COURT OF APPEAL FOR BRITISH COLUMBIA

Citation: *Jones v. Zimmer GMBH,*
2013 BCCA 21

Date: 20130122
Docket: CA039378

Between:

Dennis Jones and Susan Wilkinson

Respondents
(Plaintiffs)

And

Zimmer GMBH, Zimmer, Inc., and Zimmer of Canada Limited

Appellants
(Defendants)

Before: The Honourable Mr. Justice K. Smith
The Honourable Mr. Justice Chiasson
The Honourable Madam Justice Bennett

On appeal from: Supreme Court of British Columbia, September 2, 2011
(*Jones v. Zimmer GMBH*, 2011 BCSC 1198, Vancouver Docket No. S095493)

Counsel for the Appellants:	A.D. Borrell P. Pliszka
Counsel for the Respondents:	D.A. Klein J.Z. Murray
Place and Date of Hearing:	Vancouver, British Columbia May 29-30, 2012
Place and Date of Judgment:	Vancouver, British Columbia January 22, 2013

Written Reasons by:
The Honourable Mr. Justice K. Smith

Concurred in by:
The Honourable Mr. Justice Chiasson
The Honourable Madam Justice Bennett

Reasons for Judgment of the Honourable Mr. Justice K. Smith:

[1] This appeal is from an order made by the Honourable Mr. Justice Bowden of the Supreme Court of British Columbia pursuant to the *Class Proceedings Act*, R.S.B.C. 1996, c. 50, certifying the underlying product liability action as a class proceeding and appointing the respondent Susan Wilkinson as representative plaintiff for "[a]ll persons who were implanted with the Durom acetabular hip implant in Canada."

[2] The appellants (nothing turns on their separate corporate identities) manufacture and distribute a hip implant known as the "Durom Cup", which is intended to adhere, without cement, to the surrounding bone as it grows during recovery from hip implant surgery. The respondents received Durom Cup implants in 2008. Each subsequently experienced pain and disability and had revision surgery to have the Durom Cup removed. In each case it appeared during the revision surgery that the Durom Cups had failed to adhere properly to the surrounding bone. The respondents claim damages for alleged negligence in the research, development, testing, manufacture, distribution, and sale of the Durom Cup and, as well, declaratory and injunctive relief, damages, and statutory compensation pursuant to the *Business Practices and Consumer Protection Act*, S.B.C. 2004, c. 2 for alleged deceptive acts and practices.

[3] The appellants contend the certification judge erred in certifying the following questions for trial as "common issues":

(a) Was the Durom acetabular hip implant defective and/or unfit for its intended use?

(b) With respect to British Columbia residents, did any of the defendants breach a statutory duty under the *Business Practices and Consumer Protection Act* owed to class members who received the Durom acetabular hip implant in British Columbia and, if so, when and how?

The judge also certified the questions "Did any of the defendants breach a duty of care owed to class members and, if so, when and how?" and "Does the defendants' conduct warrant an award of punitive damages, and, if so, to whom should they be paid and in what amount?" as common issues. It is not disputed that these questions can go forward as common issues if the impugned questions can properly do so.

[4] To be a "common issue", an issue must be a substantial and necessary ingredient of the claim of each member of the class: *Hollick v. Toronto (City)*, 2001 SCC 68 at para. 18, [2001] 3 S.C.R. 158. It need not be determinative of liability: rather, it will be sufficient if it is an issue of fact or law common to all claims and if its resolution will move the litigation forward: *Campbell v. Flexwatt Corp.* (1997), 44 B.C.L.R. (3d) 343 at para. 53, 98 B.C.A.C. 22, leave to appeal ref'd [1998] S.C.C.A. No. 13.

[5] The proper approach to be taken by the judge hearing a certification application is summarized in *Pro-Sys Consultants Ltd. v. Infineon Technologies AG*, 2009 BCCA 503 at paras. 64-65, 312 D.L.R. (4th) 419, leave to appeal ref'd [2010] S.C.C.A. 32:

