IN THE SUPREME COURT OF NOVA SCOTIA
Citation: Bezanson v. Hayter, 2008 NSSC 280

Date: 20080926
Docket: SH 191553
Registry: Halifax

Between:

Alan Bezanson

Plaintiff

and

Travis Hayter

Defendant

DECISION

Corrected Decision:	The text of the original decision has been corrected on September 23, 2009 and replaces the previously distributed decision.
Judge:	The Honourable Justice Arthur J. LeBlanc
Heard:	January 7, 8, 9, 10, 11, 14, 15, 2008, in Halifax
Final Written Submissions:	March 28, 2008
Counsel:	Ms. Jean McKenna and Mr. Roger Shepherd for the plaintiff Mr. Grant Machum and Ms. Sheree Conlon for the defendant

By the Court:

INTRODUCTION

[1] This is an action for damages arising out of injuries allegedly caused by being struck by a golf ball. The plaintiff was struck in the area of the left wrist by a ball hit by the defendant. The plaintiff alleges that the manner in which the defendant hit the ball was negligent, and that the subsequent damage to his hand and wrist was caused by the golf ball.

THE GOLFING INCIDENT

[2] The plaintiff, George Alan Bezanson, was 38 years of age at the time of trial. He was born in New Glasgow, N.S.. The plaintiff had lived away from the area, but in 1995 he moved back. The plaintiff and his wife, Jennifer Bezanson, had three children aged eight years old or younger at the time of trial. Jennifer Bezanson works as a caregiver at a seniors' home. They began living together in 1998. The plaintiff and his family live in a house on a 254-acre farm property owned by his father. The property is half cultivated and half wooded. He does not earn income from the farm, but has access to meat, produce and wood. The plaintiff has done farm chores since he was five years old. He left school in grade eight and started working in the woods and using a power saw at 14 or 15 years of age.

[3] The golf match during which the plaintiff was hit by ball was organized in connection with the upcoming wedding of James (Jamie) Bezanson, the plaintiff’s cousin. According to the plaintiff, the defendant and Marvin Weeks, who were also in the wedding brought 28 beer and a

bottle of tequila to the course, and bought more alcohol after nine holes. The plaintiff did not drink any alcohol, but he did smoke some marijuana. He said Mr. Weeks and the defendant were drinking beer on the front nine. Mr. Weeks became more relaxed, while the defendant became belligerent. Jamie Bezanson said the defendant and Mr. Weeks had beer in their bags, and the defendant also had a bottle of tequila. He said the plaintiff consumed some marijuana on the front nine. Mr. Bezanson said the defendant and Mr. Weeks also used marijuana. He himself had one or two beer, but said he did not have any side effects, nor did the plaintiff appear to have any side effects. The plaintiff agreed that Jamie Bezanson drank two beer and appeared unaffected by the alcohol.

[4] On the back nine, the plaintiff said, Mr. Weeks and the defendant started to clown around while driving an electric cart, and nearly drove into a pond. At another point, the cart started to go down a gravel slope, with the defendant doing "power slides" by applying the brakes and sliding backwards. Jamie Bezanson agreed that the defendant and Mr. Weeks were showing the effects of alcohol. After the first nine holes they got an electric cart. He recalled them goofing around and fighting for control of the cart. He also saw the defendant smashing his clubs against trees. On the 15th hole – a short par three – the defendant shot his ball to the side or into the rough, and became angry. Mr. Weeks, Jamie Bezanson and the plaintiff walked ahead. The defendant was moody and was hitting trees with his clubs.

[5] The defendant described drinking on the golf course as normal and described drinking to excess as a part of any social occasion. He confirmed that he has smoked marijuana, although he

did not admit to smoking it on the day of the golf game, as Jamie Bezanson believed. He acknowledged in cross-examination that by the time of the shot that hit the plaintiff, he had consumed nine beer and half a pint of Baja Rosa tequila. He said the beer lasted until the ninth hole and he would have had five or six on the course. Between the ninth and tenth hole, he believed, he retrieved the Baja Rosa from the car. The defendant admitted to doing "power slides" with the cart on the fourteenth hole. He admitting to driving the cart on the side of a gravel mound but does not admit to having it turn over, as the plaintiff recalled. As to Jamie Bezanson's description of him as being belligerent, he acknowledged that he was mad at himself after playing the 15th hole badly, and swore and struck his club off trees as he walked to the 16th.

[6] On the 16th hole the defendant hit his first shot into the woods and took a second shot (a “mulligan”). The other players had moved ahead with their carts up the fairway. After the defendant’s mulligan, the other players started towards their balls. According to Jamie Bezanson, the plaintiff, Mr. Weeks and Mr. Bezanson walked together to the 16th hole and took their tee shots. Mr. Bezanson thought the plaintiff's first shot was perhaps 100 yards up the fairway, while his and Mr. Weeks’ were off the fairway. After the others had taken their shots, the defendant sliced his tee shot to the right and into the trees, and took a provisional second shot. At that point, Mr. Bezanson said, he assumed that the defendant was done.

[7] According to the plaintiff, at this point he heard someone call, “Heads up, he’s going to hit again.” He looked over his shoulder and saw the defendant behind the ball, then taking a run

at the tee before hitting it, a so-called “Happy Gilmore” shot (named for a film character). Prior to the call of “heads up”, the plaintiff testified, there was no warning that the defendant was going to take another shot. Jamie Bezanson’s evidence was that he was about ten to 20 yards up the fairway, beyond the end of the cart path, when he heard someone yell “heads up.” He and the plaintiff turned around and faced the tee. The plaintiff was ten yards behind him on the fairway. The two of them were looking back towards the defendant while moving left, towards the trees. They had not reached the trees when the defendant ran up and hit the ball. Mr. Bezanson said the ball came straight at the plaintiff, who had a “millisecond” to react. Mr. Bezanson said he had thought the defendant would walk back to the ball in the normal manner, which would give himself and the plaintiff time to get out of the way. Instead, the defendant made a “Happy Gilmore” shot, running from five to ten feet behind the ball and hitting it on the run. Mr. Bezanson had seen the defendant do this before. He considered it a difficult shot to control.

[8] The defendant claimed that as they approached the sixteenth hole "the party was good," contrary to the evidence of Jamie Bezanson and the plaintiff. His first ball off the 16th tee sliced into the woods on the right. On his second shot the ball "dribbled up the fairway". Before hitting the second shot, he testified, he told the other players that he was going to hit again. He said Marvin was in the power cart and that the plaintiff and Jamie Bezanson had started away from the tee together after his second shot. While they were on the pathway he said, "well I'm going to shoot again" and went to the cart to get another ball. In his direct evidence he said Marvin was in the cart. He then said Marvin was "a bit up the path". He confirmed that he went

back, re-teed his ball, and did a “Happy Gilmore” swing. He stepped back five or six feet from the ball and took two full steps up to the ball. He said the plaintiff was off to the left of the cart path. He claimed the ball went off the heel of the club. He admitted that it happened quickly and that the plaintiff put his arm up to block the ball. He agreed that after the ball struck the plaintiff, both Marvin and Jamie were angry with him.

[9] On discovery in June 2003, and again in June 2005, the plaintiff said he had taken shelter in the trees to the left of the fairway, along with Mr. Weeks, when the ball was hit. At trial, however, he could not recall exactly where he was, but believed he was on the fairway. With respect to the plaintiff’s location when the defendant took the shot, Jamie Bezanson was firm in stating that the plaintiff was not in the woods with Mr. Weeks, as the plaintiff had stated on discovery. The plaintiff says Jamie Bezanson’s evidence is preferable to his own on the question of where he was when the ball hit him. The plaintiff denied that his recollection was unclear as a result of marijuana use on the day of the game. He said he had smoked one-and-a-half-joints, all before the third hole. Jamie Bezanson testified that he did not notice any effects of marijuana on the plaintiff. Further, the plaintiff submits, his recollection is reasonably clear with respect to other events of the day.

[10] According to the plaintiff, the defendant's description of the location of the Bezansons is illogical, as there would be no reason for them to leave the cart path before they reached the end, particularly given the undisputed location of their balls, directly up the fairway. The plaintiff submits that the defendant's evidence as to the location of Marvin on the cart also conflicts with

his discovery evidence, where he located the golf cart as ahead and up to the crest of the hill on the left side.

[11] As to the impact itself, the plaintiff testified that he saw the ball coming towards him, straight and fast. He put his hand up. The ball hit his left wrist, glanced off, and hit him in the chest. He dropped to the ground. According to Jamie Bezanson, it looked like the plaintiff had been shot or struck in the head. They were standing about 20 feet in elevation from the tee, and the shot was low. If not for the plaintiff standing where he was, Mr. Bezanson believed, the ball would have hit him. The plaintiff fell to the ground immediately upon being hit. Mr. Bezanson said he swore at the defendant. The plaintiff said he was in excruciating pain and stayed down for a couple of minutes. His hand was initially red in the wrist and palm area, then turned black. He did not seek medical attention before the wedding.

[12] The defendant claimed that he never hits a ball to the left off the tee, but that he is a "slicer," meaning that his shot curves to the right. The plaintiff points out that on discovery the defendant admitted that on occasion he would hit a shot to the left down the fairway. In cross-examination the defendant acknowledged that normally he would tee his ball up and then stand some distance behind it, with his club pointing towards the target, in order to establish the proper line for the shot. He would then approach the ball taking a stance with his left shoulder pointing at the green, facing 90 percent from the anticipated flight path. He agreed that any number of variables could affect the flight of the ball – such as hand position, an open or closed club face, and head position – and he agreed that it was important to eliminate or control as

may of those variables as possible and to establish a firm and steady base. It was put to him in cross-examination that with the "Happy Gilmore" swing there was no solid base and in fact the entire body was moving. He claimed to be comfortable shooting it. He agreed that from the perspective of players ahead of him, by taking a stance several feet behind the ball he would appear to be preparing to set up prior to a normal swing. This, the plaintiff submits, would lead his fellow players to believe that it was safe to after he had hit his second shot.

[13] With respect to the location of the other players, the defendant agreed that Jamie Bezanson and the plaintiff were close together, with the plaintiff nearer to him. He agreed that after his second shot it would have appeared to them that he would play that shot, as it was on the fairway, and that therefore they could proceed up the fairway safely. He knew that they were ahead of him and to the left, but he hit his "Happy Gilmore" shot without waiting for them to get out of the way. He agreed that he did not tell them that he was about to hit a "Happy Gilmore." The defendant maintained that he can reliably hit a "Happy Gilmore" shot.

[14] I am satisfied that the plaintiff and Jamie Bezanson were in the positions indicated by Jamie Bezanson when the defendant, having already made a provisional “mulligan” shot that landed on the fairway (thus leading the other players to believe he was finished at the tee) and took a running wind-up in order to shoot a “Happy Gilmore” shot, which flew directly at, and hit, the plaintiff.

ARGUMENT ON STANDARD OF CARE

[15] According to the plaintiff, the defendant is liable for his injuries sustained as a result of being hit by the golf ball. The defendant, having consumed an “excessive” amount of alcohol, “hit the ball in a manner that cannot even be described as a golf swing and he did so at a time when his fellow players were ahead of him.” The other players, it is submitted, were vulnerable, and the defendant could not control his swing. While the plaintiff has no explanation for the confusion in his own version of events, he submits that the evidence of Jamie Bezanson, “who was not intoxicated,” should be accepted. The plaintiff submits that it is "completely unreasonable" to suggest that the defendant could reliably hit a "Happy Gilmore" shot, let alone after consuming at least nine beer and half a pint of tequila.

