IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation: *Kherani v. Da Silva,*
2024 BCSC 1349

Date: 20240726
Docket: M193001
Registry: Vancouver

Between:

Femida Kherani

Plaintiff

And:

Max Antonio Da Silva and Keith Rollins

Defendants

Before: The Honourable Justice G.C. Weatherill

Reasons for Judgment

Counsel for the Plaintiff:	A.E. Maragos K. Hennebery R. Powell
Counsel for the Defendants:	J.P. Cahan B. Devlin A. Alimadad J. Zhang, Articled Student (June 13 and 18, 2024)
Place and Dates of Trial:	Vancouver, B.C. June 3–7, 12–14, 17–21 24–25, 27–28, 2024
Place and Date of Judgment:	Vancouver, B.C. July 26, 2024

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Introduction

[1] The plaintiff claims damages for personal injuries arising from a motor vehicle collision on March 30, 2017 ("MVA"). The plaintiff's vehicle was stopped at a red light when it was rear-ended by a vehicle owned by the defendant, Max Da Silva, and driven by the defendant, Keith Rollins.

[2] Although the defendants have not admitted liability for the MVA, they called no evidence challenging it.

[3] It is not disputed that, as a result of the MVA, the plaintiff suffered injuries that have impacted her ability to work as an ophthalmic surgeon. What is disputed is whether the right shoulder surgery the plaintiff underwent six years after the MVA was causally connected to it.

The Plaintiff's Life Prior to the MVA

[4] The plaintiff is 52 years old. She is a highly specialized oculoplastic surgeon. She is married to Dr. Perhez Jaffer ("Perhez"), a family doctor. They have two children, now aged 19 and 17.

[5] The plaintiff was born in Uganda. She immigrated to Canada as a young child with her parents, ultimately settling in Edmonton, Alberta. From a young age, her parents instilled in her the importance of both education and community service. She excelled in both.

[6] The plaintiff graduated from high school in 1990 and immediately enrolled at the University of Alberta ("U of A") in sciences. After only two years, she was accepted into U of A's medical school. In 1994, she received her Bachelor of Science degree in Health Sciences. That year, she also received a one-year scholarship to Oxford, England. While there, she played both varsity volleyball and ice hockey.

[7] The plaintiff graduated from medical school in 1997 and began a five-year residency at the U of A in ophthalmology. Following completion of her ophthalmology

residency in 2002, she received a fellowship into a two-year pediatric oculoplastic and orbit sub-specialty program at the University of Pennsylvania (“U of Penn”).

[8] The plaintiff completed her fellowship in 2004 and returned to Canada, setting up an oculoplastic and orbit surgery practice in Burnaby, BC in an office space at 3994 East Hastings Street (“3994”) that had been leased by Perhez for his family medical practice.

[9] It proved to be difficult for the plaintiff to obtain hospital privileges and surgery time at the various hospitals in the Vancouver area. In 2005, she was able to obtain both in Alberta. She began working as a locum in Calgary and later full-time in both a clinical and surgical practice out of a clinic owned by her brother, Dr. Amin Kherani (“Amin”), a retinal ophthalmologist, with whom she stayed while in Calgary. She returned home to her family in Burnaby on weekends.

[10] In 2005, Perhez rented additional office at 4446 East Hastings Street (“4446”) into which the plaintiff moved her practice. 4446 was also used by the plaintiff and Perhez for a cosmetic laser clinic and for Perhez’s walk-in clinic. Later, the plaintiff moved her clinic back to 3994 and Perhez moved his family practice to 4446.

[11] The plaintiff’s practice in Calgary was primarily pediatric. She was on-call in Calgary two weeks per year. She received 60% of her fee billings. The clinic retained the remaining 40% (with a minimum payment of $5,000 per month) but supplied the clinic space, equipment, and most of the staff.

[12] In 2008, the plaintiff was granted privileges in BC’s Fraser North Health Region, which included four hospitals: Ridge Meadows Hospital in Maple Ridge, Eagle Ridge Hospital in Port Moody, Royal Columbian Hospital in New Westminster, and Burnaby General Hospital (“BGH”). However, her operating room access was limited to BGH’s surgical facilities.

[13] Between 2008 and 2017, the plaintiff’s privileges at BGH slowly increased from an initial two hours per month to six days per month for minor surgeries and from a one-half day to one to two days per month for major surgeries. She

transitioned her practice from the Calgary to her Burnaby clinic such that, at the time of the MVA, she was working one week per month in Calgary and the rest of her time in Burnaby. During the Calgary week, the plaintiff typically performed surgeries two to three days and worked in her clinic two to three days. The plaintiff's practice in Burnaby is primarily adult (non-pediatric) patients.

[14] The plaintiff testified that she enjoyed working at the clinic in Calgary because she was able to see a variety of patients, the practice was multi-disciplinary, she had more operating room time and was paid a higher fee for her work than what she is paid for in BC.

[15] As the plaintiff's Burnaby clinic became busier, she and Perhez invested more money into it, both in terms of equipment and staff.

[16] The vast majority of the plaintiff's Burnaby practice involves "functional" consultations and surgeries for which she is paid a fee by BC's Medical Services Plan. She described these functional procedures as "major" (dealing with tumors, traumatic injuries, eye socket reconstruction, prosthetics, grafts, tear ducts, eyelids, etc.) and "minor" (drooping eyelids, small cancers, degenerative issues, etc.). The balance of the plaintiff's practice, about ten percent, involves cosmetic/aesthetic surgery performed in the laser clinic for which she is paid by the patient directly. She testified that this cosmetic surgery practice complements her oculoplastic practice.

[17] Prior to the MVA, the plaintiff was able to perform on a daily basis five to six surgeries during her major surgery operating room time and eight to ten minor surgeries during her minor operating room time at BGH. During her non-operating days, the plaintiff saw an average of 50 and up to 60 patients per day in her clinic, which was made up of consultations, pre-operation and post-operation examinations.

[18] In addition to her clinic and operating practice, the plaintiff worked "on-call" four weeks per year. During those weeks, she worked or had to be available for work 24 hours per day, 7 days a week.

[19] During trial, the plaintiff demonstrated the ergonomic movements, postures, positions and dexterity necessary for the delicate microscopic surgeries she performs. She is right-handed and held the required instruments with her right hand. She testified that, before the MVA, she typically had pain after a day of surgery but was nevertheless able to fully function and the number of patients she saw and the surgeries she conducted were not affected.

[20] In addition to her own practice, the plaintiff contributes to and is heavily involved in the administrative and educational processes of the various societies in her specialties. Her contributions include teaching at the University of British Columbia as an Ophthalmology Clinical Associate Professor and speaking at national and international conferences. She is on the Board of Directors at Orbis Canada and is a national examiner for the Royal College of Physicians and Surgeons.

[21] Since starting her practice in 2004, the plaintiff's expertise and efficiencies in her practice steadily improved. Her reputation grew and, by the time of the MVA, her waitlist had increased to 15 to 16 months. There was no doubt in the plaintiff's mind that her practice would continue to grow and expand.

[22] The plaintiff's clinic manager, Lindsey Braacx, described the plaintiff as very driven, thorough with her patients and encouraging of her staff. She testified that, prior to the MVA, the plaintiff did not take any breaks during her clinic days. Ms. Braacx was not aware of the plaintiff having any functional capacity issues. The plaintiff and her clinic were working at full capacity.

[23] The plaintiff's brother, Amin, described the plaintiff as a "one of a kind" individual who excelled in her accomplishments. She was a "vibrant", "vigorous", "motivated", "talented" surgeon who was driven by the spirit of giving her time and energy to the needs of her patients, in "selfless service" to them. She embraced her work in that regard. Amin testified that the plaintiff was a committed to her family as well as to her advocacy for diversity and inclusion for women in surgery. He testified that any physical or functional limitations she had prior to the MVA were "minimal".

[24] In September 2010, the plaintiff was involved in a motor vehicle accident. Over the course of the next month, she attended three massage therapy sessions administered by William Allen, a registered massage therapist, for complaints of back pain, neck pain and headaches which were aggravated by her work activities.

[25] In January 2012, the plaintiff was involved in a rear-end collision after which she complained of and was treated for neck and back pain (the "January 2012 motor vehicle accident"). The plaintiff testified that she recovered fully from those injuries. An MRI of her cervical and lumbar spine indicated "unremarkable" spine segments other than "borderline central canal stenosis" at her C5-6 level (but "no definite neural foraminal stenosis") and "borderline bilateral neural foraminal narrowing" at her L4-5 level.

[26] Dr. Collin McNeill was the plaintiff's family doctor from 2012 until his retirement in 2019 at age 82. Based upon a review of his clinical records, Dr. McNeill testified that the plaintiff saw him in March 2012 after her January 2012 motor vehicle accident, complaining of headaches, dizziness, and pain in her neck, thoracic and lumbar spine regions, shoulder girdle, and some right hand "pins and needles". Dr. McNeill was concerned at the time that she had suffered a concussion. He confirmed that the plaintiff's complaints in this regard continued throughout 2012. She attended one session with Mr. Allen in March 2012 for massage therapy treatment to her back, shoulder, and neck regions.

[27] Between December 2013 and September 2014, the plaintiff attended six more massage therapy sessions with Mr. Allen for pain in her neck, back, and shoulder regions. She advised Mr. Allen that her pain symptoms flared up with prolonged standing and the necessary stooping postures during surgeries.

[28] In 2014, Perhez rented office space at 3990 East Hastings Street ("3990") into which he moved his family practice, leaving only the cosmetic laser and walk-in clinics at 4446.

[29] In February 2015, the plaintiff had another massage therapy treatment with Mr. Allen for back pain.

[30] In approximately 2015, the plaintiff decided to develop a multi-disciplinary clinic modelled after her brother's Calgary clinic. Over the course of the next year or so, she and Perhez acquired additional office space at 3992 East Hastings ("3992") which was between and contiguous with 3990 and 3994. They planned the renovations needed to expand the plaintiff's clinic into this new space. At the time, Dr. Azien Safarpour, an ophthalmologist from the plaintiff's Calgary clinic, wanted to move to BC and performed several short-term locums for the plaintiff in the plaintiff's Burnaby clinic.

[31] In 2016, 12 years after receiving her credentials as a pediatric oculoplastic and orbit surgeon, the plaintiff was granted on-call surgical privileges at B.C. Children's Hospital in Vancouver.

[32] During the period of July 2016 to November 2016, the plaintiff had eight more massage therapy sessions with Mr. Allen for pain in her back and back regions likely brought on by her posture during surgeries. Mr. Allen testified that all of his massage therapies comprised Swedish, deep tissue and trigger point massages. Mr. Allen testified that the plaintiff's treatment pattern prior to the MVA was that he treated her when she had flareups, she would be fine for a while and would see him again when she had another flareup.

[33] Despite the aches and pains from her job, the plaintiff maintained an active lifestyle and was fully functioning. She participated in a number of sports at a high level, including representing Canada at an Ismaili volleyball competition in Dubai in August 2016. She skied, fished, played soccer, ran and did yoga. She and her family are involved in the local Ismaili community and participate in its social and cultural activities.

[34] The plaintiff testified that after returning from the Dubai tournament in 2016, she developed "tennis elbow" (brachioradialis tendonitis) in her right arm. She was

referred by Dr. McNeill to a physiatrist, Dr. Catherine Ho, who performed trigger point injections in September and December 2016, as well as in February 2017. The plaintiff testified that her symptoms resolved after those injections.

[35] The plaintiff conceded on cross-examination that, after returning from the Dubai volleyball tournament, her complaints of pain were not limited to right arm tennis elbow, but also included pain in her shoulder girdle and neck. She attributed these symptoms to both her months of intense high-level volleyball and her surgical work.

[36] Dr. Ho's consult report to Dr. McNeill dated September 20, 2016 stated, in part:

> CHIEF COMPLAINT
>
> Low back, neck, shoulder, right arm pain
>
> HISTORY OF PRESENTING ILLNESS
>
> Femida describes a longstanding history of bilateral neck pain that has worsened in the past few months. She reports constant 4/10 aching pain in her bilateral neck that is worse with positions associated with suboptimal posture, such as operating. Her symptoms are better with rest, heat and massage. She describes bilateral headaches that are 'band-like" and worse with grinding or clenching her teeth. She also has right lateral elbow pain along with intermittent numbness and paresthesias in the ulnar forearm and 5th digit. She denies any weakness or loss of fine motor dexterity.

[37] Dr. Ho's clinical record dated December 13, 2016 stated that the plaintiff reported "having challenges with OR because of arm pain".

[38] Dr. Ho's consult report to Dr. McNeill dated February 21, 2017 referenced the plaintiff's chronic cervical and forearm myofascial pain. The plaintiff agreed that she must have provided this information to Dr. Ho but did not recall having done so, except as it related to her tennis elbow. She testified that her right arm pain symptoms had resolved after Dr. Ho's trigger point injection on February 21, 2017, and thereafter were not functionally limiting and did not affect her ability to perform surgical procedures prior to the MVA. She readily conceded, however, that these symptoms could have been indicative of an underlying medical condition.

[39] Dr. Ho testified that, based upon her four examinations and treatments of the plaintiff prior to the MVA, she considered the plaintiff to be a highly functioning surgeon who was suffering from strained muscles likely caused and aggravated by the postures and positions required of her during operating procedures. Her treatments of and therapeutic recommendations to the plaintiff were focused on providing pain relief and improving the ergonomics of her work methods. She described the plaintiff's headache symptoms as "tension headaches" related to these postures.

[40] Dr. Dimithra Hippola attended medical school with the plaintiff and has been a close friend of hers ever since. Their children grew up together and their respective families often socialized. Despite their respective busy medical practices, they regularly spoke on the phone. Dr. Hippola described the plaintiff as an outgoing, extremely energetic, diligent, hardworking and driven person who was an "incredible leader", being passionate about everything she did. She did not notice the plaintiff having any functional limitations prior to the MVA.

[41] During her cross-examination, Dr. Hippola testified that, although the plaintiff usually confided in her about her personal issues, she was unaware of the plaintiff's January 2012 motor vehicle accident and was surprised to learn that the plaintiff had complained in the months before the MVA of longstanding pain. She was also unaware that the plaintiff had received trigger point injections.

[42] Dr. Linda Rose is another of the plaintiff's medical school colleagues. They met at U of Penn while Dr. Rose was doing her ophthalmology residency there. The plaintiff was her residency supervisor. In the years that followed, Dr. Rose and the plaintiff maintained a close relationship, always sharing hotel rooms during medical conferences several times per year. During the conferences they engaged in various physical activities together such as yoga, going to the gym, and running. Dr. Rose described the plaintiff as an "incredible woman" who never complained, was passionate about life, driven to succeed, energetic, hardworking, and was encouraging and supportive of those around her. Dr. Rose and the plaintiff

volunteered together in Mexico and India performing eye surgeries for those who were unable to afford them. She testified that "everybody in my world knows Femida".

[43] Dr. Rose testified that, prior to the MVA, she never noticed the plaintiff having any functional difficulties.

