

CANADA / JUDGMENT

Barkhuizen v. Leguerrier

2022 BCSC 153

COURT

Supreme Court of British Columbia

DECIDED

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2022 BCSC 153 Barkhuizen v. Leguerrier

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Barkhuizen v. Leguerrier,

2022 BCSC 153

Date: 20220201

Docket: M42975

Registry: Penticton

Between:

Frederick Barkhuizen

Plaintiff

And

Leon Joseph Leguerrier and Laura Ann Williams

Defendants

Before: The Honourable Mr. Justice H. Slade

Reasons for Judgment

Counsel for the Plaintiff:

T.A. Duerr

Counsel for the Defendant, Leon Joseph Leguerrier:

J.A. Hemmerling

M. Prah

Counsel for the Defendant, Laura Ann Williams:

J.R. Walsh

Place and Date of Trial:

Kelowna, B.C.

May 3-7, 10-14 and 17-19, 2021

Place and Date of Judgment:

Penticton, B.C.

February 1, 2022

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I. Introduction

- [1] The plaintiff is a medical doctor, specifically, a family practitioner. He is 61 years of age. He emigrated from South Africa to Canada in 1991. He initially practiced in Newfoundland then practiced in Chetwynd, BC for nine years. After receiving his permanent licence to practice in BC he relocated to the Okanagan in 2000.
- [2] The plaintiff sustained injuries in a motor vehicle accident on August 4, 2016 (the "Accident"). He was then 56 years of age. He sustained soft tissue injuries, and claims that he sustained a brain injury that resulted in him giving up his private practice due to cognitive changes that prevented him from carrying out the tasks of a family practitioner, and exercising the professional judgment demanded by this role: in particular, his ability to provide some aspects of the medical services needed by regular patients who entrusted him with their care.
- [3] The plaintiff's claim that he sustained a disabling traumatic brain injury is supported by treating physicians and independent medical experts. The defendants rely on the expert reports of medical specialists and others whose opinions differ from those of the plaintiff on the central issue of fact, namely whether the plaintiff suffered a brain injury in the Accident. The defendants take the position that the plaintiff is not impaired in his ability to function as a family practitioner and, if in fact he is, it is due to episodic depression.
- [4] The defendants maintain that the plaintiff's departure from family practice was planned pre-Accident and unrelated to any injury he may have suffered as a result of the Accident. The defendant points to the plaintiff's prior dissatisfaction with some aspects of medical practice, his 2014-2015 episode of depression, and his change in residence from Penticton to Kelowna to argue that he put a plan in motion to wind up his practice and relocate to Kelowna. They argue that this plan had nothing to do with injuries sustained in the Accident, if indeed he had sustained a brain injury, and that the losses claimed can therefore not be attributed to the negligence of the defendant.

II. Evidence

A. Dr. Frederick Barkhuizen

- [5] In order to address the central issue, it is necessary to set out the plaintiff's evidence of his personal history as it relates to the presence and effect of depression and the basis for and timing of his decision to cease private practice, interspersed with evidence of his communications with and treatment by medical professionals before and following the Accident. To the extent relevant to the question of brain injury, details of the Accident will be considered. I will digress from the narrative to address the issue of liability for the accident along the way.
- [6] While in Chetwynd, the plaintiff's wife and their daughter moved to a home they had purchased in Summerland. The marriage was "troubled."

- [7] Under financial stress due to the maintenance of two households and financial support for his family, the plaintiff declared bankruptcy in 2001. He had by then moved to Summerland in hope of saving the marriage.
- [8] Between 2000 and 2003, the plaintiff worked as a locum at various medical offices from Osoyoos to Kelowna. He found the work stressful and his income was sporadic. He missed being able to have a base of patients in his care and forming relationships with colleagues.
- [9] The plaintiff suffered a depressive episode in 2002, and was treated by Dr. Alexander McIntyre, a psychiatrist practicing in Penticton.
- [10] The couple divorced in 2003, and in time the plaintiff's relationship with his daughter took a bad turn. They remain estranged.
- [11] In 2003 the plaintiff took over the Penticton based practice of a retiring family physician. This was a stable practice, which grew in the ensuing years. His spousal and child support obligations continued at a time when he was "starting from scratch" at 43 years of age. He commenced RRSP contributions in 2005, under a matching donation program with the BC Medical Association.
- [12] The plaintiff's life took another positive turn when he and his present spouse, Karon Barkhuizen, entered a common-law relationship in 2005. The couple purchased a home together in July 2008 (the "Penticton Home"). They married in 2010. She had a catering business in Penticton, and also worked periodically at the plaintiff's medical clinic as an office administrator.
- [13] The plaintiff suffered several health disorders between 2003 (the year in which he took over the medical practice in Penticton) and 2015. He had a quadruple bypass in 2004, with a good outcome. He takes medication for an "ancient" thyroid disorder which remains stable under medication. He has diverticulitis, which is mostly stable since he underwent a bowel resection while living in Chetwynd. The occasional flare ups resolve after a few days.
- [14] The plaintiff suffered another depressive episode in 2009, and returned to the care of Dr. McIntyre, who authored two of the medical reports in evidence. In his report dated October 6, 2020 he relates that the plaintiff was under his care in 2002 and 2009. Nothing is said about symptoms or course of treatment.
- [15] Dr. McIntyre testified on matters of "fact" and his opinion. He met the plaintiff in 2000 "in the hallway" at the hospital and they encountered each other at social gatherings. The plaintiff became a patient in 2002 for treatment for depressive episodes. It appears that the condition was resolved, then re-occurred in 2009, at which time he once again sought Dr. McIntyre's care. They remained in regular contact throughout due to patient referrals and consultations, which Dr. McIntyre testified were appropriate and timely. He found the plaintiff professional and diligent. He functioned well between psychiatric episodes, and when ill he responded well to treatment.

- [16] Throughout the 2002 and 2009 episodes of serious depression he continued his medical practice.
- [17] In 2012, he seized on an opportunity to relocate the practice to a new premises with space to take on other physicians in a new building with improved amenities. His income declined initially then grew steadily in the ensuing years.
- [18] Two family practitioners joined him at the new premises on a cost sharing arrangement. Each conducted business as a sole practitioner.
- [19] The plaintiff was in his early 50s when he took additional measures to save for the future. On the advice of his accountant he incorporated his practice in 2012, intending to accumulate retained earnings in the company as his "main vehicle for saving for retirement." Salaries would be paid to him and his wife, income splitting for tax purposes.

B. Depressive Episode, 2014 to 2015

- [20] The plaintiff had another flare up of depression in 2014. The plaintiff was treated by Dr. David Coulter, a psychiatrist practicing in Vernon, BC. He engaged in psychotherapy for a period of six months. As his condition remained unimproved he switched his care to Dr. Neil Hanon, a psychiatrist practicing in Kelowna, BC. On increasing dosages of medication he "got to feeling really well" in late 2015, early 2016.
- [21] In cross-examination, the plaintiff was referred to Dr. Coulter's clinical notes for the period from June to November, 2014. The notes reveal that on June 26, 2014, the plaintiff felt "apprehensive about going to work feeling he has lost his innate confidence." On July 31, 2014 it is noted that "[he] expresses the concern that he may not return to work or rather that he may not feel like returning to work after his vacation." On October 21, 2014 the plaintiff stated "I think I need to change my job." Dr. Coulter notes, in this regard, that "[on] his holiday he felt emotionally well and he was keen to return to work but on his return he reports 'I entered a disaster. I had 1,080 results to review as the locums did not do a thorough job.'" It is noted that "[he] recognizes that he has to make fundamental changes in his life and at times he just wants to put an ad in the paper stating his practice is closing in two weeks." He also reported snapping at his wife and feeling "anything but content."
- [22] Dr. Coulter had recommended ways that the plaintiff could change his daily schedule of time at the clinic seeing patients and making hospital rounds, which the plaintiff testified he had implemented.
- [23] In the course of treatment with Dr. Coulter the plaintiff reported stressors associated with repairs to the Penticton Home and dissatisfaction with his office administrator. He testified that the latter problem was resolved with the hiring of a replacement.

[24] On November 20, 2014, Dr. Coulter noted that "[overall] this gentleman is progressing quite well and he reports benefit from psychotherapy sessions." In his December 4, 2014 note, Dr. Coulter says:

Generally he has a different attitude now regarding his practice and feels much [less] pressured to make an immediate change. What appears to be good repair work is also encouraging him regarding the fractured roof of his home.

[25] The plaintiff testified that he did not feel he was getting the help he needed from his attendances with Dr. Coulter.

[26] On referral from his family physician Dr. David Paisley, the plaintiff was examined by Dr. Hanon, a psychiatrist, on February 18, 2015. His report to Dr. Paisley is in evidence, together with his clinical records from March 4, 2015 - January 13, 2016. The plaintiff said he read these two weeks before commencement of the trial. He had little recall of much that was noted by Dr. Hanon, but generally accepted that he would have given him the information Dr. Hanon noted.

[27] The plaintiff's "Chief Complaint" is recorded in the report as follows: "I'm really anxious and somewhat depressed." Dr. Hanon briefly reviews reports detailing his history of depression from 1995 to February 18, 2015. This includes mention of several stressful events (divorce and bankruptcy) and his response to prescribed anti-depressant medications. The plaintiff reported to Dr. Hanon that his memory was generally good, but his reading retention was poor. He worried about patients incessantly and felt his confidence was gone. He came to dread going to work and the hospital.

[28] The plaintiff testified that this was his longest period of depression.

[29] Dr. Hanon's clinical record states:

- a) March 4, 2015: he was "flat", anxiety no worse no better. He does a good job but gets no joy from what he does. Sad, desperate but not suicidal. Rates self 4/10 on the scale from lowest in life to normal. Continue Trintellis, add Ability to meds;
- b) March 18, 2015: feels better, not great. Anxiety not as bad. Still not enjoying work. Self rating 5/10;
- c) April 1, 2015: Doing better, sense of humour back. Judgment better. More affectionate with wife. Work still drudgery;
- d) April 29, 2015: Not doing great, feels flat and blunted cognitively. Neither depressed nor happy. Better than he was, 60% normal. Increase Trintellis;
- e) May 20, June 10, June 24, 2015: Not depressed but "flat and uninterested". Concentration improved. Medication change improved focus. Gets up and goes to work as has to;

- f) July 8, 2015: Says he is better. Enjoying his work. Still flat, not joyful for past two years. Not depressed but disengaged. Does not dread going to work. Better focused. Mood 6/10;
 - g) July 29, 2015: Doing better, able to manage stress after a busy day. Content but not joyful. Mood 7/10;
 - h) September 2, 2015: Says he is better, doesn't feel normal but normal range of emotion. Not depressed;
 - i) September 23, 2015: 75% back to normal. Hospital and office work ok. Wouldn't work if didn't have to. If had enough money would return to university to study engineering. Mood 8/10. Plans for holiday in Europe; and
 - j) January 13, 2016: At a high level of functioning. Not happy, not depressed. Mood 6-6.5/10. Goes to work and does a good job. Plans to get house fixed and sell, move to Kelowna and buy condo. "Wants to retire but locuming isn't path to retirement." Says dream job is to join MSF (Doctors Without Borders) but only pays \$1,000/month.
- [30] The plaintiff was 55 years of age during the above attendances with Dr. Hanon. He was in the fourth year of his plan to accumulate savings for retirement using a corporate vehicle.
- [31] The plaintiff testified that when he stopped seeing Dr. Hanon in January 2016, he felt "excellent, an 8/10." This seems at odds with his report in a later session that he reported feeling 6.5/10. However, he also reported that he was not depressed.
- [32] Dr. Hanon's care ended with the above attendance on the basis that the plaintiff would call if necessary. He was given prescriptions for medications for six months. Dr. McIntyre testified that this is common practice in the course of treatment for depression. It was Dr. Hanon's call on the course of treatment, and he would have taken into account the plaintiff's presentation over the entire course of treatment while the plaintiff was in his care.

C. Dissatisfaction with medical practice

- [33] The plaintiff had reported to treating physicians that he was unhappy with some aspects of medical practice. He disagreed with changes implemented by the Medical Services Plan ("MSP"). Among these was a requirement that charts be kept electronically; he was a poor typist and found it hard to keep his records up to date. He believed that other changes diminished his ability to provide effective care to long term and, in particular, elderly patients. He expressed that changes in hospital administrative practices affected quality of care and the local culture of collegiality among physicians was in decline. The plaintiff did not attempt to minimize these concerns in his testimony.

- [34] It is, in my view, significant that the plaintiff took no measures to leave or alter his private practice during his episodes of depression in 2002, 2009, or 2014-2015. Quite the opposite: the plaintiff continued working throughout despite his dissatisfaction with some aspects of private practice and his difficulty in adapting to new technology for keeping patient records. His practice grew steadily. His billings to the MSP increased from \$276,000 in 2011/2012 to \$376,000 in 2015/2016.
- [35] The plaintiff testified that he was not dissatisfied with the practice of medicine as of January 2016.
- [36] The Accident occurred on August 4, 2016.
- [37] It is necessary to examine the evidence going to the reason for the plaintiff's decision to leave private practice. I now return to the narrative based primarily on the plaintiff's testimony, starting with the Accident.

