

CANADA / JUDGMENT

Parhar v. Weaver

2021 BCSC 123

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2021 BCSC 123 Parhar v. Weaver

IN THE SUPREME COURT OF BRITISH COLUMBIA

Citation:

Parhar v. Weaver,

2021 BCSC 123

Date: 20210128

Docket: S177047

Registry: Vancouver

Between:

Karunbir Parhar

Plaintiff

And

Dr. Brennan James Weaver

Defendant

Before: The Honourable Mr. Justice Riley

Reasons for Judgment

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Place and Dates of Trial:

Vancouver, B.C.

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Introduction

- [1] The plaintiff Karunbir Parhar seeks damages for negligence and breach of contract in relation to a root canal procedure on what is commonly known as tooth 46, the first molar in the lower right quadrant of the mouth. The procedure was performed by the defendant Dr. Brennan Weaver in Terrace, British Columbia on 24 September 2014. Shortly thereafter, Mr. Parhar began to experience debilitating pain, which has persisted over a number of years and which he believes is associated with the root canal. Mr. Parhar does not allege that Dr. Weaver performed the root canal in a negligent manner. Rather, he says that Dr. Weaver did not tell him about a material risk of chronic nerve pain, and thereby failed to obtain informed consent before conducting the root canal.

Facts

Plaintiff's Background

- [2] Mr. Parhar grew up in Terrace. After graduating from high school, he entered the automotive service technician training program at Northwest Community College. He completed his studies in 2010 or 2011, and since then he has had various jobs in the automotive service industry. At the time of the root canal procedure that is the subject of this action, he was 26 years old, single, and lived with his parents at the family home in Terrace.

Plaintiff's Dental History

- [3] Because of the nature of the claim, namely an allegation that Mr. Parhar was not properly informed of the risks of a particular dental procedure, the plaintiff's dental history, including prior dental treatments performed by Dr. Weaver, is relevant and is reviewed here in some detail.
- [4] In 2007, at the age of about 20, Mr. Parhar received dental treatment from Dr. Cooper at the Park Avenue Dental Clinic in Terrace. I will not review all of the details. Two things are relevant for present purposes. First, in the course of the treatment, Dr. Cooper noted significant decay on many of Mr. Parhar's molars, as a result of which the doctor informed Mr. Parhar that he would likely require a number of root canal or extraction procedures in the future. Second, it is noteworthy that Dr. Cooper ultimately performed extractions on two of Mr. Parhar's teeth, tooth 17 and tooth 47, without incident or complication.
- [5] Between 2007 and 2012, Mr. Parhar did not see a dentist for regular dental care or checkups. The only dental care Mr. Parhar received over this entire period was a crown procedure on a tooth in the upper left quadrant of his mouth, performed by a dentist in India during a trip that Mr. Parhar took in 2007 or 2008.

Dr. Weaver's Treatment of Mr. Parhar

- [6] Mr. Parhar began to receive dental treatment from Dr. Weaver in 2012. By way of background, Dr. Weaver graduated from the University of British Columbia School of Dentistry in 2009, and obtained certification by the College of Dental Surgeons of British Columbia to practice general dentistry. Since that time, Dr. Weaver has run his own general dentistry practice at the Park Avenue Dental Clinic in Terrace. To maintain his professional certification, he is required to complete a certain number of continuing education programs every three years.
- [7] There are three noteworthy points with respect to Dr. Weaver's treatment of Mr. Parhar prior to the tooth 46 root canal procedure that is the subject of this lawsuit.

- [8] First, insofar as Mr. Parhar's overall dental health and treatment priorities are concerned, the evidence indicates that when he first saw Dr. Weaver, Mr. Parhar's dental health was poor. In an initial oral examination, Dr. Weaver saw that Mr. Parhar had gingivitis, heavy buildup of calculus, and tooth decay. In a new patient information form, Mr. Parhar indicated that his current dental health was poor. In the part of the form that addressed emotional concerns about dental treatment, Mr. Parhar checked the boxes for "time" and "money", and did not check the boxes for "fear" and "pain".
- [9] Second, there is evidence that in one of his first appointments with Mr. Parhar, Dr. Weaver developed and presented a treatment plan that detailed a number of proposed dental procedures for specific teeth, listed by number, with estimated costs. The plan proposed extractions, root canals, or simple fillings for various teeth depending upon their state of decay and anatomical significance. In trial testimony, Dr. Weaver was unable to recall exactly what he said to Mr. Parhar about the treatment plan, but was confident that they discussed it in some detail. When referred to the treatment plan during his testimony, Mr. Parhar said he had seen it before but did not believe Dr. Weaver gave him a copy in the course of his treatment. To the extent that there is any conflict on the evidence on this point, I accept the testimony of Dr. Weaver that he reviewed the treatment plan with Mr. Parhar, for two reasons. First, I accept Dr. Weaver's testimony that it is his common practice to review a proposed treatment plan with a new patient. Second, I accept his testimony that he has a genuine recollection of discussing certain treatment priorities with Mr. Parhar, as discussed below.
- [10] The third noteworthy point about Dr. Weaver's prior treatment of Mr. Parhar is that it involved successful tooth extraction and root canal procedures. Although not the focus of the current lawsuit, these are discussed in detail below because Mr. Parhar's prior experience with such procedures is relevant to the issues in this case.

Prior Tooth Extraction Performed by Dr. Weaver

- [11] It is an admitted fact that on 12 September 2012, Dr. Weaver extracted tooth 28, a molar in the upper left quadrant of Mr. Parhar's mouth. It is further admitted that Mr. Parhar consented to the extraction, and did not experience any complications as a result of this procedure.
- [12] In his testimony, Dr. Weaver was unable to recall the specifics of the 12 September 2012 appointment, but said the details would be noted in his records. He testified that it is his standard practice to review the benefits and detriments of extraction, the patient's priorities, the nature of the procedure itself, and the risks and potential post-operative complications. All of the information on the informed consent form is reviewed with the patient. Dr. Weaver always asks the patient whether he or she has any questions. In this particular instance, Dr. Weaver also has a note that he discussed implants, flippers, crowns and bridges, and showed Mr. Parhar examples of each. In cross-examination, Dr. Weaver testified that the risks listed on the written consent form are reviewed with the patient

multiple times. Dr. Weaver discusses them with the patient, and then his assistant reviews them when the patient signs the form. Dr. Weaver had no independent recollection of what was said in this particular case, but knows it was done because that is what he always does.

