# Cancers Claims Guide *2026 Edition*

*The plaintiffs comprehensive guide to navigating claims related to harm caused by delayed diagnoses or mismanagment of Cancers in*

# Atlantic Canada

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# Cancer in Canada: Why Timely Diagnosis Matters

A cancer diagnosis is one of the most life-altering events a person can face. It arrives with fear, uncertainty, and a cascade of questions about what comes next. When that diagnosis is delivered months or even years later than it should have been, because a physician missed a warning sign, misread an imaging result, dismissed a complaint, or failed to follow up on an abnormal test, the harm can extend far beyond the delay itself.

## The Scale of the Problem

Cancer is the leading cause of death in Canada, responsible for approximately 30% of all deaths nationally. According to the Canadian Cancer Society, nearly 1 in 2 Canadians will develop cancer during their lifetime.

With many types of cancer, the stage at which the disease is first detected is one of the most powerful predictors of survival. A patient diagnosed with stage I breast cancer has a five-year survival rate of 90 to 99%. The same patient diagnosed at stage IV faces a dramatically different prognosis. The same pattern, earlier stage means better outcome, holds for colorectal, lung, prostate, cervical, and many other cancers.

This is why the timing of diagnosis matters so much, both medically and legally. Every month of unnecessary delay is a month during which a cancer may grow, invade surrounding tissue, or metastasize to distant organs. The question that sits at the heart of every cancer diagnosis malpractice claim is: what stage was this cancer when it should have been found, and what would have happened if it had been found then?

## Why Delayed Diagnosis Is Different from Other Medical Errors

Most medical errors are discrete events, a surgical mistake, a wrong medication, a failure to respond to a clear warning sign. Delayed cancer diagnosis is different in a way that makes these claims both more common and legally more complex.

Cancer grows and evolves over time. By the time a negligent delay is recognized, the disease itself has changed. The patient's treatment options may have narrowed. The prognosis may have worsened. But because cancer is inherently unpredictable in its behaviour, different cancers grow at different rates, respond differently to treatment, and carry different statistical survival profiles, it is often genuinely difficult to say with certainty what would have happened with an earlier diagnosis.

This difficulty is not a reason to avoid pursuing a claim. It is a feature of the legal landscape that a skilled cancer malpractice lawyer and experienced oncological experts know how to navigate.

## Missed, Delayed, and Misdiagnosis: The Difference

These three terms are used somewhat interchangeably, but they describe distinct situations with different legal implications.

A **missed diagnosis** means the cancer was never identified at all during the patient's contact with the healthcare system, it was simply overlooked. This is the clearest form of diagnostic failure.

A **delayed diagnosis** means the cancer was eventually identified, but later than it should have been given the information available to the treating provider at an earlier point in time. Delays of months or years, during which the cancer progressed, are the most common subject of cancer malpractice claims.

A **misdiagnosis** means the patient was given an incorrect diagnosis, a cancer dismissed as benign, or a benign condition diagnosed as cancer requiring treatment with serious side effects. Both situations can form the basis of a claim.

**A delayed cancer diagnosis does not automatically mean malpractice occurred. Cancer is difficult to diagnose, and not every missed finding or late diagnosis represents a breach of the standard of care. The legal question is always whether a reasonably competent physician, in the same circumstances and with the same information, would have made the diagnosis earlier. Expert medical evidence is required to answer that question.**

# How Cancer Is Supposed to Be Diagnosed: The Standard of Care

Understanding what proper cancer diagnosis looks like, the standard against which a physician's conduct is measured, is the foundation of any cancer malpractice claim.

## The History and Physical Examination

There are no shortcuts in medicine, and nowhere is this more true than in cancer diagnosis. A thorough history and physical examination remains the foundation of all diagnostic work. The standard of care requires that a physician:

- Take a complete and careful history of presenting complaints, including the duration, progression, and character of symptoms
- Investigate systemic symptoms that can signal malignancy: unintended weight loss, persistent fevers, night sweats, fatigue, and anemia
- Elicit a complete family history, since first-degree relatives with certain cancers significantly raise a patient's individual risk and change the threshold for investigation
- Document personal risk factors including smoking history, environmental and occupational exposures, previous cancer diagnoses, and relevant lifestyle factors
- Not dismiss a symptom as benign or mechanical without ruling out a serious

underlying cause; persistent back pain assumed to be musculoskeletal may reflect retroperitoneal malignancy or metastatic disease

Physical examination must be comprehensive and not perfunctory. Palpation for masses, lymph node assessment, examination of the skin for jaundice or pallor, and organ examination are all expected components of a thorough assessment in a patient presenting with relevant complaints.

**A commonly litigated failure in cancer diagnosis cases is the dismissal of a patient's complaint without adequate investigation. A palpable breast mass reassured as "likely benign," a persistent cough attributed to allergies, or an unintended weight loss dismissed as stress, when these assumptions prove wrong and a cancer is later found, the critical question is whether a competent physician would have investigated further at the first presentation.**

## Screening: What Canadian Guidelines Require

Organized cancer screening programs are intended to detect cancer before symptoms appear, when treatment is most effective. The standard of care includes an obligation to offer screening to eligible patients and to follow up on abnormal screening results. The Canadian Task Force on Preventive Health Care (CTFPHC) issues national screening guidelines, and provincial programs implement organized screening.

However, Canadian screening guidelines are not identical to the standard of care in every individual case. Where a patient has elevated risk factors, strong family history, genetic mutations, prior cancer, or significant environmental exposures, the standard of care may require earlier or more intensive screening than the population-level guidelines recommend. A physician who treats a high-risk patient the same as an average-risk patient may breach the standard of care even while technically following general guidelines.

It is also worth noting that Canada's national cancer screening guidelines have been subject to significant professional debate. In 2024, the CBC reported that experts characterized Canadian Task Force guidelines on breast and prostate cancer as

outdated and lagging behind the evidence from other jurisdictions. This professional disagreement does not directly create legal liability, but it is part of the context in which courts and experts assess what a competent physician should have done for a particular patient at a particular time.

