COURT OF APPEAL FOR ONTARIO

CITATION: Shaw Estate v. Handler, 2025 ONCA 868
DATE: 20251216
DOCKET: COA-24-CV-0072

van Rensburg, Sossin and Gomery JJ.A.

BETWEEN

Merton Thompson, as litigation administrator for the Estate of Elisha Shaw, deceased, Merton Thompson, personally, and Ky-Mani-Joel James Thompson, Blessed-Zi'onna Eva Thompson, Nehemiah-Joseph Peter Thomson and King-Johiah Thompson, minors by their litigation guardian, Merton Thompson

Plaintiffs (Respondents)

and

Dr. Jeffrey Handler*, Dr. Mary Patricia Fitzgerald, Dr. Jonathan Singer-Jordan, Dr. Kalkidan Belay, Dr. John Doe and William Osler Health System

Defendants (Appellant*)

Jaan Lilles, Adam Davis and Liza Leshchynska, for the appellant

Christopher I.R. Morrison, Paul J. Cahill and Hudson Chalmers, for the respondents

Heard: May 12, 2025

On appeal from the judgment of Justice William M. LeMay of the Superior Court of Justice, dated December 7, 2023, with reasons reported at 2023 ONSC 5042.

van Rensburg J.A.:

Overview

[1] This is an appeal from a judgment in a delayed diagnosis medical malpractice case that proceeded to trial against one defendant, the appellant, on the issues of liability and damages. The appeal concerns only the trial judge's determination with respect to liability.

[2] The case arises out of the death of Elisha Shaw, a 34-year-old woman. Following bariatric surgery in 2012, Ms. Shaw had a history of abdominal pain and nausea. On November 16, 2015, she went to the emergency department of the Brampton Civic Hospital (the "Hospital")[1] shortly before midnight, complaining of severe abdominal pain.

[3] The appellant, who was the treating emergency room physician, discharged Ms. Shaw the morning of November 17, approximately seven hours after her arrival at the Hospital, having received a report from the on-call radiologist that her abdominal CT scan was essentially normal and concluding her pain had decreased. The appellant recommended that Ms. Shaw obtain an expedited appointment with her bariatric surgeon.

[4] Shortly after Ms. Shaw's discharge, the appellant was contacted by a Hospital radiologist, whose duties included reviewing overnight CT scans to ensure

[1] The Brampton Civic Hospital is part of the William Osler Health System, a defendant in the proceeding.

that written reports were filed. She reported that the CT scan showed an impression of twisting of mesenteric vessels (blood vessels in the abdomen), which can be consistent with a post-operative hernia. The appellant did not take any steps to contact Ms. Shaw or to have her return to the Hospital after receiving this information.

[5] In the late morning of November 18, Ms. Shaw returned to the Hospital by ambulance due to ongoing pain. She was referred for a surgical consultation, which was completed at around 5:00 p.m., and operated on by a general surgeon at 9:00 p.m. The surgery identified that Ms. Shaw's bowel was both herniated and showed signs of ischemia (inadequate blood supply), which later led to necrosis (tissue death). Efforts to repair the damage failed, and Ms. Shaw unfortunately passed away on November 25, 2015.

[6] The trial judge concluded that the appellant's decision to discharge Ms. Shaw from the Hospital the morning of November 17 was not negligent, but that the standard of care was breached when the appellant failed to call Ms. Shaw back to the Hospital for a surgical consultation after receiving the updated CT scan results. The trial judge rejected the appellant's evidence that Ms. Shaw's pain level had improved by the time of her discharge and that the information received from the second radiologist suggested a low probability of a hernia. The trial judge concluded that the appellant's breach of the standard of care was a cause of Ms. Shaw's death.

[7] The appellant asserts that the trial judge erred both by choosing and relying on a standard of care that was not articulated by any of the experts and was not available on the evidence at trial, and by failing to make necessary and sufficient factual findings to establish causation, in particular with respect to the timing of the necrosis of Ms. Shaw's bowel and when the surgery that should have occurred would have taken place.

[8] The appellant asks that this court allow the appeal and dismiss the action, as he claims the respondents failed to meet their burden at trial to adduce sufficient evidence to prove their claim. In the alternative, he seeks a new trial.

[9] For the reasons that follow, I would dismiss the appeal. As I will explain, the appellant has not established that the trial judge made any reversible error in respect of the issues of standard of care or causation. The trial judge's approach and reasoning were analytically sound, and his findings were fully supported by the evidence.

Facts

[10] In 2012, Ms. Shaw underwent bariatric surgery. A known risk of such surgery is subsequent shifting and tangling of the shortened intestines in the abdominal cavity. In the years after the surgery, Ms. Shaw had ongoing gastric pain that waxed and waned, and in the months prior to her attendance at the Hospital in November 2015, she had regularly been taking opioids prescribed by her bariatric

surgeon. In July 2014, a CT scan suggested that Ms. Shaw might have an internal hernia, based on twisting of the mesenteric vessels and distension of the bowels. She was scheduled for a diagnostic laparoscopy (the insertion of a camera into the abdomen) in August 2014, but this never took place.[2]

[11] On November 16, 2015, Ms. Shaw was taken by her husband to the Hospital emergency department at around 11:30 p.m. She was complaining of abdominal pain she described as “10/10 on the pain scale.” The appellant, whose shift as the on-duty emergency room physician began at midnight, examined Ms. Shaw and ordered blood work and an abdominal CT scan. The blood work did not raise any urgent issues. Dr. Jonathan Singer-Jordan, the on-call radiologist, reviewed the CT scan, and at around 4:00 a.m., he verbally reported to the appellant that, other than showing an ovarian cyst, the CT scan was normal.

