Date: 19970411
Docket: B940866
Registry: Vancouver

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

RANDALL BRENT MONAHAN

PLAINTIFF

AND:

MERVIN JOHN NELSON and
KATHY LORRAINE NELSON

DEFENDANTS

AND

Docket: B940867
Registry: Vancouver

BETWEEN:

RANDALL BRENT MONAHAN

PLAINTIFF

AND:

DOUGLAS BROOKS OLDHAM, BURNABY METRO LIMO LTD.,
JOHN STEWARD MULDER, POT MU WONG, SHU CHUAN CHANG,
and WALLACE STANLEY HAROLD BRADLEY

DEFENDANTS

REASONS FOR JUDGMENT

OF THE

HONOURABLE MR. JUSTICE COULTAS

Counsel for the Plaintiff: F.G. Potts
Timothy J. Delaney

Counsel for the Defendants: Douglas A. Nuyts
E. Tutiah

Place and Dates of Hearing: Vancouver, B.C.
May 6 - 10, 1996
September 30, 1996
October 1 - 4, 1996
November 8, 1996
December 13, 1996

I N D E X

Page

I N D E X (Cont'd.)

[1] These two actions were tried together.

[2] In Monahan v. Oldam and others, before trial the action was discontinued against all defendants save for Pot Mu Wong and Shu Chuan Chang, and they have admitted liability.

[3] In Monahan v. Nelson et al. the defendants have admitted liability.

[4] The actions arise from motor vehicle collisions occurring on March 7, 1992 (Monahan v. Oldham et al.) and December 24, 1992 (Monahan v. Nelson et al.). In the first, the plaintiff was a passenger in his own vehicle when it was struck from behind and in the second he was the driver of that vehicle when again it was struck from behind. In the first collision the plaintiff suffered injuries: soft tissue injury to the neck, shoulder, mid and lower back, and an undisplaced ninth rib fracture. In the second collision he suffered fresh injuries to his neck, shoulder and mid back and an exacerbation of pain in his lower back and right leg caused in the first collision.

[5] In March 1995 after suffering prolonged back and leg pain, an MRI revealed that the plaintiff had a herniated disc at the L5-S1 level. The principal issue in these trials is causation Ä did either accident cause or contribute to that herniation? Did either accident cause degenerative disc disease or "trigger" pain from a pre-morbid degenerative disc disease?

PART A

THE PLAINTIFF Ä HIS BACKGROUND, AVOCATIONS AND HIS PERSONALITY

[6] The plaintiff is 40 years of age, born March 27, 1957. He stands 6 feet 4 inches tall, weighing 235-240 pounds. He appears strong and fit; his appearance is deceiving for he is not fit. His herniated disc has caused him chronic pain and physical disabilities.

[7] He left school after completing grade 10 in 1974. He was a slow reader and had difficulty retaining what he read; those deficits he has still.

[8] In 1977 he commenced driving large trucks. In 1979 he borrowed money and bought a Peterbilt long-haul truck and trailer ("rig"). He has been a long-haul truck driver ever since, operating his own rig, driving for trucking firms on contract. He prefers working on his own rather than for others. He enjoyed his work for it permitted him to be independent, controlling his own hours of work and producing a good income. He has never wished to do any other kind of work and does not today despite his chronic pain. Before the first accident he did most of the maintenance on his truck and trailer Ä brakes, oil changes, replacing motor mounts, shock absorbers and maintaining the suspension system. In 1981 he purchased a new cab/over truck which he still drives. It is old but in excellent condition.

[9] Before the first accident he enjoyed good health for the most part save for a few months in 1975 when he was injured in an accident from which he made a full recovery. He had experienced short periods of back strain and he suffered some from kidney stones.

AVOCATIONS

[10] Before the first accident he was a vigorous, physically active man. He rode horses, bicycled, hiked, gardened and belonged to a bowling league. His wife was a keen rider, owning a Morgan horse which she rode competitively at horse shows; the plaintiff assisted her in that activity. He maintained a large vegetable and flower garden and he mowed the lawns. He operated carpenter's power tools building furniture and improving and maintaining their home.

HIS PERSONALITY

[11] Witnesses described his personality. From their evidence and my own observation, I conclude he is a reserved, reticent, very private person, little inclined to talk about himself or his physical problems. He is stoical. He has a strong work ethic. He is not a good historian when relating his physical difficulties to medical people and he has a poor memory. His wife testified he does not explain or express himself well. Doctor Ng who has been his family doctor since 1983 described his patient at trial as a reckless kind of historian making it very difficult to piece together what is troubling him, but stoical, not a complainer. He believes the plaintiff suppresses "a lot of problems and just carries on working." Dr. Ng has found him different from the usual motor vehicle accident victim for only when he was at a crisis point or when pushed by his wife would he force himself to seek Dr. Ng's medical help. His reluctance to speak of his ailments likely accounts in part for the casual way in which Dr. Ng treated his injuries and for the long delay in diagnosing his herniated disc. Mrs. Monahan, his wife, was the spur to have him see Dr. Ng at all. She testified:

I set up doctor's appointments because Randy won't go to doctors, he doesn't believe in them and he is really stubborn. He doesn't say he is hurt, he won't admit to it. He thinks you have to be like dead before you go to doctors in the first place.

Part B

THE CHARACTER OF HIS WORK

[12] Long distance hauling is labour intensive work and some of the physical demands exceed those of medium strength work. The loads have to be secured with nylon straps every four feet along the trailer's length (40 feet fully loaded). The straps are winched tight and that requires muscle power. Very occasionally he has to adjust the loads manually. If the load has to be protected from the weather, and it frequently does, it is tarped. The tarps weigh from 80-230 pounds each. He uses two tarps. A dry load is usually 12-13 feet from the top of the load to the ground. If there is no fork-lift available he has to climb to the top of the load, pull up the tarps by hand, adjust them over the top and sides and then secure them by muscle power. After use, the tarps are rolled up and lifted onto the empty trailer. If no fork lift is available they must be lifted by hand. On occasion snow chains have to be put on Ä a minimum of four wheels, the chains weighing 75 pounds each.

[13] The floor of the cab of his truck is four and a half feet from the ground, four steps up. In the truck the engine is beneath him with the "sleeper" behind the seats. To get into the sleeper he must lift himself out of the driver's seat onto the engine compartment and slide his body backwards into the sleeper. To remove his clothes he must lie on his back for there is no standing room in the sleeper. Before the first accident he had no difficulty performing any of these work functions, nor any of his leisure pursuits.

[14] For many years his hauling route has been Vancouver into Washington and Oregon States along Interstate Highway 5 and because it is of concrete construction, Highway 5 provides a very rough ride, particularly in a cab/over truck.

PART C

CREDIBILITY

[15] I found the plaintiff and his wife Debbie Monahan to be reliable and credible witnesses. The plaintiff is not a malingerer and he does not exaggerate his physical difficulties. He freely confesses that he has a poor memory. Given his personality as I have described it, it is not astonishing that his description at trial of his medical difficulties was more graphic than his reports of them to Dr. Ng and other medical people.

Part D

HIS INJURIES AND THEIR PROGRESS

[16] Causation is in issue and therefore I shall recite the evidence under this Part in greater depth than I would customarily do.THE PLAINTIFF'S ACCOUNT
The March 7, 1992 Accident

[17] Immediately following the collision he felt pain in his lower and mid-back in the rib area and in his left shoulder. The pain persisted and he didn't work for some days. He saw Dr. Ng on March 9th who found tenderness in his lumbar spine over the fifth lumbar vertebra and neck stiffness. He diagnosed mild neck and mid and lower back pain and prescribed ice, compresses, stretches and Tylenol 3.

[18] On March 16th Dr. Ng noted residual neck and mid and lower back pain and stiffness, and on March 25th he noted that x-rays revealed a duodenal ulcer. I find that the ulcer was not caused by medication administered following the March 7th accident.

[19] On April the 25th the plaintiff complained to Dr. Ng of mid-back pain and lower back pain particularly before urination. There is an important reference in Dr. Ng's clinical notes of that day which I emphasis for it is the first note of radicular pain:

Aches back to right knee every day.

Past history: piece of steel hit right patella (walked into it) one year ago Ä wound, injured, hurt bad six to eight months and sore since then.

On exam: patellofemoral crepitus right more than left.

Assessment: traumatic chondromalacia patella. (Emphasis added)

[20] By April 25th the plaintiff had been experiencing right leg problems which he described at trial:

leg going numb and aching and tingling and doing strange things.... I told Dr. Ng (on April 25th) about the tingling and activity. I asked him because I didn't connect it to my back because I didn't know anything about how back injuries affect you and a few months before that I had hit my knee with a chunk of steel. I asked Dr. Ng if this is what caused my leg to bother me and he seemed to think it was because he felt I only had a soft tissue injury from the accident and so the two were two separate things.

[21] The plaintiff said he had never before experienced a pain "that aches back to knee."

[22] At trial Dr. Ng was asked to explain his note "aches back to right knee" and said:

Q ...does your note, does it mean back of right knee, or does it mean it refers from the back to the right knee, or what does that mean?
A I think it means from back to right knee. At that time I diagnosed as a traumatic chondromalacia patella, but in hindsight now then, even though he had normal straight leg raising, I wondered whether there could be a slight weakening of that disc, could have caused those symptoms. At that time the diagnosis was not evident to me.

Q It appeared as a case of traumatic chondromalacia patella at the time?
A That's right.

[23] His back and right leg condition continued. In early June 1992 he attended a Morgan Horse Association show. He irritated his wife because he could not sit in the bleachers for long due to back and right leg pain. Mrs. Monahan noticed him rubbing his thigh, rotating his ankle and he spoke of his toes tingling. He had trouble climbing the bleachers for it hurt to lift his leg. On occasion this leg pain became severe starting in the back and radiating down his leg and at times into his toes. When it was not so severe he experienced a numbness in the right leg. That condition continued into September 1992 and beyond.

[24] By September 5th his lower back pain had become more severe. He saw Dr. Ng on that day who recorded in his clinicals:

Driver has to move tarpaulin 200 pounds. Lower and mid-back ache. Aches easily with any prolonged activities. Occasional ache down right thigh to right knee last four hour.

Dr. Ng testified that the leg pain could have been related to the back injury. Mrs. Monahan attended the September 5th meeting and testified that when her husband again complained of leg pain on that day, Dr. Ng again attributed it to the knee injury arising from hitting a piece of steel.

[25] At a Christmas dinner and dance in early December 1992 the plaintiff and his wife left early because he was experiencing pain in his right leg into his toes. It prevented him dancing.

[26] Between March 7, 1992 and Christmas Eve of that year, the day of the second accident, the plaintiff's physical and recreational activities were greatly curtailed. He could not ride a bike. He tried an exercise bike and it made his condition worse. He had to lay on his bed or a chair to put on his socks and shoes; on one occasion it took him thirty minutes to put on his trousers. He did not garden in the summer and he gave up his woodworking. He gave up bowling. He no longer went to church because he could not sit for any prolonged period of time. He tried to ride a horse and the pain prevented it. He had sleeping difficulties. He had to pay others to do the truck maintenance he had formerly enjoyed. He had great difficulty lifting his tarpaulins. To alleviate his pain he took large doses of Tylenol 3, up to 12 a day, and unusual for him, he mixed the pills with alcohol Ä beer and hard liquor. Mrs. Monahan accompanied him on two or three hauling trips during that period and observed that he drove more slowly and stopped more frequently so that he could walk about. He had trouble walking any distance. He continued, so far as he was able, to transport the same kind of loads, but avoided as best he could overnight trips, finding it very difficult to crawl in and out of his sleeper. On September 5th and 12th he attended Dr. Short, a chiropractor who had treated him once before March 7, 1992 Ä in 1990. He found that the chiropractor greatly aggravated his back pain and he went no more. He purchased an air suspension seat hoping it would relieve his back.

