SUPREME COURT OF NOVA SCOTIA
Citation: Urbenz-Jacks v. Ploudre, 2011 NSSC 278

Date: (20110708)
Docket: Hfx. No. 230586
Registry: Halifax

Between:

Sharen Urbenz-Jacks

Plaintiff

v.

Bernard Ploudre and Jill Olscamp

Defendants

Judge:	The Honourable Justice Arthur J. LeBlanc
Heard:	November 22, 23, 24, 25 and 29, 2010 in Halifax, Nova Scotia
Written Submissions:	December 20, 2010
Counsel:	Glenn E. Jones, for the plaintiff
	James L. Chipman, Q.C. and Kate A. Marshall, for the defendants

By the Court:

INTRODUCTION

[1] The plaintiff, Ms. Urbenz-Jacks, seeks damages from the defendants, Mr. Ploudre and Ms. Olscamp, on account of injuries arising out of a car accident in 2002. The defendants admit liability, but damages are at issue. The main issue in this case is the extent to which the Defendant is liable to the Plaintiff for her condition after the 2002 accident.

[2] The plaintiff was born in June 1956 and grew up in Toronto. She studied design after high school. She married and had two children, who were 24 and 27 years old at the time of trial. She enjoyed camping, skiing and skating, competitive dance and floral crafts. She and her husband separated in 1992. She remarried in 2003.

[3] Although she did not work outside the home during her first marriage, being a stay-at-home mother responsible for running the household, after the separation, the plaintiff began to work part–time. Her availability for work depended on the children's schedule. She worked as a waitress, in gift and craft sales and at a physiotherapy clinic, where she work-shared with another employee. Her duties

included reception, booking appointments, dealing with accounts and month-end balancing.

[4] The plaintiff was involved in a motor vehicle accident in 1996. Her vehicle was rear-ended while stopped in traffic. She was wearing a seat belt. She suffered neck, shoulder and lower back pain for an extended period.

[5] The plaintiff was working at Burnside Physiotherapy at the time of the 1996 accident. She continued to work after the accident. She stopped doing craft sales on account of her injury, finding the binders very heavy to lift. She attended physiotherapy. She said she eventually resumed a normal routine, except that she gave up her membership in a dance troupe. She continued to dance socially. The plaintiff completed a travel-tourism course in 1997 or 1998 and worked for Ambassatours for a year. She subsequently obtained a full-time position in a medical office. Her duties included reception, booking appointments, phone calls, and completing referrals. She was rotated with another employee.

[6] The plaintiff was involved in a second car accident in 1999. A vehicle in which she was a passenger was hit, and suffered a similar injury to that she experienced in the 1996 accident. She had neck, shoulder, lower back, and hip

pain, as well as headaches. Prior to the 1999 accident, she was still having residual discomfort from the 1996 injuries.

[7] The plaintiff was unemployed in 1999. In November of that year, she started work at Park Lane Dental, managing the office of Dr. Price and Dr. Davis. She said her recovery from the 1999 accident was considerably slower than in 1996. She was more cautious in resuming activities. She underwent physiotherapy and acupuncture after the second accident.

[8] Before the third accident the plaintiff was still experiencing discomfort, fatigue, pain and headaches, as well as unrelated health issues. She was working four days per week as a receptionist, and dealing with accounts. She had started working at five days, but changed to four days in early 2000. She averaged 32 hours per week working Monday, Tuesday, Thursday and Friday. She would do housework and some typing (at home, taking breaks as required) on Wednesdays. She continued with this arrangement until the staff was enlarged in 2002.

[9] Prior to the 2002 accident, the plaintiff's son Kyle was living with her. He was in junior high school. He helped with mowing the lawn, vacuuming, putting in firewood and snow shovelling. Her sister also lived with her and assisted with

housework. The plaintiff said she avoided heavy housework to avoid putting strain on her neck. She did, however, cook, clean, shop and do laundry. She cut back on dancing, but exercised by jogging and using a treadmill. For a time she played pickup baseball. She regularly drove to work, and drove to Newfoundland on occasion.

THE 2002 ACCIDENT

[10] On April 11, 2002, the plaintiff was on her way to work, driving her Plymouth Sundance in normal rush hour traffic, and stopped for a traffic light. The weather was clear. She proceeded across an intersection, and was hit from behind. She said she was tossed around. She recalled her head striking the headrest. She could see people in the car behind her being jostled around. She pulled over near a bus stop. At first, she did not think the accident was as severe as the second accident. However, she noticed weakness in her hips when she got out of the car, and she was dizzy. She said her vehicle was not seriously damaged. The other vehicles involved had greater damage.

THE PLAINTIFF

[11] The plaintiff said she was stiffening up and developing headaches within an hour of the collision. She went to work at Park Lane Dental. That day she experienced increasing pain and discomfort. The neck pain and headaches became

more severe. She felt uncomfortable and had difficulty concentrating. She left work at 3:00 p.m. She was unable to reach her doctor that day. The next day (a Friday) she was stiff and sore, and did not go to work. She had numbness on the left side of her head, and experienced headaches, neck pain and lower back pain. Dr. Nancy Robertson, her physician, suggested Tylenol and possibly physiotherapy. She said that if the symptoms intensified she would go to physiotherapy. She then rested on the weekend.

[12] The plaintiff returned to work the next week. Her symptoms, however, did not clear up. She was fatigued and confused and became irritable and impatient. Around June 2002, after another dentist joined the practice, she was told by the manager that she could work with the new doctor or with the orthodontic team four days per week.

[13] The plaintiff attended physiotherapy after the 2002 accident. The therapy included cranial stimulation, which did not produce positive results, and acupuncture, which gave her mild and temporary headache relief for maybe a day. She felt constant pressure in her head. She was always dizzy and felt imbalanced. The pain in her upper back was severe, and she was still having lower back pain, but these seemed secondary to what was going on in her head.

[14] The plaintiff started massage therapy in the fall of 2002, and found more relief. On occasion she threw up after therapy or in the morning after a sleepless night. At the time of trial, she was still receiving massage therapy. She had a TENS, which did not give significant relief. She used ice or heat periodically.

[15] The plaintiff had difficulty focusing on her work after the accident. She said she was reprimanded daily for errors. She said this resulted from dealing with pain and fatigue daily. She was forgetting things and felt overwhelmed with her duties, and was not getting along with her coworkers. During the period after the accident, the office was relocating and installing a new phone system. She was the liaison person in the office for training the staff on the new phone system, as well as overseeing the computer system.

[16] In the fall of 2002, while planning for her marriage, the plaintiff informed her supervisor that she was getting married while one of the doctors was on vacation. She was informed that the employer did not want her to be off without pay, and they wanted her to make up the time. She reluctantly agreed. Dr. G.J.H. Colwell, a physician she had consulted, suggested that she reduce her working

hours. Dr. Nancy Robertson, her family doctor, agreed to this course of action, and recommended that she take a medical leave, which she subsequently did.

[17] The plaintiff got married on October 25, 2002. The next morning she left with her husband for a honeymoon in Jamaica. During the next week, she said, she was very tired and uncomfortable with pain. She limited her activities, and spent most of the week lying on the beach. Her husband massaged her back in an attempt to give her some relief.

[18] The plaintiff was off work for six weeks. She expected to attend more therapy and to return to work. She said she did not progress well. She had to limit her activities; for instance, a Christmas event at her home was called off. In the New Year, Dr. Robertson suggested more time off work, along with a “return to work” program.

[19] While she was off work, the plaintiff helped her husband set up the bookkeeping for a company he was starting. She received no pay, as she was receiving Employment Insurance benefits. Her application for disability benefits was denied.

[20] Park Lane Dental wanted the plaintiff to return to a five-day work week. She was not favourable to this, nor were Dr. Colwell or Dr. Robertson, who were of the opinion she should maintain a four-day work week. The plaintiff began working three hours per day for Pivotal Power. This involved bookkeeping, travel arrangements and answering phones. She intended to start working a reduced workday, but to return to full capacity on a graduated basis. She worked for Pivotal until 2004, when the company proposed to turn her position to a five day per week job. She then worked at Met Communication, working five half-days per week, with bookkeeping and accounts receivable. She did not work with the public, and could take breaks. She said she initially had difficulty grasping instructions. In 2005, the business was sold. The plaintiff was not kept on with the new company.

[21] Park Lane Dental had terminated the plaintiff's position due to her inability to work five days a week. She returned to the dental field, however, in December 2005, working four days a week at Scotia Dental. She had difficulty adjusting, and was making mistakes, and was released during a probationary period of employment. She was advised that she was irritable. She said she was experiencing pain and confusion and had difficulty retaining instructions.