[12] The amount of pain Ms. Shaw was in while she was in the emergency department and at the time of her discharge was described by the trial judge as a “contentious and significant issue” at trial. The trial judge found that, throughout the course of Ms. Shaw’s attendance at the Hospital, she complained of significant pain, consistently reporting that it was at a level of “10/10”. By 12:20 a.m., the appellant had ordered Gravol and morphine for Ms. Shaw’s nausea and pain, and she received additional doses of morphine and other painkillers throughout the

[2] There was no suggestion that the appellant was aware of the earlier investigation and recommendation at the time he provided care to Ms. Shaw, nor is this evidence relevant to the appeal.

night. Ms. Shaw was reported as sleeping at 4:00 a.m., but by 4:45 she was awake and once again in severe pain. These findings are not disputed on appeal.

[13] The appellant discharged Ms. Shaw from the Hospital at approximately 7:10 a.m. on November 17, with the recommendation that she seek an expedited referral to her bariatric surgeon. (Later that day Ms. Shaw scheduled an appointment with her bariatric surgeon for the following week.)

[14] Within one hour of Ms. Shaw's discharge, the appellant was contacted by radiologist Dr. Mary Patricia Fitzgerald, whose duties included reviewing overnight CT scans at the Hospital and ensuring that written reports of the radiological findings had been prepared. Not finding a written report for Ms. Shaw's abdominal CT scan, Dr. Fitzgerald reviewed it and contacted the appellant. Dr. Fitzgerald testified at trial that she wanted to ensure that the appellant had received a readout of the CT scan and that he was aware that the scan showed twisting blood vessels in Ms. Shaw's middle abdominal region. This is a finding that can be consistent with mesenteric post-operative hernias, a complication that may arise from gastric bypass surgery. The appellant testified that, while he did not recall the details of this conversation, he understood from Dr. Fitzgerald that there were no acute findings on the CT scan and that "the likelihood of a hernia [was] low." Ms. Shaw was not contacted by the appellant or anyone at the Hospital.

[15] Ms. Shaw spent the remainder of November 17 at home, but by the next morning her pain was so severe that she returned to the Hospital by ambulance. She was promptly examined and referred for a surgical consultation, which was completed by general surgeon Dr. Kalkidan Belay around 5:00 p.m. Dr. Belay operated on Ms. Shaw around 9:00 p.m. With respect to the delay between the surgical consultation and the surgery, the trial judge noted that "[t]here were some issues on the timing of the surgery because Ms. Shaw needed to be stabilized before she could be operated on."[3] Dr. Belay initially planned to conduct only a laparoscopic examination. When he observed that Ms. Shaw had a herniated bowel with signs of ischemia during this examination, however, he performed a laparotomy to untwist her bowel.[4] After a remote consultation with an on-call bariatric surgeon at Humber River Regional Hospital, Dr. Belay decided to see if Ms. Shaw's bowel would regain blood circulation before conducting a follow-up surgery, which was scheduled for 24 hours later.

[16] The morning of November 19, Ms. Shaw's abdominal pressure was increasing, and a decision was made to urgently take her back to the operating room. Surgical exploration uncovered signs of necrosis on parts of Ms. Shaw's

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[3] While the appellant asserts that there was no evidence of this being the reason for the delay, the trial judge's observation is consistent with the testimony of Dr. Holliday that this was a possible cause of the delay.

[4] As the trial judge explained at para. 27 of his reasons, "[a] laparoscopy is the insertion of a camera into the abdomen to determine whether there are issues. It is less invasive than a laparotomy, which is a full incision into the abdomen that allows for repairs to significant problems that exist in the abdomen, including problems with the small bowel."

small bowel. A resection of her small bowel was performed to try to repair the damage, and she was then transferred to Humber River Regional Hospital. Ms. Shaw's condition continued to deteriorate, with the necrosis being identified in other parts of her digestive system. A final surgery was performed at the second hospital on November 22 to try to remove this damage, but it was unsuccessful. Ms. Shaw's condition continued to deteriorate, and she died on November 25, 2015.

The Proceedings Below

[17] Merton Thompson, Ms. Shaw's husband, brought an action in negligence in the Superior Court on behalf of himself, Ms. Shaw's estate, and their four children, against the doctors who treated Ms. Shaw and the William Osler Health System.

[18] The only claims that proceeded at the trial were against the appellant. It was conceded that the appellant owed a duty of care to Ms. Shaw and that she had suffered an injury while in his care. Accordingly, the live issues for determination at trial respecting liability were standard of care and causation. These issues required the trial judge to consider extensive and competing expert evidence.

(1) The Expert Evidence

[19] The trial judge admitted the opinion evidence of each of the parties' expert witnesses, but he limited the issues on which some experts could testify.

[20] The trial judge qualified Dr. Singer-Jordan and Dr. Fitzgerald without objection as participant experts in the care of Ms. Shaw with respect to diagnostic radiology.

[21] Dr. Amit Shah was qualified, without objection from the plaintiffs, as an expert on the standard of care of an emergency physician practising in Ontario in 2015. The plaintiffs' standard of care expert, Dr. Alan Drummond, was permitted to testify about the standard of care of an emergency room physician, including the knowledge that an emergency physician should have had about Ms. Shaw's condition. Dr. Drummond was also qualified to give general evidence on causation, including, for example, testifying that "bad outcomes" might flow from a misdiagnosis or non-diagnosis.

[22] The trial judge qualified the plaintiffs' causation expert, Dr. Ron Holliday, despite the appellant's objections, as well as the defence causation expert, Dr. Timothy Jackson. Both were qualified as experts in the area of general surgery, specifically regarding the involvement of a general surgeon in the care and treatment of a patient in the emergency room in 2015 and the impact of any delay in the treatment of Ms. Shaw's abdominal pain in 2015. Although both had also offered opinions on standard of care in their written reports, this evidence was not admitted.