[44] Perhez described the plaintiff prior to the MVA a person who had high energy, was "strong", "outgoing", "smart", "hardworking", "driven" and passionate about and dedicated to her work. He testified that, after being in her practice for almost 14 years, the plaintiff was "happy" and "fulfilled" at having climbed to the top of her profession. She was very busy and active with her family. He testified that although he was aware that the plaintiff had some neck, shoulder and back pain, those symptoms did not affect her ability to function.

[45] On March 15, 2017, the plaintiff and Perhez received the building permit they needed to expand the plaintiff's clinic into 3992.

[46] The plaintiff testified that the weekend prior to the MVA, she was skiing at Whistler with her family. She flew to Calgary on Sunday evening, worked in the Calgary clinic on Monday, performed surgeries on Tuesday, and further worked in the clinic on Wednesday, before returning to BC on Wednesday night.

[47] The MVA occurred the following morning.

The MVA

[48] The plaintiff testified that, on the morning of Thursday, March 30, 2017, she was driving east on West 41st Avenue in Vancouver on her way to BGH where she was scheduled for a full day of surgeries. She came to a full stop at a red light at the intersection of Angus Drive and watched a pedestrian walk across the West 41st Avenue in front of her. Just as the pedestrian had completed the crossing, she heard a "screech". Her right arm was on the steering wheel. She turned her head to look in her side mirror and the rear of her vehicle was impacted by the defendants' vehicle.

[49] Excerpts from the examination for discovery of Mr. Rollins were read into evidence by the plaintiff. In summary, his evidence about the MVA was that:

a) it was a sunny “bluebird” day between 6 a.m. and 7 a.m.;

b) the sun was in his eyes as he was travelling eastbound on West 41st Avenue and he did not notice the plaintiff’s stationary vehicle until he was approximately four car lengths behind her;

c) he estimated his speed at “about 50 kilometres an hour”; and

d) he braked hard but it was too late and he “rammed” the back of the plaintiff’s vehicle.

[50] The plaintiff testified that, upon impact, her head hit the headrest with such force that the headrest broke. She felt immediate tingling in her right arm and right shoulder pain. She stayed in her vehicle until paramedics arrived. The ambulance took her to Vancouver General Hospital (“VGH”) for assessment. By then, she was experiencing headaches, neck, lower back and shoulder pain. She also had tingling on the medial side of her right arm.

[51] The plaintiff was given both an MRI and CT scan. She was discharged approximately eight hours later with concussion protocol instructions.

The Plaintiff’s Life After the MVA

[52] Immediately after the MVA, all of the plaintiff’s patients’ appointments were cancelled and had to be rescheduled. Dr. Safarpour filled in as a locum at the plaintiff’s clinic for a few days after the MVA, seeing new referrals only.

[53] In the days, weeks, months and years following the MVA, the plaintiff suffered and continues to suffer persistent and severe headaches as well as pain in her neck, upper and mid back, shoulder (posterior in the right shoulder), lower back (SI joint), right hip and knee. Her symptoms included tingling in her right arm and fingers.

[54] The plaintiff initially experienced “foggy brain” and significant light and sound sensitivity as well as dizziness and unsteadiness. Her cognition was slow. She was

confused. However, those symptoms dissipated over time with medication and rest at home in a dark, quiet room. However, she continues to be sensitive to light.

[55] Dr. Hippola testified that the plaintiff was not herself after the MVA. Although she was still relatively energetic and appeared to function at a high level, she was in obvious pain, seemed angry, get tired easily, and withdrew socially.

[56] The plaintiff was unable to work after until her scheduled “on-call” week beginning April 18, 2017. Over the weeks that followed, the plaintiff slowly returned to work at her Burnaby clinic. Initially, she was only able to see five to ten clinical patients per day. Ms. Braacx testified that each clinical patient was allocated more appointment time because the plaintiff was moving much slower than before the MVA.

[57] Commencing April 3, 2017 and continuing until to the present, the plaintiff consulted and was treated on a regular basis by numerous medical and rehabilitation professionals including Dr. McNeill, physiatrists, neurologists, anesthesiologists, physiotherapists, interventional radiologists, massage therapists, and strength conditioning coaches, all in an effort to assess and reduce her pain symptoms and increase her stamina. Her treatments included a regular regime of trigger point injections, nerve blocks, Botox injections (up to 18 per session), various prescription and over-the-counter pain medications and vitamins. The plaintiff followed the programs of exercise, stretching, yoga and pilates that were recommended. These treatments and exercises provided, at best, only temporary pain relief.

[58] Dr. McNeill testified that he saw and examined the plaintiff numerous times following the MVA. He testified that, although the plaintiff’s pain complaints overlapped with some of those that she had prior to the MVA, there is no question that her pain in all areas were much more severe than they had been previously. In early April 2017, he referred the plaintiff to Dr. Ho for concussion assessment.

[59] On April 21, 2017, the plaintiff was referred to a neurologist, Dr. Cory Toth, regarding her complaint of right-hand paresthesia and muscle strength. His examination of her showed no evidence of nerve injury.

[60] After the MVA, the plaintiff attended 15 massage therapy sessions with Mr. Allen between April 22, 2017 and September 21, 2017. His treatments focused on her neck, shoulder, back and knee pain as well as her headaches. Mr. Allen described the plaintiff's symptoms as much worse than they had been at any period of time prior to the MVA. He testified that the MVA "really affected her".

[61] Lauren Watson is a physiotherapist who treated the plaintiff on approximately 90 separate occasions for her MVA-related pain symptoms from April 25, 2017 to December 29, 2023. Her focus was on the soft tissue muscles in the plaintiff's neck, right shoulder, mid/low back, left knee and hip.

[62] Dr. Ho saw the plaintiff on 39 different occasions after the MVA, from April 5, 2017 to the present and plans to continue her treatments of her. She diagnosed the plaintiff's headaches after the MVA as being "migraines" which are significantly more severe than the tension headaches she had experienced prior to the MVA. Dr. Ho testified that throughout her treatment, the plaintiff was anxious to return to a full workload but that she had to "hold her back" to a gradual return to work schedule. Dr. Ho described the plaintiff's recovery progress as "slow" and that her complaints of severe headaches, dizziness and pain in her neck, right jaw, right shoulder girdle, entire spine including her S1 sacroiliac joint, right arm ,left knee as well as "pins and needles" were aggravated as her work pace increased.

[63] Dr. Ho testified that, as the plaintiff's symptoms persisted, the investigation into their source widened, with different treatment strategies being explored as well as different modes of scans, treatments and referrals to specialists. Dr. Ho testified that the plaintiff's pain symptoms were at a significantly increased level of severity and her functionality has seriously decreased than it had been before the MVA.

[64] The plaintiff testified that any pain relief she was able to attain plateaued after the first several months of treatments and thereafter the treatments and exercises at most maintained the relief she had been able to achieve. She testified that her goal since the MVA has been to return to work and treat as many patients as possible.

[65] The plaintiff was able to maintain her major surgery and most of her minor surgery schedules, but with a reduced volume of only three to four patients each day. She found the clinical and surgical work to be physically challenging and fatiguing as it exacerbated her pain symptoms. The prolonged postures and fine motor skills required of her during surgeries were particularly difficult for her. On several occasions during surgery, she dropped her instruments due to right arm pain and lack of grip strength. She did her best to modify her positioning while working.

[66] On July 24, 2017, Dr. Safarpour began working full-time in the plaintiff's expanded Burnaby clinic as a general ophthalmologist. Since then, Dr. Safarpour has developed her own ophthalmology practice. She does not have hospital surgery privileges but, on occasion, assists the plaintiff with surgeries at BGH. She pays the plaintiff's clinic 35% of her billings for physician services and 65% of her billings for testing services.

[67] By the end of the summer of 2017, the plaintiff's symptoms had improved sufficiently to enable her to see up to 20 to 25 patients a day in her Burnaby clinic, albeit by having to work through the pain. In August 2017, she resumed her one-week-per-month schedule in Calgary, again with a reduced patient workload. By the end of 2017, she was able to see up to approximately 30 patients a day in Burnaby.

[68] In January, 2018, the plaintiff complained to Dr. Ho of right knee pain. Dr. Ho attributed this new symptom to the plaintiff's regime of active rehabilitation after a period of deconditioning.

[69] At the recommendation of her physiotherapist, the plaintiff took one month off work during the summer of 2018 to focus on her rehabilitation in the form of a strength and conditioning program. She hired an oculoplastic surgeon as locums for

her practice named Dr. Dena Hammoudi. The plaintiff testified that she felt stronger and her stamina increased as a result of her time off, however, her physiotherapist, Ms. Watson continued to assess her with less than full range of movement in her neck, spine and hip regions. Perhez testified that the plaintiff's month of focused active rehabilitation did not seem to improve her functioning.

[70] From October 2018 to March 2020, the plaintiff was examined and treated on 22 occasions by Dr. Patrick Yu, an anesthetist specializing in pain management. His treatments included trigger point injections to the myofascial tissues in the plaintiff's neck, shoulders and mid/upper back. Dr. Yu testified that, although the areas of the plaintiff's subjective pain tended to shift around these areas, there nevertheless was a pattern to the pain. Dr. Yu noted sustained improvement in the plaintiff's pain symptoms and functionality over the course of his treatments of her. Dr. Yu recommended continued trigger point injections, a pain education program, and a pain coach to help the plaintiff manage her symptoms.

[71] In October 2018, based upon the findings of an ultrasound of the plaintiff's right shoulder, both Dr. McNeill and Dr. Ho assessed the plaintiff as having full range of motion ("ROM") in her right shoulder with no impingements. Dr. Ho concluded that the plaintiff's ongoing pain symptoms were caused by "over use", but nevertheless continued her quest to determine the cause of the shoulder pain. She counselled the plaintiff regarding balancing her work with her pain symptoms.

[72] Dr. Toth, the neurologist, saw the plaintiff again on December 11, 2018 regarding her ongoing right-hand paresthesia symptoms. Again, he found no abnormalities.

[73] During 2019 and 2020, the plaintiff continued to have headaches, neck pain, mid/low back pain, knee pain and right arm paresthesia.

[74] During the period March to June 2020, the plaintiff saw fewer patients than she normally would have due to the COVID-19 pandemic. She performed only

urgent surgeries. Perhez's laser clinic (where the plaintiff performed her cosmetic surgeries) closed until after the pandemic. In June 2020, it reopened at 3992.

[75] As a result of the COVID shutdown, the plaintiff did not have access to the treatments she had been receiving and her pain symptoms increased. She was able to resume her physiotherapy treatments in September 2020 and attended ten sessions during the next three months. Her goal was to attain her pre-COVID level of health.

[76] In the fall of 2020, both the BC and Alberta governments dramatically increased the availability of operating room time in an attempt to deal with the surgical backlog that resulted from the pandemic. The plaintiff was given access to both the False Creek Surgical Center in Vancouver and significantly more operating room time at Calgary's hospital facilities. Her minimum "overhead quota" at the Calgary clinic increased from $5,000 to $10,000 per month due to increased costs. She was able to operate on more patients per day in Alberta than in BC because the medical system in Alberta is more efficient with less "down time" between surgeries.

[77] Amin testified that his Calgary clinic's activities generally ceased for almost two years as a result of COVID. Only emergency surgeries were performed. Elective patients were deferred and the resulting wait list is still being dealt with. He testified that the plaintiff was allocated an additional day in his clinic for her practice as part of her attempt to "catch up".

[78] The plaintiff testified that her level of pain increased with the number of patients she saw. It took her longer to recover and "regroup". She continued to work through the pain because operating room time was precious, she had a long list of patients who needed surgery and she felt that she did not have the luxury of turning down operating time.

[79] The plaintiff and Perhez purchased some exercise equipment for their home where they exercised together during COVID. When working in Calgary, she used

exercise equipment in Amin's home. Although she was in pain, she was able to function.

[80] The plaintiff's Burnaby clinic did not return to its pre-COVID pace until approximately March 2021.

[81] By December 2021, the plaintiff was very discouraged by her ongoing headaches, the pain in her neck, upper and lower back, right shoulder, right hip, and knee. Nevertheless, she insisted that she was "managing". Perhez testified that he considered she was minimizing her symptoms.

[82] Ms. Iris Djebbari began working at the plaintiff's clinic in March 2022 as a medical office assistant. She testified that the clinic scheduled a maximum of 30 patients per day for the plaintiff, but the plaintiff often advised that the workload was too much for her and many of the patients had to be cancelled and re-scheduled.

[83] Perhez testified that after the MVA, the plaintiff was not her normal self. She was slow and had difficulty moving. She mixed up words and complained of sensitivity to both light and sound. He testified that over the years since the MVA the plaintiff has become anxious, angry and impatient with him and their children. He testified that her entire focus is on finding the energy and stamina she needs to return to work the next day. He testified that she has gained 40-50 pounds since the MVA.

[84] Amin also testified that his sister was not the same person after the MVA. The conversations they had during the evenings at his home after their respective workdays changed from intellectual and medically-related to how she was having difficulty managing her pain symptoms, both physically and emotionally. He testified that she did not cope well. The longer her symptoms endured, the more frustrated and easily angered she became. She was constantly focused on the need to "recharge" so that she would be able to function at work the following day.

[85] Ms. Braacx testified that it was obvious to her that the plaintiff was not able to see her patients at the pace she had before the MVA, and that she had become tired

quickly and had asked for more support from the clinic's staff. Ms. Braacx testified that the plaintiff needed to take breaks, whereas she did not take any breaks prior to the MVA.

[86] Dr. Rose testified that, since the MVA, the plaintiff is not the energetic, outgoing person she was before the MVA. She looks physically uncomfortable, she is hunched over, she looks aged and has gained weight. Dr. Rose testified that the plaintiff's overall health has declined markedly from what it was. On cross-examination, however, Dr. Rose acknowledged that neck and back pain complaints are normal among ophthalmologists.

Right Shoulder Surgery

[87] The plaintiff testified that, by 2022, her overall pain symptoms had become more significant. The pain in the plaintiff's right shoulder pain was, in her words, "intolerable" and "the loudest voice in the pain symphony".

[88] In August 2022 the plaintiff consulted Dr. Farhad Moola, an orthopaedic surgeon specializing in shoulders. He noted that the plaintiff had full ROM in her right shoulder, but had mild weakness and atrophy in that area. He noted that the radiologist's report regarding the March 2022 MRI diagnosed a labral tear and a paralabral cyst in the plaintiff's right shoulder. The report also diagnosed a rotator cuff tear but Dr. Moola doubted that diagnosis. He ordered an MR arthrogram for the plaintiff's right shoulder and right hip. The arthrogram confirmed his assessment that there was a superior labral tear and a paralabral cyst but that there was no tear in the rotator cuff, rather only minor fraying of it. Dr. Moola discussed with the plaintiff the option of shoulder surgery. The plaintiff was apprehensive about it but, after consulting several other physicians about her options, including Dr. Jordan Leith, an orthopaedic surgeon, and because she felt that the pace she was working was not sustainable for her, she decided to proceed with the right shoulder surgery.

[89] The plaintiff was advised that her recovery would take three to six months. She arranged for locums to take over her practice and patients in Burnaby. She was, however, unable to get approval for a locum for her Calgary practice.