[22] The plaintiff later did temporary fill-in work at various dental offices: the Fall River Dental Group, the Bayer’s Road Dental Centre and the St. Margaret's Bay Dental Clinic, in late 2006. She began working as a receptionist, working an eight-hour shift, sharing the position. She was satisfied with a three-day-per-week schedule, with additional hours during holidays. In 2007, her employer wanted her to work four days per week. She was reluctant to move from three days to four days, and was replaced. After this she did fill-in work in various clinics, but declined jobs with extended hours or more days per week.

[23] The plaintiff said she had pressure in her head on a daily basis between 2002 and 2008. In 2008, she started receiving injections of methylprednisolone for head pain, at a cost of $50 per vial for three injections, and it became more manageable. By the fall of 2008, she was able to jog again. She would still experience pain from turning her head. With the injections, she could do more housework and grocery shopping. She was undergoing massage therapy and her husband would often massage her back. She was prescribed Toradol. The head pressure continued, and she suffered from numbness and dizziness. She continues to complain of nausea and occasionally vomits.

[24] In 2009, the plaintiff testified, she was extremely fatigued. When driving, she kept the window open to be refreshed. She was still suffering from head pressure. She was tired through the day at work, and missed days due to fatigue. She would leave parties early, and did not go to the office Christmas Party or to a gold f tournament. She recalled an event in April 2009 where she had had a few glasses of wine and she became ill and vomited. She could not get out of bed the next day. On one occasion she missed an exit while driving home from work, and found herself disoriented.

[25] In June 2010 the plaintiff refused to travel to North Carolina for her husband's family reunion. While waiting for an MRI she became ill, fainted and vomited, to the point that she had to be taken to the Emergency Room by ambulance. Her physicians considered whether her symptoms arose from another cause, such as diabetes or celiac disease. She has not worked since June 25, 2010.

[26] The plaintiff said that since the 2002 accident, she has pain that goes from her neck to her head. There is a "swooshing" noise in her head; she said she experienced this during the trial. She said it keeps her awake at night, so that she cannot sleep even when she is totally exhausted. She said she is nauseated and dizzy. The plaintiff does not claim that all of her symptoms are due to the accident.

She complains of confusion, insomnia, lightheadedness, numbness in her limbs, dizziness, loss of appetite, thirst, head pressure and fatigue, vomiting after drinking, disorientation and memory problems. She said that before the 2002 accident, she did not vomit after drinking, nor did she have the rushing or constant pressure in her head. She did not have fainting spells or blackouts.

[27] The plaintiff said exercise and aerobics would release endorphins and relieve some of the pain. She has tried various types of exercise, including a treadmill and DVD home exercise program. She took exercise classes and joined a gym. She had to stop these activities because of pain. Up-and-down motions would bring on dizziness. She joined a gym, but this involved machine-based exercise. Any kind of weight routine on her shoulder hurts. She said she canceled her membership because the aerobics were similar to the program she could do on her own. She returned to using a treadmill and walking.

[28] The plaintiff said she now has no recreational activities. Though formerly an avid swimmer, she does not swim because she cannot tread water, as the movement causes pain. She uses a flotation device in the pool. She agreed on cross-examination that she began jogging and dancing again in 2008, but said she had to stop jogging in the spring of 2009, and did not dance in 2009. The plaintiff

said she is not active, and her time is spent sitting with her feet up or standing up. She does puzzles and finds reading a chore. On good days, she goes for walks, but sparingly. She said noise confuses her.

[29] The plaintiff prepared a list of symptoms resulting from the 1999 accident for Dr. Robertson in October 2001. She agreed that many of the symptoms she presently experiences are similar to those she identified in October 2001. The 2001 list, which was handwritten, read as follows:

> -constant fatigue no matter how much or how little sleep
> -felt like I would pass out at work
> -light headed
> -dizzy
> -numb limbs
> -numbness frequent
> -pee a lot
> -through the night
> Nauseated after –sometimes crampy
> -less of an appetite but hungry more often
> -craving but not know what for (always)
> -thirsty
> -head pressure with fatigue & dizziness
> -threw up after 3 glasses of wine
> -protien [*sic?*] –feel better
> -carbos –fatigue/faint
> -can't recall words –poor memory in general
> -disoriented often
> -loose stool (off & on for days at a time)
> -insomnia/exhaustion
> -poor circulation in feat [*sic*]
> -blurred vision (up close)

[30] The 2010 list, which was typed, with handwritten additions, and read as follows:

-extreme fatigue/exhaustion every day
-Sleep deprivation
-Waking unroasted no matter how much sleep
-Brain fog, can't focus, scattered, confusion
-Freezing cold
-Unable to cope with any stress – routine or otherwise
-Difficult to keep up with work, make mistakes, miss little things
-Getting to work up 45 min later most days
-Have to lay down after work – don't nap well
-In bed earlier than usual but don't sleep any more
-Wanting to fall asleep while driving
-Feeling rushed/pushed all the time
-Anxious always a sense of urgency
-Irritable
-Acne
-Lower back pain/burn (new)
-Loss of appetite – not weight loss or gain
-Nausea – sporadic
-Dizzy spells, light headedness, shaky
-Needing more coffee during day but doesn't help
-Began adding more salt to diet naturally about 2mos ago – though not craving
-Uncomfortable in crowds or busy places
-Cutting corners with personal hygiene on days off
-Feeling like head will pop off
-Ready to sleep at work by early morning
-Can't keep going all day and night
-Cancel personal/social plans due to exhaustion
-Cry easily due to exhaustion
-Changes to daily routine due to exhaustion
-Want to fall asleep while driving especially after work
-Can't handle crowds busy places
-Alcohol does not agree with me even one drink – have been violently ill
-Unable to fight off colds/illness
-Have one good day about every 2 weeks
-Hot flashes/early evening & through night mostly

[31] The plaintiff said she delayed going to physiotherapy after the 2002 accident because Dr. Robertson told her to wait to see if she could deal with it herself. Since there was no particular damage to her vehicle she did not have the sense it was a bad accident. She said she thought that she would be fine.

[32] The plaintiff acknowledged that she experienced headaches, occasionally migraines, prior to the 2002 accident. She said they were of a different type than those she experienced later. She said bad weather does not aggravate her headaches. She said the low back pain has resolved and, because of the injections, neck pain is less of a problem.

[33] The plaintiff saw Dr. Mahar on account of a thyroid condition about six months prior to her third accident. He suggested that this condition could cause fatigue and dizziness. In the plaintiff's case, she felt mostly fatigued. She also stated that her fingers were cold. She was on medication for this condition.

[34] The plaintiff's husband operates Accurate Installation, a business he established. He does most of the work, but the income is divided equally for tax purposes. She does the bookkeeping work for the company. Her salary/dividend is equal to that of her husband, although she works fewer hours. In 2009 she earned total income of about $67,300, of which about $29,800.00 was employment income and $37,500.00 was dividends from the company. The equivalent approximate figures for 2008 are $34,375 (dividend) and about $26,400 (employment); for 2007, $26,500 (dividend) and about $19, 250 (employment);

and for 2006, $15,625 (dividend), $630 (employment) and about $14,000 (self-employed business income). The plaintiff did not report dividend income before 2006.

CHRISTOPHER DAVID JACKS

[35] Mr. Jacks is the plaintiff's husband. He said he has been owner of Accurate Installation since 2002. The business was incorporated in 2005.

[36] Mr. Jacks said that when he met the plaintiff in January 2002, before the third accident, there were no limitations on her activities. They would go driving, ice skating, dancing, to dinner and meet with friends. He said she would tire by the end of the day. She would, however, work out on the treadmill or skate for an entire afternoon. He said the plaintiff enjoyed running and dancing. Mr. Jacks said the plaintiff's son Kyle did a substantial amount of housework, such as dealing with firewood, shovelling and vacuuming. Mr. Jacks helped as well. He realized that the plaintiff had limitations, such as cleaning.

[37] Mr. Jacks said the plaintiff was distraught after the April 2002 accident. The night of the accident she complained of tightness and he massaged her back. She complained of headaches shooting up her neck, which have continued until trial. Mr. Jacks said the plaintiff spends a lot of time in bed. During the first year, her

pain became worse and she relied on painkillers to manage her pain. Occasionally, she spent the entire day in bed. Her sleep was affected. Little things aggravated her pain. He said she is sometimes short-tempered. He said he did not know her to have serious pain before the 2002 accident, to the point where she had to avoid certain tasks. When she tried to do housework, the onset of pain would be immediate and the fallout of doing the chores would be hard on her. Mr. Jacks said the plaintiff appeared to be increasingly stressed by conflicts at work. He acknowledged that he and the plaintiff had travelled to Jamaica, Chicago and the Dominican Republic after the 2002 accident, and that she had been on a sailboat.