> [64] The provisions of the [*Class Proceedings Act*] should be construed generously in order to achieve its objects: judicial economy (by combining similar actions and avoiding unnecessary duplication in fact-finding and legal analysis); access to justice (by spreading litigation costs over a large number of plaintiffs, thereby making economical the prosecution of otherwise unaffordable claims); and behaviour modification (by deterring wrongdoers and potential wrongdoers through disabusing them of the assumption that minor but widespread harm will not result in litigation): *Western Canadian Shopping Centres Inc. v. Dutton*, 2001 SCC 46, [2001] 2 S.C.R. 534 at paras. 26-29 [*Western Canadian Shopping Centres*]; *Hollick v. Toronto (City)*, 2001 SCC 68, [2001] 3 S.C.R. 158 at para. 15 [*Hollick*].
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> [65] The certification hearing does not involve an assessment of the merits of the claim; rather, it focuses on the form of the action in order to determine whether the action can appropriately go forward as a class proceeding: *Hollick* at para. 16. The burden is on the plaintiff to show "some basis in fact" for each of the certification requirements, other than the requirement that the pleading disclose a cause of action: *Hollick*, at para. 25. However, in conformity with the liberal and purposive approach to certification, the evidentiary burden is not an onerous one – it requires only a "minimum evidentiary basis": *Hollick*, at paras. 21, 24-25; *Stewart v. General Motors of Canada Ltd.*, [2007] O.J. No. 2319 (S.C.J.) at para. 19. As stated in *Cloud v.*

> *Canada (Attorney General)* (2004), 247 D.L.R. (4th) 667 at para. 50, 73 O.R. (3d) 401 (C.A.), leave to appeal ref'd [2005] S.C.C.A. No. 50 [*Cloud*],
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> > [O]n a certification motion the court is ill equipped to resolve conflicts in the evidence or to engage in finely calibrated assessments of evidentiary weight. What it must find is some basis in fact for the certification requirement in issue.

[6] The appellants submit the impugned questions are not "common issues" as that phrase has been defined, that the certification judge relied on irrelevant and inadmissible evidence, and that no "basis in fact" was established to support these questions as common issues. For the reasons that follow, I would reject these submissions and dismiss the appeal.

The Respondents' Claim

[7] In their statement of claim, the respondents alleged that the Durom Cup "was defective in that it fails to properly heal or adhere to the surrounding bone": that it remains loose or separates from the bone causing the patient pain and necessitating further hip surgery. They pleaded that the appellants were negligent in the research, development, testing, manufacture, distribution and sale of the Durom Cup; that they failed to ensure it was effective in adhering to bone before marketing it; that they failed to monitor its safety after marketing it; and that they failed to warn the respondents, class members, their health care providers, and Health Canada (the responsible federal regulator) of the problems with the Cup. Further, they alleged these acts and omissions were breaches of the requirements of the *Medical Devices Regulations*, S.O.R./98-282.

[8] The respondents also pleaded that they received Durom Cup implants (Mr. Jones in January 2008 and Ms. Wilkinson in April 2008), that the implants failed, that Mr. Jones had further surgery in May 2009 in which the Durom Cup was removed and replaced with a new implant, that Ms. Wilkinson was on the waiting list for similar surgery, and that both experienced pain and suffering and other damage as a result of the failures.

[9] The relevant provisions in respect of the respondents' statutory claims are set out in s. 4 of the *Business Practices and Consumer Protection Act*:

> **4** (1) In this Division:
>
> **"deceptive act or practice"** means, in relation to a consumer transaction,
>
> (a) an oral, written, visual, descriptive or other representation by a supplier, or
>
> (b) any conduct by a supplier
>
> that has the capability, tendency or effect of deceiving or misleading a consumer or guarantor;
>
> **"representation"** includes any term or form of a contract, notice or other document used or relied on by a supplier in connection with a consumer transaction.
>
> ...
>
> (3) Without limiting subsection (1), one or more of the following constitutes a deceptive act or practice:
>
> ...
>
> (b) a representation by a supplier
>
> vi) that uses exaggeration, innuendo or ambiguity about a material fact or that fails to state a material fact, if the effect is misleading ....

[10] The respondents pleaded, and it was not disputed, that the appellants and respondents were "suppliers" and "consumers" respectively and that they were engaged in "consumer transactions". The respondents alleged deceptive and misleading acts and omissions by the appellants as follows:

> 27. The Defendants' conduct in their solicitations, offers, advertisements, promotions, sales and supply of the Product, as particularized above, had the capability, tendency or effect of deceiving or misleading consumers regarding the safety and efficacy of the Product. The Defendants' conduct in its solicitations, offers, advertisements, promotions, sales and supply of the Product were deceptive acts and practices contrary to s.4 of the BPCPA. The Defendants' deceptive acts and practices include the Defendants' failure to properly disclose all material facts regarding the safety and efficacy of the Product.
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> 28. Further, in their marketing brochures, promotional materials, and website directed both to consumers and their physicians, the Defendants made representations concerning the efficacy of the Product, including a description of studies that suggested that the Product had a success rate of

> up to 99%. In reality, the Product's failure rate is unreasonably high compared to other, available implants. The Defendants knew or ought to have known that their marketing claims regarding the Product were inaccurate, incomplete or misleading, and that the Product had an unreasonably high failure rate. Such marketing claims were deceptive and had the tendency, capability or effect of misleading consumers and their physicians.

