IN THE MATTER OF AN ARBITRATON PURUSANT TO S. 148.2 OF THE REVISED REGULATION 1984 UNDER THE INSURANCE (VEHICLE) ACT R.S.B.C. 1996, c.231 (B.C. REG 447/83) AND THE ARBITRATION ACT R.S.B.C. 1996, c. 55

BETWEEN:

BM

CLAIMANT

AND:

INSURANCE CORPORATION OF BRITISH COLUMBIA

RESPONDENT

ARBITRATION AWARD

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I. Introduction: An Insurance Arbitration

1. On the evening of Saturday, November 3, 2012, BM, a 22-year old farmworker, was driving her mother's vehicle, a Pontiac Sunfire, on Highway 17 westbound towards Victoria on Vancouver Island. She was unexpectedly struck from behind by an inattentive motorist. She was injured and since then her life has never been the same. Her happy care-free life has been profoundly transformed into a life of misery, unhappiness, focused primarily on daily medical treatment and therapy, none of which has resulted in any significant improvement over the interim of more than seven years.

2. This proceeding is an arbitration pursuant to Section 148.2 of Part 10, Division 2 of the Revised Regulation 1984 (B.C. Reg. 447/83) under the *Insurance (Vehicle) Act* RSBC 1996 c. 231 (the "Regulation") commonly referred to as Underinsured Motorist Protection or UMP. I will refer to the provisions of the Regulation as the UMP provisions or UMP coverage.

3. This arbitration was brought by BM (the "Claimant") against the Insurance Corporation of British Columbia (the "Respondent" or "ICBC") further to an agreement between the Claimant and the Respondent as part of a settlement of a tort action arising out of the motor vehicle accident which occurred on November 3, 2012 (the "Accident") in which action the Claimant made a claim for damages for personal injuries.

4. The Pontiac Sunfire was insured by ICBC and owned by BM's mother, PM. The Claimant was stopped at a traffic light on the Highway and had with her, as a passenger, her then boyfriend and now common law spouse RR, when it was forcefully struck from behind by another motorist driving a vehicle also insured by ICBC with minimum third party limits of $200,000. Both RR and PM testified in this proceeding.

5. The Claimant brought the tort action in the Supreme Court of British Columbia ("S.C.B.C.") alleging negligence against the driver that struck her vehicle. The tort action included, *inter alia*, a significant economic loss claim for loss of earning capacity. The tort action was settled for the remaining balance of the defendant driver's third party limits releasing the defendant, but allowing the Claimant, with the agreement of ICBC, to pursue a first party UMP claim under her mother's extension UMP policy for compensation exceeding the compensation she received from the defendant's auto policy.

6. The Claimant could have proceeded with her S.C.B.C. tort action to have the court assess and award her damages but she elected to proceed, with ICBC's agreement, with an UMP arbitration to assess damages and ultimately to determine the compensation to which she is entitled as an insured under the UMP provisions, which incorporate by reference the *Arbitration Act*, R.S.B.C. 1996 c. 55. Ultimately the purpose of this arbitration is to determine the Claimant's entitlement to insurance monies owed by the Respondent under the UMP provisions and PM's excess UMP policy with limits of $2,000,000.

7. The parties agreed to adopt and apply the Supreme Court Civil Rules in this proceeding. The arbitration hearing has proceeded accordingly. The parties also agreed to a two-stage process: the first stage is to determine the amount of damages as part of the quantification of the claim. In this current phase of the arbitration, I will determine an award of damages in accordance with the common law. The second stage will deal with deductible amounts as they are defined by the UMP provisions and I will ultimately determine the compensation to which the Claimant is entitled by virtue of her UMP claim.

8. The parties have also agreed that any appeal from my awards will be limited to excess of jurisdiction or conduct that raises an apprehension of bias.

9. Finally, the Respondent has agreed that liability for the Accident is not contested. Accordingly, my Award will not deal with fault for the Accident.

II. Issues/Overview//Preliminary Observations

10. In assessing damages in this phase of the arbitration, I must focus, according to the common law, on the nature and extent of the Claimant's injuries focusing on her individual loss and the extent of her loss that the tortfeasor must pay as compensation.

11. In assessing loss and ultimately damages I must consider the Claimant's "Original Position" as it was and might have been against her "Injured Position", as she is now and will be. One hopes hypothetical projections involve some educated "crystal ball gazing" measured by simple probabilities or real and substantial possibilities rooted in evidence,

not pure speculation. The judgment of the trier of fact is engaged in the assessment of damages. The overall fairness and reasonableness of the award must be considered.

12. The claim as presented is primarily a “chronic pain” case resulting in near total disability. Having heard nine days of evidence, having read numerous expert reports, having reviewed the documentary record, having re-read my notes, having read numerous transcripts of the evidence, having read the written arguments of counsel and having heard oral argument, I confess that this a very difficult claim to analyze and assess. Although, on balance, I found the Claimant to be a believable and credible witness, her claim is not without some contradictions. Chronic pain cases like cases of mild brain injury have challenged the courts from both a medical and a legal perspective. I suspect that this is because the extent of injury is based primarily on subjective complaints made by persons in full possession of their senses and faculties who do not recover as ordinarily expected but rather present with profound impairment and near total disability.

13. For example, in a somewhat similar vein, Dr. Corrie Graboski, a litigation expert in physiatry called by the Claimant, testified that her clinical exam of the patient was challenging to interpret meaning that Dr. Graboski could not adequately assess soft tissues because of diffuse tenderness. BM was tentative in her movements but showed no obvious muscle atrophy on testing. Dr. Graboski also testified in cross-examination that the Claimant presented with catastrophic thinking, pain focus, disability beliefs and kinesiophobia. Those factors apparently confound recovery from chronic pain by way of cognitive behaviour therapy and active rehabilitation. For different but somewhat related reasons, I have found the Claimant’s individual loss challenging to analyze and assess. There are contradictions and inconsistencies with the claim. However, having heard all the witnesses and after review of the record in this case, no one else would appear to be in a better position than myself to evaluate the issues which need to be addressed.

14. It is important to indicate at the outset what the parties have put in issue and what they have not. The Respondent has not put in issue liability for negligence in accordance with the established essential averments of the tort of negligence. The Respondent does not contest that the Claimant has met the four requirements to prove negligence: a duty, a breach of duty, loss, factual causation as per the “but for” test and causation in law, i.e.

that the loss is not too remote.[1] The Supreme Court of Canada in both *Mustapha* and *Saadati* have confirmed these averments are necessary to prove liability for psychological injury as well as physical injury. The Respondent has not argued that the Claimant's reaction to her Accident injuries is too remote or unforeseeable meaning that the Claimant has failed to prove causation in law. Nor has the Respondent made an argument on causation in accordance with the B.C. Court of Appeal's decisions in *Maslen v. Rubenstein,* (1993), 83 B.C.L.R. (2d) 131 (C.A.) and *Yoshikawa v. Yu*, (1996), 21 B.C.L.R. (3d) 318 (C.A.). The Respondent does not contest that the Claimant has proven the injury or condition known as chronic pain, a complicated condition which, as I assess the evidence, is primarily a psychological injury.

15. The Respondent also accepts the Accident will likely have a serious long term effect and concedes a degree of permanence to the Claimant's chronic pain condition but that her impairments and disability will only be partial, with appropriate and focused treatment. In written argument, the Respondent stated "the Respondent accepts a permanent and serious impact to BM's work capacity. But the Respondent does not accept that she is incapable of work and that she will be wholly incapable of work for the next 41 years [to age 65]". The Respondent argues there is a significant chance that the Claimant should be able to achieve considerable improvement in function and in managing her mental outlook on her health and ability to lead a relatively normal life.

16. On the other hand, it is argued on behalf of the Claimant that her chronic pain and related symptoms of anxiety and depression and more recently panic attacks and agoraphobia are severe, permanent and intractable such that for the rest of her life the Claimant will live with unrelenting extreme pain, disability, anxiety, depression and other psychological distress. The Claimant submits that she has no vocational capacity and never will. She submits that she requires ongoing care and support.

17. I am satisfied that the preponderance of evidence in this arbitration points to a psychological overlay or, as the Claimant's forensic psychiatrist called it, an adjustment disorder to a stressful situation or event as the real cause of the Claimant's functional

[1] *Mustapha v. Culligan of Canada Ltd.* SCC 27, [2008] 2 S.C.R. 114;
Saadati v. Morehead 2017 SCC 28, [2017] 1 S.C.R. 543.

impairment and vocational as well as avocational disability. Labels probably do not matter. I will comment later in this Award on the Claimant's psychological condition and the relevant medical evidence including the psychiatric evidence.

III. Guiding Common Law Principles of Personal Injury Damages

18. My task and focus in assessing damages are to put the Claimant in the position she would have been in had she not been injured in the Accident. Compensation for pecuniary loss should be full in keeping with the principle of "*restitutio in integrum"*. However, compensation cannot be "perfect" or "complete" and there is a duty to be reasonable. As stated by Dickson J. in *Andrews v. Grand & Toy Alberta Ltd.* (1978), 83 D.L.R. (3d) 452 at 463, [1978] 2 S.C.R. 229, compensation must not be determined on the basis of sympathy or compassion for the plight of the injured person. What is being sought is compensation, not retribution. Reasonableness or fairness is achieved by assuring claims are "legitimate and justifiable".

19. However, as was established by the Supreme Court of Canada in the 1978 trilogy of cases, of which the *Andrews* case was one, the principle of restitution has only limited application in assessing non-pecuniary damages.

20. As Mr. Justice Dickson put it in Andrews (D.L.R. at 475):

> There is no medium of exchange for happiness. There is no market for expectation of life. The monetary evaluation of non-pecuniary losses is a philosophical and policy exercise more than a legal or logical one.

21. Since the Supreme Court of Canada trilogy in 1978 the courts have adopted the "functional approach" discussed in the *Andrews*' case to assess non-pecuniary damages. As stated in *Andrews* [D.L.R. at 476]:

> The functional approach attempts to assess compensation to provide the injured person with "reasonable solace for [his or her] misfortune".

22. In *Lindal v. Lindal* (1982), 34 B.C.L.R. 273 (S.C.C.) Dickson J. summarized the functional approach as follows [B.C.L.R. 279]:

> The court adopted the third approach, the "functional", which, rather than attempting to set a value on lost happiness attempts to assess the compensation required to provide the injured person with reasonable solace for his misfortune. Money is awarded not because lost faculties have a dollar value, but because money can be used to substitute other enjoyments and pleasures for those that have been lost.

23. Therefore, as much as one would feel sympathy or empathy for the Claimant, I must be guided by the above principles concerning pecuniary and non-pecuniary losses. I emphasize that the Respondent raises no issue of proof of factual or legal causation on the issue of liability and the burden of proof governed by the "but for" test on a "balance of probabilities". However, I must be guided by the principles of causation as it relates to damages. As McLachlin C.J. wrote in *Blackwater v. Plint*, [2005] 3 S.C.R. 3 at 31.

> It is important to distinguish between causation as the source of the loss and the rules of damage assessment in tort. The rules of causation consider generally whether "but for" the defendant's acts, the plaintiff's damages would have been incurred on a balance of probabilities. Even though there may be several tortious and non-tortious causes of injury, so long as the defendant's act is a cause of the plaintiff's damage, the defendant is fully liable for that damage. The rules of damages then consider what the original position of the plaintiff would have been. The governing principle is that the defendant need not put the plaintiff in a better position than his original position and should not compensate the plaintiff for any damages he would suffered anyway.

24. As stated by Major J. in *Athey v. Leonati* (1996), 35 C.R. 458 at 472 it is the difference between "Original Position" and "Injured Position" that is the Plaintiff's loss.

25. The following passage from the majority judgment in *Reilly v. Lynn* 2013 BCCA 49 at para. 101 remains good law when a trier of fact determines past and future hypothetical events including the trajectory of a person's career absent injury ("Original Position") and the Claimant's future trajectory taken in to account his or her loss ("Injured Position").

> The relevant principles may be briefly summarized. The standard of proof in relation to future events is simple probability not the balance of probabilities, and hypothetical events are to be given weight according to the their relative likelihood: Athey v. Leonati [1996] 3 S.C.R. 458 (S.C.C.) at para. 27. A plaintiff is entitled to compensation for real and substantial possibilities of loss, which are to be quantified by estimating the chance of a loss occurring: Athey v. Leonati supra at para. 57, Steenblok v. Funk [1990] 46 B.C.L.R. (2d) 133 (B.C.C.A.) at 135. The valuation of the loss of earning capacity may involve a comparison of what the plaintiff would probably have earned but for the accident with what he will probably earn in his injured condition: Milina v.

> Bartsch (1995) 49 B.C.L.R. (2d) 33 (B.C.S.C.) at 93. However, that is not the end of the inquiry: the overall fairness and reasonableness of the award must be considered: Rosvold v. Dunlop (2001) 84 B.C.L.R. (3d) 158, 2001 B.C.C.A. 1 at para. 11; Ryder (Guardian ad litem of) v. Jubaal [1995] B.C.J. No. 644 (B.C.C.A.). Moreover the task of the court is to assess the losses, not to calculate them mathematically: Mulholland (Guardian ad litem of) v. Riley Estate (1995) 12 B.C.L.R. (3d) 248 (B.C.C.A.). Finally since the course of future events is unknown, allowance must be made for the contingency that the assumptions upon which the award is based may prove to be wrong: Milina v. Bartsch supra at 79.

26. More recently the BCCA confirmed the legal test for assessing damages in line with the test enunciated in *Reilly v. Lynn*. In *Grewal v. Naumann*, 2017 BCCA 158 at paras. 48 and 49 the court stated:

> [48] In summary, an assessment of both past and future earning capacity involves a consideration of hypothetical events. The plaintiff is not required to prove these hypothetical events on a balance of probabilities. A future hypothetical possibility will be taken in to an account as long as there is a real and substantial possibility not mere speculation. If the plaintiff establishes a real and substantial possibility, the court must then determine the measure of damages by assessing the likelihood of the event. Depending on the facts of the case, a loss may be quantified.
>
> [49] The assessment of past or future loss requires the court to estimate a pecuniary loss by weighing possibilities and probabilities of hypothetical events. The use of economical and statistical evidence does not turn the assessment into a calculation but can be a helpful tool in determining what is fair and reasonable in the circumstances: *Dunbar v. Mendez* 2016 B.C.C.A. 211 at para. 21

27. I am guided by the principles established in the authorities that although the burden of the proof of damages remains on a plaintiff or claimant the burden of proof related to damages is “simple probability” explained as a “real and significant risk”. In determining the Claimant’s damages, one must “gaze deeply into the crystal ball”. I must assess (according to the foregoing principles) what the Claimant’s trajectory in life would have been had she not been injured and compare that with what her trajectory is now.

28. As the Respondent put it in its written submissions “the two major issues in this case” are:

(1) what BM’s life would likely have looked like absent the accident; and

(2) what lies in front of her from here.

29. In this proceeding I note that the Respondent does not assert the Claimant has not suffered both past and future pecuniary losses. It argues the nature and extent of these losses. It also argues that the Claimant has failed to mitigate her losses. Later in this Award I will deal with the issue of mitigation.

IV. The Claimant: Preliminary Observations and Findings

30. I will make some observations about the Claimant, her life before the Accident, the injury she sustained and the general nature of some of the issues and claims that I must consider and determine. I will also discuss matters of credibility.

31. By all accounts according to the evidence, prior to the Accident, BM was a fit, healthy, active, vibrant, and happy 22-year old young woman (DOB June 29, 1990). She led a full life unrestricted, for the most part, by any physical or psychological health issues except for one incident, a work-related injury, which I shall discuss. She was a full-time farm labourer engaged in physical work. She was a valued employee. She had pursued some post-secondary study beyond high school but had not settled into pursuing any academic college or university program. In 2011 she completed a two-year diploma course in exercise and wellness at Camosun College. She had also taken one course at the University of Victoria before transferring to Camosun College. For the year prior to the Accident BM spent most of her time working for Vantreight Farms, enjoying a close relationship with RR who also worked for Vantreight Farms, playing competitive soccer and engaging in other activities such as ethnic dancing, hiking, dancing, canoeing and snowboarding. She was also socially active with family and friends.

32. Soccer was a passionate pursuit of BM. She played at a relatively high recreational level but not at the highest level. The evidence from her former coaches speaks to her strong defensive play and leadership skills. At one point she played for two teams, practicing and playing six days per week. For whatever reason she never played in the highest championship league for women or at the college or university level. Nevertheless, one would have expected she would have continued to play for years if the Accident had not intervened while balancing work, continued education and family commitments.

33. Unfortunately, and tragically, BM's promising and likely happy future dramatically changed following the Accident on November 3, 2012. The Accident itself was not extraordinary. However, the forces must have been significant although there is no engineering evidence of the speed of the tortfeasor's vehicle. BM was in the driver's seat of her mother's car wearing her seatbelt. The Pontiac Sunfire apparently sustained damage to the point that it was written off as salvage.

34. Without doubt, the Claimant suffered moderate to moderately severe soft tissue injuries from the impact of the collision. Headaches followed. That she was wearing her seatbelt is demonstrated by a seatbelt bruise or mark recorded in the Primary Nursing Assessment of the Victoria General Emergency Hospital records which were entered as an exhibit in these proceedings. Also recorded was an entry that the patient was rear-ended by a car going 60-70 kilometres per hour (which in a later clinical record entry was increased to an estimate of 70-80 kilometres per hour). BM attended the Emergency Department of Victoria General Hospital by ambulance; however, no emergency crew report was put into evidence in this proceeding. The Victoria General Hospital Triage Form indicates that the patient had incurred "whiplash from a work injury on October 3". In the ER on November 3, 2012 the Claimant presented with mild to moderate neck pain consistent with whiplash injury. She also complained of tingling to her left small finger and an odd sensation to the left side of her face. She did not present with headache, dizziness, confusion, or pain to other bodily systems. She had a complaint of right hip pain due to the seatbelt, but it resolved. The diagnosis by the emergency physician was "neck strain". Out of caution, BM was given a head injury sheet for ongoing observation.