Current Canadian national screening guidance, as a general reference:

- **Breast cancer:** Mammography every 2 to 3 years from age 40 for those who wish to be screened, with universal screening recommended from age 50; women with dense breast tissue, strong family history, or elevated genetic risk may require earlier or additional imaging.
- **Colorectal cancer:** Fecal immunochemical test (FIT) or colonoscopy from age 50; the Canadian Cancer Society has called for screening to begin at age 45 given rising rates in younger adults; those with a first-degree relative with colorectal cancer should begin earlier.
- **Lung cancer:** Low-dose CT (LDCT) screening for adults aged 50 to 74 with a significant smoking history (current or former smokers with 20+ pack-years), endorsed by the Canadian Cancer Society and provincial lung screening programs.
- **Prostate cancer:** PSA testing is not universally recommended, but the Canadian Cancer Society advises men discuss PSA testing with their physician from age 50 (age 45 for Black men, who have elevated risk).
- **Cervical cancer:** Pap smear or HPV testing as directed by provincial programs, with universal screening recommended from age 25 for those with a cervix.

## Diagnostic Investigations: Imaging, Blood Work, and Biopsy

Screening is only one pathway to a cancer diagnosis. The other is through clinical assessment when a patient presents with symptoms. The standard of care in diagnostic investigation requires that:

- Imaging is ordered when a clinical presentation warrants it, not withheld because of resource pressures, patient reluctance, or false reassurance
- Imaging results are read accurately and interpreted in the context of the patient's full clinical picture
- Blood work that suggests possible malignancy, including anemia, elevated

inflammatory markers, rising or elevated CEA, or rising PSA, is investigated further rather than attributed to benign causes without adequate evidence
- Tissue biopsy is arranged when imaging or clinical findings suggest a potentially malignant lesion, rather than watchful waiting without justification
- Incidental findings on imaging ordered for other purposes are followed up appropriately; an abnormal shadow on a chest X-ray taken for an unrelated complaint must not be ignored

A critical point: a normal-range result does not always mean a result can be dismissed. A drop in hemoglobin from the upper normal range to the lower normal range may technically be “normal” but may represent a meaningful change for a specific patient that requires investigation. Physicians have an obligation to interpret results in the context of the individual patient's baseline, history, and clinical presentation.

## Referral to Specialists

The standard of care recognizes that cancer diagnosis frequently requires specialist expertise beyond the capacity of a family physician. Direct visualization with endoscopy is essential for diagnosing esophageal, gastric, and colorectal cancers; diagnostic imaging alone is often insufficient to evaluate the mucosal lining of the gastrointestinal tract. A family physician who manages symptoms suggestive of gastrointestinal malignancy without arranging timely endoscopy referral may be found to have breached the standard of care.

Similarly, a suspicious breast mass warrants referral to a breast surgeon or specialist in the absence of prompt resolution or clear benign diagnosis. Suspicious pulmonary findings should prompt respiratory medicine or thoracic surgery involvement. Concerning prostate findings on digital rectal examination or rising PSA warrant urological consultation.

A recurring failure in cancer diagnosis cases is the physician who recognizes an abnormality but does not refer promptly due to system pressures, patient reluctance, or a misjudgment that “we can wait and see.” In cancer, waiting is frequently not neutral. Every month matters.

## Follow-Up and the Duty Not to Let Things Fall Through the Cracks

Follow-up is where many cancer diagnoses are lost. The standard of care requires that when a test returns an abnormal or equivocal result, a physician ensures that:

- The result is reviewed and communicated to the patient
- Further investigation is arranged if indicated
- The patient is followed until the issue is resolved or a definitive diagnosis is reached
- The patient understands what symptoms or changes should prompt them to return sooner

A physician who orders an investigation and does not follow up on its results, because of a communication failure, an administrative gap, or a failure of the clinic's recall system, has not met the standard of care, regardless of whether the initial decision to order the test was appropriate.

Patients do not always know what they do not know. The obligation to ensure follow-up is not discharged simply by telling a patient to “come back if things change.” Where the risk is significant and the patient may not recognize warning signs, the physician has an obligation to be more proactive.

# Common Cancers and How Each Can Be Missed or Delayed

The following covers the five cancers most frequently the subject of delayed diagnosis malpractice claims in Canada, along with the specific ways in which diagnosis is commonly delayed. Each section draws on both the clinical source material provided for this guide and the published Canadian clinical literature.

# Breast Cancer

Breast cancer is among the most litigated cancer diagnoses in Canada. Near-half of all delayed-diagnosis cases in the published malpractice literature involve radiology, reflecting the central role of mammography and imaging in diagnosis. The most common contributing factors are misinterpretation of diagnostic studies, delay or failure to order diagnostic tests, and failure to obtain a consultation.

The standard of care requires:

- Offering and performing age-appropriate and risk-appropriate screening
- Reading mammograms accurately, including recognizing the reduced sensitivity of standard mammography in patients with dense breast tissue
- Investigating palpable masses with ultrasound, MRI, and/or biopsy, not dismissing them as benign based on clinical feel alone
- Accounting for family history and personal risk factors when deciding whether further investigation is warranted
- Following up equivocal findings with appropriate interval imaging or biopsy rather than watchful waiting without adequate clinical justification

A palpable mass is never simply reassured away as benign based on clinical assessment alone. **Triple assessment**, clinical examination, imaging, and tissue biopsy, is the standard for evaluating a suspicious breast lesion. A breach of any one of these components, where the clinical picture warranted it, is the subject of regular litigation.

In Deboer v Kolyn, 2016 ONSC 7108, an Ontario court awarded damages to a breast cancer patient where both a radiologist and a general surgeon breached the standard of care in ways that delayed her diagnosis. The court found that but for the defendants' negligence, the plaintiff would not be suffering from bone metastases and would not die prematurely from the disease.