[27] His personality changed; he became irritable and difficult to live with.

[28] His neck, shoulder and mid-back pain steadily improved and after 6-8 months it had fully resolved. He was not suffering any pain symptoms in those areas at the time of the second accident.

[29] I have recited his physical condition and limitations as I find them, from March 7, 1992 to December 24, 1992 when the second accident occurred.

The Second Accident, December 24, 1992

[30] From the second accident he again experienced shoulder and neck pain which were fully resolved by the end of two months. He again experienced mid-back pain for an indeterminate time. His low back and leg difficulties were also exacerbated in the

second accident.

[31] He saw Dr. Ng on December 29, 1992 who noted soreness in the mid-back and shoulder Ä "lots of right paraspinal spasm." His reference in clinicals to the plaintiff having "no residual problem from last MVA when this occurred," relates to mid-back pain only. Mrs. Monahan attended on that day with her husband and testified:

> Randy (the plaintiff) told Dr. Ng he was having pain in his leg and back and Dr. Ng sort of did what he normally did and gave him some more pills and... patted him on the back and said "it will get better."

[32] It did not get better.

[33] The plaintiff did not see Dr. Ng thereafter until October 9, 1993. He says he did not because he felt frustrated Ä "nothing was changing and I did not feel Dr. Ng had done anything for me except to tell me I was getting better; I did not think I was."

[34] Mr. Monahan continued to have leg and back symptoms which sometimes "were less severe, sometimes more severe than formerly." The back pain was ever present, the leg pain came and went and when it came it radiated down his leg and into his toes. His toes became numb, the leg ached and tingled. After a time the pain in both back and legs reached the level they had been before the second accident. His sleeping difficulties continued. His pill and liquor ingestion to relieve pain continued unabated.

[35] On April 17, 1993 he attended a funeral in Enderby and had difficulty climbing a hill to the gravesite due to pain in his lower back and leg.

[36] On October 9, 1993 he saw Dr. Ng at his wife's insistence. Dr. Ng recorded "back ache."

[37] On October 30th the plaintiff and his wife saw Dr. Ng. Mrs. Monahan insisted on a specialist being retained. She testified she was angry because "he (Ng) was so lethargic about the whole thing." Dr. Ng sent him for x-rays of the lumbar spine. The radiology revealed a narrowing of the L5 disc space by almost 50% of normal. At trial Dr. Ng spoke of that result:

> That told me he had a significantly crunched down disc and there may be a bulging of the disc margins against the ligaments maybe causing pain.

[38] Dr. Ng examined him again on January 15, 1994. The plaintiff reported he was having difficulty walking and had difficulty urinating and defecating because of back pain. He reporting occasional numbness in the right knee. He was able to straight leg raise to 70ø, left and right. Dr. Ng sent him for a CT scan.

[39] On January 28, 1994 Dr. Ng found he had a straight right leg raise of only 40ø. He noted "sciatica worsened this a.m. Unable to drive today." At trial Dr. Ng spoke of the reference to sciatica:

> Sciatica is a term we give to the sciatic nerve; if there is an irritation along its path, pain results. It can be caused by tumor or herniated disc which we call soft tissue. In my reports when I spoke of soft tissue injury, I did not include a herniated disc. The diagnosis (herniated disc) was already there on January 15, 1994, although I did not notice it before.

Dr. Ng spoke of the time he first suspected a herniated disc:

> I suppose if you could look back on it, it was the wife coming in to say the severity of his complaints (October 30, 1993) and then... radiology showed there was a narrowing and then with him... saying the numbness going down, even though he still had a normal straight leg raise. I felt we had to pursue further to see what that disc had been doing and, and in fact he came back two weeks later on January 28th

with a classic case of sciatica, which was a reduction of a straight leg raising to 40ø and that really sort of confirms the whole episode of the sciatica...

You can have a disc protrusion without a restricted leg raise. A person will have good and bad days. A 70ø leg raise is inconsistent with a severe herniated disc but it can be therefore an amount of moderate disc protrusion in its not, acute phase.

[40] By February 25, 1994, Dr. Ng had received the CT scan results and noted them:

CT scan lumbar spine: no abnormality demonstrated at L3-4. At L4-5, there is mild narrowing of the central spinal canal due to slight posterior disc bulging and hypertrophy at the ligamentum flavum. No disc herniation demonstrated at this level. At L5-S1, there is posterior displacement of the dural sac and nerve roots by a large heterogeneous soft tissue mass in the anterior portion of the spinal canal. This is centre at and above the disc space. The disc itself demonstrates posterior bulging. A portion of the abnormal soft tissue density at this level is of attenuation characteristics similar to the disc. The remainder is of low density at this level is of attenuation characteristics similar to the disc. The remainder is of low density. [sic] No bony abnormality of the L5 or S1 vertebral elements is demonstrated.
Impression: large extradural soft tissue opacity anterior to the dural sac at L5-S1. The appearance is atypical for a disc herniation, and therefore an interspinal mass lesion must be included in the differential diagnosis.

[41] On March 12, 1994 Dr. Ng noted that his lower back pain had improved. He had symptoms of pain down the left leg the previous few days but it had resolved. On examination Dr. Ng found the straight leg raises of both legs were 70ø. He recommended the plaintiff to Dr. Gittens, neurosurgeon, who saw him on June 21, 1994. Dr. Ng did not see Mr. Monahan again until February 18, 1995.

[42] In his first examination Dr. Gittens did not diagnosis a herniated disc. Dr. Gittens sent the plaintiff for an MRI, which was performed in March 1995 and it confirmed that the plaintiff had suffered a herniated disc at level L5-S1.

[43] I return now to the plaintiff's account of his condition and his deficits. In December 1993 while in Seattle at work, he experienced the most severe attack of pain he had yet experienced. He could scarcely move. He lay on his sleeper with his feet between the seats.

[44] He spoke of his physical condition before the first accident saying that from time to time he strained his back when working but the resulting pain always resolved in short order. On January 20, 1988 he fell off his truck and took chiropractic. Dr. Stork, chiropractor, reported that he suffered a right L4 facet strain resulting from the fall which resolved after two visits. He did receive some chiropractic treatment thereafter before March 7, 1992, which I shall speak of later. He had difficulty with kidney stones in the mid-1980s and after, but the pain associated with it was in the lower abdomen not the lower back.

[45] Mrs. Monahan described his physical condition before the first accident:

He was in good physical shape. Very strong. He strained his back and neck and went to the chiropractor a couple of times but nothing prevented him working. He has a very strong work ethic. He never took time off because of illness. He drank very little alcohol.

HIS PRESENT CONDITION

[46] His back and leg difficulties have not improved. He has

not resumed any of his former leisure activities. On some days when the back pain is very severe Mrs. Monahan has helped to put on his socks and shoes for he could not bend to do so. He has continued to work but is never without pain. He has worn a back brace since the first accident.

PART E

THE MEDICAL EVIDENCE
FOR THE PLAINTIFF
DR. KENNETH NG

[47] I have already referred to some of Dr. Ng's evidence and need not repeat it. In his Report of April 21, 1995 Dr. Ng wrote:

Randall Monahan's sustained soft tissue injury to the neck mid and lower back and an undisplaced ninth rib fracture from his first MVA. The anti-inflammatory medication also probably caused his duodenal ulcer. The second MVA aggravated his lower back ache and probably caused the weakness to his ligaments surrounding the L5, predisposing the disc to rupture and causing him on Ä going sciatica.

[48] At trial Dr. Ng was asked the basis for that conclusion, saying:

First he did have some lower back aches from the first accident. It was only after the second accident when we diagnosed the 50% degree in disc space and when he came back on that, that I sent him for a CT scan that I felt it was the second accident that caused the worsening or caused the sciatica to happen, was on that basis.

[49] Despite the plaintiff's continuing complaints of back pain and leg symptoms commencing after the first accident, it was not until October 30, 1993 that Dr. Ng ordered x-rays of his lumbar spine and I conclude did so then only at the insistence of Mrs. Monahan.

DR. WINSTON GITTENS

[50] Dr. Gittens is Chief of Neurosciences at Royal Columbian Hospital and a neurosurgeon. He first saw the plaintiff on June 21, 1994 and examined him. The previous x-rays and CT scan results were not available to him. He reported to Dr. Ng on June 27, 1994 asking to see them and suggesting if they did not reveal a disc herniation, that he be referred to the Canadian Back Institute for an aggressive back rehabilitation program and that Dr. Ng might suggest he lose some weight.

[51] By August 9, 1994 Dr. Gittens had seen the CT scan results and reported to Dr. Ng:

The L4-5 disc shows a diffuse bulge and possible central and slightly left-sided herniation. However, there is quite a dramatic abnormality noted at the L5Ä S1 level. The etiology of this is obscure. It either represents a large sequestered disc or some other space occupying pathology.

[52] On October 12, 1994 he informed Dr. Ng that he was arranging for an MRI and on November 30th reported to Dr. Ng that a radiologist at St. Paul's Hospital had interpreted the earlier CT scan and felt that the mixed density lesion represented hemorrhage possibly associated with a disc fragment and was recommending a repeat CT scan.

[53] On April 19, 1995 Dr. Gittens wrote to Dr. Ng giving his opinion and prognosis.

I had the opportunity of reviewing the MRI scan which is reported by Dr. Harrison to demonstrate a mixed density mass of the epidural space at the L5-S1 level on the right side. I have reviewed this and I believe it represents a disc fragment. I don't think it represents any other lesion. The MRI scan also shows degenerative changes at the L4-5 and the L5-S1 disc.

As this man remains terribly symptomatic I see no point in repeating the investigations. He has two options at this stage. One would be to continue to accept his present disability. The second option would be to consider a diskectomy at the L5-S1 level on the right side. I have explained the operation to him in great detail, the risks, including risk of hemmorhage, neurological deficit, various pain syndromes, and I have gone over the success rate of the operation. It appears that he may be leaning towards surgery. Therefore, he has signed a consent, but he will call my office to notify me ultimately as to his final decision.

[54] In the result, the plaintiff declined to undergo surgery and the defendants have no quarrel with that decision.

[55] On May 2, 1995 Dr. Gittens sent a Report to the plaintiff's lawyers writing:

At this stage, therefore, I can only conclude that the accidents of 1992 did contribute to his symptoms and possibly also to the disc herniation. Prior to the accidents he had reported some intermittent episodes of back pain, I believe diagnosed as back strains, but possibly could also have been diagnosed as being related to early degenerative disc disease. This factor, therefore, cannot be totally excluded in the equation.

I believe that the accident caused a strain to the dorsal area, a strain to the lower back, and possibly contributed to the disc herniation noted at the L5-S1 level, and hence, his persistent symptoms in the lower back and right lower extremity.