[23] On appeal, the appellant does not suggest that there was any reversible error in the admissibility and permitted scope of expert testimony, as determined by the trial judge.

(2) Findings on the Standard of Care

[24] The trial judge found that the appellant had breached the standard of care he owed to Ms. Shaw.

[25] The respondents' standard of care expert, Dr. Drummond, testified that, while the appellant met the standard of care for most of the time Ms. Shaw was under his care (in that he understood the risks of her bariatric surgery and had ordered appropriate tests), he breached the standard of care in two respects: first, by discharging Ms. Shaw from the Hospital the morning of November 17, even though her pain was not controlled; and second, by failing to pursue further steps, such as contacting Ms. Shaw, after Dr. Fitzgerald informed him about the concerning CT scan results.

[26] The appellant's standard of care expert, Dr. Shah, disagreed. In his view, it was not unusual for an emergency room patient to be discharged home for observation. He considered continued observation at the Hospital to be unnecessary because all the required tests had been performed and Ms. Shaw's symptoms had decreased by the time she was discharged. Dr. Shah testified that nothing indicated that Ms. Shaw's problems were acute and that the appellant's

recommendation that Ms. Shaw see her bariatric surgeon promptly was appropriate. He also expressed the opinion that there was no need to call Ms. Shaw back to the Hospital, as she had been referred to her bariatric surgeon for follow-up.

[27] The trial judge noted that the expert witnesses based their opinions on different starting assumptions with respect to Ms. Shaw's condition at the time of her discharge. Dr. Shah assumed that Ms. Shaw's pain had decreased when the appellant discharged her, however the trial judge found as a fact that Ms. Shaw was still experiencing significant pain and that her condition had not improved in any meaningful way from the time of her admission to the Hospital. The trial judge accepted Dr. Shah's evidence that it is common for doctors to send patients home, even if they are experiencing pain and have not received a clear diagnosis, as a statement of how an emergency room doctor might generally perform their job. However, he accepted Dr. Drummond's opinion that applied to the specific facts of the case, "that patients with undifferentiated abdominal pain are not usually sent home if they have a history of bariatric surgery, especially when they have a CT scan that suggests that there might be a hernia."

[28] When the appellant discharged Ms. Shaw, he was not aware of any abnormalities in the results of her CT scan, and he reasonably believed the results of the scan were normal. At that point, the decision to discharge Ms. Shaw was, in

the trial judge's view, one that "might very well be a matter of judgment … instead of being a breach of the standard of care."

[29] Where the trial judge took issue with the appellant's care of Ms. Shaw was in relation to his actions after he was contacted by Dr. Fitzgerald and told that the CT scan showed signs of a hernia. It was then that the appellant became aware that Ms. Shaw had both abdominal pain and a CT scan that might support a diagnosis of an internal hernia. Particularly in light of her history of bariatric surgery, this meant there was a real likelihood of a hernia. The trial judge held that at that point the appellant "ought to have called Ms. Shaw back to the hospital and referred her to one of the surgeons on duty for an emergency consultation." He concluded that the failure to do so was not a mere matter of judgment, that the appellant was mistaken in his view that Ms. Shaw's symptoms had improved, and that he had either missed or ignored the fact that Ms. Shaw's pain was radiating into her back.

[30] The trial judge noted that the appellant had worsened matters by "brushing off" the call from Dr. Fitzgerald outlining that Ms. Shaw had another one of the symptoms indicative of a hernia; the appellant testified that Dr. Fitzgerald gave the impression that there was nothing acute on the CT scan and communicated that the likelihood of a hernia was low. The trial judge concluded that when the appellant received the report on the CT scan from Dr. Fitzgerald, it was incumbent on him to contact Ms. Shaw and have her return to the emergency department and

to refer her case to an on-call surgeon for an immediate consultation. The appellant's failure to take any steps to contact Ms. Shaw was a breach of the standard of care.

(3) Findings on Causation

[31] After finding a breach of the standard of care, the trial judge turned to the issue of causation. He noted that the appellant would only be liable if causation was established on a "but for" basis: on a balance of probabilities, would Ms. Shaw's death have been avoided if the appellant had met the standard of care? According to the trial judge, in order to decide this issue he needed to determine (a) what was the cause of Ms. Shaw's death; (b) what would have occurred if the appellant had acted in accordance with the standard of care; and (c) based on what would have occurred, whether it was more likely than not that Ms. Shaw would not have died.[5]

[32] The trial judge noted that this was a case where the factual cause of death was clear, and relatively undisputed: Ms. Shaw's death after developing complications following the removal of necrosis in her bowels flowed from the herniated intestines and ischemia. The trial judge identified as the "more significant question" whether the hernia developed before Ms. Shaw's discharge from the

[5] The trial judge noted that the parties agreed that these were the questions he needed to ask in conducting his causation analysis, and a review of the oral submissions at trial confirms this was the case.

Hospital on November 17, and whether undergoing surgery on that day would have led to a different outcome.

[33] A key point of disagreement between the two causation experts was whether, if Ms. Shaw had been called back for a surgical consultation on November 17, the surgical examination would have taken place earlier. It was Dr. Holliday's opinion that Ms. Shaw would have been scheduled for a laparoscopic exploration within hours of the consultation taking place and that the hernia would have been discovered. It could then have been repaired, with few, if any, long-lasting problems for Ms. Shaw. By contrast, Dr. Jackson was of the opinion that a surgeon would have supported the appellant's plan to refer Ms. Shaw to her bariatric surgeon: even with the concerning CT scan results, it would have been preferable for a specialist to perform the laparoscopic exploration.