D. The Accident

1. Evidence

- [38] The plaintiff left his clinic on Warren Avenue, Penticton, and proceeded east toward his home. Warren Avenue is a through road at the intersection with Camrose Street. Entry to Warren Avenue from Camrose Street is controlled by stop signs.
- [39] There was traffic in both directions on Warren Avenue. Upon entering the intersection, the plaintiff felt an impact and heard a "loud bang." He "hit the brakes and [in quick succession] heard another bang".
- [40] This, based on the evidence of the plaintiff, Mr. Leguerrier and Ms. Williams, is what happened: Mr. Leguerrier approached Warren Avenue from the north side of Camrose Street and entered the intersection without stopping, or stopped then booted his Honda vehicle across Warren Avenue. In doing so, he crossed the lane of traffic proceeding west and struck the plaintiff's vehicle on the driver's side at the rear wheel. The force of the impact spun the plaintiff's vehicle (a full size Audi sedan) clockwise across the oncoming lane of traffic on Warren Avenue. The second crash was the passenger side of the plaintiff's vehicle coming into contact with the left front corner of Ms. Williams' vehicle (a 1999 Ford F-150 pick-up truck.) The plaintiff's vehicle came to rest alongside Ms. Williams' vehicle, facing in the same direction.
- [41] Ms. Williams, travelling west, had seen Mr. Leguerrier's vehicle proceed past the stop sign and, anticipating trouble, pulled over to the edge of the road and stopped. She witnessed the collision with the Plaintiff's vehicle.
- [42] Mr. Leguerrier testified that the impact with the plaintiff's vehicle was "pow," a "hard knock" which brought his vehicle to a "dead stop."

- [43] The force of the first collision spun the plaintiff's vehicle clockwise across Warren Avenue and into the stationary vehicle of Ms. Williams. Mr. Leguerrier said that the plaintiff's vehicle spun twice and "must have gone around 200 feet down Warren [Avenue]."
- [44] The plaintiff testified on cross-examination that on the first impact the windshield of his vehicle "tilted up" which suggests that the driver's side wheels lifted off the road.
- [45] The repairs to the plaintiff's vehicle cost over \$19,000, and most of the damage appears to have been on the passenger side. Ms. Williams' vehicle was a write off as the cost of repair exceeded its value (around \$4,500). The extent of damage to both vehicles indicates a forceful second impact.

2. Liability

- [46] Justice Legg, writing for the BC Court of Appeal in the case of Pacheco (Guardian of) v. Robinson (1993), 75 B.C.L.R. (2d) 273, 22 B.C.A.C. 185 [Pacheco], paraphrased at para. 18 the Supreme Court of Canada's reasons for judgment in the case of Walker v. Brownlee, [1952] 2 D.L.R. 450 (S.C.C.) at 461 as follows:

In my opinion when a driver in the servient position disregards his statutory duty to yield the right of way and a collision results, then to fix any blame on the dominant driver, the servient driver must establish after the dominant driver became aware, or by the exercise of reasonable care should have become aware, of the servient driver's disregard of the law, the dominant driver had sufficient opportunity to avoid the accident of which a reasonably careful and skillful driver would have availed himself.

- [47] Section 175 of the Motor Vehicle Act, R.S.B.C. 1996, c. 318 imposed a statutory duty on the defendant, Mr. Leguerrier to yield the right of way to traffic on Warren Avenue and to proceed with caution. Therefore, whether or not Mr. Leguerrier stopped at the stop sign, he breached his statutory duty regardless in failing to proceed with caution. As set out above in Pacheco, being the servient driver, Mr. Leguerrier is therefore at fault unless the dominant driver, the plaintiff, had sufficient opportunity to avoid the Accident. There was, I find, no such opportunity.
- [48] Mr. Leguerrier entered the intersection when it was unsafe to do so. He did not keep a proper lookout for approaching vehicles which had the right of way. His negligence was the sole cause of the collision with the plaintiff's vehicle and the following collision with Ms. Williams' vehicle.
- [49] Ms. Williams bears no responsibility for the collision between her vehicle and that of the plaintiff. It is likely that her attention to other vehicles, including Mr. Leguerrier's, and her action of pulling over to the side of the road and stopping, averted a much more serious impact with the plaintiff's vehicle.
- [50] I pause to note that all references to follow to the "defendant" are directed towards Mr. Leguerrier.

E. The Immediate Sequelae

- [51] The plaintiff testified of his reactions and feelings after the impacts. He thought "what the hell just happened." He said there was no warning, "it was just out of the blue." He did not know how long he sat in the car, but he assumes a few minutes. He was "surprised, shocked, bewildered, and confused." Exiting the vehicle he thought "oh, the door opens, that's nice." He inspected the passenger side and opened the door, thinking "wow, this door still opens." He recalls seeing parts of Mr. Leguerrier's vehicle laying on the road.
- [52] The plaintiff drove his vehicle off the road to clear the intersection, and remembers photographing driver's licences with his phone.
- [53] His memory is "a little disjointed." He testified: "Like, I don't have a clear memory of the flow of events." He remembers talking with Ms. Williams, and that she was angry with Mr. Leguerrier for saying that the plaintiff was driving too fast.
- [54] His recollection of where his vehicle came to rest in relation to Ms. Williams' vehicle was unclear.
- [55] His wife, Ms. Barkhuizen, came to fetch him, but he does not recall contacting her. He was upset over being unable to find his keys. His wife found them in his pant pocket.
- [56] He recalls nothing more from the day after leaving the scene with his wife.

F. Karon Barkhuizen

- [57] Ms. Barkhuizen and the plaintiff met in 2005, dated, then entered a common-law relationship. They married in November 2010.
- [58] The plaintiff had told her of his history of depression and they were together through the episodes of severe depression in 2009 and 2014-2015.
- [59] She described her husband as shy, introverted, and passionate in his work. His day started at 7:00 a.m., an hour before the clinic opened for patients. After seeing patients at the clinic and his hospital rounds he volunteered at a walk in clinic. He took calls from patients in the evening when at home. He also did rounds on weekends.
- [60] In 2015, on the advice of his psychiatrist, he started taking a 1.5 hour lunch break, extending his day later to make up for the time. This coincided in time with his 2014-2015 treatment for depression. He became more relaxed.
- [61] His practice grew throughout. She occasionally helped out at the office on weekends then in 2017, during the absence of his medical office assistant ("MOA") on leave, she commenced doing correspondence with lawyers in litigation matters and the Workers Compensation Board. This was sporadic until she took over as his MOA in 2014.

- [62] They had discussed future retirement plans before the Accident. Due to his divorce and bankruptcy their financial circumstances were such that he planned to work until age 70 and possibly beyond.
- [63] The plaintiff had at some time prior to the Accident, voiced his dislike for paperwork and "interior health politics".
- [64] She learned of the Accident on receiving a phone call from the plaintiff. She attended at the scene. She saw him "chatting with two women and a man", then he came over to meet her. She testified that "he was very confused, kind of out of it, spacey" and was "unusual for him." In light of the medical evidence that confusion after a blow to the head suggests concussion, I consider her observation somewhat important as it was measured against his normal state.
- [65] To her, the plaintiff appeared "flustered" and she suggested they go to the hospital. She asked about the keys for his car, he could not find them after searching for several minutes. They were found in his pant pockets.
- [66] He declined the suggestion of going to the hospital and said he "just wanted to go home."
- [67] Ms. Barkhuizen drove the plaintiff to their home. She testified that the plaintiff took a nap, then at his request and despite her concerns, she drove him to the hospital where he did his rounds with patients he had admitted. He then participated in procuring a rental vehicle which he drove to their home.
- [68] On their return home she made supper, but he did not want to eat and went to bed.
- [69] In the morning, the plaintiff said he felt battered and bruised. Ms. Barkhuizen observed bruising on the left side of his face.
- [70] She became aware after a week or two that her husband had no recollection of what occurred after she picked him up at the scene of the Accident, and told him about his actions for the remainder of the day.
- [71] Asked about his behavior in the course of his 2014-2015 episode, she testified that he was sad, uncharacteristically quiet, subdued and avoided social activities. He worked more than normal, and said he felt safe at work. He was occasionally but not unusually irritable.
- [72] In the course of treatment he changed his daily routine to take a mid-day break, with positive results.
- [73] While under Dr. Hanon's care the plaintiff "was becoming himself again, seeing friends ... cheerful" active and positive toward life. Up to the Accident he was "normal Derrick."
- [74] She testified of changes in the plaintiff's behavior and functioning in the time following the Accident. He was irritable, temperamental and impulsive. His characteristic kindness was absent. His memory was poor, there was trouble retaining material he had read. He appeared stressed and overwhelmed.

- [75] She was the plaintiff's MOA at this time. She was aware that there were calls from pharmacies over incorrectly noted prescriptions. He lacked recall of the names of patients, his charting notes were poor.
- [76] In late October/early November 2016 she informed Dr. Paisley's MOA that her husband was not doing well.
- [77] The plaintiff told her of his concerns over patient care.
- [78] They considered having a locum stand in for the medical practice. This was done, the outcome was poor. In April/May 2017, the developments around the sale of the Penticton Home and the purchase of a condo in Kelowna (discussed below at paragraphs 114-119) played out. It was during this period that the plaintiff took steps to leave private practice. He had returned to the care of Dr. McIntyre, who recommended taking time off.
- [79] After Drs. Donald Cameron and Raymond Ancill were retained to conduct independent medical examinations, both interviewed Ms. Barkhuizen. She testified that after the diagnosis of brain injury the plaintiff was "crestfallen, wounded at the prospect of no full recovery."
- [80] In July, 2017, the plaintiff applied to the BCMA disability program for coverage for one year. He described his condition as anxiety and depression. The section of the form entitled "Disability due to Injury" was not filled in as, at the time, he did not attribute his condition to an injury suffered in the Accident. His application was approved.
- [81] Ms. Barkhuizen testified of their travels to Spain and England while the plaintiff received the disability pension. He subsequently tried working as a locum but lacked confidence and was concerned over patient care. In March 2020, he secured his present employment at the urgent care clinic. The pace is slower, more time allowed with each patient, more variety.
- [82] By her account there was some improvement in late 2020, but the plaintiff has stabilized without restoration of his pre-Accident state. He remains volatile, impulsive and given to anger. His retention of medical material remains a challenge and, unlike previously he does not read for pleasure. They are active together with walking and cycling.
- [83] There has been no sexual intimacy since the Accident.
- [84] Ms. Barkhuizen was cross-examined on their travels to Spain, twice, the United Kingdom, and Croatia, prior to the plaintiff taking work as a locum when disability payments ended. I do not consider their activities during this period to have any bearing on the central question of whether the plaintiff suffered a brain injury that has disabled him from private practice. This does, however, suggest that physical injuries sustained in or exacerbated by the Accident were not disabling to any significant degree.

- [85] Much was made of her failure to mention in testimony that the plaintiff had a heart incident when in the United Kingdom, but this was not an advertent omission in the plaintiff's case generally, as the defendant would have known this from disclosed medical records.
- [86] It became apparent that the plaintiff had not apprised his wife fully of the concerns over his functioning as related to Dr. Hanon when in treatment for depression in 2014-2015. These go to the question of whether his functional problems were much the same during that episode as after the Accident. This will be determined based on the whole of the evidence.
- [87] The defendant argues that an inconsistency in Ms. Barkhuizen's evidence on direct- and cross-examination undermines the reliability of her evidence. She did not testify on direct that she and the plaintiff had dinner before going to the hospital, but agreed on cross that they had.
- [88] The defendant also points to inconsistencies between her evidence and that of the plaintiff in their testimony and in what they had respectively reported to attending and IME physicians and in their evidence at trial.
- [89] The inconsistencies highlighted by the defence are generally over details, and are likely due to imperfect recall of past events. It is not unusual that such differences appear. The context and purpose for which events and observations are related also affects the content and level of detail that is offered.
- [90] It is my assessment that the plaintiff and Ms. Barkhuizen were forthright and honest in their testimony, and reliable on matters of substance relevant to the grounds on which the claim is advanced.
- [91] In particular, I accept the plaintiff's evidence that he had no recollection of his actions on August 4, 2016 after his wife picked him up.

G. The Following Days and Months

- [92] The morning following the Accident, the plaintiff noticed bruising in the area of his left ear. He thought it strange as he had "no memory of any kind of injury to [his] head." He remembers suffering pain in his left shoulder, upper mid back, low back, and "pins and needles" in his right thigh.
- [93] Asked on direct-examination about how his work went over the next few months he testified:

A: Not well. I started noticing things that I was doing wrong. I was having trouble finding words. I - I would find that I couldn't remember patients' names that I had for years and years and years. I occasionally forgot to write notes in patients' charts, and when I saw them again, I would have no idea of what was going on or why I had seen them before. I couldn't focus. I couldn't sort of - I found it hard to reason, to sort of think things through linearly. I was really irritable. I had - I didn't feel any compassion for my patients at all. It was really weird. I was irritable. I was angry

all the time. I became Incredibly anxious, and I - I didn't really understand what was going on. I was very worried about the care I was providing, and I was extremely worried that I would make a mistake and harm somebody. My anxiety became overwhelming, and my confidence was gone. I was embarrassed. You know, I - I would - I would - I just - I don't know. I don't even know how to describe it. It was - it was like an insidious thing in the sense that - I guess the fact that I didn't understand what was going on was what made it really scary.

Q: Over what period of time was this happening?

A: I don't really know. I have - I have such gaps in my memory. Probably that first year that have been refreshed by looking at these notes and things. But, I mean, I got to the point where I was really worried about continuing to practice, and I was really worried about harming somebody. I was worried about my reputation.

[94] On August 8, 2016, the plaintiff saw Dr. Tom Francis, a locum for his family physician, Dr. Paisley. He told Dr. Francis that he had been in a car accident, had struck his head on the driver's side door, and initially experienced confusion. His concern was with "muscular-skeletal symptoms" and he was provided a referral for physiotherapy. He attended numerous times.

[95] The plaintiff is by his account and that of his wife, a very private person. He reveals to others only that which is relevant to the subject at hand. This is mentioned in the clinical notes of Dr. Coulter, psychiatrist, who attended on him during the earlier stages of his 2014-2015 episode of depression.

[96] He made little of his blow to the head when he saw Dr. Francis, but his immediate concern was physical pain following the Accident. He did not mention having struck his head to the physiotherapist, whom he went to for treatment of back pain.