## Colorectal Cancer

Colorectal cancer typically develops slowly from adenomatous polyps, progressing through stages of dysplasia to adenocarcinoma over years. This gradual progression is precisely what makes it both highly preventable and frequently delayed in diagnosis, there is a long window during which the cancer could have been detected and removed, but was not.

Common diagnostic failures include:

- Failure to screen eligible patients with a FIT test or colonoscopy, particularly those over 50, those with a positive family history, or those with ongoing gastrointestinal symptoms
- Misinterpreting subtle changes in bowel habits, increased frequency, blood in stool, narrowing of stool calibre, as irritable bowel syndrome or hemorrhoids without appropriate investigation
- Failure to investigate rectal bleeding in a patient old enough to be at meaningful risk, attributing it to hemorrhoids without endoscopic assessment
- Not recognizing iron deficiency anemia as a warning sign of occult gastrointestinal blood loss that requires investigation
- Failing to act on elevated CEA as potentially significant, treating it as a non-specific finding rather than investigating in the context of the patient's full clinical picture
- Delayed endoscopy referral when symptoms persisted or progressed

Failure to arrange colonoscopy is a recurring ground for litigation. Radiology, CT scanning and barium enema, is limited in its ability to assess the mucosal lining of the colon. Where clinical suspicion of colorectal cancer exists, endoscopic visualization is the standard of care. A physician who manages suspicious symptoms with repeat imaging rather than colonoscopy referral is not meeting that standard.

## Lung Cancer

Lung cancer remains the leading cause of cancer-related death in Canada, in large part because it is so frequently diagnosed at an advanced stage. The vast majority of lung cancers are found in current or former smokers, and the identification of high-risk patients, those over 50 with a 20+ pack-year smoking history, is a core obligation in the standard of care.

Common diagnostic failures include:

- Failure to offer low-dose CT lung cancer screening to eligible high-risk patients, where organized provincial screening programs are available
- Not ordering a chest X-ray, or misinterpreting one, in a patient with a chronic cough, hemoptysis, unexplained weight loss, or night sweats
- Attributing respiratory symptoms in a smoker to COPD, asthma, or recurrent infection without investigating for malignancy
- Failure to act on an incidental finding on a chest X-ray or CT scan ordered for another purpose; a pulmonary nodule or opacity must be followed up, not ignored
- Not recognizing systemic symptoms as potentially indicating malignancy: persistent fatigue, unexplained weight loss, and bone pain may reflect metastatic disease

The standard for investigating a pulmonary nodule found incidentally on imaging is set out in Canadian and international guidelines. Physicians who dismiss nodules as incidental without arranging interval follow-up imaging, or who fail to refer to a respirologist or thoracic surgeon for lesions meeting applicable size or risk thresholds, may be found to have fallen below the standard of care.

## Prostate Cancer

Prostate cancer is one of the most common cancers in Canadian men, and its diagnosis turns heavily on PSA testing and digital rectal examination. Litigation tends to focus on one of two failure modes: inadequate investigation of an elevated or rising PSA, and an inadequate or absent digital rectal examination.

Common diagnostic failures include:

- Failing to discuss PSA testing with men in at-risk age groups or with elevated familial or racial risk (Black men face approximately double the prostate cancer risk and should be offered earlier testing)
- Treating an elevated PSA as “only mildly elevated” without serial testing or further investigation such as MRI or biopsy
- Failing to recognize the significance of a rising PSA trend over serial measurements, even if each individual result is within normal limits
- Performing a digital rectal examination poorly or omitting it entirely

- Acting on a single normal PSA result without the context of prior values or clinical features that should have prompted greater concern
- Failing to refer to urology for imaging or biopsy in a patient whose combined clinical picture warranted it

The Canadian Cancer Society recommends that men begin discussing PSA testing with their physician from age 50, and from age 45 for Black men given their elevated risk.

## Cervical Cancer

Cervical cancer is largely preventable through organized screening and HPV vaccination. Delays in diagnosis typically arise from either a failure to screen within provincial program recommendations or from a failure to investigate abnormal screening results.

Common diagnostic failures include:

- Failure to offer or perform Pap smear or HPV screening at the recommended intervals under the applicable provincial program
- Failure to follow up on abnormal smear results with colposcopy and biopsy
- Dismissing symptoms including abnormal vaginal bleeding, post-coital bleeding, or pelvic pain without cervical assessment
- Failure to ensure patients understand the need for follow-up after an abnormal result and the urgency of returning

## Other Cancers: Recognizing the Universal Warning Signs

Beyond the five cancers discussed above, delayed diagnosis claims arise across virtually all cancer types. The common thread is the failure to recognize and investigate warning signs that a competent clinician should have taken seriously. The following systemic symptoms are well-recognized potential indicators of malignancy and must be investigated rather than attributed to benign causes without adequate evidence:

- Unintentional weight loss (generally 5% or more of body weight over 6 to 12 months without explanation)

- Persistent unexplained fevers or night sweats
- Fatigue disproportionate to known clinical conditions
- New or unexplained pain in bone, abdomen, or chest that does not resolve
- Unexplained lymph node enlargement persisting beyond 4 to 6 weeks
- Jaundice or abnormal liver function in the absence of a known cause
- Unexplained anemia not attributable to a common dietary or bleeding cause
- Pallor inconsistent with the patient's baseline or history

Persistent symptoms are an important signal. A complaint that has not resolved over multiple clinic visits, or that is progressing despite treatment for a presumed benign cause, should trigger reconsideration of the diagnosis. The standard of care requires that physicians follow the evidence in front of them, not the original assumption.

# How Do I Know If a Delayed or Missed Diagnosis Was Due to Negligence?

A cancer diagnosis that comes later than it should have is not automatically a legal claim. Not every late diagnosis reflects a failure of care. The legal standard requires more: that a reasonably competent physician in the same circumstances would have made the diagnosis sooner, and that the delay caused the patient harm.