- [13] Dr. Weaver's file includes an "Informed Consent for Oral Surgery" form with respect to these extraction procedures. The form specifies that alternatives to surgery were discussed, and that failure to extract the listed teeth could result in infection, loss of additional teeth, and pain. It also indicates that "possible complications" had been explained to the patient, listing seven possible complications, one of which was "paresthesia". The form states that Mr. Parhar was given the opportunity to discuss the surgery with Dr. Weaver and to ask questions. It concludes by stating, "I consent to surgery as described", and bears the signature of Mr. Parhar as the patient and one of Dr. Weaver's dental assistants as a witness.
- [14] In his testimony, Mr. Parhar initially stated that he did not recall the 12 September 2012 appointment, having any teeth extracted in 2012, or signing the written consent form. When referred to Dr. Weaver's clinical notes, he agreed that the 12 September 2012 appointment involved, among other things, the extraction of tooth 28. Mr. Parhar acknowledged his signature on the consent form. He recalled being told about one of the potential complications, "dry socket", but did not recall any discussion of the other listed complications. One of the listed complications was "paresthesia". In his testimony, Mr. Parhar said he did not know what this was, and did not ask about it when he signed the form. Mr. Parhar agreed that he was prepared to proceed with the extraction despite the risks listed on the form. He assumed that "dry socket" was the most significant risk and believed that if the others were of any real concern they would have been discussed with him. Mr. Parhar agreed that implants, flippers, and bridges were explained to him but he had no recollection of being shown any samples.

Prior Root Canal Performed by Dr. Weaver

- [15] It is admitted that on 19 November 2012, Dr. Weaver performed a root canal on tooth 24, a canine in the upper right quadrant of Mr. Parhar's mouth. It is further admitted that Mr. Parhar did not have any complications arising from this procedure.
- [16] Dr. Weaver testified that this root canal was part of his treatment plan, initially discussed with Mr. Parhar on 12 August 2012. Dr. Weaver explained to Mr. Parhar that to "save" this tooth, he would have to open it up and remove the decay, arrange for crown lengthening by a specialist, perform the root canal, and then crown it. It would be a lot of money and work to save one tooth. The alternative would have been to extract the tooth with a view to replacing it later with a prosthetic. Dr. Weaver's recollection was that Mr. Parhar was "motivated" to save tooth 24 because it was a visible tooth.
- [17] Dr. Weaver was unable to recall specifically what he told Mr. Parhar about the root canal procedure itself. He testified that any time he discusses a root canal with a new patient, he explains the procedure and tells the patient what to expect. This would include a description

of post-operative pain and use of painkillers. He always asks the patient whether there are any questions. In this particular case, he does not recall any questions, adding that Mr. Parhar was not a very talkative patient. Dr. Weaver explained that if Mr. Parhar did have questions, they would be recorded in his clinical notes, and no questions are noted in his chart for the relevant dates.

- [18] When pressed on the discussion about tooth 24, Dr. Weaver did not accept the suggestion that Mr. Parhar wanted an extraction but was convinced to get a root canal. Dr. Weaver conceded that he was relying principally on his notes to give this evidence. He had a vague recollection of Mr. Parhar saying he wanted to save tooth 24, but could not recall the details of the discussion because it took place more than eight years ago. He also pointed out in his testimony that he treats many patients each day. When pressed on the fact that the notes do not specifically include any reference to Mr. Parhar wanting to save tooth 24, Dr. Weaver responded by saying he has no vivid memory of such a statement, but could recall Mr. Parhar wanting to save that tooth. Dr. Weaver found this surprising because it was going to be costly and time-consuming.
- [19] Dr. Weaver agreed that not everything said during his appointments is included in his notes. In particular, Dr. Weaver agreed that he and Mr. Parhar had a specific discussion about extraction of tooth 24 that is not recorded in his notes. Dr. Weaver also agreed that the clinical notes do not include any reference to post-operative pain following the proposed root canal procedure for tooth 24.
- [20] Dr. Weaver's notes reflect that he started treatment for tooth 24 on 12 September 2012, but that upon examining it he concluded that crown lengthening would be required before a root canal could be completed. Mr. Parhar wanted time to think about that, so Dr. Weaver drained the tooth and then capped it. He then referred Mr. Parhar to a periodontics specialist, Dr. Louie, to do the crown lengthening, which was completed some time in October 2012.
- [21] In an appointment on 19 November 2012, Dr. Weaver proceeded with the root canal for tooth 24. There was no written consent form for this procedure in Dr. Weaver's file. Dr. Weaver's notes set out the details of the procedure. No complications were noted. In his viva voce testimony, Dr. Weaver testified that the root canal on tooth 24 was uneventful.
- [22] Mr. Parhar testified that the procedure on tooth 24 was his first root canal. He recalled that there were no complications. He agreed that Dr. Weaver might have said that if the pain persisted for more than a week, he should come back for another appointment. In any event, this proved unnecessary as Mr. Parhar had a "normal" amount of post-operative pain that cleared up after less than one week.

[23] Dr. Weaver completed the work on tooth 24 in several more appointments over the next several months. In particular, in an appointment on 12 December 2012 Dr. Weaver prepared tooth 24 for crowning, and then crowned it in another appointment on 2 January 2013. The details are noted in Dr. Weaver's chart notes. The process was uneventful and there were no complications.

Continuing Dental Treatments in 2013 and 2014

[24] Mr. Parhar had more appointments with Dr. Weaver in 2013 and early 2014, during which Dr. Weaver placed fillings on some of Mr. Parhar's teeth. One of the appointments involved a filling on tooth 46, a lower right molar that is the subject of the current lawsuit. Dr. Weaver's records show that on 20 January 2014, he placed a filling on this tooth. The procedure was uneventful. Dr. Weaver cautioned Mr. Parhar about post-operative sensitivity and warned of a risk that a root canal may be required for this tooth in the future.

Root Canal Procedure on Tooth 46

[25] The focus of this action is on Dr. Weaver's treatment of tooth 46. Tooth 46 first became problematic for Mr. Parhar in January 2014, resulting in a filling as described above. The tooth began to cause Mr. Parhar pain again in September 2014, leading to the root canal on 29 September 2014, as described below.

Serious Pain in Tooth 46

[26] On 24 September 2014, Mr. Parhar attended Dr. Weaver's office with complaints of pain in tooth 46. The pain had begun a few weeks earlier, and became more or less constant in the preceding few days. In his trial testimony, Mr. Parhar described it as a "non-stop" pain, different from and more severe than any tooth pain he had experienced before. He found that dousing the tooth with cold water afforded some relief, but only for a few seconds at a time.