[90] In December 2022, at the recommendation of Dr. Ho, the plaintiff and Perhez renovated various areas of her clinic to enable the plaintiff to stand during her examinations and better accommodate her pain symptoms ergonomically. The cost was funded by the laser clinic.

[91] The plaintiff agreed on cross-examination that, by the beginning of 2023, she was performing all of the same types of surgeries as she had done prior to the MVA, with the exception of those procedures involving the use of heavier instruments such as some lacrimo (tear duct), orbital and fracture surgeries which she had trouble performing due to her shoulder pain.

[92] Dr. Moola performed the shoulder surgery on February 15, 2023. He resected the paralabral cyst and repaired the labral tear.

[93] Another oculoplastic surgeon, Dr. Ricarda Bentham, was hired as a locum to assist Dr. Hammoudi.

Post-Shoulder Surgery

[94] Following the surgery, the plaintiff began regular physiotherapy treatments in order to mobilize her right shoulder and arm and improve her functionality as quickly as possible. Dr. Moola agreed on cross-examination that the plaintiff appeared to be fully compliant with the recommended rehabilitation.

[95] Unfortunately, the plaintiff's recovery did not unfold as had been hoped. She testified that, whereas her posterior shoulder pain prior to the surgery had resolved, she had new anterior shoulder pain. She had trouble coping with both the challenges she faced returning to her practice and her concerns that her patients were not receiving the care they needed. Over the course of the next eight months, she saw a counsellor on fourteen occasions. These sessions helped her deal with her emotional issues.

[96] After three months post-surgery, the plaintiff continued to have considerable pain and very limited ROM in her right shoulder. Dr. Moola diagnosed the plaintiff

having frozen shoulders (adhesive capsulitis), a common complication of the surgery that was performed. Dr. Moola testified that, while 80 to 90% of such complications resolve within one year, 5% of the cases end up being permanent.

[97] Dr. Moola injected the plaintiff's shoulder with ultrasound-guided steroid injections. The plaintiff testified that they helped the pain, but not her ROM.

[98] In June 2023, both Dr. Moola and Andrea Reid, the plaintiff's physiotherapist, , assessed the plaintiff's right shoulder ROM as being substantially reduced.

[99] In June 2023, the plaintiff was referred to a physiatrist and pain specialist, Dr. Najam Mian, for her ongoing hip pain. He performed two image-guided nerve blocks in her right hip and SI joint.

[100] Commencing early July 2023, the plaintiff gradually returned to work at her Burnaby clinic. In August 2023, the plaintiff was assessed by Ms. Watson, her physiotherapist, regarding her frozen right shoulder. Both Ms. Watson and Ms. Reid prescribed specific exercises for it.

[101] In December 2023, Ms. Reid referred the plaintiff to a kinesiologist. She testified that these sessions have helped reduce her pain levels and increase her functionality.

[102] Both Dr. Moola and Ms. Reid have noted modest improvement in the plaintiff's right shoulder ROM over time. By January 2024, her ROM was approximately 70 to 80% of full range. Dr. Moola testified that, while there may be further improvement in the future, it will likely peak after 24 months.

[103] In March 2024, Dr. Mian performed a "radio frequency ablation" on the plaintiff's hip. In May 2024, the plaintiff saw an interventional radiologist, Dr. Fenton, who injected her neck with a nerve block and steroids. She found these treatments to be helpful as well.

[104] Ms. Reid testified that, by May 2024, the plaintiff's right shoulder/arm strength has improved, but there has been little, if any, improvement in her right shoulder ROM since January 2024.

[105] Although the plaintiff now works "full-time", the number of patients she treats is approximately 50% of the number she had treated prior to the MVA, the actual number being dictated by her pain symptoms day-to-day. She has also had to be selective regarding the surgeries she performs. If the surgery is physically difficult such that there is risk to the patient, she refers the patient to another specialist. The plaintiff testified that, with her current pain and restricted ROM, she does not believe she will be able to increase her patient numbers and that her work pace has likely plateaued. She is unable to perform the lacrimo (tear duct), orbital and fracture surgeries that utilize heavier instruments.

[106] The plaintiff continues to work in her cosmetic clinic one day a week. That day is typically slower paced and allows her time to recover from the strains from the rest of her work week.

[107] The plaintiff did not return to work at her Calgary clinic after her shoulder surgery. She decided to close her practice there because her post-surgery recovery time was such that the delay in patient treatment would have been a risk to them and she could not get approval for a locum who could treat her patients in her absence. Her patients needed continuity of care. She referred all of her patients to other Calgary ophthalmologists and all of her surgery time was re-assigned. She has no plans to return to her practice in Calgary because she would have to start anew.

[108] Amin confirmed that, after the plaintiff's planned three to four month leave for the shoulder surgery kept being extended, he discussed with the plaintiff the needs of her patients and for his office's overhead to be paid. They determined that there was no choice other than to close her practice in Calgary and refer her patients to other oculoplastic surgeons.

[109] Each of the plaintiff and Amin testified regarding the hurdles the plaintiff would face attempting to reopen a practice in Calgary. The plaintiff would have to lease clinic space, hire staff, organize equipment and establish a supply chain. She would have to re-grow her patient population and establish a surgery waitlist in order to be allocated operating room time. She would also face resistance from established surgeons who would be reluctant to give up operating room time.

[110] Ms. Braacx testified that the one-week-per-month schedule that the plaintiff was working in her Calgary practice is now used to lighten the load at her Burnaby clinic. The plaintiff now sees approximately the same number of patients per day in her Burnaby clinic during that week as she does during other weeks.

[111] It has been over seven years since the MVA. The plaintiff testified that she continues to experience “one continuous cape of pain” from the top of her head to her mid-back, and from her SI joint to her hip. Her pain symptoms increase with sustained positions both during her clinical work and surgeries. Nevertheless, she plans to remain working as an oculoplastic and orbital surgeon, maintain her operating room privileges and work in her cosmetic clinic.

[112] Dr. Hippola testified that she noticed a significant change in the plaintiff after her right shoulder surgery. She gained weight, was much slower in her movements, she would hold her back and right arm, and she seems exhausted.

[113] Ms. Djebbari testified that when the plaintiff returned to the clinic after her right shoulder surgery, her patient bookings were limited to ten to fifteen patients per day. Those numbers slowly increased to twenty to twenty-five patients per day over time. She testified that the plaintiff requires frequent breaks and usually uses a heat or cold pack for her right shoulder.

[114] In October 2023, Ms. Djebbari assumed the role of surgical coordinator at the plaintiff’s clinic in Burnaby, although she spends most of her time assisting the plaintiff during patient examinations due to the plaintiff’s functional limitations. Ms. Djebbari testified that she schedules only four to five patients per day and three

to five patients per day in BGH's major and minor operating rooms respectively in order to accommodate the plaintiff's limited functioning. For the plaintiff's cosmetic practice, Ms. Djebbari schedules up to ten patients per day, but confirmed that most of those are follow up consultations rather than new procedures.

[115] The plaintiff continues with regular sessions of physiotherapy, and kinesiology. She "cold plunges" two to three times per week which she finds helps numbing her pain symptoms. She avoids alcohol and certain foods. The plaintiff's right shoulder ROM remains significantly compromised as a result of the surgery. She has done her best to adjust to using her left hand rather than her right hand. Dr. Ho testified that the plaintiff will continue her treatments into the future. The plaintiff has declined a number of international speaking invitations due to her ongoing injuries.

[116] Perhez testified that the plaintiff is exhausted after a workday and is abrupt with him and their children. She is worse after a day of surgery.

[117] The plaintiff testified that she plans to continue working in her Burnaby clinic, the laser cosmetic clinic, performing operations at BGH, and maintaining her current hospital privileges, as well as her teaching and advocacy. She has no desire to change her practice to one of a non-surgical ophthalmologist. She testified that she has no plans to retire and will not be retiring at the "statistical average age" for physicians because both her children plan to continue their studies beyond high school. She plans to continue working for at least as long as they continue their studies. Perhez confirmed that he and the plaintiff have not discussed retirement or any expectations of when one of them might do so.

[118] Amin testified on cross-examination that the ophthalmology profession is accommodating to those who wish to have a longer career and that it is not unusual for ophthalmologists to work or plan to work into their late 60s or mid-70s and even older.

Agreed Statement of Facts

[119] During the course of the trial, counsel filed an Agreed Statement of Facts as Exhibit 17. It is appended to these Reasons as Schedule “A”.

Expert Evidence

Opinion Evidence Tendered by the Plaintiff

Dr. Peter Zarkadas, Orthopaedic Surgeon

[120] Dr. Zarkadas is an orthopaedic surgeon with a subspecialty in shoulders. He assessed the plaintiff on March 13, 2024. His report is dated April 9, 2024. He was qualified without challenge as an expert capable of providing opinion evidence on the plaintiff’s orthopaedic and musculoskeletal injuries sustained by trauma.

[121] Dr. Zarkadas noted from the pre-MVA MRI imaging that the plaintiff had mild multi-level degenerative changes in her spine, pronounced at the C5-6, L4-5 and L5-S-1 levels. However, he noted from the MRI taken immediately after the MVA that there were multi-level degenerative changes pronounced at the C5-6 level with mild diffuse posterior disc bulge and osteophyte complex indenting the thecal sac and mild to moderate right foraminal narrowing. He also noted degenerative changes at the plaintiff’s L4-5 and L5-S-1 level of her lumbar spine. He noted that the plaintiff’s ongoing pain symptoms “are consistent with myofascial pain of her paracervical spinal and trapezial musculature as well as her rhomboids bilaterally”.

[122] Dr. Zarkadas opined that the MVA significantly aggravated the plaintiff’s pre-existing neck and lower back pain and degenerative changes. He opined in his report that the MVA likely caused the labral tear of the plaintiff’s right shoulder rotator cuff and the development of a paralabral cyst in her right shoulder. However, on cross examination he agreed that if the labral tear occurred during the MVA, he would have expected the diagnosis relatively soon thereafter. Although he also agreed that the labral tear may have pre-existed the MVA, he noted that if so, the tear was asymptomatic and the plaintiff was able to fully function with it and the MVA significantly aggravated it, causing it to become symptomatic. He opined that, either

way, it is unlikely that the plaintiff would have required surgery to her right shoulder but for the MVA.

[123] Dr. Zarkadas opined that the plaintiff is still in the recovery phase regarding her right shoulder surgery and that, although he expects her symptoms will improve with time and continued physiotherapy, he does not believe they will completely resolve. He opined that the plaintiff will likely be left with permanent partial disability of her right shoulder and to a lesser degree of her neck and lower back. He opined that the plaintiff will not likely be able to function as an oculoplastic surgeon beyond her current pace of approximately 50% of her pre-MVA pace.

[124] On cross-examination, Dr. Zarkadas agreed that the plaintiff's pain symptoms after the MVA overlapped with those pre-MVA and that labral tears can be common among middle-aged people and particularly those who were involved in "overhead sports" such as volleyball. He also agreed that, given the plaintiff's pre-MVA history of chronic neck, shoulder, and back pain, it would have been unusual for her symptoms to have been fully resolved one month before the MVA.

[125] Dr. Zarkadas also acknowledged the existence of studies indicating that the plaintiff's occupation as an ophthalmologist put her at risk of developing musculoskeletal pain. He testified that he was not surprised that the plaintiff had a history of such pain prior to the MVA, but pointed out that she was nevertheless able to fully function both at work and recreationally, whereas after the MVA her functioning has been significantly compromised and became bad enough that she had shoulder surgery. He opined that something must happened during the MVA that caused her previously asymptomatic condition to become symptomatic.

[126] Dr. Zarkadas' opinions were not dispelled during cross-examination.

Dr. Tony Giantomaso, Physiatrist

[127] Dr. Giantomaso is a physiatrist who was qualified without objection as an expert in the field of physical medicine. He interviewed and conducted a physical examination of the plaintiff on April 13, 2023 and again on December 14, 2023. He

also reviewed the extensive clinical records relating to the plaintiff's medical history. His expert reports are dated April 27, 2023 and January 2, 2024, respectively.

[128] Dr. Giantomaso opined that the following conditions in the plaintiff likely pre-existed the MVA and were unrelated to it:

a) mild and sporadic right epicondylitis and ulnar nerve irritation;

b) intermittent mild but chronic mechanical neck pain; and

c) mild and sporadic right shoulder impingement.

[129] Dr. Giantomaso opined that, given the plaintiff's high level of functioning prior to the MVA as compared with that after the MVA, the following conditions in the plaintiff were likely causally related to the MVA:

a) Short-lived mild traumatic brain injury that has resolved;

b) migraine and occipital/cervicogenic headaches;

c) cervical sprain/strain injury consistent with a WAD-II whiplash; and

d) thoracic sprain/strain grade 1-2 injury.

[130] Dr. Giantomaso noted that one cause of deep-seated shoulder pain can be a labral tear. He opined that, given the plaintiff's complaints of right shoulder pain as well as the significant level of her functional decline after the MVA, the following conditions in the plaintiff are likely attributable to the MVA but acknowledged that he would defer to those with more specific expertise in these areas:

a) right shoulder labral tear;

b) chronic temporomandibular joint dysfunction;

c) chronic adjustment disorder/increased anxiety and decreased mood; and

d) Exacerbation and aggravation of pre-existing right arm ulnar nerve irritation.

[131] Dr. Giantomaso opined that it is likely the plaintiff will continue to experience chronic pain in all of these areas in the future, although she may experience decreased pain and increased function as time passes. He recommended:

a) ongoing follow up with Dr. Moola and Dr. Ho and/or Dr. Mast;

b) consideration of alternate medication management using topical lidocaine, diclofenac and Flexeril Transderm cream as well as some newer migraine medications such as Ubrelvy or Ajovy;

c) ongoing active rehabilitation, including with a certified personal trainer or kinesiologist;

d) occasional ongoing passive therapies such as physical therapy, chiropractic, massage and acupuncture during times of flare-ups;

e) following the recommendations of an occupational therapist regarding her workplace ergonomics; and

f) ongoing support through counselling or psychology.

[132] Dr. Giantomaso opined that, given the extent of the medical and rehabilitation intervention and treatment the plaintiff received between the MVA and her right shoulder surgery, her level of recovery and function likely plateaued prior to the surgery. He opined that the plaintiff's current functional limitations are significant and likely lifelong. He opined that it is very unlikely that the plaintiff will be able to return to her pre-MVA level of work intensity and duration.

[133] As noted, Dr. Giantomaso assessed the plaintiff a second time on December 14, 2023 specifically regarding her frozen right shoulder (adhesive capsulitis). He recommended EMG studies of her right arm and hyper-volumized corticosteroid injections to her subacromial bursa and glenohumeral joint, along with focused and ongoing physiotherapy for her right shoulder.