[97] Dr. Paisley's clinical records for October 13, 2016 mention that the plaintiff experienced confusion following the Accident and that the plaintiff had "been repeating to himself following [the Accident]." He noted that on November 24, 2016, the plaintiff told Dr. Paisley that his wife had observed that "he has been asking questions, she feels repeatedly, some short term memory loss."

[98] There is no note of facial discoloration in the clinical record of Dr. Francis or Dr. Paisley. The plaintiff testified on cross-examination that he doubted that he had ear pain on the first visit. There is no evidence that the bruising observed the morning after the Accident remained visible.

[99] In the months following the Accident, the plaintiff thought he was having a "flare-up" of depression. He was, at his request, referred to Dr. McIntyre who treated him for episodes of depression in 2002 and 2009. His first consultation with Dr. McIntyre after the Accident was on May 2, 2017.

[100] In the testimony reproduced below the plaintiff explains the difference between his symptoms experienced during episodes of depression and that experienced following the Accident. He speaks of the impairments associated with the latter and his concern that he had become unable to take care of his patients: "the only way that I knew to do that in any meaningful way was to essentially have someone take over my practice or buy it." The plaintiff further went on saying:

A: At the time, I thought that it was a flare of my depression. I have the benefit of hindsight that I can - I know now that my predominant symptom then was anxiety. With my other depressions, my - my predominant symptom was sadness and feelings of worthlessness and the occasional suicidal thoughts. With this particular episode, I don't recall feeling that at any point. So with my other depressions, sadness was the predominant symptom. With this, anxiety was my predominant symptom.

Q: Anxiety about what? Were you able - was there -

A: I -

Q: Was it connected to something, or was it just -

A: My life was falling apart, and I didn't know what was happening at the time. I had no understanding of what was going on. I simply knew that something had changed, and I had gone from being somebody who was extremely proud of what they did and how well I did it to being somebody that was now terrified that I was marginally functional and--

Q: What particular aspects of your function were you concerned about?

A: My memory was extremely impaired. I struggled to remember drug names and drug dosages. I would frequently have prescriptions faxed back to me by pharmacies with errors on them that I would have to correct and send back. I was omitting notes from patients' charts. I was finding it hard to reason in a linear fashion. I was very irritable. I was very emotional. I couldn't remember people I knew well. I would have problems remembering their names.

[101] Some, but not all of the post-Accident deficits testified of by the plaintiff were, as recorded by Dr. Hanon, present with the plaintiff during his 2014 episode of depression. However, these were not so pronounced as to cause him the self doubt he experienced in the months following the Accident. With previous episodes he maintained his practice throughout and was able to grow his practice and increase his revenues up to the time of the Accident.

[102] To the extent that there was memory impairment when experiencing severe depression, the plaintiff's post Accident onset problems with memory, in particular the impact on aspects of practice critical to his ability to provide competent health care and maintain his relationship with regular patients, were not previously present.

- [103] In January 2017, he placed an advertisement in the BC Medical Journal seeking a doctor to take over his practice. He also placed an ad in the Canadian Medical Association Journal. Neither ad generated any interest in acquisition of his practice.
- [104] On May 18, 2017, the plaintiff informed the Royal College of Physicians and Surgeons Canada (the "College") of his intention to take a one-year sabbatical. He was asked on cross-examination if he agreed that it was his intention, on writing to the College, to close his practice. He disagreed. However, when asked on discovery whether he, on May 18, 2017, intended to close his practice he said he did.
- [105] On cross-examination, the plaintiff was asked who he had spoken to about his intention to retire. The names included Dr. McIntyre. Then followed another impeachment. He had testified on discovery, when pressed, that he "probably" told Dr. McIntyre as "I'm just thinking that it's the most appropriate thing."
- [106] Between the first and second "impeachment" the plaintiff testified, "I'm just trying to remember the chronology."
- [107] As for the inconsistencies, they are understandable given the passage of time from the plaintiff's post-Accident condition which led to his decision to close his practice, up to the examination for discovery in September 2020, and his testimony on May 6, 2021.
- [108] When pressed further on cross-examination about his intentions to sell his practice the plaintiff explained that he was desperate at that point (January 2017) to ensure that his patients would be looked after. It was put to him that his intention was to sell it or close it. He replied:
- A: That was not my primary intention. You're - implying it was - my primary intention was to walk away from this practice and move to Kelowna. I'm saying that my intention was to find somebody to care for my patients primarily and then deal with whatever I needed to. And I couldn't have a[n] open-ended, vague deal for somebody who was going to come and look after my patients. I needed something concrete
- [109] Asked on cross-examination whether he had decided on January 5, 2017, that if the practice did not sell he would simply walk away, he testified "I would say that is probably correct, yes." But the plaintiff did not in fact just "walk away."
- [110] After a further exchange with defence counsel the plaintiff reiterated his earlier statement that in January 2017 he was looking for anyone who would look after his patients. He knew there was no market for his practice and he would ultimately give it away.
- [111] The plaintiff did walk away from his practice in June 2017, but not until after the family physicians with whom he shared the clinic with agreed to take over his patients. The timing and the fact he had made arrangements for the continued care of his patients lends credit to his assertion that, unlike when in an episode of depression, he was now unable to provide ongoing care as a family physician.

- [112] The first firm offer on the Penticton Home came in April 2017. It was after this that the plaintiff and his wife looked at homes in Kelowna, and entered a contract for the purchase of a condo in Kelowna on April 27, 2017.
- [113] Indication that the plaintiff may have suffered a brain injury first appeared on an independent medical examination by Dr. Cameron, neurologist, in a report dated September 22, 2017. In a report of an independent medical examination conducted on August 4, 2018, Dr. Raymond Ancill, psychiatrist, concluded that the plaintiff had sustained a mild traumatic brain injury (MTBI) in the Accident.

H. Retirement and move to Kelowna

- [114] The plaintiff's decision to retire came after the Accident, as did his move to Kelowna. The move coincided with events concerning the Penticton Home. The Penticton Home was severely damaged by flooding from a burst pipe in December 2009. It was uninhabitable. The restoration work progressed slowly, in part due to conflict with the insurer. At some point the couple "had no love for the house whatsoever." In anticipation of the completion of repairs the plaintiff and his wife looked at condos and homes listed for sale in Penticton. The restoration was completed in 2015. Once completed, the Penticton Home was listed for sale on October 13, 2016. At that point in time they had taken no steps toward a move to Kelowna.
- [115] The first firm offer on the Penticton Home came in April 2017. The plaintiff had by then decided to leave private practice due to his heightened anxiety, deficiencies in memory and concern over his ability to attend to patient care in the period following the Accident.
- [116] Although it is not clear on the evidence just when, the couple had by then discussed the possibility of moving to Kelowna. Proximity to an international airport was a factor as they hoped to travel abroad. It was part of their long term plan, upon retirement, to live in a community in the Okanagan far enough distant from Penticton that he would not encounter former patients in public places.
- [117] The plaintiff was scheduled for eyelid surgery in Kelowna on April 27, 2017. He attended the surgery while accompanied by Ms. Barkhuizen. While the procedure was in progress, Ms. Barkhuizen attended an open house showing of a new condominium. They went to view it together later that day. Ms. Barkhuizen testified that, to her surprise, the plaintiff decided they would purchase the home on the spot. Their offer was accepted.
- [118] The defendant places great emphasis on the fact that the plaintiff had, prior to purchasing a home in Kelowna, decided to close his practice. This of course is the case. But this does not establish that the home purchase and the closure of the plaintiff's private practice were planned prior to the Accident. The evidence reveals that although the plaintiff and his wife thought about relocating from Penticton to Kelowna at some time in the future, they took no action until he had retired from private practice. This was almost one year after the Accident and the onset of cognitive problems that, according to the plaintiff, precipitated

his decision to leave private practice.

[119] There is no evidence of action by the plaintiff to move to Kelowna or wind up his practice prior to the Accident. The couple did not take concrete steps in furtherance of a move to Kelowna until April 2017, 16 months after the plaintiff sustained injuries in the Accident. I do not agree with the defendant's contention that the fact that the couple moved to Kelowna when they did reveals a concrete pre-Accident plan in place for a move prior to the plaintiff withdrawing from private practice.

I. Collateral Witnesses

1. Gordon Anderson

[120] Mr. Anderson is a medical laboratory manager. He is stationed in Cranbrook, which is within the same health region (Interior) as the Okanagan.

[121] He and the plaintiff met in Chetwynd in 1993. They established a close friendship, and so it remains to the present.

[122] They have vacationed together, and he is a frequent guest in the Barkhuizen home when work occasions his travel to the Okanagan. They share text and email messages, and phone calls on holidays and other occasions.

[123] He described the plaintiff, up to summer 2016, as "calm, cool and collected." Between 2012 and 2016 the plaintiff was "normal; happy, competent, good practice in Penticton." He knew about the Barkhuizens' house troubles, which they considered an inconvenience.

[124] He was told about the Accident when visiting on a return from Vancouver. On a subsequent visit in October 2016, the plaintiff told him about his problem recalling the names of patients and medications. The Barkhuizens argued, which Mr. Anderson thought was "strange for them" as he knew them to be a "perfect match, leading a busy life and happy together."

[125] On a visit in spring 2017, he found the plaintiff "troubled, and noticeably forgetful", and he "appeared distant and seemed depressed." In conversation he would lose track of the topic and repeat stories. He had never before seen this in the plaintiff. I note in this regard that their friendship had bridged the plaintiff's 2014-2015 episode of depression.

[126] He was later informed by the plaintiff that to he closed his practice due to concerns over his care for patients. He had lost interest in his new hobby of investing, and his long time hobby of building electronic devices.

[127] There was a visit in July, 2018, when the plaintiff took work as a locum. He was unsure of himself and struggling to keep notes of patient attendances. He said he was still forgetting things but felt he could do a little work.

[128] In March 2020, the plaintiff was working at the urgent care centre and appeared "more engaged and positive, normalized but not back to his self" according to Mr. Anderson.

[129] I accept Mr. Anderson's evidence of observed changes in the plaintiff's presentation in the time following the Accident.

2. Gerry Lou Barrett

[130] Ms. Barrett and the plaintiff have been acquainted since 1971.

[131] She worked at the plaintiff's medical office intermittently between June 2007 and November 2015. She was there for the 2007 move from the small office to the premises occupied until he left the practice. The move was a "huge undertaking."

[132] Ms. Barrett retired in 2013, but she and the plaintiff remained in contact. She returned temporarily as the MOA in 2014 as the plaintiff's MOA had been let go. The plaintiff did not, between 2012 and 2014, mention retirement. They remain friends.

[133] Between 2015 and 2016 he was "happy, always doing things."

[134] She learned of the Accident in 2016. He reported that he was going to physiotherapy, "everything was fine." In 2017, he contacted her with questions about patients' medications and personal lives. This surprised her as he always had a good memory.

[135] On being told by the plaintiff that he had closed his practice, it appeared to her that he had no plan, unlike previously when he "had direction." She found him uncharacteristically unhappy and irritable.

[136] On cross-examination she agreed that she had initially declined to converse with counsel for the defendant. Asked whether she wanted the plaintiff to do well, and is "here to advocate for him in this matter" she agreed.

[137] She confirmed her evidence on direct that she did some work for the plaintiff in 2014. It was put to her that her name last appeared on the payroll record on September 27, 2013. She confirmed that as her retirement date, but remained positive that she had worked sporadically in 2014.

[138] Her agreement with counsel's "advocacy" question was not played out, considering the substance of her evidence. She was straightforward in her testimony and did not advocate for the plaintiff's cause.

[139] Whether she worked for the plaintiff in 2014 is of no consequence as she and the plaintiff were socially acquainted as well as co-workers. I accept her evidence of observed changes in the plaintiff's presentation in the time following the Accident.

III. Depression and Brain Injury

A. Episodes of Depression

[140] The plaintiff testified that he had episodes of depression in 2002, 2009 and 2014-2015. Dr. McIntyre was his treating psychiatrist. Following the Accident he saw the plaintiff for a consultation:

He was referred to me in April 2017 for assessment of a depressive disorder. Dr. Barkhuizen has previously been under my care in 2002 and 2009. The patient's past diagnosis was that of a Major Depressive Disorder Recurrent. The patient was seen in consultation on May 2, 2017.

[141] Dr. McIntyre did not treat the plaintiff during the course of his 2014-2015 episodes. The plaintiff was treated by Drs. Coulter and Hanon, psychiatrists.

B. Brain Injury

[142] It would be almost two years post Accident before the spectre of a diagnosis of an Accident related brain injury would appear.

[143] Dr. Cameron assessed the plaintiff at the request of his counsel, on June 29, 2017. In his September 22, 2017 report he says, in part:

9. Dr. Barkhuizen was the driver of a motor vehicle involved in a T-bone type motor vehicle accident. He was struck by a Ford f-150 truck within moments on the passenger side of his vehicle. He states that he recalls the impact but does not recall what his head hit during the accident. He has no recall of his head hitting anything at the time of the impact, but he feels that his left side of head and left ear struck something at the time of the impact as he reported significant pain in this area immediately after the impact.

10. Dr. Barkhuizen was confused immediately after the accident.

...

12. He does report suffering with decreased multitasking abilities, decreased memory, irritability, mood swings, difficulty making decisions, decreased self confidence, decreased interest in socializing, change in sleep pattern, feelings of depression, problems with repeating questions, and repeating statements all present following this accident.

...

22. He also reported irritability, mood swings, difficulty making decisions, decreased self-confidence, decreased interest in socializing, and requirement to sleep excessively since the accident.

23. He states that he is making more mistakes at work and filling out prescriptions. Because of these problems present since this accident he has closed his practice in the last week.