As far as the prognosis is concerned, Mr. Monahan can be expected to continue to be symptomatic if he elects not to consider surgery. Surgery will in no way guarantee him complete relief of pain but I believe would have a greater than 60 to 70 per cent chance of alleviating his acute pain, and particularly the pain radiating into the right lower extremity.

[56] On November 1, 1995 Dr. Gittens again reported to the plaintiff's lawyers:

Mr. Monahan has continued to work in spite of his persistent symptomatology. This is quite gratifying. Whether he will be able to continue to do so indefinitely in his present capacity is doubtful. However, his present condition, namely, the disc pathology is not enough to render him totally disabled. I believe that with appropriate counselling and a functional evaluation assessment he could be guided into other possible occupations. (Emphasis added)

DR. GITTENS' TRIAL EVIDENCE

[57] Dr. Gittens testified at trial. A summary of his evidence on the crucial issue of causation and his prognosis follows.

[58] At the first visit Dr. Gittens examined the plaintiff without the assistance of x-ray or CT scan results. He concluded the plaintiff had mechanical lower back pain caused by degenerative disc disease or chronic back strain and related it to the history of trauma (the accidents). He believed the mid-back pain was related to muscle injuries. After seeing the radiological reports he could not rule out a tumour in the spinal canal or a herniated disc. The MRI results revealed that the lesion which had been present the year before and which he felt might have been a tumour had resolved. After the MRI results were in, Dr. Gittens diagnosed a moderate right-sided disc protrusion at L5ÄS1 displacing the right S1 nerve route, pushing on the nerve. He concluded that his persistent lower back pain was related to the herniated disc.

[59] From the patient history, Dr. Gittens concluded there was a clear history of nerve root irritation evidenced by numbness

and tingling and verticular pain from the back, which the plaintiff had experienced by December 1993. He took that date because Monahan told him of the extreme pain he experienced on an occasion in Seattle. Dr. Gittens was asked if the plaintiff placed that incident in December 1992 and said it was possible he had misunderstood but because it had occurred when he was driving in the United States in that month and year, believed it occurred then. Dr. Gittens clinical notes speak of December but omit the year. The plaintiff cannot remember whether it occurred in December 1992 or 1993. I conclude it probably occurred in December 1993.

[60] Dr. Gittens was referred to his written opinion that the 1992 accident did contribute to the symptoms and "possibly also to disc herniation" and was asked how the accidents contributed to the symptoms. He said:

...So there was a history of increasing symptoms following the accident which were not there before the accident, based on the history which I obtained, so that was one bit of information that I used.
I also decided that, or assumed that because of the persistent and increasing symptoms, that the possibility existed that there could have been injury to the disc superimposed upon the degenerative change, which might have been there, to weaken the disc to the point where it could have resulted in subsequent herniation in the absence of any other clear significant traumatic event.

...

THE COURT: Just a second, please. You probably have explained it, but if so, I'd like you to do it for me again. Are you saying that the pain that he has complained of is a pain resulting solely from the herniated disc, or is it a pain emanating from the degenerative changes or both, or there is probably no pain associated with the degenerative changes?
THE WITNESS: Well, I think the symptoms, or the pain -- actually, it's a combination of both. Degenerative changes can certainly exist in the spine and be totally asymptomatic, this is well documented; and in fact, most people who have degenerative changes in the lower spine are asymptomatic.
THE COURT: Until the triggering event?
THE WITNESS: Until the triggering event. Sometimes the triggering event doesn't necessarily need to be major. Sometimes it can be -- sometimes we never know what the triggering event is, based on history that we've brought in. So in this case, I think it's a combination of things.
THE COURT: The disc and the degenerative changes?
THE WITNESS: I think the degenerative changes, and based on the history, I believe that there was probably injury to the disc which subsequently resulted in herniation.

[61] Under cross-examination, Dr. Gittens said that in terms of relating disc damage to a traumatic event the symptoms associated with this damage must be concurrent with or occurring within a reasonable time after the event and continue to the time of a positive diagnosis. However, continuity of symptoms does not necessarily mean constant pain, it may mean intermittent symptoms over a period of time.

[62] Dr. Stork's report, Exhibit 6, in which he spoke of sacroiliac pain with radiation in 1990, was put to Dr. Gittens and he was asked if that entry indicated a neurological sign. He replied:

Q It says, "weak radiates to knee". Now, I know it's difficult working with a translation of scanty clinical records, but would you read that as sort of a neurological sign?
A Well, it depends on what radiates to the knee.
Q Okay, let's assume it's pain.
A Well, it could be, could be a neurological sign.
Q And then we have another entry four days later,

once again, "low back pain" and it says, "no radiation right" this time. So it came and went, apparently?

A Yes.

Q Okay. So you'd have to agree that the chiropractor's notes do show some indication that in this area of the back there were, the S1-L5-L4 area, there was some indication of a problem, and perhaps some radiological or neurological symptoms in 1990, 1991?

A I would only go so far as to say that it does indicate that the chiropractor treated him for problems in the lower part of the back. I wouldn't comment on the neurological, whether there was neurological symptoms or not. Radiation might suggest that, but I'd need a lot more clinical data before I'd make that judgment.

Q But in any event, these notes would perhaps weaken the one part of the factual basis that you've drawn your conclusions from, which is the onset of the symptoms in the low back, would it not?

A Not necessarily, because he reported to me that he did have symptoms in his lower back before the car accident, and he reported to me that the symptoms sometimes lasted a short period of time and sometimes lasted up to three weeks. So you know, it just confirms there that no, he did receive treatment for back, lower back pain prior to the accident, yes.

[63] Dr. Gittens testified that in as many as 30% of disc herniations there are no pain symptoms whatsoever. Pain radiating from the back to the right knee is consistent with a herniated disc but there are also other causes for a pain of that character.

[64] Dr. Gittens opined there are three possible sources of the back pain:

Ä herniated disc

Ä soft tissue injuries

Ä a triggering of a pre-existing but quiescent degenerative condition.

[65] With respect to the plaintiff's future, Dr. Gittens believes he should avoid physical work that makes demands on the back. He found it impossible to say how long the plaintiff would be able to continue his present work.

[66] The court asked him about his earlier recommendation to Dr. Ng that the plaintiff undertake an aggressive program and the use of a one-to-one therapist, and said:

THE COURT: ...if he were to put himself in the hands of a physiotherapist on a one on one basis with respect to exercising, is his -- is it likely that he will receive some relief from his back pain and which might render him more capable of continuing to drive, over time, than he would be without undertaking any of these things?

THE WITNESS: I think that might be possible. My recommendation -- there are two reasons why I recommend an aggressive back rehabilitation program. The first reason is to try to get the individual, particularly the individual's back, to the best functional level that we can. And, therefore, a properly directed program, based on some general principles but taylored [sic] to the individual, can sometimes do that. There are some organizations currently in this province who will provide that service. The second reason is that during the process of this rehabilitation program a lot of back education is given to the individual about property body mechanics, sitting properly, et cetera, how to lift, how to bend, and these things can be used throughout life thereafter in order to reduce back discomfort, so the aim of this is to improve the general status of the individual and in many instances it does help and we are able

to get them to function a lot better. Sometimes it fails and sometimes, unfortunately, I have had to take a few persons out of the program because they were made worse by the aggressive exercise program. (Emphasis added)

THE MEDICAL EVIDENCE FOR THE DEFENCE
DR. MARK BOYLE

[67] An orthopedic surgeon, Dr.Boyle was qualified in the assessment, diagnosis and treatment of back problems.

[68] He saw the plaintiff only once, on November 24, 1994, took a history and examined him. The appointment lasted one hour. His first Report to the Insurers is dated November 25, 1994 in which he related the history of pain and the following is significant:

In early 1994 he described an episode of increasing low back pain with radiation into the buttocks, thighs and calves. He had almost global numbness in both extremities.

That is the first reference to radicular pain in the history related by Dr. Boyle. Clearly, the plaintiff was suffering radicular pain as early as April 1992, Dr. Ng noted it and it continued. The plaintiff is a poor historian and he may have been referring to the severe episode of pain experienced in December 1993, but placing its occurrence in early 1994. I do not know. In any event, the history as Dr. Boyle related it is not correct.

[69] When he wrote his Report he did not have x-ray or CT scan results. He found evidence of moderate chondromalacia patella in both knees which he attributed to pre-morbid disease. Dr. Boyle gave his diagnosis with respect to his spine.

LUMBOSACRAL SPINE: physical examination is consistent with mechanical low back pain i.e. secondary to disc degeneration and diarthrodial arthritis. I feel that this is a spine at risk. I feel that the disc degeneration and diarthrodial arthritis likely antedated the MVA. He is in poor physical condition. He is obese and his muscular tone is poor. I feel that the persistence of symptoms secondary to the MVA's is likely attributable to antecedent disease and to the lack of proper treatment. He has not carried out self administered physiotherapy. He would be well served by performing such exercises 2 to 3 times a day. He would be well served by a weight loss program. He would be well served by an aerobic exercise program i.e. walking.

...

I do not feel that he has to interrupt his work as a truck driver. I do feel that he would be best served and have quite a high likelihood of resolution of his symptoms if he performs a well organized self administered exercise program.

Attempts will be made to obtain the radiological examinations performed previously and comment on these.

If he did obtain the results of the radiological examinations he did not report on them until nearly a year later, in his second Report dated October 30, 1995. That report, too, was directed to the Insurance Corporation of British Columbia. The defendants do not suggest that the recommendations for weight loss and exercise in both Reports were communicated to the plaintiff.

DR. BOYLE'S REPORT OF OCTOBER 30, 1995

[70] Dr. Boyle had the radiology result and reports from Drs. Gittens, Ng and Thompson at the time of this second report. He wrote:

It is my opinion that this man's axial skeleton was

at risk. He had a history of low back pain of a recurring and persisting nature in the past. (At trial he abandoned "persisting".)

He was physically unfit. He was obese. His muscle tone was poor. He was not involved in a thrice daily stretching and strengthening program. He was not involved in an aerobic fitness program. He was a smoker.

[71] At trial the Court asked him:

> ...You saw this man two and a half years after the first accident. He had become a good deal less physically active over those two and a half years, rightly or wrongly, the fact is he did. I noted that in the report of Dr. Fuller. Dr. Fuller was -- do you know Dr. Fuller? He examined the plaintiff in March of 1993, just about a year after the first accident, and he noted the patient was of normal weight. He was tall, 6 foot 5 inches. You saw him a year and a half after that examination and you found him obese. He had been doing very little physical exercise of any kind since the accident. Is it, do you think, significant that Dr. Fuller who examined him in March of 1993 did not find him obese and he had been complaining at that time of consistent back pain from the time of the accident until Dr. Fuller's examination. Is that of any significance to you?
>
> THE WITNESS: Yes.
>
> THE COURT: What significance is it?
>
> THE WITNESS: It means one of the contributing factors which is poor muscle tone and carrying extra weight may not be playing much of a role in this situation here.

[72] He described "obese." If a person's abdomen is not flat and does not show good abdominal muscle tone, that is obesity.

[73] In his October Report he continued:

His occupation as a truck driver would contribute to recurrence and persistence of symptoms.