35. The initial medical records are not inconsistent with the diagnosis of the Respondent's forensic orthopaedic surgeon, Dr. Louis Weisleder, of uncomplicated cervical, thoracic, and lumbar strains. Dr. Graboski's diagnosis of the initial injury is similar.

36. Dr. Weisleder gave evidence that the usual healing period for such injuries is six to twelve weeks. The Claimant saw her then GP, Dr. Jussak-Kiellerman on November 5, 2012, and on the same day or one day later she saw a lawyer about the Accident which is confirmed by correspondence. The GP's clinical record on November 5, 2012 noted

stiffness and limitation of movement in her neck and lower back as well as indicating some left shoulder and neck guarding. Accordingly, there is some documentation of stiffness of the neck, lower back, left shoulder as well as muscle spasm or tension. She was referred to physiotherapy and it was suggested that she be off work for one or two weeks. She saw Dr. Jussak-Kiellerman for the last time on November 12, 2012. The Claimant's chart was transferred to Dr. Laura Spratt on June 25, 2013.

37. BM saw Dr. Spratt for the first time on November 13, 2012 at which time the speed of the "sleeping driver" was given at 80 kilometers per hour. Dr. Spratt, who testified in this proceeding, noted BM had had a recent head injury [the work or WCB injury] with "a mild whiplash and headaches". It was noted that BM **now** has more headaches, a lot of neck pain and jaw stiffness. She also complained of lower back pain. There was limitation of rotation and flexion of the neck and muscle spasm noted in the trapezius SCM muscles. Lower back range of motion was 70% in all quadrants. The initial assessment was soft tissue injury to the neck and back with a previous WCB claim in the prior month regarding a head injury.

38. Therefore, there is confirming medical evidence that the Claimant's initial injuries from the Accident were soft tissue injuries in the context of recovery from a work site injury one month before which involved a concussion, whiplash injury and headaches. BM commented on the "sleeping driver" and obviously gave an estimate of highway traffic speeds although she had no chance to estimate the defendant driver's speed as she was hit unexpectedly. She testified that she did not know the defendant driver's speed. This may have been the start of focus on the negligent defendant who apparently stated at the scene that he was trying to keep awake by drinking coffee and eating chocolate.

39. The above records and other records relating to the WCB claim of October 3, 2012 prove that BM suffered a fairly serious accident at work when she was kicked in the head by a fellow employee dismounting from a forklift resulting in a laceration to her upper lip, concussion, whiplash and symptoms of headaches, nausea, dizziness and neck soreness. On October 31, 2012, on visiting the Quadra Dental Clinic, those symptoms were reported as continuing. There was also right TMJ tenderness. The dentist

apparently informed the Claimant of TMJ dysfunction that may be caused by whiplash injury.

40. The Claimant's former GP, Dr. Jussak-Kiellerman, gave a prescription for massage therapy for post-concussion symptoms, whiplash injury and tension headaches. When seen by a massage therapist on October 23, 2012 she had restricted range of motion and hypertonic muscles in the cervical spine as well as headache to the frontal bone rated at 6-9.5 out of 10, i.e. moderate to severe headache pain. Massage treatments continued on October 25, October 29 and November 1. She continued to have headaches and nausea as of November 1, 2012.

41. Although a head injury or brain injury was considered by the emergency physician at the time of BM's first visit to the emergency clinic on November 3, 2012, a diagnosis of a concussion from the Accident was dismissed by the majority of medical witnesses who gave opinion evidence in this case. As Dr. Graboski stated in her medical legal report of April 21, 2017 "there is no consistent presentation of a mild traumatic brain injury". Dr. Graboski stated that any cognitive difficulties experienced by BM could be explained as arising from the effects from chronic pain and sleep deprivation.

42. In addition to (i) the work-related injuries suffered by the Claimant shortly before the Accident; (ii) the apparent anger at the defendant driver for his assumed high speed and inattentive driving and rather cavalier attitude to which BM was subjected to at the scene of the Accident; and (iii) early potential consideration of litigation, there is another factor that is important in understanding the circumstances at play in this case. In his initial medical legal report dated January 17, 2018 the Claimant's forensic psychiatrist Dr. O'Breasail wrote that although BM had no past psychiatric history there was indication of her being "somatically pre-occupied" or having concerns about medical illness or mental symptoms which may have had a psychological basis. Dr. O'Breasail expanded upon that in giving his *viva voce* evidence that BM's rather extreme somatic fear manifested itself when she was in grade school and developed an emotional fear that she might get HIV or AIDS quite readily. At that time, she was seen by a psychiatrist to be reassured. Dr. O'Breasail thought that this history showed a pre-disposition to what I can only call significant anxiety about risk to her health which Dr. O'Breasail called a "psychological

vulnerability". I would think it tends to show that BM may well have had a personality trait of fear and anxiety about risk to her health such that it pre-disposed her to pain focus and catastrophic thinking which the Respondent submitted were barriers to recovery and healthy functioning. It also seems to indicate a degree of suggestibility. There was certainly evidence about suggestibility in a large percentage of people in the general population. Dr. O'Breasail estimated that 50% to 60% of patients who take antidepressants enjoy some improvement. By the same token, approximately 40% of patients showed improvement by taking a placebo, a sugar pill. Dr. Graboski said the placebo effect was 30 percent.

43. In this case I have concluded that there were factors or forces at play which have led to the rather tragic result of worsening of BM's health rather than improvement. Those factors included being injured in a work-related accident shortly before the Accident. The Claimant probably suffered the worst injuries she had ever suffered in her 22 years to that point in the accident at the farm. I don't accept she was completely recovered from the work-related accident before the automobile Accident; however, even if she were fully recovered from those injuries, they were fresh in her mind. There was then the building anger she felt towards the defendant driver compounded by focus on litigation which was prolonged in this case as well as the fact that, for all intents and purposes, BM became medicalized, a patient or victim who in her view required virtually daily medical treatment. She admitted in cross-examination, daily treatment was equivalent to full-time employment. Finally, there seems to have been a psychological predisposition to illness focused and catastrophic thinking. These factors, in my view heavily interacted with and influenced BM's reaction to trauma from the Accident.

44. With respect to the work-related injury, the Claimant had taken time off work for which WCB benefits were paid and she had taken time off soccer as well. The evidence about the details of a graduated return to work and return to soccer are somewhat murky. It is not clear at the time of the Accident whether BM was only working part-time on lighter duties or had returned to full-time work with her usual duties. She says that she had returned to full duties at work and intended to play soccer during the week following her Accident. It would seem she started back on a graduated return to work which typically means work hours are initially reduced and duties are less heavy. Moreover, the Claimant

had taken time off soccer although the evidence was less than clear to what extent she had returned to soccer practice as opposed to games at the time of the Accident. I am not satisfied that the Claimant had fully recovered from the work-related accident when she was injured in the Accident. The records of treatment and the GP records bring into doubt BM's current recollection of full recovery. The hospital ER records suggest symptoms from the WCB accident were ongoing at the time of the Accident and that the Accident had increased her symptoms.

45. Although I have doubts that one can extrapolate from a dated anxious reaction related to a misinformed belief about contracting HIV and AIDS to conclude BM had an ingrained personality trait of somatic pre-occupation, I find that based on all the evidence, it is likely BM had a personality trait which pre-disposed her to physical or somatic concerns following stress or trauma. Dr. O'Breasail also mentioned that athletic people often do not react well to trauma. While I may have my doubts about that theory, I do believe that the Claimant's personality and psyche pre-disposed her to react negatively to stress and trauma. She may have handled well the work-related trauma but the additional Accident trauma following in short order after the work-related injury of a serious nature must have had a negative effect upon the Claimant. Although in another person such soft tissue injuries the Claimant sustained in the Accident may have resolved in fairly short order they did not resolve with BM, not because of physiological cellular tissue injury, but because of her reaction to trauma which the Respondent does not suggest is not compensable.

46. I find that the Claimant was likely still suffering to a degree from physical trauma and stress from the work-related accident (although she denies it) and was pre-disposed by her personality trait to not intersect well with further trauma.

47. Thus in experiencing stress and anxiety from the work-related accident and being predisposed to potentially dysfunctional reaction to further stress, she also became negatively affected by the defendant driver's negligent behaviour which was caused by inattention and related to poor diet and lack of sleep. Although the defendant driver is now deceased, the Claimant's obsessive anger with the defendant, which seems to have

dissipated to a degree following his death, did not help the pre-existing factors I have mentioned.

48. As noted, the Claimant also met with a lawyer the same day as her first visit with her GP or the day after. Litigation no doubt gradually added to the Claimant's stress and anxiety. Human experience informs us that litigation can be stressful and the end of litigation a relief. This added to the toxic mix of factors which seems to have doomed satisfactory recovery given BM's apparent "vulnerability".

49. In addition, the Claimant's role in life changed dramatically from an active happy young adult taking pleasure from work, education, recreation and relationships to someone whose overwhelming focus in life is that of being a patient and victim. The past seven and a half years have been an unrelenting regime of multiple modalities of treatment of generally a passive nature including physiotherapy, acupuncture, massage therapy and psychological treatment. I will have more to say about these treatment claims under the heading of Special Damages. The number of passive treatment appointments have been astronomical and contrary to the opinion of most of the medical and vocational experts who have suggested that the best chance for rehabilitation lies in active exercise, a reduction in passive treatment combined with psychiatric and psychological attention and treatment which focuses on the judicious use of antidepressants and antianxiety prescribed medication and psychotherapy involving CBT.

50. It is tragic what the Claimant's life has become following the Accident. Since November 3, 2012 she has not worked or even tried to work; she has not played soccer or any other sport; she has not attended any college or university courses nor made any attempts at voluntary service or unpaid work.

V. Chronic Pain/The Psychiatric Opinion Evidence

51. One would have expected the Claimant, without unforeseen adversity, to have enjoyed her third decade in her 20's as one of the most active, busy and enjoyable times in her life. Her life since the Accident has been the opposite. She has been a professional patient with little if any joy in her life. Fortunately, she has maintained a stable relationship

with her partner, RR, and has remained involved with her extended family and friends, although not to the same extent pre-Accident.

52. I do not accept as proven any theory of chronic pain espoused by the Claimant's medical experts, Dr. O'Breasail and Dr. Graboski, of a physiological explanation for chronic pain. Dr. Graboski suggested a theory of the "receptors of the spinal cord crosstalking to each other in an aberrant way". She suggested structural changes to the brain. Dr. O'Breasail mentioned a similar physiological theory. Neither physician offered any scientific proof or scientific literature to support such theories. I do not consider that the Claimant has proven the physiological basis for chronic pain based on what Dr. Graboski called a "central sensitization and chronic pain phenomenology". Nor do I accept the theory that chronic pain is a disease. Scientific evidence is lacking that proves such a theory. Furthermore, there is no objective evidence of structural changes to BM's brain. All radiological studies, including MRI, are normal.

53. Instead of a physiological basis for the Claimant's rather miserable condition, I believe, and the evidence suggests, that the Claimant's response and reaction to the Accident and her physical injuries were rooted in latent anxiety some of which predisposed her to a pathological response to injury and trauma. Her anxiety became pathological because of her anger and obsession with the defendant driver and her overall condition was exacerbated by becoming medicalized combined with the stress of litigation. She became obsessed with her pain and obsessed with negative thoughts about her health and her inability to function as she had once done. Her anxiety has led to symptoms of depression and lately even panic attacks and agoraphobia.

54. Since the Claimant's injuries are primarily psychological, it is unfortunate that she has never been treated by a psychiatrist. The treating psychologist in this case, Dr. Marion Ehrenberg, testified only as a fact witness without giving any admissible opinions. Unfortunately, I found the psychiatric and psychological evidence somewhat unhelpful in this case.

55. The Respondent's psychiatrist, Dr. Farcnik, saw the Claimant only once and reviewed medical records. He testified by way of Zoom but there were technical challenges which caused his connection to become frozen and ultimately his testimony

proceeded by audio only. Putting aside the technological difficulties which caused some frustration, I was still left with the impression that Dr. Farcnik tended to be an advocate for the defence and did not provide straightforward answers to relatively simple questions in cross-examination. Some of his testimony was unnecessarily argumentative. However, I did gain the positive impression that Dr. Farcnik was sincere in wanting to see the Claimant improve by further treatment which should include consistent ongoing psychiatric/psychological care including pharmacological treatment overseen by a psychiatrist and intense psychotherapy or CBT. While generally I attach little weight to Dr. Farcnik's opinion, I accept his view that not all treatment options have been explored. His recommendation that it is imperative that BM be treated by a psychiatrist and there be ongoing psychiatric care makes sense to me. Dr. Spratt, the Claimant's GP, agreed generally with the recommendation.

56. With respect to the Claimant's forensic psychiatrist, Dr. O'Breasail, I also found him to be an advocate in some important respects although he was less oppositional in cross-examination and for the most part admitted those propositions that he ought to have. He was more objective and neutral in cross-examination than Dr. Farcnik. However, I was troubled by his change in opinion on prognosis virtually on the eve of the arbitration hearing.

57. I accept Dr. O'Breasail's primary psychiatric diagnosis, with some hesitation, that the Claimant went on to suffer an adjustment disorder with mixed emotional features. My hesitation is related to the fact that the DSM-V, describes such disorders as limited to six months. Unfortunately, Dr. O'Breasail placed too much weight on inadmissible opinion evidence of Dr. Ehrenberg and statements of fact in a letter of instruction which arguably pointed toward a particular conclusion. Dr. O'Breasail noted that associated emotional features include anxiety, panic and depression related to the Adjustment Disorder. He also said, "it was unlikely the Claimant had suffered a concussion or traumatic brain injury". His diagnosis of Adjustment Disorder, which is a DSM-V diagnosis under Trauma and Stressor Related Disorders, was not really the subject of cross-examination. Adjustment disorders do not generally persist for longer than six months; however, counsel for the Respondent did not pursue whether the criteria of adjustment disorder

was met. Dr. O'Breasail gave evidence to the effect that in some uncommon cases the symptoms will persist longer than six months and can become chronic.

58. In his first report dated January 17, 2018 Dr. O'Breasail was of the opinion the Claimant has not reached the point of maximum medical improvement, but it is likely that she is left with a "restriction in vocational functioning". He did not say that she would never function vocationally. He recommended further treatment. He stated his hope and expectation that with appropriate treatment there would be some improvement in her condition. It is important to note that Dr. O'Breasail thought she might be able to return to recreational sports or activities but not likely at the same level she was at prior to the Accident which was seven and a half years ago. His opinion was that although many of her symptoms will persist in the long term, with appropriate treatment and over time her condition would improve and "**she likely will be able to return to school or return to work at some level**".

59. However in a supplementary report dated February 25, 2020, without seeing the Claimant again, and basing his opinion on an instruction letter dated February 24, 2020 from counsel for the Claimant and a one page consultation report from Dr. Ehrenberg which contains certain diagnoses which were not admissible in this arbitration, Dr. O'Breasail dramatically changed his opinion from something reasonably hopeful in terms of improvement and likelihood of return to school or return to work to an opinion that she has now reached the point of maximum medical improvement and there will be no major change in her condition in the long term.

60. I find that Dr. O'Breasail's revised opinion in his February 25, 2020 report was based upon inadmissible opinions of Dr. Ehrenberg of major depressive disorder and generalized anxiety disorder with panic attacks which Dr. O'Breasail seems to have relied upon. Further, I find it illogical that after five years of ongoing chronic dysfunction despite apparent psychological care and unsuccessful trials of antidepressants, Dr. O'Breasail held the opinion that the Claimant would likely be able to return to school or work at some level but that after seven unsuccessful years of treatment that was no longer the case. I find that there is no significant difference between five years and seven years of

essentially the same misguided treatment over those years sufficient to justify a reversal of opinions on prognosis.

61. According to Dr. O'Breasail the fact that the Claimant has not yet found an antidepressant of choice that produces some improvement in mood is not surprising; Dr. O'Breasail believes that the Claimant should have a trial of more antidepressants. It is clear from the evidence that the Claimant did not have a positive attitude towards antidepressants. To a certain extent I can completely understand that sentiment. However, she has only had three trials of antidepressants in seven and half years. Those trials included a three-month trial of Cymbalta between October and December 2013 and a three-month trial of Cipralex between November 2017 and January 2018 which overlapped with Dr. O'Breasail's only examination of the Claimant. There was a more recent trial in 2019 with a non-sedating antidepressant Wellbutrin which Dr. O'Breasail explained was not so effective with patients with anxiety and panic attacks. That would be a problem for the Claimant. Dr. O'Breasail did testify that Cipralex was usually well tolerated. In January 2018 there is a record that Dr. Spratt was considering the use of Zoloft which did not happen. Indeed, a medication list of Dr. Spratt (Exhibit "20") shows an apparently unfilled prescription for Zoloft in February 2018. Dr. O'Breasail noted that there was a change in medication to Wellbutrin although he was unaware of its dosage and how long she had tried the medication (apparently approximately nine months). It was clear to him that she did not respond to Welburtin. In his report of February 25, 2020, Dr. O'Breasail stated his belief that it is appropriate to continue further antidepressant medication trials. He considered it appropriate to continue to try different antidepressants which might decrease the intensity of her symptoms and help her with lifestyle but he remained of the changed view that they would have no major effect on vocational functioning.

62. In his reports and testimony Dr. O'Breasail recommended active rehabilitation rather than passive treatments, further trials on antidepressants and psychotherapy focused on CBT. Dr. O'Breasail specifically commented that passive therapy like massage was not useful on its own. He would not recommend passive therapy, chiropractic, massage therapy nor acupuncture as a mainstay of treatment but suggested it can be a help on occasion as active therapy is being pursued. Dr. O'Breasail has seen thousands of

chronic pain patients and he generally recommends active rehabilitation as opposed to passive treatment.