Dr. Weaver's Examination of Tooth 46

[27] Dr. Weaver's chart notes for 24 September 2014 indicate that he physically examined tooth 46, conducted a cold test, and took an x-ray. Decay was visible. Dr. Weaver determined that the tooth was infected and recommended a root canal. The procedure did not take place that day. In his testimony, Dr. Weaver said this was probably because "the patient would want to think about it". In the meantime, he prescribed penicillin and advised Mr. Parhar to return if the pain did not subside within a few days.

- [28] For his part, Mr. Parhar testified that Dr. Weaver examined tooth 46 and said it was abscessed, which Mr. Parhar took to mean that it was infected. Dr. Weaver recommended a root canal, a subject discussed in detail under the next heading. Mr. Parhar's recollection was that there was no time to do the root canal on 24 September 2014, so the procedure was booked for 29 September 2014.

Discussion of Treatment Options for Tooth 46

- [29] Dr. Weaver testified that at the 24 September 2014 appointment, he examined tooth 46 and then had a discussion with Mr. Parhar about saving it. Although his chart notes for this date are brief, Dr. Weaver was confident in his testimony about his advice to Mr. Parhar. It is not clear whether he had an independent recollection of the discussion, or whether he was simply attempting to reconstruct the discussion based on a review of his notes. At one point in his testimony on this particular point, Dr. Weaver referred to what he "would have said" to Mr. Parhar, namely that "nothing is guaranteed", but a root canal was "viable", tooth 46 was important and could be saved, and he recommended a root canal. He explained that molars are important for chewing, and tooth 46 was the last molar in this quadrant of Mr. Parhar's mouth.
- [30] Mr. Parhar testified that during the 24 September 2014 appointment, Dr. Weaver told him tooth 46 was abscessed but should be saved because it was an important tooth for chewing. Removing this tooth could also put greater strain on the surrounding teeth. Dr. Weaver recommended a root canal. Mr. Parhar testified that his initial preference was to have tooth 46 extracted, to stop the pain, but ultimately accepted the doctor's recommendation to get a root canal.
- [31] In cross-examination, Mr. Parhar agreed that Dr. Weaver explained to him the importance of tooth 46. Specifically, Mr. Parhar did not have any other remaining lower right molars, so tooth 46 was important for chewing on that side of his mouth. Mr. Parhar agreed that chewing is important to him. He was also aware at the time that even if he had a root canal on tooth 46, it might later have to be extracted. The only question Mr. Parhar asked was how long the crown would last. He did not ask any other questions about root canals. Mr. Parhar had prior experience with a successful root canal on another tooth.
- [32] Dr. Weaver denied that Mr. Parhar ever expressly asked for an extraction of tooth 46. He denied counsel's suggestion that there was a "five minute conversation" in which Mr. Parhar said he wanted an extraction rather than a root canal. Dr. Weaver was steadfast in his testimony that Mr. Parhar "did not come in saying he wanted an extraction". Although Dr. Weaver had no independent recollection of what was said, he was confident that if Mr. Parhar said he wanted tooth 46 extracted, it would have been noted in his chart. Dr. Weaver explained that whenever there is a discrepancy between what the doctor recommends and what the patient wants, that is recorded in the chart notes. Thus, if Mr. Parhar had expressed a preference for extraction over a root canal, it would have been noted in the chart, and it was not.

- [33] Dr. Weaver agreed in cross-examination that a root canal was a relatively involved procedure. The root canal procedure itself normally takes two to three hours. Then there are follow-up treatments where the tooth is prepared for crowning, and the crown is ultimately placed on the tooth and sealed. The cost of the entire process is approximately \$2,000 to \$2,200.
- [34] Dr. Weaver further agreed that by contrast, a tooth extraction procedure does not take as long as a root canal. The extraction procedure takes about an hour, and there are usually no follow-up appointments. The cost of an extraction ranges from \$100 to just under \$400.
- [35] To be fair, at other points of his testimony Dr. Weaver pointed out that extraction is quite invasive and is often complex. Teeth with deep roots often have to be sectioned before they are removed. There is also a risk that the tooth could crack or break during the removal process. Moreover, it is sometimes necessary to cut away part of the bone in order to remove the tooth, and to cut a flap in the gums to access the tooth and the bone. Finally, when a tooth that is visible or used in chewing is extracted, a replacement of some form is normally recommended. This involves resort to one of a number of techniques that can be costly and time-consuming.
- [36] Dr. Weaver summarized by stating that overall, a tooth extraction is cheaper and quicker than a root canal, but extraction is also more invasive, and involves greater risks than a root canal. I note that in giving this testimony, Dr. Weaver was in effect asked to offer his opinion on these matters. Since he was not qualified as an expert witness, his opinions are not admissible for the truth of their contents, but they are admissible for the limited purposes of explaining his state of mind and his actions and conduct in this case.

Continuing Pain around Tooth 46

- [37] After the 24 September 2014 appointment, Mr. Parhar took antibiotics as prescribed by Dr. Weaver. However, the pain continued. On 26 September 2014, Mr. Parhar went to the local hospital reporting that the pain in his tooth was so severe that he was unable to sleep or eat. The emergency room physician prescribed an anti-inflammatory pain medication, which Mr. Parhar took to address the pain pending further dental treatment on 29 September 2014.

Root Canal on Tooth 46

- [38] Mr. Parhar returned to Dr. Weaver's office on 29 September 2014 for the root canal on tooth 46. He was not asked to sign a consent form for the root canal procedure.
- [39] Dr. Weaver testified that before commencing the root canal, he "would have given" a "standard" description of the procedure, including what Mr. Parhar could expect during the procedure, what he should do if he experienced any pain during the procedure itself, and the probability of post-operative pain and tenderness that could last for up to a week or longer. Dr. Weaver testified that these things are not noted in his chart because he says the same thing every time. It would be repetitive to write exactly the same note for every root

canal he did. As Dr. Weaver put it, his charts "would be ridiculously long if we noted all the standard things we do".