I feel there were conditions antecedent to the MVA which would have led over time to persisting low back pain. There was evidence to suggest antecedent disc degeneration which could possibly lead to disc herniation.

There is little doubt that the two MVA's contributed to an increase in his symptom complex.

It is impossible to determine whether the disc herniation at L5-S1 was brought on by the MVA. However it is my impression that in terms of probability, the following can be stated:

It is more likely that the patient would have gone on to a disc herniation and the symptom complex described over time without the intervening MVA's because of factors previously mentioned.

It is felt that the likelihood of the natural progression of this disease leading to the disc herniation and the aforementioned disc complex is greater than the likelihood of the MVA's contributing directly to the disc herniation. (Emphasis added)

DR. BOYLE'S TRIAL EVIDENCE

[74] Dr. Boyle was cross-examined vigorously but fairly. I shall summarize some of his evidence. Degenerative disc disease is common; a majority of people over 40 will have it. The symptoms are early morning stiffness and pain and post-activity stiffness and soreness in the lower back to a major or minor degree. The pain is secondary to disc degeneration and early diarthrodial arthritis and the latter condition is universal in people in their 30s. The condition does not

normally lead to disc herniation. A herniated disc can occur silently Ä without a known cause. It can be caused by trauma.

[75] A herniation at L5-S1 may produce radicular pain Ä from the spine into and down the leg; it may produce continuous pain, intermittent pain or no pain at all. In Dr. Boyle's opinion surgery is a last resort.

[76] Dr. Boyle described methods employed to diagnosis a herniated disc: interview and examination of the patient. The examination focuses on the low back and function of the nerves, one or more of which may be compromised by the herniation. Radiological investigations are then undertaken, including a CT scan, which is done to confirm the diagnosis. In a majority of cases a preliminary diagnosis of a herniated disc can be made using a patient history and physical examination. An accurate patient history is important when making a diagnosis. Leg raises are a component of a physical examination and if on the day of testing, the pain is asymptomatic, a patient would perform a leg raise easily.

[77] It is Dr. Boyle's practice to assess a patient's credibility. He made no negative findings with respect to Mr. Monahan.

[78] Dr. Boyle believes the degenerative changes found in the CT scan pre-existed the first accident but did not render him more susceptible to a disc herniation. The 50% reduction in disc spacing seen in the November 1993 x-ray is a function of disc degeneration occurring over a number of years.

[79] Studies of long-haul truckers have shown that degenerative disc disease is accelerated in that occupation, due to long periods of sitting and road vibration. In recent times trucks have been designed to reduce vibration.

[80] Under cross-examination Dr. Boyle said:

Q Would you agree with this: For the majority of people that have degenerative disk disease, that is the level of symptom you would expect, minor back aches and so on of one sort or another?
A Yes.
Q Do you agree with that?
A Yes
Q How can you predict which people with degenerative back disease would go on to have a herniated disk?
A I don't think you can.
Q Well, you have, sir?
A No I didn't.
Q Have a look please at page two of your October 30th, '95 report?
A Yes.
Q Bottom of the page, paragraph:

> "It is more likely that the patient would have gone on to a disk herniation and a symptom complex described over time without the intervening MVAs."

Now, I read and please tell me if I have it wrong, as you opining that it is likely that Mr. Monahan would have gone on to a disk herniation without the accident?
A No. What I am saying is that this patient has a disk herniation.
Q Yes.
A And therefore what caused it. Is it the natural progression or is it the motor vehicle accident? And my feeling is that it is part of the progression and part of the symptom complex. Part of his low back disease.
Q I am not quite following that. You say it is universal to have disk degeneration?
A Yes.
Q And you say that it is normal for people with disk degeneration to have minor symptoms, certainly not debilitating symptoms, is that correct?
A Um-hm.

Q And you say there is no way to predict which people with degenerative disk disease will end up with a disk herniation?
A Right.
Q And then you say but because Mr. Monahan has one it must be because of the antecedent disk disease; have I got that right?
A To a agree [sic] you are right. I think that of the two factors, that is the natural occurrence of difficulties herniation in people and his symptom complex over the years, that it is more likely that the disk herniation is simply a natural phenomenon rather than one brought on by the motor vehicle accidents. That is what I am saying.
Q On what basis do you say that -- how can you say that?
A Well, because of the previous history of back pain that he had including radicular pain or pain from the nerves dating back from 1988 and 1990. The fact that the motor vehicle accident is not a mechanism that is commonly associated with disk herniation in the low back. The fact that his earlier complaints were more thoracal lumbar from my understanding of reading reports rather than sacral. From the fact that there was a year or more between the onset of the motor vehicle accident and the occurrence of radicular pain and --
THE COURT: I am sorry and the occurrence of what pain?
THE WITNESS: Of the nerve pain that would suggest a disk herniation. So the -- if you follow it temporally it seems to be unassociated with the motor vehicle accident, rather something that has happened as it happens to a large number of people without the intervening accidents. The accidents did worsen his back complaints but I don't think they brought on the disk herniation.

...

Q And you are saying that one of the reasons for your opinion is because it was a year after the second accident that there was radicular pain?
A Yes. (Emphasis added)

[81] Dr. Boyle conceded a disc herniation would not necessarily result in immediate pain by pressing on the nerve root. Symptoms could be postponed. He said:

Q All right. I would like to you make this assumption, sir, for the purposes of your opinion, assume after the first accident within six or eight weeks Mr. Monahan started having radicular pain going into his leg; would that affect your opinion?
A Sure.
Q Would it make it more likely that the accident-- that the herniated disk was caused or contributed to by the motor vehicle accident?
A It lends more credence to it. (Emphasis added)

[82] Dr. Boyle agreed with Dr. Gittens that pain could have arisen from three sources Ä soft tissue injury, a degenerative disc condition aggravated by the accident and from a herniated disc. He concedes that a patient could not distinguish between those sources.

DR. GORDON THOMPSON

[83] Dr. Thompson is a neurosurgeon of great experience and distinction. He graduated from McGill School of Medicine in 1952 and came to British Columbia for part of his Internship. From 1965 to 1991, he was Chief of Division of Neurosurgery at the University of British Columbia and at Vancouver General Hospital and Head of the Neurosurgery Division at University Hospital, Shaughnessy. Presently he is Professor Emeritus of Surgery at the University of British Columbia and is still engaged in clinical practice, specializing in spinal work. He has performed thousands of lumbar disc operations.

[84] The plaintiff was sent to him by his solicitors for examination and opinion. The defendants entered his Report into evidence and called him as their witness. Mr. Monahan was seen on June 6, 1995 and Dr. Thompson submitted a Report dated June 14, 1995. He did not have radiology scans for review but he had seen radiological reports following the CT and MRI scans. He took a history.

[85] The plaintiff described a constant low back pain of varying intensity at times severe and disabling. He described pain in the right hip and buttock extending into the posterior thigh to the calf of his leg and at times to his foot. This pain usually came on with increased low back pain. He described "occasional numbness" over the lateral aspect of his right thigh. He spoke of numbness being present "a couple of months ago, in his left thigh and in his right foot.

[86] The plaintiff told him those symptoms began about three years previously. He spoke of a severe back pain after the first accident lasting over one year and then he began to have pain extending into his right hip through his calf.

[87] That history related by Mr. Monahan was incorrect.

[88] Dr. Thompson examined him and I need only refer to the straight leg raising Ä 80ø right compared to 90ø left, with a slight hamstring tightness bilaterally, notable sitting and lying.

[89] Dr. Thompson gave his clinical impression:

This man at the present time continues to have back and right lower limb pain. The description of his right lower limb pain sounds as if it could be radicular in nature. These are times when he has had paresthesias with localization to the lateral aspect of his foot, suggestive of a first sacral nerve root dermatome distribution.

At the present time his neurological examination is entirely normal. I don't think the 1cm difference in thigh girth on the right compared to the left is of any clinical significance.

He does have, however, minimal root tension signs on the right which would indicate a nerve root irritation within the lower lumbar or upper sacral spinal canal. This does not give any specific nerve root localization.

...

It is of interest to me that his symptoms related to his right lower extremity did not come on until "about one year" after his first MVA and four or five months after his second MVA. The relationship, therefore, with the onset of his radicular right lower extremity pain, which has all the characteristics of lower lumbar or upper sacral nerve root pain, i.e. sciatica, is not entirely clear with respect to cause. Nevertheless, he does indicate that he has had continuous ongoing back pain following his first motor vehicle accident aggravated by a second motor vehicle accident and is still present currently, although he has much less right lower limb pain.

Unfortunately, the scans have not been made available to me and I would like to review them.

I would say, however, that the various opinions offered by the radiologists on the CT scan and the MRI scan indicate that the MRI scan of March 3, 1995 revealed a "moderate right posterolateral protrusion of the L5-S1 disc with slight displacement of the right first sacral root posteriorly".

There would appear, therefore, to be some correlation between this man's symptoms of pain and paresthesias affecting his lower back and right lower limb, and particularly the foot paresthesias with the MRI scan

findings. (Emphasis added)

[90] At trial Dr. Thompson testified the plaintiff's weight was of no significance. Dr. Thompson did not find the "possible" hemorrhage shown on the CT scan significant. It could have been a soft tissue "artifact" found in large heavy people.

Dr. Thompson spoke of the significance of a bulging disc:

A bulging disc is not significant without appropriate history and appropriate findings. Now that doesn't mean to say that a lot of those people don't get operated on, but they wouldn't in my hands.

[92] Under cross-examination, Dr. Thompson said he found the plaintiff in quite good shape when he examined him; his muscle tone was good and he did not find him at all "deconditioned." He spoke of the significance of radicular pain:

A Therefore, the cause of it, lower limb pain is referred pain and is due entirely different. It is not due to the disc. It is due to the nerve root being irritated and that's why it was of interest to me that if he had a ruptured disc, or at least a protruded disc, irritated nerve root, I would have thought that he, in my opinion, he would have had symptoms.
Q At an earlier time?
A Very early following the accident.
Q That was my point, sir. The closer in time those symptoms manifest themselves to the accident, the more likely it is that the accident caused the herniated disc; is that accurate?
A That's correct.
Q What you are saying here is because, on your understanding of the facts, those symptoms didn't manifest themselves until later, it is less likely that the accident caused a herniated disc?
A That's correct.
Q When you say that you would expect those symptoms to show up within a relatively short period of time if the accident caused a herniated disc, what does that mean?
A I would say it can occur immediately. They can occur within a few weeks but if they are significant with a herniation, they are there within a couple of months in my opinion.

...
Q One of, I suppose one of concerns in assessing the likelihood whether the accident caused a herniated disc was the fact that on the facts, as you understood them, there was a about a year gap and that is too long in your view?
A That's correct.
Q If you made this assumption though, sir, that is, if you had numbness and tingling in the leg, pins and needles sort of feeling which started occurring within two months of the accident, I take it then that would affect your view; would it?
A If they were persistent; in other words, you know, they are constant. They never let up.
Q Is it the case, sir, every herniated disc will cause persistent pain in the leg?
A Any -- well, not necessarily but the determining factor as to whether you develop these syndromes is the size of the spinal canal and now-a-days we know the size of the spinal canal because we have scanning but I think it's, in my opinion, that people that have, you know, a serious disc problem they have sciatica and they usually have it usually quite soon after a traumatic incident. There may not even be a traumatic incident. Might be a little cough or something. There is a tremendous variation.
Q It is difficult to assess what causes a herniated disc?
A That's correct.