63. Dr. O'Breasail accepted Mr. Selly's statement in his letter of instruction that the focus of Dr. Ehrenberg's psychological treatment was CBT, but he had no independent knowledge of that. As I understand Dr. O'Breasail's primary diagnosis, it is an adjustment disorder to a stressor with features of depression and anxiety. Although Dr. O'Breasail claimed he diagnosed chronic pain initially that is not a specific diagnosis in his first report of January 17, 2018 although emotional features included anxiety, panic, and depression. It seems that Dr. O'Breasail was trying to expand his original diagnosis which was not mentioned in his first report. However, the Claimant does report chronic pain. I cite this as an example of Dr. O'Breasail's tendency to be an advocate.

64. I also have some concern about Dr. O'Breasail's objectivity as he was prepared to rely upon the accuracy of factual statements in Mr. Selly's letter of instruction, without review and confirmation from contemporaneous records. He also did not comment on the fact that his advice of focus on active therapy was not followed. He did concede, as no doubt he had to given his knowledge of the placebo effect, that a person's state of mind and outlook can have a great effect upon the efficacy of medications such as antidepressants. At best the Claimant's outlook on antidepressants was ambivalent. However, accepting her evidence at face value, she is prepared to try further treatment. She says she wants to get better and that can only be a good thing.

VI. A Discussion Concerning Credibility and Reliability

65. The reliability of some aspects of the Claimant's evidence is difficult to assess because her level of symptoms, impairment and disability ultimately depend on her self-report of pain and limitations. As noted, I suspect the subjectivity of pain has contributed to the challenge that the courts have faced in assessing chronic pain cases. However, my general impression is that the Claimant is credible. For the most part, I find her to be honest and sincere. Nonetheless, it is trite law that a trier of fact may accept all, part, or none of a witness' testimony: *R v. Francois* [1994] 2 S.C.R. 819 at 837.

66. In *Dahlaiwal v. Greyhound Transportation Corp.*, 2015 BCSC 2147 Mr. Justice Silverman summarized the principles to be applied in assessing credibility and reliability in chronic pain cases:

> [280] A number of principles emerged from the case law which address the question of assessing credibility in a case such as this, all of which I am guided by:
>
> > (1) It is well accepted that courts should be careful in assessing compensation where there is little to no objective medical evidence supporting a plaintiff's self reported symptoms, particularly where those symptoms persist beyond the usual course of recovery: *Price v. Kostryba* (1982) 70 B.C.L.R. 397 (S.C.) at 399 [*Price*] *Tal v. DeBusscher*, 207 BCCA 371 at para. 41 (*Tal*).
> >
> > (2) To justify an award of damages in the absence of corroborating evidence, the plaintiff's own evidence must be examined with "a skeptical eye": *Sevinski v. Vance* 2011 B.C.S.C. 892, at paras. 42-46.
> >
> > (3) Where the plaintiff's self report is in doubt, the court should place the most reliance on objective medical evidence that does not depend on the credibility of the plaintiff: *Sharifi v. Chakalder*, 2012 B.C.S.C. 685, at paras. 97-98.
> >
> > (4) There must be compelling evidence that the plaintiff's complaints are a true reflection of a continuing injury: *Price* at pp. 398-399.
> >
> > (5) While Mr. Dhaliwal's physicians are entitled to take Mr. Dhaliwal's complaints at face value, this court is required to take a more critical view: *Edmondson v. Payre*, 2011 BCSC 118 at para. 77, aff'd 2012 BCCA 114.
> >
> > (6) Credibility involves an assessment of the reliability of a witness' testimony based on their appearance, sincerity and truthfulness and the accuracy of their evidence: *Raymond v. Bosanquet (Township)* (1919) 59 S.C.R. 452, 50 D.L.R. 560 (SCC), as cited in *Karim v. Li* 2015 BCSC 498 [*Karim*] at para. 88.
> >
> > (7) As a starting point a witness is presumed to be truthful; however the presumption is displaced by evidence of deliberate falsehood: *Hardychuck v. Johnstone* 2012 BCSC 1359, at para. 9.
>
> [281] The plaintiff acknowledges that when dealing with chronic pain cases, there are few objective symptoms of injury and that therefore, the court must be extremely cautious in assessing the credibility of the Claimant.
>
> [282] The Court must review the evidence in this case as a whole when looking at Mr. Dhaliwal's credibility, rather than looking at small inconsistencies here and there.

67. *Dhaliwal* was affirmed on appeal 2017 BCCA 260.

68. A distinction may be validity drawn between credibility of a witness (his or her honestly and sincerity) and the reliability of their evidence. From time to time reliability is considered a feature of the overall issue of credibility of a witness.

69. In *Wright v. Sun Life Assurance Company of Canada*, 2015 BCSC 776, Madam Justice Adair drew the distinction between credibility and reliability. She discussed the assessment of credibility as follows:

> [121] One of the leading cases discussing the assessment of credibility is Madam Justice Dhillon's decision in Bradshaw v. Stenner 2010 BCSC 1398; aff'd 2012 BCCA 296. Madam Justice Dhillon wrote at para. 186:
>
>> [186] Credibility involves an assessment of the trustworthiness of a witness' testimony based upon the veracity or sincerity of a witness and the accuracy of the evidence that the witness provides [citation omitted]. The art of assessment involves examination of various factors such as the ability and opportunity to observe events, the firmness of his memory, the ability to resist the influence of interest to modify his recollection, whether the witness' evidence harmonizes with independent evidence that has been accepted, whether the witness changes his testimony during direct and cross-examination, whether the witness' testimony seems unreasonable, impossible, or unlikely, whether a witness has a motive to lie, and the demeanour of a witness generally (*Wallace v. Davis* [1926] 31 Ont. 202 [Ont. H.C.]; *Farnya v. Chorny*, 1952 [2d] D.L.R. 152 (B.C.C.A.)) [*Farnya] R. v. S.* (R.D.), [1997] 3 S.C.R. 484 at para. 128 (S.C.C.). Ultimately the validity of the evidence depends on whether the evidence is consistent with the probabilities affecting the case as a whole and shown to be in existence at the time (*Farnya* at para. 356).
>
> [122] Credibility and reliability are different: see, for example, Hardychuk v. Johnston, 2012 BCSC 1359 at para. 10. A witness whose evidence on a point is not credible cannot give reliable evidence on that point. On the other hand, a credible witness may provide unreliable evidence.

70. While I find that generally the Claimant is credible, the reliability of the Claimant's evidence of extreme severe pain, debilitating headaches and almost total incapacity must be examined carefully in relationship to the determination of the Claimant's future trajectory as part of her "Injured Position". My view is that a determination of the Claimant's future trajectory is the most critical issue in this arbitration. Her self-report of extreme pain and near total incapacity also forms the basis of the medical and vocational experts upon whom she relies.

71. Counsel for the Claimant argues that the Claimant was a compelling and credible witness who did not exaggerate while describing her symptoms. Counsel referred to her physical difficulty in providing her testimony over three days with an ergonomic chair, lumbar foot cushion and foot stool to assist her.

72. On the other hand, the Respondent argues that important aspects of the Claimant's testimony lack reliability which affects the critical issues of "Original Position" and "Injured Position". The Respondent cites specific examples which when taken together should be considered in my findings of fact. Those specific examples include:

(1) Purporting to know the speed of the tortfeasor's vehicle which may have affected the impression of medical evaluators and which shows an unhealthy attitude of anger towards the defendant driver and which contributes to her perception of victimization;

(2) The Claimant downplayed the severity of a quite serious work-related accident in which she suffered multiple injuries. She also seemed not to recall important aspects of that injury which must have been fresh in her mind at the time of the Accident. In addition, in giving a history to Dr. Graboski she appears to have made statements contrary to the records concerning headaches prior to the Accident, that she had fully recovered from her neck injury and concussion and that her TMJ was normal before the Accident. That seems to demonstrate a tendency to cast all blame for all negative effects on the Accident and not on other relevant events;

(3) There is also the repeated self-report of extreme pain at levels in the very severe range that would prevent a person from doing almost anything such that an ordinary person would probably has gone directly to an emergency clinic or to their GP. Even before the Accident the Claimant did report very severe headaches from the work-related incident involving pain as high as 10 out of 10. Ongoing estimates according to pain scales showed that the Claimant never reported a mild degree of pain and always reported a moderate to moderately severe to very severe ranges of pain. Frequently the pain was estimated at the very severe pain level usually 7 to 10 or 8 to 10. Such high levels of pain do not accord with reason and common sense. It is probably explained by pain focus which is part of her adjustment disorder of which anxiety is a prominent feature of her presentation;

(4) Although the Claimant adamantly states she will try anything to get better including antidepressants – the evidence shows a reluctance to try treatments suggested including refusing to try Zoloft and refusing targeted injections to a specific area of her neck to relieve cervical pain.;

(5) The Respondent also argues that the Claimant's disability is selective and therefore her current level of function is actually understated. Her

> actual ability to function is greater if the activity aligns with her inclination to do something. I find this to be one of the most serious contradictions in presentation of the Claimant's case. The Claimant will go on outings and attempt normal activities. In the past several years she has gone a cruise to Alaska, driven to Tofino, attended weddings in Smithers, B.C. and Cuba; gone to the Gulf islands, gone on a trip with RR through the Rockies to Alberta, and in 2019 travelled to Portugal from Victoria for a family holiday. She has spent the greater part of seven years driving to and form appointments in the Victoria area which is the equivalent of driving to and from a place of employment. On the other hand, she has not even once tried to work, attend an educational course or even to try to volunteer in some capacity. She says she is in too much pain and cannot even try volunteering, work or return to school.

Such inconsistency affects my view of the Claimant's actual state of impairment and disability. It reinforces the Respondent's argument that undue pain focus, disability beliefs, catastrophization and kinesiophobia are unhealthy negative barriers to more normal functioning.

73. With appropriate rehabilitation focused on exercise, CVT and gradual reinforcement of functioning (such as attempting volunteering) her outlook and health ought to improve.

74. The degree to which BM suffers severe headaches is also troubling. Dr. Graboski has testified that the Claimant complains of headaches at the top level of the scale. There appears to be a migraine aspect to her headaches but generally the cause is thought to relate more to her whiplash type flexion extension injury. Nonetheless, one would have thought that with such severe headaches one would seek out a range of treatment. If the headaches have a migraine aspect the first level of defence is typically a medication called Triptan which apparently has a good success rate in dealing with migraine like headaches. Yet over the past seven years that treatment has apparently not been considered. Dr. Graboski thought that a trial of Triptan would be appropriate. Dr. Graboski even mentioned possible headache treatment by Botox injections. Botox treatment is included as an item of future care.

75. There is one other factor that is somewhat concerning in this case. Three years ago, Dr. Graboski did a forensic assessment for the tort action for which she wrote an opinion letter on April 21, 2017 and suggested that a limited course of targeted therapy such as a C2 Plexus Block could be helpful to deal with neck pain and headaches.

Apparently, such therapy was never followed up. Dr. Graboski recommended that the Claimant should diminish and cut down on use of passive therapies. That did not happen at that time.

76. One would have thought that there would have been a more diligent pursuit of these type of treatment options, such as Triptan and targeted injections, especially with a young person whose life had changed so drastically and who was functioning very poorly and scoring pain ratings at 8 to 9.5 out of 10 where 10 is pain that completely interferes with one's ability to function and where she was reporting on a Symptoms Severity Score, severity of symptoms of 11 out of 12. Included are endorsement of symptoms of muscle pain, fatigue, tiredness, difficulties with thinking and remembering, muscle weakness, headache, numbness, tingling, dizziness, insomnia, depression, constipation, nausea, and nervousness.

77. I have explained why I believe the Claimant has fallen into the state that she has and have discussed the various contributing phenomenon. A central question is will she continue as someone in a permanently disabled chronic pain state. I do not believe so.

78. Firstly, my analysis of credibility and reliability suggests she is capable in achieving more productive function than she perceives at present. Secondly, her anger towards the tortfeasor is and will continue to dissipate. The Claimant will gradually see herself as less of a victim. Thirdly, when the persistent merry-go-round of passive therapies is greatly reduced, if not eliminated, the Claimant will focus on healthy modalities of recovery particularly active rehabilitation with a focus on exercise combined with more intense CBT and other psychotherapies to become less medicalized. Lastly, the end of litigation will also be a benefit to her outlook. She will no longer be required to focus on the Accident and the seven years to date of its aftermath. I believe there is hope that the Claimant will stop mourning the loss of her previous life and focus on a brighter future and more productive life.

VII. The Evidence: Discussion of Aspects of the Testimony

79. As I advised counsel during submission, it is not my intention to repeat in my award all the evidence that was presented over nine days. I have already discussed the evidence of the psychiatrists, Dr. O'Breasail and Dr. Farcnik. I will highlight some of the prior evidence as it relates to pertinent issues. That I do not parrot back the evidence does not mean that I did not listen carefully to the *viva voice* testimony or read thoroughly the exhibits including the expert reports. I have also read the transcripts of evidence provided by counsel and I have re-read my notes and the written submissions of counsel which include a review of much of the evidence.

80. I will divide this section of my award into parts dealing again with the Claimant's evidence, the lay witnesses, and the expert witnesses not previously discussed.

A. The Claimant

81. Mr. Selly put some emphasis in argument upon the obvious physical difficulty the Claimant appeared to experience during her testimony even with using an ergonomic chair, a lumbar cushion and foot stool to assist her. The Claimant gave evidence for more than nine hours over three days. She was subjected to a stiff cross-examination. She did move slowly and some of her movements appeared guarded. She did grimace from time to time. She did show pain behaviour. Notwithstanding the stress of giving evidence over three days, something that would be difficult for anyone, she kept her focus and held up well during cross-examination. For the most part her evidence was responsive and on point. She controlled her emotions well. Granted she had a few teary moments and she asked for a few short breaks. For someone who complains of moderately severe to very severe pain and who takes little or no pain medication her ability to persevere over three days and function well was quite impressive. Overall, she seems to have handled well whatever pain she was experiencing.

82. In addition, the Claimant appeared reasonably fit and physically healthy. Although she is, no doubt, not as fit as she was eight years ago when she played competitive soccer her overall physical health seemed quite good. I observed no problems with cognition and mental functioning. My observations seem to accord with clinical examinations by medical practitioners. Dr. Graboski found that the Claimant had good

strength in her arms and legs. She found no obvious muscle tone nor any obvious atrophy or muscle wasting, although the Claimant expressed significant pain to light touch. Dr. Weisleder's clinical examination was not inconsistent with the clinical examination of Dr. Graboski. He found some limitation of range of motion and tenderness. He found no medical indication to impose physical restrictions regarding return to work and household duties. That does not answer the subjective complaints of extreme pain and headaches. Nor does it answer psychological disorders such as adjustment disorder, depression, and anxiety.

83. I have already discussed my assessment of the Claimant's credibility as well as aspects of the evidence that bring into question the reliability of aspects of her evidence, in particular as it relates to inconsistencies concerning her present ability to function and her potential ability to overcome her symptoms which will lead to greater functionality. As noted, some of those aspects of the evidence include:

i. her apparent downplaying of the effects of the work-related accident and placing all blame for her symptoms on the Accident;

ii. her anger at the negligent defendant driver exhibited in part by her unfounded statements of the speed of his vehicle at the time of the Accident;

iii. her complaints of such severe pain that would cause most people to go to the hospital yet on a daily basis she is able to have the necessary focus and combined cognitive and physical ability to drive back and forth on virtually a daily basis to medical appointments;

iv. an intransigence of a mindset of total disability such that she has made no attempt to work, study or volunteer yet she seems to be able to undertake the demands of various activities, such as a number of trips and holidays, that she wanted to enjoy and that would bring her pleasure (although she testified as to how little she enjoyed her trips and vacations);

v. a reluctance to pursue treatment through invasive techniques such as injections or nerve blocks, an aversion to pain medication and antidepressants, yet over the past seven years she has been able to drive thousands of miles

to attend passive therapies such as acupuncture, chiropractic treatment and massage therapy without any significant improvement although the Claimant maintains the treatment has helped her in not becoming worse.

84. Nonetheless, I do not think the Claimant is a malingerer or deceitful in any way. I have described the above confluence of forces, events and previous disposition that has pitched the Claimant into a pit of misery since the Accident. The Respondent does not contest that the Accident is a material cause permitting recovery at law. However, I stress the above contradictions and inconsistencies to demonstrate that in future the Claimant may well climb out of her present state of misery and despair. A new focus on ability rather than disability should derive from i) less anger at her fate, ii) eliminating incessant medicalization by daily passive therapies, iii) monitored use of pharmacological treatment, iv) the end of litigation and v) emphasis on psychotherapy based on CBT (which all the experts seems to agree with the gold standard of treatment) that will reduce pain focus, disability mindset, catastrophic thinking and fear of movement, should pave the way for the Claimant to recapture the joy and happiness she enjoyed prior to the Accident.

B. Lay Witnesses

85. I heard testimony from the following individuals: the Claimant's mother PM, BM's significant other for the past 10 years RR, two of her pre-Accident soccer coaches MA and AS, and her former employer and supervisor at Vantreight Farms, RV. I also heard evidence from her cousins JM and BB.

86. As Mr. Justice MacIntosh commented in a recent decision in *Macie v. Deguzman*, 2019 BCSC 1509 at para. 8:

> A trier of fact can sometimes find "before and after" witnesses to be less than fully helpful because of a tendency, in the course of such evidence, to portray a plaintiff as exceptionally gifted or capable before a traumatic event and fully devastated afterwards, when the truth is more nuanced.

87. However, in this proceeding I agree with Mr. Selly that the evidence of the lay witnesses was given in a forthright way without embellishment or apparent exaggeration. Not surprisingly and without exception, all testified honestly to the profound physical and mental change in the Claimant since November 3, 2012. All were credible witnesses whose evidence was internally and externally consistent.

88. The soccer coaches testified that the Claimant was an excellent soccer player for her level and a good person to coach. RV testified that the Claimant was a valued employee, a hard worker and capable of achieving promotions to more supervisory or leadership positions. At times in her testimony PM, the Claimant's mother, was quite emotional. She corroborated an impression that the Claimant is depressed and suffers panic attacks. Her impression was that her daughter "missed her old life". However, she said "we are hopeful she will get better". She testified to her daughter's nervousness while driving. The biggest difference she noticed in her daughter since the Accident is that she is not as active now. In cross-examination she confirmed that the Claimant makes her own appointments and is independent in attending those appointments. She understood the Claimant's career goals to involve teaching or physiotherapy with children.