[38] Currently, Mr. Jacks does most of the housekeeping. The housekeeper comes every second week. The plaintiff has attempted to help with housework, but when she tries, she is immobilized with pain for about a week. They initially got the housekeeper when they were living on First St. which was prior to October 2005. The plaintiff may load the dishwasher, but he does the pots and pans. He has been doing the housework since the accident. He did some housework before the 2002 accident, but not to the same extent. He said the housekeeper's time is limited by their finances.

KYLE BURNETT

[39] Mr. Burnett is the plaintiff's son. He was 24 years of age at the time of the trial. After his parents separated, he lived with his mother until May or June of 2003. He said that before the third accident, he did some vacuuming, mowing grass and other small jobs, while the plaintiff did most of the housework. After the third accident, he did dishes, cooked and did laundry as well. He stated that after the 2002 accident they frequently argued.

MARY DANISZEWSKI

[40] Ms. Daniszewski is a friend of the plaintiff. She testified that they have been together on camping trips, vacations, shopping and to the beach. She said that after the 2002 accident, her contact with the plaintiff diminished. She said the plaintiff appears more irritable, her personality changed, and she is limited in her physical activity. After two hours of shopping, for example, she returns home. Prior to the 2002 accident, Ms. Daniszewski said, the plaintiff was very physically fit and did what she wanted to do. Their relationship is still a good one, and they have had but one disagreement.

SUSAN DUNFEE

[41] Ms. Dunfee, a friend of the plaintiff, works as a dental receptionist. She said that before 2002 she and the plaintiff spent more time together than they have since then. They would go shopping and dancing, and to movies and dinner. Ms. Dunfee was unaware of the details of the 2002 accident, and did not make a connection between the plaintiff's pain and headaches and the third accident. After the 2002 accident, she observed that the plaintiff had less energy, and there was a personality change. They went on fewer trips together. Ms. Dunfee worked with the plaintiff at the Bayer's Road Dental Clinic in 2007 and 2008. She noticed that the plaintiff appeared tired and pale at the end of shifts, and appeared to be under stress. The plaintiff was having difficulty working eight hours per day. She could not do after-hour shifts.

HEATHER LYNNE McLEOD

[42] Ms. McLeod is a registered massage therapist. She was qualified as an expert in the field of athletic therapy. She does therapy and treatment for recreational injuries, high-performance injuries, injuries sustained in motor vehicle accidents and industrial accidents. She has treated the plaintiff since March 2009. The plaintiff had previously been treated by another massage therapist.

[43] Ms. McLeod said physiotherapy and massage therapy blend together. Massage therapy is a technique to find a tolerable level of activity. She said the plaintiff's symptoms were pain, nausea, fatigue, discomfort and headaches. She would see the plaintiff every four to six weeks. After treatment, the plaintiff would report feeling better for several hours or days and, in two or three instances, throughout the time between sessions.

[44] Ms. McLeod testified that as a physical manual practitioner she could feel the tissue softening with her hands. She said that when working the plaintiff's lower cervical and upper thoracic areas, as well as the "glutes", she felt the tissues in those regions soften, and the bony skeleton start to loosen up. She also referred to the feedback from the plaintiff as she was performing the therapy and after the sessions. In cross-examination, she described the area she was referring to as including the musculature and ligament structure between the ribs. She added that it was quite common to find rib injuries in motor vehicle accidents because of the force through the rib cage caused by the seat belt.

[45] While the plaintiff receives treatment every four to six weeks, Ms. Mcleod said that optimally the plaintiff should be seen every second week. Her current fee is $80.00/hr.

DR. NANCY ROBERTSON

[46] Dr. Robertson was qualified to give expert evidence as a family physician. She has been the plaintiff's family physician since 1992. She said that prior to the second accident, the plaintiff occasionally suffered from migraines, with residual muscular neck and head pain. She had unrelated surgery and was required to wear orthotics for high impact activities such as dancing.

[47] Dr. Robertson testified that she saw the plaintiff on November 13, 1996, the day of the first accident. The plaintiff reported that about 90 minutes after the accident she felt stiff all over, with some neck numbness, but no pain. She had a full range of motion of her cervical spine, but reported a pulling sensation on the left, with lateral bending to the right. The left paracervical musculature was tender to palpation. Neurological examination was within normal limits. Dr. Robertson recommended ice for 24 hours and use of Advil or Motrin, followed by heat packs.

[48] Dr. Robertson saw the plaintiff again on November 19, 1996, and the plaintiff reported feeling stiff and sore with neck pain, as well as left elbow and hip pain and generalized lumbar discomfort. Dr. Robertson noted that she had cervical pain with lateral bending to the right and left and both ranges were pain limited. Although she had full extension of the cervical spine, there were palpable spasms

of the cervical musculature on the left, and tenderness of the paraspinal area of the left from the base of the skull to mid-cervical region. When pressure was applied over this area, she reported pain radiating to her arm and thorax. She reported tenderness over the TMJ joints bilaterally. She also noted tenderness to palpation over the medial epicondyl of the elbow, but the joint was intact and there was a full range of motion of the elbow, wrist, and fingers with normal grip strength. There was tenderness over the greater trochanter of the left hip, but no joint compromise. Dr. Robertson recommended physiotherapy because of the trigger point tenderness and spasms.

[49] The plaintiff saw Dr. Robertson again on November 27, 1996, with essentially the same presentation and findings. She complained of nausea and increased pain in her shoulders. She said she had a constant dull headache, particularly around the crown of her head. On December 11, the plaintiff had started physiotherapy and was doing much better. Her headaches had improved and the TMJ was slightly better. She still had neck and shoulder pain, as well as pain in the lower back and chest. Dr. Robertson detected spasms and trigger points in the paracervical musculature. The left upper trapezius was very tender. There was some tenderness over the lumbar musculature with some spasms on the left. The plaintiff had a full range of motion of the lower spine with full straight leg

raising and normal reflexes. The range of motion of the cervical spine was essentially unchanged. She was getting relief from Pain Master electrodes, which are similar to a TENS machine.

[50] On February 24, 1997, the plaintiff complained of increasing lower back pain. Her upper back and neck were slowly improving. She reported a tingling sensation radiating down her right arm to her thumb. This improved with manipulation and heat. She had sustained lower back pain extending down between her shoulder blades. She said she had difficulty scrubbing a floor. On examination, Dr. Robertson noted that she had a full range of motion of her cervical spine with the exception of pain limitation on the lateral bending to the right at the extremes of range. Although she had full lumbo-sacral flexion, she was still reporting painful pulling sensations in the thoracic region.

[51] The plaintiff saw Dr. Robertson again on May 1, 1997. At this time, Dr. Robertson noted improvement which she described as dramatic. Although the plaintiff was still experiencing some pain with lateral flexion of her cervical spine, and some trigger point tenderness over the lower right trapezius and the mid-dashed transthoracic spine, it was less serious. She was having problems with non-restorative sleep.

[52] On December 23, 1997, Dr. Robertson noted that plaintiff was reporting a sudden onset of lower back pain when she bent forward to put her glasses in her bag. On examination, the plaintiff still showed tenderness over the extensor tendon of the left wrist and forearm. She also reported that she was tender to the point of nausea over the L4 – 5 area. She reported a good range of motion. Full leg raising was not tested due to the level of discomfort that the plaintiff was experiencing.

[53] Dr. Robertson examined the plaintiff on April 12, 2002, the day after the third accident. She reported that the plaintiff had full flexion of her cervical spine, but she had pain throughout the last part of extension. The plaintiff was reporting a pulling sensation on lateral bending bilaterally throughout the range. There was a full range of motion of the lumbosacral spine. She reported tenderness to palpation over the occiput, but there was no palpable swelling or fracture. She had increased tone to palpation throughout the entire back musculature from cervical to sacral levels. Dr. Robertson described the injuries as being of the soft tissue injury type and representing an acute injury on top of the chronic pre-existing problem. She prescribed Toradol and Flexeril.

[54] On May 1, 2002, the plaintiff reported constant muscular-type headaches, with discomfort centered in the lower neck radiating to both shoulders. She was tender to palpation over the jaw muscles, but could fully open her mouth. She had full flexion of the cervical spine, but reported pain at the end of the range for extension. She had full rotation and lateral bending, but again reported pain at the end of the range. She observed increased tone with palpation of the trapezeii, sternocleidomastoids, scalenes and levetors bilaterally, but there was no trigger point tenderness.

