently endured commencing in June 2016.

Conclusion

[132] Mr. Hewer has failed to establish that Dr. Cambridge's conduct breached the standard of care of a general practitioner in British Columbia when treating Mr. Hewer or that he suffered a loss caused by Dr. Cambridge's treatment, either of which is fatal to Mr. Hewer's claim of medical malpractice.

[133] The evidence shows that a reasonable practitioner in Dr. Cambridge's situation would not have found it necessary to send Mr. Hewer for a biopsy immediately, and even if Dr. Cambridge had done so, Mr. Hewer would not have received different treatment for the cancer.

Disposition

[134] It follows from the above that Mr. Hewer's claim is dismissed.

"Wilson J."