The Evidence

[11] The respondents and Gloria McSherry, the proposed representative plaintiff in a parallel action in Ontario, gave evidence by affidavit that they received Durom Cup hip implants in January 2008, April 2008, and August 2007 respectively. All said they subsequently suffered debilitating pain in the region of their replaced hip, and that they had surgery to remove and replace the Durom Cup in May 2009, October 2009, and June 2010 respectively. Mr. Jones' surgeon said, in his operative note, that the Durom Cup was "tapped and easily removed showing no bony ingrowth in any area." Ms. Wilkinson deposed that she was awake and aware during her replacement surgery and remembers the Durom Cup "popping out merely with the force" of her surgeon's hand. Ms. McSherry's surgeon said, in his operative note, "Durom cup appeared to be solid but following removal there was no bone ingrowth on cup."

[12] In April 2008, an American orthopaedic surgeon published a letter he wrote to his colleagues in the American Association of Hip and Knee Surgeons advising of several Durom Cup failures among his patients. As a result, the appellants undertook an investigation and, on July 22, 2008, they issued an "Urgent Device Correction" letter to U.S. surgeons to whom they had supplied Durom Cups. In the letter, they attributed the failures to the surgical techniques used by the doctors and disclaimed any defect in the Durom Cup. The letter said their investigation led them to conclude that "additional surgical technique instructions and training are necessary" for surgeons in the U.S. and strongly recommended that "U.S. surgeons stop implanting the *Durom* Cup until receiving such training." The letter announced that the appellants would suspend marketing and distribution of the Durom Cup in the U.S. "while we update product labeling to provide more detailed surgical

technique instructions and implement a surgical training program for U.S. surgeons." It added that they had found "[n]o evidence of a defect in the materials, manufacture, or design" of the Durom Cup. The letter also stated the appellants would be developing a "comprehensive surgical skills training curriculum, working with experts in the U.S. and in Europe" and that the Cup would be "made available to surgeons as they complete training."

[13] Also on July 22, 2008, the appellants published a press release announcing the suspension of marketing and distribution of the Durom Cup in the U.S. and adding that it would continue to be marketed outside the U.S., including in Canada where it had been made available in 2003. The press release contained this passage:

> Data from clinical trials sponsored by Zimmer and conducted outside the U.S. have demonstrated no revisions with the *Durom* Cup in 386 cases, after two to seven years of follow-up. In addition, the Swedish Registry, an independent total joint registry, reports a 99.5 percent survivorship with the *Durom* Cup (222 patients with three-year follow-up).

[14] In a letter of October 3, 2008 to "Canadian Durom Cup users", the appellants described their U.S. investigation and stated that because "substantial surgeon training for the *Durom* Cup has been offered in Canada since the system ... was launched, and because the reported clinical results for the *Durom* Cup in Canada have been excellent, Zimmer determined that no suspension of marketing in Canada is required." The letter noted that, over the next several weeks, they would provide "updated Instructions For Use ... commonly called package inserts or product labeling, as well as updated surgical techniques that will include more detailed surgical technique instructions in Canada, as has already been done in the US."

[15] One year later, in response to reports of Durom Cup implant failures in Europe, the appellants issued an "Urgent Field Safety Notice" to surgeons using the Durom Cup in Europe. The notice, dated October 13, 2009, stated that the "most probable root cause" of the failures was the use of incorrect surgical technique and advised that "additional training" was required and that the surgeons would receive

"updated written surgical techniques", a "training DVD", and "knowledge checks" to be completed before they could obtain further supply of the Cup.

[16] On November 9, 2009, the appellants sent a letter to Canadian user surgeons in which they advised of the reports of revision surgeries in Europe involving loose Durom Cups. The letter stated that "the most probable root cause for the reported revisions for loose acetabular cups is using a surgical technique which differs from that prescribed in the surgical technique for the *Durom* Acetabular cup." They enclosed "updated surgical techniques", the training DVD, and the "knowledge-check" questionnaire, and said Canadian surgeons would not be supplied with further Durom Cups until they certified to the appellants that they had reviewed and understood the updated instructions and the DVD and had completed the knowledge-check questions.

[17] Also enclosed with the letter of November 9 was an "Urgent Field Safety Notice" to Canadian surgeons, which the appellants delivered concurrently to Health Canada and which was subsequently published by Health Canada on December 7, 2009. The notice advised that the appellants had concluded that the "most probable root cause" of the reported failures in Europe was deficient surgical technique. This document fell within the definition of a "recall" in s. 1 of the *Medical Devices Regulations* (enacted pursuant to the *Food and Drugs Act*, R.S.C. 1985, c. F-27) and as such it was posted on Health Canada's Medical Device Recall List from October 2009 to December 2009.