89. RR, the Claimant's significant other for many years, testified that they have been a couple since 2009. They went to the same high school and both attended Comosun College in the same exercise and wellness diploma program. The Claimant followed RR in working at Ventreight Farms. In other words, the couple were together before the Accident with much of the time at school and at work. They did not live together in 2012 and both stayed at their respective parents' houses. RR described the Claimant pre-Accident as very kind, honest, straightforward and generally a very good person.

90. RR was in the Pontiac Sunfire at the time of the collision. He does not recall the collision but recalls that afterwards he was in shock and felt disoriented. He went to Victoria General Hospital in an ambulance with the Claimant. He described the Claimant as being worried and afraid. RR is 6 feet 6 inches and appears to have struck the back of his head on the roof of the vehicle.

91. Shortly after the Accident, RR had symptoms of back pain – missed work at the farm and went (as well as the Claimant) to CBI for physio and rehabilitation. He and the Claimant did not have the same therapist. RR had little recall and information about the Claimant's workplace injury and did not recall the date in relation to the Accident. He did not recall if the Claimant had returned to full duties at the farm before the Accident. He knew that she missed some work. He described her job as a physically demanding general labourer. He describes the Claimant as "tough" and someone who took pride in

her work. RR put himself through trade school and became a heavy duty mechanic; he now works in the shop at Vantreight Farms as a mechanic and is working on getting his "red seal". Prior to the Accident he and BM had discussed general plans which included working, saving money, backpacking/overseas travel and after travel, likely in 2013, to return with hopefully a better idea of future work plans.

92. Post-Accident RR observes the Claimant to be limited in what she can do. She appears to be in a lot of pain. Currently the Claimant shares a basement suite with RR but when RR is at work the Claimant spends most of her time at her mother's house. He describes his role with the Claimant as more of a caregiver. He admits that he does not like to the think about the difference in their lives before and after the Accident as it seems to help him avoid dwelling on the change in BM.

93. RR observed that the biggest impact on the Claimant was probably the mental side. She is frequently tired, not happy, and not as hopeful as she once was. He observed that the Claimant does not like being taken care of. She tries to do some household chores such as washing the dishes. She will come with him in his truck to shop but she stays in the truck as RR goes into the stores.

94. RR testified about trips post-Accident that he and the Claimant had been on. He mentioned a train trip from Vancouver through the Rockies, Jasper and Calgary. RR also went to Portugal with the Claimant and members of her family. They did not do any eco-tourism such as hiking but did get out for sight-seeing, going to restaurants and socializing with family members. They stayed in a small house owned by the Claimant's grandmother's sister.

95. In cross-examination RR confirmed that he and the Claimant have lived together now for a few years.

96. In cross-examination, RR said he did not witness the work-related accident, but he had an understanding that the Claimant was injured when an employee got off a forklift to repair a garage door. RR did not recall how much soccer the Claimant missed after the work-related accident and does not recall her complaints of headaches, neck pain or nausea.

97. In cross-examination, RR confirmed that he rents a basement suite on Royal Oak Avenue. He has some savings but not enough to buy a property. He works at the farm full time from Monday to Friday and until noon on Saturday. He was offered a better paying job in Nanaimo but decided to stay at Vantreight Farms. His “red” seal hourly rate will be $35 per hour. In terms of the future he hopes he and the Claimant will have as many children as “we could handle”. That may be three to four children.

C. Expert Witnesses

1. Dr. Corrie Graboski, Physiatrist

98. Dr. Graboski was the first witness for the Claimant. I have already discussed some aspects of Dr. Graboski’s evidence and her report dated April 21, 2017. Dr. Graboski’s primary diagnosis was a chronic pain disorder, meeting diagnostic criteria for fibromyalgia. Her prognosis was dim based on medical literature of patients with ongoing pain two years after injury. Her diagnosis also included neck and back strains, cervicogenic headache, soft tissue injury to the right shoulder, mood disorder and sleep disruption.

99. Dr. Graboski had reviewed CDI clinical records from December 2012 to July 2013. She agreed that BM scored moderately high in pain catastrophization. She scored moderate to high on pain disability. Dr. Graboski agreed that the best way to replace negative thoughts with positive thoughts is through cognitive behavioural therapy (“CBT”). BM could learn distraction techniques to avoid pain focus. Reliance on passive therapies reinforces her role as a patient. A better approach is self-management by retraining her brain in how she thinks about pain and pacing herself into reincorporating activity would follow. If her barriers were treated successfully with CBT, her chance of participation in a progressive goal attainment program would more likely be successful. CBT can be combined with active rehabilitation.

100. Dr. Graboski had not reviewed Dr. Ehrenberg’s clinical notes. Nor had she reviewed the clinical records relating to BM’s work-related injury.

101. Part of a pain program is to teach a person that certain movements may hurt and cause pain, but they are not going to harm them. The goal of physical rehabilitation is to allow the person to progress to high level activities and increased function.

102. If years later a person is angry about the circumstances in which they were injured that is an indication of likely extended symptoms or poor prognosis.

103. Dr. Graboski agreed that volunteering could give a person something to focus upon. Volunteering would reduce anxiety, frustration, social isolation and perhaps depression. It would likely result in higher function because of distraction.

104. In cross-examination, Dr. Graboski was taken through the clinical records relating to the work-related injury and treatment between October 3 and November 1, 2012, two days before the Accident. Having been taken through that assembly of records, Dr. Graboski agreed that she could not rule out that the October 2012 injury caused ongoing issues with whiplash and headaches. That was contrary to the history given by the Claimant.

105. In re-examination, Mr. Selly questioned Dr. Graboski about the psychological barriers to recover from chronic pain, i.e. pain focus, catastrophization and kinesiophobia. Those barriers are corelative with people with chronic pain as opposed to being caused by chronic pain.

106. In cross-examination of Dr. Graboski, Mr. Deshon first introduced his model of certain psychological barriers as part of a chronic pain syndrome. Dr. Graboski essentially agreed with Mr. Deshon's triad of pain catastrophization, pain focus and a disability mindset. Dr. Graboski agreed that his aspects of a triad are barriers to be overcome in the treatment of chronic pain. Therefore, there is a large psychological component to chronic pain. There is also a fourth barrier which was described as kinesiophobia. That is essentially a fear of movement. An example was noted as the way the Claimant guarded movement by holding her right arm still or tucking it up under a garment. Dr. Graboski agreed that BM exhibited pain focus (reports of severe pain up to and comparable to childbirth), kinesiophobia, catastrophic thinking and a mindset focused on disability rather than recovery. All are barriers to treatment of chronic pain. Dr. Graboski stated that when she sees such high levels of scores on a pain inventory

she thinks that the patient will be challenging to treat. She agreed in cross-examination that the patient will be hard to treat because catastrophic thinking is a significant barrier to the treatment of chronic pain.

107. Dr. Graboski also agreed in cross-examination that, in addition to psychological approaches through CBT, there are specific therapies that could be tried in BM's case including Triptan for headaches and targeted injections in the cervical area for headache and neck pain as well as a trial of Botox. As noted, Dr. Graboski suggested reduced reliance on passive therapies and an increase in exercise and active rehabilitation.

108. Dr. Graboski agreed that BM presented with pain behaviours and pain focus. She confirmed that BM ticked all four boxes of barriers to chronic pain recovery including catastrophization, pain focus, disability beliefs and kinesiophobia. Psychological therapy, based upon CBT, assists in self management of the patient's condition and, in effect, BM needs to re-train her brain in how she thinks about pain and pace herself into reincorporating activity into her life. If she can be treated for the above-noted barriers, Dr. Graboski agreed she would have a much better chance of participating in a progressive attainment program. Successful treatment with CBT would improve BM's chance of participating in progressive goal attainment that would more likely be successful. CBT can be used in conjunction with active rehabilitation therapy. Dr. Graboski agreed that the large expenditure of money on treatment of passive therapies such as massage is not the gold standard for the treatment of chronic pain. Dr. Graboski agreed that such passive therapy might be appropriate for intermittent flareups but should not be used as a prime focus. Dr. Graboski also agreed with Dr. Spratt's advice to BM to focus on exercise and less on passive treatment. Similar suggestions were made by all treating specialists including Dr. Yip, Dr. MacNicol and Dr. Church. Dr. Graboski agreed that early treatment by CBT, for example in mid 2016, was an appropriate way of treating self-defeating and negative beliefs.

109. Dr. Graboski agreed that a patient with a negative view of antidepressants will likely result in antidepressants being less effective. It is common to try a few antidepressants before finding the right one. Patients may get more side effects and use them as a reason to stop taking the medication that they did not want to take in the first place and are more

likely to be non-compliant in taking the medication. CBT and a pain program educate a person about chronic pain. A patient is taught the difference between hurt and harm. Certain movements and activities may cause pain, but they are not going to harm the person. The goal of physical rehabilitation is to allow the person to progress back to high a level of activity and increased function. The point of a pain program is progress. If a person feared losing the ability to perform simple daily activities such as feeding themselves or turning a doorknob that is an example of catastrophic thinking and would demonstrate a lack of understanding of hurt versus harm.

110. Catastrophization is an exaggeration of negative beliefs about pain experiences. A person may think there is nothing they can do to reduce the intensity of their pain; it will never end and indeed they fear it will get worse. The more catastrophic one's mindset the more likely they will experience disability from prolonged pain. The more pain focused the more likely they will experience disability from prolonged chronic pain. Disability beliefs are that a person cannot do a certain thing or a set of things without ever trying them because they believe they cannot do them. Disability beliefs contribute to actual disability.

111. Dr. Gabroski agreed that kinesiophobia is a fear of movement. The manner in which BM held her right arm flexed and hand pointing upward and how she held her arm and hand during examination by Dr. MacNicol are examples of kinesiophobia which could lead to more problems such as loss of range of motion, even adhesive capsulitis. Such kinesiophobia is a poor prognosis factor for chronic pain.

112. Other examples of catastrophic thinking would be describing headaches as 10 out of 10. The report by BM of pervasive pain with a light touch is an example of pain focus.

113. It is my impression that Dr. Graboski's unfavourable prognosis is influenced by her theory that chronic pain is a disease with an organic basis. On a balance of probabilities I do not accept her theory as proven. I was also left with the impression that Dr. Graboski had not reviewed all the relevant clinical records; indeed, she was unaware of the treatment that BM had received through psychological counselling by Dr. Marion Ehrenberg. Further, it would appear that none of her recommendations for treatment including injections and decreased reliance on passive therapies had been tried. Clearly

BM had not tried Triptan for “migraine-like” headaches. Dr. Graboski also agreed with the cross-examination by Mr. Deshon that resolution of the identified pain barriers to treatment of chronic pain would improve the chances of recovery through an active rehabilitation program and learning about chronic pain and the management of chronic pain techniques. Dr. Graboski did refer to the idea that it would be important for BM to continue to work towards an activation program and learn about chronic pain and its management. She went further in cross-examination by indicating that focus on active rehabilitation and CBT could lead to greater function through a goal attainment program, modifying BM’s mindset and attempting greater function and distraction through volunteering. In short, the treatment regime suggested by Mr. Deshon had some hope of changing BM’s mindset which would change her behaviour and potential function.

114. The cross-examination of Dr. Graboski revealed the Respondent’s approach to BM’s Injured Position. BM will not remain a chronic pain patient with little or no prospect of improvement. Mr. Deshon also brought out some inconsistencies in the Claimant’s narrative and self-report that may have affected the medical opinions upon which the Claimant relies.

115. Dr. Graboski had a theory that chronic pain is a disease not a symptom or a syndrome. She discussed a theory of brain alteration where a part of the brain undergoes cellular change. She discussed an organic pathology of receptors of the spinal cord “cross-talking” to each other in an aberrant way. Dr. Graboski discussed that there is supportive developing research in MRI studies of the brain, but it has not reached the stage of clinical application nor has BM undergone any of the MRI research studies.

116. As noted, I do not accept Dr. Graboski’s theory of chronic pain as a disease involving changes to a patient’s brain as an accepted and proven medical theory supported by scientific research and experiment. No peer-reviewed medical research studies were put forward to support the theory. In cross-examination Dr. Graboski confirmed that BM did not have an MRI of the brain, experimental or otherwise. There is no objective proof of any enlargement of the brain. Specifically, one does not know if the Claimant’s brain changed in any way. I am more inclined to accept that chronic pain is better described

as a syndrome and better explained as a psychiatric or psychological disorder or response.

117. That there must be a psychological component to chronic pain seems to be supported by the Claimant's changing pain symptoms. Dr. Graboski mentioned wide-spread pain on clinical examination in 2017. However, immediately following the Accident judging by the ER records and a first visit with Dr. Jussak-Kiellerman, the original GP on November 5, 2012, BM's complaints of pain seem to have been limited to the left-side of her neck and the lower right-side of the lumbar area. When seen in 2016 by the psychologist Dr. Ehrenberg, BM specifically described pain, tingling, numbness and shooting pain on the right side of her neck into her right arm and pain over the entire low back with symptoms of numbness shooting pain and tingling in both legs. This contrasts with normal neurological examination, normal strength and no muscle atrophy or wasting.

118. Dr. Graboski confirmed pertinent aspects of BM's history and treatment. Arrangements were made for spinal MRI studies. The MRI imaging was essentially normal. BM complained of side effects from the antidepressant Cymbalta including fatigue, constipation, nausea dizziness and poor appetite. By December 2013 BM wanted to ween off Cymbalta which had been prescribed by Dr. Yip. The trial of Cymbalta lasted only a matter of months. Another antidepressant Elavil was considered by Dr. Spratt in December 2013 but never taken. In February 2014, Dr. Spratt considered trying Zoloft for the first time. In May 2014, BM also reported symptoms of tiredness, dizziness, and nausea following a trial of the pain mediation Tramadol, a pain medication. In October 2015 BM was not inclined to attempt antidepressant therapy. Hence the comment of Dr. MacNicol that in January 2016 BM was on a "chemical vacation". Visits with Dr. Yip continued in 2015 and 2016. Unfortunately, I did not have the benefit of testimony directly from Dr. Yip or Dr. MacNicol.

119. In giving her history to Dr. Graboski BM repeated that the defendant driver was travelling at approximately 80 kilometres per hour and had fallen asleep. BM admitted that she had no personal knowledge of the speed of the negligent driver. BM reported moderate to moderately severe pain between 6 to 9/10. She rated shoulder pain as 8 to 9 out of 10. Headache pain when severe is 10 out of 10. Dr. Graboski was of the opinion

there were some features of migraine in BM's headache complaints. Yet she had not been trialed with the first line of defence for migraine like headaches with the medication commonly known as Triptan.

120. Dr. Graboski's clinical exam of soft tissues was limited by BM's hyper-sensitivity to a light touch. She found no obvious increase in muscle tone, but it was hard to assess. BM had good strength in her arms and legs and Dr. Graboski found no obvious atrophy or wasting.

121. Dr. Graboski is of the opinion that BM met the diagnostic criteria for fibromyalgia based on the 2010 Diagnostic Criteria. There is now a 2019 Diagnostic Criteria. In any event, the diagnostic criteria of 2010 did not involve testing of tender points by palpation. Diagnosis is based solely on self-report of subjective symptoms. BM scored 14/19 on the Widespread Pain Index and 11 out of 12 on the Symptom Severity Score. My understanding is that fibromyalgia as a diagnosis is generally accepted in the field of rheumatology but is viewed as a more controversial syndrome in other medical disciplines.

122. Dr. Graboski did not find any pre-Accident factors which made her more susceptible to the injuries sustained in the Accident. BM only reported rare headaches prior to the motor vehicle collision and failed to mention the ongoing headaches she was experiencing from the work-related injury. Nor did Dr. Graboski find any pre-existing somatic pre-occupation as was found by the forensic psychiatrist Dr. O'Breasail. Dr. Graboski recommended Botox injections which have some potential with migraine variant headaches. She recommended a trial of three injections every three months. If successful, these injections may need to be continued. As noted, she also recommended a limited course of targeted therapies such as a C2 plexus block. Dr. Graboski also recommended that BM diminish reliance on passive therapies and continue with an active rehabilitation program. She also recommended continuing with psychological therapy. Dr. Graboski was of the opinion continued adherence to an active rehabilitation program and learning about chronic pain and its management will be important to her. She did not feel BM *"would be able to return to work in any capacity at this point in time"*. She thought

it unlikely she would return to her "*high level of recreational activities in the foreseeable future*".

123. I do not doubt Dr. Graboski's opinion as set out in her medical legal report of April 21, 2017 that B M could not then or now return to work. The question that I face is whether there is any real possibility that she will return to work in the future.

2. Niall Trainor, Vocational Consultant

124. Mr. Trainor is well-known to the courts of British Columbia as an experienced vocational and rehabilitation consultant. He is a registered rehabilitation professional recognized by the Professional Rehabilitation Association of Canada, a certified vocational rehabilitation professional and a fellow of the Canadian College of Vocational and Rehabilitation Professionals. His academic background is primarily in the field of sociology and in 1983 he obtained a master's degree in Sociology from the University of British Columbia. Mr. Trainor was the second expert to testify on behalf of the Claimant. He was tendered and accepted as an expert in vocational rehabilitation and assessment of employability entitled to given opinion evidence in those fields. He also has an interest in chronic pain rehabilitation.