- [40] Dr. Weaver volunteered in his testimony in chief that he did not advise Mr. Parhar about the possibility of chronic nerve pain as a complicating factor of the root canal procedure. He explained that in dental school he had never been taught that chronic nerve pain was a risk in root canal procedures, nor had he ever heard about it in continuing education seminars, or encountered it in his practice. He most certainly would have told Mr. Parhar about post-operative pain following the root canal, but not chronic nerve pain.
- [41] In cross-examination, Dr. Weaver acknowledged that he had no recollection of exactly what he said to Mr. Parhar about the risks and consequences of a root canal. Dr. Weaver maintained that he "would have informed" Mr. Parhar about the likelihood of post-operative pain following a root canal, but not chronic nerve pain. He was certain that he did not say anything about chronic nerve pain. He does not consider pain of this sort to be a relevant consideration in root canal procedures. He testified that at the time, he was unaware of any risk of nerve damage or chronic pain from a root canal. He has attended numerous continuing education seminars about root canals and has never heard anything about a risk of nerve damage or chronic pain.
- [42] Mr. Parhar testified in chief that at no time - during either the 24 September 2014 appointment or the 29 September 2014 appointment - did Dr. Weaver ever tell him there was a risk the root canal would not work, that there was a risk or likelihood of pain of any kind, or that there was a risk of nerve damage leading to ongoing pain. If Dr. Weaver had told him about a risk of nerve damage with the potential for ongoing pain, Mr. Parhar would have opted to have tooth 46 extracted, because his principal concern was to stop the pain. Mr. Parhar said he went to the dentist intending to have the tooth extracted, and only decided against it based on the advice given by Dr. Weaver.
- [43] In cross-examination, Mr. Parhar agreed that he was going to have the tooth treated one way or another, either by extraction or by a root canal. Even if told that the risk of nerve damage was the same for both procedures, he would have opted for extraction because he just wanted to get rid of the pain.
- [44] Mr. Parhar agreed that when asked in examination for discovery what he would have done if told that the risk of chronic nerve pain was equal for both procedures, his response was that he would "lean toward" extraction, but if the tooth could be saved a root canal "was an option". He also conceded in his discovery testimony that it is hard to say for sure what he would have done, but if there was any risk at all he would have chosen to get an extraction.
- [45] With regard to the root canal procedure itself, Dr. Weaver testified that he had no independent recall of performing the procedure, but explained that the details were recorded in his chart notes for 29 September 2014. When referred to those notes, Dr. Weaver described the root canal in some detail. He testified that it was uneventful. Part of his standard practice is to instruct the patient to tell him about any pain experienced at any

point during the procedure. Dr. Weaver's assistants are also expected to monitor the patient for signs of pain. In this particular case, there is no note of anything unusual, indicating to Dr. Weaver that the procedure itself was uneventful. In cross-examination, Dr. Weaver added that if a root canal "goes less than ideal", that would be noted in his chart, and the patient would be informed. In this case, neither of those things occurred.

- [46] For his part, Mr. Parhar testified that the root canal took about two hours. At one point, just before Dr. Weaver started to use the ultraviolet light, Mr. Parhar felt a sharp pain just below tooth 46. Mr. Parhar believes Dr. Weaver was in the process of filing one of the canals in his tooth when he felt this pain. He had never felt anything like it before. Nothing else unusual happened during the procedure. Mr. Parhar agreed in cross-examination that he did not say anything when he felt the pain. He did not tell anyone about it until years later, when specifically asked.

Continuing Concerns

- [47] Mr. Parhar's mouth pain intensified after the root canal procedure on tooth 46. Throughout October and November 2014, Mr. Parhar experienced pain around tooth 46 and other parts of his mouth. Over this time, Mr. Parhar had a number of further consultations with Dr. Weaver. He also had appointments with another dentist at the Park Avenue Dental Clinic, several dentists at other offices, and other medical professionals, as outlined in detail below.

Pain after the Tooth 46 Root Canal

- [48] Mr. Parhar testified in chief that he began to experience severe pain more or less right after the root canal procedure. In cross-examination, Mr. Parhar agreed that he might not have felt anything unusual right after the freezing wore off, but he definitely began to experience pain within a day of the procedure. The pain was in the area of tooth 46 in the lower right quadrant of his mouth, but also in the lower left quadrant, and in the upper right. It alternated or moved around. He took Tylenol, with no noticeable improvement. One night he took Percocet, also to no effect. Mr. Parhar testified that the pain was debilitating. It confined him to his bed and he was unable to do anything. He could not sleep and had difficulty eating.
- [49] Mr. Parhar testified in chief that he was unable to work due to the pain. In cross-examination, he asserted that he tried to go to work several days after the root canal but could not make it through the full day. When pressed on details in his employment file showing that he worked a total of five days in the period right after the procedure, Mr. Parhar explained that now, years later, he cannot remember the details of when he stopped working.

Follow Up Appointments at Park Avenue Dental Clinic

- [50] Mr. Parhar returned to the Park Avenue Dental Clinic on 14 October 2014 and again on 15 October 2014. He was examined by Dr. Tambert, whose chart notes reflect that Mr. Parhar reported pain in or around two molars on the left side of his mouth, and that tooth 46 was "better", but still causing some sharp pain which comes and goes. Mr. Parhar wanted both tooth 27 (upper right quadrant) and tooth 37 (lower right quadrant) extracted.
- [51] When asked about this appointment in cross-examination, Mr. Parhar agreed that when he saw Dr. Tambert, he reported pain on the left side of his mouth around tooth 27 and tooth 37. Mr. Parhar responded that at this point he just wanted all the pain in his mouth to go away. When asked to respond to the suggestion that the dentist observed decay in tooth 27 and tooth 37, Mr. Parhar replied that the pain was much worse than the tooth decay pain he had experienced in the past. He accepted that he might have told the dentist that the pain around tooth 46 was "a bit improved" or "a bit less", explaining that there were periods when the pain was less intense.

Extraction of Tooth 27 and Tooth 37, Further Concern about Tooth 46

- [52] Mr. Parhar returned to the Park Avenue Dental Clinic on 20 October 2014, where he was once again treated by Dr. Weaver. Mr. Parhar reported continuing pain on both sides of his mouth. Dr. Weaver extracted tooth 27 and tooth 37 and consulted with Mr. Parhar about continuing pain in an around tooth 46 and tooth 16. There was some discussion about a root canal for tooth 16, a tooth in the upper right quadrant above tooth 46.
- [53] In his testimony in chief, Mr. Parhar asserted that tooth 27 and tooth 37 were probably extracted at his request because they were causing extreme pain and he just wanted them removed. He could not recall if Dr. Weaver offered any other options, but he was "pretty intent" on getting these teeth removed to stop the pain. In cross-examination, Mr. Parhar agreed that with respect to tooth 27 and 37, Dr. Weaver presented him with the options of root canal or extraction, and Mr. Parhar opted for extraction.
- [54] For his part, Dr. Weaver testified that during the 20 October 2014 appointment, he was concerned that Mr. Parhar "kept wanting teeth out". Dr. Weaver could see visible signs of decay on tooth 27 and tooth 37. However, he felt that these molars were important teeth, not easy to get out, and probably saveable in Mr. Parhar's case. On the other hand, Mr. Parhar "wanted them out", and Dr. Weaver knew "what he had been through". Dr. Weaver also had in mind that these teeth were not as important as tooth 46, so he agreed to remove them. When referred to his chart notes for this date, Dr. Weaver added that Mr. Parhar also expressed continuing concern about the right side of his mouth. He was still having pain around tooth 46, and also felt pain around tooth 16.