## What Is the Standard of Care in Cancer Diagnosis?

The standard of care in cancer diagnosis is defined by what a reasonably competent physician in the same specialty, general practitioner, radiologist, internist, or specialist, would have done in the same circumstances. It is informed by:

- Clinical practice guidelines from bodies such as the Canadian Task Force on Preventive Health Care, the Canadian Cancer Society, and specialty societies
- Accepted clinical teaching on the significance of symptoms, imaging findings, and laboratory results
- The published evidence on the behaviour and progression of the specific cancer type at issue

The standard is not perfection. Cancer is difficult to diagnose. Some cancers grow in ways that are genuinely invisible to clinical and radiological assessment for a period of time. A false-negative mammogram in a patient with dense breast tissue is not automatically negligent. A physician who orders appropriate investigations and follows them up reasonably, and who reaches a conclusion that a competent peer might also have reached, has not breached the standard of care. The question is always: would a competent, reasonable physician in this specialty, with this information, have acted differently?

## Negligence in Screening

A physician who fails to offer screening to an eligible patient, whether because of a failure to identify risk factors, a failure to follow provincial program recommendations, or a decision to deprioritize preventive care, may be found negligent if a cancer that would have been caught at an earlier stage is subsequently discovered at a more advanced stage. This is particularly straightforward where an organized provincial screening program applies to the patient's age and risk profile, and there is no documented clinical reason for the decision not to screen.

## Negligence in Interpreting Imaging and Test Results

Radiology errors are among the most common and most clearly actionable failures in cancer diagnosis. A radiologist who misreads a mammogram, CT scan, or chest X-ray, and reports a finding as normal or benign when it should have prompted further investigation, may be liable for the delay that follows.

Radiologists are held to the standard of a competent radiologist in the same sub-specialty. The standard of care for reading a screening mammogram, a chest CT for a smoker, or a CT colonography is defined by the published literature and by expert opinion on what a competent radiologist, applying reasonable care and attention, would have identified. A physician who receives a radiology report and fails to act on its findings, or who misunderstands its implications, may also be negligent, separate from any radiologist error.

## Negligence in Clinical Assessment

Clinical assessment failures include dismissing a palpable mass without appropriate investigation, attributing systemic symptoms to benign causes without ruling out malignancy, and failing to elicit or consider the significance of risk factors. The obligation is not simply to examine a patient, but to think critically about what the findings mean. A physician who palpates a breast mass and reassures the patient without arranging imaging and tissue assessment has not met the standard of care, regardless of how reassuring the mass felt on examination.

## Negligence in Follow-Up

Follow-up failures are a common and frequently successful ground for cancer diagnosis malpractice claims. The standard of care requires:

- That abnormal test results are reviewed, communicated to the patient, and acted upon
- That equivocal findings are followed until resolved, not simply noted and forgotten
- That interval imaging recommended in a radiology report is actually arranged
- That patients with ongoing symptoms are reassessed rather than repeatedly reassured

A clinic system failure, an abnormal test result that reaches the office but is not reviewed because of an administrative gap, is not a defence. The physician is responsible for ensuring that their patients' test results are reviewed and acted upon.

## Negligence in Referring to a Specialist

A failure to refer is a distinct and commonly litigated form of negligence in cancer diagnosis. Where a patient's presentation warrants specialist assessment, endoscopy, bronchoscopy, specialist breast clinic, urology consultation, and the referring physician delays or does not arrange that referral, they may bear responsibility for the diagnostic delay that follows. The existence of system pressures and wait times does not extinguish the obligation to refer. Where wait times are unreasonable in the context of the urgency of the presentation, the physician may need to pursue

expedited pathways or document the clinical rationale for the approach taken.

### What Distinguishes Negligence from an Honest Clinical Error

Not every mistake is negligence. Medicine involves genuine uncertainty, and the standard of care does not require that a physician always reach the correct diagnosis, only that they conduct their assessment in a way that a competent peer would endorse.

A physician who orders appropriate investigations, interprets them carefully, follows the results up in a timely way, and documents their reasoning is far less likely to be found negligent than one who dismisses a concerning symptom without investigation, fails to follow up an abnormal result, or ignores a pattern of deteriorating findings.

Expert evidence from a qualified oncologist or specialist in the relevant field is required to establish the standard of care and whether it was breached. Courts do not accept lay opinion on what a physician should have done, they rely on expert clinicians who practice in the same field.

## Proving That the Delay Made a Difference: The Causation Challenge

Cancer diagnosis malpractice cases have a feature that sets them apart from many other medical negligence claims: even after a breach of the standard of care is established, there remains the separate and often more difficult question of whether the delay actually changed the outcome. This is the causation challenge, and it is the central contested issue in most cancer malpractice cases.

## Why Causation Is the Central Legal Issue

A person who receives a delayed cancer diagnosis has often suffered real and quantifiable harm. Their cancer is at a later stage than it would have been. Their treatment options may be fewer or harsher. Their prognosis may be worse. But the legal system requires more than this general connection, it requires proof, on the balance of probabilities, that the specific delay caused by the specific negligence changed the outcome in a way that meets the legal threshold.

The reason causation is so contested is the biology of cancer itself. Some cancers are fast-growing and highly aggressive; they might have spread to distant organs regardless of whether diagnosis was delayed by six months or not. Others are slow-growing and indolent; a year's delay may have made no material difference to outcome. The expert analysis must address not just the delay, but the likely behaviour of this specific cancer in this specific patient during the period of delay.