[16] The defendant says he shoots with a consistent slice to the right, which he has been unable to correct. He says the only difference between a normal swing and a “Happy Gilmore” swing is the run-up, and said the “Happy Gilmore” swing tends to give more distance. He points to Jamie Bezanson’s evidence that he had seen it done before. He says there was nothing unusual in the way he played, nor in swearing and swinging his club after a bad shot. The way he was “playing around” in the golf cart was likewise “not unexpected during a bachelor party,” he says. He says that, while he was “feeling the effects” of alcohol, he was not intoxicated.

[17] In any event, the defendant says, his conduct is irrelevant, as the only relevant issue is how the incident occurred and, in particular, where the plaintiff was standing when the defendant took his shot. According to the defendant, the plaintiff and Jamie Bezanson had moved up the

cart path and were to the left of the tee. Before shooting, the defendant claims, he "looked at the others, including the plaintiff, to make sure they were well out of his trajectory. He made eye contact with them. He was satisfied they were aware he was taking another shot...". According to the defendant, the plaintiff was "well out of the way of the anticipated trajectory and only marginally forward of the tee.... [N]o where near where [the defendant] intended and expected to hit the ball." He says the plaintiff was standing beside the path, to the left of the tee.

[18] An injury sustained a result of a broken rule will not, by itself, impose liability: *Agar v. Canning* (1965), 54 W.W.R. 302. Nor will every accident on a golf course result in liability. In *Ellison v. Rogers* (1967), 67 D.L.R. (2d) 21 (Ont. H.C.), an unexpected hook of a shot by a player who usually sliced the ball was not a basis for liability for hitting another player, as it was not foreseeable that his ball would go where it did. The plaintiff says *Ellison* is distinguishable on the basis that in that case the defendant was sober and was using a normal swing, and that the plaintiff was on another fairway. In this case, the plaintiff says, the defendant failed to exercise the "scrupulous standard of care" required in playing a ball (see *Pope v. RGC Management Inc.*, 2002 ABQB 823).

[19] The defendant argues that the plaintiff consented to the natural risk of golfing, and had an obligation to take care for his own safety. If he had believed his position was unsafe, he should have taken steps to get out of danger. The defendant says the course of the shot was not predictable and, in any event, he was not negligent.

[20] I am satisfied that the defendant breached the standard of care owed to other players on the course. Having taken his tee shot, and then a provisional second shot, he was, or ought to have been, aware that the players ahead of him believed he was finished at the tee. He did not give any indication that he was taking a third shot – let alone a "Happy Gilmore" shot – until he was in the process of doing so. I am convinced that the "Happy Gilmore" shot would have been less controllable than a normal tee shot, both because it involved a run-up to the ball (rather than an aimed shot from a stationary position) and because the defendant had been drinking throughout the day. The defendant acknowledged that he knew the plaintiff (as well as Jamie Bezanson) was ahead of him, that he did not announce he was about to take another shot, and that he did not wait for them to get out of the way. I ascribe no relevance to whether the defendant had taken a "Happy Gilmore" shot in the past or to whether any of the other witnesses had seen him do so. The defendant's conduct breached the standard of care required of a golfer playing on a course with other golfers. The defendant's behaviour was not among the "natural risks" of golfing to which the plaintiff can be said to have consented. Nor is it of much significance whether the defendant usually pulled or sliced the ball.

MEDICAL EVIDENCE

[21] At the outset, I note that the medical evidence before the court was broad in scope and addressed a great many issues and complaints that have affected the plaintiff throughout his life. While I have not gone into detail on all of these issues, I emphasize that I have considered all of the medical evidence that was before the court.

Dr. Robert Bush

[22] Dr. Bush is the plaintiff's family physician. He has practised in the Tatamagouche and River John area since 1993. He was qualified as an expert in family medicine in a rural practice. He reviewed the plaintiff's medical history, based largely on MSI and Workers Compensation Board records. The records suggested that the plaintiff had experienced back problems, and had been treated for osteoarthritis, among other things, in the early 1990s, and had consulted various physicians before he became Dr. Bush's patient. Dr. Bush suggested caution with respect to the MSI records, stating that they were "billing requirements." In the absence of medical evidence beyond the bare records, I do not make any findings as to the plaintiff's state of health prior to becoming a patient of Dr. Bush, beyond concluding that there is some evidence that the plaintiff had some health problems since his youth. Dr. Bush has indicated that the plaintiff was reporting abdominal pain and shoulder problems several years before the carpal tunnel surgery.

[23] In 1997, the plaintiff consulted Dr. Bush about hand and wrist pain and stiffness. He was experiencing numbness and tingling in both hands, which became worse when he worked with a chainsaw. Dr. Bush referred him to Dr. M.S. Sebastian, who performed surgery for bilateral carpal tunnel syndrome, first on the left wrist and then on the right, in January and March 1998. In April 1998, Dr. Bush reported to the Workers' Compensation Board (WCB) that the plaintiff had a prognosis of improvement over the next three to four months. Dr. Bush agreed that recovering from carpal tunnel surgery can take an extended time in order for the nerve to regrow

from the spinal cord, at about one foot per month. He agreed that the WCB took the view that the plaintiff should take up other employment.

[24] After the carpal tunnel surgery, the plaintiff continued to have pain, sometimes prolonged, more on the left side than on the right. He saw Dr. Bush frequently in 1998 and 1999. In early April 1998 the plaintiff complained of left wrist pain and tenderness around the left flexor pollicis longus, for which Dr. Bush gave an injection for tendonitis.

[25] In June 1998 Dr. J. Patil conducted EMG studies and reported that there was "no clear-cut electrophysiologic evidence of a generalized peripheral neuropathy." The findings in the median nerves (in the wrists) suggested "a very mild early bilateral carpal tunnel syndrome" and could also represent "stigmata of a fairly advanced old carpal tunnel syndrome." Dr. Bush reported to WCB that the plaintiff had ongoing bilateral hand weakness, and that EMG studies done by Dr. Patil showed chronic bilateral carpal tunnel syndrome. Over the next several months the plaintiff complained of numbness and weakness in his hands. According to a report after a visit on August 11, Dr. Bush noted that the plaintiff was unable to hold vibrating instruments. The prognosis remained stable.

[26] In September 1998 the plaintiff underwent a hand assessment by an occupational therapist, who suggested a course of work conditioning, with a hand program designed to strengthen his upper extremities. The therapist's report also suggested that the plaintiff would

benefit from custom wrist splints, in place of the commercial splints he had been using, in order to maintain his wrists in a neutral position.

[27] In a report to WCB on November 10, 1998, Dr. Bush stated that the plaintiff's condition was chronic. In December he wrote that it was unlikely to improve. In a referral to Dr. Patil in December 1998, he wrote that he did not think there was anything further he could do. After further EMG testing in September 1999, Dr. Patil had again reported that there was "no clear-cut electrophysiologic evidence of a generalized peripheral neuropathy," but that there were findings suggesting "a very mild, bilateral carpal tunnel syndrome," as he had observed in June 1998. He again added that "this abnormal finding could represent a stigmata of a fairly advanced, old carpal tunnel syndrome." There had been no "progression in the electrodiagnostic parameters of the median nerve" since June 1998. Dr. Patil wrote that the findings were "not convincing of a recurrence of carpal tunnel syndrome."

[28] In January 1999, the WCB notified Dr. Bush that, as the plaintiff had "plateaued and there has been no change to his condition, the only Physician's Report required at this time are those noting any changes in the compensable condition." The plaintiff saw Dr. Kevin Bourke for the purposes of a WCB permanent medical impairment assessment in October 1999. Dr. Bourke noted weakness in the hands (the right worse than the left), particularly when grasping objects. He indicated that the plaintiff had difficulty with manual tasks requiring grip/pinch strength. There was also "burning thumb discomfort bilaterally. As a result of the finding of permanent

medical impairment by Dr. Bourke in October 1999, the plaintiff received a lump sum payment of $4,429.06. The plaintiff's appeal of this decision was dismissed in July 2000.

[29] In January 2000 Dr. Bush referred the plaintiff to the Nova Scotia Rehabilitation Centre to be fitted for bilateral wrist splints, as suggested by Dr. Patil. In August 2000 Dr. Bush referred the plaintiff to an Orthopaedic Surgeon, Dr. Gerald Reardon, for consultation respecting recurring dislocation of his left shoulder. In July 2001 the plaintiff had surgery to remove his gall bladder. He acknowledged at trial that he had experienced complaints in his flank and abdomen over the years, and that his back and abdominal pain had been investigated. He said that once he had his gallbladder removed these symptoms disappeared and never returned.

[30] The plaintiff was hit by the golf ball on June 8, 2002. There was immediate discoloration, and the pain was such that he became unable to handle a chainsaw in the days after the accident. He saw Dr. Bush on June 17. At trial Dr. Bush described the area of impact as "the palmar aspect," that is, the palm side. The impact, he believed, based on the plaintiff's description, was at the base of a lump of muscle at the base of the thumb called the thenar eminence, at the base of the first metacarpal, on the palmar aspect (i.e. the palm, or interior, side of the hand). The plaintiff had tingling in the left hand, called median nerve neuroproxia. This resolved, but the plaintiff then experienced significant wrist pain. He was also resisting flexion and there was tenderness along the tendon.

[31] In early July 2002 the plaintiff reported “ongoing left wrist pain and ... tingling in his left medial nerve distribution following local trauma of his flexor reticulum” (as Dr. Bush described it in a letter to Dr. Patil requesting more EMG studies). Dr. Patil’s finding from an EMG study conducted in September 2002 suggested “a recurrence of left carpal tunnel syndrome of mild degree” but “no evidence of recurrence of right carpal tunnel syndrome.”

[32] On December 20, 2002, Dr. Bush reported to Canada Life, in response to an inquiry about s disability claim made by the plaintiff, that the plaintiff had “significant daily left hand and wrist pain and he tells me that he is unable to grip to hold his chain saw.” On February 18, 2003, he noted that the plaintiff had chronic pain and could not hold a chainsaw. There had been no change in the plaintiff’s functioning since September 2002, and he informed Canada Life that the plaintiff was “completely disabled from doing his work.”

Dr. Michael Brennan

[33] Dr. Bush referred the plaintiff to Dr. Michael Brennan, a plastic and reconstructive surgeon. Dr. Brennan practices in Antigonish through St. Martha’s Hospital. He is a plastic and reconstructive surgeon, with about one third of his practice relating to hands, including carpal tunnel syndrome. He was qualified as an expert in plastic and reconstructive surgery with experience and expertise with respect to hand surgery and the nerves associated with the hand. Dr. Brennan completed an outpatient consult note when he saw the plaintiff on February 19, 2003. He recorded that the golf ball apparently hit the plaintiff “at the base of the thenar

eminence of the left wrist." He had "associated swelling and tenderness of the hand, particularly the wrist area, which thereafter subsided. He has since been left with a burning type of discomfort at the site of trauma that is particularly bothersome at night." There was continuing weakness in the left hand, and numbness "along the dorsal base of the thumb and index finger." The symptoms became worse with increased activity. There were "insignificant" scars from the carpal tunnel surgery. He went on:

> "... He had no swelling of the wrist or hand evidence. I felt he had good color and warmth of both hands as well as reasonable muscle bulk of the thenar eminence and good strength testing of the abductor pollicis brevis muscle. He had a negative Tinel's sign bilaterally as well as a negative compression test over the median nerve. He did, however, have a positive Finkelstein's test. The wrist was particularly tender in one spot, more or less over the tubercle of the left scaphoid. The scaphoid did not appear to be unstable, however. He appeared to have some tenderness over the first dorsal compartment of the left wrist."