[144] Under the heading "Opinion", Dr. Cameron says, in part:

30. Following my neurological assessment of Dr. Barkhuizen and following my review of the family physician records, it is my opinion that Dr. Barkhuizen probably did suffer an altered state of consciousness or a brief loss of consciousness at the time of the motor vehicle accident on August 4, 2016.
31. He indicated that he recalled the two impacts that he was involved in but he does not recall the left side of his head or his left ear striking something at the time of the impact. The family physician notes document that he felt that he struck the side window at the time of the impact but he does not actually recall doing this. He was reported to be confused immediately following the accident.
32. It is therefore my opinion that Dr. Barkhuizen does fulfill the criteria in order to make a diagnosis of mild traumatic brain injury sustained at the time of accident on August 4, 2016
- ...
42. It is my opinion that Dr. Barkhuizen has been rendered partially disabled because of the residual adverse effects of the injuries sustained at the time of the accident on August 4, 2016, and these predominantly include cognitive dysfunction and psychological dysfunction.
- [145] At the request of plaintiff's counsel, Dr. Ancill interviewed the plaintiff on July 26, 2018. He also interviewed Ms. Barkhuizen. He later reviewed Dr. Paisley's clinical records and reports dated May 17, 2017 and June 9, 2018, and a second report from Dr. Cameron dated September 22, 2018. In his initial report dated August 4, 2018, he says, "It is my opinion that Dr. Barkhuizen was seriously injured in the collision of August 4, 2016 and sustained a mild traumatic brain injury." He opined further that the plaintiff "... further presents with a persistent Post-Concussion syndrome, a set of symptoms that may continue for weeks, months or years after a concussion and reflects a traumatic brain injury ". He was aware of the plaintiff's history of depression, of which he says:

Dr. Barkhuizen had never been assessed for, or diagnosed with, any disorder of attention, conduct or learning. There was a past history of depression which started in 1993 and was treated with antidepressants. He was on venlafaxine for a year. He estimated he had four depressive episodes in total prior to the collision, the last one being in 2015. He was not on antidepressants at the time of the subject collision and both he and his wife agreed he was not depressed

- [146] The opinion of Dr. Ancill, a full two years post-Accident, confirmed what Dr. Paisley had come to suspect and came as a revelation to the plaintiff, who could not understand why what appeared as another episode of depression had, unlike in any previous episode, a profound effect on his ability to perform tasks necessary for his work.

C. Subsequent Examinations and Medical Reports

[147] The evidence under this heading is extensive. It canvasses the period from the 2014-2015 episode of depression up to the final exchange of medical reports, response reports and supplemental reports. This evidence cannot be conveniently broken down sequentially by author of reports and clinical notes under a series of discrete headings.

[148] Dr. McIntyre provided plaintiff's counsel with a further medical-legal report dated October 6, 2020. He said, in part:

4. Dr. Barkhuizen was involved in a motor vehicle accident on August 4, 2016. Dr. Barkhuizen reported that his vehicle was struck twice at the intersection. He recalled some aspects of the collision. He recalled calling his wife Karon following the accident. He returned to work and attended patients at the hospital on the same day. He was referred to me on April 2017 for assessment of a depressive disorder. Dr. Barkhuizen had previously been under my care in 2002 and 2009. The patient's past diagnosis was that of a Major Depressive Disorder Recurrent. The patient was seen in consultation on May 2, 2017.

...

6. The patient reported that he was unable to recall when he last felt good for more than 2 months at a time. He stated that the previous 5 months have been extremely difficult for him. He identified several stressful events that he believed that may have contributed to his depression. Work was difficult. He struggled with the day-to-day activities of work. . . .

...

33. I was asked what the impact, if any, that Dr. Barkhuizen's motor vehicle collision had on his psychological and psychiatric situation. I was consulted regarding Dr. Barkhuizen's Recurrent Depressive Disorder. Primary focus was the treatment of his depressive disorder. Having reviewed the collateral information available, I am of the opinion that Dr. Barkhuizen likely suffered A Mild Neurocognitive Disorder Due to a Traumatic Brain Injury because of the collision. The motor vehicle collision has contributed to the exacerbation/relapse of his Depressive Disorder.

...

35. Dr. Barkhuizen's psychiatric condition has improved since the collision. When last seen in June 2020 he was much improved. Dr. Barkhuizen has had a waxing and waning course of his depressive disorder since the initial consult in 2002. Since the May 2017 consultation, Dr. Barkhuizen experienced several psychosocial stressors that may have contributed to the course of his illness.

[Underline in original.]

[149] Dr. McIntyre testified. Under cross-examination on the contents of paragraph 33 of his report, he agreed that his opinion that the plaintiff had sustained a brain injury was based on collateral information, in particular the reports provided to plaintiff's counsel by Drs. Paisley, Cameron and Ancill. The plaintiff continued his clinical practice throughout his attendances with Dr. McIntyre up until he left his practice in June 2017 and was treated by him subsequently up to June 9, 2020.

[150] Dr. Paisley, the plaintiff's family physician since 2012, provided a report dated May 17, 2017. He attended on the plaintiff for Accident related complaints from August 8, 2016 onward. These included injuries to his left shoulder, left chest wall, and sacral iliac area. The plaintiff attended on October 14, 2016 with a complaint of confusion following the Accident. He was repeating himself. He said that work was okay and sleeping was not a problem. Dr. Paisley's report says, in part:

He was seen on November 24, 2016 at the request of his wife as she had felt that he had some short-term memory changes following the motor vehicle accident as he repeatedly asked the same question, having difficulty with his memory. At that stage he denied any problems with short-term memory, he denied any headaches or photophobia or vertigo. He did not find any problems at work.

...

Following the motor vehicle accident, he still complains of pain in his neck and shoulder from soft tissue injury from the motor vehicle accident. He had been noted to have intermittent episodes of confusion and short-term memory loss following the motor vehicle accident and then his wife later although this has not impacted his working ability suggesting a concussion injury. These symptoms were not present prior to the motor vehicle accident. His short-term memory difficulty and confusion were not present prior to the motor vehicle accident, so I do not think that his depression has a significant role in this. I anticipate these symptoms will gradually wane.

[Emphasis added.]

[151] The defendant introduced a response to Dr. Cameron's report from Dr. Rehan Dost (neurologist), who assessed the plaintiff on December 1, 2020 and provided his report the same day.

[152] The plaintiff was seen virtually. Dr. Dost also reviewed the following:

- a) Insurance Claim Application dated September 20, 2016;
- b) ICBC Medical Report (Dr. Paisley) dated October 31, 2016;
- c) Handwritten Clinical Records (Dr. Paisley) date unknown;
- d) Report (Dr. Davidson) dated September 1, 2016;
- e) Report (Dr. Davidson) dated September 7, 2016

- f) Report (Dr. McIntyre) dated May 4, 2017;
- g) Report (Dr. Cameron) dated September 22, 2017;
- h) Report (Dr. Ancill) dated August 4, 2018;
- i) Vocational Rehabilitation Assessment (Niall Trainor) dated October 14, 2020; and
- j) Report (Dr. McIntyre) dated October 6, 2020.

[153] He set out in summary, what he appeared to consider the salient contents of each document above. The primary focus is on the plaintiff's history of depression, summarized briefly in Dr. McIntyre's report dated May 4, 2017 as "persistent depressive disorder with intermittent episodes within the current episode. Very moderate to severe." This report was written prior to the findings of Drs. Cameron and Ancill that the plaintiff had suffered a brain injury in the Accident.

[154] Dr. Dost sets out, in brief, the history given to him on his interview of the plaintiff, including the plaintiff's post-Accident concerns with regard to heightened anxiety, errors, forgetfulness, and deficiency in note taking for charting. The plaintiff was concerned for patient care. He also reported a significant flare in his depressive symptoms and headaches. Dr. Dost reported that the plaintiff saw his treating psychiatrist (this was Dr. McIntyre at the time, 2017) and "tried a number of medications, which made no difference to his anxiety or depressive symptoms." I note in this regard the plaintiff's evidence, supported by the clinical notes of Dr. Hanon, that his depression had responded to medication in pre-Accident episodes.

[155] Dr. Dost sets criteria for diagnosis on MTBIs/concussions, which includes:

In order to diagnose mild traumatic brain injury/concussion the criteria (CDC, WHO, DSM-5) stipulate that one must have all of the following:

...

- b. One of loss of consciousness, amnesia, disorientation or confusional state at the time of trauma as per the medical definitions of these terms.
- c. The above cannot be due to non-traumatic factors such as psychological duress, acute pain, attrition of memories with time, physiological amnesia, et cetera.

...

[156] He then reviews the "Evidence", (reports and interviews with the plaintiff) and says:

The type of post- traumatic amnesia that Dr. Barkhuizen has described is atypical for mild traumatic brain injury/concussion:

- a. As I have articulated above, the type of post-traumatic amnesia occurs is dense and not delayed. The objective test for post-traumatic amnesia is at the time of trauma and is the Galveston Orientation and Amnesia Test (GOAT), which records the time required to begin laying down memories.
- b. In this respect it is unusual that Dr. Barkhuizen is able to recall the details of the accident, speaking with individuals at the scene, having the foresight to move his vehicle off to the side of the road, exchange information with the other driver and contact his wife. All of this indicates the ability to lay down memories and therefore he was not in a state of post-traumatic amnesia at that time.
- c. Dr. Barkhuizen's ability to complete these functions also indicates that he was not confused, as he was able to organize his thoughts and direct his attention. The confusion begins approximately 30 minutes post event, when Dr. Barkhuizen has some difficulty finding the keys in his pocket. Thus, there also appears to be a delay in the onset of his "confusional state."
- d. I refer the reader to the CDC definition of mTBI/concussion and the Berlin and Zurich Consensus papers on concussion which state that the neurological impairment is "rapid in onset". This does not appear to be the case here.

[157] Dr. Dost does not fall fully on one side or the other on the question whether the plaintiff sustained an MTBI:

If the Courts find that Dr. Barkhuizen's delayed onsets post-traumatic amnesia and confusional state are not related to brain trauma, then Dr. Barkhuizen did not sustain a mild traumatic brain injury/concussion. In this scenario, his ongoing cognitive issues reflect the influence of psychiatric factors with superimposed ongoing chronic pain, consistent with Dr. Barkhuizen's self-report that the chronic pain is correlated with his cognitive function

If the Courts find that Dr. Barkhuizen did indeed have a confusional state and post-traumatic amnesia attributable to brain trauma, then he sustained a mild traumatic brain injury/concussion.

If the Courts finds that the plaintiff sustained an mTBI, it might be useful to the Court to outline the pathophysiology of mTBI, the outcomes, the nature and origin of persisting symptoms which can occur in a minority of patients, the differential diagnosis of such symptoms and the methodology used to arrive at the most plausible working diagnosis

In this manner one can follow the logic and rationale in arriving at the working diagnosis for the plaintiff's ongoing symptoms in this particular case.

[158] Dr. Dost continues with an explanation of symptoms and the nature of the traumatic event that, when "lumped together" and labelled post-concussion syndrome (PCS), leads to "misdiagnosis, misattribution and under treatment of those symptoms." He then discusses "the significant role of non-brain injury factors in the pathogenesis of post concussion syndrome." The "evidence" takes several forms, one of which is:

- c. The effect size of mTBI on neuropsychological outcomes is negligible whilst the effect sizes of litigation, psychiatric problems and diagnosis threat are significant. . . Effect size refers to the level of impairment seen on formalized neurocognitive testing.

[159] Dr. Dost points to the need to consider "psychiatric factors," among others, in "formulating a differential diagnosis in this particular case, for the plaintiff's cognitive complaints," and continues with the following:

When a physician is faced with multiple etiologies for an outcome, the physician should select the cause or causes known to result in the outcome and then select those factors with the greatest effect size.

In this particular case, we have no evidence of brain damage (speculation) and we have evidence from self-report of pain and psychiatric factors. Moreover, the effect size of the latter two is large and the effect size of any hypothesized brain damage is non-existent

Thus, it is the non-brain injury factors which are causing the cognitive symptoms, in this particular case.

[Emphasis in original.]

[160] Put another way, if the plaintiff sustained a brain injury, Dr. Dost nevertheless attributes his cognitive symptoms to his depression.

[161] Following his review of Dr. Dost's report, Dr. Cameron provided a further report dated February 15, 2021. In this report he takes exception to Dr. Dost's application of the Galveston Orientation and Amnesia Test (GOAT) for the diagnosis of brain injury on the basis that the test is designed to determine the outcome and prognosis for patients who have sustained a severe brain injury and it is "performed by medical staff in a hospital setting following a severe traumatic brain injury."

[162] He also differs from Dr. Dost's reliance on the Centers for Disease Control and Prevention's definition of MTBI and the Berlin and Zurich consensus papers on concussion which "state that the neurological impairment (following the event) is rapid in onset." He says, "These papers and other authors' document that symptoms of post traumatic amnesia develop immediately or within many minutes of the mild traumatic brain injury." Dr. Dost's understanding was that the plaintiff became confused 30 minutes after the Accident. In fact, the plaintiff reported confusion immediately following the two impacts in the collisions and, although he recalled some details while at the Accident scene, he had memory problems within the short time, less than 30 minutes, after his wife picked him up.