[34] The trial judge concluded that a surgical consultation on November 17 would have led to a laparoscopic exploration later that day. He based that conclusion in part on medical literature relied on by the experts that suggested that there was a low bar for ordering a surgical exploration in patients who had previously undergone bariatric surgery, precisely because of the high risk of developing herniated bowels. He accepted that, if Ms. Shaw had returned to the Hospital, an emergency room surgeon would have reviewed her chart and CT scan, and as Dr. Belay did the following day, the surgeon would have concluded a laparoscopic exploration was necessary. While it might have been preferable, in an ideal world,

for a specialized bariatric surgeon to perform the operation, there were clear signs that Ms. Shaw's symptoms were part of "an evolving and urgent situation". These signs were concerning enough that a laparoscopic investigation would have occurred on November 17 if Ms. Shaw had been called back in for a surgical consultation.

[35] The trial judge acknowledged that Ms. Shaw's condition was significantly worse by the morning of November 18. Nonetheless, he rejected the idea that there were two separate events across the two days. Instead, he found that the herniating of Ms. Shaw's bowels was already present on November 17 and had progressively worsened across that period. He concluded that a laparoscopic investigation would have confirmed its presence, and it could have been operated on.

[36] Finally, the trial judge concluded that, had Ms. Shaw undergone surgery on November 17, she would have been likely to fully recover. In his view, during November 17, there was no necrosis in Ms. Shaw's bowels, and they were healthy enough that no necrosis would have developed. A timely intervention would have reversed her condition without long-term complications or the need for more invasive surgeries. He concluded that, but for the appellant's negligence in not following up with Ms. Shaw, she would not have died.

[37] The appellant was found liable for negligence causing Ms. Shaw's death, and the respondents were awarded $1,640,026.67 in damages and $675,000 in costs.

Issues

[38] The appellant raises two issues on appeal. He asserts that:

1. The trial judge erred in his articulation of the standard of care and identified a standard of care that was unsupported by the evidence at trial; and
2. The trial judge erred in his causation analysis by failing to make the necessary factual findings to determine whether Ms. Shaw would have lived, had the appellant met the standard of care.

Analysis

(1) The Trial Judge Did Not Err in His Standard of Care Analysis

[39] In a medical malpractice case where standard of care is at issue, the court must determine "what a reasonable physician would have done (or not done) in order to meet the standard of care": *Levac v. James*, 2023 ONCA 73, 89 C.C.L.T. (4th) 27, at para. 48. Given the complexity of medical malpractice cases, expert evidence plays an essential role in establishing the standard of care, breach of the standard of care and causation: *Liu v. Wong*, 2016 ONCA 366, at para. 14, leave to appeal refused, [2016] S.C.C.A. No. 264.

[40] The appellant's primary argument on the standard of care ground of appeal is that the trial judge reached a conclusion that was unavailable on the evidence when he found that "[the appellant] ought to have called Ms. Shaw back to the Hospital and referred her to one of the surgeons on duty for an emergency consultation." He argues that this conclusion was not supported by the evidence of the respondents' expert witness, Dr. Drummond.

[41] The appellant's counsel points to Dr. Drummond's response during his examination in chief to the question, "What would the standard of care require [after the appellant received the phone call from the second radiologist]?" The appellant contends that, based on this evidence, it was Dr. Drummond's opinion that it would have been sufficient to meet the standard of care if he had simply called Ms. Shaw to see how she was doing, and that it was not in fact Dr. Drummond's opinion that Ms. Shaw would have had to have been brought back to the Hospital for a surgical consultation.

[42] The exchange (which I have underlined) appears in the following passage from Dr. Drummond's evidence:

> Q. The other piece of this is the phone call from the radiologist. And in your opinion after receiving that phone call did Dr. Handler meet the standard of care?
>
> A. Right. So, that was concerning to me because I – again, I think it's an unusual thing to hear from a radiologist to say I'm calling specifically to alert you to a finding, which in the clinical context [may be] important in your deliberations. And, yeah, there's no obstruction,

yeah, there's no obvious evidence of ischemic bowel at that point, but there is this finding that was missed by Dr. Singer-Jordan about the twirling of the mesentery vessels, and that is a bit of a sensitive sign of a potential for an internal hernia. Does that fit your patient? And it was kind of – I don't know it's hard to read just from the clinical note or from the discovery evidence, but it sounds like that was just kind of brushed off, like the patient's left and she's fine, and you know, no, I'm not going to do anything about it.

Q. And did that response by Dr. Handler meet the standard of care?

A. No. Again, I think if the radiologist calls with a very specific concern and which he – it was to alert, to alert him to a potentially significant finding, then it would be kind of ridiculous to ignore this new information in light of what he's just experienced.

Q. What would the standard of care require in that situation?

A. Well, I think a call back to the patient really. And it doesn't have to be him. I mean I know he's going off shift. I assume like me he's probably tired after, after a 12-hour shift. You know, so it's like, tell the nurse, I've got this information, I've sent this patient home. You know, looking back in retrospect, she may be an internal hernia, you know pain out of proportion to the physical findings, high risk by virtue of previous gastric bypass. Yeah, she's got a normal initial CT scan, but now we've got this new information provided to us that it may be an internal hernia. How about a phone call? How are you doing? You know, are you doing great? Well, okay great, but if you're doing poorly, well then you best come back and we will get a surgeon to see you to make sure that you don't have an internal hernia.

Q. So, you mentioned involving a surgeon in her care just now. Can you explain a little bit more about how that would – how the standard of care would have applied to involve a surgeon in this case?