[55] On May 29, 2002, the plaintiff reported that she was having physiotherapy and acupuncture treatment, which improved her headaches. Her principal complaint was back and neck pain. She said she was having difficulty working all day, and said she could not do light housework. She continued to have pain at the extremes of the range of the cervical spine motion. She lacked the last 10% of extension of the lumbosacral area and she continued to have hypertonicity to palpation throughout the back and neck musculature, most prominently in the trapezeii. Dr. Robertson summarized the plaintiff's condition as being consistent with soft tissue injury aggravating injuries from the previous accidents of 1996 and 1999. She anticipated that this was an acute or chronic insult and that it might take

longer than usual to recover to the plaintiff's pre-accident level.

[56] On September 27, 2002, the plaintiff reported constant pain from the crown of her head to the nape of her neck. She reported that she had to work a five-day week during an office reorganization. As the working day went on, the pain would become severe. Within two hours of starting work the pain extended to the entire neck and shoulders bilaterally. By the end of the day the pain would extend to the lower back. She was not sleeping well. She reported moodiness and irritability, and said she had difficulty focusing, leading to mistakes at work as a result. The plaintiff reported pain throughout the range of motion for all of the C-spine manoeuvres. She had 50% of normal expected range for extension, pain but full forward flexion, 80% of expected range for rotation bilaterally and 50% for lateral bending bilaterally with audible crepitus. She had full range of motion of the lumbar – sacral spine, but reported pain throughout the extension manoeuvre. There was palpable hypertonicity throughout the cervical and paracervical musculature with trigger point tenderness. Dr. Robertson observed tenderness to palpation over the right lumbar – sacral musculature. She concluded that the plaintiff's injury was an acute injury superimposed upon a chronic injury, and that it was being aggravated by working, and suggested that the plaintiff go off work. She recommended continuing physiotherapy and massage therapy. She prescribed

medication which the plaintiff eventually discontinued, explaining that made her foggy and irritable.

[57] On December 18, 2002, the plaintiff reported discomfort and pain in her neck. She was also experiencing trismus with bilateral TMJ tenderness. Dr. Robertson recommended that she see a neurologist and a TMJ specialist.

[58] On February 5, 2003, the plaintiff reported that she had been waking tired with pain and nausea. She said her sitting tolerance was about a half-hour, and that driving aggravated her pain quickly. On examination, Dr. Robertson observed that the plaintiff could not extend her lower back. She said the plaintiff had a slight kyphosis. She could flex at the waist, but full bending bilaterally was pain-limited to about 50% of the normal range. There was hypertonicity to palpation, more so on the left side, extending from the neck to the coccyx. She reported being tired and sore and said her concentration, cognitive processing skills, and short-term memory were affected. She continued to have non-restorative sleep. She was continued on Toradol.

[59] Dr. Robertson expressed the opinion that it was not uncommon for soft tissue injuries without complications to take up to two years to resolve. Given the

fact that the plaintiff had been in two previous motor vehicle accidents, she concluded that it would not be unexpected for the plaintiff to require even longer than two years to return to her pre-accident function level.

[60] In April 2008, Dr. Robertson noted that the plaintiff continued to have neck pain, headaches to the point of nausea, lightheadedness and sleep disturbance. All of these symptoms contribute to fatigue. She concluded that the plaintiff's recovery had plateaued, and stated that she would not expect further major improvement. On her last visit with Dr. Robertson, on March 19, 2008, the plaintiff reported a flare up of neck pain and headaches. She had been temporarily working at a job requiring her to shift between workstations. She had left a job because she could not tolerate working five consecutive days. The plaintiff's cervical spine demonstrated full flexion and extension, but rotation to both right and left was decreased to approximately 50% of normal expected range. Lateral bending to the right was full range, but was decreased to the left, with pain through the last 20% of the manoeuvre. Grip strength was normal and there was no muscle wasting as had been the case in the past. Dr. Robertson noted increased muscle spasm. She injected with steroids and Xylocaine.

[61] In her final report of September 13, 2010, Dr. Robertson said she was not qualified to state whether vertebral artery compression could result from the accident and what the significance of such compression would be. She could not explain the plaintiff's persistent symptoms over such a long time. She testified that she did not expect further improvement in the plaintiff's condition.

[62] Dr. Robertson agreed that the plaintiff had not fully recovered from the second accident at the time of the third accident. She agreed that the plaintiff suffered from migraines and had problems at work prior to the third accident. She saw Dr. Colwell, and Dr. Thompson for TMJ in 2001. She was still using the TENS at that time. She was also having difficulty sleeping and she gave up bike riding and swimming. After the 1999 accident, she reduced her work week to four days. Dr. Robertson agreed that before the 2002 accident, the plaintiff was functioning at approximately 80%.

[63] Dr. Robertson agreed that the bite plane cut down on the migraines, and that some of the plaintiff's conditions, such as thyroid, migraine headaches and complaints relating to menopause and heart palpations, are unrelated to the accident.

[64] Dr. Robertson characterized her role as a family physician as being an advocate on behalf of her patients, while emphasizing that this role was bounded by professional and ethical constraints.

[65] At the plaintiff's request, in July 2010 Dr. Robertson prepared a medical report for Great West Life, listing all three motor vehicle accidents. The plaintiff asked her to delete the references to the previous accidents, and she complied. She said she agreed to their removal because she felt that the symptoms were not related to any of the accidents. Dr. Robertson was referred to the lists of symptoms prepared by the plaintiff in 2001 and 2010. Dr. Robertson explained that in 2010 the plaintiff was put off work due to syncopal attacks and associated symptoms, not related to the accidents.

[66] Dr. Robertson agreed that she had indicated in correspondence with the plaintiff's counsel that she herself had been in two motor vehicle accidents, with loss of consciousness, and could not explain the plaintiff's situation. She explained on cross-examination, however, that she was referring to Mr. Jones's query as to whether she felt the vertebral artery compression could have contributed to the plaintiff's symptoms, which she said was beyond her expertise. She added that her injury was of a different type than the plaintiff's.

DR. DAVID KING

[67] Dr. King was qualified as an expert in the field of neurology, with a subspecialty in movement disorders. The defence accepted Dr. King's qualifications and expertise. He examined the plaintiff twice and issued reports dated August 21, 2006, and May 6, 2008, which were admitted into evidence. Before seeing the plaintiff, Dr. King reviewed existing reports, clinical notes and her discovery transcript. He based his opinion on the history, physical examination and collateral information which he reviewed. He provided a diagnosis based on subjective and objective data. He also provided a measure of handicap in accordance with the London Handicap Scale.

[68] Dr. King was aware that the plaintiff had been previously injured in two motor vehicle accidents, the latter of which caused her significant pain and discomfort, which continued until the 2002 accident. He believed that she had regained about 80% of her function prior to the third accident.

[69] Dr. King concluded in his 2006 report that the April 11, 2002, accident caused "a cervical pain syndrome of myofascial origin," which was "associated with headaches secondary to the cervical strain, vascular factors and temperomandibular joint dysfunction. The headaches and cervical pain syndrome

led to cognitive inefficiency due to pain and sleep deprivation." The sleep problems had improved significantly (Report of 21 August 2006, p. 28). He provided the following diagnoses:

> 1. Myofascial pain syndrome involving the cervical muscles, particularly splenius capitis, multifidus and rhomboids bilaterally, secondary to motor vehicle accident of April 11, 2002 and an aggravation of a pre-existing WAD-2.
>
> 2. Vascular headache syndrome representing an exacerbation of a pre-existing condition exacerbated by the motor vehicle accident of 11 April 11 2002.
>
> 3. Temporomandibular joint dysfunction of mild degree representing a temporary exacerbation of a pre-existing condition.
>
> 4. Lumbar spine strain secondary to motor vehicle accident 11 April 2002, now resolved. (Report of 21 August 2006, p. 28).

[70] At trial, Dr. King described myofascial pain syndrome as pain in the soft tissue. He referred to the theory that there are a number of trigger points in the muscle, and these represent areas where the muscle fiber has been damaged. The release of calcium causes the muscles to contract, which is an abnormal occurrence, and would not necessarily occur to someone who did not have myofascial pain. He said this was consistent with the pain experienced by the plaintiff.