- [163] While Dr. Cameron agrees that according to the literature the majority of patients who suffered a mild traumatic migraine do not develop symptoms of PCS following the initial MTBI, up to " 25% of patients suffer long-term cognitive and physiological sequela following the MTBI."
- [164] Dr. Cameron agrees with Dr. Dost that the plaintiff's ongoing cognitive problems are probably multifactorial in etiology, including ongoing psychological issues, but believes that they are " probably in part residual to the MTBI he sustained at the time of the [Accident]."
- [165] He refers to Dr. Dost's reliance on the fact that the plaintiff did, after discontinuing his practice, return to work as a locum for other family physicians, then became employed at an urgent care clinic for eight hour shifts, three times a week. He notes that the plaintiff found work as a locum stressful. Dr. Cameron notes that the plaintiff is in constant fear of making mistakes and because of ongoing cognitive problems he continues to rely on support staff to handle the administrative aspects of patient care.
- [166] Dr. Cameron's opinion in his previous report does not change.
- [167] The defendant introduced the medical report of Dr. Paul Janke, psychiatrist, dated May 7, 2020. He interviewed the plaintiff on March 3, 2020, and reviewed various records and reports (27 total) pertaining to the plaintiff and medical attendances by the plaintiff between June 2014 and October 2019. He refers in his report to clinical records and medical reports of Drs. Coulter, Hanon, McIntyre, Paisley, Sochting (psychologist) and Rajasekaran.
- [168] Dr. Janke refers to a comment in Dr. Paisley's report dated May 17, 2017, to the effect that the plaintiff's cognitive complaints after the Accident had "not impacted on his working ability suggesting a cognitive injury," and surmised that the word "not" was a typographical error. The "not," viewed in the light of the overall content of Dr. Paisley's report must be a typographical error.
- [169] The focus of Dr. Janke's report is on the opinions of Drs. Cameron and Ancill; he disagrees with both. He says that Dr. Cameron failed to appreciate the impact of major depressive disorder and medications on cognitive function and thus its role in the complainant's "complaint." He notes that " as described by Dr. Cameron Dr. Barkhuizen met only the very minimum level of symptoms to make a diagnosis of MTBI." He says that Dr. Ancill did not, in his report dated August 4, 2018, appreciate the presence of pre-existing post-traumatic stress disorder (PTSD) " as disclosed by Dr. Barkhuizen when seen by myself, and relied solely on the plaintiff's self report, information from his wife, and the report of Dr. Cameron."
- [170] Dr. Janke says, in part:

26. Dr. Paisley, in a note dated August 17, 2018 indicates that Dr. Barkhuizen closed his practice because of increasing mistakes although again there is no indication that this in any way compromised the medical care provided to his patients.
- ...
29. When seen by myself, he did report confusion in the period immediately following the motor vehicle accident but also indicated that he lost no work time in the period immediately following the accident and had not committed any patient errors.
- [171] The plaintiff did not testify that he made errors, and there is nothing to indicate that he told Dr. Janke that he had. The plaintiff did continue working after the Accident, but feared that he would make errors due to heightened anxiety and memory loss.
- [172] The plaintiff was exposed to brutality when in military service as a young man. Dr. Janke attributes the plaintiff's cognitive issues at least in part to PTSD. He does not elaborate on or explain the connection between PTSD and the cognitive problems reported by the plaintiff. In short, there is no evidence connecting the plaintiff's cognitive disorders to PTSD.
- [173] Apart from Dr. Janke's opinion and a mention of PTSD in Dr. Sochting's report, the plaintiff's medical history makes no mention of PTSD. In Dr. Ancill's subsequent interview with the plaintiff on January 8, 2021 he denied ever being diagnosed with, or having any symptoms, of PTSD.
- [174] Dr. Cameron reviewed the records and reports of, among others, Drs. McIntyre, Hanon Coulter and Dr. Davidson, neurologist, and authored a further report dated June 28, 2020. He had read Dr. Janke's report and says, in part:
6. Following my review of these updated records, I do not change my opinions that I have outlined in my previous report. Dr. Janke is of the opinion that Dr. Barkhuizen may have suffered a mild traumatic brain injury at the time of the accident because he had manifested confusion at the scene of the accident and immediately following the accident. As I have outlined in my previous report, this history is indicative that Dr. Barkhuizen probably did suffer a mild traumatic brain injury "not possibly". I disagree with Dr. Janke regarding this diagnosis.
7. Dr. Janke then indicates that any cognitive complaints present following this accident are probably due to a major depressive disorder. I have outlined in my previous report that Dr. Barkhuizen had suffered with clinical depression and anxiety disorder prior to this accident, and that he had not complained of any significant cognitive problems. The cognitive problems developed very shortly after the accident of August 4, 2016, and in my opinion are resultant from the mild traumatic brain injury. Subsequently, the exacerbation of the anxiety disorder and symptoms of depression have also been a contributing factor to ongoing cognitive complaints. It is probable that the ongoing cognitive complaints are multifactorial in etiology, i.e., residual to traumatic brain injury, due to exacerbation of psychological problems as a result of the injuries that he sustained at the time of the

accident and due to pain and discomfort that he has developed as a result of the soft tissue and musculoskeletal injuries that he sustained at the time of the accident.

8. Dr. Davidson, Neurologist, assessed Dr. Barkhuizen following the accident of August 4, 2016. Dr. Davidson assessed Dr. Barkhuizen in 2017 and also in 2018 regarding fatigue and also problems with carpal tunnel syndrome or median nerve neuropathy and ulnar nerve palsies. Dr. Davidson also assessed Dr. Barkhuizen in September of 2016, several weeks following the accident on August 4, 2016. Dr. Barkhuizen did not report to Dr. Davidson, and Dr. Davidson did not document the history of the motor vehicle accident at the time of his neurological assessment. Dr. Davidson assessed Dr. Barkhuizen because of fatigue or muscle weakness associated with exercise and pursued investigations regarding this possible diagnosis. Dr. Davidson did not find any neurological cause for this problem. The other clinical records that I reviewed did document that Dr. Barkhuizen has been hesitant to tell all of his history to various physicians who were assessing him at various times over the years because he is a general practitioner working in a very small community. Dr. Davidson did document that he knew Dr. Barkhuizen very well prior to his neurological assessment. . . .

. . .

10. Following my review of all of these clinical records, I do not change my opinions that I have outlined in my previous report of September 22, 2017.

[175] In Dr. Ancill's report dated July 3, 2020, he responds to Dr. Janke's report.

[176] Dr. Ancill comments on the use of DSM-5 and DSM-IV as a guideline for psychiatric diagnoses, saying, "It is not a 'cookbook' where the criteria for any diagnosis are simply checked off and a diagnosis made or rejected." He says it is, "the clinical judgment of the psychiatrist which is the final determinant of any ... diagnosis." A patient may meet all the criteria for a DSM-5 diagnosis but the psychiatrist can conclude that such a diagnosis is not warranted. Conversely, despite a failure to meet the criteria a psychiatrist can conclude that the diagnosis is warranted.

[177] He relates that the plaintiff had recovered from his 2014-2015 depressive episode and was not on antidepressants at the time of the Accident. When assessed by Dr. Ancill on July 26, 2018 he was not depressed and was not on antidepressants. In his opinion, his cognitive and other PCS symptoms were not related to his prior mood disorder. His prior psychiatric history would, however, render him more vulnerable to the persistent effects of a concussion.

[178] The five elements to be satisfied for a diagnosis of concussive MTBI are present:

- a) an incident in which such an injury could have occurred;
- b) a clinical history of disturbance in level of consciousness, confusion or some form of amnesia;

- c) acute symptoms consistent with concussion, immediate or delayed;
- d) emergence and persistence of PCS symptoms; and
- e) change in personality or function as confirmed by a collateral source.

[179] Dr. Ancill sets out the events of the incident, the indications of a blow to the head, the plaintiff's recollection of his actions and observations at the scene of the Accident, and the emergence of lapse in memory. He refers to the plaintiff's report that he was unable to perform routine tasks and recall names of long-time patients.

[180] I accept the plaintiff's evidence of the problems he relayed to Dr. Ancill.

[181] Dr. Ancill sets out the numerous (14 total) PCS symptoms present on his examination two years post-Accident. All but a few were testified of by the plaintiff and his wife at trial. I accept their evidence.

[182] Dr. Ancill says it appears from the history elicited from the plaintiff that it was when he was back at work as a physician that he "realized that things were awry."

[183] Dr. Ancill disagrees with Dr. Janke's opinion that the plaintiff "might" have suffered a very minor MTBI with no meaningful impact on his medical practice and general functioning. In Dr. Ancill's opinion the plaintiff did suffer a MTBI and this did impact on his medical practice and general functioning.

[184] As the plaintiff was seen in July 2018, Dr. Ancill does not comment on his symptomology or functioning in his July 3, 2020 report.

[185] Dr. Ancill interviewed the plaintiff and his wife for a second time on December 8, 2020. He ensured that the plaintiff understood the difference between relating what he understood had happened and what he could actually remember. He reviewed the records previously provided, reports from physicians following his previous interview, and additional clinical records from Drs. Paisley and Coulter.

[186] Dr. Ancill once again reviewed the plaintiff's clinical history as previously recorded and augmented by the additional clinical records. I note that in the plaintiff's testimony he had little recollection of what had been noted when he testified, but accepted what had been written, with few exceptions.

[187] The plaintiff informed Dr. Ancill that he had been off work for one year during which he and his wife spent time in Spain where her mother resides. Upon return, he worked as a locum, travelled to Spain again, and then resumed work as a locum until February 2020.

[188] It is in evidence that he had approval from the insurer for disability pay for one year.

[189] I digress to note that the plaintiff, on his application form for disability coverage, specified depression with no reference to the Accident. This was prior in time to the assessments by Drs. Cameron and Ancill. These would be available to the insurer during the period of disability coverage as the plaintiff had authorized ongoing access to treatment records. Moreover, on September 27, 2018, the plaintiff was assessed by Dr. Sochting at the behest of the disability insurer. She was informed of the Accident.

[190] The plaintiff reported that on returning to work as a locum his mental and cognitive state, and his functioning, had not improved.

[191] He was not depressed at the time of the second interview. He reported that he continued having many of the problems that Dr. Ancill recorded in the earlier interview, with some improvement in focus, concentration and memory.

[192] Dr. Ancill says at page 34, in part:

It remains my opinion that Dr. Barkhuizen satisfies the ICD-10 criteria (WHO International Classification of Diseases) for having sustained a Concussion, without LOC (S06.0X0) in the collision of subject collision. There was likely no loss of consciousness (LOC) but LOC does now predict the severity of outcome of a concussion.

...

Dr. Barkhuizen continues to present with a persistent Post-Concussion Syndrome and, as noted in my 1st report, post-concussive symptoms were noted by Dr. Cameron, although he referred to these as a "post traumatic brain injury syndrome".

[Bold and italic emphasis in original.]

[193] Dr. Ancill says, in conclusion, at page 50:

It is now 52 months since the MVC in question. It is my opinion that there will be no further spontaneous recovery from his traumatic brain injury but, in concert with other brain injury survivors, I would anticipate a waxing and waning clinical course in the future as he has to deal with the stress and travails of his life. Any future relapse of his mood disorder will exacerbate his collision-related symptomatology and further impair his function.

To summarize, I have not changed my opinions as stated in my first report of August 4, 2018.

[194] In closing, the defendant emphasized the evidence that the plaintiff recalled details of the collision and observations at the scene which, according to Dr. Dost, indicated little likelihood of concussion and MTBI.

[195] In a further report dated January 11, 2021, Dr. Ancill says, in part:

During the period that extends from some minutes after a concussion to several days thereafter, brain cells that were not initially irreversibly damaged remain alive but exist in a vulnerable state and will subsequently fail. It is now recognized that the symptoms of an acute concussion are not

necessarily maximal immediately after injury and the CDC (2017) noted that while some of the symptoms of a concussion may appear right away, others might not be noticed for days or months after the injury or until the person resumes their everyday life. In the case of Dr. Barkhuizen, it appears that in his case, the symptoms of concussion did not appear for a few days.

D. Findings Based on Medical Evidence

[196] The difference of opinion between Drs. Cameron and Ancill on one hand, and Dr. Dost on the other, turn to some extent on the question of whether the diagnostic criteria for MTBI require a lapse in memory immediately following the causal event. Both Dr. Ancill and Dr. Dost refer to articles that set out diagnostic criteria for MTBI. These seem to differ on the question, and to the extent that this is the case the Court is in no position to resolve the question.

[197] I find Dr. Ancill's explanation of the criteria, as applied in psychiatric practice, of greater assistance than that of Dr. Dost. I also find the evidence of Dr. Cameron who, like Dr. Dost is a neurologist, of assistance on the question.

[198] I accept the evidence of the plaintiff that he experienced confusion immediately after the impacts, and had no memory of the remainder of the day from around 30 minutes after the Accident. I accept the evidence of Dr. Ancill that these factors support a diagnosis of MTBI.

[199] I also accept Dr. Ancill's explanation of the factors that informed his opinion that the cognitive problems experienced by the plaintiff after the Accident are not attributable to depression. I note in this regard that the plaintiff was not depressed when the Accident occurred, and his cognitive and related problems became apparent soon after. If depression did emerge as a factor in his cognitive functioning, I note and accept the opinion of Drs. Ancill and Cameron that the impacts in the collisions exacerbated any pre-existing deficiencies associated with depression and was a material contributing factor.

E. Psychological and Other Reports

1. Neuropsychological Assessment Report, Dr. Ingrid Friesen

[200] Dr. Friesen is a Clinical Psychologist, with 20 years in practice as of her December 2020 report. She conducted a clinical examination of the plaintiff on October 9-10, 2020. She also interviewed Ms. Barkhuizen as a collateral informant.

[201] Her document review included all medical reports of the plaintiff and defendant up to her report date, and the clinical records of several of the treating physicians. Her clinical examination canvassed the plaintiff's description of the collision, personal history, education and work history, and his report of current symptoms including physical, cognitive and emotional/psychological factors.

[202] Under the Heading "Test Results" she explained that these were " compared against norms developed through clinical and/or research experience." She explains that "[a]n individual is defined as having impaired functioning in a domain if his or her test scores fall below what is statistically expected when compared with relevant normative groups" from which percentiles are derived which "reflect an individual's performance relative to others of the general population that are of the same age (and where available, education, gender, and/or handedness)."

[203] Dr. Friesen reports, in part, the following:

Effort

...

36. ...He did not exhibit inconsistent behaviour during the assessment and his test results did not have unusual patterns. His scores on the neuropsychological test battery, therefore, were determined to be valid and reflective of his actual level of ability.