125. Mr. Trainor performed a vocational assessment of the Claimant on April 6, 2018. His report bears that date. Mr. Trainor noted that at the time of the Accident BM was working as a farm labourer and retail produce clerk. She professed an interest in returning to university to pursue a professional career. She has not worked or pursued retraining since the Accident. BM is pessimistic about her chances of re-employment and is at a loss to identify a feasible employment objective. Vocational testing of BM revealed, *inter alia*, she would prefer working with people more than working with ideas or things; she would prefer hands-on practical experiential learning rather than academic learning such as lectures and books; and she showed an aversion to risk taking. Furthermore, she scored in the 16th percentile equivalent to a grade 7 level in study skills. The report cautions that there is not a precise correspondence between test items and what is taught in classrooms. However, such testing would show some contra-indication to university study, at the master's level or professional level. I mention that because there is an economic earnings projection based on BM obtaining a master's degree. In answer to a

question from myself as to any statistics about teachers with a Bachelor of Education going on to obtain a master's degree, Mr. Trainor indicated that not many teachers with a Bachelor of Education achieve a master's degree. A master's program is a more academic program and her ability to purse it would have been contingent on how well she did in the last couple of years of an undergraduate program because she would have to shine there in order to be able to qualify. Although there may be a financial incentive for a teacher with a bachelor's degree to seek out a master's degree it is harder to get into and graduate school is tough. It seems to me that although the Claimant's testing was limited it suggests that she would not have preferred an academic environment and her study skills may not have been strong enough to pursue a master's degree.

126. Mr. Trainor was advised by BM that she had an interest in the teaching profession but was reconsidering her options at the time of the Accident while taking time from academics to work. BM did not expand upon the specifics of her professional goals which, according to her evidence in chief, were focused on elementary school teaching including physical education or alternatively a physiotherapist working with children with disabilities. In cross-examination Mr. Trainor indicated that it was his understanding that at the time of the Accident BM did not know what she wanted to do in terms of future education and employment. There is also the matter of her community college and university grades which included an F in Human Physiology.

127. Mr. Trainor noted that BM suffers from chronic pain, including daily headaches. In his opinion, the nature and severity of her reported pain would preclude participation in any training or employment on a regular and reliable basis. Mr. Trainor singled out BM's headache disorder as precluding sustained employment including the least physically demanding. Mr. Trainor also assumed BM had been diagnosed with depression. Workers with physical ailments and depression are twice as likely to be disabled than patients with physical problems alone such as arthritis, migraine headaches and back pain. Mr. Trainor also stressed the low probability of work return in a case reflecting the development of negative thinking, i.e. pessimism. Workers with chronic pain also develop negative feelings and expectations about their ability to find and keep employment. In this case, BM fosters significant doubts about her ability to work and she is at a loss to identify any occupation that would seem feasible given her ongoing symptoms.

128. On his assessment, Mr. Trainor found BM to be competitively unemployable. However, he wrote in his report that it is possible but nor probable that BM can find and keep employment. Although he assumed that BM had plateaued in her recovery, he did not preclude the possibility of her one day attempting to pursue employment but if she were to succeed, it would be because she has experience at reduction in pain and/or an improvement in pain coping skills that allows her to commit to employer expectations regarding attendance and productivity. That would mean committing to two to four hours of productive work per day on a regular and reliable basis.

129. To achieve such goals Mr. Trainor encourages BM to develop goals aimed at making measurable improvement in her ability to commit to regular employment. One of the methods would be taking gradual steps with volunteering. Mr. Trainor suggested regular scheduled volunteer work such as visiting seniors in a residence or a day program. Her initial commitment of hours and days could be arbitrary based on what she feels comfortable with as a starting place. Over time, she should challenge herself to take on more hours and duties. Mr. Trainor gave an example of BM leading a seniors' exercise program. Mr. Trainor also suggested volunteer work or pursuit of education can be a meaningful activity that can prove job readiness.

130. Given the chronicity of BM's symptoms and disability, Mr. Trainor was of the belief that it would not be probable for BM to rekindle her premorbid career ambition of obtaining a university and professional career; however, he would not preclude that possibility completely if the education plan included gradually increasing her course load.

131. Mr. Trainor was cross-examined by Mr. Deshon concerning the theory of the defence that BM might respond positively to psychological therapy including CBT. Mr. Trainor agreed that CBT is a technique that could address BM's pessimism regarding future work and education.

132. Mr. Trainor agreed that litigation can be a potential barrier to employment because some might feel their entire life is on hold until such time as the litigation has settled.

133. Mr. Trainor had experience working with a multi-disciplinary team where CBT was a component of the treatment approach to those with chronic pain.

134. Mr. Trainor also gave evidence that the pre-Accident perspective would include that it may well take BM some time to organize an undergraduate degree in teaching. Mr. Trainor gave evidence that in the 1980's there was a trend in the labour force to become more transient. Employers structured their workforce to have more part-time workers with no benefits as opposed to full-time employees with salaries and benefits. Today people are organizing careers later and are changing careers more frequently.

135. Since BM was apparently considering other options for future employment, she might have considered becoming an athletic program director or sports event coordinator which usually pays in the range of $30,000 to $60,000 per year.

136. Mr. Trainor also testified that if there were a reduction in BM's headache pain that would improve her potential for employability. Given his experience with chronic pain patients several clients use Triptan to abort headaches or Elavil or Amitriptyline to treat headaches. If BM had a treatment available to her for headaches it would be more likely that she could do a sedentary job.

137. Mr. Trainor is familiar with CBT from a rehabilitation standpoint, but he does not do it. Mr. Trainor has some experience with CBT and gave evidence about his understanding of it. The psychologist does it and they may achieve a certain degree of success. One looks for a change in the thought "I can't work" to "I can work", including a change from "I can't volunteer" to "I can volunteer". A further change may be in the approach "I can't study" to "I can study". The goal of CBT is to change the thought process or mindset of the individual to believe that they are going to be fine to go to work rather than have a negative experience because they anticipate a bad experience in the workplace. Mr. Trainor explained that the work of a psychologist is not just changing thoughts, i.e. about pain but exploring those thoughts, understanding the patient's anxieties and then potentially developing relaxation techniques that can be used.

138. On further cross-examination Mr. Trainor agreed that chronic pain is a bio-psychosocial phenomenon. By that he means that people experience their pain physically; react to it emotionally; then they learn how to deal with it rationally. Some people can develop "adaptive" ways of dealing with their pain and others do not learn how to deal with their pain, described as "maladaptative". Mr. Trainor conceded that if BM had

an improvement in pain coping skills she could possibly work. Pain-coping skills include pacing, part-time work, learning relaxation techniques, breathing techniques, slowing one's mind down and possibly meditation.

139. Mr. Trainor confirmed he encouraged BM to develop goals for measurable improvement in her ability to work, like a progressive goal attainment program. Mr. Trainor recommended volunteering as a step in that direction. It is important to have a goal of incrementally increasing volunteering such as at a senior's residence. That builds up stamina and is an anchor for development of further progress. As I see it, a person can develop some confidence.

140. Mr. Trainor confirmed that BM has work disability beliefs. Mr. Trainor then gave evidence that the longer a worker is out of the loop in terms of employment, the longer disability ideations become more fixed and more difficult to change. Early active intervention works, in part, because one can catch a person before negative disability ideas take hold. Some people are going to get better no matter what. It starts with having a regime or structure, including waking up at a certain time, having breakfast, going for a walk, and eventually going to work. BM's previous competitive nature could help her see a progressive attaining program as a challenge.

141. Mr. Trainor wanted to see BM start volunteering and progressively build that up to four hours per day which would facilitate an entry into the workforce. Then she could have a goal of part-time employment and might meet a sympathetic employer. Presumably, that might be an employer she finds through her personal network. Another option would be to take one university course. Presumably then she could build up to taking more courses. That would depend on a reduction in pain and/or improved pain coping skills. I interject to say that the proposed treatment and reduction in passive treatment might well improve her pain and an intensive course of CBT would improve her pain coping skills.

142. Mr. Trainor agreed that focusing on abilities and not pain disability is a key to changing a pessimistic view to an optimistic view for a person with chronic pain. If a person says "I can't volunteer because my body can't do it" that is a negative view but

maybe there are other kinds of volunteer work they could do. It may simply be a matter of trying to figure out alternatives.

143. There was extensive cross-examination on Mr. Trainor's experience with chronic pain clients and the success or failure of return to work. It has been Mr. Trainor's experience that the likelihood of returning to the workforce is quite dim for workers who were entrenched in the workforce but because of an injury involving chronic pain remain out of the workforce for years. Mr. Trainor agreed that some people with chronic pain work full-time, some work part-time and some do not work. I must say on this point that Mr. Trainor's experience differed from that of Dr. Denise Hall, vocational expert for the Respondent. In any event, I have no reason to disbelieve Mr. Trainor's experience. However, I believe this case is distinguishable. Here we are not speaking of a person who had been entrenched in the workforce for some time; instead, we are dealing with a relatively young person who has yet to become entrenched in the workforce and has yet to settle upon a career and an educational path to pursue that career. That may well have taken BM several years to work through. BM's youth and the fact that her career plans were not yet totally settled and achieved, indicate to me that there is a greater chance she could re-establish her education/vocational goals with the appropriate change in regime that would include diminished reliance on passive treatment, more focused pharmacological regimes and intensive psychological treatment including intensive CBT. Dr. Farcnik's recommendation that BM be treated by a psychiatrist seems essential for someone who has had no meaningful improvement after seven years.

144. Mr. Trainor also accepted that catastrophization, pain focus and disability beliefs are features of BM's presentation. A progressive goal attainment program aims to have the individual resume activity rather than reduce pain. Mr. Trainor's understanding of BM's approach was a focus on physical rehabilitation and pain reduction before contemplating a return to the workforce. For example, if BM's chronic headaches were treated such that pain was reduced, or if her depression was treated and at least managed, or if she learned how to manage chronic pain, that would increase the possibility of return to work. Mr. Trainor also thought that if BM were to return to an educational pursuit her first step might be in auditing a course rather than trying to achieve certain marks. If she can do that perhaps that could lead to taking a course or two courses for grades.

145. Mr. Trainor also projected that if BM had children the parenting role would likely fall to her as RR is a heavy duty mechanic and would likely be the major breadwinner. Caring for children under the age of six is usually the time for maximum parental involvement because of the high cost of daycare. When the children are in the school system, paid part-time work is more probable than full-time work.

146. Mr. Trainor thought that BM's relative youth is a point in her favour to be rehabilitated. Although Mr. Trainor would not say that there was a probability BM would be able to achieve her vocational goals in the future, being able to articulate a rehabilitation plan means that there is a possibility.

147. Mr. Trainor had not seen anyone make a successful return to work after being out of the workforce for seven years with chronic pain. Such people often have an entrenched belief that they are unemployable. They become a "self-fulfilling prophecy", in that they predict they will remain unemployable and as time passes they are unemployed. However, I would point out that the premise assumes failed treatment for chronic pain or failed improvement in management or coping skills with respect to chronic pain. In cross-examination Mr. Deshon established that Mr. Trainor believes that BM is not dealing with her chronic pain. Anger at the person responsible for injury is potentially an explanation for perpetuation of chronic pain and disability. If the anger and lack of acceptance of her dilemma is successfully treated, the chances of better function are improved. As Mr. Trainor said, "the whole issue centres around the potential for these things to be successfully treated". However, BM still has anger and is in denial but there is hope of improvement through treatment and appropriate rehabilitation.

3. Dr. Laura Spratt, GP

148. Dr. Laura Spratt first saw BM as a patient on November 13, 2012. BM had seen her long-time general practitioner Dr. Jussak-Kiellerman the day before, November 12, 2012. It appears that BM had lost confidence in her long-time general practitioner. Dr. Spratt was the only treating physician to testify in the arbitration proceedings. She recognized the conflict between being an advocate for her patient in the medical system contrasted with her role in providing medical opinion evidence to the courts in an unbiased objective manner. She endeavours to keep the two roles separate. Nonetheless, it seemed to me

that Dr. Spratt was quite supportive of her patient whom she continues to treat. My impression was that Dr. Spratt wanted BM to focus more on active therapy and exercise in her quest to recover and not rely so much on passive therapy. For example, it was BM's desire to try acupuncture not that of Dr. Spratt. In an office visit on January 17, 2013 BM said she wanted to try acupuncture. Dr. Spratt recommended exercise although she did not disapprove of trying acupuncture. Further, Dr. Spratt really knew little about Dr. Ehrenberg's psychological approach to treatment. Initially she was concerned that Dr. Ehrenberg's treatment did not focus sufficiently on CBT. Apparently, she later changed that view but in the context that she knew little about Dr. Ehrenberg's approach. Dr. Spratt has a special interest in CBT and believes CBT is the best way to replace negative thoughts with positive thoughts in dealing with chronic pain.

149. The initial visit of Dr. Spratt with BM is set out in some detail in her medical legal report January 12, 2018 (Exhibit 19) and in an earlier medical legal report dated August 2, 2013 to BM's then counsel (Exhibit 22). In the initial visit of November 13, 2012, the Claimant gave details of the accident of November 3, 2012 having occurred at about 6:50 p.m. when she was stopped at an intersection and then rear-ended by an inattentive driver travelling at 80 km per hour. In a clinical note of the visit on November 13, 2012 Dr. Spratt recorded more detail including that the driver was sleeping and the car was written off and had a broken axle. BM gave a history of a recent head injury at work with mild whiplash and headaches and "has more headaches, a lot more neck pain and jaw stiffness now as well as lower back pain which started about 48 hours after the motor vehicle accident". She stated that her usual work was in shipping, produce and preparing orders. She had been attending physiotherapy two times per week. There was no mention of headaches in Dr. Spratt's initial medical legal report in 2013. In the medical legal report of January 2018 there is mention of associated headaches with increased pain in her neck and pain and stiffness in her lower back.

150. In testimony Dr. Spratt stated that she did not consider headaches to be a prominent feature of BM's presentation. She was of the view that BM is not a patient with chronic headaches but rather has chronic pain in her neck and back with associated headaches.

151. Dr. Spratt testified BM was very worried about the effects of medication. In cross-examination Dr. Spratt agreed that BM is terrified of medications. Nonetheless Dr. Spratt believes that BM has a willingness to try to get better and has some optimism that she will get better. Dr. Spratt has had more time to get to know BM than any other physicians testifying in this proceeding. There is some contradiction between BM's statement that she will try anything to get better and Dr. Spratt's acceptance of that statement contrasted with BM's refusal to try injection therapy and her discontinuance of the usage of some medications and reluctance to try others. Exhibit 20 was a list of medications prepared by Dr. Laura Spratt's office. While it showed some trials of antidepressants including Cypralex and Wellbutrin, BM did not fill her prescription for another antidepressant which was apparently suggested in 2014, an antidepressant called Zoloft. Elavil was considered by Dr. Spratt but not trialed. Although she did trials of Cymbalta (prescribed by Dr. Yip) in 2013, Cypralex in 2017-2018 and Wellbutrin in 2019, there were other antidepressants that BM could have tried to find a more appropriate antidepressant and those antidepressants included Luvox, Remeron and Effexor. However, Dr. Spratt acknowledged that if BM has a negative attitude towards medications like antidepressants it will be that much harder for the patient to overcome negative thoughts.

152. Dr. Spratt did not believe that depression was a huge part of BM's presentation. BM exhibited no physical signs of depression. Suicide ideation was not a part of her early presentation. For these reasons Dr. Spratt did not make any psychiatric referral. However, it seems that as BM's psychological problems have developed adversely, apparently to include panic attacks and agoraphobia Dr. Spratt agrees with the recommendation of Dr. Farcnik that a referral to a treating psychiatrist should occur if one is available. In her medical legal report of January 12, 2018 Dr. Spratt recommended that BM continue in the care of a psychologist as she is at risk for long term depression. Dr. Spratt believes CBT is an appropriate therapy for a patient such as BM to learn how to live with chronic pain. Dr. Spratt was not sure she recommended Dr. Ehrenberg [it was apparently recommended by an OT] and has not considered a referral to another psychologist. She acknowledges that BM has a great deal of CBT knowledge but struggles to apply her "tools". An intensive course of CBT assists a patient to learn how to apply skills. Eight weeks of treatment may not be enough. Dr. Spratt acknowledged

that a patient should as a first step in CBT accept that they will have pain, learn distraction techniques to avoid pain focus and focus on positive matters, accept that they may live with pain and attempt progressive goals. It is important to adjust behaviour, through accomplishment which can change negative feelings about pain and disability.

153. Dr. Spratt agreed that BM needs to learn the mechanics of chronic pain, diminish reliance on passive treatment and focus on active management and CBT. While BM may need intermittent access to passive therapy it should not be a focus. Dr. Spratt agreed that BM could try volunteering. That would be an example of behaviour aimed at changing thoughts and feelings. Otherwise BM is in a trap of her mind governed by the triad of pain focus, disability belief and catastrophic thinking. That is accompanied by worry, rumination, and negative thinking.

154. Dr. Spratt agreed that attitude can affect outcome. If a person believes they cannot do something it isn't likely they will do it. Beliefs are treatable by CBT. Dr. Spratt agreed with Dr. Graboski and Dr. O'Breasail that the primary focus of BM's recovery should be on active management involving CBT and exploration to find an appropriate antidepressant. However, BM does not agree she is depressed. She is not opposed to trying a new medication. She did not try Zoloft but there are other antidepressants such as Elavil, Effexor, Luvox and Remoril that have yet to be tried. While BM had some symptoms of depression according to Dr. Spratt, chronic pain is the predominant feature of presentation. Dr. Spratt has made no investigation that BM may have a sleep disorder as considered by Dr. Farcnik. Currently she is on an acceptance and commitment therapy program at Royal Jubilee Hospital. That is encouraging.

155. When I said earlier on that Dr. Spratt was concerned that psychological counselling was not focused on CBT there is a clinical note of June 16, 2016 that "counsellor not too directed to CBT". However, she was satisfied after November 2019 that there had been a redirection to CBT but admitted that she does now know Dr. Ehrenberg's approach. Dr. Spratt's note of January 29, 2019 said that BM had CBT skills but struggled to apply them.

156. Dr. Spratt agreed to the following:

a. BM should see a treating psychiatrist;

b. Focus on active rehabilitation;

c. focus on self management;

d. focus on exercise therapy such as the gym and pool therapy;

e. retrain her brain in the way she is thinks about pain (CBT).