[34] At trial Dr. Brennan explained that the Tinel sign and the compression test are "provocative tests ... to determine if the median nerve is irritated or agitated.... [A] Tinel sign could be administered over ... any nerve and is simply a shock-like sensation that you would have at the level of ... injury or insult or further downstream." As an example, he described testing the carpal tunnel, with the "insult" being located where the nerve is compressed. In that instance, he said, "you could tap on the nerve distribution downstream," or, in medical terms, distally. He said, "you can start tapping distal and working your way towards ... the area of the carpal tunnel and you might get a positive Tinel sign anywhere between the fingertips and the carpal tunnel. You might only get it directly over the area of compression or it could be further down," i.e., further distal. As to the compression test, Dr. Brennan said it involves placing a

thumb “directly over the median nerve at the zone of most compression,” and holding it there for up to a minute. A positive test would occur where, within that time frame, the patient developed numbness, pain or an odd feeling in the median nerve distribution. The Finkelstein’s test is “a provocative test to look at tendinitis in the wrist area.” It is “performed by dropping the wrist towards the floor and then flexing the thumb towards the little finger across the palm ... to see if that will elicit pain.” In the plaintiff’s case, the tendons affected by the Finkelstein’s test lay in the “direct vicinity” of the wrist scars.

[35] Dr. Brennan did not believe there was any residual carpal tunnel syndrome. There appeared to be “two problems ongoing”: “neurogenic pain from where the golf ball hit him.... [A] neuropraxic injury giving him this deep burning dyesthetic type pain, his major problem.” He suggested a referral to the Chronic Pain Clinic and splinting. At trial he confirmed that neurogenic pain had its origin in a nerve. He described ‘neuropraxic” as meaning “a deep bruise so if one’s struck with ... a blunt instrument, they could develop a neuropraxic injury that often will resolve on its own ... but may not.” He believed that the injured nerve in the plaintiff’s case was the radial sensory nerve, which, as he put it, “supplies the dorsal aspect of the thumb and the index finger.”

[36] The second problem Dr. Brennan identified as De Quervain’s tenosynovitis, based on the positive Finkelstein’s test. He had suggested a steroid injection for this issue, but reported that the plaintiff refused, “as he felt steroids were of no value to him.” At trial he explained that this disorder involves an inflammation of the synovial lining around the tendons in the relevant area,

generally arising from trauma, hyperactivity, overuse or repetitive strain, often in people who work with their hands. If it were caused by trauma, it would be a blunt trauma in close vicinity to the compartment where the tendons were affected. He said a reasonable "zone of injury" would be five or six centimetres in a circle around the area affected, in the plaintiff's case the base of the thumb. He demonstrated the area he was discussing with a golf ball.

Dr. Winston S. Parkhill

[37] Dr. Parkhill was qualified as an expert in hand and wrist surgery. After a consultation on April 23, 2003, Dr. Parkhill reported that the diagnosis was unclear. He described the impact as being on the volar radial wrist. At trial he agreed that this meant an impact "somewhat to the volar, somewhat to the radial. He noted that there was no Tinel's sign; at trial he described Tinel's sign as "a clinical way of assessing nerve function," explaining that "if you take a nerve along its distribution and ... go from distal to proximal ... the point of irritation will be felt as a tingling and pain. It may come out that ... the nerve has been injured or compressed or cut...." There did not appear to be "a DeQuervain's tenosynovitis as his Finkelstein's test was negative." There did not appear to be a significant vascular injury. Dr. Parkill suggested that "[a]n unrecognized ganglion or diffuse soft tissue injury may explain the presentation." He called for an MRI of the wrist. At trial he described a "diffuse soft tissue injury," noting that the plaintiff was hit by a golf ball, "and if you hit a golf ball on something hard, it bounces back ... hit it into grass it will cause a divot. So it's analogous to what ... if he was hit with a golf ball and he has a

soft tissue injury, it could ... cause injury right directly where it was hit. But it also can cause changes in the soft tissues....”

[38] The plaintiff saw Dr. Parkhill again on June 3, 2003. Dr. Parkhill reported to Dr. Brennan that he could not add anything to Dr. Brennan’s injections for a possible DeQuervain’s tenosynovitis. Dr. Parkhill said he did not see any symptoms of reflex sympathetic dystrophy. In his report of June 22, 2006, Dr. Parkhill wrote that the plaintiff “has had a chronic pain syndrome complex similar to sympathetic dystrophy of his left hand and wrist and forearm for the past four years,” a description that he said at trial was based on the history, although he had not seen it in 2003. Dr. Parkhill said he observed no symptomology between 2003 and 2006 that he would attribute to carpal tunnel syndrome.

[39] In June 2006 Dr. Parkhill performed surgery on the plaintiff’s left wrist. This involved exploration of the left wrist at the radial aspect of the wrist and up into the forearm; neurolysis; and a release of the first extensor compartment. Dr. Parkhill reported that the radial nerve “looked fine distally. There were no areas of neuroma formation on the radial nerve. We also explored his first extensor compartment, identified the extensor pollicis brevis and the abductor musculature. This was totally free, and the patients digits moved through the first extensor compartment without any difficulty.” He noted that the nerve was “running quite normally in its path.” He concluded that the plaintiff’s symptomology was directly related to the area explored.

Dr. Ian Beauprie

[40] Dr. Beauprie is a staff anesthesiologist at the Queen Elizabeth II Medical Science Centre in Halifax. He spends half his time with the pain management unit. While he has no special expertise in wrist conditions, he has significant experience with nerves, which represent the majority of his work. He was qualified as an expert in pain treatment and diagnosis, including complex regional pain syndrome, nerve stimulation and neuropathic pain.

[41] Dr. Beauprie explained (in his 2005 report and at trial) that there are three important nerves in the wrist and hand:

> "The median nerve typically provides sensation to most of the palm and the palmar aspect of the index and long finger. This is the [nerve] commonly entrapped in carpal tunnel syndrome.... The ulnar nerve is on the side of the wrist opposite the thumb. It gives sensation to the little and sometimes to half of or all of the ring finger on the palm side and back side of the hand and fingers. The radial nerve is purely sensory, not a motor at the wrist. It emerges from a muscle in the distal third of the forearm and takes a somewhat variable course and branches variably. This means there are some differences from person to person. Typically it provides sensation to the back of the hand, thumb and first two and [a] half fingers. Most physicians recognize it as a nerve only involving the back of the hand. However, it travels on the very lateral (radial) aspect of the forearm and branches of it can innervate the palmar side of the thumb. This nerve is liable to injury by placement of intravenous needles. It could also be injured by trauma on the radial (lateral) side of the wrist." [report, October 20, 2005, pp. 4-5.]

[42] In his 2005 report Dr. Beauprie stated that on his first consultation with the plaintiff, on July 19, 2004, he "noted some swelling of the thumb in the left compared to the right" and "some weakness of the muscles in the left hand." There was "localized tenderness over the

typical location of the radial sensory nerve in the left forearm." He found "slight thickening in the forearm over this radial nerve location about 4-5 cm back from the tip of the radius forearm bone." He also observed "decreased sensation to light touch over the cutaneous sensory branch of the radial nerve," which was tender, "as was the wrist joint at the base of the thumb." There was reduced range of motion of the left side of the neck, tenderness of the left occipital nerve and "trigger points on the left shoulder muscles." There was a temperature asymmetry between the two hands, 35 degrees on the left versus 37 degrees on the right.

[43] Dr. Beauprie's physical findings varied slightly on subsequent visits. During consultations in 2004 and 2005 he noted pain from a non-painful stimulus (allodynia) and light touch over the wrist and base of the thumb;" decreased sensation to pinprick; and exaggerated sensation to cold alcohol wipes. He described these as "typical features of injury to a sensory nerve." On other visits there was "tenderness in the radial aspect of the distal left forearm" and the left hand was "dusky, swollen and sweaty compared to the right," and there was again temperature asymmetry between the hands. At trial he said decreased sensation would suggest that "that there is decreased function of the sensory nerve in that area, so that would be the radial sensory nerve."

[44] As to treatment, Dr. Beauprie initially recommended Nortriptyline and a switch from MS Contin to Methodone. At trial he said Nortriptlyine would have less severe side effects than Amitriptlyne. In his initial consultation, Dr. Beauprie administered a radial nerve blockade approximately ten centimetres proximal to the wrist with Medrol and bupivacine. He thought

that this significantly decreased the pain. Gabapentin was used for the left wrist pain. At first it was extremely helpful, but the side effects, most commonly sedation, became intolerable. Dr. Beauprie said neurontin is the same as Gabapentin, and would have the same effect, making the user "sleepy, slow thinking, drowsy, tired, fatigued." While he noted that the plaintiff had found marijuana useful for pain relief, Dr. Beauprie said at trial that marijuana was a therapy that was beginning to emerge and that "mainstream evidence is beginning to support [marijuana] as a treatment of neuropathic pain," although he did not claim any expertise on this point.

[45] On February 17, 2005, Dr. Beauprie noted a modest pain reduction with a combination of Methodone and radial sensory blocks. He performed a stellate ganglion block of the radial sensory site and several centimetres proximal to it. He described the block as "an injection into the front part of the neck beside the voice box" whose purpose is "to freeze the sympathetic nerves of the arm." The stellate ganglion block and left radial sensory block were repeated on May 26, 2005. At trial Dr. Beauprie said introducing the blocks was an attempt to reset the pain threshold; he likened it to a computer rebooting. He said there was some benefit as a result of the introduction of the stellate block and the radial sensory block.

[46] In September 2005, the plaintiff was switched to slow release Morphine. Dr. Beauprie noted that "Gabapentin has not been overly successful, nor has nortriptyline, methadone or morphine." Dr. Beauprie suggested Pregabalin, a neuropathic pain drug, in place of Gabapentin. He administered a third stellate ganglion block. At trial, Dr. Beauprie stated that at this time he could report that there was no carpal tunnel issue.

[47] As of October 2005, Dr. Beauprie reported that despite his treatment, the plaintiff had "made relatively little or no progress. He remains considerably limited by his left hand and wrist." This resulted in difficulty with household and farm chores, and meant that "he can not continue his work as a woodcutter." With respect to diagnosis, Dr. Beauprie wrote that the plaintiff "suffered a blunt impact to his left wrist area." The plaintiff's description and re-enactment of the ball "hitting the volar aspect of the wrist and bouncing to the chest ... suggest that the force was delivered to the most lateral (radial i.e. close to the thumb) side of the wrist." The plaintiff's subsequent symptoms were "typical features of neuropathic pain extending into the thumb." The physical examination was "consistent with altered pain and sensation in the radial sensory nerve at the wrist." The swelling, colour change and temperature asymmetry that had been recorded were consistent with complex regional pain syndrome (CRPS), formerly known as reflex sympathetic dystrophy (RSD). Dr. Beauprie concluded that, based on the "history of injury in a location typical for a nerve, findings and description of a neuropathic pain, altered sensation of a known distribution of a cutaneous nerve, and symptoms and findings consistent with [CRPS], the diagnosis is ... complex regional pain syndrome type II."