Intellectual Functioning

...

41. In sum, Dr. Barkhuizen's verbal intelligence was above average and his non-verbal intelligence was high average, although the difference was not significant. He processed information at an average rate, and relatively slowly compared with his intellectual abilities. A calculation of his pre-collision IQ indicated that he has sustained a mild, but significant, decrease in his general intellectual abilities, likely due to slowed processing speed.

Attention

...

46. In sum, Dr. Barkhuizen's sustained auditory attention was impaired. His selective attention was within normal limits, although he worked relatively slowly to preserve accuracy. His complex auditory and switching attention were within normal limits.

Memory

...

50. In sum. Dr. Barkhuizen's verbal and visual memory were within normal limits. He, however, had difficulty monitoring his output and was susceptible to proactive interference. These factors have been associated with frontal lobe dysfunction.

Language

...

54. In sum, Dr. Barkhuizen's word finding was impaired and his category fluency was relatively weak compared with letter fluency. This pattern of results was suggestive of relative left temporal dysfunction.

Executive Functions

...

59. In sum, Dr. Barkhuizen had initial poor problem solving. His mental flexibility, inhibition, abstract thinking, and reasoning were within normal limits. He also exhibited frontal lobe dysfunction on a measure of memory, as discussed above.

Motor & Sensory Skills

...

64. In sum, Dr. Barkhuizen's motor speed and fine motor coordination were relatively weak compared for his left hand when compared to his right hand. His pattern of results was suggestive of lateralized impairment of brain function of the right hemisphere. His sense of smell was impaired.

Personality/Mood

...

67. Dr. Barkhuizen's clinical scales were entirely within normal limits and there was no evidence of depression, anxiety, or any other psychological disorder.

[204] As for current neurocognitive symptoms, Dr. Friesen reports, in part:

68. ... A calculation of his pre-collision IQ indicated him to have sustained a mild, but significant, decrease in his general intelligence. Likely, this was due to relatively slowed processing speed. . .

[205] On the question whether it is more likely than not that Dr. Barkhuizen's past and current neurocognitive symptoms are as a result of the motor vehicle collision, she says, in part:

69. ... it is plausible and probable that they are due to the motor vehicle collision.

[206] She addresses Dr. Janke's opinion that the plaintiff's and says:

70. ... neurocognitive complaints were due to the side effects of medications and depression. He also diagnosed Dr. Barkhuizen with Posttraumatic Stress Disorder as a result of military experiences in South Africa . . . It is noteworthy that in my assessment of Dr. Barkhuizen, psychological test results were entirely within normal limits and there was no evidence of depression, anxiety, posttraumatic stress, or any other psychological disorder. The objectively measurable neurocognitive weakness/deficits delineated in my assessment, therefore, were not due to depression, the side effects of medications, or Posttraumatic Stress Disorder. . . .

[207] Under the third heading in Dr. Friesen's report, she says:

74. Dr. Barkhuizen meets the following DSM-5 diagnoses:

75. Mental Disorders: Mild Neurocognitive Disorder Due to Traumatic Brain Injury

[208] As I understand it, she does not purport to make a medical diagnosis but indicates that the criteria for a DSM-5 diagnosis are met.

[209] She continues:

79. At the time of this assessment, Dr. Barkhuizen was more than four years post-collision. Individuals who have experienced a traumatic brain injury typically experience the greatest spontaneous neurological recovery within the first six months of injury and rarely after two years. His neurocognitive deficits/weaknesses, therefore, are considered to be permanent and will persist into the future.

...

81. Research indicates that individuals with a history of traumatic brain injury are up to three times greater risk of sustaining another head injury because of poor attention, slowed reflexes, and decrease balance. Likely, this will be the case for Dr. Barkhuizen as well.

[210] As for treatment recommendations:

84. Given the time that has elapsed since the collision, there are no empirically-validated treatments to address Dr. Barkhuizen's neurocognitive deficits. As such, it is not probable that Dr. Barkhuizen will be able to manage a full private practise nor full-time work as a primary care provider.

[211] Dr. Friesen's method for eliciting and marshalling the information on which she relies, and her testing of her subject against norms in order to arrive at her conclusions inspires confidence in her findings.

[212] It is significant with regard to the issue over whether the plaintiff's cognitive functioning post Accident differs from that in pre-Accident periods of depression that the impairments he reports were found on testing to be present when he is not in a depressed state. This suggests that the cause is not depression, but rather the symptoms of a brain injury. Of course, they would also be present during a period of depression, but are not related to depression. This supports a finding, and I agree, that the plaintiff's cognitive deficits are, in probability, caused by the Accident.

2. Occupational Therapists

a) Nadia Hudon, MSc (Occupational Therapist)

- [213] The plaintiff introduced the report of Nadia Hudon, occupational therapist (OT), dated August 20, 2020. This is a functional capacity evaluation of the plaintiff. It addresses the question whether his injuries or other limitations are inconsistent with working as a physician, and whether his functional capacity is "more consistent with full- or part-time work." Physical and cognitive capacities are evaluated. Her report contains the results of testing for the 13 physical tasks performed by the plaintiff at her direction.
- [214] The plaintiff met most of the criteria for physical demands of his profession. He experienced back pain with some work activities.
- [215] Ms. Hudon employed a cognitive profiler, specific to work as a family and general practitioner, to evaluate the plaintiff's cognitive abilities. He scored low on selective attention which could "translate, functionally in difficulty maintaining his concentration on one task while exposed to distracting stimuli." He "demonstrated difficulty with task switching " Based on her clinical analysis, Ms. Hudon opined that:
- . . . Dr. Barkhuizen would experience challenges working in a fast-paced clinical environment where multitasking, task-switching and managing distractions is required on a daily basis. . . .
- [216] The defendant argues that little weight should be given to the plaintiff's post-Accident cognitive functioning as it was not measured against a baseline established prior to the Accident. Suffice it to say with regard to this argument that the plaintiff's prior competence as a family physician indicates at least an average level of cognitive capacity to perform tasks essential to private practice. I accept the plaintiff's evidence of his diminished functionality, which finds support in the evidence of Ms. Hudon and the medical opinions that I accept, and that the post Accident deficiencies were such that the plaintiff was disabled from private practice by a brain injury sustained in the Accident.
- b) Lydia Phillips, Occupational Therapist
- [217] The defendant introduced the report of Lydia Phillips dated January 11, 2021. She assessed the plaintiff on December 15, 2020.
- [218] Ms. Phillips found inconsistencies between the plaintiff's reports to her that he had not, pre-Accident, had cognitive difficulties related to his work, and medical records of Drs. Coulter and Hanon. She therefore placed more weight on the latter than on the plaintiff's memory of his previous function. I note in this regard that the plaintiff had not, prior to the Accident, been put through the testing process utilized by occupational therapists. Reports by treating psychiatrists reflect subjective self reporting, while reports based on testing are, or purport to be, objective.
- [219] Ms. Phillips did not "formally assess" the plaintiff's physical capacity, but noted Ms. Hudon's findings. She says she observed no difficulties with the tasks of, sitting, standing, reaching, walking around the clinic, and writing during her assessment. She elicited his subjective reports of limitations and pain symptoms, which she assumed to be accurate.

- [220] In Ms. Phillips opinion, the plaintiff, although suffering from back pain, is not prevented from performing home or work tasks. She reviewed her opinion with the plaintiff, and says he agreed.
- [221] Ms. Phillips employed what she calls "top down" and "bottom up" testing techniques to assess the plaintiff's cognitive functioning. The former involved performance of a simulation of his job duties and using standardized assessments that simulate complex jobs and daily tasks. The latter " provides general and indirect information that can be used to make broad predictions about performance in a wide variety of tasks."
- [222] On standardized testing for "high level executive functioning," verbal reasoning and executive strategies she found the plaintiff to be average for accuracy, for speed of work, reasoning and idea generation, and below average for "rationale" based on his failure to "provide solutions in a letter of complaint."
- [223] Ms. Phillips explains that his scores in the low-average range were considered in the light of his comments that his memory and attention skills were, historically, excellent. I repeat my earlier observation that the plaintiff had not, pre-Accident, undergone standardized testing for executive functioning. If the plaintiff's self-assessment of his pre- and post-Accident cognitive functioning is subjective, so is Ms. Phillips'.
- [224] Ms. Phillips then relates information from the plaintiff "relevant to his cognitive abilities." He related his problems with note taking while evaluating a patient, which he has overcome using sticky notes and transferring the contents to electronic format. It is, however, apparent that he was explaining his method in the context of his present job, not his previous experience in private practice. He sees but a few patients daily at the urgent care centre and saw between 6-10 hourly when in private practice.
- [225] For the "top down" test of cognitive functioning, Ms. Phillips' simulation of the plaintiff's performance involved having her associates act out scenarios, three in total, in which they would visit the plaintiff with physical and other complaints. He would perform diagnoses and provide advice. I note that this simulation is akin to the plaintiff's present work at the clinic, not a replication of the fast paced, high turnover, demands of private practice.
- [226] Ms. Phillips concludes that the plaintiff has sufficient cognitive skills to perform the daily work tasks of his current employment. This, however, is not in issue.
- [227] Ms. Phillips then opines that the plaintiff would be functionally capable of performing his pre-Accident work if he "obtains the systems and/or equipment that will help him be more organized and stay on top of charting."
- c) Analysis and Conclusion
- [228] Ms. Hudon assessed the plaintiff using a cognitive profiler specific to work as a family and general practitioner to evaluate the plaintiff's cognitive abilities.

- [229] Ms. Phillips based her opinion on an assessment that employed a replication of the plaintiff's present employment tasks. She minimized the effect of the deficiencies found to be present by Ms. Hudon, and those present based on her testing, by attributing to the plaintiff a sense that the changes from pre- to post-Accident reflected his above average pre-Accident abilities. As she considered the only difficulty the plaintiff had with the fast pace of private practice was note taking, she concluded that improved systems would fully resolve the problem and that the plaintiff would then be functionally capable of returning to private practice.
- [230] Ms. Phillips did not take into account the fact that the plaintiff's problems go well beyond difficulty with taking notes. Unlike that of Ms. Hudon, her assessment did not utilize a standard that is specific to the tasks and cognitive capacity required of a physician in general and private practice. Her opinion is, therefore, of little assistance.
- [231] I accept the opinion of Ms. Hudon.

IV. Plaintiff's Retirement Plans

- [232] The plaintiff's colleagues in the clinic, Drs. Walter and Killiam, were called under subpoena to testify by the defendant. Both said that the plaintiff often spoke about retirement. The defendant cites this as evidence that the plaintiff would, absent any injury sustained in the Accident, have retired due to the stresses of practice and frustration he related to his treating psychiatrists (Drs. Coulter and Hanon) during the 2014-2015 depression episode.
- [233] The evidence of Drs. Walter and Killiam was not directed to any discrete period of time in the years they practiced together with the plaintiff in the clinic.
- [234] The plaintiff's planning for his eventual retirement took form when, in 2012, he incorporated his practice. His MSP billings and income increased in the period between the 2014-2015 depression episode and the Accident. There is no evidence of him taking steps toward an imminent retirement before the Accident. After the Accident, he took measures to wind-up his private practice. Whether he spoke with his colleagues about his strategy for financial security upon retirement prior to the Accident is not in evidence; although he is private about his personal life it seems a natural thing to share with those in a business relationship. After the Accident, he resolved to wind up his practice and informed his colleagues of his plans.
- [235] The defendant submits that there is no evidence that the plaintiff was not in a financial position to retire before the Accident. The intended inference, although unstated, is that he may have been and that injuries sustained in the Accident had no bearing on the plaintiff's decision to leave private practice.
- [236] The plaintiff worked through his 2014-2015 depression episode, and continued working post-Accident. There is no indication of a financial ability to retire up to the time that his cognitive problems caused him concern over his ability to remain in private practice.

- [237] Robert Carson (economist) reports that retained earnings in the plaintiff's corporation reached their maximum in 2017 at \$281,421 and fell in 2020 to \$55,059.
- [238] The plaintiff did not give up private practice until July, 2017, almost a full year following the Accident. He was concerned over his ability to provide adequate patient care during that period, and sought treatment from Dr. McIntyre as he thought it was another episode of depression. Although some of his cognitive problems were similar to those he experienced when depressed, it was not until he was examined (post-retirement) by Dr. Cameron that the possibility of a brain injury became apparent. After closing his practice, the plaintiff worked as a locum until May 2018. He ceased locum work due to stressors associated with cognitive functioning. He then became employed in his present capacity, part-time at the urgent care clinic.
- [239] As at 2017, the retained earnings in the plaintiff's professional corporation were approximately \$280,000.
- [240] The evidence does not support an inference that the plaintiff was in a financial position to retire, or irrespective of his financial circumstances, intended before the Accident to retire in the near future.

V. Liability

- [241] The defendant, Mr. Leguerrier, is liable for the Accident and injuries to the plaintiff, as found at paras. 46-50 of these reasons.

VI. Causation

- [242] As for causation of the injury, "the plaintiff must also establish that the defendant's negligence caused the injury": *Clements v. Clements*, 2012 SCC 32 at para. 6. The Supreme Court of Canada has established the test for causation as the "but for" test, which requires that the plaintiff show on a balance of probabilities that but for the actions of the negligent defendant, they would not have sustained their injuries: *Clements*, para. 8; *Athey v. Leonati*, [1996] 3 S.C.R. 458 at para. 14; *Hanke v. Resurface Corp.*, 2007 SCC 7 at para. 21. Causation is not a precise scientific inquiry, but rather a factual one.
- [243] Therefore, I must ask whether the plaintiff sustained a MTBI as a result of the Accident. As I set out at para. 178 of these reasons, the five elements required for a diagnosis of a concussive MTBI are present. I found Drs. Ancill and Cameron's evidence of most assistance on this issue, and accept their opinions, respectively, that the facts support a diagnosis of MTBI. In particular, Dr. Ancill found that not all of cognitive problems experienced by the plaintiff following the Accident are attributable to depression. On the whole of the medical and other evidence that I accept, I find it proven that the plaintiff sustained a brain injury as a result of the Accident.