Request for Extraction of Tooth 46 and Tooth 16

- [55] Mr. Parhar went back to see Dr. Weaver again on 22 October 2014. He reported that the pain on the right side of his mouth was persisting. Dr. Weaver's clinical notes indicate that Mr. Parhar described it as "nerve pain", which was so bad that it prevented him from sleeping. Dr. Weaver tested both teeth and found that the nerve in tooth 46 was dead as expected after a root canal, and the nerve in tooth 16 was still sensitive.
- [56] Dr. Weaver recommended a root canal for tooth 16. Mr. Parhar said he wanted both teeth extracted because they were causing pain and affecting his ability to work and sleep. Dr. Weaver advised against extraction because these teeth were important. His view was that Mr. Parhar was still experiencing post-operative pain in tooth 46. When Mr. Parhar said he wanted to book an appointment for extraction, Dr. Weaver recommended that he see his family doctor for a broad-spectrum antibiotic, and wait to see if the pain resolved.
- [57] Dr. Weaver testified that if Mr. Parhar had come back for another appointment after 22 October 2014, he would have been prepared to do an extraction of tooth 46, although he probably would have referred Mr. Parhar to a neurologist to rule out any other problems before doing so. However, things never progressed to that point because Mr. Parhar went to see another dentist for a second opinion. As Dr. Weaver put it, "things went in a different direction".
- [58] Dr. Weaver testified that after the 22 October 2014 appointment, he consulted with other dentists in his office. What Dr. Weaver's colleagues said to him during these consultations is hearsay, but admissible for the limited purpose of explaining Dr. Weaver's state of mind and his subsequent conduct. Dr. Weaver's opinions regarding Mr. Parhar's condition are admissible for the same limited purpose. Dr. Weaver testified that after consulting with his colleagues, his view was that Mr. Parhar was most likely experiencing continuing post-operative pain. Dr. Weaver acknowledged in cross-examination that the topic of "trigeminal neuralgia" came up in discussions with his colleagues, but he regarded it as a diagnosis of last resort, for patients who have continuing and unexplained facial pain that cannot be attributed to any other known condition.

Efforts to Diagnose and Treat the Plaintiff's Continuing Pain

- [59] Mr. Parhar testified that after tooth 27 and 37 were extracted, it felt like the pain shifted to adjacent teeth. He went back to Park Avenue Dental Clinic on 28 October 2014 for more help. Mr. Parhar testified that he saw Dr. Weaver, but the clinical records reflect that he actually saw another dentist, Dr. Hodgson. Dr. Hodgson suggested that Mr. Parhar's continuing pain could be from grinding his teeth at night and recommended a night guard.
- [60] Dr. Weaver testified that on 30 October 2014, he called Mr. Parhar to inquire about his condition, and Mr. Parhar reported that he was still having pain around the area of tooth 46 (lower right quadrant) and also around tooth 35 (lower left quadrant). Dr. Weaver did not believe pain associated with a tooth on the right side of the mouth could "transfer to" or

cause pain on the left side of the mouth. Following up on Dr. Hodgson's theory about tooth grinding, Dr. Weaver recommended that Mr. Parhar get a mouth guard. Dr. Weaver has not personally spoken to Mr. Parhar since the telephone conversation on 30 October 2014.

- [61] Mr. Parhar eventually followed Dr. Hodgson's recommendation to get a mouth guard, but he did not experience any relief.
- [62] In early November 2014, Mr. Parhar traveled from Terrace to the Lower Mainland to see other dentists. On 3 November 2014, he had an appointment with Dr. Hui in Surrey. On 4 November 2014, he saw Dr. Panos in Delta.
- [63] Later in November 2014, Mr. Parhar returned to Terrace where he saw Dr. Olivier Drouin, a specialist in internal medicine. Dr. Drouin formed the opinion that Mr. Parhar may have suffered "trigeminal neuralgia", described in subsequent correspondence as a form of "dental induced neuralgia". Dr. Drouin's opinion was placed before the court for narrative purposes only, and is not admissible for the truth of its contents. Dr. Drouin referred Mr. Parhar to his brother Dr. Vincent Drouin, a dentist, for follow-up including nerve block treatment.
- [64] On 19 November 2014, Mr. Parhar had an appointment with Dr. Vincent Drouin at Cedar Coast Dental Clinic in Terrace. Dr. Drouin attempted a mandibular nerve block treatment, which did not materially improve Mr. Parhar's condition.
- [65] On 30 November 2014, Mr. Parhar had another appointment with Dr. Vincent Drouin. With Mr. Parhar's consent, Dr. Drouin removed the filling on tooth 46 to investigate the possibility of an extra root that might have been missed in the original root canal procedure. Dr. Drouin did not find anything noteworthy.

Mr. Parhar's Unresolved Pain and its Effects on his Lifestyle

- [66] Mr. Parhar testified that throughout this time he was continuing to suffer from severe pain, alternating from one side of his mouth to the other. About 60% of the time, the pain was on the right side, around tooth 46; the rest of the time the pain was on the left. The pain was so intense that Mr. Parhar was confined to his bed most of the time. Mr. Parhar further testified that the pain made it difficult to eat anything that required chewing. He was unable to go to work for the better part of a year, and only left his house for medical appointments.
- [67] In terms of the nature of the pain, Mr. Parhar testified it takes a variety of forms. The most noticeable pain is a sharp, stabbing pain. He also experiences less severe pains that feel like electricity or an electrical current. He sometimes experiences a burning pain covering larger areas of his mouth.