[48] Dr. Beauprie wrote that the CRPS type II diagnosis effectively included "a nerve injury together with secondary sympathetic nervous system features." In addition, there was a possibility of tendonitis in the wrist; however, Finkelstein's test was "neither sensitive or specific given the radial sensory nerve injury." A bone scan ruled out actively inflamed synovitis. Tenderness over the antomic snuff box and the wrist raised the possibility of

traumatic wrist joint injury. An MRI of the wrist in May 2003 ruled out large-scale anatomic injury to the joint structure, and the bone scan ruled out inflammation. Neither of these, however, ruled out pain. He went on to state that finding:

> "...a mixed picture of tendon joint and nerve injury together with the sympathetic features of RSD is not unknown. Wartenburg's syndrome ... is a painful syndrome involving the radial sensory nerve which has tendonitis in about 50% of the cases. Radial sensory nerve injury is [not] unknown to anesthetists, as the nerve is beside a large vein."

[49] Dr. Beauprie noted in his 2005 report that diagnosing CRPS "is often challenging," with "typical diagnostic criteria of an initiating noxious event, continued pain, allodynia or hyperalgesia disproportionate to the event" as well as "swelling, changes of skin blood flow (temperature change) or abnormal sweating, motor function, dystrophy or atrophy." Given that the plaintiff's injury featured "allodynia, hyperalgesia, swelling, temperature asymmetry, impaired motor function and ongoing symptoms of cold related hyperalgesia," Dr. Beauprie's view was that the diagnostic criteria for CRPS were met. He noted that it is not unusual for patients "to have variability in their findings from day to day or even hour to hour."

[50] Dr. Beauprie went on to remark that in most cases of complex regional pain syndrome and sensory nerve injuries the injuries are too small to be seen on MRI. They do not show up in x-rays, not being bony injuries. Without active inflammation bone scans are not useful. Most importantly, EMG and nerve conduction studies tend to determine the function only of large motor and sensory fibres. He added that few neurologists do nerve conduction studies of the small, delicate sensory nerves. Dr. Patil investigated the motor function of the median and ulnar

nerve and the sensory function of the median and ulnar nerve, but not the radial sensory nerve. While “Dr. Patil is a very experienced electromyagrapher ... to my knowledge, [he] does not possess the equipment to do small fibre electro diagnostic studies,” Dr. Beauprie wrote.

[51] In his October 2005 report, Dr. Beauprie observed that there had been little improvement over the three years since the injury, and stated that as “a general rule of rehabilitation ... a patient who has been off work due to disability for two year[s] has a less than 2% chance of return to work.” He placed the plaintiff’s chance of returning to his previous capacity with a chainsaw as less than ten percent. He saw little prospect of further treatments, noting that surgery, in the context of CRPS, may be associated with a worsening of symptoms.

[52] Dr. Beauprie commented on causation, offering the opinion, based on the patient history as well as other physicians’ notes, that the plaintiff’s symptoms and physical findings could have arisen from the injury described. He wrote that it was “entirely possible” that the pain, radial sensory nerve injury and complex regional pain syndrome could have resulted from “a forceful but glancing blow to the volar/lateral aspect of the wrist by a golf ball.” The pain that would typically result from working with a chainsaw, he stated, would more likely take the form of carpal tunnel syndrome or tennis elbow, either of which would have a “relatively gradual onset” instead of “the sudden onset of the condition following the golf ball injury....” Dr. Beauprie did not believe that the findings were typical for a re-aggravation of carpal tunnel syndrome, or “a primary tendonitis associated with overuse of a chainsaw.” As such, he did not think that pre-existing conditions were important in relation to the chief existing complaint.

[53] Dr. Beauprie's view of the angle at which the ball hit the plaintiff differed from that of Dr. Sapp (discussed in more detail below). If the ball struck square on the wrist, as suggested by Dr. Sapp, Dr, Beauprie believed, it would have ricocheted "more or less straight away from the patient," while if, as he believed, it glanced off the radial (thumb side) of the wrist, it would have deflected downwards towards the chest. He added that the"edge of the wrist or distal forearm is a typical location for the radial sensory nerve or its branches."

[54] In a subsequent consultation report, dated February 9, 2006, Dr. Beauprie reported that the left hand was "obviously sweatier compared to the right" and there were colour and temperature variations. change that varied during the day. The radial sensory nerve at the base of the thumb was "very tender to palpation with cutaneous allodynia at the base of the thumb on the left." There was increased pain with finger movement and fist clenching. The diagnosis remained radial sensory nerve injury with complex regional pain syndrome type 2, although Dr. Beauprie added that there was possible aggravation of the previously treated carpal tunnel.

[55] Dr. Sapp, an expert for the defence, wrote (in a supplemental report dated September 6, 2005) that Dr. Beauprie's statement that "motor strength of the radial nerve and median nerve in the left hand is decreased over the right" was "anatomically incorrect in regards to the radial nerve," which "does not innervate or control movement of any muscles within the left hand." It was put to Dr. Beauprie at trial that the median nerve is not a motor nerve. Dr. Beauprie acknowledged that "the radial nerve is not motor in the hand...." It was, he said, "a less then

perfect choice of words ... what I'm doing is testing strength of wrist extension by pulling on the back of the hand and having the patient pull against me and that tests radial nerve strength." The muscle is in the forearm, so that, "while I'm pulling on the hand, I should say it's radial nerve innervated strength of wrist extensors." He had stated it as "motor strength of the radial nerve. Indeed it's motor strength of the radial nerve but not in the hand." He said he was referring to "the dorsal or back aspect of the forearm." With respect to the decreased motor strength of the left over the right, Dr. Beauprie confirmed that he had tested the strength of the right hand in the same distribution, and there was a difference between the two.

[56] As to his statement that the plaintiff was "exquisitely tender ... over the course of the radial sensory nerve from approximately mid forearm into the anatomical snuffbox," Dr. Beauprie explained that "it wouldn't be precisely halfway down the forearm, but perhaps a few centimetres further down than that" where the "side of the forearm, that leads to the base of the thumb was tender." The anatomical snuffbox, he said, "is not as easily seen in someone who has a little wrist swelling like [the plaintiff], but it's a little concavity formed by two or three tendons at the base of the thumb when you extend the wrist and the thumb."

[57] Dr. Beauprie confirmed at trial that he had not seen "any reflection of any issue regarding [the plaintiff's] previous carpal tunnel injury" at the time of his 2004 report, nor had he seen "anything reflective of [the] previous carpal tunnel injury at any point over the course of ... treatment to date."

[58] Dr. Beauprie took the view that the angle of the golf ball strike as he understood it differed from the angle as understood by Dr. Sapp. The ball hit the wrist, bounced off and hit the chest. If it had struck squarely on the wrist the ricochet would have been more or less straight away from the plaintiff, in Dr. Beauprie's view. However, if the ball struck a glancing blow on the radial (thumb side) of the wrist, with the plaintiff's arm up in front of his face and his palm facing outward, the ball would be deflected down towards his chest. As it happened, this edge of the wrist or distal forearm is a typical location for the radial sensory nerve or its branches.

[59] With respect to causation, Dr. Beauprie stated in a subsequent report, dated May 19, 2006:

> "There are patients who develop complex regional pain syndrome after repetitive or trivial injuries. There are patients who develop Wartenberg syndrome after repetitive heavy use such as using a chainsaw. However, it is also very possible for Mr. Bezanson's complex of signs and symptoms to develop following a trauma to the wrist area. Most treating physicians would determine cause based on the history given by the patient rather than by the physical examination findings when seeing the patient well after the injury. In a medical legal case a corollary history from other sources is obviously important. I think a great number of physicians could gather and argue over subtle points of radial versus median nerve distribution, anatomic variation, and the relative weight given to the wrist joint, tendon sheath, nerve, or CRPS components of Mr. Bezanson's case. Subtleties of such argument might be diminished by the fact that a golf ball is a fairly large, blunt, often rotating object which may in the course of a glancing or reflecting blow, strike several different nerve joint or tendon areas. Using the Newtonian mechanics taught in high school curricula (i.e. not requiring expert testimony but rather general knowledge) I would suggest that this golf ball struck the radial (thumb) side of the wrist and thereby reflected downwards to hit Mr. Bezanson in the chest. It would be unlikely to strike square in the middle of the palm surface of the wrist (i.e. over the median nerve) and be able to do anything other than bounce away from Mr. Bezanson as [opposed] to hitting his chest. But again the laws of physics may take a back seat to the bigger picture of whether or not Mr. Bezanson was able to work a day with a chain saw before the golf ball

> injury of June 2002 and not afterwards. On cross examination Dr. Beauprie agreed that his observation as to the plaintiff's ability to return to work after the bilateral carpal tunnel syndrome surgery was based on information provided by the plaintiff, as was his knowledge of the plaintiff's medical history. Dr. Beauprie had no independent information. His mandate, he said, is the condition of the patient as he presents at the time of treatment. Although he opined that CRPS could arise from repetitive injuries, Dr. Beauprie had not seen such a situation. He agreed that it would be possible to develop Wartenberg's syndrome after repetitive heavy use of a chainsaw."

[60] In August 2007 the plaintiff underwent surgery by Dr. Ivar Mendez, a neurosurgeon, to insert a cervical spinal cord stimulator. Dr. Beauprie noted at trial that the stimulator appears to have some effect on the pain, but that if the voltage is high enough to block pain, it causes muscle spasms. Dr. Beauprie did not believe that there was any further treatment that was likely to reduce the plaintiff's pain, noting that even amputation could result in "phantom limb" pain.

Dr. John Sapp

[61] Dr. Sapp is a physiatrist and a specialist in physical medicine and rehabilitation. Now retired, he served as director of the Nova Scotia Rehabilitation Centre. In his practice Dr. Sapp dealt with nerve injuries, including acquired entrapment injuries and injuries resulting from trauma and from a repetitive use, with an interest in neurological aspects. He started an EMG Laboratory at the Rehabilitation Centre. He established a clinic for upper body injuries in Bridgewater, where his patients were mostly fishermen, lumbermen and production line workers. He said he had treated about 10,000 carpal tunnel patients. Dr. Sapp was qualified as an expert

in physical medicine and rehabilitation, with a sub-specialty in peripheral nerve diseases and acquired entrapment injuries.

[62] Dr. Sapp was retained by the defendant to conduct an independent medical examination of the plaintiff. He provided a report dated May 12, 2004. According to Dr. Sapp's report, the plaintiff indicated that "the ball hit the front or palmar surface of his wrist and then ricocheted down and hit the front of his chest. He indicated ... that the area where it hit was on the radial or thumb side of the wrist just below the base of the thumb...." He described the plaintiff's complaints as follows:

> "He said he was still having pain on a daily basis. He describes an aching pain in the wrist. He indicates it on the palmar aspect or front of the wrist more on the radial side which is near the base of the thumb. He said that he also gets burning pain on the same side of the forearm whenever using his hand or when bending the wrist. He said that at times with movements of the wrist he gets a sharp pain. Sometimes the pain goes into the fingers. It mainly goes into the index, long finger and ring fingers. He describes sharp and stabbing pain going out to the finger tips. he also said that he sometimes has throbbing at the finger tips.... He said that when he lifts or grips anything the pain is aggravated and can radiate out to the fingers. He said that he has tried using the power saw but it aggravates the pain.... He said that he can make a fist but it is painful to do so. He said that when he grips using his thumb it causes more pain. He also notes that if he is out in the cold that he gets tingling in the fingers but never has it at any other time. He does not describe any numbness in the fingers."