[244] It is well established that a tortfeasor must take their victim as they find them. The "thin skull" rule dictates that a negligent actor is liable for a plaintiff's injuries regardless of whether such injuries were "unexpectedly severe owing to a pre-existing condition": *Athey* at para 34. Therefore, regardless of whether the plaintiff's pre-existing depressive episodes exacerbated or made more likely his injuries caused by the Accident, causation is nonetheless established.

VII. damages

A. Loss of Earning Capacity

1. Legal Framework

[245] I must determine whether the MTBI sustained by the plaintiff as a result of the defendant's negligence has resulted in or contributed to a loss of earning capacity. A plaintiff will be entitled to damages for loss of earning capacity if the accident caused an injury "which limit[s] [them] in [their] capacity to perform certain activities and which, therefore, impair[s] [their] income earning capacity.": *Pallos v. Insurance Corp. of British Columbia*, [1995] 100 B.C.L.R. (2d) 260 (C.A.) at para. 29.

[246] Loss of earning capacity can cover past earnings (between the Accident and the trial) as well as future earnings. An award for loss of future income "involves a comparison between the likely future of the plaintiff if the Accident had not happened and the plaintiff's likely future after the accident has happened": *Gregory v. Insurance Corporation of British Columbia*, 2011 BCCA 144 at para. 32.

[247] *Rab v. Prescott*, 2021 BCCA 345, a recent authority from the Court of Appeal, establishes a three-step process for considering claims of loss of future earning capacity at para. 47. The considerations are:

- a) whether there is a potential future event which could lead to a further loss of capacity;
- b) whether there is a real and substantial possibility that this future event will cause a pecuniary loss; and
- c) the relative likelihood of that pecuniary loss.

[248] This test considers hypothetical future events and impairments, and their potential impacts. In *Rab*, the plaintiff did not have a loss of income at the time of trial, but her injuries had the potential to worsen or expose her to future problems. Justice Grauer acknowledged that the application of the test will be simpler in some cases than others. He says the following at para. 29:

Some claims for loss of future earning capacity are less challenging than others. In cases where, for instance, the evidence establishes that the accident caused significant and lasting injury that left the plaintiff unable to work at the time of the trial and for the foreseeable future, the existence of a real and substantial possibility of an event giving rise to future loss may be obvious

and the assessment of its relative likelihood superfluous. Yet it may still be necessary to assess the possibility and likelihood of future hypothetical events occurring that may affect the quantification of the loss, such as potential positive or negative contingencies. Dornan was such a case.

[249] In *Dornan v. Silva*, 2021 BCCA 228, the plaintiff, who had suffered a serious concussion, was unable to work at the time of trial. Therefore, as referenced by Grauer J.A. in the preceding paragraph, the trial judge was not required to contemplate events giving rise to future loss. The plaintiff's impairment and subsequent loss of income were both already present. As such, the Court found that the trial judge was required to consider the appellants with and without accident earning potential, as contemplated in *Gregory*.

2. Analysis

[250] The defendant submits that if the plaintiff is impaired in his ability to function as a private practitioner (they say he is not), this was not caused by an MTBI but rather the plaintiff's episodic depression, his dissatisfaction with medical practice, and his desire to move to Kelowna. I find that the MTBI sustained by the plaintiff caused a deterioration of his ability to perform the tasks demanded of a private practitioner of medicine in his area of practice beyond those that may have previously been present in his periods of episodic depression.

[251] The plaintiff continued working during his 2002, 2009 and 2014-2015 bouts with depression. His highest income years were in 2014 and 2015. In Mr. Carson's report entitled *Evaluation of Earning Loss*, dated January 29, 2021 (the "Carson Report"), he says that the plaintiff's 2012-2015 gross income was 10% above the "high" Canadian Institute for Health Information level for full-time family physicians. In 2015 it was \$439,000, about 18.5% above the benchmark. Whatever effect depression had on the plaintiff's overall functioning, it did not impair him in his work. The MTBI sustained in the Accident caused cognitive problems that were not attributable to depression, or caused the onset of active depression with the additional cognitive effects associated with a MTBI.

[252] Further, the evidence before me does not substantiate that the Plaintiff left his practice for other reasons, as argued by the defendant, namely his dissatisfaction with medical practice, and his desire to move to Kelowna. First, as I have already canvassed, the Plaintiff continued working in medical practice throughout his depressive episodes, despite complaints about changes in practice. In fact, his earnings grew during this time. The Plaintiff testified he was not dissatisfied with the practice of medicine as of January 2016, only months prior to the Accident. Second, while the Plaintiff did eventually move to Kelowna upon giving up his practice, this happened well after the Accident and there is no evidence that the Plaintiff took any concrete steps to close his practice and move prior to the Accident.

- [253] In the result, the plaintiff's departure from his private practice of medicine and his subsequent loss of earning capacity, were caused by injuries sustained in the Accident, specifically the MTBI. Having found this, determining loss of earning capacity involves an assessment of what the plaintiff would have likely earned but for the Accident, in a manner that is fair and reasonable: *Reilly v. Lynn*, 2003 BCCA 49 at para. 101.
- [254] In the case before me, although the plaintiff was still able to work at the time of trial, he submits, and the evidence supports, that he is not able to work at the same capacity as before (i.e. as a family practitioner). This is not a case where the plaintiff is still working at the same capacity as they were pre-accident and the Court must hypothesize about a future deficit or a worsening of their condition that could arise and impair them in their function at work; the impairment has already arisen, as in *Dornan*. I have found that the plaintiff's move from private practice was caused by his injuries sustained in the Accident. This is such a case where the "real and substantial possibility" analysis is superfluous.
- [255] As such, the analysis must focus on the difference between the plaintiff's without Accident earning capacity and with Accident earning capacity, taking contingencies into account: *Gregory* at para. 32; *Dornan* at para. 156; *Rab* at para. 29.
- [256] I have accepted on the evidence that but for the Accident, the plaintiff would have continued in working in private practice until his retirement. This is supported by the evidence that the plaintiff had plans to work until he was at least 70 due to financial issues from his divorce and bankruptcy, and the evidence that doctors tend to stay in the workforce longer than other professionals. Therefore, the without Accident earnings of the plaintiff should be premised on him continuing in his capacity as a family practitioner, or in other words, premised on his pre-Accident earnings. This is reflected in the report discussed below. As for the plaintiff's without Accident earning capacity, the plaintiff has been working part-time at a walk-in clinic since the Accident, and I am satisfied on the evidence that this is what he is capable of given the ongoing effects of the MTBI he suffered in the Accident.
- [257] The plaintiff relies on the report authored by Mr. Carson. The Carson Report provides estimates of past and future earning loss that take into account past income reported for tax purposes by the plaintiff and his wife. Amounts that Ms. Barkhuizen reported as income were paid from the practice.
- [258] The defendant introduced several reports in response to Mr. Carson's. Two reports, one dated January 27, 2021, and another dated March 16, 2021 were authored by Stephen Graff, chartered accountant. The third report, dated February 18, 2021, was authored by Mark Szekely, an economist. These reports comment on and provide opinions on the approach, assumptions and information used by Mr. Carson. The following discussion addresses some of the criticisms of his report by, respectively, Mr. Graff and Mr. Szekely.

- [259] Mr. Carson uses the average combined net income for the plaintiff and his wife from 2009 to 2015, \$297,744, as a base from which to assess the past loss to date of trial, and future loss of earning capacity. This figure includes all money paid to both, whether by way of dividend or salary, net of tax. Mr. Graff takes exception to the use of a 7-year period to derive an average annual income. This and other concerns are discussed below.
- [260] To put Mr. Graff's concern in context it is necessary to review the approach taken by Mr. Carson to arrive at his conclusion of a past wage loss of \$694,198.
- [261] Mr. Carson adjusts the base annual wage loss of \$297,744 upward, annually, from 2016 to 2020 using the "BC Wage Index to restate this 2021-dollar value at wage levels that were current in BC in each of the years 2016 to 2020." He applies the Wage Index to adjust the annual adjusted figures upward to produce the equivalent purchasing power in 2021.
- [262] Income received from 2016 to 2020 is deducted.
- [263] The resulting past wage loss calculation is \$694,198.
- [264] Mr. Carson commences his discussion of future earnings loss by determining the multiplier to use the net rate, 1.5% set by regulation for claims of loss of future employment earnings. In Table 4 he sets out the present value multipliers that would apply in each year, commencing with the 2021 trial date, up to 2034, the year in which the plaintiff would turn 75. As an example, the application of the multiplier up to the end of 2029, the year in which the plaintiff would turn 70, would yield a present value of \$7,806 for a future annual loss of \$10,000.
- [265] Using the average of past earnings, \$297,744 in 2021 dollars, and assuming that the plaintiff would work to age 71, the loss up to 2030 is calculated at \$2,587,214. An adjustment is then made to take into account the general pattern in medical practice of decreased work after age 65 of 14.6%. The resulting figure is \$2,184,906.
- [266] Based on assumptions provided by counsel, Mr. Carson calculates the plaintiff's post-2021 income (46 weeks per annum, 22.16 hours of work/week, at \$152.04/hour) for a gross pre-tax income of \$154,983. After expenses at an assumed 25% of gross revenue, the annual pre-tax figure is \$116,237. If the absent Accident work period extended to 2030, the "absent Accident" future income is, at present value \$2,184,906. The present value of the "with Accident" future income is \$852,987. Mr. Carson's present value of the loss is the difference: \$1,331,919.
- [267] The figures in the preceding paragraph are premised on the plaintiff's wife continuing to work in the medical clinic until he retires in 2030, near the end of his 71st year. Her income from the clinic is included in the calculation of the present value of the loss. She did work up to the date of trial, but there is no evidence of her intentions beyond the date of trial.
- [268] The above future wage loss figures also include an annual BCMA benefit, but it is unclear on the evidence whether this benefit would continue past the date of trial.

- [269] Mr. Graff raises questions over the inclusion of Mrs. Barkhuizen's income and the BCMA benefit in the calculation of future loss of income,
- [270] In closing submissions, plaintiff's counsel provided a table based on various figures set out in the Carson Report. These include a calculation of present value less Mrs. Barkhuizen's wages and the BCMA benefit. The net change in future earnings is shown as \$988,848. I accept this as the net loss.
- [271] In his report dated March 16, 2021, Mr. Graff raises several questions over certain of the dollar amounts Mr. Carson's included in his calculation of past and future income loss:
- a) There are several entries on the income information that reflect interest from investments and dividends from sources other than the plaintiff's corporation. The point seems well taken, but the amounts are small in relation to the whole. Nevertheless, the defendant is entitled to an adjustment. I suggest that the plaintiff have Mr. Carson recalculate the base income figure and make such adjustments to his concluded figures on past and future income loss as may result. If the defendant is dissatisfied with the result, the matter can be resolved on application to the Court.
 - b) Carson includes income received by Ms. Barkhuizen in the income on which the past and future income losses are based. In Mr. Graff's opinion these are not entirely attributable to income-splitting. I disagree. The services provided by Mrs. Barkhuizen were temporary and minimal for a short period during which the practice had no administrative assistant.
 - c) Mr. Graff maintains that Mr. Carson departed from standard practice by basing his income figure on the average of seven years net income. He says that three to five years is the norm, and that "these are more 'current' and are more representative of the future period." It seems that Mr. Graff proposes that the averaging of the plaintiff's annual income reflect the post-Accident period after he closed his private practice and worked as a locum.

The seven-year period used by Mr. Carson to determine the average seems reasonable as it covers the entire period from the 2012 incorporation of the practice up to the year in which the plaintiff's productivity became affected by his post-Accident cognitive problems.

- d) Mr. Graff takes exception to the use of the Wage Index to adjust the base income figure on the ground that annual billing rates for physicians are set by the BC Medical Services Commission and "will likely not change similar to the changes in average wages reported in the general market."

Mr. Carson's use of the Wage Index is not the only factor in play to derive his projection of annual growth of the plaintiff's income as a component of the present value multiplier he applies in the case of the plaintiff. The Wage Index is used only to adjust the base figure for equivalency of purchasing power in the future. In his March 3, 2021 response report Mr. Carson discusses the plaintiff's 2013 to 2015 increases in net income despite the flattening of gross revenues for the period. He points to the tendency of physicians to continue working past age 65. These and other factors affect his growth projections and his present value multiplier.

- e) Mr. Graff points to an inconsistency in the attribution to income of a benefit available to the plaintiff from the BC Medical Association. Mr. Carson includes this in his income figure for past loss up to 2021, but not for future losses. The effect is to raise the income loss figure for the past, but reduce the post-2021 income to be deducted from the future loss.

The benefit is an RRSP matching contribution. It is treated as income for tax purposes, and appears on the plaintiff's tax returns prior to the date of trial. To treat this as income for determination of future income calls for an assumption that it will be received. There is no evidence in support.

I consider it reasonable to include this benefit up to the 2021 trial date.

[272] Mr. Szekely applies average labour market contingencies for males in BC with professional degrees to conclude for an economic multiplier for the future of \$6,495. Mr. Carson applies a multiplier of \$8,098. Mr. Carson's multiplier takes it into account that medical doctors in general have a higher than average rate of participation in the work force and, in particular, continue working longer than other professionals. I accept his evidence and find his multiplier applicable.

[273] The figure I accept for past wage loss is \$694,198. The figure I accept for future loss of income, after deduction of earnings after the trial date and subject to adjustment as discussed above, is \$988,848.