[18] The appellants were required to deliver "Medical Devices Problem Reports" to Health Canada in respect of all Canadian revision surgeries. As of September 1, 2010, there had been 33 such reports delivered since March 2008 and others were "in process". Nineteen of these reports described patient pain in the hip and groin area and eleven referred to Cup loosening and/or absence of bone ingrowth.

[19] Also in evidence was an excerpt from a "Correction and Removal Report" dated July 31, 2008 submitted by the appellants to the U.S. Food and Drug

Administration. The accompanying letter advised the FDA that the appellants had "received some reports of persistent post-operative pain, dislocation, and loosening of the acetabular implant leading to revision surgery" and said the purpose of the submission was to report their corrective actions. Included in the report was a table listing 51 revision surgeries reported in Medical Device Reports filed between March 16, 2006 and July 15, 2008, of which 45 reported pain, loosening, and/or lack of bone ingrowth as the reason for the revision.

[20] The respondents placed in evidence the expert opinion of Dr. Nizar Mahomed, an orthopaedic surgeon with extensive experience in adult hip and knee replacement surgeries. His qualifications were not challenged by the appellants. Dr. Mahomed stated he had reviewed the "Urgent Device Correction" sent by the appellants in July 2008 to American orthopaedic surgeons (described in paragraph 12 above); a published medical article by Long et al, "Failure of the Durom Metasul Acetabular Component", Clin Orthop Relat Res (2010) 468:400-405; the Urgent Field Safety Notice dated October 13, 2009 sent by the appellants to European orthopaedic surgeons (described in paragraph 15 above); and the "recall listing" on Health Canada's website indicating a recall for the Durom Cup posted December 7, 2009 (described in paragraph 17 above), copies of all of which he attached to his opinion.

[21] Dr. Mahomed opined,

> Based on the information in these four documents including the excellent peer reviewed published article by Long et al about the performance of the Zimmer Durom Cup, there is clear concern about the clinical performance of this device in the clinical situation. The failure rates reported by Long et al are quite concerning and clearly not in keeping with what would be expected for the clinical performance of an average total hip replacement device.
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> The revision rates quoted in the paper, as well as in Zimmer's own documents to surgeons in the United States would quote revisio[n] rates ranging from 1 to 15% at one to two years post surgery; this failure rate is far in excess of what would be expected in the performance of an average hip replacement done at this point in time.

[22] In reference to the respondents' emphasis on surgical technique as the cause of the failures, Dr. Mahomed opined as follows:

> The documents provided point toward surgical technique as the cause of failure for the implants. In the materials provided, including the materials Zimmer United States to the Zimmer Orthopaedic Surgeons, the technique described in that document is not significantly different than what would be described for insertion of a standard uncemented acetabular component. The articles from Long et al highlights the issues of difficulty in adequate insertion and fixation of this device, given its unique geometric construct, particularly the fact that this is not a hemispherical cup but it has multiple radii of curvature making fixations and insertion technically much more demanding and challenging. Given this scenario, it would in my opinion, be the manufacture[r's] responsibility to provide adequate information and training to surgeons who choose to use this device, in order to obtain optimal clinical performance. Given the unique geometric design of this implant, it would be the manufacturer's responsibility to highlight changes in surgical technique over the standard technique most surgeons would employ to insert an uncemented acetabular component.
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> Furthermore, as Zimmer in the US moved towards requiring surgeons to complete adequate training prior to further distribution of their implant. This strategy should have been implemented by the manufacturer before allowing clinical use of the device from the outset given the change in decision philosophy of this device.

[23] In response, the appellants filed the opinion of Dr. Etienne Belzile, also a well-qualified orthopaedic surgeon with extensive experience in hip replacements, including replacements done with the Durom Cup. Dr. Belzile disagreed with Dr. Mahomed's opinion. In his view, revisions of the Durom Cup implants would have been dependent on a number of individualized factors unique to each patient. Further, he said, acetabular cups like the Durom Cup can become loose for a variety of reasons having nothing to do with the device itself, including the patient's post-operative care and activities. Relying on information provided by the appellants, he derived a reported revision rate for Canadian Durom Cup recipients of 0.67% which, in his opinion, was "very low" and "does not present a cause for concern about the safety and effectiveness of this device as used in Canada." He opined that "no one could state, to a reasonable degree of medical certainty, that these 33 patients shared a common clinical experience." On reviewing the affidavit evidence given by the respondents, he concluded it could not be said "to a reasonable degree of

medical certainty" that they "shared a common clinical experience." He observed that it appeared to him that Dr. Mahomed "has no actual clinical experience with the Durom Cup" and that his conclusions were based on a review of events in the U.S. without reference to the Canadian clinical experience. Dr. Belzile said it appeared to him the revision rates in Europe and the U.S. were "quite different and not analogous to the Canadian revision rate." He stated that Dr. Mahomed's opinion "ignores the plethora of reasons that any implantable medical device, including the Durom Cup, might fail."