- [68] Mr. Parhar testified that the pain was so bad that he did not sleep at all for about three months after the root canal procedure on tooth 46. Things improved when he was given a prescription for sleep medication in early 2015. At first he was only able to sleep for a few hours at a time, but within about six months of starting the medication he was able to sleep through the night.
- [69] Mr. Parhar has tried a number of different prescription pain medications. They give him some relief, but he is still in pain most of the time. He says it is hard to put a number on it but estimates he is in pain about 90 percent of the time. He acknowledges having pain-free days, but says they are rare.
- [70] Since 2015, Mr. Parhar has been receiving dental treatment from Dr. Cooper at a clinic in Terrace. In March 2019, Dr. Cooper advised Mr. Parhar about the option of extracting tooth 46, which Mr. Parhar declined. In cross-examination, Mr. Parhar explained that he does not want any further treatment to worsen his condition.
- [71] Mr. Parhar's mother and brother were called as witnesses in the plaintiff's case, to support Mr. Parhar's claims concerning the nature of his condition and its effect on his lifestyle. Their testimony, which was largely unchallenged, was to the effect that Mr. Parhar is less active, less outgoing, and does not socialize as much as he did prior to the dental problems that had emerged in the fall of 2014.

Expert Evidence

- [72] The court heard evidence from four expert witnesses. In this section of the reasons, I have summarized the background, expertise, and subject matters of the opinions offered by each of the witnesses. I have done this in order to provide context for my review of the substance of the expert opinion evidence as set out in the analysis portion of the reasons.
- [73] The plaintiff adduced evidence from Dr. Mehta, a dentist, who was qualified as an expert in orofacial pain, and specifically the effects of root canals. Counsel for the defendant objected to Dr. Mehta's qualification with respect to root canals, arguing that he does not perform them as part of his regular practice and has limited experience with this procedure. I did not accept this submission. I was satisfied that although it has been a number of years since Dr. Mehta was personally involved in root canal procedures, he has expert knowledge of orofacial pain from root canals based on his prior education, his past practical experience, his role in dentistry education, his role as a complaint investigator for the College of Dental Surgeons, and his current practice. Dr. Mehta testified that his current practice involves consulting with and treating patients who have encountered orofacial pain from a variety of circumstances, including orofacial pain from prior dental procedures such as root canals. Dr. Mehta initially conducted a records review resulting in a report dated 14 July 2017. This report was not favourable to the plaintiff's position and was not disclosed to plaintiff's counsel prior to trial. Through cross-examination and discussion with counsel, it became clear that Dr. Mehta provided the records review report to an expert referral service, and

assumed it would be distributed to both parties when in fact it was not. This mistake appears to have been a product of assumptions and poor communication, and I do not consider this to have any bearing on Dr. Mehta's objectivity as an expert or his credibility as a witness. Dr. Mehta later conducted a personal examination of Mr. Parhar and produced an independent medical examination report dated 11 September 2019, which was more favourable to the plaintiff's position. Dr. Mehta's opinion addresses the topics of diagnosis, causation, informed consent, materiality of risk, prognosis, and future treatment. I have summarized the relevant findings in the analysis portion of my reasons.

- [74] The plaintiff also presented evidence from Dr. Medvedev, a neurologist qualified to give opinion evidence on neurology, and in particular the trigeminal nerve. Dr. Medvedev prepared an expert report based on a review of Mr. Parhar's medical records. He did not physically examine Mr. Parhar. The defence objected to Dr. Medvedev's report on the basis that it failed to set out the facts and assumptions on which the report was based, and the documents relied upon, as required under Rule 11-6(1)(f) of the Supreme Court Civil Rules, B.C. Reg. 168/2009. After lengthy submissions on the point, I ruled that to the extent Dr. Medvedev's report was deficient in failing to set out the underlying facts, assumptions and the supporting documents, I would exercise my discretion to admit the report on the condition that Dr. Medvedev was to produce an addendum particularizing records relied upon to reach his conclusions, prior to the commencement of his cross-examination. The substance of Dr. Medvedev's opinion is addressed later in these reasons. It must also be noted that in cross-examination, Dr. Medvedev agreed that he offered a medical opinion without examining the subject, explaining that he would have preferred to meet with Mr. Parhar but was not given that option. This affects the weight attached to Dr. Medvedev's opinion as discussed below.
- [75] The defendant presented evidence from Dr. Coil, an endodontologist who was qualified to give opinion evidence on the effects and risks of root canal procedures. Dr. Coil provided an opinion based on a review of a subset of Mr. Parhar's medical records and the expert report of Dr. Mehta. The fact that Dr. Coil did not physically examine Mr. Parhar once again has some bearing on the weight attached to his opinions. Moreover, because his expert report was offered principally in response to that of Dr. Mehta, Dr. Coil was not given all of Mr. Parhar's clinical records. I nevertheless consider Dr. Coil's opinion evidence to be helpful in evaluating the soundness of Dr. Mehta's opinions regarding materiality of risk, and marginally helpful on the issue of causation.
- [76] The defendant also adduced evidence from Dr. Nielson, a dentist, who was recognized as an expert in relation to the practice of dentistry, the standard of care for general practitioner dentists in British Columbia, and the standard of care for informed consent. Dr. Nielson based his opinions on a set of assumed facts that had been furnished to him by the defendants, along with Mr. Parhar's clinical records and copies of the relevant medical images. He did not meet or speak with either Mr. Parhar or Dr. Weaver. For the most part, I found Dr. Nielson's report to be helpful and his evidence balanced and objective. However, I

did find that in both his report and his viva voce testimony, he tended to conflate the concept of normal post-operative pain with the concept of ongoing or chronic nerve-related pain, as discussed in greater detail below. This point aside, I found Dr. Nielson's opinion evidence to be helpful in evaluating the extent to which Dr. Weaver's performance of the root canal procedure and his discussion of the nature of the procedure and relevant risks met the standard of care that would be expected of a practitioner of general dentistry in British Columbia.

Analysis

[77] The focal point of the plaintiff's claim is the allegation that the defendant failed to obtain informed consent for the root canal procedure on tooth 46, by failing to advise the plaintiff of all material, special, or unusual risks of the procedure, and failing to properly advise him of the alternatives. The plaintiff says this constitutes negligence and breach of contract.

Credibility and Reliability of the Witness Testimony

[78] Before addressing the legal elements of each cause of action, it is necessary to address the credibility and reliability of the testimony of both the plaintiff Mr. Parhar and the defendant Dr. Weaver. I will say from the outset that I found both witnesses to be credible, and I have no problem concluding that both witnesses tried their best to honestly recount their experiences and recollections.