Q Is if fair to say, sir, that even with a herniated disc some people will have persistent and ongoing sciatica and other people have it on an intermittent basis and other people won't have it at all?
A Well, I think that most people that have it, what I call a significant disc protrusion, lumbar disc protrusion, have ongoing persistent sciatica that doesn't let up. (Emphasis added)

[93] Dr. Thompson does not share Dr. Boyle's opinion that everybody by age 40 will have degenerative disc disease and arthritis; according to him some will and some will not. Because an individual has disc degeneration, it does not follow that person will end up with a herniated disc and if they do, it does not follow it will always be symptomatic; it depends on the size of the spinal canal. With respect to diagnosing a degenerative disc disease he said:

Q Is it possible, sir, on the basis of just a physical examination and a patient history, to state with certainty whether or not someone has degenerative disc disease?
A No, I don't think you can say they have degenerative disc disease. You can say they have symptomatic lumbar disc protrusion with root syndrome.
Q Would you agree with this, sir, the only way to be certain that there is degenerative disc disease is to get an x-ray?
A Plain x-rays will often show degenerative disc disease. You don't need a scan to show you that.

[94] Dr. Thompson was asked if Mr. Monahan might benefit from a back rehabilitation program:

THE WITNESS:...I am a great believer in having people exposed to a, you know, multi-disciplinary type of back rehabilitation. The -- one of the very first things being that the educational value of teaching people how to, you know, use their back, and Mr. Monahan told me that he had been involved in the transportation industry for about 20 years and, you never know, but I would assume from what I know about people like that, there is a heavy use of their back and I think a lot of those people feel because they are heavily involved in that type of work, that is the exercise, and I think that's wrong. So they need, number one, a good education program, and then he's got to be taught to do -- how to do the proper exercise program, and then it has to be checked periodically to -- by some medically responsible person, to see that they are doing them properly and they usually, over a few months, usually 3 or 4 months, they benefit by that, and a weight program, if there is excessive weight. I didn't get the impression that although he was heavy that he was, you know, that he had deconditioned himself by this, and I think what goes wrong in a lot of those physiotherapy programs is that they go for 20 minutes or once a week or Monday, Wednesday and Friday. I don't think it takes much imagination to realize that is, you know, that is not a very logical way of getting somebody rehabilitated and if they are going -- so if it is done the way I have suggested, education, taught how to do the proper exercises, and not necessarily going back to the therapist, ad infinitum, but with periodic checks to see how they are doing, but they must do those exercises seven days a week just like if you are a pro hockey player, you don't make the team if you don't keep in shape. I am very strong about that.
THE COURT: Dr. Thompson, is it likely a person with the back condition that he has will have to do exercises for the rest of his life if he wishes to keep active?
THE WITNESS: I believe that with the way it is

presented to me that he should have a program in which a very important part of his life is doing the proper exercise program for his back.

THE COURT: Can some of these exercises be done in one's own home rather than a gym?

THE WITNESS: Absolutely.

[95] Dr. Thompson believes the plaintiff would be better advised to be treated by a physiotherapist experienced in treating back disorders rather than the Canadian Back Institute, and the family physician is the person to monitor the success of the treatment.

PART F

CONCLUSIONS WITH RESPECT TO CAUSATION AND INJURIES ARISING FROM BOTH ACCIDENTS

[96] The Supreme Court of Canada has said proof for legal purposes in a civil action differs from scientific or medical proof: Snell v. Farrell (1990), 72 D.L.R. (4th) 289. The case was one of medical malpractice. At p. 300, Sopinka J. delivering the judgment of the court, said:

I am of the opinion that the dissatisfaction with the traditional approach to causation stems to a large extent from its too rigid application by the courts in many cases. Causation need not be determined by scientific precision. It is, as stated by Lord Salmon in Alphacell Ltd. v. Woodward, [1972] 2 All E.R. 475 (H.L.), at p. 490, "...essentially a practical question of fact which can best be answered by ordinary common sense rather than abstract metaphysical theory." Furthermore, as I observed earlier, the allocation of the burden of proof is not immutable. Both the burden and the standard of proof are flexible concepts. In Blatch v. Archer (1774), 1 Cowp. 63 at p. 65, 98 E.R. 969 at p. 970, Lord Mansfield stated: "It is certainly a maxim that all evidence is to be weighed according to the proof which it was in the power of one side to have produced, and in the power of the other to have contradicted."

And at p. 301:

The legal or ultimate burden (of proof) remains with the plaintiff, but in the absence of evidence to the contrary adduced by the defendant, an inference of causation may be drawn, although positive or scientific proof of causation has not been adduced. If some evidence to the contrary is adduced by the defendant, the trial judge is entitled to take account of Lord Mansfield's famous precept. This is, I believe, what Lord Bridge had in mind in Wilsher when he referred to a "robust and pragmatic approach to the ... facts" (p. 569).

It is not, therefore, essential that the medical experts provide a firm opinion supporting the plaintiff's theory of causation. Medical experts ordinarily determine causation in terms of certainties whereas a lesser standard is demanded by the law.

[97] Newbury J. (as she then was) adopted that principle in Pausche v. Wood (7 January 1994), Vancouver B920511 (B.C.S.C.), an action for damages arising from a motor vehicle accident. At pp. 16 and 17, she said:

Snell v. Farrell has been applied by our Court of Appeal in another medical malpractice case, Lankenau Estate v. Dutton (1991) 79 D.L.R. (4th) 705, and by Braidwood, J. of this Court in Shepard v. Wright (Vancouver Registry No. B895424, dated November 7, 1991), a personal injury case in which the plaintiff, who was clearly diabetic at the time of the accident, successfully argued that the accident had seriously impaired her blood sugar control, thus accelerating the onset of diabetic retinopathy. The application of this "robust approach", which Mr. Maryn advocates

in this case, does not however shift the onus of proof to the defendant in cases involving complex medical evidence. It still remains necessary for a plaintiff to satisfy the court on the evidence that notwithstanding the lack of certainty in medical opinion, it is more probable than not that the defendant's conduct caused the injury or condition complained of: Snell v. Farrell, supra, at 299; Oiom v. Brassington (1990) 52 B.C.L.R. (2d) 240 (B.C.C.A.).

[98] I conclude on a balance of probabilities, that the plaintiff's disc at L5-S1 was injured in the March 7th accident, which led to its herniation. My reasons follow.

[99] For some years before March 7, 1992 the plaintiff had experienced incidents of back strain causing pain which soon resolved. At times he sought chiropractic treatment for it. I have examined the clinical notes from the time he first became Dr. Ng's patient in 1983 until March 7, 1992 and the doctor does not record complaints of or treatment for a back condition.

[100] In his Report (Ex. 6) Dr. Stork, Chiropractor, reports the plaintiff's pre-morbid back complaints and their duration:

January 20, 1988

Right L4 facet strain after falling off truck Ä no further treatment.

March 25, 1989

Left O5 2T strain Ä two days later responded well Ä no further treatment

December 24, 1990

Right L4 and sacroiliac pain with sciatic radiation down to his knee. This is the only episode possibly relating to disk involvement although the dermatomal pain could also come from the sacroiliac joint. The patient saw my associate on December 28, 1990 but didn't keep his December 29, 1990 appointment allowing me to speculate he was recovering well (see Dr. Short's comment).

June 7, 1991

Left C5 T2 strain Ä one visit.

[101] In Exhibit 6 Dr. Stork commented on his treatment:

I have not seen Mr. Monahan since 1992 and cannot comment on his present condition relative to his MVA. As of November 1991, I could confidently say that Mr. Monahan had no major chronic back problems and more specifically no major disc problems. All of his injuries were of a relatively minor functional nature and to the best of my knowledge resolved completely.

[102] His finding and comment with respect to the December 24, 1990 visit does not suggest a disc injury. The plaintiff did not take any continuing treatment and the condition resolved. Counsel for the defendants has conceded the plaintiff did not suffer a ruptured disc in 1990.

[103] The clinical notes of the Glover Medical Clinic reveal that on March 1st, one week to the day before the first accident, the plaintiff presented a number of complaints including backache. The clinical note reads:

Blood in stool on paper, black stool Ä on one occasion last night and on and off for one week, dizziness, headaches and backache. All occur at same time. Sick to stomach.

[104] In that same clinical note there is the cryptic but significant comment "poor historian."

[105] I find the plaintiff did not have disc herniation before March 7, 1992.

[106] The factor that compels my finding that he suffered a disc injury in the first accident is the pain radiating from his back into and down his right leg, pain which commenced shortly after the accident, which he reported to Dr. Ng in April and September 1992. Initially the pain ran from the lower back to the right knee and soon travelled down his leg into his foot, and on occasion into his toes, accompanied by numbness and tingling.

[107] The defendants say there is no evidence of continuity of symptoms of a herniated disk between the time of the accidents and its diagnosis in 1994, for he failed to relate to the medical people to whom he was referred for examination and opinion that the leg pain had arisen in 1992 and he failed to record it at all in his diary kept from March to December 1992. I find his failure in both respects can be accounted for: first, he was not aware that the leg symptoms were related to the back injury, for he had been told by Dr. Ng in April that they were not related, and believing him, likely he minimized the importance of that information about his leg symptoms; second, he is a poor historian, having difficulty expressing himself when relating his medical problems to doctors and it seems to anyone else; third, the leg discomfort was much less severe than the back pain which was always his principal concern and disability.

[108] The defendants would have the Court disregard the evidence of radicular pain given by the plaintiff and his wife at trial. That is not easily done, for their counsel has conceded the plaintiff is not a malingerer nor is he prone to exaggerate his physical symptoms. Mr. Nuyts, counsel for the defendants, has conceded:

as to being a credible good guy, the plaintiff gets full marks from me.

The defendants do not suggest that his wife was not credible nor do they suggest she is a poor historian.

[109] I accept the evidence of the plaintiff and his wife with respect to the character of his right leg symptoms and the time he began to experience them.

[110] He was incorrect when he testified that he had never before experienced radicular pain, for the chiropractor noted it in December 1990. I find he was mistaken and it was an unintentional mistake. The December 1990 radicular pain was an isolated instance which soon resolved and did not occur again.

[111] The fact, of course, remains that had the plaintiff accurately reported the time of the onset of his radicular pain to medical people, other than Dr. Ng, their opinions would have been significantly different. I shall speak of that later.

[112] The defendants say the pain from the back to the knee is not evidence of a herniated disk Ä that Dr. Gittens testifying for the plaintiff said that pain associated with that condition always travels to the calf and foot. With respect, that was not Dr. Gittens evidence. He was referred to Dr. Stork's clinical entry of December 4, 1990 which I have recited and asked if he would read that as a neurological sign, assuming it referred to pain. Dr. Gittens said it could be but it could also indicate other problems. He said, typically with disc herniations at the L5-S1 and the level above, one gets radiation of pain beyond the knee into the foot and calf; he did not say a person invariably experiences pain of that character.