157. Dr. Spratt testified to the effect that it was her impression that BM is quite willing to try new modalities of treatment and pushes herself to try to do what is medically recommended. It is certainly clear that since the Accident BM has participated in a regime of different therapies with considerable emphasis on passive therapy. BM has testified that she is willing to try new things. However, the evidence is quite contradictory on BM's disposition towards recommended treatment. The evidence of Dr. Spratt demonstrates BM's resistance to medication. As noted, a medication list (Exhibit 20), shows she has tried a number of medications such as Advil, Tylenol, Gabapentin, Tramacet, Cymbalta and Amitriptyline for pain but she has discontinued all except the occasional Tylenol to take the edge off "a very bad headache". As recently as November 2019, Dr. Spratt has prescribed Ativan for anxiety and panic attacks, but it was not clear to me whether she has taken any. There were prescriptions for a muscle relaxant Flexiril but as I understand it Flexiril was prescribed in 2013 but not again until 2019. My understanding of the evidence is she is not taking that medication now. BM indicates she is planning to try another antidepressant medication but there is no evidence that any has been prescribed by Dr. Spratt. Examples of other antidepressants besides those she has already trialed (Cymbalta, Cypralex and Wellbutrin), were discussed by the physicians in giving evidence.

158. Dr. Spratt made referrals to treating specialists including Dr. Yip, a physiatrist, Dr. MacNicol, an interventional pain consultant, and she saw Dr. Church, an osteopathic physician. Reference is made to a January 27, 2016 report of Dr. MacNicol and his recommendation for facet joint injections and specifically to C2 plexus nerve blocks or trigger point injections. BM declined injection treatment which might have been

widespread or specific. The comment by Dr. MacNicol that BM was "currently on a chemical vacation" seems to be supported by Exhibit 20 and which has generally been the case with some exceptions to date. The record of prescription medication seems consistent with BM's testimony that she would prefer not to take medication, which I must say is understandable but difficult to reconcile for a patient with symptoms of severe pain and disability. Dr. MacNicol, consistent with other medical advisors, stressed the importance of regular exercise. Dr. Yip prescribed Amitriptyline for pain but stopped it in 2015 to try Gabapentin.

159. I assume that it was Dr. Spratt who referred BM to the pain clinic at Royal Jubilee Hospital in 2017 and 2020. Dr. Yip also arranged for MRIs of the Claimant's spine which radiological studies showed were essentially normal. Dr. Spratt was aware that BM had seen the osteopathic physician Dr. Church and it seems his advice was to focus more on exercise and less on passive treatment. That advice is consistent with that of Dr. Spratt, Dr. Yip and Dr. MacNicol.

160. One hopes that the pain course that the Claimant is following or has followed in 2020 at the Royal Jubilee Hospital will have a positive effect and it is also hoped that Dr. Ehrenberg's ongoing treatment will have a positive outcome. However, in 2019 Dr. Spratt was concerned that while BM had lots of CBT knowledge, she did not seem able to use it. There is a clinical note to that effect dated January 29, 2019. No medical evidence was provided that the Claimant was making further progress with psychological treatment for chronic pain after that date.

4. <u>Dr. Marion Ehrenberg, Psychologist (Fact Witness Only)</u>

161. Dr. Ehrenberg, a clinical psychologist, testified solely as a fact witness. She did not provide an expert report in accordance with Supreme Court Rule 11. Therefore Ms. Ehrenberg was not permitted to give opinion evidence and her evidence concerning diagnosis and prognosis is inadmissible. Just as I was disappointed with the evidence of the two psychiatrists, Dr. O'Breasail and Dr. Farcnik, the fact that Dr. Ehrenberg gave no opinion evidence in a case very much centered on a person's psychological reaction to trauma was disappointing. The cost of Dr. Ehrenberg's continuing psychosocial treatment which began in 2016 as well as the Claimant's mileage to attend sessions with Dr.

Ehrenberg are part of the special damages claim in this arbitration. Exhibit 39 is a summary of Part 7 and Special Damages put into evidence by consent of counsel. It does not provide any detail of approximately $42,000 worth of some of the claimed special damages. I am unable to say exactly how many visits Dr. Ehrenberg had with the Claimant but there have been many.

162. Dr. Ehrenberg first saw BM on January 29, 2016 on the suggestion of an OT. BM completed a pain work sheet and pain chart. The pain chart is much more extensive than the original pain chart in Dr. Jussak-Kiellerman's records shortly after the Accident. The pain worksheet is consistent for the most part with BM's subjective complaints of pain as severe or moderately severe.

163. Counsel made minimal reference to the evidence of Dr. Ehrenberg in submissions. Mr. Selly referred to Dr. Ehrenberg's counselling since 2016 as including CBT, breathing techniques, a workbook called Mind Over Mood and a few CBT based applications that can be used on the Claimant's phone. Mr. Selly said Dr. Ehrenberg helped BM learn how to replace some of her negative thoughts with positive ones. However, given the evidence that I heard from the Claimant it seems her negative thoughts rather overwhelm any positive ones at least to date.

164. When Dr. Ehrenberg first saw BM, testing showed that she was mildly depressed. Testing also revealed that BM scored in the moderate clinical range of anxiety. Unfortunately, BM's anxiety worsened between 2016 and 2019 and now she exhibits anxiety to the point of having panic attacks and agoraphobia.

165. On testing BM scored in the higher range for compulsive personality in terms of personality patterns. That was described by Dr. Ehrenberg as "all or nothing thinking", I gather that means black or white thinking and not shades of grey or understanding nuances.

166. In cross-examination Dr. Ehrenberg agreed that initially BM presented as minimally depressed. Initially her sleep patterns were not much of a problem but later became more problematic. Apparently, her sleep became worse with anxiety which substantially increased in 2019. She exhibited examples of catastrophic thinking. For example, overestimating horrible things that could happen while driving.

167. On cross-examination Dr. Ehrenberg confirmed that initially BM's anxiety on testing was low to moderate but in the past year it has become much more prominent.

168. In cross-examination Dr. Ehrenberg agreed that a person with a mindset of "black and white thinking" would experience a change in status, such as not being able to play competitive soccer, as a loss and blow to her identity.

169. In cross-examination Dr. Ehrenberg confirmed that depression was a prominent feature of BM's presentation. She agreed that depression is treatable.

170. Dr. Ehrenberg has apparently seen BM for more than 60 sessions since the beginning of 2016. BM has had some dark and self-destructive thoughts. Dr. Ehrenberg believes those thoughts have been held at bay by her counselling. BM has also been able to use coping tools to deal with panic attacks. In my view, that BM can use coping skills to deal with panic attacks bodes well for her ability to eventually use tools to cope with chronic pain.

171. Dr. Ehrenberg commented on the triangle of pain, anxiety, and depression as challenging to overcome. A positive sign is that according to Dr. Ehrenberg BM has not yet actually taken or needed to take Ativan for panic attacks.

172. Dr. Ehrenberg believes that she should continue to provide counselling and therapy to BM, and she believes BM will try to move her life forward.

173. Dr. Ehrenberg also gave evidence that BM's anger with the defendant driver never really went away but has dissipated.

174. Dr. Ehrenberg also agreed that BM would likely have a better result with CBT if she found an antidepressant that would work for her. A combination of an effective antidepressant and CBT would likely improve her condition. Unfortunately, BM has a trepidation of antidepressants.

175. Dr. Ehrenberg agreed that BM is pain-focused, but she tries hard to distract herself. In my view, she has not had much success in distracting herself from pain. Dr. Ehrenberg agreed that a good way for BM to distract herself from pain would be volunteering or going for a walk. Dr. Ehrenberg would really like to see her volunteer especially once panic attacks are under control.

176. Dr. Ehrenberg stated in cross-examination that driving is a high-level activity and her ability to drive and be in vehicles has improved. Exposure therapy by persisting and doing something and building it up in small steps is appropriate. Dr. Ehrenberg also thought that BM could move towards volunteering at something like a senior's centre. She said: "we are getting there".

177. Dr. Ehrenberg, as did Mr. Trainor, had hopes for a progressive goal attainment program which she said now has a better chance of succeeding because they have established a foundation. Dr. Ehrenberg believes that she has assisted BM in developing thoughts and behaviours to overcome disability belief. A progressive goal attainment program tries to practically demonstrate a reality that is consistent with disability beliefs.

178. Dr. Ehrenberg also agreed with Dr. Fracnik's opinion that BM should have a treating psychiatrist. A sleep study could also be helpful. Although hard to get, a treating psychiatrist would certainly help with mediations.

179. Dr. Ehrenberg gave another example of a program that might assist BM called the BC CALM program. It features a mindfulness approach. Dr. Ehrenberg has had good experiences from some of her clients doing the BC CALM group program.

5. Other Vocational Experts

180. I have already commented at length about Mr. Trainor's opinions and evidence. I have also explained why I believe Mr. Trainor's most pessimistic anecdotal evidence of people never returning to the workplace, after several years, is not fully transferrable to BM's circumstances. In any event, Mr. Trainor did allow the possibility that after a goal attainment program BM might work in the future.

181. Two other vocational experts testified for the Respondent: Dr. Denise Hall and Dr. Colleen Quee Newell. Both submitted reports.

182. Dr. Hall assessed the Claimant on November 6, 2018 and prepared a report dated November 16, 2018 providing an opinion on her residual vocational status. Dr. Hall has impressive qualifications and experience. She has a doctorate in clinical psychology and is a vocational consultant and occupational health specialist with many years experience in those fields. She has also been a family therapist and a clinic supervisor in an addiction

treatment facility. She has published several articles as well as a book on Organizational Health for Professional Health Care workers. She testified via Zoom. I accepted that she was an expert in vocational assessments and rehabilitation. Not surprisingly, given BM's presentation, Dr. Hall considered BM to be competitively unemployable at the time. However, Dr. Hall was of the opinion that BM retained the capacity for gainful employment. She recommended that, after further treatment and guidance she start to pursue a volunteer position that would help with a transition to gainful employment. In that respect, she agreed with Mr. Trainor. Dr. Hall was also of the opinion that BM is a candidate for further post-secondary education at the diploma (community college) level or bachelor's level (university). She agreed with Dr. Farcnik's opinion of the need for ongoing psychiatric treatment including a medication review. She suggested further OT support, vocational counselling, and job placement services. She suggested accommodation for further training, education, and employment.

183. Dr. Hall administered tests similar to those of Dr. Ehrenberg. BM placed in the low end anxiety range on the Beck Anxiety Inventory (prior to developing panic attacks in 2019), in the low clinical depression range on the Beck Depression Inventory and recorded a low score for the pain catastrophizing scale (PCS). One would have though such low scales would bode well for CBT results. Dr. Hall no longer uses the PCS. Dr. Hall also stated that people work with pain because the benefits of work outweigh pain: work is itself therapeutic. Dr. Hall also had experience with many clients who did go back to work after being out of the workforce for some length of time. It helps if one is younger.

184. Dr. Quee Newell provided a report dated September 27, 2019 in response to Mr. Trainor's report. She did not have the advantage of assessing BM herself. As such her report and evidence is of limited scope. She did not agree with Mr. Trainor's methodology and she was of the view that Mr. Trainor lacked sufficient evidence to conclude that BM had the intellectual capacity and superior academic achievement to obtain a master's degree or a seat in a competitive graduate program. Having had the advantage of considering all of the evidence in this case, I agree with Dr. Quee Newell that BM's academic potential included community college and perhaps a bachelor's degree but not beyond.

185. Dr. Quee Newell also relied upon academic literature that indicated a significant proportion of chronic pain patients can work and that work is associated with a multitude of health benefits. Dr. Quee Newell recommended BM would benefit from psychological treatment addressing work-disability beliefs. She also recommended that BM participate in a standardized Progressive Goal Attainment Programme (PGAP)[2].

186. Dr. Quee Newell also agreed with Mr. Trainor's recommendation of volunteer work to increase tolerance for regular productive activity similar to paid employment. She pointed out that this would require regular, ongoing vocational support.

187. Dr. Quee Newell also relied upon an academic article from the Journal of Pain and Relief by Sullivan and Hyman (2004) which reported clinical research to the effect that a substantial percentage of chronic pain patients, on average away from the workplace for more than three years, who attended a six week multi-disciplinary program with vocational services, returned to work.

188. The mainstay of Dr. Quee Newell's work is CBT as a clinical counsellor to people with chronic pain. CBT is a coming together of therapy to address cognition, beliefs, emotions (affect) and behaviour. By addressing cognition and problematic beliefs, behaviour can be changed. PGAP is more of a behavioural-based therapy which focuses on cognitive dissonance that if one can do things inconsistent with disability beliefs, one should drop those beliefs as invalid. PGAP is typically administered by OT's. In this case BM has not had vocational rehabilitation from a vocational rehab specialist.

189. Dr. Quee Newell accepted that BM has the capacity to complete an undergraduate degree but not beyond that. BM scored a GPA of 69% in seven university transfer courses and 62% in one other course. Mr. Trainor did not do enough testing to determine that BM had the capacity for post-graduate education. It is Dr. Quee Newell's belief that vocational rehabilitation should begin immediately and should not wait until she is deemed "job-ready" as proposed by Mr. Trainor.

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[2] PGAP is a program about learning to be productive despite symptoms. It targets psychosocial risk factors: a tendency to catastrophize, a fear of symptom aggregation, disability perception and perceived injustice. The first factor is the most prominent. BM underwent a modified PGAP program in the past and must have been screened for these factors.

VIII. Findings/Conclusions Regarding Original Position and Injured Position: The Claimant's Original and Injured Trajectories

A. Original Trajectory

190. The law of damages as enunciated by the Supreme Court requires the trier of fact to consider what the original position of the injured party would have been in the absence of injury caused by the tortfeasor. Since BM was only 22 years old at the time of the Accident and did not have an established career there is uncertainty in predicting the trajectory of her life, a past future hypothetical. As I observed, we are dealing with a young adult who had not yet become entrenched in a specific career or an educational path to pursue a career. I also think there is a lot of truth in the observations of Mr. Trainor about current trends in employment, including more part-time work often without benefits, more career changes, more transient work and more delay in achieving educational goals and organizing careers later.

191. The evidence of the Claimant at the arbitration was that by the time of the Accident she intended to pursue a degree in Education with a view to becoming an elementary teacher or alternatively becoming a pediatric physiotherapist. However, when BM underwent a vocational assessment by Mr. Trainor on April 6, 2018, although BM stated an interest in teaching as a profession and attending university to pursue that goal, she told Mr. Trainor that she was reconsidering her future vocational options while taking time away from academics to work at the farm although she had previously stated an interest in teaching as a profession and attending university to pursue that goal.

192. BM's cousin JM, testified that BM wanted to work in a job helping people and "prior to the Accident" she had mentioned that she was interested in becoming a teacher or a physiotherapist, as both were focused on helping children. JM had the impression that BM was interested in more schooling and leaned towards working as a physiotherapist. However, it was her impression that she had no firm plans as to when she might follow a chosen career path.

193. Following high school graduation in June 2008, BM spent the following four years; i) attending Camosun College for two semesters (2008-2009) taking university transfer courses, achieving average grades except an "F" in Human Physiology; ii) taking a course

in Multi-Disciplinary Physical Activity at the University of Victoria (2009) achieving a B+ Grade; iii) completing a two year diploma course in Exercise and Wellness at Camosun College between 2009-2011 as well as receiving a personal training certification (BC Recreation and Parks Association) and; iv) working as a general labourer and retail produce clerk at Vantreight Farms between the Fall of 2010 up to the time of the Accident with time off for the “WCB accident” of October 3, 2012.

194. I doubt that the above education/work history is unusual in today’s economy. BM tried one diploma course of vocational education for two years and decided personal training or working in “exercise and wellness” was not for her. She enjoyed working at the produce farm but did not think that would be a long-term career. At the time of the Accident, she had no concrete plans as to when she might return to post secondary education to pursue a different career. I find that her statement to Mr. Trainor at a time when she knew she was undergoing a vocational assessment was to likely better reflect her intentions at the time of the Accident, i.e. she was considering her educational/vocational options. I do not accept her plans were limited to vocations as an elementary teacher or physiotherapist.

195. One prospective academic pursuit I reject is that BM would have pursued a post graduate degree such as a Master of Education or a professional degree. I do not accept that BM would have pursued a more challenging and longer academic option. Her testing by Mr. Trainor does not line up with such an option; her preference was not in academic learning and her study skills were weak. Her academic record up to 2011 was unexceptional. I accept Dr. Quee Newell’s opinion that BM’s academic potential included possibly more community college study and perhaps a bachelor’s degree but not beyond. Mr. Selly agrees that a master’s degree was unlikely but should not be ruled out.

196. I now come to my conclusion as a matter of real possibility or simple probability as to “Original Position” and BM’s trajectory about the Accident. Based upon the evidence, I draw the following conclusions.

1. At the time of the Accident BM was considering her options concerning future vocational plans including but not limited to physiotherapy and elementary school teaching.

2. BM was in no hurry to pursue her post-secondary education and had not decided on a specific course of education to pursue.
3. BM was content to work at the farm as a labourer and retail produce clerk where RR also worked.
4. RR and BM had some vague plans to travel internationally, probably back-packing around Europe in 2013.
5. I expect that she would have continued working at the farm in 2013 were she not travelling with RR.
6. She would have continued to work at the farm in 2014 and 2015 while RR became qualified as a heavy duty mechanic.
7. In 2016-2017 at the age of 25 or 26, BM and RR would have made plans to start a family. BM would have eventually become the primary caregiver and possibly worked part time while RR worked full time.
8. BM and RR may have had more than one child, likely two or three between 2016 to 2020 (when BM was between 26 and 30).
9. BM may have worked part time or attended university part time when their last child was approximately 5 years of age and possibly before that.
10. At approximately 34 years of age (2024) BM would have returned to post-secondary education full-time to finish a degree or diploma.
11. By approximately 2026 (at about the age of 36) BM would have pursued employment but not likely on a full time basis.
12. Therefore, for past income loss one could project farm income for 2014 and 2015 of between $19,600 and $28,800 gross income loss per year or approximately $23,700 annually as a mid-point which is almost double her pre-Accident earnings for about 10 months in 2012 of $13,258.
13. Income loss between 2016 and the commencement of the arbitration would likely have been fairly limited as BM would have become the primary caregiver and perhaps attended school part time. One could project earnings of $10,000 per

year for 2016, 2017, 2018, 2019 and 2 months of 2020. That would project to a gross loss of about $40,000.