> A. Well, it's a surgical disease which requires a surgical solution. I mean there's nothing an emergency physician is going to do really. And, you know, they are probably the best people – certainly probably more aware than the emergency physician about the risk of complications post-gastric bypass surgery. The risk of internal hernias, how internal hernias present clinically. It's a variability, but you know, typically the history of severe abdominal pain, the positive physical findings, you know, what the CT scan implies, what the mesenteric twisting of the vessels implies. A hands on assessment, has there been a change since the seven hours [that she's] been in the department? And does she need an urgent surgical exploration to rule out an internal hernia given that to delay that diagnosis could lead to catastrophic circumstances for the patient.

[43] I disagree with the proffered interpretation of Dr. Drummond's evidence about what was required for the appellant to meet the standard of care after he learned from Dr. Fitzgerald that Ms. Shaw's CT scan showed twisting blood vessels in Ms. Shaw's middle abdominal region, a finding that can be consistent with a post-operative hernia.

[44] A fair reading of this passage from Dr. Drummond's testimony (and not just the exchange highlighted by the appellant), when considered together with the whole of his evidence and the chronology of events, is that it fully supports and is consistent with the standard of care identified by the trial judge.

[45] Recall that Dr. Drummond expressed the opinion that, even without the new information from Dr. Fitzgerald about the CT scan showing the possibility of a hernia, the appellant should not have discharged Ms. Shaw from the Hospital.

Rather, Dr. Drummond testified that Ms. Shaw should have remained in the Hospital for continued observation and, depending on her condition, a surgical consultation. In the excerpted passage from his testimony, Dr. Drummond emphasized the importance of the new information as indicating the need for a surgical consultation. According to Dr. Drummond, after receiving this information the appellant ought to have called Ms. Shaw or had a nurse call her to inform her about the CT scan results and to see how she was doing – and if she was no better, she should have been asked to return to the Hospital for a surgical consultation. Dr. Drummond did not suggest that it would have been sufficient for the appellant to have simply followed up with Ms. Shaw to see how she was doing, or that it was only if she said she was doing worse (as opposed to the same) that she would need to come back to the Hospital. Indeed, central to his evidence was that a hernia was a "surgical disease" that required "a surgical solution."

[46] The context is important. Ms. Shaw's pain had not improved during the seven to eight hours she was at the Hospital. She had been discharged, still in significant pain, with instructions to make an appointment to see her bariatric surgeon. New information about her CT scan then came to light, suggesting the possible presence of a hernia which, if confirmed, would need to be repaired. At that point, less than an hour had passed since her discharge, and there was nothing in the evidence to suggest that her condition would have improved between the time of her discharge and when a call should have been made. The

call that Dr. Drummond said was required was clearly for the purpose of bringing Ms. Shaw back to the Hospital so that she could be seen by a surgeon if her condition had not improved.

[47] The appellant further submits that, in articulating the standard of care and then concluding that it was breached, the trial judge did not make the essential findings that the need for a surgical consultation was urgent, that Ms. Shaw would have been doing worse at that time, and that, had the call been made, she would have come to the Hospital and had an urgent surgical consultation. Instead, the trial judge assumed that would be the case.

[48] I disagree. Dr. Drummond's evidence clearly communicated the urgency of the situation. His opinion was that Ms. Shaw ought to have remained in the Hospital to be monitored and, if her condition had not improved, to have received a surgical consultation, and that having been discharged, once the new information was received, she ought to have been contacted to return to the Hospital for a "hands on assessment". As Dr. Drummond testified, this assessment would determine whether there had been a change since she had been in the emergency department and whether she needed "an urgent surgical exploration to rule out an internal hernia given that to delay that diagnosis could lead to catastrophic circumstances for the patient." If Dr. Drummond had not considered the need for a surgical consultation to be urgent, he would have agreed with the defence

standard of care expert that it was sufficient for Ms. Shaw to be discharged and seen in the community by her bariatric surgeon.

[49] And even if the trial judge did not expressly state that Ms. Shaw would have returned to the Hospital had she been contacted, he necessarily and reasonably inferred from the evidence that this was the case. The trial judge found that Ms. Shaw remained in significant pain throughout her time at the Hospital and upon discharge. The suggestion that Ms. Shaw might have responded that she was doing better relies on the appellant's evidence that she was not only stable but was in less pain when she left the Hospital than when she had arrived, evidence that was rejected by the trial judge. Likewise, there was no evidence that Ms. Shaw, who had followed the appellant's advice and arranged an appointment with her bariatric surgeon, would have refused to return to the Hospital knowing that a surgical consultation was recommended. On the evidence that was accepted by the trial judge, there was no basis to conclude that, if Ms. Shaw had been called and asked how she was doing shortly after she had been discharged, she would have responded that she was doing much better or refused to return to the Hospital for a surgical consultation.

[50] As an alternative argument in relation to the standard of care, the appellant submits that the trial judge ought to have considered and adopted Dr. Drummond's evidence that the appellant would have met the standard of care if a surgeon had been apprised of Ms. Shaw's condition "within a reasonable period of time". The

appellant contends that, based on this evidence, he would have met the standard of care by advising Ms. Shaw to book an expedited consultation with her bariatric surgeon.

[51] The appellant relies on the underlined questions and answers in the following exchange during Dr. Drummond's cross-examination:

> Q. You write in your report, your first report, sir, that, "the most reasonable course of action, would have been a period of further observation and/or surgical consultation."
>
> A. Right, I see that.
>
> …
>
> Q. Right. And so, that language means that there are a number of reasonable courses. But, the most reasonable course in your view, would have been a period of further observation and or surgical consultation?
>
> A. Where a patient with intractable, severe pain, yes.
>
> Q. And in your view, then, certainly notwithstanding that there are a number of reasonable courses, that could have been taken. If the patient had been kept for a period of ongoing consultation, that would meet the standard of care?
>
> A. Yes.
>
> Q. And you don't know what Ms. Shaw's symptoms were like, over the course of the rest of the day?
>
> A. After discharge?
>
> Q. Yes.
>
> A. You're right, I don't know.