[63] Dr. Sapp wrote that the plaintiff complained of pain in the thumb when gripping things, as well as trouble with pushing things and difficulty in opening the hand when it was closed. The plaintiff did not report pain extending up the arm, or in the shoulder, elbow or neck, and did

not report swelling in the wrist or forearm. His physical examination included an examination of the wrist area, of which Dr. Sapp wrote:

> "He was tender when palpating over the lateral aspects of the wrist joint or on the side of the radius near the base of the thumb. There was mild tenderness when palpating in this area. He also complained of discomfort or pain when palpating over the dorsum or the back of the wrist on the same side at the base of the thumb. When performing Finkelstein's test, he complained of discomfort on the left side. This is a test whereby the thumb is tucked in under the fingers and the wrist is flexed forward which puts a stretch on the tendons on the back of the wrist. The production of discomfort in the area would suggest evidence of involvement of the tendons on the back of the wrist. Since there was no evidence of swelling around the tendons and temperature was normal, it is likely that he may have had a previous tenosynovitis or inflammation around the tendons with adhesions in the area at this time. There was no evidence of active ongoing inflammation in the area."

[64] Phalen's test, which is a test used to indicate whether there is entrapment or pinching of the median nerves at the wrist level or at the carpal tunnel region, was negative on both sides. There was decreased flexion and extension of the left wrist by about 25 percent compared to the right side. At that point, he complained of pain in the wrist at the extreme of the movements. He was able to take full resistance to movements and did not complain of any pain at the time....

[65] Dr. Sapp wrote that there was "no evidence of loss of sensation in the fingers of either hand." There appeared to be "weakness of the hand intrinsics" on both sides, but grip strength was equal. Checking the muscles at the base of the thumb for opposition of the thumb, he found full strength on the right side, but weakness and pain on the left. Reviewing the available x-rays, Dr. Sapp did not find "evidence of bony injuries nor is there any evidence of post-traumatic

arthritis developing in the wrist joint." There was no evidence of ongoing neurological deficits or of bony injuries involving the wrist or hand. Dr. Sapp concluded that the plaintiff:

> "...received a blunt blow when the ball hit the anterior aspect of his wrist. He had immediate soft tissue injuries at the time and subsequently developed erythema or redness along with swelling within the tissues. He apparently received a ricocheted blunt injury to the chest area with initial redness and swelling where the ball had hit him. This subsequently resolved and he has not had any further complaints in regards to the injury in that area.
>
> However, he has had ongoing problems of pain and numbness in the left wrist and hand when ever using it in activities that put stress on the wrist. In particular, activities involved around use of the chain saw and cutting logs and pulpwood which causes increased pain and discomfort so that he has been limited in his ability to do so.
>
> He has undergone extensive investigation and has seen several specialists in regards to the ongoing problem with his left wrist. There have been findings in keeping with tenosynovitis of the extensor tendons on the dorsum of the wrist. This diagnosis has been made by specialists who have examined him in the past. His symptoms also were in keeping with inflammation around the tendons on the back of the wrist. This condition is most likely related to use of his hand for heavier activities and repetitive activities. It is referred to as tenosynovitis of the extensor tendons or also known as DeQuervain's disease. However I would not relate this condition to the injury that he received when he was hit by the golf ball. I believe that this is related to other activities that he performs using the left hand."

[66] Dr. Sapp found no evidence of "ongoing involvement of the median nerve at the wrist level where [the plaintiff] previously had carpal tunnel syndrome." There was no tenderness or hypersensitivity of the nerve. There were, he wrote, "periodic symptoms suggesting dysfunction of the median nerve which may be due to old scarring of the nerve associated with his previous carpal tunnel syndrome and subsequent surgery."

[67] Noting that the carpal tunnel syndrome had developed when the plaintiff was "using his hand quite excessively cutting wood," Dr. Sapp wrote that in his experience with people cutting wood the usual amount was "six to eight cords a day five or six days a week." The plaintiff, he believed, had "well exceeded that level or productivity and was working seven days a week when he developed carpal tunnel syndrome on both sides." He was "unclear" as to the level of work performance that had been regained by the time of the golf incident, but he understood that the plaintiff was not working at the same level. This suggested that there had not been a complete recovery after the surgery. The symptoms in the left wrist, however, did not appear to be on account of carpal tunnel syndrome alone, but may have arisen"from an extensor tenosynovitis of the wrist which is a separate condition." He could not account for the level of chronic pain reported by the plaintiff. Having advised a course of medication, he concluded:

> "[I]t is still my opinion that the description of the pain that is being experienced is not typical of neuralgic pain. The increased pain when carrying out repetitive activities or heavier activities using the hand most likely are related to adhesions around the tendon of the wrist. As mentioned previously, I do not feel that the golfing injury would have caused involvement of the tendons on the back of the wrist. Based on the results of clinical examination and objective investigations carried out, I am unable to determine an organic or pathophysiological basis for the level of chronic pain and dysfunction of which he complains.
>
> Based on function within the wrist, he should be able to perform lighter activities using his hands. However, it is doubtful that he will be able to return to the heavy physical use of his hands in which he was involved prior to carpal tunnel surgery.
>
> It is my opinion that the blunt injury received at the time of being hit by the golf ball was not sufficiently severe to account for the constant, ongoing chronic pain in his wrist nor would it have caused sufficient soft tissue injuries to prevent him

> from returning to a level of physical use and function of the hand which he experienced prior to being hit by the golf ball."

[68] Dr. Sapp provided a supplemental report dated September 6, 2005. He addressed Dr. Beauprie's statement (in his report of July 19, 2004), that the plaintiff "has had trauma to the radial sensory nerve of the arm and hand." Dr. Sapp wrote that there was no "direct injury to the radial sensory nerve of the wrist." Emphasizing that the nerve "is located on the dorsum or back of the distal forearm and wrist," he noted that the plaintiff's description led him to conclude that the trauma "was to the anterior or palmar aspect of the wrist just over the carpal tunnel area at the base of the thumb." As such, there was no history suggesting "direct trauma to the radial sensory nerve in this area."

[69] Dr. Sapp said he had seen carpal tunnel syndrome resulting from repetitive use, particularly in fishermen, lumbermen and production line workers. If the patient has lost feeling or function, or the EMG shows abnormality, surgery to open the tunnel is likely required in order to release pressure on the nerve. Surgery prevents further progression of the problem provided that the surgical invention is early enough to permit the recovery of the nerve. Where there is incomplete or inadequate recovery, Dr. Sapp said he would suggest that the patient not resume the activity that caused the problem. In the plaintiff's case there were post-surgery problems when he attempted to return to his employment as a lumberman. According to Dr. Sapp, the WCB rating of 13.5% disabled is close to full disability for this part of the body.

[70] Dr. Sapp said CRPS can be caused by trauma or disease, as well as by tendinitis. If it is associated with an injury, CRPS usually arises two to six months before it is seen developing. If it arises from tendinitis, it is seen after a couple of months. If it is chronic, the onset is not completely predictable.

[71] Dr. Sapp was of the opinion that the ball hit the plaintiff on the volar or interior portion of the wrist joint. Despite the continuing pain, said there was no evidence of further damage to the median nerve. He concluded that the plaintiff had suffered a soft tissue injury from being hit on the base of the thumb on the volar aspect. Dr. Sapp agreed that such a strike would be very painful; at this part of the extremity, he said, the bones are extremely superficial. He said Dr. Bush's notes of June 17 and July 2, 2002, were not consistent with trauma to the radial nerve. Dr. Sapp indicated that he would expect pain and tenderness to the posterior aspect of the wrist and pain to the base and the back of the hand, immediately after the injury to the nerve.

[72] In comparison with Dr. Beauprie's description of the trauma, Dr. Sapp said he believed that the description of the injury in his own report coincided with information provided by other specialists and made it evident that there was no direct injury to the radial sensory nerve of the wrist. The radial sensory nerve, a branch of the radial nerve, is a smaller nerve that branches off in the mid forearm and innervates the back of the wrist and hand, more on the radial or the lateral side. The area of innervation can extend down to the back of the thumb and index finger, as well as the web space between these digits. The nerve is located on the dorsum, or back, of the forearm and wrist. According to the description, the trauma was to the interior, or palmar, aspect

of the wrist, just over the carpal tunnel area at the base of the thumb. There was, Dr. Sapp asserted, no history to suggest a direct trauma to the radial sensory nerve in this area.

[73] At trial, Dr. Sapp said that he changed his position on the area of impact, to the left of the median nerve rather than directly on the median nerve itself. He accepted *Grant's Anatomy* as an authoritative textbook, and was referred by counsel to a diagram of the dorsal aspect of the left hand. On cross-examination Dr. Sapp said he had not ruled out DeQuervain's, noting that there were residual findings of discomfort with Finklestein's test. As such, "there may have been active inflammation there at some point ... but it wasn't active at the time I saw him. So there could've been some residual scarring in the ... sheath around the tendons that would ... still cause discomfort when stressing those tendons."

Dr. David B. King

[74] Dr. King was qualified as an expert in neurology. He conducted an independent medical examination on February 2, 2006, and provided a report dated March 2, 2006. He noted Dr. Bush's report of June 17, 2002, which indicated tingling in a median nerve distribution had largely resolved nine days after the trauma, with the wrist pain continuing. There was also resistance to flexion, and tenderness in the flexor tendon, of the index finger. Dr. King wrote that "all of this would be in keeping with an injury to the volar or anterior aspect of the wrist...". There was no indication of injury to the radial nerve or the tendons on the radial aspect of the arm, nor, he wrote, "would one expect this given the mechanism of injury." At trial he said that

due to the path of the radial nerve in the forearm, where it branches above the wrist, it would be "very difficult" for the ball to strike that area. Even if the ball hit the radial nerve at the wrist, he said, it would not produce the numbness experienced by the plaintiff, because the radial nerve "branches at about four to five centimetres above the wrist crease." If the ball struck the radial aspect of the wrist, it would be below where the nerve branches. Dr. King explained that one part of the nerve "comes around to the anterior aspect of the thumb" so that if the plaintiff was struck at the base of the thumb, "he might injure a radial nerve at that point, but it wouldn't produce numbness in the anatomic snuffbox and on the dorsal portion of his hand ... [b]ecause the nerve is far above that site."

[75] Dr. King wrote that the positive Finkelstein's test by Dr. Brennan in February 2003 was consistent with DeQuervain's disease, involving "the tendon on the radial side of the forearm, outside the area that had been originally injured." He wrote that there had been no recording of tenderness over the anterior wrist and flexor crease since Dr. Bush noted it on August 20, 2002. By that time there was "tingling on the dorsum of the hand on the lateral portion, without tingling of the fingers, suggesting the shift in pain from the anterior to the radial side of the wrist...." The pain was "unlikely related to the original trauma, which had largely subsided, as one might expect with a soft tissue injury within three months of the event." Dr. King noted that the possibilities of DeQuervain's or reflex sympathetic dystrophy had been rejected in April 2003, and noted Dr. Sapp's May 2004 diagnosis of "a tenosynovitis of the tendons at the back of the wrist, related to chain saw use and not to the injury to the palmar surface of the hand." Dr. King considered this reasonable. He also noted Dr. Ivan Rapchuk's July 2004 diagnosis of "a

traumatic radial neuropathy with neuropathic pain." Dr. King wrote that this "could not be related to the accident in question, given that the radial nerve was not injured in the golf ball trauma."