## The “But For” Test in Canadian Law

The foundational test for causation in Canadian negligence law is the “but for” test, established and confirmed by the Supreme Court of Canada. The plaintiff must prove, on the balance of probabilities, that but for the defendant's negligence, the harm would not have occurred as it did. In the cancer diagnosis context, this requires proof that:

- The cancer was present, or present in a more treatable stage, at the time the defendant should have made or pursued the diagnosis
- A reasonably competent physician acting within the standard of care would have diagnosed or pursued investigation of the cancer at that earlier point
- With earlier diagnosis and treatment, the outcome would probably (more likely than not) have been different: better survival, less extensive treatment, avoidance of metastatic spread, or some other measurable improvement

The “but for” test is not applied with scientific rigidity. As the Supreme Court of Canada confirmed in Snell v Farrell, 1990 CanLII 70 (SCC), causation is essentially a practical question of fact to be answered by common sense, and it does not require scientific precision. An inference of causation may be drawn from the evidence even without direct scientific proof, provided the plaintiff has established a case that a reasonable trier of fact could accept.

## What You Must Prove on the Balance of Probabilities

Courts in Canada have articulated the causation requirements in cancer cases as follows:

- The plaintiff must prove that the cancer was present when the defendant should have diagnosed or investigated it
- The plaintiff must prove that they would have received an earlier diagnosis if the defendant had met the standard of care
- The plaintiff must prove that the outcome probably, not possibly, not conceivably, but probably, would have been more favourable with the earlier diagnosis and treatment

The distinction between "probably" and "possibly" is the legal threshold of 50% plus. If the evidence supports only that an earlier diagnosis would have given the patient a chance of a better outcome, but not that it would probably have produced a better outcome, the causation requirement is not met. This is a demanding standard, and it is the reason why expert oncological evidence is so central to these cases.

## Why "Loss of Chance" Is Not Enough in Canada

Canadian law does not recognize "loss of a chance" as an independent head of damage in personal injury cases. This is an important and sometimes misunderstood distinction. In some other jurisdictions, a patient can recover damages for the statistical reduction in their chances of survival caused by a negligent delay, even if they cannot prove that earlier treatment would probably (>50%) have led to a better outcome. Under this "loss of chance" doctrine, even a 30% or 40% chance of a better outcome might be compensable.

Canadian courts have consistently rejected this approach, instead maintaining the requirement that causation be established on the balance of probabilities. If a plaintiff cannot establish that the delay more likely than not changed their outcome, the claim fails on causation, even where the breach of the standard of care is clearly established. This is not a reason to avoid pursuing a legitimate claim. It is a reason to ensure that the expert evidence addresses the staging and likely progression of the specific cancer involved.

# The Role of Adverse Inference: Benhaim v St-Germain

The Supreme Court of Canada's 2016 decision in Benhaim v St-Germain, 2016 SCC 48 is the most significant Canadian case on causation in cancer diagnosis malpractice claims.

Marc Émond died from lung cancer at age 47. In November 2005, a chest X-ray revealed an opacity in his right lung. His physician failed to consult prior X-rays for comparison (which were available) and simply ordered a follow-up X-ray. The opacity was not properly investigated until December 2006, when it had grown. Mr. Émond died in June 2008. Both his family doctor and the radiologist were found to have been negligent.

The central legal question at the Supreme Court was whether, when a defendant's negligence itself undermines the plaintiff's ability to prove causation (because the delayed investigation destroyed the evidence of the cancer's earlier stage), a court should draw an adverse inference of causation. The Court held that courts may draw an adverse inference of causation where:

- The defendant's negligence undermined the plaintiff's ability to prove causation
- The plaintiff produces at least some evidence of causation

However, and this is the critical point, the Court also held that drawing such an adverse inference is not mandatory. It is a matter for the trial judge's discretion. In Benhaim, the trial judge's original finding of no causation was ultimately upheld because, on the evidence presented, she could not conclude that the delay probably caused Mr. Émond's death. The practical lesson is twofold: expert evidence on the likely staging of the cancer at the earlier point in time is critical, and the strength of that evidence determines whether an adverse inference, and with it a finding of causation, is available.

## The Practical Approach to Causation: Snell v Farrell

Snell v Farrell confirmed that the “but for” test does not require scientific certainty. Courts approach causation as a practical question of fact, informed by evidence but not requiring mathematical proof. In cancer cases, this means that expert evidence based on the natural history of the tumour type, its typical rate of progression, the staging data available at the time of actual diagnosis, and the published survival statistics at each stage, can support a finding of causation even in the absence of a complete scientific reconstruction of the tumour's earlier state.

Evidence connecting the breach to the injury, however imprecise, permits the judge to draw an inference of causation that scientific evidence alone might not compel. The question is whether the totality of the evidence, assessed with common sense, supports the conclusion that the delay probably made a difference.

## How Staging Evidence Is Used to Establish Causation

The expert analysis in a cancer malpractice claim typically works backward from the stage at which the cancer was actually diagnosed to reconstruct, on the available evidence, what stage the cancer was likely at when it should have been diagnosed. This analysis considers:

- The known rate of progression for this specific cancer type and subtype
- Any imaging or pathology from the period of the missed diagnosis that can inform the likely state of the tumour at that time
- Published survival data at different stages, showing the likely difference in outcomes between the stage the cancer should have been diagnosed at and the stage at which it was actually found
- The specific treatment options that would have been available at each stage and their expected outcomes

A well-prepared expert opinion will express, with appropriate precision, the oncologist's view on what stage the cancer probably was at the time of the alleged negligence, and what the patient's prognosis would probably have been with timely diagnosis and treatment at that stage.

## What Happens When the Evidence Is Incomplete

As Benhaim illustrates, one of the challenges in cancer diagnosis malpractice cases is that the negligence itself may destroy or prevent the creation of the very evidence that would prove causation. If a physician fails to order an imaging study, there is no imaging study from that time to assess. If a biopsy was never performed at the relevant time, the pathology report does not exist.

Courts have recognized this problem and, as noted in Benhaim, may draw an adverse inference in the plaintiff's favour when the defendant's negligence is the reason the plaintiff cannot prove causation with precision. This does not guarantee a finding of causation, it is a tool the court may use in appropriate circumstances.