14. Such projections would produce an award of $87,400 in past income loss less an adjustment for income tax.
15. The Respondent suggests a sum of $100,000 less tax plus a further deduction for “past capacity to earn income”. I do not agree with a reduction for past capacity.
16. Since the process is an assessment net calculation, I award $1000,000 net of tax for past income loss.

197. I will now discuss BM’s potential for future earning capacity from the perspective of her “Original Position”. I project that from the arbitration hearing date to 2026, from age 30 to 36, BM’s main responsibility would have been childcare and post-secondary education. Following that, I project BM would have had a career for approximately 24-29 years to between age 60 to 65 but not likely full time for the entire period. She might have become a physiotherapist, a teacher or followed another career path. Mr. Robert Wickson a consulting economist who authored a report dated February 26, 2020 testified. He provided tables based on census data related to education levels and specific careers such as teachers at different levels. These tables reflect labour market contingencies and project from March 2020 to age 70. No specific census data was given for physiotherapists. During cross-examination census data projections were introduced for high school graduates, general farm workers and for those holding a 1-2 year college or non-university Certificate or Diploma and an Occupation Group of Program leaders and instructors in recreation, sport and fitness (Exhibit 28).

198. In assessing damages for loss of future capacity, the first step is to estimate what the Claimant might have earned but for the Accident. In this case a capital asset approach is required as opposed to an earnings approach where the Claimant was not yet established in the work force. Statistical data may be of some use and guidance but cannot masquerade as certainties. Determining damages in this context is an assessment, not a calculation. At the end of the day, the task of the trier of fact is to set an award that is fair and reasonable.

199. Considering that BM would likely have had a late start on a career, and she likely would not have worked full time to age 65, I agree with the Respondent's submission that BM's future earning capacity in her "Original Position" would not likely have exceeded $1,000,000.

B. Injured Trajectory

200. I will now gaze again into the crystal ball to project the Claimant's future considering the Accident and her Injured Position.

201. As I stated earlier a central issue is whether she will continue to be in a state of virtually complete disability and permanent incapacity due to chronic pain. For reasons already discussed, I do not believe so.

202. However, I recognize the Respondent's concession that the Accident will have a serious long-term effect including a "permanent and serious impact to BM's work capacity". That is the starting point of my analysis.

203. I also recognize that our courts have accepted two primary but not mutually exclusive approaches to loss of income: the "earnings approach" and the "capital asset approach". In this case, involving a 22-year old individual who had not established her educational path nor her career path, the "capital asset" approach as endorsed in the 1978 trilogy is the more appropriate and logical approach to apply. See also *Knapp v. O'Neill*, 2017 YKCA 10 at paras 17-20 and *R.R.S. v. M.D.F.T.*, 2020 BCSC 1735 at para 228.

204. The Respondent concedes an impairment of the Claimant's income-producing capital asset but does not concede a complete loss. The Claimant argues for a complete destruction of earning capacity based on the past seven and a half years and the poor prognosis of her medical experts. For the reasons I have already set out I do not accept the Claimant's argument. I accept the Respondent's position that BM's future will be considerably better than her experience following the Accident to the present.

205. In terms of the medical opinions, I have already explained why I do not accept Dr. O'Breasail's recently changed extremely negative prognosis. I do accept his earlier

opinion that with appropriate treatment and over time her condition would improve and "she will likely be able to return to school or return to work at some level".

206. In cross-examination, Dr. O'Breasail was in favour of a change in the rehabilitation approach with a focus on psychotherapy and CBT, diminished reliance on passive therapy, further trials of antidepressant medication and an emphasis on active rehabilitation.

207. I have also discussed in some detail the evidence of the forensic physiatrist, Dr. Graboski, upon whom Mr. Selly relies heavily for his position that BM will never materially improve. I have indicated that I did not accept Dr. Graboski's theory of chronic pain as a disease. I have also pointed out inconsistencies in BM's testimony and certain unrealistic aspects to her evidence. Since a diagnosis of fibromyalgia is based exclusively on subjective responses, to the extent they may be unreliable, the diagnosis becomes questionable.

208. In addition, the cross-examination of Dr. Graboski went a long way to establishing that there is a treatment approach, essentially i) through CBT ameliorating the psychological barriers associated with a chronic pain condition, ii) potential use of Triptan (or Botox) for headaches, iii) possible targeted spinal injections, iv) active rehabilitation therapy instead of almost exclusive reliance on passive therapy, v) finding an effective antidepressant and vi) eventually participating in a progressive goal attainment therapy, that could lead to a much improved and more functional individual.

209. I have already reviewed in detail the evidence of Mr. Trainor who also had a rather pessimistic view of BM's future. I have previously explained why I did not accept that his experience of non-existent return to the workplace after a long absence should apply in BM's case. Both Dr. Hall and Dr. Quee Newell are more optimistic that with appropriate treatment BM's future should include return to education and employment.

210. In cross-examination of Mr. Trainor, Mr. Deshon made essentially the same points that he did with Dr. Graboski. The effect was that Mr. Trainor accepted the potential or possibility that BM might overcome her present barriers to employability through a structured progressive goal attainment program and through improved pain management.

211. I am also impressed by the fact that BM does not accept the bleak prognosis of the above experts. She has hopes that she will improve. She is motivated to improve. Her mother confirms her daughter has hopes that she will get better. BM has not given up on treatment and wants to make an effort to rehabilitate.

212. I have already discussed factors that have interacted to cause BM to fall into a state of chronic pain and disability. Fortunately, many of these factors have or will dissipate over time. First and foremost is that BM will "demedicalize"; she will follow the recommended advice of virtually all the treating doctors and experts to limit what can only be described as excessive reliance on passive therapies to the point that she became a professional patient. She has already started to reduce such reliance which only seems to encourage constant focus on one's disability rather than ability. Secondly, litigation which intervened in the immediate aftermath of the Accident will come to an end soon. Litigation stress cannot be underestimated. Thirdly, BM's anger toward the negligent driver will diminish and that has already started. Such feelings of anger cause emotional upset and undue focus on an unfortunate event. Most importantly, I expect BM's recovery will be advanced by a more focused treatment plan of psychotherapy and CBT allowing BM's better use of copying strategies. I believe she will be supported by a treating psychiatrist who can help her find assistance through appropriate medications or other modalities of treatment. I expect BM will follow the consistent professional opinions given in this case that passive therapies should be replaced by active rehabilitation. She likely will never play competitive soccer again but increased exercise including hiking, walking, cycling, and pool and gym exercises should increase her feelings of well-being and increase her joy in life. There is a reasonable prospect of resuming recreational activity but likely not at the same level as before.

213. I also expect that if headaches are a serious problem, which is far from clear given the evidence of Dr. Spratt, there are treatment options available that may be effective. There is also the possibility of site-specific epidural blocks which may help, although I understand the Claimant's reluctance to try invasive procedures just as I understand her reluctance to use drugs which alter the chemistry of the brain. I believe there is a real prospect that with the right combination of CBT and active rehabilitation BM may not require interventionist techniques nor much in the way of psychotropic drugs.

214. I believe there will come a time when BM will appreciate that she is more functional than she realizes and can overcome her pain focus and become quite active. She should eventually realize that she can find purpose in her life through work, through family and overcoming the unfortunate state she has been in these past several years. She will realize that though one cannot control what happens, one can control how one will feel and what one can attempt to do in response. Work should be therapeutic.

215. I believe that there is a real and substantial possibility that BM will find productive employment in the future; that she and RR will remain together and have a family of likely more than one child, for whom she will be able to care. I accept that she may never achieve all she might have in her "Original Position" but she will have a fairly robust residual capacity to function and take pleasure in life.

IX HEADS OF DAMAGES

A. Non-Pecuniary Loss

216. Earlier in this award, I briefly summarized the fundamental legal principles and policy considerations related to non-pecuniary loss as established forty years ago by the Supreme Court of Canada. While subsequent appellate authority has further refined the law, the theory of an award for non-pecuniary loss has not changed.

217. In this arbitration both counsel cite the appellate decision *Stapley v. Hejslet*, 2006 BCCA 34 for a recitation of non-exhaustive relevant factors to be considered in determining non-pecuniary damages. However, I would stress that the Court emphasized the fundamental concept that appreciation of the individual's loss is the key in awarding general damages for non-pecuniary loss:

> [45] Before embarking on that task, I think it is instructive to reiterate the underlying purpose of non-pecuniary damages. Much, of course, has been said about this topic. However, given the not-infrequent inclination by lawyers and judges to compare only injuries, the following passage from *Lindal v. Lindal,* supra, at 637 is a helpful reminder:
>
> > Thus the amount of an award for non-pecuniary damage should not depend alone upon the seriousness of the injury but upon its ability to ameliorate the condition of the victim considering his or her particular

> situation. It therefore will not follow that in considering what part of the maximum should be awarded the gravity of the injury alone will be determinative. An appreciation of the individual's loss is the key and the "need for solace will not necessarily correlate with the seriousness of the injury" (Cooper-Stephenson and Saunders, *Personal Injury Damages* in Canada (q1981), at p. 373). In dealing with an award of this nature it will be impossible to develop a "tariff". An award will vary in each case "to meet the specific circumstances of the individual case" (*Thornton* at p. 284 of S.C.R.). [Emphasis Added]
>
> [46] The inexhaustive list of common factors cited in ***Boyd*** that influence an award of non-pecuniary damages included:
>
> (a) age of plaintiff;
> (b) nature of the injury;
> (c) severity and duration of pain;
> (d) disability;
> (e) emotional suffering; and
> (f) loss or impairment of life;
>
> I would add the following factors, although they may arguably be subsumed in the above list:
>
> (g) impairment of family, marital and social relationships;
> (h) impairment of physical and mental abilities;
> (i) loss of lifestyle; and
> (j) the plaintiffs stoicism (as a factor that should not, generally speaking, penalize the plaintiff: ***Giang v. Clayton***, [2005] B.C.J. No. 163 (QL), 2005 BCCA 54).

218. Mr. Selly also relied quite heavily upon the *Saadati* case (SCC) concerning psychological injuries. I accept that injury to a person's psyche or mental well being is just as worthy of compensation as physical injury, if not more. Without getting too philosophical, experience suggests that physical injuries manifest in adverse emotional and psychological effects such as mental distress just as much as they affect physical function.

219. The Claimant also relies on four previous B.C. Court awards which she says are "analogous". Each case must be decided on its own facts: *Trites v. Penner*, 2010 BCSC 882 at para 189. In comparing cases, I keep in mind the caution that my goal is to assess BM's unique individual loss and not to focus on comparison of injuries. Comparative cases provide only a rough guide. A further complication is that two of the three cases relied upon by the Claimant are not typical awards but followed rather atypical procedural

paths. Both *Bransford v. Yilmazcam*, 2010 BCCA 271 and *Courdin v. Myers*, 2005 BCCA 91 were jury awards exceeding the rough upper limit in the absence of an instruction on the rough upper limit. In both cases the trial judges reduced the awards to the rough upper limit; appeals were launched and the BCCA set aside the trial judges' awards and reassessed damages.

220. The Claimant suggests the *Courdin* decision and another decision of the BCCA in *Alden v. Spooner*, 2002 BCCA 592 are "most analgous". *Alden* was also a jury verdict. The jury verdict of $200,000 was appealed. It is trite law that the bar to reverse a jury award of damages is high. Damages are a question of fact. The award must be "wholly out of proportion", or a "wholly erroneous assessment of the loss" as opposed to a lower bar of an appeal from a trial judge which is whether an award is "inordinately high" or "inordinately low".

221. The Claimant suggests an appropriate range of damages for non-pecuniary loss is $250,000 to $280,000. She asks for $275,000. Such a range of damages suggests a near catastrophic effect upon the Claimant. In *Alden* Rowles, J.A. observed that one view of the evidence was that the injuries "may have had a catastrophic and devastating effect" on the plaintiff. My view of the evidence in this case is that while the injury to the Claimant is serious and prolonged, it is not catastrophic or near catastrophic.

222. The Respondent relies on several more recent cases assessing non-pecuniary loss involving younger individuals who had a variety of injuries involving chronic pain conditions, headaches, and psychological conditions such as anxiety, depression, and somatic disorders. Damages for non-pecuniary loss were in a range between $125,000 to $185,000. The Respondent suggests a fair and reasonable award for BM is $150,000. However, while I must resist falling into the trap of comparison of injuries, the following cases are informative on the facts and the law.

223. *R.R.S. v. M.D.F.T* is a recent personal injury damages assessment arising out of a vicious assault and battery in April 2009 on the then 14-year old plaintiff. When the case came to trial in 2020 the male plaintiff was 26 years old. The plaintiff's injuries were extensive and severe, both physically and psychologically, including:

1. concussion/MTBI;

2. adjustment disorder with depression and anxiety;
3. post traumatic migraine-like headaches;
4. chronic sleep disruption;
5. chronic mechanical neck and back pain on the basis of myofascial injury and probable lumbar disc bulging with annular tears at LS-4 and LS-5;
6. post traumatic nightmares;
7. post traumatic stress disorder (Dr. Prout); and
8. aggravation of pre-existing migraine type headaches.

224. The trial judge accepted the opinion of a physiatrist, Dr. Koo, and a neurologist, Dr. Prout, to the effect that:

1. ongoing intermittent headaches are likely due to neck and upper back injuries known as a cervicogenic etiology;
2. post-accident concerns with concentration, memory and poor scholastic performance are more likely related to chronic pain, sleep disruption, and secondary psychological factors and social stresses;
3. the plaintiff's current level of disability is severe; and
4. the plaintiff's disability for long term employment as a cabinet manufacturer is in doubt (Dr. Koo)

225. Walker J. found that at age 26 the plaintiff is left with permanent ongoing chronic pain that causes frequent, severe, disabling headaches (migrainious in nature and about half of the time cause the plaintiff to vomit). The trial judge also found that the assault and battery has left the plaintiff anxious and depressed, socially withdrawn and caused suicidal ideations and panic attacks. The plaintiff no longer engages in sports and refrains from social events outside of his home which puts a burden on his marriage. His injuries have adversely affected his ability to work and earn income and to carry out many household tasks. The plaintiff finds it painful to engage in physical activities with his two young children. The plaintiff graduated from high school; had a family at a very young age; was unable to complete an apprenticeship in carpentry because of back pain; tried

a cashier job at a Chevron gas station but left it when his back pain became too much to cope with the work; found a job with an accommodating employer working in a woodshop but a new owner was not prepared to accommodate his need for breaks and time off. He then went on medical disability insurance benefits which he was on at the time of the trial. He hopes to find a job in carpentry or woodworking that can accommodate his restrictions.

226. Ultimately, Walker J. assessed $125,000 as a fair and appropriate settlement for non-pecuniary damages.

227. Walker J. also determined that the loss of capacity approach or “capital asset” approach is the appropriate methodology to assess the plaintiff’s award for post and future income loss in light of the plaintiff’s age and lack of work history when injured.

228. Another recent B.C. personal injury case decided in the last year that is worthy of some note is *Dhadda v. Bradley*, 2019 BCSC 1840 which involved a woman who was 28 years old at the time of trial in 2019 and who was injured in motor vehicle accidents in 2011 and 2014. The plaintiff suffered from chronic pain, described by the trial judge as “an anxiety disorder” associated with the pain she is suffering. The psychiatrists who offered opinions endorsed other diagnosis such as clinical depression [in remission], “chronic somatic symptoms disorder” and “attachment [sic] disorder with anxiety, persistent”. I believe the reference to attachment disorder should have been to adjustment disorder, which is the diagnosis of Dr. O’Breasail in this case.

229. Mr. Justice Gomery makes these overarching findings at para 103:

> Many of these factors point in the direction of a substantial award in this case. Ms. Dhadda is relatively young. She has been dealing with chronic pain consequent on the accidents for five years, or most of her adult life, and she will probably have to deal with some degree of pain for the rest of her lift. The pain has changed her life. She is preoccupied by it and she perceives it as severe. Ms. Dhadda is partly disabled. Her anxiety disorder and recurrent clinical depression speak to substantial emotional suffering. Her injuries have contributed to a worsening of family relationships that were already difficult, and her financial situation has made it impossible for her to gain the independence from her family that she needs. Her social life is impaired. She perceives herself as confused and unable to concentrate.

230. The trial judge made an award of $110,000 for non-pecuniary loss, including past and future housekeeping capacity,

231. I recognize a difference between BM's case and *Dhadda*: BM claims total vocational incapacity; Ms. Dhadda did not. Ms. Dhadda was able to work part-time; BM has not worked at all since the Accident. She has never tried. Mr. Justice Gomery expected that Ms. Dhadda would probably always have to deal with chronic pain in any employment. Mr. Justice Gomery was optimistic that after two years of treatment Ms. Dhadda will be able to work full time.

232. On arriving at a fair and reasonable award for non-pecuniary damages, I cannot completely ignore the evidentiary contradictions and inconsistencies in BM's claims to which I have already alluded. For example, there is the matter which seems to speak to selective disability. BM claims she derived little pleasure from various trips, holidays, and outings over the past several years. If that were the case, one might think she would have discontinued such travel and social outings, but she did not. Another example would be the question of the extent of her headaches and depression. While I do not ignore the opinion of other physicians except the inadmissible opinion of Dr. Ehrenberg, the doctor who knows her best, Dr. Spratt, did not consider headaches and depression to be primary features of BM's presentation. BM does not consider herself depressed. If these conditions were problematic and disabling, one would have thought treatment would have been more aggressive. In any event, such conditions may well be treatable. Another example of day to day function, is the significant amount of driving BM has done. I note that more recently BM has learned effective coping strategies to deal with panic attacks. That bodes well for her eventually learning to cope with chronic pain.

233. I am not as optimistic about BM's employment future. However, I expect that BM will make good progress with the treatment options she will likely pursue to lead a more productive, fulfilling life. I find there is a reasonable prospect she will eventually realize an earning capacity.

234. *Dhadda* is also instructive in dealing with claims for loss of housekeeping capacity and failure to mitigate.