[113] In submission, the defendants did not comment on the treatments Dr. Short performed on September 5 and 12, 1992, but it is necessary to do so. Dr. Short has reported that he did not observe obvious signs of disc protrusion of the lumbar-lumbo sacral region on either date. That he did not is not proof that disc herniation was not present in some form at those times. There is no record of the plaintiff's complaints to Dr. Short, no evidence that Dr. Short was looking for evidence of disc herniation, no evidence of the treatment he administered.

[114] The defendants say it is probable that the herniation of the disc occurred in an injury occurring about December 1993 which accounted for the episode of greatly exacerbated back pain and leg difficulty, related by the plaintiff in evidence and reported to Dr. Gittens in 1994. The plaintiff has denied that any such injury occurred and he never spoke of it to any medical people. He testified that it was not new pain but an acute and isolated exacerbation of pain he had been experiencing since the first accident. He told Dr. Gittens that before the December incident he had not experienced a pain of that intensity nor did he after it. He had been experiencing radicular pain into the right leg for 18 months before December 1993. Significantly, on October 30, 1993, before the exacerbation of pain in December, both he and his wife related his continuing battle with pain and radicular problems in the leg to Dr. Ng and Mrs. Monahan insisted a specialist be retained. Those complaints at last compelled Dr. Ng to order the first x-ray of his back. On balance, I find that the plaintiff did not suffer an injury about December 1993 or after which injured his disc.

[115] I find that the plaintiff had disc degeneration before March 7, 1992 but it was quiescent. It was not an active continuing symptomatic disease. I am not persuaded that but for the accident, it would have become symptomatic.

[116] I find that the back pain he has suffered since the first accident arises from three causes: soft tissue injury which resolved fairly early on, a "triggering" of pre-existing disc degeneration, and from a herniated disc, which arose from the first accident. I accept Dr. Gittens evidence with respect to the sources of pain.

[117] In his 1995 Report, Dr. Boyle described the plaintiff's medical problems being akin to a crumbling skull although he did not use that expression. He wrote:

It is more likely that the patient would have gone on to a disc herniation and the symptoms complex described over time without the intervening MVAs because of factors previously mentioned.

[118] What were those factors: Ä he speaks of them in the same Report and I have recited his evidence.

[119] Considering those factors, it must not be forgotten that Dr. Boyle saw Mr. Monahan once only, in November 1994. The first accident occurred in March 1992. In that intervening time the plaintiff had been largely inactive due to his persistent pain. Dr. John Fuller, an orthopedic specialist, who examined him on March 15, 1993 said the plaintiff was of normal weight. Dr. Thompson who examined him on June 6, 1995 found him in good shape, not deconditioned at all.

[120] If he was physically unfit when Dr. Boyle saw him in November 1994, that does not translate into proof that he was so at the time of the March accident. He had a physically demanding job then which he had performed well for many years with no loss of work time.

[121] In his 1995 Report Dr. Boyle spoke of low back pain of a "recurring and persisting" nature and when asked for his source of that information, said he obtained it from the passage in Dr. Gittens' letter of May 2, 1995 which reads:

Prior to the accidents he had reported some intermittent episodes of back pain, I believed diagnosed as back strains but also could also -- but possible could also been diagnosed as being related to early degenerative disc disease.

Dr. Boyle was asked how he interpreted that comment to constitute a history of low back pain of a recurring and persisting nature and replied:

I don't know. That was just my interpretation of it.

[122] He conceded he should not have used the word "persistent."

[123] Mr. Potts, Counsel for the Plaintiff, submits:

Intermittent episodes of back pain don't reasonably translate into a history of "recurring and persisting" and I think that error undermines Dr. Boyle's whole report. I say that because the balance of the factors that he talks about even assuming they are correct, poor muscle tone being one way, are not by any stretch of the imagination the sort of things that will necessarily lead to back problems, never mind symptomatic herniated discs.

I agree with that submission.

[124] I have previously recited from the cross-examination of Dr. Boyle with respect to his conclusion that the plaintiff probably would have suffered disc herniation without the intervening accident. I found his explanation for reaching that conclusion, unconvincing.

[125] At trial Dr. Boyle testified that it is impossible to say when the disc herniation occurred:

It could have been '88, it could have been '90. It could have been in the motor vehicle accident. We are not saying it didn't but...it is likely not to have been associated with the motor vehicle accidents.

[126] That opinion was influenced by his belief that the radicular pain into the leg was delayed by at least a year.

[127] Where Dr. Thompson's evidence and that of Dr. Gittens' differs from that of Dr. Boyle, I give greater weight to their evidence. I found Dr. Thompson's Report of June 14, 1995 to be more carefully written than Dr. Boyle's 1995 Report, and unlike Dr. Boyle, he did not depart from it when testifying. Mr. Monahan was not experiencing any leg discomfort at the time of the examination by Dr. Thompson, who found his neurological examination to be entirely normal. He did find root tension signs on the right which suggested a nerve root irritation within the lower lumbar or upper sacral spinal canal.

[128] Dr. Thompson, too, was told by the plaintiff that his leg symptoms commenced about one year after his first accident, and the doctor found that significant.

[129] I find the plaintiff suffered the following injuries.

In the First Accident
Soft tissue injury to his neck, shoulder and mid and lower back which fully resolved in 6-8 months.
A triggering of a pre-morbid degenerative disc disease which is chronic and probably progressive which will cause permanent pain.
An L5-S1 disc herniation, a permanent injury which will continue to cause chronic pain in the lower back and chronic leg difficulties.

All of those injuries are compensable by the defendants in the first accident.

In the Second Accident
Soft tissue injury to the neck and shoulder which resolved within two months.
Soft tissue injury to the mid-back which resolved at an indeterminate time.
Aggravation of symptoms in the lower back and right leg, arising from the first accident.

Those injuries are compensable by the defendants in the second accident.

MITIGATION

[130] The defendants submit that the plaintiff's refusal to have surgery does not constitute a failure to mitigate; however his failure to take exercise and physiotherapy does so.

[131] With respect to exercise, the first mention of it is found in Dr. Ng's clinicals for September 5, 1992 and read

"pelvic tilts and abdominal exercises. Can join gym for back exercises." Dr. Ng gave that recommendation, he says:

Because from my examination he seemed to have a fairly full range of back movement. I thought it may be related to deconditioning of his abdominal muscles and his back muscles, and I suggested that by just conditioning, maybe we can get rid of this pain.

[132] Mr. Monahan performed the exercises recommended by Dr. Ng and found they exacerbated his back pain. He did not attend a gym. When Dr. Ng gave his recommendation for exercise he had no suspicion that the plaintiff had suffered a disc herniation. It is not astonishing that the exercises made his condition worse.

[133] In 1993 Dr. Fuller recommended he do stretching exercises and he has since that time and does them still. He finds they help. He cannot recall now if his stretching exercises are specifically those described by Dr. Fuller but believes they are. One of the exercises possibly described by Dr. Fuller or by Dr. Ng was sit-ups. He personally researched back exercise and concluded that sit-ups are:

the worst thing one can do for back problems. I don't really attempt them any more. I don't do anything that causes me pain, if I can prevent it.

[134] With respect to Dr. Ng's recommendation that he take physiotherapy, it was spoken of just once and the plaintiff said it was only a "passing comment." There is a cryptic reference to it in Dr. Ng's clinicals of December 29, 1992 which reads: "(unclear) physiotherapy". In his Report of April 21, 1995 Dr. Ng wrote:

I also referred him to Crescent Physiotherapy Clinic for treatment and to return for review two weeks later.

[135] That recommendation was made only once, long before the herniated disc was diagnosed. Dr. Gittens in his 1994 Report to Dr. Ng mentioned an aggressive rehabilitation program with the Canadian Back Institute. There is no suggestion in the evidence that Dr. Ng passed on that recommendation to the plaintiff. Dr. Boyle spoke of exercise in his written reports to the insurers. Copies were not sent to Dr. Ng and Dr. Boyle did not say he passed on his recommendation to the plaintiff when he examined him; similarly with Dr. Thompson whose Report was sent to the plaintiff's solicitors, without a copy to Dr. Ng.

[136] Whether physiotherapy taken after December 29, 1992 would have relieved the plaintiff's pain symptoms I cannot say. At trial doctors recommended physiotherapy but none could predict the result. Dr. Gittens testified that sometimes he has had to remove a patient with back problems from an exercise program. I note that in Dr. Gittens' letter to Dr. Ng of 1994 his recommendation for "aggressive back rehabilitation" is conditional upon the x-rays "not showing any frank disc herniation or nerve root compromise," which, of course, the MRI disclosed.

[137] I am not persuaded that the plaintiff failed to mitigate his damages.

THE PLAINTIFF'S VOCATIONAL
PROSPECTS AND PHYSICAL LIMITATIONS

[138] The plaintiff was interviewed by a vocational rehabilitation expert and occupational therapists, all of whom administered written tests; the occupational therapists administered physical capacity tests. For the most part I do not intend to relate the test results. Those professionals concluded that the plaintiff intends to drive so long as he is physically able and has no alternative vocational plans.

BARBARA BORYCKI

[139] Ms. Borycki testified for the plaintiff. She is a psychologist and expert Vocational Reconstruction consultant. She found the plaintiff to be stoical with a strong work ethic

who prefers solitary work. Given the concerns advanced by the occupational therapists, she concluded the plaintiff was at risk for further injury to his back if he continues to drive. If he does so, he may be compelled to reduce his driving hours, take shorter runs and adjust the loads he takes (no tarping, all container freight), which would have an impact on his earnings. Should his pain persist and his condition deteriorate, he may be forced into early retirement.

[140] Should he choose other work, he is best suited to an academic training program of one year in length and there is no assurance that he would succeed in a program of shorter duration. If he gives up his work he will be left pursuing other occupations within his abilities Ä unskilled or semi-skilled labour intensive occupations requiring a Grade 10 level of education. In 1991, at his wife's insistence, he took some night school courses to obtain a Grade 12 equivalent Ä maths and English. He persevered for a time, found it distasteful, performed poorly and gave up his studies without obtaining a certificate.

[141] Ms. Borycki concluded:

While testing has shown that Mr. Monahan is a relatively bright individual, I believe it is highly questionable whether he would succeed in a formal retraining program in light of his previous educational experience, age, lifestyle, personality factors, etcetera. It is overly simplistic to identify retraining options based on testing which in all likelihood would not be successfully completed given this man's educational history to date. As it appears that Mr. Monahan will continue to persevere in his chosen profession, I concur that appropriate rehabilitation he [sic] offered to assist him in carrying on to the best of his ability.

ALISON HENRY

[142] Ms. Henry testified for the plaintiff. She is an Occupational Therapist and Certified Work Capacity Evaluator. She performed diverse physical tests on September 18, 1995 lasting over five hours. She found the plaintiff cooperative and that he did not display exaggerated pain behaviour. Ms. Henry related her opinions.

In my opinion, Mr. Monahan is considered to be feasible for competitive employment on a full-time basis.

At his present level of function, Mr. Monahan has the potential to work in occupations up to and including medium strength work although increased symptoms with lifting heavier weights indicate that he would have greater tolerance to light work than to medium work. In addition to the strength requirement, medium strength work tends to have higher demands for physical activity, including standing.