Q. And you say in your report, you don't know what a general surgeon would have done or could have done, had they been contacted by this patient?

A. It would be a hypothesis.

Q. Right. And you don't state anywhere in your report, for either report, where you articulate a time by which any surgical consultation would have been required.

A. No, it's pretty variable on the institution, I think.

…

Q. And at the time that you wrote your reports, you did not know if Ms. Shaw communicated with her bariatric surgeons on November 17th, 2015?

A. At the time I wrote the report, no.

Q. You did not know what she told them?

A. No.

Q. And – or what they told her?

A. Not at time the writing the report.

Q. Okay. And sir, none of the literature that you cite in your report and reviewed with Mr. Cahill today provide any timeframe by which any surgical consultation is advisable or required?

A. No.

…

Q. All right. And so not having any timeframe guidance from the literature and none's articulated in either of your reports, I take it it's your – still your view that if it – as long as a general surgeon was made aware of the patient's history of bariatric surgery, abdominal pain, and twisting of the mesenteric vessels within a reasonable period of time, Dr. Handler would have met the standard of care?

A. Yes.

[52] Again, the appellant has taken a passage from Dr. Drummond's trial testimony out of context. Dr. Drummond referred in his first expert report to "the most reasonable course of action" having been "a period of further observation and/or surgical consultation." Under cross-examination he confirmed that this was his opinion, and that if Ms. Shaw had been kept at the Hospital for a period of ongoing consultation the appellant would have met the standard of care. In the question that followed, defence counsel, misstating what Dr. Drummond stated in his report, asked, "And you say in your report, you don't know what a general surgeon would have done or could have done, had they been contacted by this patient?" In fact, in his second report Dr. Drummond noted, again in the context of his opinion that Ms. Shaw ought to have been referred for a surgical consultation, that he could not comment on what a general surgeon would have done, "had Dr. Handler consulted one from the emergency department." This was followed by the question, "And you don't state anywhere in your report, for either report, where you articulate a time by which any surgical consultation would have been required"; he responded, "No, it's pretty variable on the institution, I think."

[53] In this passage, Dr. Drummond was speaking of the timing of a consultation with a Hospital surgeon had Ms. Shaw been referred for one while in the Hospital, not of the timing of a consultation with a bariatric surgeon in the community. Dr. Drummond did not testify that the appellant would have met the standard of care

by discharging Ms. Shaw with instructions to follow up with her bariatric surgeon in the community (which was the opinion of the defence standard of care expert, Dr. Shah) or that, having received the call from the second radiologist, it would have been sufficient for her to follow up with her own bariatric surgeon (also Dr. Shah's opinion). Contrary to the appellant's submission, Dr. Drummond did not contradict the firm opinion he had expressed in his reports and trial testimony, that the appellant would not have met the standard of care by ensuring that Ms. Shaw followed up with her own bariatric surgeon in the community.

[54] Finally, the appellant submits in his factum that the trial judge wrongly disregarded the evidence of the defence standard of care expert, Dr. Shah, after erroneously finding that this expert's opinion was anchored in his incorrect assumption that Ms. Shaw's pain had improved by the time of her discharge.

[55] I disagree. It was Dr. Shah's opinion that the appellant's decision to discharge Ms. Shaw from the Hospital was reasonable as all necessary tests had been performed, and that continued observation in the Hospital was not required as "her symptoms were decreasing on reassessment." He was also of the view that the standard of care did not require that Ms. Shaw be called back to the Hospital after the appellant received the CT scan results from Dr. Fitzgerald.

[56] With respect to the first standard of care issue, the trial judge, in part relying on Dr. Shah's opinion, accepted that the appellant's decision to discharge Ms.

Shaw from the Hospital might have been an exercise in clinical judgment. With respect to the second issue, however, the trial judge rejected Dr. Shah's opinion, not only because Dr. Shah had accepted that Ms. Shaw's pain had improved, or that her symptoms had otherwise improved, but for the clear reasons that he articulated. The trial judge did not accept Dr. Shah's view that there was nothing suggesting an acute problem in Ms. Shaw's case that would have been the basis for a surgical consultation. He also did not accept Dr. Shah's view that emergency doctors were not necessarily aware of the risk of internal hernia from bariatric surgery. All these considerations informed the trial judge's rejection of Dr. Shah's opinion that the standard of care did not require Ms. Shaw to be called back to the Hospital after the CT scan results were communicated to the appellant by Dr. Fitzgerald.

[57] For these reasons, I would reject the appellant's submissions on the first issue on appeal alleging errors by the trial judge in his articulation and application of the standard of care. The trial judge's findings with respect to the applicable standard of care reveal no error. They were amply supported by the evidence and clearly explained in his reasons. It was open to the trial judge to find that, once the appellant received the information about Ms. Shaw's CT scan, the standard of care required a call to Ms. Shaw to find out how she was doing, and unless she had improved, to have her return to the Hospital for an urgent surgical consultation.