[134] On cross-examination, Dr. Giantomaso acknowledged that both stress and lack of sleep are factors that could contribute to pain symptoms. He also acknowledged that cysts are common with labral tears and explained there are many causes for "deep seated" shoulder pain such as that reported by the plaintiff. However, he made clear that, while it is impossible to tell whether the plaintiff's labral

tear and cyst were degenerative or traumatic, the fact that the plaintiff reported post-MVA instability in her right shoulder makes it more likely than not that it was traumatic and caused by the MVA.

[135] Dr. Giantomaso's opinions were not dispelled during cross-examination.

Dr. Farhad Moola, Orthopaedic Surgeon

[136] Although Dr. Moola was not tendered by the plaintiff as an expert witness, he was qualified as such during the course of his cross-examination. He testified that, whereas rotator cuff tears are relatively common, labral tears are not, and that paralabral cysts are even less common. He opined that labral tears can be caused by trauma as well as from sports, particularly "overhead" sports.

[137] Dr. Moola opined that the February 2023 shoulder surgery he performed on the plaintiff's right shoulder was necessary and appropriate based on her long-standing symptoms and clinical presentation. He opined that the labral tear and paralabral cyst were likely responsible for the plaintiff's deep-seated shoulder pain.

Jodi Fischer, Occupational Therapist

[138] Ms. Fischer is an occupational therapist who conducted an eight-hour functional capacity evaluation ("FCE") of the plaintiff on February 20, 2024. Her report is dated March 1, 2024. Ms. Fischer also prepared a cost of future care analysis.

[139] Ms. Fischer testified that, prior to conducting the FCE, she researched the physical demands required of the plaintiff's specialized work, both clinically and surgical, including posture, dexterity, sustained static and repetitive reaching, and tolerance requirements.

[140] Ms. Fischer opined that, during the FCE, the plaintiff displayed multiple symptoms of functional impairment in her neck/upper back, mid back, right shoulder, lower back, right forearm, right hand and right hip. She also displayed classic

symptoms of headache and fatigue. Ms. Fischer followed up with the plaintiff by telephone the following day and discussed with her how she had endured the FCE.

[141] Ms. Fischer opined that the plaintiff's functions are limited in the following areas:

a) markedly limited right shoulder range of motion and strength which impacts her tolerance for sustained reaching and holding up her right arm;

b) well below average fine finger dexterity with increased tendency to drop items the longer she is engaged in a task; and

c) reduced sitting and standing tolerance and a need to alternate positions while engaged in tasks involving prolonged looking down, fine finger dexterity, holding and reaching;

[142] Ms. Fischer noted that the plaintiff needs medication and frequent breaks in order to manage her pain symptoms.

[143] On cross-examination, Mr. Fischer acknowledged that her opinion had been assisted by a review of an article entitled "Survey of Musculoskeletal Disorders Among US Ophthalmologists" published in December 2020 by the Digital Journal of Ophthalmology. The result of the survey was that 66% of the 127 respondents had reported experiencing work-related pain, at an average level of four out of ten, particularly neck pain. There was a significant association between ophthalmologists with musculoskeletal pain and the number of hours they spent performing surgery. The survey indicated that increased neck pain was "universal" among ophthalmologists.

[144] Ms. Fischer opined that repeated and cumulative exposure to the equipment utilized by ophthalmologists in their practices increases the risk of musculoskeletal pain symptoms and that changes in posture to alleviate the risk is not always possible.

Farida Sukhia, Economist

[145] Ms. Sukhia is a Chartered Professional Accountant and Chartered Business Valuator with expertise, *inter alia*, in quantifying economic loss claims. She was qualified without debate in that field.

[146] Ms. Sukhia provided a report dated March 11, 2024 that quantified the plaintiff's past and future loss of income-earning capacity based upon various facts she was asked to assume. She provided a second report dated March 15, 2024 that revised certain calculations in her first report based upon additional assumptions.

[147] For the purposes of her reports, Ms. Sukhia assumed that Dr. Safarpour worked at the plaintiff's Burnaby clinic as a locum after July 2017.

Darren Benning, Economist

[148] Mr. Benning prepared a report dated March 7, 2024 in which he provided tables setting out: (a) the applicable multiplier values in respect of the plaintiff's future cost of care (with provision only for the contingency of premature death), and (b) the present value of those future care costs.

[149] Mr. Benning's report was entered in evidence without the need for him to attend as a witness.

Opinion Evidence Tendered by the Defendants

Dr. Jordan Leith, Orthopaedic Surgeon

[150] Dr. Leith is an orthopaedic surgeon whose qualifications to provide opinion evidence in that field were not disputed. He prepared a report dated February 9, 2024. He did not perform a medical examination of the plaintiff prior to preparing it. He opined that, although the plaintiff may have complained of right shoulder pain after the MVA, there was no specific mention in the medical records of acute trauma to the right shoulder joint. He opined that if the plaintiff had suffered a labral tear during the MVA, there would have been a specific notation to that effect. He therefore opined that the MVA did not cause a labral tear or paralabral cyst in the

plaintiff's right shoulder. Rather, he opined that the labral tear/paralabral cyst were more likely due to the plaintiff's age or the biomechanics of the game of volleyball.

[151] Moreover, Dr. Leith opined that "the mechanism of the [MVA] was also not consistent with a trauma that would cause structural injury to the shoulder joint". He opined that the plaintiff's right shoulder issues were more consistent with degenerative changes to her labrum. He opined that the MVA possibly aggravated/irritated the already present symptoms. He noted that Dr. Moola's consult report indicated that surgery "could be considered", which Dr. Leith considered was "not a clear endorsement that surgery was required".

[152] Because of the late service of Dr. Zarkadas' report dated April 9, 2023, defendants' counsel was given liberty to arrange for Dr. Leith to conduct an independent medical examination ("IME") of the plaintiff during the course of the trial. That examination was conducted by Dr. Leith on June 19, 2024. Dr. Leith's report is dated June 24, 2024 and was admitted in evidence without objection.

[153] Dr. Leith found that the plaintiff's right shoulder ROM was only slightly decreased from normal and that it was still functional. He opined that the difficulties the plaintiff is having with her right shoulder is not due to "frozen shoulder" but rather from "surgical insult". His main criticism of Dr. Zarkadas' opinions was that Dr. Zarkadas did not appear to consider the absence in the medical records of the plaintiff having specifically complained of right shoulder joint pain immediately after the MVA. He opined that, although she did present with right shoulder pain, if it was related to the shoulder joint, there would have been specifically recorded as such in the clinical notes. He opined that, in the absence of such a record, the right shoulder pain was likely myofascial.

[154] Dr. Leith testified that, although he reviewed all of the medical records that were provided to him, he made no mention of any of them between March 30, 2017 and March 1, 2022 because he did not consider any of them to be relevant to the issue of causation of the plaintiff's right shoulder labral tear.

[155] On June 26, 2024, Dr. Leith was provided with the clinical records of Mr. Allen, the massage therapist. Those records were not available to defendants' counsel until that day. Dr. Leith provided an addendum report dated June 27, 2024 advising that, after a review of the records, his opinion was unchanged.

Dr. William Craig, Physiatrist

[156] Dr. Craig is a physiatrist. His qualifications to provide opinion evidence in that field were unchallenged.

[157] Dr. Craig performed an IME of the plaintiff on February 8, 2024. His report is dated that same day.

[158] On examination, Dr. Craig found that the plaintiff had:

a) tenderness and trigger points in her neck and upper back, greater on the right;

b) full ROM in her right shoulder, albeit with some reports of pain with "provocative maneuvers";

c) no signs of adverse neural tension in her arms other than that she did not tolerate thoracic outlet maneuvers on her right side;

d) pain in her right lateral hip with squatting and some straining sensations when reaching to her shins;

e) tenderness over her proximal right lateral thigh when her hip and sacroiliac joints were stressed; and

f) normal strength in her legs.

[159] Dr. Craig opined that the plaintiff may have had an initial mild brain injury but that any current cognitive symptoms she has are likely related to pain, mood, sleep or medication issues. He would, however, defer to a neurologist regarding whether the plaintiff's headaches meet the diagnostic criteria for migraines. He opined that the plaintiff's right shoulder pain is primarily myofascial and not due to adhesive capsulitis. He recommended that any future trigger point injections use saline rather than a local anesthetic and that she continues with Botox injections with higher doses. He opined that the plaintiff's lower back and hip pain are likely muscular and

suggested trigger point injections using longer needles. He opined that the plaintiff does not have an issue arising from her right hip joint. He is of the view that the plaintiff's mood can be a barrier to recovery, reducing pain symptoms and perceived capacity.

[160] Dr. Craig opined that the MVA caused the plaintiff to suffer moderate soft tissue and possible cervical facet joint injuries to her neck, upper back, and lower back and that it exacerbated the plaintiff's pre-existing right shoulder condition. He opined that the MVA also likely caused a soft tissue injury and possibly a labral injury of the plaintiff's right shoulder. He was unable to opine on the cause of the plaintiff's right-hand paresthesia symptoms.

[161] Dr. Craig opined that the plaintiff's pre-MVA symptoms put her at risk for a poor outcome after the MVA. He opined that she has not reached the point of full medical improvement and expects that her mood is exacerbating her pain symptoms, although he would defer to a mood disorder expert. He opined that with further treatment and time, the plaintiff "should be able to increase the hours and the number of surgeries that she is doing". On cross-examination, he was reluctant to accept that the MVA has had a "significant" impact on the plaintiff's work and daily activities. However, he agreed that he would defer to the assessments and observations of the plaintiff's work colleagues and her treating physiatrist, Dr. Ho. He also agreed that an accurate measurement of the impact would be a comparison between the plaintiff's billings pre and post-MVA.

Dr. Alister Prout, Neurologist

[162] Dr. Prout is a neurologist whose opinions were introduced in evidence without the need for him to attend court.

[163] Dr. Prout conducted an IME of the plaintiff on October 27, 2021. His report is dated November 21, 2021. He noted from his interview and physical examination of the plaintiff as well as the clinical records that the plaintiff developed a variety of symptoms following the MVA and, although some of her symptoms have improved

significantly, others (neck pain, headaches and right upper extremity pain) have persisted that are limiting and continue to impact her work and day-to-day activities.

[164] Dr. Prout opined that the plaintiff suffered a "whiplash mechanism injury to the upper back and neck regions". He opined that her C5-6 disc protrusion was not the cause of her midline neck pain or her right upper extremity symptoms. He opined that that disc changes as well as other degenerative changes in her neck and lower back are not causally related to her persistent pain symptoms. He opined:

> It is my opinion that the right arm referred symptoms of which Dr. Kherani complained early post-accident and which continue to be present to varying degrees relate to disfunction of the lower brachial plexus (bundle of nerve roots in the right armpit and shoulder/neck region) supplying the medial arm and hand. The dysfunction of the nerves in the lower brachial plexus is in turn […] due to muscular changes in the neck and shoulder girdle region, in turn secondary to the soft tissue injuries sustained at the time of a whiplash mechanism injury.

[165] Dr. Prout opined that the plaintiff's right shoulder girdle and neck region symptoms are consistent with a soft tissue injury to the right neck and shoulder girdle. He opined that, as a result of the whiplash mechanism injury sustained by the plaintiff in the MVA, she developed other symptoms consistent with components of a whiplash associated disorder – in particular persistent problems relating to headaches which, in Dr. Prout's opinion, are directly attributable to the MVA. He opined that the plaintiff's neck and shoulder girdle pain symptoms continue to compromise her ability to work full-time hours and at her pre-MVA level of intensity and endurance.

[166] Dr. Prout also opined that the plaintiff likely sustained a mild concussion as a result of the MVA.

[167] Dr. Prout opined that the plaintiff would benefit from a multidisciplinary pain management program.

[168] At the request of defence counsel, Dr. Prout reviewed and opined on additional clinical records, imaging, and expert reports that were provided to him after he authored his first report. Dr. Prout's addendum report is dated March 1,

2024. The additional documents did not alter his earlier opinion. In particular, Dr. Prout opined that the 2012 motor vehicle accident had no bearing on the plaintiff's pain symptoms after the MVA. However, Dr. Prout acknowledged that the additional clinical records do suggest that the plaintiff had pre-existing pain symptoms and probable conditions that may have contributed to her ongoing post-MVA symptoms. He wrote:

> It is my opinion the Dr. Kherani likely suffered soft tissue injuries at the time of the 2012 accident resulting in referred symptoms into the right upper extremity, very similar to those symptoms developing after the 2017 accident. This fact raises the possibility that Dr. Kherani being anatomically predisposed to symptoms of brachial plexus dysfunction (thoracic outlet syndrome) in association with two probable soft tissue injuries as well and as [sic] her occupation which requires her to operate in somewhat awkward positions and likely predispose her to sensory symptoms in the right upper extremity in the setting of prior soft tissue injuries sustained.
>
> It is also apparent from the clinical records of Dr. Ho that Dr. Kherani had fairly chronic neck and shoulder girdle symptoms in 2016 likely reflecting underlying chronic myofascial pain issues that, although significantly less problematic than following the 2017 accident were nonetheless ongoing and which would render Dr. Kherani more susceptible to effects of the injuries sustained in the 2017 accident and more likely develop symptoms of a sensory nature in the right upper extremity, in turn referred from irritation of the brachial plexus (functional thoracic outlet syndrome)…

Claudia Walker, Occupational Therapist

[169] Ms. Walker is an occupational therapist who provided a report dated April 17, 2024, critiquing the opinions of Ms. Fischer as set out in the latter's report dated March 1, 2024. Ms. Walker did not conduct an independent FCE of the plaintiff. She was qualified in her field without debate.

[170] Ms. Walker wrote:

> Purpose of assessment
>
> The goal of critique report is to comment upon the methodology utilised in the original assessment, the use of the provided documents as well as the quality/reasonableness of the recommendations and costs. A critique report does not provide an alternative opinion nor rely upon documents which the original assessor was not provided with.

Despite that stated scope, Ms. Walker strayed into providing her own opinions regarding Ms. Fischer's FCE methodologies based upon undisclosed "clinical standards", on "how it's supposed to be done" and on "what I do".

[171] Ms. Walker opined that Ms. Fischer should have conducted her own "job demands analysis" instead of relying on the plaintiff's description of her job demands. She criticized the FCE took place over the course of only one day, rather than two days as Ms. Walker testified she would have done. She was unaware that Ms. Fischer had followed up with the plaintiff the following day. Ms. Walker opined that the FCE was too broad-based and not sufficiently specific to an oculoplastic surgeon.

[172] Ms. Walker criticized Ms. Fischer's reliance on the future care recommendations of Dr. Moola because he was "not identified as a medical legal expert". She stood by her criticism despite being advised during cross examination that Dr. Moola was qualified by defence counsel as an expert during his cross examination. She asserted that it was inappropriate to consider Dr. Moola's recommendations because they were based only on historical records.

[173] On cross-examination, Ms. Walker acknowledged that she does not know what the plaintiff's job demands or future care need requirements are.

Gerard Kerr, Occupational Therapist

[174] Mr. Kerr is an occupational therapist. He conducted a FCE of the plaintiff on March 14, 2024. His report is dated April 9, 2024. His qualifications to provide opinion evidence were not challenged.

[175] Mr. Kerr's testing of the plaintiff identified functional limitations that will impact both the plaintiff's ability to engage in various of her work-related physical demands as well as her recreational/leisure pursuits.