[24] Dr. Mahomed replied. He said personal experience with the Durom Cup "does not have a meaningful bearing" on the matter since there are established clinical standards for implants in the published literature. He acknowledged there are multiple reasons for requiring hip replacement surgery, but said the majority of Durom Cup failures

> are occurring due to significant or persistent pain as a result of implantation of this device and this failure is not the common mode for revision hip surgery in the short post-operative follow-up period as is the case that has been reported for Durom cup.

He added it was not reasonable to imply that patient outcome is dependent on post-operative care and activity since established clinical expectations of performance for such a hip implant would not require specific special precautions. He said that since the clinical design and recommendations for use of the Durom Cup are materially the same in all jurisdictions, the lower Canadian reporting rate of failure may represent under-reporting "rather than a unique clinical performance of the Durom Cup in Canada versus the United States." He repeated his opinion that the early failure rate is a matter of clinical concern and added, "[e]ven if there were only a relatively small number of failures in Canada, as is suggested in Dr. Belzile's report, this would still be cause for concern" and "the failures of the Durom cup reported in the literature are fundamental to how the device is supposed to function."

The Certification Decision

[25] The certification judge correctly noted that the burden on the respondents to show some basis in fact to support the proposed common issues was "not an onerous" one. He concluded the burden had been met. He said the evidence given by Mr. Jones, Ms. Wilkinson, and Ms. McSherry "raises the question of the cause of the failure of the Durom Cup to attach itself to the bone or what is described as the 'lack of ingrowth.'" He referred to the evidence of "at least" 33 failures of Durom Cup implants in Canada and observed that the appellants' evidence of the number of suspected failures in Canada did not correspond with the experience in the U.S. and Europe even though "the clinical design and recommendations for use of the Durom Cup are materially the same in all jurisdictions." He mentioned the appellants' July 2008 suspension of marketing and distribution of the Cup in the U.S. because of elevated revision rates and the appellants' announced conclusion that additional instructions and training in surgical technique were necessary. He referred to the similar events in Europe and the "Safety" notices issued by the appellants in Europe and in Canada in the fall of 2009. As well, he noted that the Urgent Safety Notice sent to Health Canada that identified inappropriate surgical technique as the "most probable root cause" of the failures was not conclusive of the cause and that the appellants' notices made it "clear" that the surgical techniques in use had to be reviewed "as they appear to have been defective." Further, he found that the appellants' warning letter to Canadian surgeons was a "recall" of the Durom Cup within the regulatory definition of that word. He concluded, echoing the opinion of Dr. Mahomed, that "there is a clear concern about the performance of the Durom Cup in clinical situtations."

[26] The certification judge rejected the appellants' submission that, because each implant failure was unique with a multitude of possible causes and because causation must be determined on a patient-by-patient basis, the defect question was not a common issue for all class members. He quoted *Harrington v. Dow Corning Corp.*, 2000 BCCA 605 at paras. 42-46, 82 B.C.L.R. (3d) 1, leave to appeal ref'd

[2001] S.C.C.A. No. 21, to point out that the determination of individual causation and damages is the last step in a product liability action.

[27] As for the sufficiency of the evidence of "some basis in fact", he mentioned the difficulty faced by the respondents in showing a defect at the certification stage when they had not yet had any discovery from the appellants of the relevant aspects of the design and intended function of the Durom Cup, which he described as a "highly technical medical device", and observed that "it is difficult to see how the plaintiffs could present any more evidence than they have done at this Chambers hearing in support of their allegation that the Durom Cup was defective."

[28] The certification judge referred to the conflicting expert opinions and said he did not have to resolve the conflict because the certification decision was not a decision on the merits. In this regard, he referred to *Chalmers v. AMO Canada Company*, 2009 BCSC 689 at para. 17, 178 A.C.W.S. (3d) 313, aff'd 2010 BCCA 560, 297 B.C.A.C. 186.

[29] Accordingly, he concluded that whether the Durom Cup was defective or unfit for its intended use was a question common to the claims of all class members and that the determination of this question would move the litigation along.