(2) The Trial Judge Made Sufficient Findings to Determine Causation

[58] The framework for determining whether causation is established in a delayed diagnosis case requires the trier of fact to (1) determine what likely happened in actuality; and (2) consider what would likely have happened, if the defendant had not breached the standard of care. And because it is not enough that adequate diagnosis and treatment would have led to a chance of avoiding the unfavourable outcome, the court must determine whether the plaintiff has proven that it was "more likely than not" that the defendant's compliance with the standard of care would have avoided such an outcome: *Hasan v. Trillium Health Centre Mississauga*, 2024 ONCA 586, 499 D.L.R. (4th) 178, at para. 20, leave to appeal refused, *Campbell v. Hasan*, [2024] S.C.C.A. No. 402.

[59] On the second ground of appeal, the appellant argues that the trial judge erred by making insufficient findings of fact to determine causation. The appellant contends that the trial judge failed to make factual findings on two key issues: (1) what treatment Ms. Shaw needed and when she needed it, such that he could determine when the "window of opportunity" to treat her condition closed; and (2) when the surgical exploration would have taken place had Ms. Shaw been called back to the Hospital.

[60] As I will explain, there was no such error.

[61] The trial judge's reasons with respect to causation were responsive to the issues at trial and consistent with the framework set out above. He identified the issues as agreed by the parties as follows: First, what was the cause of Ms. Shaw's death? Second, what would have occurred if the appellant had acted in accordance with the standard of care? Third, based on what would have occurred, is it more likely than not that Ms. Shaw would not have died?

[62] In addressing the first question, the trial judge observed that the cause of death was clear and relatively undisputed. He found that Ms. Shaw died after developing complications subsequent to the removal of the necrotic bowel that flowed from hernias in her intestines and that her demise was clearly related back to the original bowel hernia and ischemia. There is no dispute on appeal with respect to this conclusion.

[63] The trial judge turned to the second question: what would have happened had the appellant met the standard of care by contacting Ms. Shaw, having her return to the emergency department and referring her to an on-call surgeon for an immediate consultation?

[64] The point of disagreement between the causation experts was whether a surgical consultation at the Hospital on November 17 would have led to Ms. Shaw being operated on at the Hospital. The trial judge rejected Dr. Jackson's opinion that the on-call surgeon would have recommended that Ms. Shaw follow up with

her bariatric surgeon, as well as his view that the worsening in Ms. Shaw's condition on November 18 was due to a second and separate event.

[65] Instead, the trial judge accepted Dr. Holliday's opinion that Ms. Shaw's development of ischemia and bowel necrosis was the progression of her condition when she was at the Hospital on November 17, and that, if a surgical consultation had occurred that morning, this would have resulted in the surgeon ordering a laparoscopic exploration of Ms. Shaw's abdomen. This was based on what was seen on the CT scan, what in fact happened the following day when Ms. Shaw returned to the Hospital, Dr. Jackson's admission that there was a low threshold for surgical exploration in these types of cases, and the finding that the risk of bowel ischemia associated with Ms. Shaw's surgery was well known in Ontario at the time.

[66] As for the third question, the trial judge concluded that, if the laparoscopy had taken place on November 17, 2015, the hernias would have been at a point where there was no necrosis in the bowels, Ms. Shaw's condition would have been reversed, there would not have been a need to resect any portion of her bowels, and she would not have died.

[67] With this brief summary of how the causation issues at trial were resolved by the trial judge, I turn to the appellant's arguments on the causation ground of appeal. Both have to do with an alleged lack of "precision" or "granularity" in the

findings of fact that were made by the trial judge. The appellant contends first, that the trial judge did not explain with specificity when the “window of opportunity” for the necessary surgical intervention would have closed, and second, that the trial judge failed to make findings of fact that were required for the chain of causation. In the absence of key findings of fact, the appellant submits that the respondents failed to prove that the appellant’s negligence was a cause of Ms. Shaw’s death.

[68] With respect to the first argument, the appellant submits that it was not sufficient for the trial judge to have said that surgery would have happened on November 17, when it is possible that the window of opportunity to treat the hernia had already closed at some point that day. The appellant suggests that, contrary to the opinion of defence expert Dr. Jackson that there was no evidence of ischemia or necrosis in Ms. Shaw’s presentation when she was discharged at 7:30 a.m. on November 17, her condition may already have been irreversible when she left the Hospital that day. The appellant submits that the trial judge was required to determine with specificity at what point surgery would have been too late to lead to a different result – that is, to determine the precise timing of the development of Ms. Shaw’s bowel necrosis.

[69] In some delayed diagnosis cases, including the following cases referred to by the appellant, the central causation issue will require the court to determine at what point the physician’s negligence would not have caused the patient’s injury.

Depending on the evidence, the resolution of the issue will depend on determining exactly when the “window of opportunity” would have closed.

[70] In *Salter v. Hirst*, 2011 ONCA 609, 107 O.R. (3d) 236, leave to appeal refused, [2011] S.C.C.A. No. 503, the breach of the physician’s standard of care was in failing to promptly transfer the plaintiff to another hospital for surgery, and there was clear evidence of a six hour “window of opportunity” between the onset of the plaintiff’s lower extremity symptoms and when the surgery would be required to avoid paralysis. This court dismissed the appeal from a dismissal of the action, concluding that the trial judge was correct in finding there was no evidence that the correct diagnosis likely would have been made and successful treatment likely would have been completed within the critical six-hour period.[6]

[71] Similarly, in *Barker v. Montfort Hospital*, 2007 ONCA 282, 278 D.L.R. (4th) 215, leave to appeal refused, [2007] S.C.C.A. No. 299, this court allowed an appeal, as there was no medical or other evidentiary basis for the trial judge’s inference that the delay in carrying out an operation caused the death of the plaintiff’s bowel. No expert was asked for an opinion as to whether the plaintiff’s bowel had been necrotic for less than the time it would have taken to carry out the operation. Instead, the evidence was consistent with the bowel already progressing to full strangulation before surgery could have occurred,11:00 p.m. at

[6] In that case, the trial judge overturned the jury’s finding of negligence and dismissed the action under r. 52.08 of the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194.

the earliest, and there was no basis for finding on a balance of probabilities that the bowel died only after surgery would have been performed.