[176] He opined that, although the plaintiff has the capacity to meet the physical demands of her work as an oculoplastic surgeon, she has reduced endurance for

sustained, repetitive right arm movements, right grip/torqueing actions and some body postures such as neck flexion/rotation. Mr. Kerr opined that the plaintiff is unable to perform the lengthier surgery procedures or more physically demanding surgeries including orbit fracture, socket reconstruction, melanoma large flaps grafts or combined ENT plastics or neuro cranio-facials work. Mr. Kerr testified that the plaintiff's dexterity is not her issue—rather it is her ability to perform sustained and repetitive tasks using her right arm. He conceded on cross-examination that he had mistakenly over-valued the plaintiff's dexterity score on the Valpar 204 by 41 percent.

[177] Mr. Kerr opined that the plaintiff has the potential to increase her clinical/consultation work to close to the level it was at pre-MVA. However, he agreed on cross-examination that the best indicator of her capacity to increase her clinic work pace would be the observations of those who work with her in the clinic. He opined that she would benefit from an Occupational Therapy/Ergonomic assessment of her clinic work space and practice routine to minimise symptom provoking demands. He recommended that she use pain management strategies to manage her headaches, shoulder pain, neck pain and right hip/SI pain.

[178] Mr. Kerr opined that the plaintiff's right shoulder issues will impact her ability to perform the more demanding home cleaning tasks involving right arm wiping, scrubbing or reaching activities.

Mark Szekely, Economist

[179] Mr. Szekely is an economist who prepared a report dated March 19, 2024 responding to that of Ms. Sukhia dated March 11, 2024. He was qualified in his field without debate.

[180] Mr. Szekely noted that Ms. Sukhia's loss calculations do not consider "that businesses often experience fluctuations in revenue due to a variety of factors such as market conditions, consumer demand, and operational changes". He opined that the use of a three-year average is less susceptible to the influence of such fluctuations.

[181] Mr. Szekely calculated the plaintiff's past loss of income, net of taxes, to be $262,450, based upon:

a) the use of a three-year average pre-MVA;

b) the inclusion of the actual number of procedures performed by the plaintiff in Calgary in the fiscal years 2021 and 2022; and

c) a consideration of trade-offs between the time spent in Calgary and Burnaby.

[182] Mr. Szekely also provided tables of multipliers for calculating the present value of the plaintiff's future income loss. He opined that his multipliers account for labour market contingencies that generally apply to "females with professional degrees in Medicine".

[183] Mr. Szekely provided a second report dated April 18, 2024 in response to Ms. Sukhia's report dated March 15, 2024. He questioned the validity of Ms. Sukhia's assumption that a significant and enduring locum shortage would cause the Burnaby practice to operate at a limited capacity until the plaintiff reached the age of 70 on the basis that "Ms. Sukhia offers no evidence to substantiate that assumption".

[184] On cross-examination, Mr. Szekely agreed that his use of a three-year average would be inapplicable in circumstances where the revenue trend of the business in question was increasing. He also agreed that the approximate 17.7% reduction he applied in his multiplier calculations for employment income (Table 3) in respect of unemployment and part-time employment contingencies should be ignored if the court were to find it unlikely that such contingencies are applicable in the case of the plaintiff.

[185] Mr. Szekely conceded that his calculations are based on averages and do not consider the case of a highly specialized and motivated professional who is driven to excel in her profession.

Credibility and Reliability

[186] Defendants' counsel submitted that the more impressive an expert witness's CV and experience are, the more weight that must be given to that witness's opinion. On that basis, defendants' counsel submitted that the opinions of the defendants' expert witnesses should be preferred over those of the plaintiff's expert witnesses.

[187] I disagree. An impressive CV and experience, without more, does not mean that the court is obliged to accept the person's opinion. The factors to consider in assessing the credibility and reliability of any witness are well-established. It involves an assessment of the witness's trustworthiness, sincerity and accuracy. With respect to expert witnesses, in addition to demeanour, the assessment includes whether *their* opinion is founded on and consistent with the admissible and reliable evidence before the court, whether it is within the expert's area of expertise and whether the expert has strayed into advocacy. I have assessed the credibility and reliability of the witnesses in this case, including the experts, on that basis.

[188] As I have repeatedly stated, it is generally the case in personal injury actions that the most important witness is the plaintiff herself. Once an assessment of the credibility and reliability of the plaintiff's evidence has been made, the court is in a position to determine causation, usually with the assistance of opinion evidence from qualified medical experts. A plaintiff who accurately describes her symptoms and circumstances before and after the collision, without minimizing or embellishing them, can reasonably anticipate that the court will find her evidence to have been credible and reliable.

The Plaintiff

[189] I found the plaintiff to be a genuine and honest witness. She did not attempt to embellish her symptoms. If anything, she tended to understate them. She was forthright and cooperative throughout her testimony. She was in obvious discomfort in the witness box, but did not complain. Her cross-examination did nothing to impugn her credibility—rather it enhanced it. While her recollection when testifying in

June 2024 of the various treatments she received between 2010 and the date of the MVA was not perfect, there were no material inconsistencies in her testimony. She was, by any measure, an impressive witness. I have no hesitation accepting her evidence in its entirety.

Perez

[190] Despite a husband's natural inclination to advocate for his wife, Perhez limited his testimony to his personal knowledge and observations, except when he was invited to stray from that limitation during his cross-examination. I found Perhez to have been a sincere and genuine witness who deeply cares for his wife, yet he was not prone to embellishment. I accept his evidence in its entirety.

Various Physicians, Experts, and Other Witnesses

[191] Drs. Hippola and Rose were delightful witnesses whose evidence was forthright, down-to-earth and illuminating. I have no difficulty accepting their evidence in its entirety.

[192] Dr. Ho, Dr. Moola, Dr. Yu, Dr. Giantomaso, Ms. Sukhia, Ms. Fischer, and Mr. Kerr were impressive witnesses. Each was professional, exceptionally well prepared, was objective and was very helpful to the court in his/her area of expertise. I accept their evidence without reservation.

[193] Ms. Djebbari and Ms. Braacx were good witnesses who testified with candour and impartiality. I accept their evidence.

[194] Mr. Allen was anxious to be of as much assistance to the court as he could. He was well prepared and objective. I accept his evidence.

[195] Dr. McNeill, Dr. Toth, Dr. Safapour, Ms. Watson, and Ms. Reid were thoughtful, careful and objective witnesses who testified with candor and in a helpful manner. I accept their evidence.

[196] Amin was an impressive witness with impressive credentials. He was articulate, extremely knowledgeable and helpful to the court. He was obviously

proud of the plaintiff and her accomplishments, yet despite a brother's natural inclination to protect and be an advocate for a younger sister, he largely resisted that temptation. His evidence accorded with that of the plaintiff and I accept it in its entirety.

[197] Dr. Zarkadas gave his evidence in an objective and candid manner. His evidence made sense. I accept it.

[198] Dr. Prout is well-known to this court and is highly respected in the field of neurology. His assessment of the plaintiff was thorough and objective, as was his review and analysis of the clinical records, imaging and expert reports he was given. I have no hesitation accepting his opinions.

[199] Dr. Leith was firm and unyielding in his opinions. He drifted into advocacy for the defence position, both in his reports and on the witness stand. He strayed into the area of the biomechanical forces imparted on the plaintiff during the MVA, initially refusing to accept he had done so and ultimately insisting that his opinion that only minimal energy was transferred to the plaintiff was "rudimentary". After being pressed, he asserted that his opinion in this regard was irrelevant to his overall opinion. His opinion that the labral tear and paralabral cyst and surgery the plaintiff underwent for those conditions had no causal connection to the MVA was based entirely on his interpretation of a brief shorthand note made by the VGH emergency room attendant that the plaintiff had full ROM and strength in all four extremities, together with the absence and subsequent medical records indicating the plaintiff had presented with an acute shoulder joint specific injury. He did not have the benefit of, or dismissed as irrelevant, the full evidentiary record before the court, including the plaintiff's evidence that she felt immediate right shoulder pain upon impact at the time of the MVA. It was somewhat misleading for Dr. Leith to have stated in his June 24, 2024 report the following:

> 11. Dr. Moola documented on December 9, 2022 the review of the multiple pathologies noted on the MR Arthrogram. He noted "given the multiple intra-articular abnormalities identified on the MRI […] surgical options could be considered.

The words Dr. Leith omitted from the quote were: "[…] the longevity of the symptoms and lack of full resolution […]". He also strayed into a comment on the plaintiff's credibility with respect to her evidence that her right arm symptoms resolved after Dr. Ho's final trigger point injection on February 21, 2027:

> While Dr. Kherani reported a full recovery by the time of the MVA just about 5 weeks later, this is not usual and I would venture to guess that she was still symptomatic to a certain degree.

In view of the foregoing, I prefer the opinion evidence of Drs. Moola, Giantomaso, Zarkadas and Prout over that of Dr. Leith.

[200] I found Dr. Craig's opinion evidence to have been superficial and over-generalized. His explanation for how and why he was able to find that the plaintiff had full ROM in her right shoulder given the evidence of the plaintiff and other experts, including Dr. Moola, that she had adhesive capsulitis and markedly less ROM in it than before the surgery made little sense and differed markedly from the opinions of the other medical experts. His opinions regarding how the plaintiff would be able to better tolerate her pain symptoms were, in my view, unrealistic. They included her avoiding sustained postures and repetitive tasks at work and her taking training and transferring to other areas of her specialty that he was unable to specify. He appears to have misapprehended the nature of the plaintiff's practice. His diagnosis and prognosis of the plaintiff regarding her right shoulder and level of improvement differs markedly from the opinions of Drs. Zarkadas, Giantomaso, Moola and Prout. To the extent that the opinions differ, I accept those of the latter experts over those of Dr. Craig.

[201] I found Ms. Walker to be an inflexible, unyielding witness whose "critique" of Ms. Fischer's FCE was based on an amalgam of her rigid view of the role of occupational therapists together with a misunderstanding of the facts. Had Ms. Walker's retainer included a request that she conduct her own FCE of the plaintiff, I have no doubt that her opinions would have been more helpful. Unfortunately, I found her evidence to be of no assistance and reject it.

[202] Mr. Szekely gave his evidence in a somewhat confusing fashion. On occasion, he strayed into advocacy for the defendant's position. His opinions were, in large part, based on his having assumed normal fluctuations in external forces and trends typically experienced by businesses and that use of an historical three-year average is a more stable indicator of a business's revenue than the most recent year. While that assumption may be reasonable for businesses generally, it does not reflect what might reasonably be expected of oculoplastic surgeons who have growing practices with lengthy and ever-expanding waitlists. Mr. Szekely also erroneously assumed that the increase in the plaintiff's Calgary billings was the result of her spending less time in her Burnaby clinic. The multipliers Mr. Szekely used for the future loss of income-earning capacity were very similar to those prepared by Ms. Sukhia.

[203] Overall, I find that many of the assumptions relied upon by Mr. Szekely were contrary to the factual evidence that I accept. In my view, the analysis provided by Ms. Sukhia better reflects the evidence before me and the plaintiff's particular circumstances. I accept it over that of Mr. Szekely to the extent that they differ.

Liability

[204] The defendants did not call any evidence regarding the MVA. I find that Rollins is 100% at fault for the MVA and that the defendants are jointly and severally liable for the injuries suffered by the plaintiff as a result of it.

Causation

[205] The legal test for causation is the "but for" test—the plaintiff must prove on a balance of probabilities that, but for the defendant's negligence, she would not have suffered her injuries. The defendant's negligence must have been a necessary cause of the injury. This test was summarized and affirmed by the Supreme Court of Canada in *Clements v. Clements*, 2012 SCC 32 at paras. 8–10.

[206] Causation need not be determined with scientific precision: *Snell v. Farrell*, [1990] 2 S.C.R. 311 at 328. Rather, it is a practical question of fact that can often be

answered by ordinary common sense. The plaintiff need only establish a “substantial connection between the injury and the defendant’s conduct” in order to establish causation: *Snell* at 327. A substantial connection is something beyond the *de minimus* range: *Farrant v. Laktin*, 2011 BCCA 336 at para. 9.

[207] There is no necessary connection between the force of impact and the severity of injury: *Newman v. Johal*, 2021 BCSC 65 at paras. 22–23. Rather, each case must be determined on its own facts. However, courts should exercise caution where there is little or no objective evidence of injury or continuing injury and when complaints of pain persist for long periods extending beyond the normal or usual recovery: *Price v. Kostryba* (1982), 70 B.C.L.R. 397 (S.C.) at 399. In such circumstances, a plaintiff is not entitled to compensation without some convincing evidence. The evidence can be from the plaintiff himself or herself if the surrounding circumstances are consistent with the complaints of pain and are true reflections of a continuing injury: *Price* at 397.

[208] In this case, the damage to each of the vehicles involved in the MVA together with the evidence of both the plaintiff and Mr. Rollins, the defendant driver, is consistent with the impact of the collision having been forceful. Counsel for the defendants’ described the impact as “moderately severe”.

[209] Counsel for the defendants acknowledges that the plaintiff sustained a whiplash associated injury, but submits that her post-MVA pain complaints are merely an aggravation of a significant and longstanding pre-existing chronic pain condition.

[210] An important factor in assessing causation of injuries is a comparison of a person’s function before and after the accident.

[211] Prior to the MVA, the plaintiff often complained of headaches as well as neck, shoulder and back pain. Such pain symptoms are typical for surgeons, especially oculoplastic surgeons, but they are not disabling. Indeed, the plaintiff’s closest friends were completely unaware of her pain complaints prior to the MVA. That fact

alone is telling. If, as the defendants suggest, the plaintiff was anatomically pre-disposed to her post-MVA pain symptoms, it is probable that her friends in whom she confided would have had at least an inkling of such complaints before the MVA.

[212] I find that the plaintiff's pre-MVA pain symptoms were caused by the prolonged, stooped postures she was required to engage in during her surgeries. She attended 19 massage therapy treatments in the six-and-a-half years preceding the MVA, as her symptoms flared up from time to time. Nevertheless, she remained highly functioning both in her profession and recreationally. After the MVA, her pain symptoms increased and her functioning declined significantly. The plaintiff went from an active, capable, efficient and hard-working fully functioning surgeon before the MVA, to one whose work capacity has been significantly hindered by pain.

[213] I find that the MVA caused the plaintiff to suffer the following injuries:

a) mild concussion;

b) ongoing myofascial neck, shoulder, back, hip and knee pain; and

c) frequent migraine headaches.

[214] The defendants argue that the plaintiff's right shoulder labral tear and cyst were unrelated to the MVA. They seek to attribute it to the high-level activities, such as volleyball, the plaintiff played in the year before the MVA. However, the plaintiff's position in volleyball was a "setter" which does not engage the repetitive, strenuous overhead movements (for example baseball pitchers and volleyball "spikers") that are necessary to cause a labral tear. It is significant that the plaintiff remained fully functioning despite any shoulder pain she may have had. Dr. Ho testified that, prior to the MVA, she did not specifically treat the plaintiff for right shoulder rotator cuff tendinosis or impingement (inside of the shoulder). Rather, her treatment focused on the muscles on the outside of the shoulder. The plaintiff continued working full-time at full pace. That changed immediately after the MVA.