[30] Next, the certification judge concluded that whether the appellants breached a duty of care owed was a question common to all class members and did not depend on their individual evidence. He observed, as I understand his reasons, that whether the appellants owed a duty to warn "regarding deficiencies in the surgical technique originally recommended by them as soon as that was discovered by them" would be subsumed in this question.

[31] As for the statutory claim, the certification judge began by summarizing the appellants' position that there was no evidence of any representation ever made to the respondents or to any class member and no evidence that any class member suffered loss or damage as a result of any representation. As well, he noted the respondents' position that the *Business Practices and Consumer Protection Act*

addresses conduct and representations by a supplier to the world at large in the marketing of its products, rather than to individual consumers.

[32] He accepted the respondents' submission, adopting a passage from *Wakelam v. Johnson & Johnson*, 2009 BCSC 839 at para. 39, 179 A.C.W.S. (3d) 809, in which the Court said whether a representation was deceptive or misleading does not depend on an individual inquiry but can be litigated without reference to the circumstances of the representative plaintiff or individual class members.

[33] He added that the respondents' claim was also based on the appellants' failure to state a material fact. In this regard, he noted that the appellants did not publish the "Field Safety Notification" in Canada until December 7, 2009, while they had suspended marketing and distribution in the U.S. in July 2008 and had issued an "Urgent Safety Notice" in Europe in October 2009, and that it remained to be determined how many failed Durom Cups had been implanted in Canadian residents during that intervening period of time.

Discussion

[34] The appellants submit the certification judge failed to appreciate that whether the Durom Cup was defective and/or unfit for its intended use could not be certified as a common issue unless there was some evidence that the cause of the failures in Canada was a defect in the Cup and some evidence that these defects were common across the class. They note that the respondents pleaded the Cup was defective because it failed to adhere to the surrounding bone but did not plead any causal connection between this outcome and any particular defect. In their submission, it should have been fatal to the certification application that there was no evidence before the certification judge of any specific defect or of any causal relationship between such a defect and the Canadian hip implant revisions identified in the evidence.

[35] Similarly, the appellants contend there was no evidence of any particular deficiency in their initially-recommended surgical technique and no evidence of any causal relationship between any such deficiency and the failed Canadian implants.

[36] In order to establish liability in negligence, each class member must ultimately prove that a specific defect in the Durom Cup or deficiency in the surgical instructions was a cause of the failure of his or her hip implant. However, proof of a causal connection between a defect or deficiency and an individual plaintiff's failed implant is, along with damages, the final step in a product liability action: *Harrington* at para. 46. Causation and damages are individual issues, but proof of a defect in the Cup or a deficiency in the surgical instructions is a substantial and necessary factual link in the chain of proof leading to liability for every member of the class. One or more of the respondents' allegations of defects and deficiencies must be proven before the question of individual causation can be reached. It follows that proof of a defect in the cup or a deficiency in the surgical instructions is an issue common to all plaintiffs, the resolution of which will move the litigation along significantly. Accordingly, I would reject the submission that the chambers judge erred in certifying question (a) as a common issue without evidence of a specific defect or deficiency and without evidence that specific defects or deficiencies were common to the failed implants of all class members.

[37] Next, the appellants contend the respondents failed to establish "some basis in fact" for certification of the common issues.

[38] First, in the appellants' submission, the evidence of events in the U.S. and Europe and of their responses to these events was irrelevant and the certification judge erred in relying on it. They say their investigations established that the problem in both instances was surgical technique rather than anything to do with the Durom Cup itself. They note that there was no evidence that any Canadian surgeons were not employing proper surgical techniques and emphasize their evidence that the "updated" instructions to Canadian surgeons were merely "precautionary". Thus,

they argue, the evidence of events in the other jurisdictions lacked any nexus to Canada that would make such evidence relevant on the certification application.

[39] I am unable to accept this submission.

[40] To be admissible, evidence must be relevant. In *Anderson v. Maple Ridge (District)* (1992), 71 B.C.L.R. (2d) 68 at para. 17, [1993] 1 W.W.R. 172 (C.A.), Mr. Justice Wood (as he then was), writing for the Court, described relevance as follows:

> Evidence is relevant if it is logically probative of either a fact in issue or a fact which itself is probative of a fact in issue. Evidence which tends to make the existence of a fact in issue either more or less probable is logically probative of that fact: see Stephen, *A Digest of the Law of Evidence*, 12th ed. (London: MacMillan & Co., 1948), art. 1; *Cross on Evidence*, 7th ed. (London: Butterworths, 1990), p. 51; Thayer, *A Preliminary Treatise on Evidence at the Common Law* (Boston: Little, Brown & Co.,1898), pp. 264-65.