[71] In his 2006 report, Dr. King did not suggest any further investigation, but did suggest that the plaintiff receive trigger point injections for the myofascial pain syndrome in the area of the splenius capitis, multifidus and rhomboids. He also

suggested sibelium for the post-traumatic vascular headaches, and that the plaintiff should continue her regular aerobic exercises, but not do any weights. He thought that there was “a fair chance of easing her myofascial pain syndrome,” although it was unlikely that it could be resolved completely. He also thought there was a fair chance of improving the vascular headaches (Report of 21 August 2006, p. 34).

[72] Dr. King concluded that therapeutic intervention had not resolved the plaintiff’s problems to date and that she remained with a moderate handicap. Prior to the 2002 accident the plaintiff had been left with a reduced work capacity to 80%. However, after the 2002 accident, her work capacity was at about 40%. He noted that she continued to have neck pain and headaches which, when they were severe, interfered with her concentration and memory. Her work, being of a clerical nature, required attention to detail. He concluded that the probability of her returning to work at an 80% level was fair (Report of 21 August 2006, p. 35).

[73] Dr. King examined the plaintiff again on May 6, 2008. She reported that she had been receiving injections from her family physician and that there had been some improvement in her headaches. She received injections every five to six weeks for the better part of two years. She was taking Toradol sporadically when the headaches broke through. She reported that the headaches still started

posteriorly and radiated forward. They could be pulsatile or beating. She would be nauseated, but did not usually vomit. She reported neck discomfort, with most of the pain in the cervical region, extending down between the shoulder blades on either side of her head, beginning posteriorly and radiating forward. She said her neck pain was constant; she rated it as two or three on most days, but sometimes flaring up, and that the headaches could be 10 out of 10 when this occurred. She reported that when the headaches were at the highest level, she was completely debilitated.

[74] The plaintiff reported that she was going into work for three days a week and also assisting her husband with the bookkeeping. She also reported the need for a housekeeper once or twice a month. She was no longer running. She reported substantial improvement, but was not fully recovered. She was able to function in most areas with modification and moderation.

[75] Dr. King re-examined the plaintiff. He reported that she had tenderness over the splenius capitus, multifidus and rhomboids bilaterally. He opined that she still had myofascial pain syndrome, which partially controlled with local injections. She was able to control periodic flareups of her headaches with Toradol. He estimated her handicap at a level of 25% or mild. He suggested Botox A injections,

in order to give her more sustained relief than local injections could provide. The plaintiff said she would speak to her family physician about this suggestion.

[76] Dr. King stated at trial that he would not have expected the plaintiff to go off work with symptoms of nausea, fatigue and dizziness, but added that “if she had a recurrence of her ... neck pain and her vascular headaches and associated with that she [had] nausea and vomiting and light intolerances which she’s described to me before, that wouldn’t surprise me.” He described fatigue as a “generalized symptom,” and said he would want to establish if it related to the original symptoms. Likewise, he said, he would want to establish whether vomiting was associated with headaches, or if it was independent and some other cause should be investigated.

[77] Dr. King stated that the pain in the back of the plaintiff’s head is activated with the turning of the head. It relates to the rhomboids, that is, muscles in the inner aspect of the shoulder blades, attached to the spinal column and shoulder blades. Dr. King said the headaches are similar to a migraine but these are derived from the release of active chemicals. He said it was common for people who are in constant pain to have memory failure because of their inability to concentrate. Similarly, insomnia causes memory loss, as was happening to the plaintiff.

[78] Dr. King testified that the absence of damage to a vehicle in a rear-end collision is not determinative on the extent of injury. He said the plaintiff had been jolted backwards, which could result in the injuries she reported. Dr. King indicated it was common for persons involved in such accidents not to feel pain for the first 24 hours after the accident.

[79] Dr. King stated that there are a number of causes of dizziness following a motor vehicle accident. He said it was common for people who have muscle contraction problems with the brain to sense more tension in that muscle because of a problem with the balancing apparatus, so that the patient cannot stand up properly. This can also occur when there is a problem with the neck.

[80] Dr. King agreed that the nausea pre-existed the 2002 accident. He did not characterize the plaintiff as having chronic pain syndrome. He agreed that she did not have trigger points or tender points. He also agreed that she was capable of standing and walking stairs and could lift up to five pounds.

[81] Dr. King testified that the plaintiff had an excellent chance of improving although there was less than a 50% chance that she will recover fully.

DR. JOHN McKELVEY

[82] Dr. McKelvey is a neurologist at the Dartmouth Medical Centre. He was qualified to give expert opinion in the field of neurology. He examined the plaintiff on February 25, 2003, with reference to alleged persistent symptoms subsequent to the 2002 accident.

[83] In his report of March 7, 2003, Dr. McKelvey stated that the plaintiff had a "very typical post-concussive syndrome with involvement of attention and concentration, as well as mood swings, irritability and sensitivity to environmental stimuli." He considered the headaches and neck pain to be typical for a persistent post-concussive or whiplash syndrome. The persistent dizziness was unusually prominent, particularly given the vomiting. He did not assume that the vomiting was part of the post-concussive syndrome. He stated that, while the 2002 accident was relatively minor, the nature and severity of the plaintiff's symptoms were consistent with the diagnosis, given the two previous accidents, which he concluded had left her predisposed to increased effects of the third accident.

[84] Dr. McKelvey noted that the plaintiff was attempting to increase her activity by taking up yoga, which he encouraged. He stated that she needed to increase her mental activity and continue to read. He thought that excessive rest would only

prolong the recovery. He was aware that she was contemplating returning to work in April or May 2003, and he thought that would be an appropriate course of action. However, he pointed out that was important for her to increase her mental and physical activity prior to doing so. He thought that she should make a gradual return to work because going back to work on a full-time basis immediately would be doomed to failure.

[85] Dr. McKelvey saw the plaintiff again on November 15, 2004, and issued a report on November 18. He found only slight improvement in teh symptoms she had reported in 2003. She still had daily headaches and poor sleep. With serious head pain the plaintiff was more imbalanced and staggering. She reported difficulty thinking and remembering, concentration and processing new information. She said she could do a couple of hours of bookkeeping work, but that she needed rest. She could only do light housework briefly. She had attempted other work, such as painting, but needed to rest.

[86] In his 2004 report, Dr. McKelvey noted that subsequent neuropsychological testing did not support his original conclusion that the plaintiff had sustained a concussion. He stated, at p. 3:

> As is often the case, it is difficult to sort out how much of the ongoing cognitive symptoms are related to direct brain injury versus the effects of chronic pain and

> sleep deprivation. In Sharon's case it appears that her ongoing symptoms are related to the latter, i.e. persistent pain and associated sleep deprivation. I discussed this with Sharon and her husband, emphasizing that difficulties in functioning, cognitive and otherwise, can be extremely prominent when related to the combination of chronic pain and sleep deprivation. The chronic pain and sleep deprivation are more than ample explanations for her ongoing symptoms.

[87] Dr. McKelvey did not recommend further specific neurologic investigations, emphasizing instead an emphasis on symptom control and quality of life. He noted her attempts to minimize the use of medication, and recommended more use of medication for pain control and to improve sleep, combined with ongoing efforts to increase her mental and physical activity. In this manner, Dr. McKelvey thought that the plaintiff could make significant gains in her quality of life and function over time.

DR. GERALD P. REARDON

[88] Dr. Reardon is an orthopedic surgeon. He was qualified to give expert evidence in the field of orthopedic surgery and the diagnosis and treatment of musculo-skeletal injuries. He first saw the plaintiff in December 2000, in relation to injuries related to the 1999 accident.

[89] In a report dated December 19, 2000, Dr. Reardon wrote that the plaintiff was complaining of pain in her neck and between her shoulder blades, and lesser discomfort in the lumbar spine. She reported no change in the quality of her

symptoms since the accident, although a bite plane was of help with the headaches. He concluded that there were no residual effects from the 1996 accident, and found that the level of pain in her neck was “reasonable given the type of injury in which she was involved just over one year ago.” She did not require regular medication, he noted, and her decrease in physical activity was consistent with her “present level of injury.” He noted that the main effect of the pain was in restricting the plaintiff’s extracurricular activities. He believed that working at an 80 per cent level was reasonable in view of the plaintiff’s clinical presentation.

[90] Dr. Reardon prepared a second report after seeing the plaintiff following the 2002 accident. In this report, dated December 16, 2002, he noted that the plaintiff was still experiencing pain in the back of her head, in her neck, and in her upper back and across her trapezius muscle. She was taking Toradol. She was waking up most nights with discomfort and her sleep pattern was quite disturbed. She was having difficulty concentrating and was suffering from short-term memory loss. On questioning as to her pain level, he wrote that she reported pain usually at a level of 8/10, and sometimes 10/10. He informed her that this was the most severe pain, likely in the nature of post-operative pain requiring intravenous or intramuscular morphine. The plaintiff told him that she thought that on occasion she had that type of intensive pain.