235. In his written argument Mr. Selly did specifically address the claim for loss of housekeeping capacity or loss of ability to do domestic tasks. In oral argument he suggested housekeeping services are addressed in the claim for future care. Should I

not award future special damages for homemaking assistance he suggested that I make a separate award for loss of housekeeping capacity. I will follow the approach of Mr. Justice Gomery that it would be more appropriate that the plaintiff's present and future difficulties with housework be addressed through an award of non-pecuniary damages rather than by a separate award. In my view that is appropriate in this case. I reject a separate claim for an award of housekeeping capacity.

236. I will discuss the defence of failure to mitigate later in this award. Based on my findings and the legal principles of non-pecuniary damages, I award the sum of $165,000.

Indivisibility

237. Mr. Deshon makes a submission that the workplace forklift accident of October 3, 2012 should be apportioned to some of BM's damages. He argues the Accident of November 3, 2012 should not be viewed as being responsible for BM's full loss. My view of the facts is that the non-tortious workplace accident is causally "*de minimis".* Although the exact state of BM's health at the time of the Accident is not entirely clear, it would appear to be the case that BM was virtually fully recovered from her workplace injuries when she was injured in the Accident. She had resumed working at the farm and was about to return to competitive soccer. I grant that she likely had some minor residual neck pain and headache from the work injury in early November, but she was well on the road to full recovery had the Accident not intervened.

238. Under the *Athey* principles it would be wrong to apportion causation to such a non-tortious event. The only relevance of this event was that it was one of many factors which contributed to BM's vulnerability and decline into a chronic pain state and an adjustment disorder with features of depression and anxiety.

B. Past Income Loss

239. As I have already noted, I adopt the loss of capacity approach to both past and future loss of income as stated by Walker J. in the *R.R.S.* case: "…the loss of capacity approach is the appropriate methodology to use to assess R.R.S.'s awards for past and future income loss, particularly in light of R.R.S.'s young age and lack of work history …".

240. Based on my findings concerning BM's comparative trajectories, I award BM $100,000 net of taxes for past income loss.

C. Loss of Future Earning Capacity

241. I have already cited the judgment of Low J.A. in *Reilly v. Lynn*, 2003 BCCA at para 101 for principles governing the assessment of damages for loss of future earning capacity.

242. In *Hardychuk v. Johnstone,* 2012 BCSC 1359, Madam Justice Dickson, as she then was, set out the principles to be applied in considering a claim for loss of future earning capacity at paras. 192-193:

> A claim for loss of future earning capacity raises two key question: 1) has the plaintiff's earning capacity been impaired by his or her injuries; and, if so 2) what compensation should be awarded for the resulting financial harm that will accrue over time? The assessment of loss must be based on the evidence, and not an application of a purely mathematical calculation. The appropriate means of assessment will vary from case to case: *Brown v. Golaiy* (1985), 26 B.C.L.R. (3d) 353: *Pallos v. Insurance Corp. of British Columbia* (1995), 100 B.C.L.R. (2d) 260: *Pett v. Pett*, 2009 BCCA 232
>
> The assessment of damages is a matter of judgment, not calculation: *Rosvold v. Dunlop,* 2001 BCCA1.
>
> Insofar as is possible, the plaintiff should be put in the position he or she would have been in, from a work life perspective, but for the injuries caused by the defendant's negligence. Ongoing symptoms alone do not mandate an award for loss of earning capacity. Rather, the essential task of the Court is to compare the likely future of the plaintiff's working life if the accident had not happened with the plaintiff's likely future working life after its occurrence: *Lines v. W.& D Logging Co. Ltd.,* 2009 BCCA 106: *Moore v. Cabral et. al.,* 2006 BCSC 920; *Gregory v. Insurance Corp. of British Columbia*, 2011 BCCA 144.

243. As the court stated in the *Quezada v.* Quezada, 2019 BCSC 1732, at paras. 131-134:

> There are two possible approaches to loss of future earning capacity: the "earnings approach" and the "capital asset approach". Both approaches are correct and will be more or less appropriate depending on whether the loss in question can be quantified in a measurable way: *Perren v. Lalari*, 2010 BCCA 140 at para 12.
>
> The earnings approach involves a math-oriented methodology such as either i) postulating a minimum annual income loss for the plaintiff's remaining years of work, multiplying the annual projected loss by the number of remaining years

> and calculating a present value; or ii) awarding the plaintiff's entire annual income for a year or two: *Pallos v. Insurance Corporation of British Columbia* (1995), 100 B.C.L.R. (2d) 260 (C.A.) at 271.
>
> The capital asset approach involves considering factors such as i) whether the plaintiff has been rendered less capable overall of earning income from all types of employment; ii) whether the plaintiff is less marketable or attractive as a potential employee; iii) whether the plaintiff has lost the ability to take advantage of all job opportunities that might otherwise have been open; and iv) whether the plaintiff is less valuable to herself as a person capable of earning income in a competitive labour market: *Brown v. Golaiy* (1985), 26 B.C.L.R. (3d) 353 (S.C.) at 356.
>
> Ultimately, assessment of damages must be based on what is reasonable in all the circumstances. Projections, calculations and formulas are useful only to the extent that they assist in determining what is fair and reasonable: *Grewal v. Naumann,* 2017 BCCA 158 at para. 49.

244. In *Ibbitson v. Cooper,* 2012 BCCA 249, the B.C.C.A. confirmed that at the end of the day, it is the overall fairness and reasonableness of the award, based on the evidence that is the key:

> While in many cases the actual lost income will be the most reliable measure of the value of the loss of capacity to earn income, this is not necessarily so. A hard and fast rule that actual lost income is the only measure would result in the erosion of the distinction made by this Court in *Rowe:* it is not the actual lost income which is compensable but the lost capacity i.e. the damage to the asset. The measure may vary where the circumstances require; evidence of the value of the loss may take many forms (see *Rowe*). As was held in *Rosvold v. Dunlop,* 2001 BCCA 1 at para. 11, 84 B.C.L.R. (3d) 158, the overall fairness and reasonableness of the award must be considered taking into account all the evidence. An award for loss of earning capacity requires the assessment of damages, not calculation according ot some mathematical formula.

245. Based on my assessment of the evidence and my findings of fact related to the relevant comparative trajectories of the Claimant's educational and vocational prospects, taking into account positive and negative contingencies, I conclude that the Claimant had a pre-Accident capacity in the remaining years to earn the equivalent of a lump sum discounted at the *Law and Equity Act* rule of 1.5% of $1,000,000. I further find that her Injured Trajectory vocational capacity is 45% of her Original Capacity. I therefore award the sum of $550,000 for loss of future earning capacity.

D. Cost of Future Care

246. The parties agree on the legal principles underlying an award of damages for future care. Madam Justice Horsman summarized those principles in *Long v. Thanas,* 2019 BCSC 2255 at paras 109-111 as follows:

> The purpose of an award for future care costs is to restore the plaintiff to his pre-Accident condition, to the extent that is possible with a monetary award: *Gignac v. Insurance Corporation of British Columbia*, 2012 BCCA 351 at para. 29. The award is based on what is reasonably necessary on the medical evidence to preserve and promote the plaintiff's mental and physical health. Claims must be reasonable and medically justified: *Hardychuk v. Johnstone*, 2012 BCSC 1359 [*Hardychuk*] at paras. 210-211.
>
> The test for determining the appropriate award under the cost of future care heading is objective and based on medical evidence. An award of future care costs requires: (1) a medical justification for claims for cost of future care, and (2) that the claims are reasonable: *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33 (S.C.) at 35.
>
> Future care costs must be justified both because they are medically justified and also that they are likely to be incurred by the plaintiff. The award of damages for cost of future care predicts what will happen in the future, and thus is not a precise accounting exercise: *Hardychuk* at paras. 212-214.

247. The Claimant seeks an award of $320,000 for the cost of the Claimant's future care needs based on the opinion evidence of Ms. Mair Edwards, a retired occupational therapist and rehabilitation consultant who prepared an occupational therapy assessment and Cost of Care Report dated October 22, 2018 (Exhibit 23). Ms. Edwards' care recommendations were costed by the economist Mr. Wickson in a report dated February 20, 2020. Mr. Wickson calculated different categories of costs: i) $154,940 for various predicted expenses including rehabilitation services, homebound services; assistive devices and positional aids; ii) $51,727 for a contingent claim should BM live in a house with a yard in the future; iii) $41,455 for nanny services based on one child; iv) a contingent claim of $39,800 should BM have two children in the future; and v) a contingent amount up to $42,600 for Botox therapy for life. This totals approximately $330,600. Mr. Selly claims a lesser amount of $320,000 to account for a reduction in rehabilitation services for year 1 and a 50% reduction for counselling in years 1 and 2 which results in the elimination of $4,814 and $4,700, respectively.

248. The major disconnect in terms of the claim for future care is that the factual premise of Ms. Edwards' projections is that BM is totally and permanently disabled. Ms. Edwards assumes the most negative future scenario for BM. However, she did not have the benefit of all the evidence that was presented at the arbitration from which I derived a future trajectory that should be much less pessimistic than the underlying premise of Ms. Edwards' report. For example, Ms. Edwards did not have the benefit of the cross-examination of Dr. Spratt, Dr. Graboski, Dr. O'Breasail and Mr. Trainor which established a reasonable possibility that the future may well be much brighter for BM. Ms. Edwards was not given copies of the Respondent's medical legal reports. Ms. Edwards assumes BM will forever experience severe to moderate chronic pain, headaches, anxiety and depression, soft tissue injury to her right shoulder with possible developments of adhesive capsulitis (not accepted by Dr. Weisleder but mentioned by Dr. Graboski), inability to bend, reach and balance, reduced cognition, traumatic brain injury, forgetfulness, reduced range of motion in all areas of her spine, jaw issues, reduced right arm and leg strength and non-restorative sleep.

249. I can only conclude that Ms. Edwards' approach is to project the highest future care needs and costs based on the most negative set of facts and leave it to defence counsel to point out the exaggerated nature of the projected costs. Mr. Deshon has done that in his written brief summarizing points made in cross-examination. I will mention only a few of the difficulties in Ms. Edwards' report.

1. She assumes BM suffered a brain injury in the Accident and then mentions reduced and impaired dynamic balance and reduced cognition forgetfulness. BM testified in this arbitration over three days and was subjected to a rigorous cross-examination. I saw no evidence of poor cognition nor forgetfulness. I suppose there may be times when BM experiences severe pain that will cause her to be distracted; however, the medical evidence does not support a finding of a brain injury. Indeed Dr. Graboski ruled it out. Dr. O'Breasail did not diagnose brain injury.

2. Dr. Graboski mentioned a possible trial of Botox for migraine like headaches. However, she also mentions the most common first line of defence for such

headaches is Triptan. The cost of Botox was projected at $43,600. I assume Triptan is much less expensive.

3. She found reduced strength in BM's right arm and both legs implying a functional limitation when no doctor found any clinically significant lack of strength.
4. She did not consider the recommendations of the treating doctors, Dr. Spratt and Dr. MacNicol, nor the forensic experts who recommended active rehabilitation and exercise over passive modalities.
5. She projected passive therapy sessions at the cost of $190 per hour which seems high.
6. As noted, one of the reasons given for the need for assistance for household tasks was poor dynamic balance. However, BM's static balance with eyes open was tested as virtually normal; only her static balance with eyes closed was below normal. Of course, one does not know what her test results would have been pre-Accident.

250. I was left with the impression that Ms. Edwards adopted a "kitchen sink" or "Cadillac" approach to her future care projections. Perhaps she was influenced by the Claimant's subjective complaints of extreme pain and extensive anatomical and psychological problems. A trier of fact looks for some balanced objectivity in an expert who might at least consider a contrary perspective or contrary evidence. Although Ms. Edwards defined the role of an occupational therapist to maximize an injured person's independence to return to work, she never seemed to look at BM's situation through that lens.

251. The parties have asked me to detail what future care items I will award based on the evidence and the law. In *Townsend v. Koopmans,* [2004] S.C.R. 315 at 326, para 23, Deschamps J. stated for the Court: "This head of damage is aimed at ensuring an adequate level of care to a person injured as a result of tortious conduct". As Mr. Selly submitted the principles of future care damages were summarized in *Dzomhur v. Davoody*, 2015 BCSC 2316 at para. 244. See also *Gignac v. ICBC*, 2012 BCCA 351 and more recently *Uy v. Dhillon,* 2020 BCSC 1302 at para 56.

252. Ms. Edwards also included a recommendation for future injections of Botox costed annually at $1,500 for treatment of headaches. Mr. Wickson projected a present value of $42,600 for treatments commencing in five years and continuing for life. In my view, the use of Botox was not proven to be medically justified. Further, the Claimant's evidence on trying Botox was very enigmatic. She guessed that Dr. Graboski had recommended it or talked about it but Dr. Spratt never "went further with it" and "it wasn't ... going to be beneficial to my headaches".

253. My conclusions on the items of future care which I am awarding are as follows:

I.	Rehabilitative Services	
	1. An allowance for therapy	$ 10,000
	2. Counselling (non-MSP)	$ 4,700
	3. Pool Pass	$ 9,709
II.	Household Services	
	A contingency allowance for intermittent services	$ 10,000
III.	Assistive Devices	
	Almost all of these claims are of the “Kitchen Sink” variety, and have not been needed to date or do not take into account normal requirements. My award of a lump sum contingent amount is:	$ 10,000
IV.	Household Services	
	If BM should live in a house with a yard, I award a contingent amount of:	$ 10,000
V.	Child Care	
	This is a speculative claim and I will allow:	$ 20,000
TOTAL		$ 74,409

254. I allow an amount of $75,000 in total.

E. In Trust Claim

255. Mr. Selly did not advance an in-trust claim in his written submissions. It was mentioned in oral reply as an alternative to future household services. In my view, that was an afterthought which does not provide a sufficient foundation for an award. I do not

accept such a claim was sufficiently proven nor articulated. In any event, I have made an award for loss of past and future housekeeping capacity as part of non-pecuniary damages. I have also allowed funds for future household services.

F. Special Damages

256. Exhibit 39 was put in evidence by agreement of the parties without specific proof of all expenses listed, the bulk of which were paid by ICBC under Part 7 of the Regulation. Approximately $42,125.51 of the total of approximately $122,533.52 was not specifically particularized but the Respondent took no issues with the accuracy of that number. Expenses for costs and care are governed by a “reasonableness” test and whether expenses are “medically justifiable”.

257. The reasonableness test ensures claims are not excessive which to a certain extent they have been in this case. I referred to the astronomical number for possible therapy sessions which BM attended on an almost daily basis. None of the medical experts called in this arbitration supported reliance on passive therapies as the preferred course for a prolonged chronic pain condition as opposed to active rehabilitation and exercise. I agree with the Respondent that the claims for massage, acupuncture and mileage are to a degree excessive. Together they constitute $67,789 of the total pre-hearing expenses of $122,533.52. I accept as reasonable the Respondent’s suggested allowances of $20,000 for massage, $5,000 for acupuncture and $5,000 for mileage resulting in a deduction of $35,000.

258. The parties have asked me to award total special damages because the next phase of this arbitration will deal with deductibles. Therefore, of the total special damages incurred, I award $122,533.52 minus $35,000 equals $87,533.52. However, ICBC will need to pay $33,303.25 as the unpaid balance.

X. MITIGATION

259. Mr. Deshon seeks a 10% reduction of all heads of damage for a failure to mitigate. He argues that BM failed to follow medical advice to reduce her reliance on passive

therapy and instead focus on exercise and psychological care. He also argues that she should have done more to find an effective antidepressant.

260. In *Noftle v. Bartosch,* 2018 BCSC 766 at paras 314-315 Mr. Justice Brown summarized the proof requirements on a defendant who argues the defence of mitigation:

> It is trite law that a plaintiff has a duty to mitigate their losses. If a qualified expert recommended a particular form of treatment to the plaintiff; the plaintiff failed or refused to take the treatment although it was available to them; and the plaintiff's failure was unreasonable in that if the plaintiff had taken recommended treatment, and there is some likelihood that they would have received substantial benefit from it, and the treatment would not expose the plaintiff to significant risk, the claim is established: *Turner v. Coblenz,* 2008 BCSC 1801, para. 101; *Chiu v. Chiu,* 2002 BCCA 618, para.57.
>
> The defendant, however, has an onus to do more than establish those requirements. In the case of medical treatment, for example, they must also adduce medical evidence to show, had the plaintiff acted reasonably, the extent to which the plaintiff's damages could have been lessened: *Brown v. Raffan,* 2013 BCSC 114; *La Porte v. Earl*, 2016 BCSC 2298, para. 147; *Harmati v. Williams*, 2016 BCSC 2199, paras. 125-126.

261. Mr. Deshon points to the recommendations of forensic experts (Dr. Graboski, Dr. O'Breasail and Mr. Trainor) in their reports in 2017 and 2018 to reduce reliance on passive therapies and focus on active therapy and rehabilitation. He also points to BM's limited trials of antidepressants, reluctance to use drugs and her failure to follow the recommendation to try another antidepressant such as Zoloft.

262. The problem with Mr. Deshon's argument is i) the lack of proof that BM knew of the advice of the forensic experts; ii) that a trial of Zoloft or another antidepressant would have resulted in substantial benefit; iii) the extent to which the effect of injury would have been lessened; iv) BM has tried numerous therapies including CBT and active exercise. I accept that a better focused and balanced treatment in the context of dissipation of the negative factors I have already discussed will result in a better future for BM. However, I reject the mitigation argument.

XII. AWARD

263. I assess damages for the following heads of damages as follows:

1. Non-Pecuniary Loss	$ 165,000
2. Past Net Income Loss	$ 100,000
3. Loss of Future Earning Capacity	$ 550,000
4. Cost of Future Care	$ 75,000
5. Special Damages	$ 87,533.52
TOTAL	$ 977,533.52

264. I invite counsel to set up Phase 2 of this arbitration and eventually speak to costs.

Dated at Burnaby, British Columbia this 16th day of September 2020.

Vincent R. K. Orchard, QC
Arbitrator