See also, to the same effect, *R. v. Watson* (1996), 108 C.C.C. (3d) 310 at 323-24, 30 O.R. (3d) 161 (C.A.):

> Relevance as explained in these authorities requires a determination of whether as a matter of human experience and logic the existence of "Fact A" makes the existence or non-existence of "Fact B" more probable than it would be without the existence of "Fact A." If it does then "Fact A" is relevant to "Fact B". As long as "Fact B" is itself a material fact in issue or is relevant to a material fact in issue in the litigation then "Fact A" is relevant and *prima facie* admissible.

[41] Here, the fact in issue is that the failure of the Durom Cup implants received by class members resulted from a defect in the Cup or a deficiency in the surgical instructions for which the appellants are responsible. It is not disputed that the Durom Cup was intended to adhere to the surrounding bone following implant surgery. Therefore, evidence that it failed to do so in a particular case is, as a matter of human experience and logic, circumstantial evidence that is probative of the fact in issue. Where the implants failed because the Cup did not adhere to the bone is immaterial. That the implants failed because the Cup did not adhere to the bone is relevant because that fact makes it more probable than it would otherwise be that the failures were a result of the appellants' alleged delicts.

[42] Similarly, evidence that the clinical design of the Cup and the recommended surgical technique were materially the same in the U.S., Europe, and Canada, coupled with the evidence that the appellants suspended marketing of the Cup in the U.S. because of elevated revision rates and determined that additional training in surgical technique was necessary in the U.S. and Europe as a result of the elevated revision rates, also provided relevant circumstantial evidence in support of the respondents' allegations.

[43] Relevance is not to be confused with weight. The weight to be afforded relevant evidence is for the trial judge to consider in adjudging the merits of the case. The certification judge is not to assess the merits. Rather, the certification judge needs only to be satisfied that there is a "minimum evidentiary basis" for the common issue.

[44] Accordingly, evidence of the events in the U.S. and Europe was relevant and the certification judge did not err in admitting and considering it.

[45] The appellants' second evidentiary objection is that the certification judge erred in admitting and relying on the opinion of Dr. Mahomed because it was based on hearsay statements taken from the article by Long et al and was therefore inadmissible.

[46] The appellants rely for this contention on *Ernewein v. General Motors of Canada Ltd.*, 2005 BCCA 540, 46 B.C.L.R. (4th) 234. Mr. Ernewein claimed that certain vehicles manufactured by the defendant had been negligently designed such that they created a risk of harm to consumers in the event of side-impact collisions. In support of his application to certify the action as a class proceeding, Mr. Ernewein filed an affidavit of a lawyer to which was exhibited a report prepared by an agency of the U.S. government following an investigation of the safety of the vehicles in side-impact collisions. The report supported Mr. Ernewein's case and the certification judge relied on it in certifying the action. However, the report was offered in evidence as proof of its contents without any authentication or any attempt to

prove by admissible evidence that the statements in the report were true or the conclusions were reliable. This Court observed on appeal that information that does not meet the usual criteria for admissibility of evidence is not admissible for purposes of a certification hearing (at para. 31). Thus, the report was adjudged hearsay and inadmissible as evidence of the truth of its contents.

[47] In this case, however, the evidence on which the respondents relied was the expert opinion of Dr. Mahomed. The Long article merely provided one of the bases of Dr. Mahomed's opinion. It was not offered as proof in itself of the truth of its contents. Accordingly, *Ernewein* is materially different on its facts and is of no assistance to the appellants.

[48] The criteria for admissibility of expert opinion evidence are that the expert must be properly qualified, the opinion must be relevant to a fact in issue, the opinion must be necessary to assist the trier of fact to draw a correct inference when the subject matter is likely outside the knowledge and experience of the trier of fact, and the opinion must not otherwise be excluded by an exclusionary rule of evidence: *R. v. Mohan*, [1994] 2 S.C.R. 9 at 20-25. Dr. Mahomed's opinion satisfied these criteria and was therefore admissible.

[49] Dr. Mahomed did not express an opinion on the respondents' contentions that the Durom Cup was defective and that the surgical instructions were deficient. These contentions go to the merits of the respondents' claims and, at the appropriate time, would call for an expert opinion to the standard of "a reasonable degree of medical certainty" or its equivalent, the standard to which Dr. Belzile adverted. Rather, Dr. Mahomed's opinion was that, given the information he reviewed, including the Long article, there was reason to be concerned about the efficacy of the Durom Cup and the surgical instructions provided with it. Dr. Mahomed did not comment on the truth of any of the statements made or on the quality of any opinion expressed or conclusion reached in the Long article. He characterized the article as an "excellent peer reviewed published article" and, as

such, its publication was a fact supporting his conclusion that there was reason for concern.