[79] In closing submissions, defendant's counsel advanced a number of arguments to suggest that the plaintiff was not a credible witness. I do not find these arguments convincing. Although there were some discrepancies between the plaintiff's trial testimony and other reliable sources of evidence, including admissions of fact and other contemporaneous records, these inconsistencies were in my view attributable to frailties in his recollection of the relevant events some six years after the fact. This is a question of reliability as discussed below, not credibility.

[80] As far as reliability is concerned, an important feature of this case is that Mr. Parhar's testimony is based on an independent recollection of his dealings with Dr. Weaver, whereas Dr. Weaver relied heavily on his chart notes and had little recollection of the details of Mr. Parhar's case. As a matter of common sense and basic human experience, none of this is particularly surprising. The challenge that a situation like this presents for the trier of fact was aptly described by McEachern C.J.S.C. in *Diack v. Bardsley* (1983), 46 B.C.L.R. 240 (S.C.) [Diack] at p. 246-247:

It is always difficult to decide these questions when one party, claiming to have a precise recollection, says that some specific words were said or not said two or more years earlier, and the other party has no recollection of the event but says his practice, or his invariable practice, makes it likely he did or did not say those specific words. There is no precise judicial formula for solving this question although judges have from time to time suggested some useful theories of credibility for the guidance of us all.

- [81] From Mr. Parhar's perspective, the events in question were highly personal, unique experiences. These events were important to him in that they affected his bodily integrity and his health. On this basis, it makes sense that Mr. Parhar would have an independent memory of at least some of the dental treatments he received from Dr. Weaver. Still, the events in question took place some six years ago, and Mr. Parhar's recollection was not perfect. For example, he initially forgot about the tooth extraction he had in 2012 until the signed consent form was shown to him. He was also incorrect about how many days he worked in the period immediately following the tooth 46 root canal.
- [82] From Dr. Weaver's perspective, Mr. Parhar was one of many patients he has treated over a number of years. Dr. Weaver clearly had some general recollection of Mr. Parhar and his dealings with him. For example, he recalled that Mr. Parhar was not a particularly communicative patient, an observation that fits with the testimony of other witnesses. Dr. Weaver also had a general recollection about some of the unique features of Mr. Parhar's case, including the poor state of his dental health, and some of the discussions about which teeth could or should be "saved". Beyond these general recollections, Dr. Weaver had little or no independent recollection of precisely what he said to Mr. Parhar, or the particulars of the treatment he provided. For this reason, Dr. Weaver relied heavily on entries in his clinical notes, and on his standard practice. This approach is completely understandable, considering that the details of the hundreds of patients he has treated will naturally blend to make any one case indistinguishable from many others. I take all of this into account in assessing the reliability of Dr. Weaver's testimony.
- [83] Evidence of a professional's adherence to an invariable standard practice "is an admissible substitute for present recollection and can be convincing evidence": *Raina v. Shaw*, 2006 BCSC 832 at para. 72; *Belknap v. Meakes* (1989), 64 D.L.R. (4th) 452 (B.C.C.A.) at p. 465-466. In the case at bar, Dr. Weaver's testimony was based on a combination of independent recollection, adherence to standard practice, and reliance on entries in his clinical notes. Sometimes Dr. Weaver referred to his notes to trigger an independent recollection, but in other instances he relied on his notes as a form of past recollection recorded. With respect to his general knowledge of Mr. Parhar and the overall course of his treatment, I accept that Dr. Weaver has an independent recollection. However, when it comes to particular details of Mr. Parhar's treatment, in the absence of some specific assertion of an independent recollection about a particular detail, I have proceeded on the basis that Dr. Weaver's evidence about such details is the product of either past recollection as recorded in his clinical notes, or adherence to standard practices.

[84] I also take into account Dr. Weaver's testimony about the manner in which he created and reviewed his clinical notes. I am particularly mindful of Dr. Weaver's explanation that his clinical notes contain unique details of a particular patient's treatment, including any disagreements with the patient or problems encountered during the treatment. The notes do not set out things that are standard practice. For example, Dr. Weaver's clinical notes do not set out his explanation of the particular dental procedures discussed with Mr. Parhar. As Dr. Weaver explained, his notes would be unnecessarily long and repetitive if he were to set out the details of his standard practices in the clinical notes for each and every patient. The absence of a chart note will not deprive a health practitioner of the ability to rely on his or her standard practice on a matter: *Kern v. Forest*, 2010 BCSC 938 at para. 90.

Factual Findings as to Mr. Parhar's Dental Treatments and Current Condition

[85] I make the following findings of fact with respect to Mr. Parhar's dental treatment history before the root canal procedure on tooth 46:

- a) Prior to the impugned root canal procedure performed on tooth 46, Mr. Parhar's overall dental health was poor. He had significant decay in a number of his teeth. Left untreated, this tooth decay was likely to cause intermittent but increasing pain, infection, and tooth loss.
- b) When he initially went to see Dr. Weaver in 2012, Mr. Parhar was seeking relief from pain due to tooth decay. In addition to this immediate concern about tooth pain, Mr. Parhar's primary dental concerns related to the cost and time required for dental treatments. He was not overly fearful of dental treatment nor was he concerned about pain from dental procedures.
- c) When Dr. Weaver first saw Mr. Parhar in 2012, he assessed Mr. Parhar's dental health as poor. Dr. Weaver developed a comprehensive treatment plan, which he reviewed with Mr. Parhar. This included general discussion about root canals, tooth extractions, and replacements.
- d) There was a period of time when Mr. Parhar did not have dental insurance, but by the time he had the treatments described below, he was insured.
- e) In 2012, Dr. Weaver conducted an extraction of tooth 28, a molar in the upper left quadrant of Mr. Parhar's mouth. Dr. Weaver obtained informed consent, in writing, for this extraction. Dr. Weaver followed his standard practice of reviewing the contents of the consent form before Mr. Parhar signed it. Mr. Parhar was made aware of the risks of an adverse outcome, and had no questions. The extraction proceeded without incident and Mr. Parhar had no adverse consequences.