[215] On the basis of the medical experts whose opinions I accept, I find it is more probable than not that the MVA either caused the plaintiff's right shoulder labral tear

or significantly aggravated a previously asymptomatic condition. I find that the labral tear eventually developed the paralabral cyst that caused the plaintiff's deep-seated should pain that grew over time as the cyst grew.

[216] I find that the right shoulder surgery performed by Dr. Moola was substantially necessitated by injuries suffered by the plaintiff as a result of the MVA. I find that it would not have been necessary but for the MVA.

Assessment of Damages

[217] The defendants submit that there is a measurable risk that the plaintiff's pre-existing conditions would have detrimentally affected her in the future regardless of the MVA: *Athey v. Leonati*, [1996] 3 S.C.R. 458 at para. 35. I agree. Moreover, general contingencies of everyday life must be considered in the assessment of damages. Given the evidence as a whole, this is a case that warrants a reduction in the damages award of 20%.

Non-Pecuniary Damages

[218] Non-pecuniary damages are a type of damages that are used to compensate a plaintiff for the pain, suffering, loss of enjoyment of life and loss of amenities that occur as a result of the accident: see *Trites v. Penner*, 2010 BCSC 882 at para. 188.

[219] In *Stapley v. Hejslet*, 2006 BCCA 34, the Court of Appeal set out a non-exhaustive list of common factors which influence an award of non-pecuniary damages:

> [46] The inexhaustive list of common factors cited in *Boyd* that influence an award of non-pecuniary damages includes:
>
> (a) age of the plaintiff;
>
> (b) nature of the injury;
>
> (c) severity and duration of pain;
>
> (d) disability;
>
> (e) emotional suffering; and
>
> (f) loss or impairment of life;
>
> I would add the following factors, although they may arguably be subsumed in the above list:

(g) impairment of family, marital and social relationships;

(h) impairment of physical and mental abilities;

(i) loss of lifestyle; and

(j) the plaintiff's stoicism (as a factor that should not, generally speaking, penalize the plaintiff: *Giang v. Clayton*, [2005] B.C.J. No. 163 (QL), 2005 BCCA 54).

[220] Counsel for the plaintiff submits that an award in the range of $175,000 to $225,000 for non-pecuniary damages is appropriate in this case, relying on the decisions of this Court in:

a) *Meckic v. Chan*, 2022 BCSC 182;

b) *Valcouvert v. Tariq*, 2024 BCSC 818; and

c) *Wallman v. John Doe*, 2014 BCSC 79.

[221] Counsel for the defendants submits that an award of $120,000 to $150,000 is appropriate, relying on the following decisions of this Court:

a) *Mayede v. Dominguez*, 2020 BCSC 982;

b) *Merko v. Plummer*, 2016 BCSC 1403; and

c) *Ferguson v. Watt*, 2018 BCSC 1587.

[222] The plaintiff is a stoic individual. She is a highly intelligent, skilled and trained oculoplastic and orbit surgeon. There is no question that she was a high-energy, high achieving woman. She was hard-working, accomplished and resilient. She was driven to not only be the best she could be in her specialty, but also to give back to her profession and her community. Prior to the MVA, her skills were sought-after and her clinic and surgical schedules were full with significant waitlists. Although she experienced some upper back, shoulder and neck pain, she was able to manage it with rest and massages.

[223] The plaintiff’s ability to function in that capacity was significantly diminished by the injuries she sustained in the MVA and subsequent MVA-related right shoulder surgery. Her right arm mobility is limited. She is in constant pain. She can function day-to-day, but only with decreased movements, decreased speed, and with

numerous breaks throughout the day. Her clinical and surgical pace has been reduced by approximately 50%. She has minimal reserve for doing anything after a day of work. She is frustrated about being unable to function as she had prior to the MVA.

[224] While I accept that a certain amount of musculoskeletal pain is common among ophthalmologists, particularly those who perform surgeries, the evidence is overwhelming that the MVA resulted in the plaintiff suffering a significant setback in her life.

[225] The plaintiff is no longer able to enjoy the active life she had before the MVA. Her social life and emotional well-being have been affected. She engages in fewer and less ambitious outdoor activities and sports. Her entire life experience after the MVA has been challenging for her.

[226] The plaintiff's prognosis is guarded. Although her right arm ROM continues to be limited since the February 2023 surgery, there is potential for future improvement. Nevertheless, it is likely that she will continue to have chronic pain for the foreseeable future.

[227] In my view, an award of $180,000 is appropriate for non-pecuniary loss. That amount must be reduced by 20% for the reasons set out above. Accordingly, I assess the plaintiff's non-pecuniary damages in the amount of $144,000.

Loss of Income-Earning Capacity

[228] The value of a plaintiff's capacity to earn is equivalent to the value of the earnings that she would have received over time, had the tort not been committed: *M.B. v. British Columbia*, 2003 SCC 53 at para. 50. The loss of income-earning capacity is the difference between the value of what the earnings would have been and what they are, or will be, as a result of the tort: *Johal v. Bhullar*, 2021 BCSC 427 at para. 158.

[229] A claim for past loss of income-earning capacity must be assessed in the same manner as a claim for future loss of income-earning capacity. The plaintiff must demonstrate a real and substantial possibility that the income would have been earned: *Grewal v. Naumann*, 2017 BCCA 158 at para. 48. This is a lower standard than a balance of probabilities, but higher than that of something that is merely possible or speculative: *Gao v. Dietrich*, 2018 BCCA 372 at para. 34.

[230] The overall fairness and reasonableness of the award must be considered by taking into account all of the evidence: *McColl v. Sullivan*, 2021 BCCA 181 at para. 51. Fairness is measured, in part, against awards made in comparable cases: *Trites* at para. 189. It requires an assessment of the plaintiff's past loss of income-earning capacity, not a calculation according to some mathematical formula: *Ibbitson v. Cooper*, 2012 BCCA 249 at para. 19.

Past Loss of Income-Earning Capacity

[231] The evidence is uncontroverted that prior to the MVA, the plaintiff saw up to 60 patients per day in her clinic. When she returned to work after the MVA her pace was such that she slowly increased her pace to 25 to 30 patients per day, until her right shoulder surgery. Thereafter, she was able to slowly return to that same post-MVA pace.

[232] I find that after the MVA, the plaintiff took all reasonable steps to recover from her injuries. I find that since the MVA, she has done everything that could be reasonably expected of someone in her position to continue with her oculoplastic career and function as best she could with her MVA-related injuries and physical restrictions.

[233] I reject the calculations proffered by Mr. Szekely in respect of the plaintiff's past lost of income-earning capacity for the following reasons:

a) they assume that the increase in the number of procedures performed by the plaintiff in Calgary prior to her shoulder surgery was at the expense of her Burnaby practice. There is no evidence to support that assumption. The evidence is to the contrary; and

b) they are based on the average number of procedures performed by the plaintiff in the three years immediately preceding the MVA. The plaintiff's evidence is that the more she worked the more efficient she became and was generally able to see more patients per day. Her practices in Calgary and Burnaby were growing each year. They were not subject to the fluctuations and market conditions that typically impact businesses generally. There was an increasing demand for the plaintiff's medical services, as evidenced by her growing and lengthy waitlists. Mr. Szekely's use of a three-year average does not consider these phenomena.

[234] In contrast, Ms. Sukhia's calculations are based on assumed facts that better reflect what I find would likely have occurred absent the MVA, with the exception of her assumption that Dr. Safarpour worked as a locum from and after July 2017. I prefer Ms. Sukhia's calculations over those of Mr. Szekely. I accept the 25% reduction of the number of consultations/procedures the plaintiff would have conducted but for the MVA during the COVID period as reasonable. Although a precise accuracy is neither possible nor appropriate, I assess the plaintiff's past loss of income-earning capacity calculations based on those set out in Ms. Sukhia's report.

Burnaby Practice

[235] On the whole of the evidence, I find that absent the MVA, the plaintiff's practice (through her professional corporation) would have been paid for approximately 30,000 more consultations/procedures had the MVA not occurred. I find that she, through her corporation, would have been paid an average of $60 per lost procedure. In addition, the plaintiff had expenses for her locums (Drs. Hammoudi and Bentham) that she would not have incurred but for the MVA. This expense was approximately $20 for each of approximately 13,800 consultations/procedures the locums performed for the plaintiff in her Burnaby clinic. The calculation is summarized as follows:

a) Loss of procedures:	30,000 x $60 =	$1,800,000
b) Locum expenses:	13,800 x $20 =	$ 276,000
Total:		$2,076,000

Calgary Practice

[236] Using Ms. Sukhia's Schedule 4.3, which I accept, I assess the plaintiff's past loss of income-earning capacity from her Calgary practice at $335,000.

Summary of Past Loss of Income-Earning Capacity

[237] I have assessed the plaintiff's total past loss of income-earning capacity (gross) to be $2,076,000 + $335,000 = $2,411,000. This amount must be reduced by 20%. Accordingly, the plaintiff's past loss of income-earning capacity is $1,928,800 (gross).

[238] Perhez gave evidence that his and the plaintiff's tax planning was such that they minimized the payment of personal income tax by leaving as much income in their respective professional corporations as possible. This evidence was supported by the plaintiff's personal income tax returns.

[239] Ms. Sukhia's evidence was that the plaintiff's professional corporation qualifies as a Canadian Controlled Private Corporation, such that the first $500,000 of income is taxed at 11% and the balance is taxed at 27%. The plaintiff's marginal personal tax rate is 49%.

[240] Based on the evidence as a whole, I agree with the submission of plaintiff's counsel that the application of a tax rate of 38%, being the mid-point of the highest marginal rate (49%) and the highest corporate rate (27%) is both reasonable and appropriate in this case.

[241] Accordingly, I assess the plaintiff's past loss of income-earning capacity at $1,928,800 x 62% = $1,195,856.

Future Loss of Income-Earning Capacity

[242] An award for future loss of income-earning capacity involves a comparison between the likely future of the plaintiff if the MVA had not happened and the plaintiff's likely future after the MVA. By definition, such a comparison involves

possibilities. There is no right answer, but whatever it is it must be tethered to the evidence: *Dornan v. Silva*, 2021 BCCA 228 [*Dornan*] at para. 134.

[243] The plaintiff is not required to prove these hypothetical events on a balance of probabilities. The plaintiff must demonstrate no more than that a future financial loss is a real and substantial possibility and not mere speculation. If the plaintiff does so, the Court must then determine the measure of damages by assessing the likelihood of the event. The loss may be quantified either on an earnings-based approach or on a capital asset approach: *Rab v. Prescott*, 2021 BCCA 345 at para. 48. The analysis requires that the Court to:

a) determine whether the evidence discloses a potential future loss of capacity (e.g., chronic injury, future surgery or risk of future functional loss);

b) determine whether on the evidence there is a real and substantial possibility that the future loss of capacity will cause a pecuniary loss; and

c) If so, assess the value of that possible future loss, including an assessment of the relative likelihood of the possibility occurring.

Rab at para. 47.

Does the Evidence Disclose a Potential Future Loss of Income-Earning Capacity as a Result of the MVA?

[244] I find that the evidence has established the MVA caused significant and lasting chronic pain that has left the plaintiff unable to perform many of the intricate demands of her work both as a clinical physician and an oculoplastic surgeon. I find that there is a real and substantial possibility that this loss of function will continue for the foreseeable future. Accordingly, the existence of a real and substantial possibility of a future loss of income-earning capacity is obvious and the assessment of its relative likelihood superfluous: see e.g., *Rab* at para. 29.

[245] It is, nevertheless, necessary to assess the possibility and likelihood of other future hypothetical events occurring that may lead to an increased or reduced earning capacity affecting the quantification of the loss. Possible events include positive or negative contingencies and the possibility that the plaintiff's MVA-related injuries improve or worsen: *Rab* at paras. 29, 48.

[246] There is no evidence of any measurable risk that the plaintiff's pre-existing conditions, including her history of right arm tennis elbow would have detrimentally affected her regardless of the MVA. To the contrary, the evidence is uncontroverted that she was able to manage her pain symptoms including by massage when they flared up. Her tennis elbow symptoms were fully resolved prior to the MVA and were never treated after Dr. Ho's final treatment in February 2017. Any suggestion that her tennis elbow symptoms were part of or may possibly lead to future debilitating symptoms is pure speculation.

Is there a Real and Substantial Possibility that the Plaintiff's Injuries will cause her a Pecuniary Loss?

[247] "Real and substantial possibility" is the expression used to refer to threshold likelihood. It is the standard of proof for admitting hypothetical events, both past and future, into the evidentiary record as if they already happened. It is a lower threshold than a balance of probabilities but a higher threshold than something only possible and speculative: *Dornan* at para. 94; *Gao* at para. 34.

[248] Commonly encountered risks over the course of everyday activities will generally not suffice to pose a real and substantial risk of event or outcome leading to a pecuniary loss: *Dornan* at para. 77. While every case depends on its facts, among such possibilities are: vehicle or bicycle accidents, tripping and falling, being hit by falling branches, being knocked over by pedestrians, skaters, drivers or cyclists, wrenching a knee while playing recreational sports, hurting one's back while working out or digging one's garden: *Dornan* at para. 77.

[249] The fact that the amount by which the plaintiff's income may be reduced by a future event is speculative does not mean there is no real and substantial possibility

of that future event leading to pecuniary loss for the plaintiff. It is a question of the relative likelihood of a loss: *Rab* at para. 62.

[250] The question to be determined is whether it is appropriate to apply averages in this case. In my view, it is not. Before the MVA, the plaintiff was, by all accounts, an exceptionally hardworking and competitive person. She remains so today. The uncontroverted evidence is that the plaintiff was an extremely motivated professional whose medical practice is highly specialized and sought after. Her drive as an oculoplastic surgeon was plain when, in 2007, the group of ophthalmologists at BGH who had surgical privileges failed to post the availability of positions as was required by the Board of the Fraser Health Authority but rather recommended that certain others be granted surgical privileges. The plaintiff formally challenged the recommendation. BGH's credential committee substituted the plaintiff for the doctor that had been recommended by the group. The group filed a petition seeking judicial review of the committee's decision. After a three-day hearing in this court, the petition was dismissed.

[251] Prior to her shoulder surgery the plaintiff maintained practices in two provinces, Alberta (Calgary) and BC. The uncontroverted evidence is that she intended to keep working long hours in her medical practice for the foreseeable future. I am left with no doubt that, but for the MVA, her work scheduled and pace would have continued. As a result of her MVA-related injuries, she is unable to devote the same energy, hours, and attention to her practice as she did before the MVA.

[252] I conclude that there is a real and substantial possibility that the plaintiff's reduced capacity will lead to a future income loss.

What is the Relative Likelihood of a Future Pecuniary Loss?

[253] There are two equally valid approaches to the determination of the relative likelihood of the pecuniary loss as a result of the risk. They have traditionally been referred to as the "earnings approach" and the "capital asset approach".