B. Non-Pecuniary Damages

[274] The inexhaustive list of factors for the Court to consider when deciding on an award for under this head of damages are found in the oft cited case of *Stapley v. Hejslet*, 2006 BCCA 34 are as follows:

- (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;
- (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

- [275] The defendant submits that if it is found that the plaintiff sustained a brain injury with ongoing effects his non-pecuniary damages should fall in the range of \$100,000 to \$120,000, with a negative contingency of 40% on account of his pre-existing medical problems, including depression.
- [276] The plaintiff's physical pain due to soft tissue injuries have largely resolved, leaving some exacerbation of his prior low-back pain. He has been able to resume physical activities, walking, cycling and sailing.
- [277] The plaintiff's mental abilities continue to be impacted by the injuries suffered in the Accident. The evidence shows his memory has diminished, one of the reasons he is no longer able to continue practice as a family doctor. The plaintiff's evidence showed that he cared deeply about his patients and his practice, and that it caused him emotional suffering to give this up in light of his struggles with retention, note taking, filling prescriptions etc. His enjoyment of intellectual pursuits, in particular reading and his interests in investing and building electronic devices has been lost.
- [278] The plaintiff's marital and social relationships continue to be impaired by the effects of the MTBI suffered in the Accident. I accept on the evidence of collateral witnesses, most notably Ms. Barkuizen, that the plaintiff became "volatile, impulsive and given to anger" following the Accident. Mr. Anderson testified that he was surprised to see the Barkhuizens' arguing post-Accident, as he had always known them to be a happy couple. Further, Ms. Barkhuizen testified that the plaintiff has lost his interest or ability to engage in sexual intimacy since the Accident.
- [279] I agree that the authorities presented by the defendant would suggest an award in the low range up from \$100,000. I award \$130,000. This reflects the fact that prior to the accident the 56 year old plaintiff was, despite his physical and depressive disorders, fully capable of experiencing pleasure in his pass-times, the company of friends, and a full relationship with his life-partner. These have been to a significant extent diminished.

VIII. Mitigation

- [280] After closing his practice, the plaintiff received a disability pension for one year. There is no evidence of his having pursued training for work within his capacities.
- [281] At age 56, given the time taken for retraining then finding work in the field of medicine or work outside of medical practice until retirement would have been very limited. I refer in this regard to the October 14, 2020 Vocational Rehabilitation Report of Niall Trainor. In his opinion:

Relatively speaking, in my opinion, considering the nature, severity and chronicity of his symptoms to date Dr. Barkhuizen has achieved a good vocational outcome. However, as long as he remains symptomatic he will remain at risk for vocational problems including job loss, unemployment and underemployment relative to his pre-morbid potential.

[282] And further:

. . . I think it's unlikely that at age 58 or beyond he would have sought a more dramatic career change, particularly one that would involve lengthy retraining. In my opinion, the most significant impact of his impairments and disabilities on the range of occupational options he can pursue now consists in his inability to return to full time work, or modified work approaching full-time hours. In other words, the alternate occupations that were realistic possibilities for him pre-morbidly are still possible, but his capacity to pursue these has been diminished by his post-accident symptoms which, according to his self-report, persist to the present.

[283] Under Conclusion, in part:

In my opinion, Dr. Barkhuizen has achieved a relatively good vocational outcome in that he is now working steadily on a part-time basis in conditions that are advantageous to his continuing to work. He is probably already working at his maximum, but further rehabilitation efforts could be tried in an effort to increase the number of hours worked. Given the nature, severity and chronicity of his ongoing physical and mental health symptoms, in my opinion, the long term vocational prognosis remains guarded.

[284] After the disability pension ceased the plaintiff attempted to mitigate his losses by working as a locum. He found his functioning to fall below the standard he expected of himself, which resulted in extreme stress. The results of more recent neuropsychological testing (Friesen report) bear out his concerns during this period. He then found part time work at the urgent care clinic, a more relaxed pace, and relief from the demands of providing ongoing care for regular patients and managing a private practice

[285] I consider the plaintiff's efforts to mitigate his losses adequate.

IX. Contingencies and Assessment

A. Legal Framework

[286] There is some evidence to suggest the plaintiff's injuries may be multi-factorial in etiology, or that his prior psychiatric history rendered him more vulnerable to the effects of the MTBI.

[287] Athey contemplates the "crumbling skull" rule at para. 35:

The so-called "crumbling skull" rule simply recognizes that the pre-existing condition was inherent in the plaintiff's "original position". The defendant need not put the plaintiff in a position better than his or her original position. The defendant is liable for the injuries caused, even if they are extreme, but need not compensate the plaintiff for any debilitating effects of the pre-existing condition which the plaintiff would have experienced anyway. The defendant is liable for the additional damage but not the pre-existing damage

- [288] Since *Athey*, courts have applied negative contingencies where they have found that there is a chance the plaintiff would have suffered a harm regardless of the defendant's conduct. This creates allowance for the fact that the assumptions on which an award is based may prove to be inaccurate: *York v. Johnston* [1997], B.C.J. No. 1377.
- [289] The application of a discount for contingencies is discussed in *Dornan*. In that case, Grauer J.A. applied a similar test for finding a contingency award as he did for finding an award for future loss of income in *Rab* (discussed above): *Dornan* at paras. 62-64. First, I must ask whether the plaintiff suffers from a pre-existing condition. This has been established on the evidence and agreed to by the parties. The plaintiff suffered from recurring depression episodes (among other various pre-existing conditions) prior to the Accident. Second, I must determine if there is a real and substantial possibility "that this pre-existing condition would have detrimentally affected the plaintiff in the future, regardless of the defendant's negligent conduct": *Dornan* at para. 62. If there is a real and substantial possibility then, third, I must assess its relative likelihood.
- [290] Speaking on general and specific contingencies at para. 92 of *Dornan*, Grauer J.A. cited *Graham v. Rourke* (1990), 74 D.L.R. (4th) 1, 75 O.R. (2d) 622 (ONCA) as follows:
- [46] ...[C]ontingencies can be placed into two categories: general contingencies which as a matter of human experience are likely to be the common future of all of us, e.g., promotions or sickness; and "specific" contingencies, which are peculiar to a particular plaintiff, e.g., a particularly marketable skill or a poor work record. The former type of contingency is not readily susceptible to evidentiary proof and may be considered in the absence of such evidence. However, where a trial judge directs his or her mind to the existence of these general contingencies, the trial judge must remember that everyone's life has "ups" as well as "downs". A trial judge may, not must, adjust an award for future pecuniary loss to give effect to general contingencies but where the adjustment is premised only on general contingencies, it should be modest.
- [47] If a plaintiff or defendant relies on a specific contingency, positive or negative, that party must be able to point to evidence which supports an allowance for that contingency. The evidence will not prove that the potential contingency will happen or that it would have happened had the tortious event not occurred, but the evidence must be capable of supporting the conclusion that the occurrence of the contingency is a realistic as opposed to a speculative possibility: *Schrump v. Koot*, *supra*, at p. 343 O.R.

[Emphasis added by Grauer J.A.]

B. Loss of income capacity

- [291] In order to adjust damages, there must be a real and substantial possibility that the plaintiff's pre-existing depression would have led him to leave medical practice as a family doctor earlier than intended, or specifically, before the age of 71: *Zacharias v. Leys*, 2005 BCCA 560 at para. 16.
- [292] The plaintiff's medical history includes episodic depression, hypothyroidism, Graves' disease, carpal tunnel syndrome, ulnar neuropathy at the elbow, sleep apnea, vitreous detachment, diverticular disease, right hip osteoarthritis, strabismus, gout, dyslipidemia, acute tubular necrosis from previous septicemia, spinal degenerative disease, ischemic heart disease and sleep apnea.
- [293] The defendant argues on the basis of the plaintiff's medical history there should be a 40% discount for contingencies, namely a real and substantial possibility that he may have, absent the Accident, become disabled due to recurrence and worsening of his pre-Accident medical conditions.
- [294] Dr. McIntyre testified on cross-examination that the chance of recurrence of a depressive episode after three major depressive episodes is "85-90%" even if the Accident had not occurred. However, there is no evidence to suggest that the plaintiff was at risk of a natural progression from episodic depression to an MTBI.
- [295] There is no evidence to support the defence theory that the plaintiff would, due to a recurrence of depression, experience the deficits caused by the Accident. As I canvassed earlier, the evidence shows that the plaintiff was capable of carrying on his practice as a family doctor while experiencing episodic depression. The symptoms he experienced did not preclude him from doing so. It is the additional symptoms from the MTBI that have rendered the plaintiff unable to work at the same capacity, and not the symptoms he was already experiencing as a result of depression. Dr. McIntyre's evidence that the plaintiff has a strong chance of a future depressive episode, only means that in all likelihood things would have proceeded as they did in the past; that is, that the plaintiff would seek treatment and better his condition, while maintaining his practice. There is no evidence on which I can rely to find a real and substantial possibility that future depressive episodes would have rendered him unable or materially affected his ability to continue the private practice of medicine.
- [296] Ms. Barkhuizen testified that the plaintiff intended to continue in his medical practice to age 70. Due to financial setbacks, divorce and bankruptcy, his financial planning for retirement started well in mid-life, and it is plausible that he intended to work beyond age 65. Mr. Carson considered the statistical information showing that, on average, medical doctors work to a more advanced age than other professionals with comparable educational backgrounds and demanding employment roles.

- [297] The plaintiff had worked uninterrupted by pre-existing medical problems well into mid-life. There is no evidence to support the defendant's argument that the plaintiff's before Accident medical conditions might progress sufficiently before age 71 to impair him from practice as a family practitioner. The plaintiff has experienced various of the above-mentioned medical conditions for varying periods of time, some long before the Accident. He has not up to age 57, when the Accident occurred, been impaired from continuing in his work. To apply a contingency reduction of an award of damages based on nothing more than the fact that he has a history of medical disorders does not satisfy the requirement that a finding of a real and substantial possibility of future impairment due to a pre-existing condition must be grounded in evidence. A speculative possibility is not sufficient.
- [298] A real and substantial possibility must be something more than mere speculation; it is a measurable risk: Dornan at para. 63. There is no evidence of a likelihood that any previous ailment or any combination of them would result in disability from his work as a family physician. As I have not found that there is a real and substantial possibility, it is unnecessary for me to proceed to the third step of the test laid out in Dornan.
- [299] Mr. Carson built a general contingency into his assessment of income loss. A specific contingency award must be grounded in the evidence, and in this case the evidence does not support a reduction in damages for specific health-related contingencies: Dornan at para. 92.

C. Non-pecuniary damages

- [300] As I have discussed above, although the plaintiff suffered from depressive episodes pre-Accident, he continued to find pleasure in his pass times, in his interactions with patients, and in his relationship with his wife. There is no evidence that can ground a real and substantial possibility that this would have changed in the future absent the Accident. While the plaintiff has suffered and will likely continue to suffer effects from his depressive episodes, the award for non-pecuniary damages contemplates the effects brought on by the MTBI that the plaintiff did not previously experience. Therefore, I do not award specific contingencies under non-pecuniary damages.

D. Conclusion

- [301] As stated above, I have found no basis in the evidence to adjust the award based on specific contingencies. However, general contingencies may be considered absent such evidence. I view these as distinct from the labor market factors taken into account by Mr. Carson in his downward adjustment of future wage loss.
- [302] At the age of the plaintiff the "ups" and "downs" of life tend more to the latter with respect to both health and employment opportunities. There will be a reduction of 10% applied to the awards of pecuniary and non-pecuniary damages and cost of future care.

X. Cost of Future care

- [303] Ms. Hudon indicates future expenses of between \$1,140 and \$3,200 annually for psychological counselling due to "increased risk for a relapse of Major Depressive Disorder in the face of a life stressor". This, however, is part of his pre-Accident condition and there is no evidence that the accident increased the risk.
- [304] Ms. Hudon estimates the initial cost of marital counselling at \$1,365 and \$2,400, and ongoing at between \$136.50 and \$80, annually. Her estimate for sexual health counselling and treatment for erectile dysfunction ranges from \$4,000 to \$10,000 plus periodic travel over three days to a clinic in New Westminster, mileage, accommodation and meals.
- [305] There is no evidence that the plaintiff sought marital or sexual counselling from the date of the Accident to the date of trial, a period of almost five years. It is possible that these avenues will be explored, but the projected cost seems excessive. All considered, I award \$2,500 against the cost of treatment for the sexual disorder.
- [306] The estimates for development of a fitness program and club membership, yoga and coaching by a kinesiologist range from \$75 to \$90/session for 24 sessions, plus \$472.50, annually. The plaintiff has been able to resume his previous regimen of walking, cycling and sailing without such aids. It seems unlikely that he will pursue these to the extent suggested. A program of in home exercise, comprising of ten sessions, is allowed for.
- [307] Although the evidence is that the plaintiff is already working at his maximum capacity, an award of between \$2,500 and \$5,000 is sought for occupational therapy in pursuit of a higher plateau in his recovery. I decline to make an award in this regard.
- [308] I award \$4,000 for cost of future care.

XI. Special Damages

- [309] The plaintiff will recover the cost of massage therapy, \$1,350, and mileage travelled for medical attendances, \$1,811.
- [310] The plaintiff seeks to recover the cost of private MRIs. These costs will not be awarded as there is no evidence of urgency related to treatment and these would have been available through the public system.

XII. Summary of Damage Award

[311] In summary:

Past wage loss

\$694,198

Future wage loss

\$988,848

Non-pecuniary damages

\$130,000

Cost of future care

\$4,000

Total:

\$1,817,046

Less 10%:

(\$181,704.60)

Subtotal:

\$1,635,341.40

Special damages

\$3,161

Grand Total:

\$1,638,502.40

[312] The total amount is subject to adjustment as provided in paragraph 271(a).

XIII. Costs

[313] Costs against the defendant Leguerrier are awarded to the plaintiff.

[314] The action against Ms. Williams is dismissed without costs to either party.

"Slade J."

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