[76] As to the plaintiff's status at the time of the examination (February 2006), Dr. King wrote that there was pain in "the wrist, the dorsum of the thumb and deep within the index, middle and ring finger of the left hand," extending "around the anterior aspect of the wrist." There was also an "anaesthetic syndrome" involving the radial nerve distribution. The pain had pulsating, burning and tingling components, "highly suggestive of neuropathic pain." Gentle pressure in the anatomic snuff box showed allodynia, while the sweating and colour alterations suggested "an autonomic component to the problem." Reviewing the plaintiff's pre-accident history, Dr. King stated that the carpal tunnel surgery, which "did not resolve his symptoms." He noted the persistence of weakness, pain and numbness in 1998 and 1999. Based on the callouses noted by Dr. Burke in October 1999, he suggested that the plaintiff was doing heavy work at that time. Dr. King concluded that "comparing the current circumstances to those preceding this event, there seems very little in the way of change though I have little doubt that the golf ball occasioned short-term difficulties."

[77] Dr. King did not refer in the discussion section of his report to any other findings between October 1999 and the date of the accident in 2002. At trial he said he did not have detailed medical documentation from after October 1999, which did not mean that the plaintiff had no symptoms. He thought that "by this time Workers' Compensation had decided that [the

plaintiff] had a permanent partial disability." As to the increasing amount of work the plaintiff was doing after May 1999, he said, "one has the feeling that as he got symptoms, he backed off ... and then he tried to return to work when he could." He understood that after the plaintiff's gall bladder surgery, in late 2001 or early 2002, "he was back up to full capacity in his ability to work."

[78] Noting that the distal nerve blocks targeting the radial nerve had given the plaintiff some relief, Dr. King commented that "[t]his is far removed anatomically from the site injured in the anterior wrist by the golf ball" and that "[t]he difficulties with this nerve were apparent by careful review of his past history long before the incident with the golf ball." The radial nerve, he wrote, has "no relationship to the volar aspect of the wrist...". Its involvement, he believed, related to pre-existing problems, "likely related to chronic tendinitis or over-use tendinitis of the forearm tendons with secondary compression of the superficial branch of the radial nerve, thus occasioning his pain syndrome." The sweating in the hand was "an element of a complex regional pain syndrome." While the blockade eliminated the sweating, it did not eliminate the pain. This suggested that there was not a "sympathetic dystrophy in the conventional sense of the term in which the pain is mediated by hyperactivity in the autonomic nervous system. The pain clearly has a local origin." Based on the distribution of the radial nerve and the location of the golf ball strike, Dr. King believed, the radial nerve was responsible for the pain syndrome. The pain syndrome was therefore unrelated to the golfing incident. It was, rather, "a continuation of his pre-accident pain syndrome in the left arm."

[79] Dr. King noted a significant loss of forearm girth on the left side compared to the right side, suggesting that the plaintiff "was probably not using that arm" and that "his grip strength was reduced on the left side." There were "physical findings in that arm, consistent with a radial nerve problem." He noted increased sweating and fewer callouses on the left hand. There was impregnation of oil on both hands, which "usually implies that he has been doing some kind of work with the hand," such as work on small engines or a chain saw. The nails were dirty and bitten bilaterally, again suggesting work. There was scarring at both wrists from the carpal tunnel surgery and there was tenderness over the radial tendons of the left forearm. This, he said, is the DeQuervain's distribution. With respect to the callouses, the plaintiff stated at trial that they resulted from working on the farm with a pitchfork, a shovel and a wheelbarrow. In each case, he said, he bears most of the weight on his right hand.

[80] As to the possibility of symptoms proximal in the radial nerve from a distal injury, Dr. King said this would be unusual because lesions in a nerve are localized according to the distribution of numbness. In other words, he said, "if you struck the median nerve at the wrist, it's only from the area of injury down is where the nerve is injured...." If the nerve was severed, it might retract and produce pain further up the arm; thus, it might seem as if the symptoms were occurring further up the arm. However, "[i]f the nerve were intact and [had] simply been traumatized, you'd get the symptoms distal to that site, not proximal to it." If one injures a nerve at a certain site, the symptoms occur distal – i.e. lower – to that site, below the site of the injury.

[81] Dr. King did not believe that both the radial and the median nerves had been injured by the golf ball. He said "a golf ball is not a very large object," measuring about 1.89 inches in diameter. When the plaintiff was struck, he said, it was not the whole of the diameter that struck him, but only a "very small" portion of the arc, "almost like being struck by a point." As such, the injury would be expected to be fairly well localized to the area that was hit. Furthermore, he said, a golf ball is a hard object that does not deform; an object with some deformity might wrap around the wrist and hit the radial nerve. He did not believe that it could injure both nerves, nor did he believe that it could have injured the radial nerve because "you have to also get five centimetres [proximal toward the elbow] from the site of his median nerve strike to where this nerve actually fibercates."

[82] Dr. King's opinion was that the plaintiff had CRPS type two in the radial nerve. He did not believe that it was caused by the golf ball. He believed there was chronic tenosynovitis of both hands, related to chainsaw use, dating to at least 1997, with secondary radial nerve involvement. The radial nerve problem and tendinitis on the dorsal aspect of the hand are referred to in combination as Wartenberg Syndrome. He did not think the radial nerve and the median nerve could have been injured conjointly, as the area of injury to the radial nerve is four or five centimetres proximal to the impact point. Further, the plaintiff had no radial nerve symptoms initially, and other examiners did not detect any radial nerve injury. He did not think that the initial trauma with the median nerve could have led to the problems with the radial nerve, because "they're two totally separate nerves" and only one was traumatized.

EVIDENCE ON DAMAGES

[83] The plaintiff's notice of assessment for 1997 showed income of $15,284.00. He testified that he had actually earned more, but was unable to produce documentation, as some of his work records had been accidentally destroyed. He was also referred to Unemployment Insurance documentation, found in his workers' compensation file, that indicated income of about $21,000.00 in 1992 and $3,065.00 in 1995.

[84] The plaintiff stated that after the carpal tunnel surgery in early 1998, his wrists did not heal immediately. There was some pain and discomfort. The left hand was numb and painful, but more numb. He had problems gripping small objects. He had some physiotherapy, but did not complete it because he had no vehicle and no money. In order to travel he had to borrow a vehicle. He recalled getting workers' compensation payments for at least a year, but he ultimately went back to work in the woods.

[85] As to the alternative employment suggested by WCB, many of the proposed jobs involved working with the public, to which he believed he was unsuited. He said that he had chosen work in the woods so that he did not have to deal with people. As to working in a service station, he would have to travel for that position. As well, the pay was extremely low and most

service stations are self-serve. Finally, given the pain he experiences (even with the implant), it would not be realistic to expect him to perform duties that would be reasonably acceptable to an employer. The fact that he can perform some chores on the farm, on his own schedule and in his own manner, does not make him employable, he argues.

[86] The plaintiff discontinued his workers' compensation claim in April 1999, and returned to work in the woods in May and June of that year. He then worked in a sawmill, although he found this work difficult when the mill moved to heavier green wood, and said he had some tenderness. He found cutting trees to be less intense than sawmill work. When he left the mill, he went back to the woods, working with an assistant. The assistant would lift lumber and pile bush while the plaintiff did the cutting. The plaintiff's 1999 earnings were $10,370.00 (including workers' compensation payments).

[87] The plaintiff saw Dr. Kevin Bourke for the purposes of a WCB permanent medical impairment assessment in October 1999. As a result of the finding of permanent medical impairment by Dr. Bourke in October 1999, the plaintiff received a lump sum payment of $4,429.06. The plaintiff's appeal of this decision was dismissed in July 2000. At trial the plaintiff stated that the thumb burning and discomfort reported by Dr. Bourke was not comparable to his present condition. In his words, the carpal tunnel symptoms were "burning and numbness," while his post-accident condition is pressure that he describes as "like a dog biting or driving a nail" into the wrist. As Dr. Bourke noted, these problems were then worse on the right side than on the left. He added that the worst problems at that time were related to

handling small objects, such as the file for sharpening a chainsaw. He said his left wrist became stronger over time. He maintained on cross-examination that the numbness and tingling were largely gone when he returned to work in May 1999, and that the main problem was weakness.

[88] The plaintiff earned $13,686.00 in 2000, from logging, and $7,204.00 in 2001. Jamie Bezanson confirmed that the plaintiff, who he said is a hard worker, worked for his forestry business in February or March 2001 for a couple of weeks, using a chainsaw while he operated a skidder. Mr. Bezanson said the plaintiff did not say anything about his wrist when they worked in the woods. The plaintiff said 2001 was a poor year due to deep snow and gall bladder problems, which led to surgery.

[89] The plaintiff's 2002 income was $10,184.00, from logging. Once again he worked with an assistant who piled the lumber and moved brush. The assistant was generally paid about 25% of the gross revenue for the job. The plaintiff's workbook for 2002 shows, for example, five days work between January 28 and February 1, during which he cut 18 cords of studwood and 12 cords of pulpwood. Of the total earnings of $960.00, he paid his assistant $204.00. The workbook goes on to record woodcutting activity through June 7, the day before the golfing accident. The final entry – and the only entry dated later than June 8 – is dated July 3, which records the cutting of 69.3 cords of hardwood. Of the total earnings of $1386.00 on this job, the plaintiff paid his assistant $600.00, or nearly half. At trial the plaintiff explained that the relative wages paid to his assistant increased on the July job because the assistant was required to do most of the cutting. The plaintiff was unable to use the power saw after his injury. He said that

after attempting to use the saw for three to four hours, he had to stop because his left hand became sore and swollen. He said his right hand was fine.

[90] The plaintiff maintained that in 1997, before the surgery, he was cutting ten to twelve cords per day, working six to seven days per week. The available records of the plaintiff's wood-cutting activities prior to the carpal tunnel surgery do not allow any precise conclusions to be made as to how much wood he was able to cut per day. The defendant argues that the cutting records, from January to June 1997, showing 703.5 cords, compared with the records for the same period in 2002, when he cut only 403.3 cords (and that with an assistant) indicate that the plaintiff had not returned to his pre-carpal tunnel capacity. I am not convinced that wood-cutting can be measured with the mathematical precision suggested by the defendant. The work, when available, is subject to any number of factors, including weather and the type of wood being cut.

[91] While the plaintiff maintained that by 1992 he was back to full working capacity, the defendant submits, on the basis of the opinions of Drs. King and Sapp, as well as calculations of the amount he was cutting, that the plaintiff never returned to his pre-carpal tunnel capacity after the surgery. In addition, the defendant says it is reasonable to conclude that the plaintiff's cutting capacity would have continued to decline with age, and that it was inevitable even before the surgery that he would eventually be forced to find a new line of work. In this regard, the defendant points to the plaintiff's doctor's comment (many years prior to his carpal tunnel syndrome arising) that he would have difficulty with heavy labour for the rest of his life.

[92] The plaintiff said his wrist was fine when he played golf with the defendant and Jamie Bezanson in September 2001, as well as on the day of the accident in June 2002.