**The causation challenge in cancer malpractice cases is real and demanding. It is also one of the most important reasons why retaining a lawyer with specific experience in cancer malpractice, and who has access to qualified oncological expert witnesses, makes such a difference to the outcome of a claim.**

# Will a Doctor or Hospital Tell Me If a Diagnosis Was Delayed Due to Negligence?

In most cases, not directly. The general duty of candour that applies to all Canadian healthcare providers extends to cancer diagnosis failures, but in practice families rarely receive a frank acknowledgment that a cancer was caught late due to a failure of care.

- Physicians and hospitals receive legal support from the Canadian Medical Protective Association (CMPA), which advises caution about admissions of fault.
- Many cases of delayed diagnosis involve a genuine belief on the physician's part that the earlier finding was ambiguous or that the decision made at the time was

reasonable.
- Patients are often not told what investigations were or were not ordered. The fact that a lesion was visible on earlier imaging but not acted upon may not be apparent until their records are reviewed by an independent expert.

**You have the right to request your complete medical records, including all imaging reports, laboratory results, clinic notes, and referral correspondence. If a family member died from cancer, the estate has the right to their records. Do not wait for a provider to acknowledge what may have gone wrong. Request records in writing and seek independent assessment.**

You may also file a complaint with the relevant provincial regulatory college:

- **Nova Scotia:** College of Physicians and Surgeons of Nova Scotia
- **New Brunswick:** College of Physicians and Surgeons of New Brunswick
- **Prince Edward Island:** College of Physicians and Surgeons of PEI
- **Newfoundland and Labrador:** College of Physicians and Surgeons of NL

A regulatory complaint can run alongside a civil claim. It does not extend your limitation period, but it may produce independent findings about the care provided.

## What Are the Statutes of Limitations for Filing a Cancer Diagnosis Malpractice Claim?

## General Limitation Periods in Atlantic Canada

### Nova Scotia

The Limitation of Actions Act (SNS 2014, c 35) provides a basic limitation period of 2 years from discovery, and an ultimate period of 15 years from the date of the negligent act.

### New Brunswick

The Limitation of Actions Act (SNB 2009, c L-8.5) sets a 2-year period from discovery, with an ultimate period of 15 years.

### Prince Edward Island

The Statute of Limitations (RSPEI 1988, c S-7) provides a 2-year period for personal-injury and negligence claims (s. 2(1)(d)), with discoverability applied by the courts.

### Newfoundland and Labrador

The Limitations Act (SNL 1995, c L-16.1) provides a general 2-year period from discovery.

## The Discoverability Principle in Cancer Cases

Limitation periods in cancer diagnosis malpractice cases often turn on when the claim was, or should have been, discovered. This is not necessarily the date of the original missed or delayed diagnosis. It is typically the date the patient:

- Received a cancer diagnosis at a later and more advanced stage than expected
- Was advised by another physician, oncologist, or independent expert that the cancer may have been diagnosable earlier
- Obtained access to prior imaging reports or records showing findings that were not investigated or followed up

In practice, the discoverability clock often starts when a patient or their family obtains an independent medical review and is told, for the first time, that the care they received may have fallen below the standard. This may be months or years after the

negligent events themselves. A patient who was never told that a lesion appeared on their imaging two years before diagnosis, and who only discovered this by obtaining their own records, may have their discoverability date set at the point they obtained and understood that information.

### Claims on Behalf of a Deceased Person

Where a patient died from a cancer that was delayed in diagnosis, the estate may bring both a medical malpractice claim and a fatal accident claim under the applicable provincial legislation (see the Fatal Accident Claims Guide in this series for full detail).

The limitation period for fatal accident claims is shorter in Nova Scotia (12 months from death) than for ordinary malpractice claims. Where death has occurred, both types of claim may need to be filed on different timelines. Seeking legal advice promptly after a loved one's death is essential.

**Do not assume you have time. If you have been diagnosed with a cancer you believe was delayed, or if a family member has died from a cancer you believe was caught too late, seek legal advice as soon as possible. Limitation periods can be shorter than you expect, evidence fades, and records can become harder to obtain over time.**

## What Are the Damages and Compensation Amounts Typical for Cancer Diagnosis Malpractice Claims?

# Types of Damages

### Non-Pecuniary General Damages (Pain and Suffering)

These compensate the patient for the physical and psychological suffering caused by the progression of their cancer during the period of delay. A patient whose cancer progressed from stage I to stage III because of a two-year delay has suffered pain, fear, aggressive treatment including chemotherapy and radiation they may not have needed at an earlier stage, and a profound alteration in their life expectancy.

### Pecuniary Special Damages

These cover actual out-of-pocket losses including:

- Costs of more aggressive treatment required because of the delayed diagnosis (chemotherapy, radiation, surgery) that would not have been needed at an earlier stage
- Travel and accommodation for specialist treatment
- Medications and supportive care costs not covered by provincial insurance
- Lost wages during treatment and recovery

### Future Care Costs

Where the delayed diagnosis has left the patient with a chronic condition, ongoing treatment requirements, regular monitoring, or permanent disability caused by more aggressive treatment, the future care costs are recoverable. In cases where the patient now requires palliative care as a direct result of the delayed diagnosis, these costs can be very significant.

### Loss of Income and Earning Capacity

Where the cancer's progression during the delay has impaired the patient's ability to work, loss of income and reduced future earning capacity are compensable. This calculation is particularly significant in cases where a patient who could have been cured or returned to full function with early diagnosis is now permanently disabled or facing a shortened life expectancy.

### The Cap on Non-Pecuniary Damages

Canada's Supreme Court 1978 damages trilogy established a cap on non-pecuniary damages (pain and suffering) currently at approximately $430,000 to $450,000 in the mid-2020s. This cap applies to general damages only. Future care costs, lost income, and other pecuniary losses are not capped and can be very substantial in serious cancer malpractice cases. (Andrews v Grand & Toy, SCC.)