[91] Dr. Reardon wrote that it was "somewhat unusual" that the plaintiff's symptoms had worsened in the eight months since the 2002 accident, but he believed that "considerable improvement" was possible over the next eight to twelve months. He observed, at p. 3 of his 2002 report:

> Ms. Urbenz has actually sustained only minor injury here of the soft tissue variety. It is difficult to explain the intensity of her pain on her most recent trauma alone although obviously it is playing a role. I think that there are a number of external factors also that are coming into play here. She is very anxious and quite worried about her condition. She is not coping well at all with her pain. I am somewhat surprised that she has not been referred for professional help, perhaps from a pain psychologist.
>
> I do not feel that one can be definitive with regards to prognosis as not enough time has elapsed. I will be hopeful that there will be some improvement but, of course, one must be guarded in prognosis given the fact that this injury has compounded pre-existing problems.

[92] Noting that she had been working at an 80 per cent level before the accident, Dr. Reardon believed that a gradual return to part-time work would be reasonable, but that she could not return to work on a five-day basis. He did not feel that she was totally disabled, and he took the view that there was no reason to keep her away from work for prolonged periods, "given the minor nature of her initial injury."

[93] At trial Dr. Reardon described pain as a spectrum, and said it was difficult to measure pain. He believed there was a reasonable chance of further improvement.

He watched the plaintiff over a two-year period, at which point he considered that she would have plateaued. Dr. Reardon thought that the plaintiff was being truthful and was not malingering. He thought that she had some “spunk” and drive. He thought that her history and the way that she reported her injuries and her symptoms made her believable.

[94] Dr. Reardon agreed on cross-examination that at the time of his first report, in 2000, the plaintiff was operating at 80% of functioning, working four days per week. He was aware that she had started a job in November 1999 (that is, after the 1999 accident) where she was working four days per week.

DR. MICHAEL GROSS

[95] Dr. Gross is an orthopaedic surgeon. He was qualified to give expert evidence on the musculo-skeletal system, bones, tendons and muscles. He is a full professor at the Dalhousie Medical School and is on the orthopaedic staff of the Capital Health District. He conducted an independent medical examination of the plaintiff on June 15, 2007, at the request of the defendant. His diagnosis consisted of the following (at p. 15 of his report):

> 1. Soft tissue injuries to cervical and lumbar spine.
> 2. Exacerbation of same in motor vehicle accidents of December 2002 and April of 2002.
> 3. possible post-concussive syndrome.

4. TMJ disorder.

[96] Dr. Gross concluded, at pp. 15-16 of his report, that the 2002 accident exacerbated the plaintiff's pre-existing complaints, and that she had had "significant discomfort and disability which has prevented her from returning to her full-time occupation." There was no evidence of significant impairment to the musculoskeletal system. He found that her return to work duty and other activities was delayed by her anxiety and difficulty with pain management; her disabilities, he concluded, related "not to any significant impairment of function," but to "her management and difficulties with pain and sleeping." He believed that there was "no physical impairment that would prevent her from fulfilling her previously described duties as a receptionist/administrative support person," given an "ease back program and part time working slowly progressing to full time working," in a position of light physical activity and with an ergonomic assessment of her workplace.

[97] Dr. Gross did not recommend massage therapy, but considered that she should continue with light physical activities. He said massage is useful if done early. He said exercise is essential to recovery.

DR. G.J.H. COLWELL

[98] While Dr. Colwell was not called as a witness at trial, other medical witnesses were referred to his reports, and I note that I have considered his reports in reaching this decision.

LAW AND ARGUMENT

CAUSATION

[99] It is a basic principle of tort law that causation is not apportioned. If the plaintiff proves that the defendant caused or contributed to his or her injuries on a balance of probabilities, the defendant is fully liable for those injuries. In order to prove that a defendant caused an injury, the plaintiff must show that the injury would not have occurred “but for” the defendant's actions. The plaintiff does not need to show that the defendant's actions were the sole cause of the injury, only that the defendant's actions were “part of the cause” of his or her injury, and that the injury would not have occurred without the defendant’s actions. The Supreme Court of Canada said, per Major J., in *Athey v. Leonati*, [1996] 3 S.C.R. 458, at para. 17:

> As long as a defendant is part of the cause of an injury, the defendant is liable, even though his act alone was not enough to create the injury. There is no basis for a reduction of liability because of the existence of other preconditions: defendants remain liable for all injuries caused or contributed to by their negligence. [Emphasis by Major J.]

[100] Major J. recognized that in some circumstances causation may be established when the plaintiff can only prove that the defendant's actions “materially contributed” to the injury (para. 15). This is a lower threshold than the "but for" test, as it does not require proof that the injury would absolutely not have occurred without the defendant's actions; it only requires proof that the defendant's actions contributed to the injury more than minimally.

[101] This "material contribution" test was further explained in *Resurfice Corp. v. Hanke*, [2007] 1 S.C.R. 333, 2007 SCC 7, where McLachlin C.J.C., writing for the court, reaffirmed that the "but for" test is the main test used to establish causation. She went on to state, at paras. 24-25, that the "material contribution" test is only applicable in limited circumstances:

> ... Broadly speaking, the cases in which the “material contribution” test is properly applied involve two requirements.
>
> First, it must be impossible for the plaintiff to prove that the defendant’s negligence caused the plaintiff’s injury using the “but for” test. The impossibility must be due to factors that are outside of the plaintiff’s control; for example, current limits of scientific knowledge. Second, it must be clear that the defendant breached a duty of care owed to the plaintiff, thereby exposing the plaintiff to an unreasonable risk of injury, and the plaintiff must have suffered that form of injury. In other words, the plaintiff’s injury must fall within the ambit of the risk created by the defendant’s breach. In those exceptional cases where these two requirements are satisfied, liability may be imposed, even though the “but for” test is not satisfied, because it would offend basic notions of fairness and justice to deny liability by applying a “but for” approach.

[102] Therefore, unless a plaintiff can show that it is impossible to prove that the defendant's actions caused his or her injuries using the "but for test", that the defendant breached a duty owed to the plaintiff, and that the plaintiff's injuries are of the type commonly suffered due to such a breach, the "but for" test must be used to determine causation.

[103] This distinction is not overly important in the present case. It is clear that the defendant's actions are at least "part of the cause" of the plaintiff's injuries; therefore, causation is made out using either the "but for" test or the "material contribution" test. Both counsel stated that causation was in issue, but that the defendant admitted liability. By admitting liability, the defendant has admitted that his actions caused the plaintiff's injury. Therefore, causation has been established, and the issue becomes the extent to which the defendant is liable for the plaintiff's injuries. Although addressing this issue requires determining which of the Plaintiff's injuries were "caused" by the Defendant, this is not equivalent to establishing causation, which is a required element in tort law before a finding of negligence is possible.

THE EXTENT OF LIABILITY

[104] The basic principle in tort liability is that the plaintiff must be placed in the position that he or she would have been in absent the defendant's negligence. This is known as putting the plaintiff back in his or her “original position.” The plaintiff is not to be put in a position better than his or her original one, as the defendant is not liable to compensate for damages that he or she did not cause or contribute to.

[105] Therefore, the determination of the plaintiff's original position is a key step in the apportionment of damages in negligence cases. There are instances where a plaintiff's original position is not one of full health. This is the case in the present matter, as the parties agree that Ms. Urbenz-Jacks was not fully recovered from her 1999 accident at the time of the 2002 accident.

[106] Legal principles have developed to help determine the appropriate disposition of damages in these types of cases. Two principles that aid in this determination are the “thin skull” and “crumbling skull” doctrines. The thin skull principle is related to the legal maxim that “a tortfeasor must take a plaintiff as he finds him.” This means that if a plaintiff was suffering from a condition that was stable and would have remained so but for the accident, the defendant is liable for any resulting injuries, even if they would not have occurred in a “normal” plaintiff.

For example, if a plaintiff suffered from a condition that weakened her bones slipped and fell on a defendant's unshoveled sidewalk and broke several bones, the negligent defendant would be liable for these injuries even if they would not have occurred in a plaintiff who did not have the bone-weakening condition.