[93] The defendant says his wood-cutting records from January to June 1997, when compared to the records for the same period in 2002, suggest that the plaintiff had not returned to his pre-carpal tunnel wood-cutting capacity. The plaintiff says cutting wood cannot be measured on a daily, unit, basis, being weather-dependent work that is sometimes unavailable, and being affected by the type of wood being cut. According to the plaintiff, there is no meaningful connection between the amount cut in a given period and his medical condition. He notes, however, that in six months' work in 2002 he was able to generate at least $10,124.00 in logging income, which he says was comparable to the 1997 total.

[94] The plaintiff's wife, Jennifer Bezanson, gave evidence respecting his condition. She testified that when she first met the plaintiff, he had pain at the carpal tunnel surgery sites, but he slowly recovered. In August or September 1999, when he was working at the saw mill, his hands began to get sore when he began working with heavier lumber. He had difficulties with small items, such as buttons and tight socks. However the problems went away over time, and he went back to the woods. Ms. Bezanson said she was off work from 2003 until 2006. Due to the medication that the plaintiff was taking, which she described as "crazy pills," she did not feel comfortable leaving him with the children. She said that he is a great father, but the pain and the medications made her uncomfortable. She said that the pills would be helpful in controlling the

pain for "a short while", but then it would return. The plaintiff's moods were erratic, as the medication strongly affected his personality and state of mind.

[95] I am satisfied that the plaintiff regained some of his pre-surgery ability to work at wood-cutting, but I do not accept that he had returned to his full cutting capacity. The ongoing problems with his hands and wrists had impacted his ability to cut wood. Having said that, I am not satisfied that he would inevitably have been forced to stop cutting wood. He was clearly determined to continue working, as his work records from early 2002 demonstrate. But the evidence does permit the conclusion on a balance of probabilities that the pre-existing problems would have had some effect on the plaintiff's future working ability, particularly given the history of worsening symptoms when his workload increased.

[96] The defendant suggests that the plaintiff lacks motivation to work due to having access to income from social assistance (which the plaintiff said ended when his wife began her job) and from insurance (which he said is applied directly to bank debts, without passing through his hands). The plaintiff says the notion that he is not working simply because it is easier to collect income from other sources is baseless. He says that even Dr. King and Dr. Sapp acknowledge that he is not malingering and that he is significantly disabled as a result of his injury. It is submitted that he is unsuited to work in a call centre or a commercial retail environment. As such, the plaintiff argues, the best option is self-employment.

[97] The plaintiff testified that he hoped to begin cultivating blueberries. He had some experience, having assisted a neighbour in starting a blueberry operation. He said he has land that he can till with his tractor, which he would also use (with assistance) to spread sawdust and mulch. He believed the field could be irrigated with a water pump and a hose, and he could weed, as he presently weeds the garden with his right hand. He expected it to take some three years from first planting to harvest. He expected to put in 2,500 plants and have 3,000 in reserve, at a current price which he believed to be $6.00 per plant. He anticipated costs of $1,000.00 for an irrigation pump and $750.00 per year for water soluble fertilizer some 3,000 plants and he estimated a total start up cost of between $30,000.00 and $35,000.00. Although he would have to hire people to help harvest he hoped to make at least $20,000.00 per year. Counsel admits that “he may be unrealistic regarding the prospect of success,” it is submitted that it speaks well of his character and credibility.

[98] The defendant argues that he should not be responsible for start-up capital, as this was something that the plaintiff would have in any event have had to come up with. The plaintiff responds that this would be a fair argument if blueberry production had been a concrete plan prior to the incident; it was not, however, and now it is a possible alternative to nothing. The plaintiff says any award of past loss of income could go to start up capital.

FINDINGS OF FACT

[99] I make the following findings of fact based on the evidence:

(1) The plaintiff, Alan Bezanson, is a woodsman by profession and training.

(2) In 1997 the plaintiff suffered from carpal tunnel syndrome, requiring surgery to be performed on both wrists in early 1998. There followed an extended period of rehabilitation. The plaintiff did not pursue a course of retraining.

(3) After the surgery, the plaintiff returned to his former employment as a woodsman, but in a reduced capacity due to impairment resulting from ongoing carpal tunnel complaints. He required an assistant to conduct other tasks while he worked with the saw.

(4) The plaintiff was advised by medical and other professionals that he should seek alternate, lighter, employment due to his ongoing carpal tunnel problems. His disability was rated at 13.5 percent by the Worker's Compensation Board. He continued to work in the woods, however, and was doing so in June 2002.

(5) On June 8, 2002, the plaintiff was hit by a golf ball in the palmar area of the left wrist, distal from the thumb. The ball hit the thumb-side of the wrist, not the centre of the wrist. The ball was hit by the defendant, Travis Hayter, who took an uncontrollable shot from a running start, without adequate warning, while under the influence of alcohol. The plaintiff did not have time to get out of the way of the shot. I am satisfied that the defendant was negligent and that there is no question of contributory negligence.

(6) The impact of the ball was a blunt impact, not a pointed impact. The ball bounced from the wrist area at an angle and struck the plaintiff's chest, causing an injury that later resolved. The ball's shape did not change in flight or at the time of impact with the wrist or chest. The strike by the golf ball caused immediate pain and discoloration in the area of the hand and wrist. In the longer term, the plaintiff suffered pain and injury in the wrist and hand that, on a balance of probabilities, were caused by the ball striking his wrist. The ball caused permanent damage to the radial nerve or to a branch of the radial nerve. The plaintiff's complex regional pain syndrome is directly attributable to the golf ball injury.

(7) Since the golf ball incident, the plaintiff has been unable to return to his former work as a woodsman on account of the persisting injury caused by the defendant hitting him with the golf ball. He has done light farm work, including driving a tractor.

ARGUMENT ON CAUSATION

[100] The plaintiff maintains that the descriptions of the impact given to the various physicians were consistent. He says the ball did not strike a "point," as Dr. King described it, but "traversed an area of the wrist, leaving a track comparable to the divot or gouge created by a golf ball in the course of play...."

[101] The plaintiff points to Dr. Beauprie's evidence to explain the apparent delay in the onset of symptoms in the radial nerve distribution until after July 2, 2002, noting that he has been involved in "experimental neurolysis where injury to one nerve ... will subsequently produce pain in a completely separate nerve... (ephaptic syndrome)." Further, the plaintiff argues, it is not certain that there was no pain in the radial nerve distribution after the accident. As with the balls track, the exact location of the pain was not pinpointed.

[102] As to the suggestion that his condition results from DeQuervain's tenosynovitis arising from repetitive chainsaw use, the plaintiff says there was no such chainsaw use, and points out that Dr. Sapp and Dr. King acknowledged that DeQuervain's can result from trauma. Further, it is claimed, Dr. Sapp and Dr. King use "misleading language" to describe the tendons affected by DeQuervain's, and refer to the affected tendons as being located on the back of the wrist, which, the plaintiff says, is not supported by the anatomical diagrams nor by the location of the scar left by Dr. Parkhill's surgery, which is "essentially on the side of [the] wrist."

[103] The plaintiff also criticizes the emphasis by Dr. King and Dr. Sapp on the requirement for a precise impact on the radial nerve, given that "the treating physicians ... confirm that the injury could be caused by a blow ... in a zone which would be up to 5 cm in total width ... by [which] the median and the radial nerve could easily by directly impacted."

[104] As to the assertion that the neuropathic pain/CRPS arises from a pre-existing condition, the plaintiff submits that Dr. King never identified "when and what the pre-existing condition

was" and that he implied that the treating physicians misdiagnosed the plaintiff; this, it is argued, is not reasonable, given that Dr. King saw the plaintiff only once, four years after the accident and eight years after the carpal tunnel.

[105] The defendant says the golf ball strike on the front of the wrist could not have injured the radial nerve. The defendant notes Dr. Sapp's view that if the ball hit more than one centimetre from the centre of the wrist, the median nerve would not have been injured, and that the radial and median nerves could have both been injured, due to their respective locations. The defendant adds that if the injury was to the radial nerve, there should have been immediate symptoms in the radial nerve distribution; the fact that there were no such immediate symptoms, the defendant says, confirms that the injury was to the median nerve. Finally, the defendant says that because symptoms would move down the arm, not up, the nerve injury further up the arm could not have been caused by the golf ball.

[106] The defendant says there is no evidence to support Dr. Beauprie's description of a glancing blow moving from the front to the back of the wrist. Specifically, the defendant points to Dr. Beauprie's evidence that the ball "glanced along the lateral aspect of the wrist, starting on the volar side." According to the defendant, Dr. Beauprie "agreed that his opinion on causation is based on his understanding of the mechanism of injury." As such, the defendant says, Dr. Beauprie's opinion on causation is unsupported by the evidence and should be disregarded.

[107] I considered Dr. Bush to be a credible family physician. He did not exaggerate the plaintiff's condition, nor did he minimize it. Similarly, I place significant confidence in Dr. Beauprie's evidence, in part because of his extended treatment of the plaintiff.

[108] Dr. King offered the view at trial that being struck by a golf ball would be similar to being hit by a point, and that it would involve only a small portion of the ball. Being a hard object, he said, the ball does not "deform" in flight. An object that did deform, by comparison, might "lap around the wrist" and hit the radial nerve. I am not satisfied that Dr. King had any expertise to make such a statement. His view on the precision of the impact appears to have been crucial to his final opinion. There was no expert evidence on the issue of how a golf ball behaves in flight. I am prepared to take notice that a golf ball is a round object, not a pointed one. I am also prepared to note that, even if a golf ball does not deform in flight (a point upon which there is no evidence before the court), a human wrist obviously would deform, to some degree, under such an impact. I note also that Dr. Sapp referred to a "blunt injury."

[109] This is a case where there is significant conflict in the views of the experts for the respective parties. I am satisfied, however, that the mechanics of the actual impact are of crucial significance. To be absolutely clear, I find that the plaintiff's wrist injury resulted from being struck by a golf ball on the radial nerve, a branch of the radial nerve or within an adjacent "zone of injury" that caused an adverse effect on the radial nerve or a branch thereof.

ARGUMENT ON DAMAGES

Non-pecuniary Damages

[110] The Plaintiff says that the evidence is clear that he suffers from severely debilitating chronic pain which cannot be treated. He says he is in a worse situation than the plaintiff in *Abbott v. Sharpe* (2007) N.S.J. No. 21, where the Court of Appeal reduced a jury award of non-pecuniary damages from $225,000.00 to $100,000.00. In that case there was a prospect of recovery. The plaintiff here has no such prospect. As such the plaintiff seeks non-pecuniary damages of $125,000.00.

[111] According to the defendant, relying upon the opinions of Dr. King and Dr. Sapp, the plaintiff's injury resulting from the golf ball impact amounted to nothing more than a soft tissue injury in his wrist, causing some bruising, swelling, numbness and tingling, which resolved within a few months of the accident. On this basis, the defendant suggests general damages of $10,000.00. In the alternative, if some of the plaintiff's current complaints are attributable to the accident, the defendant says the pre-existing conditions must be considered, and suggests general damages of $30,000.00, plus pre-judgment interest of 2.5 percent for four years.