Light work is defined in the CCDO as lifting 20 pounds maximum with frequent lifting and/or carrying of objects weighing up to 10 pounds. Even though the weight lifted may be only a negligible amount, an occupation is in this category (a) when it requires walking or standing to a significant degree, or (b) when it involves sitting most of the time with a degree of pushing and pulling of arm and/or leg controls.

Medium work is defined in the CCDO as lifting 50 pounds maximum with frequent lifting and/or carrying of objects weighing up to 20 pounds.

Further restrictions to work are listed above.

With respect to Mr. Monahan's occupation as a semi-trailer truck driver, review of the CCDO shows that this is classified (#9175-1110) as being medium strength work requiring significant amounts of reaching/handling and operation of hand and/or foot controls. It is noted that Mr. Monahan's description

of his work activities when loading and unloading his trailer indicates that the physical demands exceed those of medium work. His reports of increased symptoms with work would correspond to the finding of reduced strength. Working above his strength capacity would pre-disposed Mr.Monahan to risk of injury.

Mr. Monahan's ability to continue in his present occupation will depend in part on his ability to continue to tolerate the pain he experiences and on there not being any deterioration in his condition. He expressed the intention of continuing to work, despite the pain. However, increased symptoms affect what he is able to do in his leisure time and around the home. According to Mr. Monahan, this has contributed to the stress in his relationship with his wife.

In my opinion, Mr. Monahan would be able to achieve better symptom control, be working more safely and have a better balance between work and home activities if he was in a less physically demanding job.

Mr. Monahan's feasibility for competitive employability as outlined in this report is based on his present physical capacity. Test results show that Mr. Monahan is somewhat deconditioned. He has not had the opportunity to participate in a structured active exercise programme. Improved back fitness would be expected to decrease some of his back pain and reduce the risk of injury. However, a physician's opinion should be sought as to whether such a programme would be appropriate with his diagnosis. It is noted that with his work schedule Mr. Monahan would have difficulty attending a programme and would probably have to take time off work.

Mr. Monahan also has problems related to his knees. Since this affects his ability to protect his back, investigation of this problem and review of any treatment options would appear to be indicated. This recommendation also applies to Mr. Monahan's right ankle problem. A physician's opinion could be obtained as to whether uneven weight bearing through his foot is contributing to Mr. Monahan's back symptoms and whether orthoses would be of benefit.

...

If Mr. Monahan's condition remains unimproved to the degree required to work safely and without significant pain in his present job, then I would recommend a change of occupation or review of the possibility of changing to different type of driving such as hauling ready loaded trailers. Based on assessment findings, he would perform best, at his present level of function, in light work occupations which do not involve standing or sitting as the primary work positions or require significant amounts of body dexterity. (Emphasis added)

GERARD KERR

[143] Mr. Kerr testified for the defendants. He is an Occupational Therapist and Work Capacity Evaluator who performed diverse physical tests on October 17, 1995 relative to the physical activities factors defined by the Canadian Classification and Dictionary of Occupations (C.C.D.O.). He found the plaintiff participated willingly and with good effort. Mr. Kerr gave his opinions and recommendations:

Mr. Monahan would benefit from a structured and graduated fitness program aimed at improving his general fitness levels. In particular a fitness program should focus on improving his low back flexibility and abdominal muscle strength.

Mr. Monahan may have difficulty performing work

demands involving: more than moderate amounts of walking; more than moderate amounts of repetitive and/or sustained (marked) stooping. He is not suited more than occasional demands for crouching or kneeling.

Demonstrated lifting, carrying, pushing and pulling ability shows that Mr. Monahan is capable of work in the sedentary, light, medium and some lighter heavier strength work categories.

Mr. Monahan presents with no significant limitations to sitting to periods of 1.5 to 2 hours provided he is able to make postural changes as required. His tolerance for sitting while driving will likely vary according to his low back symptomatology on the day. A reasonable maximum standing tolerance for Mr. Monahan is presently 1 hour. He is felt to be more ideally suited to work where he has the opportunity to alternate between sitting and standing or be able to take breaks as required. In terms of his sustained working tolerance it was felt the demands of sustained (marked) stooping, repetitive crouching, and heavy lifting exceeded his tolerance levels to a moderate degree. He is considered to be competitively employable on a full time basis provided the physical job demands are in keeping with the restrictions outlined in this report.

...

The results of this assessment identify two aspects of Mr. Monahan's [occupation] that may at times exceed his physical tolerance levels. These include the prolonged sitting during driving and the demands for tarping a load. I would point out that generally he has been able to meet the job demands albeit with reports of low back pain. He reports occasional episodes where his back pain has been such that the job demands have seriously challenged his tolerance.

In considering the job demands I note there are differences in what Ms. Alison Henry reports in her Physical Capacity Evaluation dated September 25, 1995, and what Mr. Monahan reported to me during this assessment. For example on page 4 of her report she described the belts thrown over the load to be "heavy". Mr. Monahan reported to me that these were light weight but he found the throwing motion awkward. He also reported that the load chains "did not seem heavy" to him. Ms. Henry also described the tarping to command heavy strength demands while lifting it onto the deck and over the load. However, Mr. Monahan reports that he only tarps 5 percent of his loads currently and further the tarps are usually lifted onto a load by the fork lift while loading is occurring. The driver therefore is only required to roll it out and tie it down. This reduces the physical demands significantly and may only command light strength demands on an occasional basis ie: 1 in 20 hauls (or one haul every two weeks). It would have been useful therefore to carry out a job demands analysis to clarify these issues. It is my understanding that plaintiff counsel did not agree to this and therefore I can only speculate on these issues. On this note Ms. Henry's comment that throwing (presumably the retraining belts) and loading and unloading a trailer (I believe she is referring to tarping as Mr. Monahan does not load or unload) exceeds medium strength demands (see page 12) can only be speculative.

With respect to the demands for prolonged sitting (1 to 1.5 hours) while driving it is conceivable the cumulative effect of vibration and pounding could aggravate his low back condition. The Vancouver - Seattle corridor is noted for the rough concrete roads in Washington State. He is also disadvantaged by operating a cab over tractor which provides a rougher ride than a conventional one. In spite of investigating various seats he continues to feel the

prolonged sitting aggravates his pain.

My opinion regarding Mr. Monahan's ability to continue with his current work is two fold. Firstly the results of this testing and his reported work history indicates he is able to perform the job demands. In this sense Mr. Monahan is capable of continuing to work as a driver. Accepting that he does experience low back pain I would agree with Ms. Henry that his ability to continue driving will, in part, depend on his ability to tolerate his reported pain. He ought however, to avoid work that requires frequent tarping demands.

As Ms. Henry points out in her report it is possible Mr. Monahan could improve his functional ability following surgery and/or with a structured active exercise program. I do respect Mr. Monahan's right to decide the surgical option for himself. An active exercise program should focus on teaching a regime of exercises to improve the low back musculature. Improved low back fitness is known to decrease low back symptoms and lessen the risk of acute low back pain episodes. I would agree also that this needs to be done with the appropriate medical approval. This may well enhance Mr. Monahan's ability to tolerate the job demands. (Emphasis added)

[144] Mr. Kerr testified that the plaintiff's own assessment of pain was consistent with Mr. Kerr's observations of him and his body movements while performing the physical tests and that his credibility was excellent.

[145] Mr. Kerr estimates the cost of a one-on-one exercise program to be $1,500. If he were to take a "live-in" rehabilitation program, the cost would be approximately $10,000. The Canadian Back Institute does not provide a live-in program.

[146] Under cross-examination Mr. Kerr testified that with a herniated disc condition, a person can be quite symptomatic one day and asymptomatic the next. He was asked:

Q Let me ask you about this, sir, when a person has a herniated disk what effect would crepitus in both knees have on their ability to do manual labour?
A Again depending on the degree, because crepitus in itself is not a problem. It is only a problem if there is pain associated with it. In this case I believe there was some pain associated with the crepitus and what -- the person would tend to not want to c[r]ouch or would not want to kneel and would tend to be more -- use their trunk more. In other words, they would stoop more to reach lower levels.
Q Would you agree with this, sir, that if you have got a bad back, that is if you have a herniated disk, for example, what you would try and do is not to put any strain on that back, do you agree with that?
A Yes.
Q And one way of doing that when you're lifting or something is to use your knees instead of your back?
A Yes
Q Do you agree with that?
A Correct.
Q So if someone has crepitus in both knees is going to have much more difficulty dealing with a herniated disk than someone who has two good knees, would you agree with that?
A Yes, I would. (Emphasis added)

[147] One of the tests administered involved partial sit-ups and it was abandoned when the plaintiff reported they aggravated his lower back. That complaint is consistent with the plaintiff's evidence that he had encountered that same problem much earlier when doing sit-up exercises.

[148] Mr. Kerr testified that one of the problems the

plaintiff faces in "prolonged sitting" is road vibrations. He conceded:

Q And you also talk about the demands for tarping a load?
A Correct.
Q Would you agree with this, sir, that the demands involved in, for example, setting the brakes on these larger rigs could exceed his physical capacities when he was symptomatic?
A When he is symptomatic I would agree.
Q Crouching down in any respect when he is symptomatic would be a problem for him?
A Crouching is not the problem, it is the stooping.
Q Yes.
A I am not sure whether he has enough room to crouch and to check the brakes or whether he has to bend over at the waist to see that.
Q What about climbing under the truck?
A I think it is the same thing.
Q Yes.
A Sometimes observing people do that sometimes there is enough room to do a crouch walk.
Q Yes. Sir, when he was symptomatic I take it you would agree with that he would have difficulty climbing up onto the load?
A Yes.
Q He would have difficulty lifting the cab up to get at the engine room?
A It would depend on the position that he is in.
Q He would have difficulty cinching down the load using a bar on the straps?
A Yes, to some degree.
Q Would you agree with this, sir, that when he was symptomatic in respect of the disk herniation all of those jobs would exceed his physical capacity?
A I can't say it would exceed it because I don't know to what degree his symptomatology is there. What I can say is that those activities would likely aggravate it. (Emphasis added)

...

Q Would you agree with this, sir, that you assumed with the assistance of the odd Tylenol, Mr. Monahan was generally able to do his job?
A Yes.
Q And on the basis of that assumption you came to the conclusions you came to in the report, that and your tests?
A And the test results.
Q I suppose if Mr. Monahan was incapable of doing the job on days he was symptomatic that would affect your final conclusion, would it?
A Yes, well, yes. Depending on why he was not doing the job, but given the fact that he was -- he gave full effort, I had no problems with that, then I think it would be significant.
Q Look at page 16, if you would, please, second paragraph.
A Yes.
Q In so far as you concluded that Mr. Monahan can continue with his current work, you say you came to that conclusion for two reasons, is that correct so far?
A Yes.
Q The first thing you relied upon were the results of your testing on that day?
A Correct.
Q You agree with me, sir, that with a herniated disk he would be symptomatic one day and not another day?
A Correct.
Q And on the day you tested Mr. Monahan he assessed his condition as number one at the beginning of the tests?
A Yes.
Q Okay. The second reason you concluded that Mr. Monahan could continue with his job is because

he has kept working, is that correct?
A Yes.

[149] He spoke of the advantages of one-on-one fitness programs.