[254] Under the earnings approach, the court determines the plaintiff's without-accident future earning capacity. The court then assesses the difference between the without-accident earning capacity and the with-accident earning capacity. That amount may be further adjusted based on applicable contingencies.

[255] The capital asset approach is used in circumstances where the plaintiff continues to earn income at or close to her pre-accident level, but has suffered an impairment that may affect her ability to continue doing so at some point in the future, or where the evidence (or lack thereof) is such that her post-accident future earning capacity cannot be determined. The court's award is based on the plaintiff's pre-accident annual income over one or two years to calculate the without-accident future earning capacity.

[256] Under both approaches, the amount arrived at must be adjusted to account for the relative likelihood of the pecuniary loss occurring, taking into consideration relevant contingencies. Factors relevant to determining what the relative likelihood of the risk is include:

a) history of and the nature of the sources of past income;

b) profitability and the nature of the plaintiff's intended future economic activities;

c) plaintiff's pre-existing limitations concerning capacity to work due to age or health;

d) strength of the evidentiary basis for the amount whereby the plaintiff's income is alleged to have been reduced; and

e) level of continuing exposure to risk given the plaintiff's intentions concerning their future activities, and the risk inherent in those plans.

Rab at para. 80; *Dornan* at para. 135.

[257] The application of each of these factors to the plaintiff has been set out in detail above. In my view, this is an appropriate case to apply the earnings approach.

[258] I do not accept that the statistical contingencies applicable to "females with professional degrees in Medicine" are apt in the case of the plaintiff. By any measure, she is a hardworking, self-motivated and driven individual who intends to continue in her profession as long as she can. While I accept that various surveys of a limited number of ophthalmologists suggest that some experience work-related myofascial pain symptoms, there is no evidentiary basis for a finding that such a potential future event would likely have resulted in the plaintiff retiring early from her practice absent the MVA. Accordingly, there is good reason depart from the median retirement age of 64 for ophthalmologists in Canada. I have no difficulty concluding that the plaintiff will continue to work in her career to that age of at least 70.

[259] I accept the opinions of Drs. Leith, Moola, and Zarkadas that the plaintiff's right shoulder and arm function may increase over the course of the next ten months and find there is a real and substantial possibility of it doing so. With that exception, I conclude that, on the evidence, there is no reasonable and substantial risk of any non-MVA-related future hypothetical event occurring that warrants the application of a positive or negative contingency in this case.

Quantifying the Loss

[260] Quantifying the plaintiff's future loss of income-earning capacity is a challenging task. However, the mere fact that quantifying the loss is difficult is no reason for not making an award. Rather, the court must simply do the best it can with the evidence it has: *Rab* at para. 76.

Calgary Practice

[261] The plaintiff's decision to close her Calgary practice after her 2023 shoulder surgery was judicious. Indeed, I find that she had no choice. I also find that there is very little chance that she will re-open her practice there, given her prognosis and the hurdles she will face if she attempts to do so in the future.

[262] In my view, Ms. Sukhia's analysis of the plaintiff's future pre-tax annual income loss from her Calgary practice of $137,698 is reasonable. Using

Ms. Sukhia's multiplier of 15.117, the present value of the plaintiff's loss of income-earning capacity from the closure of her Calgary practice is $2,081,581. That amount must be reduced by 20% for the reasons set out above. Accordingly, I assess the plaintiff's non-pecuniary damages in the amount of $1,665,265.

Burnaby Practice

[263] Prior to the MVA, the plaintiff was able to perform 12,613 procedures during the 40 weeks of the year she was in her Burnaby clinic immediately preceding the MVA. During the remaining 12 weeks per year she worked in her Calgary clinic (one week per month).

[264] Since the MVA, the total number of patients the plaintiff has been able to see is approximately 50% of her pre-MVA numbers. That pace is likely to continue for the foreseeable future. The closure of the plaintiff's Calgary practice has resulted in her being able to fill those 12 weeks with Burnaby clinic patients, albeit with 50% of what her pre-MVA bookings would have been. These additional procedures have been factored into Ms. Sukhia's analysis. However, Ms. Sukhia's analysis of the plaintiff's loss included Dr. Safarpour's revenue on the basis that it was earned by her as a locum. It should not have been because Dr. Safarpour was not a locum from and after July 2017.

[265] In my view, a rational and principled basis for valuing the plaintiff's loss of future earning capacity from her Burnaby practice is arrived at by averaging her pre-tax past wage loss of $1,800,000 over the seven years since the MVA, which results in an annual pre-tax loss of $257,143/year. Using Ms. Sukhia's multiplier of 15.117, the loss equals $3,887,231. I note that this figure does not provide any contingency for the potential growth of the plaintiff's Burnaby practice, but does include the 1.5% *Law and Equity Act* discount rate and female mortality factors. That amount must be reduced by 20% for the reasons set out above.

[266] Taking all of the foregoing into account, I assess the value of the plaintiff's future loss of income-earning capacity in respect of her Burnaby practice at $3,887,231 x 80% = $3,109,785.

Future Loss of Income-Earning Capacity - Summary

[267] The plaintiff is entitled to damages for future loss of income-earning capacity as follows:

a) Calgary practice:	$1,665,265
b) Burnaby practice:	$3,109,785
Total:	$4,775,050
	rounded to $4,775,000

Cost of Future Care

[268] In *Peters v. Ortner*, 2013 BCSC 1861, Madam Justice Harris outlined the general principles to be considered when assessing a plaintiff's cost of future care:

> [141] The plaintiff is entitled to compensation for the cost of future care based on what is reasonably necessary to restore him to his pre-accident condition in so far as that is possible. The award is to be based on what is reasonably necessary on the medical evidence to preserve and promote the plaintiff's mental and physical health: *Milina v. Bartsch* (1985), 49 B.C.L.R. (2d) 33 (S.C.); *Williams v. Low*, 2000 BCSC 345; *Spehar v. Beazley*, 2002 BCSC 1104; *Gignac v. Rozylo*, 2012 BCCA 351.
>
> [142] The test for determining the appropriate award under the heading of cost of future care is an objective one based on the medical evidence. For an award of future care: there must be a medical justification for claims for cost of future care and the claims must be reasonable: *Milina; Tsalamandris v. McLeod*, 2012 BCCA 239 at paras. 62-63.
>
> [143] Future care costs are "justified" if they are both medically necessary and likely to be incurred by the plaintiff. The award of damages is thus a matter of prediction as to what will happen in the future. If a plaintiff has not used a particular item or service in the past it may be inappropriate to include its cost in a future care award. However, if the evidence shows that previously rejected services will not be or be able to be, rejected in the future, the plaintiff can recover for such services: *Izony v. Weidlich*, 2006 BCSC 1315 at para. 74; *O'Connell v. Yung*, 2012 BCCA 57 at paras. 55, 60, 68-70.
>
> [144] The extent, if any, to which a future care costs award should be adjusted for contingencies depends on the specific care needs of the plaintiff. In some cases negative contingencies are offset by positive contingencies and, therefore, a contingency adjustment is not required. In other cases, however, the award is reduced based on the prospect of improvement in the plaintiff's condition or increased based on the prospect that additional care will be required. Each case falls to be determined on its particular facts: *Gilbert v. Bottle*, 2011 BCSC 1389 at para. 253.

> [145] An assessment of damages for cost of future care is not a precise accounting exercise: *Krangle (Guardian ad litem of) v. Brisco*, 2002 SCC 9 at para. 21.

[269] Medical justification "requires only some evidence that the expense claimed is directly related to the disability arising out of the accident, and is incurred with a view toward ameliorating its impact: *Harrington v. Sangha*, 2011 BCSC 1035 at para. 151.

[270] Reasonableness is assessed in light of whether a reasonably-minded person of ample means would incur the expense and whether the plaintiff is likely to actually incur the cost in the future: *Brewster v. Li*, 2013 BCSC 774 at para. 158.

[271] Ms. Fischer opined that:

> Dr. Kherani's function is impacted by many different symptoms in addition to her shoulder. According to Dr. Giantomaso it is anticipated that in all likelihood she will continue to experience chronic pain to some degree on a long term basis. Cost of future care recommendations are provided …to outline a recovery plan from shoulder surgery and adhesive capsulitis, help her best manage her overall pain, and promote long term maintenance of function.

[272] Counsel for the plaintiff submits that an award of $425,000 is necessary to compensate the plaintiff for the cost of her future care. Counsel for the defendant submits that an award of $304,379 is appropriate. These figures include compensation for the loss of housekeeping capacity.

[273] The plaintiff testified that she intends to continue following all of the recommendations of her treating physicians, her physiotherapist, her kinesiologist and occupational therapist. The recommendations of the medical experts and occupational therapist for the plaintiff's future treatment modalities were remarkably consistent. The evidence demonstrates that she will experience ongoing pain symptoms and limitations affecting her work, recreation and other day-to-day activities. I find there is a real and substantial possibility that the following treatments and costs will be medically justified and would be reasonably incurred by a person of ample means in the plaintiff's position:

a) injections for pain management;

b) platelet rich plasma therapy;

c) Botox injections;

d) Botox drug costs;

e) kinesiology, short term and long term;

f) pain management therapies;

g) occupational therapy; and

h) pain medications.

[274] Ms. Fischer provided an analysis of the costs of foregoing treatments. Mr. Benning provided the multipliers for determining the present values of those costs over various time periods with the contingencies for the plaintiff's premature death. Using Mr. Benning's Table 2, the present value of the cost of the foregoing treatments totals $303,652.

[275] I decline to award compensation for psychological counselling on the basis that there is insufficient evidence demonstrating that it will be needed.

[276] With respect to loss of housekeeping capacity, our Court of Appeal in *Kim v. Lin*, 2018 BCCA 77, discussed the circumstances in which pecuniary damages may be available:

> [33] […] [W]here a plaintiff suffers an injury which would make a reasonable person in the plaintiff's circumstances unable to perform usual and necessary household work – i.e. where the plaintiff has suffered a true loss of capacity – that loss may be compensated by a pecuniary damages award. Where the plaintiff suffers a loss that is more in keeping with a loss of amenities, or increased pain and suffering, that loss may instead be compensated by a non-pecuniary damages award […] [i]t lies in the trial judge's discretion whether to address such a claim as part of the non-pecuniary loss or as a segregated pecuniary head of damage […] [citation omitted.]

[277] The plaintiff testified that she enjoys the limited housekeeping she is able to perform because she finds it soothing. Her husband does most of the housework. They have a gardener who assists with the yard work.

[278] I conclude from the evidence as a whole that the plaintiff's housekeeping and yard work challenges are more in keeping with a loss of amenities and increased pain and suffering. Accordingly, I have taken her loss of capacity to perform homemaking chores into account in my award for non-pecuniary damages above. This includes a global assessment for all facets of her pain, suffering, and loss of enjoyment of life, including loss of amenities and housekeeping capacity. A segregated award for loss of housekeeping capacity is not warranted.

[279] I assess the plaintiff's cost of future care at $303,652, rounded to $300,000. As set out above, this amount must be reduced by 20%. Accordingly, the plaintiff is entitled to an award for the cost of future care of $300,000 x 80% = $240,000.

Special Damages

[280] I accept the special damages claimed by the plaintiff as set out in Exhibit 6, $45,714. The plaintiff is entitled to an award in that amount.

Conclusion

[281] The plaintiff is entitled to judgement against the defendants, jointly and severally, in the amount of $6,400,597, calculated as follows:

a) Non-pecuniary damages:	$144,000
b) Past loss of income-earning capacity:	$1,195,856
c) Future loss of income-earning capacity:	$4,775,000
d) Cost of future care:	$240,000
e) Special damages:	$45,741
Total:	**$6,400,570**

[282] The foregoing award is subject to any statutory deduction, including those under s. 83 of the *Insurance (Vehicle) Act*, R.S.B.C. 1996, c. 231.

Costs

[283] Subject to any submissions the parties wish to make, the plaintiff is entitled to her costs at Scale B. If the parities wishes to make submissions on costs, they may make arrangements for a hearing through Supreme Court Scheduling.

"G.C. Weatherill J."

Schedule "A"

AGREED STATEMENT OF FACTS

EDUCATION

[1] Dr. Kherani completed a two-year American Society of Ophthalmic Plastic and Reconstructive Surgery (ASOPRS) Fellowship in Ophthalmic Plastic and Reconstructive Surgery at the University of Pennsylvania and the Children's Hospital of Philadelphia. She completed her Fellowship in 2004.

TREATMENT AND REHABILITATION

[2] The plaintiff has been treated by the following doctors and practitioners since the date of the Accident.

[3] Dr. Kherani has seen Dr. McNeil and Dr. Catherine Ho prior to the Accident as well as post-Accident.

HEALTHCARE PROVIDER CLINIC PRACTICE AREA

Medical Doctors

- Dr. Colin McNeil, Heights Medical Centre, Family medicine
- Dr. Lindsay McCaffrey, Norburn Medical Clinic, Family Medicine
- Dr. Devon Christin, ChangePain Anesthesiology
- Dr. Catherine Ho, Fortius Sport & Health Restore, Physical Medicine and Rehabilitation
- Dr. Keith Baxter Gordon & Leslie, Diamond Health Care Centre, Vascular Surgeon
- Dr. Alina Webber, Elicare Medical Neurologist
- Dr. Cory Toth, Burnaby Neurology Neurologist
- Dr. Azien Safarpour, Ophthalmologist
- Dr. Kenneth Mast Elicare, Medical Anaesthesiologist
- Dr. Patrick Yu, CHANGEpain Clinic Anaesthesiologist
- Dr. Brenda Lau, CHANGEpain Clinic Anaesthesiologist

- Dr. Kshitij Chawla, CPRI Physical Medicine and Rehabilitation
- Dr. Najam Mian, CPRI Physiatry
- Dr. Farhad Moola, Orthopaedic Surgery
- Dr. Parth Lodhia, Fraser Orthopedic Institute, Orthopaedic Surgery
- Dr. Sushil Singla, CPRI Physical Medicine and Rehabilitation

Treatment Providers

- Aaron Ashe, Fortius Sport & Health Massage Therapy/Performance Coaching
- Abby Galenzoski, Fortius Sport & Health Strength and Conditioning
- Andrea Reid, Allan McGavin Sports, Medicine Physiotherapy
- Anna Stec, Fortius Sport & Health Massage Therapy
- Dakota Turner-Johnston, Allan McGavin Sports, Medicine Physiotherapy
- James Allen, Edmonds Massage Clinic, Massage Therapy
- Kate Meredith, Fortius Sport & Health Strength and Conditioning/Performance Coaching
- Kobi Jack, Fortius Sport & Health Pilates
- Lauren Watson, Fortius Sport & Health Physiotherapy
- Matt Thompson, Fortius Sport & Health Massage Therapy
- Matthew Kore, Allan McGavin Sports Medicine, Kinesiology
- Stephania Rizzo, Fortius Sport & Health Physiotherapy
- Tamara Adilman, Counselling
- Teri-Rose Davis, Fortius Sport & Health Massage Therapy
- Trish Hopkins Allan, McGavin Sports Medicine Physiotherapy

Dr. Colin McNeil, GP

[4] Dr. Colin McNeil was Dr. Kherani's family doctor during the period March 2012 until 2019, when he retired.