[112] The plaintiff's injury has resulted in extensive pain and discomfort which has affected his everyday life, as well as his working ability, to a severe degree. He has been required to take narcotics in an attempt to quell the pain, as well as go through surgery and the placement of an implant. I am satisfied from the evidence that the plaintiff's pain and discomfort, and the

resulting effect on his daily life, is severe and chronic, and appears unlikely to fully resolve. The consequences of the defendant's action have been far more serious than the defendant would argue. As a point of comparison, I would refer to *Wood v. Boutilier* (1998), 171 N.S.R. (2d) 18; 1998 Carswell NS 429 (S.C.), where the plaintiff's injuries arising from a motor vehicle accident, where Scanlan, J. described the plaintiff's injuries as follows:

> 11 It is clear that the plaintiff sustained a number of extremely serious and complex injuries as a result of the accident. He had a dislocated right elbow and a puncture wound in his back. Medical exams revealed objective evidence of muscle and nerve damage in the plaintiff's right arm. There was a loss of sensation in the right hand and a significant loss of nerve function in his right arm and hand. There was a resulting diminution of strength and control in his right arm. The injuries caused back and neck pain. The accident and resulting injuries also caused severe headaches. In addition Mr. Wood had ongoing pain in his right leg after the accident.
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> 12 The pain and nerve damage left the plaintiff unable to effectively use his right arm. The various injuries caused Mr. Wood so much pain that it rendered him disabled from doing any work. I briefly summarize the evidence of the medical experts by saying the plaintiff could do little more than move his wrist and arm against gravity. His back pain was aggravated by walking. He could only sit or stand for short periods of time. Even though this back pain would not allow him to sit or stand for any length of time, Dr. Watt said this was the least severe of his problems. In a report of October, 1994, Dr. Watt noted an obvious wasting of the muscles in the right arm. The plaintiff was not able to regain the strength in his right arm to the extent that it would be of any functional use. Dr. Watt indicated that there was also a grinding in the plaintiff's right knee and signs of damage on the surface of the kneecap. The plaintiff's right leg was turned out slightly. The plaintiff also had scars on his right forehead, arm and back as a result of the accident. [Emphasis added.]

[113] The plaintiff's treatment included nerve blocks and narcotics for pain control. Concluding, among other things, that the plaintiff suffered excruciating pain and had an effectively useless arm, Scanlan, J. awarded general damages of $85,000.00. In present-day

figures, this equates to roughly $107,000.00. Clearly, the plaintiff's situation in *Wood* was significantly more serious than that in the present case, both in terms of the scale of injuries and the degree and location of the resulting pain, and the general damages here will be accordingly lower. At the same time, I find that the general damages in this case are above the level described in *Smith v. Stubbert* (1992), 117 N.S.R. (2d) 118; 1992 Carswell NS 250 (C.A.), for an injury that it "persistently troubling but not totally disabling" (para. 33), which in current funds would have a high end of approximately $55,000.00. As such, I conclude the general non-pecuniary damages of $85,000 will be appropriate and I award that amount.

Loss of Income

[114] The plaintiff's past earnings were variable, both on an annual and on a monthly and even weekly basis. His income tax records show earnings of $15,284.00 in 1997, the year his carpal tunnel injury surfaced, which the plaintiff says provides a reasonable basis for projecting income loss. He did not work in 1998. In 1999 he returned to work at a reduced level, earning $10,370.00 in less than a year. His earnings in 2000 rose to $13,686.00, but there was again a drop of income in 2001, at least in part as a result of his gallbladder surgery. In 2002 the plaintiff worked only sightly more than five months and earned $10,124.00.

[115] By the time of the golf accident, the plaintiff had two children, and a third subsequently. It is submitted that he would certainly have been motivated to maximize his hours of work in the woods had the injury not occurred. His evidence is that once he had his gallbladder surgery his

abdominal and back problems resolved. His shoulder did not present any problems, even after his injury and his right wrist did not present any problems even though it "carried the load". In addition to documented reported income, his labours on the farm would generate income in kind. On this basis, the plaintiff submits that $20,000.00 is a reasonable figure to serve as a basis for past loss of income.

[116] The defendant says the plaintiff's past lost income would amount to no more than $4,000.00.

[117] I am unable to agree with the figures advanced by either party. By the time of the accident in 2002, the plaintiff was working full-time, but with a reduced capacity and requiring a helper. Based on his-pre accident condition, I accept that total annual earnings of $15,000.00 would be realistic, an amount that I reduce by 25 percent in order to reflect the need to pay a helper's wages. This results in an annual income to the plaintiff of $11,250.00. I find that an appropriate figure for past loss of income is $67,500.00 between 2003 and the present.

Future Income and Earning Capacity

[118] Assuming that his wood-cutting income would not have remained static, and would have increased to as much as $25,000.00 per annum, the plaintiff says the net present value of that figure to age 65 is $492,150.00. The plaintiff offers this amount as a basis for calculating future loss.

[119] As noted above, the plaintiff proposes to set up a blueberry-growing operation, which he believed could be done for between $30,000.00 and $35,000.00. The plaintiff acknowledges the merit of the defendant's claim that he should not be obliged to provide the capital cost of the set-up. The defendant also argues that the blueberry set-up is something that the plaintiff may well have undertaken in any event. If indeed this is the case, the plaintiff submits, he has lost the ability to generate income for the start-up costs; as such, the Defendant should bear the cost occasioned by his inability to do so. As well, the plaintiff submits, the blueberry operation set-up would not require the acquisition of land.

[120] The defendant says the plaintiff has made multiple claims for the same loss by claiming simultaneously for past loss of income ($84,000.00), diminished earning capacity ($150,000.00), future loss of income ($60,000.00) and the cost of the blueberry set-up ($65,000.00). The defendant protests, firstly, that these figures are based on an annual income of $20,000.00, which the plaintiff has never earned in the past; and secondly, that the plaintiff cannot advance multiple claims for the same loss. The defendant adds that he has no responsibility to provide capital funding for the plaintiff's blueberry business, given that (as the defendant claims) the plaintiff was inevitably going to be forced to stop cutting wood, even without the golf ball incident. The

defendant also claims that the plaintiff overstates the cost of setting up the blueberry operation; the defendant maintains that the plaintiff's own evidence establishes that it would only cost $20,000.00 to $25,000.00. In any event, the defendant says, the plaintiff is capable of working, even if he cannot cut wood. He has, the defendant says, simply chosen not to pursue other employment options.

[121] The plaintiff responds that the claim for future loss of income is based on the three-year start up requirement for the blueberry operation. The diminished earning capacity claim is based on the possibility that the plaintiff will not be able to earn income from a blueberry operation given his limited education, and the management and marketing skills which would be necessary in a successful blueberry operation. There is a risk that he would be under-compensated if his future earnings loss is terminated after three years. In addition, the plaintiff has lost the ability to generate income or sustenance from the farm that he stands to inherit from his father. Whether this income is in cash or in kind, it has value, which may be difficult to measure but for which he submits that he should be compensated. I believe that the best way to approach future income loss in this case is by way of lost capacity.

[122] The defendant says the plaintiff has failed to mitigate his damages by seeking alternate employment. It is clear that the plaintiff was not interested in, or felt he was unsuited for, certain types of work. The defendant submits that the plaintiff's preference for certain types of work does not excuse him from the duty to mitigate. The defendant says the plaintiff is capable of working in a light or medium capacity, as was suggested by Dr. King and Dr. Sapp. The issue,

says the defendant, is not whether the plaintiff is capable of working in his former employment, but whether he is capable of working in alternate employment, earning a commensurate income. The defendant refers to *Leddicote v. Nova Scotia (Attorney General)* (2002), 203 N.S.R. (2d) 271; 2002 Carswell NS 135 (C.A.), where the Court of Appeal distinguished the concepts of "function" and "capacity."

> 71 Properly understood in the circumstances of this case, function should be seen as a physical limitation, whereas capacity is intended to mean an ability to earn income. The two are not synonymous and should not be confused.
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> 72 Badly broken fingers in a car crash might intuitively lead one to imagine a demonstrable claim for future income loss, were the claimant a potter or a painter or a computer programmer. But such is not a foregone conclusion. Such a claimant may, by the time of trial, have developed other skills enabling the individual to pursue different but gainful, satisfying employment. In such a case it may be difficult to prove any claim for either future loss of income or a diminution of earning capacity.
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> 76 Loss of future income, whether measured as a distinct pecuniary loss or as a diminishment of earning capacity factored in as part of general damages, cannot be assessed in a vacuum. Trial judges are expected to consider the medical and other evidence related to the claimant in the context of his or her particular work history and, where appropriate, employment aspirations and prospects....

[123] The defendant maintains that the plaintiff is capable of working in jobs that would bring him income commensurate with that which he earned cutting wood, for instance, in a service station or on a farm. He proposes to start a blueberry operation. The defendant says the plaintiff has chosen not to work for paid income, and there is therefore no demonstrable loss. I find that

there is no basis upon which to conclude that employment of the kind that the defendant refers to, such as working in a gas station, is actually available. In this respect I note the prevalence of self-serve gas stations, and I add that I am satisfied that the plaintiff is not qualified by interest, education or aptitude to work as a clerk or manager in a gas station.

[124] The plaintiff relies upon *Gaudet v. Doucet* (1991), 101 N.S.R. (2d) 309, where the court awarded $200,000.00 for diminished earning capacity to a plaintiff with some employment prospects; *LeClerc v. Sunbury*, [1996] N.B.J. No. 600 (C.A.), where there was an award of $150,000.00 for future loss of income to a plaintiff whose future ability to earn income was uncertain despite his optimistic outlook; and *Erickson v. Bowie*, 2007 BCSC 1465, where the plaintiff was unlikely to return to his career in fishing and was awarded $300,000.00 for loss of earning capacity. None of these cases parallel these facts closely, although they do provide some guidance for assessing lost earning capacity, which seems an appropriate approach in situation, like this one, where the plaintiff's past income is erratic and does not provide a sure guide to his future income.

[125] The evidence of the plaintiff's income from wood-cutting demonstrates that it was erratic. There is little basis upon which to conclude that his income would have risen to $25,000.00 per year, particularly given the reduced capacity he was working at even before the injury to his hand. While the plaintiff's assumption of an income of $25,000.00 per year is, I find, higher than the income he would actually have collected, I do not accept the defendant's view that the plaintiff should be denied a damage award simply because he could theoretically

do jobs for which he has neither experience, aptitude, training or interest. On this basis, I find that the plaintiff's lost earning capacity should be valued at $125,000.00. I reduce this amount by 40 percent to reflect the fact that I am satisfied that the plaintiff would have been forced to leave wood-cutting eventually due to his pre-existing health conditions. This leaves an award for lost earning capacity of $75,000.00**.**

Other Heads of Damages

[126] The Plaintiff seeks damages for past and future loss of valuable services and future care costs. The defendant says there is no claim, noting that the plaintiff works extensively around the farm, hunts, fishes and has helped build a new house. As to costs of future care, the defendant says there was no evidence of such costs advanced, and that any award would be no more than guesswork. I am not satisfied that the evidence establishes a claim for damages for loss of services or for future care.

[127] The defendant notes that pre-judgment interest is not recoverable on future claims. I allow prejudgment interest of 4.5 percent on the plaintiff's past lost wages, and 2.5 percent on general non-pecuniary damages. There will be no pre-judgment interest on the damages for loss of earning capacity.

CONCLUSION

[128] I therefore find the defendant liable to the plaintiff and award damages accordingly. The parties may provide written submissions on costs.

LeBlanc, J.