[72] And in *Farej v. Fellows*, 2022 ONCA 254, leave to appeal refused, [2022] S.C.C.A. No. 180, this court allowed an appeal and directed a new trial, in part, because the trial judge, in concluding that the physician's decision to proceed with a vaginal delivery of the infant plaintiff rather than an emergency C-section was not the cause of the plaintiff's injuries, had failed to make the important factual determination of the timeframe within which the emergency C-section could have been completed – in respect of which there was conflicting evidence.

[73] In this case, however, it was not necessary for the trial judge to determine when the "window of opportunity" would have closed – that is when Ms. Shaw's herniation had progressed to ischemia and bowel necrosis such that an operation would have been too late. There was no suggestion at trial that, if Ms. Shaw had returned to the Hospital on November 17 and received laparoscopic surgery that day, she would not have survived. There were no signs of prolonged ischemic bowel when Ms. Shaw was discharged; the clinical signs, including lactate in her blood test, were only apparent when she returned to the Hospital the following day. When she was operated on at 9:00 p.m. on November 18, there was significant evidence of ischemia, while necrosis was identified 12 hours later.

[74] In any event, the experts agreed that, if surgery had taken place on November 17, Ms. Shaw would likely have survived. Indeed, Dr. Jackson testified in cross-examination:

> Q. And, we mentioned earlier that the general surgeon who was coming to see this patient on the 17th to be careful in assessing the patient, they'd be looking for life threatening illnesses, correct?
>
> A. Correct.
>
> Q. And, finding two non-specific indicators of an internal hernia would certainly lead them down the road of thinking there's an internal hernia causing pain for this patient?
>
> A. I think that, you know, having taken a detailed history, they would also clue into that as well. And again, recommend that diagnostic laparoscopy, which is, you know, what we've discussed before. So, I think they would recommend that as well, at that time.
>
> Q. If a diagnostic laparoscopy was done on the 17th and reduced the hernias, that would have significantly improved the patient's outcome?
>
> A. I think that is reasonable to say, knowing what happened. Absolutely.
>
> Q. She probably wouldn't have died?
>
> A. Probably not, yes.

[75] In other words, there was no issue in this case as to whether, if Ms. Shaw had been operated on at some point on November 17, she would have survived. I agree with the respondents that in this case a finding as to the precise time when Ms. Shaw's trajectory would have progressed to the point where surgery would not

have altered her outcome was not required. The trial judge did not have to determine when the “window of opportunity” would have closed but only that it had not closed by when Ms. Shaw would reasonably have been operated on had she returned to the Hospital.

[76] This takes us to the second and related argument of the appellant with respect to causation: that the trial judge did not make the necessary factual findings with respect to the chain of causation. The appellant contends that the trial judge did not determine when Ms. Shaw would have returned to the Hospital had she been contacted the morning of November 17, how long it would have taken for her to be seen by an on-call surgeon, and when a laparoscopic exploration would have taken place. The appellant submits that there was no evidence about how long it would have taken for Ms. Shaw to get to surgery at this particular institution other than what happened on November 18, which entailed a five-hour delay before Ms. Shaw had a surgical consultation and another four-hour delay before the surgery took place. The appellant submits it is reasonable to assume that it would have taken even longer on November 17 because Ms. Shaw would have been in a less critical condition.

[77] I disagree. As I have already observed in relation to the standard of care issue, there was no reason to believe that, if Ms. Shaw had been contacted shortly after she was discharged from the Hospital while still in acute pain, telling her about

the CT results showing a possible hernia and suggesting she return to the Hospital to be seen by a surgeon, she would have refused to return to the Hospital.

[78] The trial judge found that the delay in getting Ms. Shaw to surgery on November 18 could be explained by her condition, as she needed to be stabilized before an operation could take place. As set out above, the trial judge reasonably inferred that, if Ms. Shaw had been called back to the Hospital on November 17, she would have returned to the Hospital that morning and been seen in an urgent surgical consultation and operated on that day. Contrary to the appellant's submissions, these conclusions were supported by the evidence. Ms. Shaw had already been triaged, and she would have returned to the Hospital specifically to be seen by a surgeon. As the experts agreed, had she been in the Hospital, her condition would have been monitored, possibly with new blood work. Dr. Jackson testified that, if a general surgeon had been paged at the Hospital, Ms. Shaw would have been seen within a few hours and that, based on her presentation and the CT scan, the surgeon would have recommended a diagnostic laparoscopy. Dr. Holliday testified that an emergency room surgeon who reviewed Ms. Shaw's chart would have concluded the patient needed a diagnostic laparoscopy, that a reasonable time frame for Ms. Shaw to have been in the operating room would be four to six hours, and that, if her condition was deteriorating, the surgery could have been moved up.

[79] In these circumstances there is no basis for the appellant's contention that the trial judge failed to make the necessary "granular" findings about when the call would have been made to Ms. Shaw; how long it would have taken her to return to the Hospital, be triaged and for a surgical consultation to be arranged; and when she would have been operated on.

[80] For these reasons I would not give effect to the appellant's second ground of appeal. The trial judge's reasons and conclusions with respect to causation reveal no reversible error.

Disposition

[81] I would dismiss the appeal, with costs to the respondents fixed in the agreed amount of $62,500, all-inclusive.

Released: December 16, 2025 KMvR

K. van Rhijgga

I agree. Sossin J.A.

I agree. A. Gomery J.A.