[107] The crumbling skull doctrine, by contrast, applies where a plaintiff was in a state of continuing deterioration at the time of the accident, and the accident accelerated this deterioration. When this occurs, the defendant is not liable for all post-accident effects, as his or her negligence is only an aggravating cause, and not the sole cause of the injuries. Major J. clearly explained the crumbling skull doctrine in *Athey*, at para. 35 (citations omitted):

> The so-called "crumbling skull" rule simply recognizes that the pre-existing condition was inherent in the plaintiff's "original position". The defendant need not put the plaintiff in a position better than his or her original position. The defendant is liable for the injuries caused, even if they are extreme, but need not compensate the plaintiff for any debilitating effects of the pre-existing condition which the plaintiff would have experienced anyway. The defendant is liable for the additional damage but not the pre-existing damage.... Likewise, if there is a measurable risk that the pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligence, then this can be taken into account in reducing the overall award.... This is consistent with the general rule that the plaintiff must be returned to the position he would have been in, with all of its attendant risks and shortcomings, and not a better position.

[108] Therefore, in the case of a plaintiff with a crumbling skull, the court should take into account any "debilitating effects" of pre-existing conditions when determining the plaintiff's original position, and should consider the risk that the

pre-existing conditions would have detrimentally affected the plaintiff in the future when determining damages.

[109] Ms. Urbenz-Jacks is an example of a plaintiff with a crumbling skull, not a thin skull. Her pre-existing conditions were not stable. She was suffering debilitating effects arising from injuries incurred in the 1999 accident, which were accelerated by the 2002 accident. As such, the defendant is liable to put the plaintiff back in the position that she was in immediately prior to the 2002 accident. To accomplish this, it is necessary to consider both the plaintiff's original position immediately before the 2002 accident and her position after the accident. Damages should compensate for the difference between these two positions. Unfortunately this is easier said than done, as the plaintiff's original position prior to the 2002 accident is not clearly known, and there is conflicting evidence concerning her position after the 2002 accident and her subsequent recovery.

OBJECTIVE ASSESSMENT OF PAIN

[110] One of the problems related to assessing damages in this case is that many of the injuries that Ms. Urbenz-Jacks complains of are related to pain, which is very difficult to quantify objectively. Medical professionals and courts must rely on the

plaintiff's subjective description of the pain to determine the severity of the injuries. This raises issues of credibility.

[111] The British Columbia Court of Appeal addressed this issue in *Maslen v. Rubenstein*, [1994] 1 W.W.R. 53, 1993 CarswellBC 236. Taylor J.A. stated, for the court, that “there must be evidence of a ‘convincing’ nature to overcome the improbability that pain will continue, in the absence of objective symptoms, well beyond the normal recovery period, but the plaintiff's own evidence, if consistent with the surrounding circumstances, may nevertheless suffice for the purpose” (para. 16). Although the court was referring to chronic pain syndrome, which is not present in the current case, this statement has been adopted in decisions involving all types of pain (see, for instance, *Mariano v. Campbell*, 2010 BCCA 410, 2010 CarswellBC 2498, at para. 40).

[112] Therefore, although Ms. Urbenz-Jacks' evidence concerning her pain may suffice to prove its severity, her evidence must be “convincing” to do so, and she must also be found to be a credible witness. There were, in addition, other witnesses whose evidence addressed the degree of pain the plaintiff was apparently experiencing. While Ms. Urbenz-Jacks' massage therapist was not qualified as an expert, she testified that she could tell that Ms. Urbenz-Jacks was in pain by the

state of the muscles in her neck and back. The evidence of a trained massage therapist regarding a plaintiff's apparent level of pain may be entitled to some weight. Ms. McLeod testified that she could tell that the plaintiff's neck and back were very stiff after the 2002 accident until the present, and therefore it is very likely that the plaintiff felt a considerable amount of pain from her injuries. This removes some of the subjectivity from the assessment of the pain. This evidence would be accorded even greater weight if corroborated by other medical personnel.

PLAINTIFF'S PRE AND POST-ACCIDENT CIRCUMSTANCES

[113] In assessing the plaintiff's medical condition, I note that where Dr. King's evidence conflicts with that of other medical witnesses, I prefer the evidence of Dr. King. His evidence is more current than that of the other specialists (he last saw the plaintiff in 2008), and he appears to have spent more time with the plaintiff than other specialists. Finally, I believe that his specialization in neurology is of greater assistance in assessing the plaintiff's issues with pain than that of the other medical professionals.

[114] The evidence indicates that prior to the 2002 accident, the plaintiff was suffering neck and pack pain as well as migraine headaches, and that she was only able to work four days per week. After the 2002 accident, the Plaintiff complained

of several injuries similar to those that she complained of before the accident. These include neck and back pain and headaches. However, she also reported difficulty concentrating, non-restorative sleep, lack of energy, different types of headaches, and nausea upon waking in the morning. Dr. King verified the majority of these conditions, with the exception of nausea (he did not have an explanation for this). Dr. Robertson also verified the existence of many of these conditions. It appears clear that the plaintiff's level of pain and suffering increased after the 2002 accident, and that some of the subsequent injuries were different in type from those complained of prior to the 2002 accident.

LOST INCOME AFTER 2002 ACCIDENT

[115] The effect of the 2002 accident on the plaintiff's ability to work is not entirely clear. She initially returned to work at Park Lane Dental, remaining in this position until September 2002, more than four months after the accident. She worked five days per week for a time during this period. Just prior her wedding in October 2002, the plaintiff was put off on medical leave by Dr. Robertson. While she wished to return to Park Lane Dental after her wedding, the company wanted her to work five days per week. She never recovered to this level, and thus did not return to Park Lane Dental. However, she was not able to work five days per week

before the 2002 accident. Therefore, it appears, the 2002 accident was not the sole cause for the end of her employment with Park Lane Dental.

[116] Although the plaintiff has worked at other jobs since 2002, she has not steadily worked more than three days per week since leaving Park Lane Dental. Unfortunately it is unclear whether this is due to her physical condition, to the inability to find suitable work, or to a combination of these factors. It is clear that after the accident the plaintiff had difficulty learning new techniques due to her inability to concentrate. However, Dr. King found that her condition had improved considerably between 2006 and 2008.

[117] If Park Lane Dental had been more accommodating, Ms. Urbenz-Jacks may have been able to work three or four days per week at some point after the accident. I am not satisfied that the 2002 accident led to a significant long-term decrease in earning capacity compared with the plaintiff's capacity before the accident, but I am satisfied that it caused her to lose some income over the interim period, given that she was advised by her physician to work fewer hours.

[118] The plaintiff claims that she earned an average of $26,398.00 in 2000 and 2001. She submits that this should be her base salary, and that any shortfall

between this amount and her actual earnings between 2002 and 2010 should be attributed to her injuries from the 2002 accident, with an additional allowance of two per cent for inflation. Without evidence on the point, I cannot agree that lost wages should attract a two per cent inflation rate. Wages and salaries do not necessarily track the rate of inflation.

[119] Accepting for the moment that a pre-accident base salary of $26,398.00 is an appropriate starting point, I conclude it is necessary to reduce this by 20 per cent, for an adjusted annual amount of $21,000.00, on account of contingencies related to her injuries from the previous accidents. During the years in question, the plaintiff actually earned a total of $138,000. This averages out to $15,000.00 per year. Therefore, the net difference between the amount that she would have earned had she been working four days per week and the amount she actually earned is $6000.00 on a yearly basis, for a total of $51,000.00 between 2002 and June 2010.

[120] Since 2006, the plaintiff has received dividends from her husband's company, Accurate Installation. Although these dividends do not reflect the actual work the plaintiff does, she does perform some accounting functions that would otherwise have to be completed by an outside accountants or a paid employee. Although there is no proper estimate, apart from the suggestion by Mr. Jack that

there are only a few accounts involved, I conclude that he would have to pay between $3000.00 and $3500.00 annually to have this accounting done if it were not done by plaintiff. I characterize this as additional income earned by the plaintiff, although it is paid to her as a dividend. I make an adjustment of $3,250.00 per year on that account, for a total of $13,000.00 over four years.

[121] Taking all of these factors into account, I award the plaintiff $38,000.00 for loss of income after the 2002 accident, to the present.

DIMINISHED EARNING CAPACITY

[122] I have considered the principles of diminished earning capacity as set out in *Leddicote v. Nova Scotia (Attorney General)*, 2002 NSCA 47, 2002 CarswellNS 135 (C.A.) and *Mawdsley v. McCarthy's Towing & Recovery Ltd.*, 2010 NSSC 168, 2010 CarswellNS 334 (S.C.). It is clear that Dr. Robertson advised the plaintiff to stop working on account of new symptoms which she reported in 2010. Up until that point in time, the plaintiff had been working, albeit on a reduced schedule. Dr. Robertson’s evidence that it was the syncopal attacks and the related symptoms that caused her to put the plaintiff off work, and that these issues were not related to the car accidents. As has been noted, Dr. Robertson said that she would not have deleted the references to the accidents from the insurance form in

2010 if she had not been satisfied that the symptoms were unrelated to the motor vehicle accident.