[50] Moreover, even if Dr. Mahomed's opinion was based in part on hearsay, that is no objection to its admissibility. Experts must as a matter of practical necessity rely on second-hand source material for their opinions. Proponents of expert opinions cannot be expected to prove independently the truth of what the experts were taught by others during their education, training, and experience or the truth of second-hand information of a type customarily and reasonably relied upon by experts in the field. Accordingly, the degree to which an expert opinion is based on hearsay evidence is a matter to be considered in assessing the weight to be given the opinion: *R. v. Wilband*, [1967] S.C.R. 14 at 21, [1967] 2 C.C.C. 6; *R. v. Lavallee*, [1990] 1 S.C.R. 852 at 896, 899-900, 55 C.C.C. (3d) 97.

[51] Assessing the weight of the evidence was within the province of the certification judge. This Court will not substitute its view of the weight of the evidence and will not interfere with the certification judge's assessment in the absence of an error in principle or unless he was clearly wrong. In my view, neither ground for interference was shown here.

[52] Accordingly, I would not accede to the appellants' submission that the certification judge erred in admitting and relying upon Dr. Mahomed's opinion.

[53] Finally, the appellants submit the certification judge erred in certifying the statutory common issue since there was no evidence that the appellants committed any deceptive acts or engaged in any deceptive practices in British Columbia. Clearly, the *Business Practices and Consumer Protection Act*, a provincial statute, can have no application to deceptive acts and practices occurring outside the territorial boundaries of this province.

[54] The respondents allege the July 22, 2008 press release issued by the appellants, which claims a "99.5 percent survivorship with the *Durom* Cup (222 patients with three-year follow-up)" in Sweden, was deceptive and misleading

because, in Dr. Mahomed's opinion, the published revision rates quoted in the Long paper and those set out in the appellants' documents sent to U.S. surgeons demonstrated a "failure rate [that] is far in excess of what would be expected in the performance of an average hip replacement done at this point in time." However, there is nothing in the evidence to suggest that this representation was published anywhere other than in the United States. The respondents identify no similar statement made in British Columbia and I therefore agree with the appellants that the respondents have shown no deceptive or misleading statement that would be actionable under the statute.

[55] However, the respondents point out that a "representation" under s. 4(3)(b)(vi) includes a failure to state a material fact if the effect is misleading. The certification judge found there was a basis in fact for the statutory common issue on this ground. As I have already noted, he said the appellants did not publish the "Field Safety Notification" in Canada until December 7, 2009, while they had suspended marketing and distribution in the U.S. in July 2008 and had issued an "Urgent Safety Notice" in Europe in October 2009, and that it remained to be determined how many failed Durom Cups had been implanted in Canadian residents during that intervening period of time.

[56] That a failure to state a material fact can ground a claim of deceptive acts or practices under s. 4 has been confirmed since the hearing of this appeal: see *Stanway v. Wyeth Canada Inc.*, 2012 BCCA 260 at para. 80, 34 B.C.L.R. (5th) 85.

[57] The appellants also argue that the statutory common issue could not be certified in the absence of some basis in fact that the respondents relied on the alleged deceptive acts and practices. They cite a passage from *Loychuk v. Cougar Mountain Adventures Ltd.*, 2012 BCCA 122 at paras. 59-60, 31 B.C.L.R. (5th) 23, in support of this argument. However, *Loychuk* was not an action brought under the statute. Rather, the appellants, who were injured in an accident on the respondent's zip-line, claimed damages for the respondent's negligence and they invoked the statutory provisions in an attempt to avoid the effect of liability waivers they had

signed. In the passage in question, the Court noted that the appellants could not resist the operation of the waivers on the basis of allegedly deceptive statements unless they showed they had relied on the statements. These remarks must be considered in their particular context and they are of no assistance to the appellants for present purposes. It may be that class members who claim compensatory damages pursuant to the *Business Practices and Consumer Protection Act* will have to prove reliance to recover them. However, that question does not arise at the certification stage. All that is required at this stage is a common issue the resolution of which will move the action along. I am satisfied that the certification judge did not err in certifying the statutory common issue for trial on that basis.

[58] For the reasons I have set out, I would dismiss the appeal.

"The Honourable Mr. Justice K. Smith"

I agree:

"The Honourable Mr. Justice Chiasson"

I agree:

"The Honourable Madam Justice Bennett"