[5] Dr. Kherani saw Dr. McNeil prior to and after the Accident. Between August 15, 2016, and October 9, 2018, Dr. Kherani saw Dr. McNeil on the following dates:

- August 15, 2016
- September 15, 2016
- April 3, 2017
- April 6, 2017
- April 12, 2017
- April 19, 2017
- April 25, 2017
- May 4, 2017
- May 17, 2017
- September 7, 2017
- October 25, 2017
- June 29, 2018
- August 1, 2018
- August 2, 2018
- September 4, 2018
- October 2, 2018
- October 9, 2018

Dr. Lindsay McCaffrey, GP

[6] Dr. McCaffrey has been Dr. Kherani's family doctor since on or around March 5, 2020.

[7] Between March 5, 2020, and February 21, 2024, Dr. Kherani saw Dr. McCaffrey on the following dates:

- March 5, 2020
- November 17, 2020
- July 6, 2022
- November 2, 2022

- January 11, 2023
- March 1, 2023
- March 13, 2023
- April 27, 2023
- May 3, 2023
- May 14, 2023
- May 31, 2023
- June 20, 2023
- September 17, 2023
- January 1, 2024
- February 21, 2024

[8] Dr. McCaffrey made the following referrals and recommendations:

- September 23, 2020 – Referral to Dr. Catherine Ho, physiatrist at Restore Sports Medicine
- November 18, 2020 – Referral to Dr. Briar Sexton, ophthalmologist
- September 23, 2021 – Referral to Dr. Catherine Ho, physiatrist at Restore Sports Medicine
- January 12, 2022 – Referral to Dr. Alina Webber, neurologist at Elicare Medical Clinic
- July 6, 2022 – Referral to Dr. Catherine Ho, physiatrist at Restore Sports Medicine
- July 6, 2022 – Referral to Dr. Farhad Moola, orthopaedic surgeon
- April 27, 2023 – Referral to Dr. Catherine Ho, physiatrist at Restore Sports Medicine
- May 14, 2023 – Referral to Dr. Mark McConkey, orthopaedic surgeon at Pacific Orthopaedics and Sports Medicine
- January 1, 2024 – Referral to Dr. Catherine Ho, physiatrist at Restore Sports Medicine
- January 1, 2024 – Referral to Dr. May Ong, internist

Dr. Alina Webber, Neurologist, Elicare Medical

[9] Between April 8, 2017 and December 4, 2018, Dr. Kherani saw Dr. Webber on the following dates, was treated for the following dates, was treated for the following issues, and the following recommendations or treatment were provided:

- April 8, 2017 – Dr. Kherani was treated for headaches, cognitive symptoms, and arm sensory symptoms
- July 10, 2017- Dr. Kherani was treated for headaches. Dr. Webber administered Botox injections and arranged for an MRI of the brain
- March 20, 2018 – Dr. Kherani was treated for headaches. Dr. Webber administered Botox injections
- December 4, 2018 – Dr. Kherani was treated for headaches. Dr. Webber administered Botox injections

Dr. Kenneth Mast, Anesthesiologist, Elicare Medical

[10] Between July 17, 2018 and May 2, 2024, Dr. Kherani saw Dr. Mast on the following dates, was treated for the following dates, was treated for the following issues, and the following recommendations or treatment were provided:

- July 17, 2018 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- November 30, 2018 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- December 1, 2018 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- December 8, 2018 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- December 18, 2018 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- March 2, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks

- March 14, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks. As well, xylocaine was applied via nasal swab to the sphenopalatine ganglions bilaterally
- April 12, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- May 4, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- June 22, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- July 13, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- August 20, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- September 17, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- October 26, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks. As well, xylocaine was applied via a nasal swab to the sphenopalatine ganglions bilaterally
- December 7, 2019 – Dr. Kherani was treated for headaches. Dr. Mast administered bilateral greater and lesser occipital nerve blocks
- January 4, 2020 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- April 19, 2020 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- December 22, 2020 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- March 18, 2021 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections

- June 14, 2021 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- September 24, 2021 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- April 29, 2022 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- July 23, 2022 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- November 3, 2022 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- February 25, 2023 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- May 27, 2023 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- August 12, 2023 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- November 18, 2023 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- February 16, 2024 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections
- May 2, 2024 – Dr. Kherani was treated for headaches. Dr. Mast administered Botox injections

[11] Dr. Mast continues to administer Botox injections to Dr. Kherani.

Dr. Devon Christie, Chronic Pain Specialist, CHANGEpain Clinic

[12] Between March 25, 2020, and May 20, 2020, Dr. Kherani saw Dr. Christie at the CHANGEpain Clinic on the following dates, was treated for the following issues, and the following recommendations or treatment were made:

- March 25, 2020 – Dr. Kherani was treated for upper back pain and right arm pain

- Dr. Christie administered trigger point injections to the upper thoracic multifidus, and the medial mid trapezius fibres, right side, and the right quadratus lumborum
- May 6, 2020 – Dr. Kherani was treated for chronic myofascial pain in the right shoulder with central sensitivity. Dr. Christie administered trigger point injections to the right shoulder scars x 2, and infraspinatus. Dr. Christie also prescribed Naltrexone 1.5 mg
- May 20, 2020 – Dr. Kherani was treated for central sensitivity to the right shoulder girdle. Dr. Christie administered trigger point injections to the right serratus anterior and the right middle trapezius. Dr. Christie also prescribed Maltrexone 1.5 mg

Dr. Brenda Lau, Pain Specialist/Anesthesiologist, CHANGEpain Clinic

[13] Dr. Kherani saw Dr. Lau on April 23, 2019. Dr. Lau conducted a physical examination.

Dr. Houchmond, North Burnaby Dental

[14] Dr. Kherani saw Dr. Houchmond on June 1, 2017, with respect to pain in her TMJ region. She was referred to Dr. Ian Matthew.

Dr. Ian Matthew, Dentist, Burnaby Oral Surgery

[15] Dr. Kherani saw Dr. Matthew on August 24, 2017, in relation to her temporomandibular pain and dysfunction.

Dr. Parth Lodhia

[16] Dr. Kherani saw Dr. Parth Lodhia on May 19, 2023, in relation to her right hip symptoms. Dr. Lodhia noted tenderness to palpation over the greater trochanter, posterolateral soft tissues and SI joint. He tested for impingement with negative findings and was uncertain if whether or not her hip joint was truly contributing to her pain.

[17] Dr. Lodhia suggested it may be worthwhile to explore whether Dr. Kherani's SI joint was contributing to pain and referred her to Dr. Najam Mian for consideration of image guided SI joint injection. He also gave her a lateral hip pain protocol for loading her gluteal tendons therapeutically and after rehabilitation.

Dr. Kshitij Chawla, Physical Medicine and Rehabilitation, Canadian Pain and Regenerative Institute (CPRI)

[18] Dr. Kherani saw Dr. Kshitij Chawla, at CPRI or at the Jim Pattison Outpatient Care and Surgery Centre on the following dates:

- December 14, 2018 – Dr. Kherani was treated for headaches, neck, pain, and shoulder girdle pain. Dr. Chawla performed a physical examination Dr. Chawla and Dr. Kherani discussed an overall multidisciplinary pain management approach, and the importance of stretching and exercise
- November 19, 2019 – Dr Kherani was treated for headaches, neck pain, and right arm paresthesia. Dr. Chawla performed physical and neurological examinations. Dr. Chawla recommended Dr. Kherani continue a self-managed program of strength and conditioning with an emphasis on flexibility in the neck, back, and anterior chest muscle groups, a pharmacological trial of Tramadol, continued Botox injections and a trial of Aimovig, and consideration of medial branch blocks, radiofrequency neurotomy, and ultrasound-guided occipital nerve block with pulsed radiofrequency

Dr. Najam Mian, Physical Medicine and Rehabilitation, Canadian Pain and Regenerative Institute (CPRI)

[19] Between June 13, 2023, and March 26, 2024, Dr. Kherani saw Dr. Mian at CPRI on the following dates, was treated for the following issues, and the following recommendations or treatment were made:

- June 13, 2023 – Dr. Kherani was treated for her right hip pain. Dr. Mian performed a physical examination, including a neurological exam and

range of motion/special tests. Dr. Mian performed right sided S1, S3, and S3 lateral branch block injections

- June 22, 2023 – This was a telephone follow up appointment to determine how Dr. Kherani tolerated the previous lateral branch block injections
- June 27, 2023 – Dr. Kherani was treated for her right hip pain. Dr. Mian performed right sided S1, S2, and S3 lateral branch block injections
- January 29, 2024 – This was a telephone follow up appointment. Dr. Kherani and Dr. Mian discussed the efficacy of the lateral branch block injections and agreed to proceed with radiofrequency ablation
- March 26, 2024 – Dr. Kherani was treated for her right hip pain. Dr. Mian performed continuous bipolar radiofrequency lesion of the right S1, S2 and S3 lateral branches

Diagnostic Imaging

[20] Between August 7, 2012, and April 23, 2023, Dr. Kherani has undergone the following diagnostic imaging:

- August 7, 2012 – MR cervical spine and lumbar spine – Burnaby Hospital
- March 30, 2017 – Vancouver General Hospital
  - CT Head non-contrast
  - CT Cervical Spine
  - CT Chest, abdomen and pelvis
  - CT Abdomen and Pelvis in venous phase
  - CT Thoracic and Lumbar Spine
  - MR Cervical, Thoracic and Lumbar Spine
- May 1, 2017 – X-ray of both knees – Greig Associates
- October 10, 2017 – MR of head, cervical spine, TMJ – Burnaby Hospital
- December 14, 2017 – MR lumbar spine – Burnaby Hospital
- September 15, 2018 – MR Right Knee – Richmond Hospital
- September 25, 2018 - Ultrasound Right Shoulder – St. Paul's Hospital
- April 8, 2019 – Ultrasound/Doppler Low Ext Venous – Burnaby Hospital

- October 16, 2019 – MRI Cervical Spine – Vancouver General Hospital
- December 23, 2021 – Three-phase partial bone scan with tomography – Vancouver General Hospital
- March 1, 2022 – MRI Right Shoulder – Vancouver General Hospital
- March 1, 2022 – MR Head – Vancouver General Hospital
- November 9, 2022 – RAD of Right hip, MR Arthrogram of right shoulder joint, RAD injection joint fluoro right shoulder – Burnaby Hospital
- April 23, 2023 – MR Right hip joint – Burnaby Hospital

Physical Therapy

Stefania Rizzo, Physiotherapist, Fortius Sport & Health Sport & Health

[21] Between April 4, 2017, and April 19, 2017, Dr. Kherani attended physiotherapy sessions with saw Stefania Rizzo on the following dates:

- April 4, 2017
- April 6. 2017
- April 10, 2017
- April 12, 2017
- April 17, 2017
- April 19, 2017

James Allen, Registered Massage Therapy, Edmonds Massage Clinic

[22] Between April 22, 2017, and September 21, 2017, Dr. Kherani attended registered massage therapy sessions with James Allen on the following dates:

- April 22, 2017
- April 29, 2017
- May 1, 2017
- May 3, 2017
- May 13, 2017
- May 18, 2017

- May 20, 2017
- May 23, 2017
- May 25, 2017
- July 27, 207
- September 2, 2017
- September 5, 2017
- September 14, 2017
- September 16, 2017
- September 21, 2017

Kobi Jack, Pilates, Fortius Sport & Health Sport & Health

[23] Between May 16, 2017, and June 6, 2017, Dr. Kherani attended Pilates sessions with Kobi Jack on the following dates:

- May 16, 2017
- May 30, 2017
- June 6, 2017

Abby Galenzoski, Strength and Conditioning, Fortius Sport & Health Sport & Health

[24] Between July 16, 2018, and December 13, 2018, Dr. Kherani attended strength and conditioning training with Abby Galenzoski on the following dates:

- July 16, 2018
- July 20, 2018
- July 25, 2018
- July 27, 2018
- August 1, 2018
- August 10, 2018
- August 31, 2018
- October 9, 2018
- October 18, 2018

- November 8, 2018
- November 15, 2018
- November 22, 2018
- November 29, 2018
- December 11, 2018
- December 13, 2018

Registered Massage Therapy, Fortius Sport & Health Sport & Health

[25] Between April 10, 2019, and August 15, 2019, Dr. Kherani attended massage therapy sessions with various massage therapists at Fortius Sport & Health Sport & Health on the following dates:

- April 10, 2019 – Anna Stec
- April 20, 2019 – Anna Stec
- May 1, 2019 – Anna Stec
- May 15, 2019 – Anna Stec
- June 1, 2019 – Anna Stec
- June 8, 2019 – Teri-Rose Davis
- June 22, 2019 – Aaron Ashe
- June 29, 2019 – Aaron Ashe
- July 20, 2019 – Aaron Ashe
- July 29, 2019 - Matt Thompson
- August 15, 2019 – Aaron Ashe

Katie Meridith, Active Rehabilitation/Performance Coaching Rehab, Fortius Sport & Health Sport & Health

[26] Between April 16, 2019, and August 19, 2019, Dr. Kherani attended active rehabilitation and performance coaching with Katie Meridith on the following dates:

- April 16, 2019
- April 25, 2019
- April 30, 2019

- May 4, 2019
- May 14, 2019
- June 1, 2019
- June 10, 2019
- June 17, 2019
- June 20, 2019
- July 2, 2019
- July 9, 2019
- July 11, 2019
- August 19, 2019

Tamara Adilman, Counsellor

[27] Between February 17, 2023, and October 24, 2023, Dr. Kherani attended counselling sessions with Tamara Adilman on the following dates:

- February 17, 2023
- February 23, 2023
- March 1, 2023
- March 8, 2023
- March 13, 2023
- April 11, 2023
- May 11, 2023
- May 30, 2023
- June 20, 2023
- July 31, 2023
- September 1, 2023
- September 5, 2023
- October 3, 2023
- October 24, 2023

Physiotherapy, Allan McGavin Sports Medicine Clinic

[28] Between December 22, 2021, and August 4, 2023, Dr. Kherani has attended physiotherapy sessions with various physiotherapist at Allan McGavin on the following dates:

- December 22, 2021 – Trish Hopkins
- January 26, 2022 – Trish Hopkins
- July 7, 2023 – Dakota Turner-Johnston
- August 4, 2023 – Dallas Siemens

Matthew Kore, Kinesiology, Allan McGavin Sports Medicine Clinic

[29] Between December 1, 2023, and April 23, 2024, Dr. Kherani has attended kinesiology sessions with Matthew Kore at Allan McGavin on the following dates:

- December 21, 2023
- December 27, 2023
- April 1, 2024
- April 9, 2024
- April 23, 2024

[30] Dr. Kherani continues to see Matthew Kore for kinesiology sessions at Allan McGavin.

SCHEDULES

[31] The facts contained in the following schedules:

- Schedule A: Chronological Summary of Treatment