Q There is a question of the community based fitness programme and you expressed a concern about the CBI programme as to the person might not get enough individual attention. Could you just explain the kind of individual attention that a person would get on the community based fitness programme to the court?
A Yes, I have no problem at all with the Canadian Back Institute, I think there [sic] are a fabulous programme and do a great job. The difference is that they usually run group programmes. So, you could be involved with one therapist and maybe four to five people that are doing your programme.

On a community based supervised programme you have one on one tutoring the whole time. So it means that you get much more specific instruction so that the learning process is a little bit quicker. That is the essential difference.

PART G

NON-PECUNIARY DAMAGES

[150] I have been assisted with case precedent of awards for non-pecuniary damages. In Fletcher et al. v. Meyer and I.C.B.C. (1992), Vancouver B890522, the plaintiff was a 45 year old heavy duty equipment operator. Holmes, J. the trial judge, described him at the time of the accident: he had established himself in the workplace earning a substantial income, doing work he loved. He was happy and felt his future was secure. He was injured when his vehicle was struck from behind with considerable force. He was off work for a time and when he returned he had neck and back pain. He could not put in the long hours he had worked before the accident and found the constant vibration, jarring and jolting caused by the operation of heavy duty equipment constantly exacerbated his neck, upper, mid and low back pain. X-rays demonstrated prior degenerative change in the cervical spine. His specialist concluded the continuing pain was a combination of soft tissue injury from the accident and a mechanical low back pain exacerbated by the character of his work. He was advised to seek less physically demanding work, which he did. At the time of trial he was depressed and negative in regard to his future ability to maintain gainful employment. Holmes, J. found:

The plaintiff has had five years of neck and back pain associated discomfort, disability and restriction. He is unlikely to ever be without some degree of pain, discomfort, and disability in the future regardless of occupational change or with diminished activity and a more guarded personal life style.

The accident has cost the plaintiff an ability to work at an occupation he truly enjoyed and from which he derived a great deal of pleasure and satisfaction apart from economic reward.

The plaintiff's recreational and leisure lifestyle which had been active and outdoor oriented is for practical purposes likely lost to him in the future.

The plaintiff's inter-personal relationships with his wife and children has [sic] been interfered with and has caused him a great deal of angst.

The plaintiff's personality has altered, although I do not believe permanently so. Prior to the accident he was a stable, active, even tempered, and hard working person and a good father and husband. In the past five years he became a person easily frustrated, quick to anger, resentful, and

fearful and depressed regarding his economic future. He has for some time been a lesser father and husband. He is sensitive to not "pulling his weight" in the family as he used to do and is ashamed and embarrassed because of that.

The plaintiff's life will be markedly different in the future than it was before the accident. His loss has been, and will continue to be, a significant one.

I have reviewed the authorities cited to me by counsel for the parties. The range of damages urged by plaintiff's counsel is $100,000 to $150,000; those of defendant's counsel range from $40,000 to $55,000.

I find the effect on the plaintiff's life physically and emotionally to be serious but I do not feel it can be fairly described as "devastating" or "near catastrophic" as those terms have become used in the legal context of damage assessment. I feel the plaintiff's future need not be bleak, nor will the pain, disability, and interference with his life over the past five years continue unabated through his future. I believe the worst is past, and given a reasonable time period for adjustment to a new occupational status, the plaintiff's life will become more stable, his depression and anxiety will abate, and he will become closer to the type of person he was before the accident.

[151] Judge Holmes awarded $85,000 non-pecuniary damages.

[152] That case must be distinguished from this for Mr. Monahan has continued in his occupation but the enjoyment he has derived from it has been diminished; second, it cannot be said of the plaintiff that "the worst is past."

[153] In Lussier v. Johnston et al. (1996), Nanaimo O5187, the plaintiff, 33 years of age, and a heavy equipment operator was injured in a motor vehicle accident in December 1992. He suffered a disc herniation at the left C5-S1 level. He had an open discectomy and laminectomy on October 4, 1993 in which a portion of a sequestered disc was removed. The surgery resulted in "a marked dramatic improvement in his condition." Since the surgery he experienced discomfort to the extent that he missed work, nevertheless his prognosis was favourable. The surgeon gave his prognosis:

He is capable of moderately heavy work as mentioned above and sporting activities such as swimming, tennis, skiing, etc. He should avoid contact sports such as football, rugby and hockey. He is capable of doing these sports but there is a greater risk of him injuring his back as the disc is slightly weaker in that area, L5-S1, and this could cause more back pain and/or leg pain.

[154] In May 1995 the plaintiff in Lussier was examined by Dr. Malone, an orthopedic surgeon. Shabbits, J., the trial judge, related Dr. Malone's opinion and prognosis at page 6:

...Dr. Malone saw Mr. Lussier on May 5, 1995. Dr. Malone said that, although Mr. Lussier's symptoms did improve following the surgery, Mr. Lussier's back and leg pain never did settle completely. Dr. Malone accepts that back and leg pain continue to be a problem for Mr. Lussier. He attributes those problems to mechanical symptoms, aggravated by strenuous physical activity. Dr. Malone said that Mr. Lussier falls within the 50 percent of patients who have mechanical back discomfort following lumbar discectomy.

Dr. Malone's prognosis was that Mr. Lussier would experience continuing improvement in his back condition over the next one to two years following his consultation with Mr. Lussier, although he said there was a very significant possibility that Mr. Lussier's back ache would never resolve completely. Dr. Malone said that it was safe for Mr. Lussier to

drive a truck. Dr. Malone said that he reassured Mr. Lussier that discomfort in his back which followed reasonable activity would not be associated with further damage to the low back. Dr. Malone cautioned Mr. Lussier against returning to physically demanding work while he had back symptoms. His opinion was that that could cause degenerative change which might result in more troublesome and disabling pain. Mr. Malone did not anticipate that Mr. Lussier would require further surgery on his back.

Judge Shabbits summarized the plaintiff's injuries:

The plaintiff suffered a serious back injury involving disc herniation at the L5-S1 level with sequestration of a portion of the disc. His symptoms escalated over a period of several months, culminating in surgery. Following the accident, his pain increased to the point that, by the time of his surgery, it was difficult for the plaintiff to cope with it. The plaintiff is left with permanent disability and, in all likelihood, continuing symptoms and pain. He is controlling his symptoms only by a regimen of exercise. His activities are permanently restricted.

[155] He awarded $65,000 in non-pecuniary damages.

[156] In Burgess v. Lau (1995), New Westminster S016923, the plaintiff, 42 years old (at trial) and a member of the R.C.M.P., was injured in a motor vehicle accident in March 1993. Initially he experienced left lumbar pain and sciatic pain in the right lumbar area. He continued to work. In July 1993 he experienced severe pain radiating to his right leg and into his foot. A CT scan revealed a disc herniation at L5-S1. He had a disc excision and decompression of the right S1 nerve root. After the surgery he suffered depression and was treated by a psychologist. After some months he returned to work.

[157] Judge Leggatt, the trial judge, related a history of pre-morbid back problems including at least one herniated disc. He spoke of the plaintiff's injuries at page 8:

> The plaintiff has suffered a permanent partial disability as a result of the defendant's negligence. This is confirmed by the report of all his attending physicians, particularly in the September 27th, 1995, report of Dr. Hunt who states as follows:
>
> > Based on Corporal Burgess' progress from when he was first seen until the present time, and based on the CT Scan findings from Burnaby Hospital, dated June 20, 1995, this writer believes that Corporal Burgess has a permanent partial disability. He should avoid excessive heavy lifting and he should avoid prolonged periods of sitting and in particular sitting in a vehicle driving long distances. It is this writer's recommendation that Corporal Burgess should limit his work to lighter duties which allow him to sit and stand and move about, while at the same time avoiding the need to wrestle or fight with resisting individuals which he would need to do if he was working as a regular patrol officer.
>
> Corporal Burgess is a person with high skills and strong devotion to duty in a stressful occupation. This stress has led him to have some emotional difficulties which he has overcome. In dealing with non-pecuniary damages one has to assess the impact on the individual and clearly this motor vehicle accident which has caused serious and permanent back difficulties has had a significant impact upon him. It has led to some marital difficulties, which have been resolved. There are problems in commuting to work from his home in Maple Ridge to his office in Vancouver, which exacerbates his ongoing back pain. He has had a significant

reduction in his leisure activities which involved jogging, racquet ball and coaching. His ability to do household chores has been restricted.

He continues to try to alleviate his distress with a Tens machine. He has obtained a spa for purposes of soaking, and massage therapy may have to be renewed in the future. The distress associated not only with the motor vehicle accident but with the back operation is very significant.

Judge Leggatt awarded $60,000 in non-pecuniary damages.

AWARDS OF DAMAGES
NON-PECUNIARY DAMAGES

[158] For "triggering" of pain arising from a pre-accident asymptomatic degenerative disc disease and for a herniation of the L5-S1 disc causing chronic and permanent back pain and leg discomfort, all arising from the first accident and exacerbated in the second accident, I award $70,000.

[159] For soft tissue injury to his neck, shoulder, mid and lower back arising from the first accident, I award $10,000.

[160] For fresh soft tissue injury to his neck, shoulder and mid-back arising from the second accident, I award $3,000.

[161] I attribute five percent of the award of $70,000 to the second accident.

PAST WAGE LOSS

[162] The plaintiff retained Robert Sandy, C.A., of Coopers Lybrand to compute the estimated loss of earnings suffered by the plaintiff arising from the two accidents. Mr. Sandy was provided with Mr. Monahan's monthly log books and day-time journals amongst other things, to assist in his calculation.

[163] Mr. Sandy has calculated a net past income loss of $17,901. The defendants dispute that wage loss figure. At his Discovery on March 10, 1995 the plaintiff produced a document which listed days lost from March 1992 to and including January 1993 Ä 15. The plaintiff did so using his log books. Mr. Sandy calculated 21 days lost in 1992 using the same log books and the day-time journals and information provided by Mr. and Mrs. Monahan in telephone conversations in 1996. I am not persuaded to accept Mr. Sandy's calculation of days lost in 1992 in preference to the plaintiff's own calculation of days lost, a calculation which he made in 1993 when "days lost" would be much fresher in his mind than in 1996. (By Sandy's calculation he did not miss any days in 1993.)

[164] Calculating the days lost in 1992 as 15, not 21, I fix his past wage loss at $16,065. I leave it to counsel to allocate this wage loss to the respective accidents.

SPECIAL DAMAGES

[165] Exhibit 13 lists past special damages. The parties have agreed that the amounts are payable, save for a prescription cost of $18.98. I award the sum of $2,246.60. I draw counsels' attention to the plaintiff's Summary of Damages Sought in which special damages are listed at $2,625.58. I suspect that is an error. I leave it to counsel to resolve it. I leave it to counsel also to resolve the allocation of special damages to the respective accidents. If they cannot, the matter may be spoken to.

[166] IN SUMMARY, the awards of damages are:
non-pecuniary damages Ä $83,000
past wage loss Ä $16,065 past special damages Ä $2,246.60
future economic loss Ä yet to be determined

DISCUSSION

[167] When the trial concluded on December 13, 1996 I said I hoped to hand down judgment by the end of February 1997. In mid-February I was apprised of an unforeseen circumstance, well known to counsel, which has delayed judgment. I expect to hand down Supplementary Reasons for Judgment dealing with future

economic loss, in about a fortnight's time.

"Coultas, J."