[123] The plaintiff clearly has not suffered a total loss of earning capacity as a result of the 2002 accident. As should now be clear, her medical problems relate to her pre-accident condition, as compounded by the 2002 accident, and her current inability to work is attributable to causes unrelated to the accident. In these circumstances, in my view, the claim for any ongoing lost earning capacity from the motor vehicle accident is best addressed under the heading of general damages: see, for instance, *Warner v. 2331653 Nova Scotia Ltd.*, 2004 NSSC 142, 2004 CarswellNS 305, at paras. 67-73, and the cases cited therein.

GENERAL DAMAGES

[124] The plaintiff relies particularly on *Kuskis v. Tin*, 2008 BCSC 862, 2008 CarswellBC 1367, where the plaintiff suffered from ongoing headaches and neck and back pain before the accident that was the subject of the proceeding, although this pain did not significantly compromise her activities (paras. 28-29). The court held, at paras. 141-144:

> Ms. Kuskis has suffered a significant worsening of her painful pre-existing migraine disorder and a new form of headache due to her soft tissue injuries. She has also suffered a new form of low grade, but persistent, neck and shoulder pain. As a result of her increased headaches and pain, she is sometimes exhausted, irritable and unhappy. She is

> also less able to produce large volumes of computer-based work in short periods of time. Given her changed employment circumstances this compromised work capacity, though minimal, is a source of potential frustration and stress.
>
> Ms. Kuskis is a stoic and determined person. Despite her increased headaches and neck pain she remains physically active, upbeat and productive most of the time. She requires painful steroid injections, however, to control her increased neck and shoulder pain and associated symptoms. She also occasionally requires strong medication such as Oxycodone to manage her pain.
>
> Although Ms. Kuskis can work, travel and socialise most of the time without significant impairment, her personal life has been diminished by her increased headaches and pain. In particular, Ms. Kuskis' ability to form and maintain intimate relationships has been compromised by her increased irritability and fatigue. This, too, is a source of frustration and stress.
>
> Taking into account all of the circumstances and the referenced authorities I assess non-pecuniary damages at $65,000.

[125] The plaintiff seeks general damages of $55,000.00, submitting that her working capacity has been impacted more significantly than in cases such as *Kuskis*, *Terry v. Mullowney*, 2009 NLTD 56, 2009 CarswellNfld 85 ($40,000.00) and *Arsenault v. Léger*, 2003 NBQB 459, 2003 CarswellNB 588 ($35,000.00). The plaintiff relies particularly heavily on *Kuskis*. It appears to me that the effects of the accident upon the plaintiff's pre-accident condition were clearer in *Kuskis* than they are in this case. I note in particular the court's finding that the plaintiff in *Kuskis* did not have significant compromise of her activities before the accident. That is not the case here.

[126] In *Richard v. Arsenault*, 2002 NBQB 94, 2002 CarswellNB 97, a woman of approximately the Plaintiff's age suffered moderate whiplash and injuries to her neck and shoulder during a car accident. These injuries created additional symptoms, including sleep disruption, depression and dizziness. The plaintiff was diagnosed with chronic myofascial pain and prescribed pain killers. She received $45,000 in general damages. These injuries are quite similar to the Plaintiff's injuries; however, in *Richard* the plaintiff was in good physical health prior to the accident, a significant point of distinction with the present case.

[127] The defendants submit that the plaintiff’s injuries call for damages at the low end of the range described in *Smith v. Stubbert* (1992), 117 N.S.R. (2d) 118, 1992 CarswellNS 250, where Chipman J.A., for the majority, a range for “non-pecuniary damage awards for ... persistently troubling but not totally disabling injury” in the range of $18,000.00 to $40,000.00. That range has risen with inflation (see *Merrick v. Guilbeault*, 2009 NSSC 60, 2009 CarswellNS 208, where it was quantified, at para. 36, at $27,000.00 to $54,000.00 in 2009).

[128] It is clear that the plaintiff has suffered increased pain and discomfort, along with a decrease in earning potential, since the 2002 accident. The accident is not the sole cause of these issues; however it has clearly contributed to them. I am

satisfied on a balance of probabilities that her general damages for pain and suffering arising from injuries suffered in the 2002 accident should fall in the upper middle range of the *Smith v. Stubbert* scale. In addition, I am satisfied that the plaintiff has suffered a degree of diminished earning capacity as a result of the 2002 accident, albeit one that is virtually impossible to quantify and is best treated as an aspect of her claim for general damages.

[129] I believe that an appropriate starting point for a global amount of general damages for pain and suffering and for diminished earning capacity is $75,000.00. This amount is based on the plaintiff's injuries being at the upper middle range contemplated by *Smith v. Stubbert*. It is then necessary to apply a contingency to reflect the fact that the plaintiff had significant symptoms from the 1999 accident. She had only returned to the level of 80 per cent at the time of the 2002 accident. In 2008, Dr. King placed her level of disability at 25 per cent, placing her at a level of 75 per cent. In practical terms, the plaintiff ultimately found herself unable to work more than three days per week after the 2002 accident, compared to the four days she could work previously. Taking these figures as a general gauge of her working capacity – and inferring that she would have been unable to work more than three days per week in the future as a result of the 2002 accident – it is also

necessary to consider that her present inability to work at all is due to symptoms unrelated to the accident.

[130] Taking all of these factors into consideration, I believe an appropriate contingency reduction would be roughly 30 per cent. On that basis, I reduce the $75,000.00 global figure to $52,000.00.

COST OF CARE

[131] The plaintiff claims that she should be compensated for the cost of care, in particular, ongoing medication and massage therapy. Until July 2005, her medical costs were covered by the plaintiff's Section B insurer. After that, she paid these costs out of her own pocket.

[132] Although the plaintiff claims that she incurred expenses for medication prescribed between November 2006 and December 2009, there is no detailed evidence of these expenses. Although the plaintiff suggests that these are easily determined by reviewing earlier records (many of the prescriptions being refills), I am not prepared to accept that that the costs are as claimed by the plaintiff. It would have been appropriate to obtain detailed expense reports from the pharmacy in question. However, notwithstanding their absence, I am prepared to recognize

that the plaintiff did expend her own funds to pay for prescriptions, attend massage therapy and also cover such costs as gym membership.

[133] Certain of these expenditures were recommended or prescribed by physicians. Dr. Robertson recommended that she attend for massage therapy. Dr. King, too, thought that this would be helpful, although Dr. Gross was less enthusiastic, particularly where it was not recommended from the outset. I award the amount of $5,000.00 for the cost of past care.

[134] As to future care costs, both Dr. Robertson and Dr. King believe that the plaintiff would receive some substantial relief from massage therapy, injections, and perhaps Botox. She has declined to undergo a treatment of Botox largely due to the cost. Dr. King explained the benefits of Botox, and expressed the view that it could have positive benefits. I am satisfied that the value of this treatment is established on the evidence. Therefore, I award an amount of $10,000.00 for future Botox treatments. I also award $7,000.00 to cover the future cost of massage therapy.

LOSS OF VALUABLE SERVICES

[135] I am unable to accept the plaintiff's contention that the court should award $25,000.00 for loss of valuable services. Prior to the 2002 accident, the plaintiff was unable to do heavy housework and was not doing any outside work. She was relying on her son and her husband to assist her. Her son cleared snow, mowed the lawn and was responsible for the wood for the furnace. He also vacuumed and did other heavy lifting. Obviously, since the 2002 accident, the plaintiff has been forced to cut back on the amount of housework she is able to do. Her husband testified that he does almost all of it. Although they were relying on outside housekeeping prior to the 2002 accident, this has increased over time and is limited only by the cost of housekeeping services. Consequently, I award the amount of $7,000.00 on account of the cost of additional housekeeping services attributable to symptoms arising from the 2002 accident.

CONCLUSION

[136] Accordingly, the plaintiff shall be entitled to damages in the amounts of $38,000.00 for past loss of income, $52,000.00 for general damages, $5,000.00 for the cost of past care, $17,000 for costs of future care (Botox and massage therapy) and $7,000.00 for loss of valuable services.

[137] The parties may provide written submissions on costs by August 31, 2011 if they are unable to reach agreement.

LeBlanc, J.