### When Cancer Has Become Terminal: Fatal Accident Claims

Where a delayed cancer diagnosis has progressed to a terminal illness, the patient and their family may have both a personal injury claim for the patient's own suffering and, following death, a fatal accident claim for the family's loss. These two claims can and should be pursued together where possible. The fatal accident legislation in each Atlantic province sets the parameters for who can claim and what they can recover after the patient's death.

## How Much Does It Cost to Pursue a Cancer Diagnosis Malpractice Claim?

### Contingency Fee Arrangements

Cancer malpractice claims in Canada are almost always handled on a contingency fee basis. No fee is charged unless the case succeeds. Contingency fees in medical malpractice cases in Atlantic Canada typically range from 25% to 33% of the final recovery. The arrangement must be set out in writing.

This is particularly important in cancer cases, where the patient is often managing the financial and physical demands of ongoing treatment at the same time as contemplating litigation. Contingency fee arrangements ensure that access to legal

representation is not limited by the patient's immediate financial capacity.

### Disbursements and Expert Costs

Cancer diagnosis malpractice cases require extensive expert evidence. Typical disbursements include:

- Oncology expert reports on the standard of care (commonly $10,000 to $30,000 or more depending on the specialty and scope)
- Radiology expert reports where imaging misinterpretation is at issue
- Pathology expert reports on staging and tumour progression
- Medical record retrieval costs
- Forensic economist reports in cases involving significant income loss
- Court filing, discovery transcript, and travel costs

Most firms working on contingency advance these costs, to be recovered from the settlement or judgment at the end of the case. Confirm this in writing before retaining counsel.

### What Happens If You Lose?

An unsuccessful party in Canadian civil litigation may be ordered to pay a portion of the successful party's legal costs. This adverse costs risk is a genuine consideration in deciding whether to proceed to trial or accept a settlement at each stage. A good lawyer will be frank with you about this risk throughout the litigation process.

## How Long Does a Cancer Diagnosis Malpractice Case Typically Take?

Cancer diagnosis malpractice cases are among the more complex medical negligence claims, requiring substantial expert evidence on both the standard of care and the

causation analysis. From initial consultation to resolution, families should expect a process measured in years.

## Stages of a Claim

**Stage 1: Initial Consultation and Case Evaluation (1 to 3 months)**
The lawyer reviews available records and preliminary information. Cancer cases often involve a review of prior imaging and clinic notes to identify whether earlier abnormalities were visible but not acted upon. Some firms engage an oncology consultant at this preliminary stage.

**Stage 2: Record Collection and Expert Review (6 to 18 months)**
Obtaining all clinic notes, imaging reports, laboratory results, pathology reports, referral correspondence, and oncology records is the foundation of the case. Prior imaging may need to be retrieved and re-read by an independent radiologist. Expert opinions on the standard of care and causation must be obtained before a claim is filed.

**Stage 3: Issuing the Statement of Claim**
Once expert evidence supports the claim, proceedings are formally commenced.

**Stage 4: Pleadings and Discoveries (1 to 2 years)**
The defendant responds. Both parties exchange documents and examine witnesses under oath. The plaintiff's complete medical history, including prior imaging and clinical encounters, is intensively reviewed. Expert staging evidence and causation are the central areas of inquiry.

**Stage 5: Expert Report Exchange and Pre-Trial Motions**
Opposing expert reports are exchanged and form the basis for settlement negotiations. The defendant will retain their own oncology, radiology, and causation experts. The gap between the parties' expert positions on causation often determines whether the case settles or proceeds to trial.

**Stage 6: Mediation and Negotiation (ongoing)**
Settlement discussions are most productive after discoveries and expert reports are exchanged. Cases where causation is strong and the expert evidence is clear tend to

settle; cases where causation is genuinely contested are more likely to proceed to trial.

**Stage 7: Trial (if necessary)**
Trials in cancer malpractice cases can run from two to four weeks or more, depending on the number of expert witnesses and the complexity of the staging and causation evidence.

## When Settlements Are Most Likely

Cancer cases where the staging evidence strongly supports the causation argument, where the expert opinion establishes clearly that the cancer probably would have been found at a more treatable stage with timely investigation, tend to settle before trial. Cases where causation is genuinely uncertain are more likely to proceed to judgment. The strength of the causation evidence is therefore not just a legal requirement, it is the primary driver of settlement value and timing.

## The Reality of Protracted Litigation

From initial consultation to resolution, a cancer diagnosis malpractice case will typically take four to six years. Causation disputes are inherently expert-intensive and contested. In cases where the cancer has progressed to a terminal illness, there may be urgency in expediting the proceedings that lawyers and courts can address, but the fundamental complexity of these cases does not change. As illustrated by Benhaim v St-Germain, where the Supreme Court was still ruling on causation principles nearly a decade after Mr. Émond's death, these cases can be protracted. Going in with experienced counsel and realistic expectations is essential.

# Things to Consider When Choosing a Lawyer for a Cancer Diagnosis Malpractice Claim

Cancer diagnosis malpractice is a specialized and demanding area within medical malpractice law. The combination of complex medical science, the difficult causation analysis, and the personal weight of a cancer diagnosis makes the choice of lawyer particularly important.

### Experience in cancer or oncology malpractice specifically

Ask directly whether the lawyer has handled cancer diagnosis malpractice cases and what those outcomes were. The specific challenges of the causation analysis in a delayed diagnosis case, staging evidence, tumour progression modelling, statistical survival data, require experience that general personal injury practice does not provide.

### Access to qualified oncological and radiological expert witnesses

These cases are built on expert evidence. Ask whether the lawyer has established working relationships with qualified oncologists, radiologists, and pathologists who can provide credible expert opinions on both the standard of care and the causation analysis. The quality of expert evidence is often the determining factor in whether a cancer malpractice case succeeds.

### Understanding of the causation challenge

Given the complexity of causation in delayed diagnosis cases, and the specific framework established by Benhaim v St-Germain and Snell v Farrell, the lawyer must have a thorough understanding of how Canadian courts approach this issue and how to construct the strongest possible causation argument from the available staging evidence.

### Compassion and communication

A patient managing cancer treatment while also contemplating malpractice litigation faces extraordinary demands. The right lawyer will handle the process with care, communicate clearly about progress and setbacks, and ensure that the patient is not

required to engage more intensely with the litigation than their condition allows.

**Resources to sustain complex litigation**
Expert oncology, radiology, and pathology reports in combination can represent very significant disbursements. Confirm that the firm has the financial capacity to advance and sustain these costs over a multi-year case.

**Written fee agreement**
The contingency fee percentage, disbursement terms, and adverse cost risk should all be clearly set out in writing before you sign a retainer agreement.

**Many medical malpractice lawyers offer a free initial consultation. A cancer malpractice claim is the kind of case where this conversation is particularly important, it gives you an opportunity to assess whether the lawyer has genuine experience in this area and the kind of relationship that will sustain you through what can be a long and emotionally demanding process. You are not obligated to retain anyone you consult with, and speaking with more than one firm before deciding is entirely reasonable.**

# References and Additional Support Resources

## References Cited in This Guide

**Case Law (CanLII)**

**Benhaim v St-Germain, 2016 SCC 48 (CanLII)**
Supreme Court of Canada, delayed lung cancer diagnosis; causation; adverse inference.
https://www.canlii.org/en/ca/scc/doc/2016/2016scc48/2016scc48.html

**Snell v Farrell, 1990 CanLII 70 (SCC)**
Supreme Court of Canada, the “but for” test and the practical approach to causation.
https://www.canlii.org/en/ca/scc/doc/1990/1990canlii70/1990canlii70.html

**Deboer v Kolyn, 2016 ONSC 7108 (CanLII)**
Ontario Superior Court, delayed breast cancer diagnosis; radiologist and surgeon negligence.
https://www.canlii.org/en/on/onsc/doc/2016/2016onsc7108/2016onsc7108.html

**Andrews v Grand & Toy Alberta Ltd [1978] 2 SCR 229**
https://www.canlii.org/en/ca/scc/doc/1978/1978canlii1/1978canlii1.html

**Causation in Tort Law: A Decade in the Supreme Court, 2000 CanLIIDocs 499**
https://www.canlii.org/en/commentary/doc/2000CanLIIDocs499

**Legal Texts**

**Robertson & Picard, Legal Liability of Doctors and Hospitals in Canada (5th ed.)**
Irwin Law, 2017
https://store.thomsonreuters.ca/en-ca/products/legal-liability-of-doctors-and-hospitals-in-canada-5th-edition-30835555

**Clinical Standards and Screening Guidelines**

**Canadian Task Force on Preventive Health Care, Published Guidelines**
https://canadiantaskforce.ca/guidelines/published-guidelines/

**Canadian Task Force, Breast Cancer Screening (2024 Update)**
https://canadiantaskforce.ca/guidelines/published-guidelines/breast-cancer-update-2024/

**Canadian Cancer Society, Cancer Screening Overview**
https://cancer.ca/en/cancer-information/find-cancer-early/screening-for-cancer

**Canadian Cancer Society, Cancer Statistics**
https://cancer.ca/en/research/cancer-statistics/cancer-statistics-at-a-glance

**CBC News, Canadian Cancer Screening Guidelines: Expert Criticism (2024)**
https://www.cbc.ca/news/politics/cancer-screening-canada-guidelines-1.7180878

**Canadian Medical Protective Association (CMPA)**
https://www.cmpa-acpm.ca/

**Provincial Limitations Legislation**

**Nova Scotia Limitation of Actions Act (SNS 2014, c 35)**
https://nslegislature.ca/sites/default/files/legc/statutes/limitation%20of%20actions.pdf

**New Brunswick Limitation of Actions Act (SNB 2009, c L-8.5)**
https://laws.gnb.ca/en/BrowseTitle

**PEI Statute of Limitations (RSPEI 1988, c S-7)**
https://www.princeedwardisland.ca/en/legislation/statute-limitations

**Newfoundland and Labrador Limitations Act (SNL 1995, c L-16.1)**
https://www.assembly.nl.ca/legislation/sr/statutes/l16-1.htm

## Further Reading and Support Organizations

### Cancer Support

**Canadian Cancer Society**
Information, support programs, and advocacy
https://cancer.ca/

**Cancer Care Nova Scotia**
https://www.nshealth.ca/cancer-care-program

**PEI Cancer Treatment Centre**
https://www.princeedwardisland.ca/en/information/health-pei/cancer-treatment-centre

**Canadian Cancer Survivor Network**
Patient-driven advocacy for survivors
https://survivornet.ca/

### Patient Rights and Safety

**Canadian Patient Safety Institute**
https://www.healthcareexcellence.ca/

**Patients for Patient Safety Canada**
https://www.healthcareexcellence.ca/

**CanLII**
Free access to Canadian case law
https://www.canlii.org/

## Regulatory Colleges

**College of Physicians and Surgeons of Nova Scotia**
https://cpsns.ns.ca/

**College of Physicians and Surgeons of New Brunswick**
https://cpsnb.org/en/

**College of Physicians and Surgeons of PEI**
https://cpspei.ca/

**College of Physicians and Surgeons of NL**
https://cpsnl.ca/

## Legal Research and Referral

**Law Society of Nova Scotia**
Lawyer Referral Service
https://www.nsbs.org/

**Law Society of New Brunswick**
https://www.lawsociety-barreau.nb.ca/en/

**Law Society of Prince Edward Island**
https://lawsocietypei.ca/

**Law Society of Newfoundland and Labrador**
https://lsnl.ca/