- f) Also in 2012, Dr. Weaver performed a root canal on tooth 24, a canine in the upper left quadrant of Mr. Parhar's mouth. Although Dr. Weaver did not obtain consent in writing, he explained the procedure to Mr. Parhar and told him about the likelihood of post-operative pain. Mr. Parhar had no questions and consented to the procedure. The root canal proceeded without incident and Mr. Parhar had no adverse consequences.
- [86] I make the following findings of fact with respect to Dr. Weaver's treatment of tooth 46, which is the subject of the present action:
- a) Tooth 46 became problematic in early 2014. Dr. Weaver placed a filling on it, and informed Mr. Parhar of the risk that this tooth could further deteriorate to the point where it would require either a root canal or extraction.
 - b) The pain in tooth 46 flared up again in September 2014. Mr. Parhar went to see Dr. Weaver about it on 24 September 2014, a few weeks after the pain had begun. Dr. Weaver said the tooth was abscessed and recommended a root canal. The root canal procedure did not take place on 24 September 2014. Mr. Parhar was given a prescription for antibiotics and was told to make a further appointment if he wanted to proceed.
 - c) During the 24 September 2014 appointment, Dr. Weaver had a discussion with Mr. Parhar about the treatment options for tooth 46. Dr. Weaver emphasized the importance of saving tooth 46 for chewing because it was the only remaining molar in the lower right quadrant of Mr. Parhar's mouth. This was the basis for Dr. Weaver's recommendation for a root canal.
 - d) I accept that prior to the consultation with Dr. Weaver on 24 September 2014, Mr. Parhar had a subjective preference for extraction of tooth 46. However, I find that he did not express this preference to Dr. Weaver. I reach this conclusion for two reasons. First, I accept the evidence of Dr. Weaver, supported by testimony from other witnesses in this trial, that Mr. Parhar was not a particularly talkative or assertive person. Second, I accept Dr. Weaver's testimony that his practice is to record in his chart when a patient expresses disagreement with a recommended course of treatment. Looking at the whole of Dr. Weaver's clinical notes, I would say they are reasonably detailed. They do in fact refer to Mr. Parhar's expressed preference for one treatment option over another from time to time, though not on this occasion. This gives me confidence in the accuracy of Dr. Weaver's notes. In the result, while I accept that Mr. Parhar went into the 24 September 2014 appointment with a subjective preference for extraction of tooth 46, I find that he never voiced that concern to Dr. Weaver. And when Dr. Weaver outlined the reasons for performing a root canal on tooth 24 to "save" it rather than extracting it, Mr. Parhar accepted Dr. Weaver's recommendation.
 - e) In between the consultation with Dr. Weaver on 24 September 2014 and the root canal procedure on 29 September 2014, Mr. Parhar experienced continuing pain in tooth 46. The pain was serious enough to cause Mr. Parhar to visit the hospital on 26 September 2014, where the doctor gave him anti-inflammatory pain medication pending his next dental appointment.

- f) I accept Dr. Weaver's testimony that during the appointment on 29 September 2014, prior to commencing the root canal on tooth 46, he described the procedure to Mr. Parhar. This included a description of what Mr. Parhar could expect in the procedure, what to do if he experienced any pain during the procedure, and the probability of post-operative pain that could be expected to subside within a week. I also accept Dr. Weaver's admission that he did not specifically advise Mr. Parhar of the risk of ongoing or chronic nerve-related pain, because Dr. Weaver was not aware of such a risk. One of the key legal issues addressed below is whether the risk of continuing or chronic nerve-related pain is properly characterized as a material, special, or unusual risk associated with a root canal.
- g) I accept Mr. Parhar's testimony that, by the time he gave evidence at trial, he honestly believed if he had been informed about a risk of chronic nerve-related pain, he would have opted for extraction rather than a root canal. Mr. Parhar clearly believes that to be the case now. Another key legal issue addressed below is whether the evidence as a whole, including but not limited to Mr. Parhar's subjective belief, satisfies the modified objective test required to prove causation for the purposes of negligence based on an alleged failure to obtain informed consent.
- h) With regard to Dr. Weaver's performance of the root canal on tooth 46, I find that it was uneventful and involved no apparent complications. I accept the testimony of Dr. Weaver that if there were any complications or signs that the procedure unfolded in a manner that was "less than ideal", they would have been referenced in his clinical notes. I further accept Dr. Weaver's evidence that his dental staff is trained to watch the patient for signs of discomfort during the procedure, and none were observed or noted.
- i) I accept that Mr. Parhar honestly believes - at this point in time - that he experienced a sharp pain during the root canal procedure. Mr. Parhar presented as a credible witness and I have no reason to reject his testimony on the basis that it was not given honestly. However, the reliability of Mr. Parhar's belief is another matter. Mr. Parhar admits to making no mention of pain at the time of the procedure. Even allowing for the fact that Mr. Parhar is not a particularly talkative or expressive person, I find it likely that if he did experience a sharp pain during the procedure, he would have said something about it at the time as Dr. Weaver had advised him to do, or the dental staff would have noticed signs of pain. Furthermore, Mr. Parhar said nothing about a sharp pain during the root canal procedure in follow-up visits to Dr. Weaver over the following weeks, where the subject of the discussion was Mr. Parhar's pain after the tooth 46 root canal. Nor is there any indication of a complication in Dr. Weaver's clinical notes. Thus, despite Mr. Parhar's honestly-held belief, I am not satisfied that Mr. Parhar in fact experienced a sharp pain in or around tooth 46 during the root canal procedure.
- [87] I make the following findings with respect to the nature and extent of Mr. Parhar's pain following the tooth 46 root canal, and his current condition:

- a) Without one day of the root canal procedure on tooth 46, Mr. Parhar experienced pain that was more severe and debilitating than the tooth decay pain he had experienced in the past.
- b) The pain was initially in the area of tooth 46, although more or less right away it moved around or shifted to different parts of Mr. Parhar's mouth. The pain has continued to alternate between the right side and left side of his mouth. On average or in the aggregate, the pain is on the right side about 60% of the time, and on the left side about 40% of the time.
- c) The pain has been so bad that it has significantly affected Mr. Parhar's lifestyle and activities of daily living. Mr. Parhar was bedridden but unable to sleep properly for at least three months. He went to work for about a week, but after that was unable to concentrate for a full shift. He also had difficulty eating.
- d) After the root canal, Mr. Parhar saw Dr. Weaver and a number of other dentists and doctors. None of them were able to diagnose or resolve the problem.
- e) Eventually Mr. Parhar was prescribed medication that has helped him sleep. With the assistance of this medication, Mr. Parhar is now able to manage his sleep and go to work. However, the pain in his mouth still affects him in a number of ways. He has difficulty eating. He is also less active, less outgoing, and does not socialize as much as he did.
- f) The pain is present most of the time, though not always. There are some days when he is pain-free. Mr. Parhar estimates that he is in pain about 90% of the time. It also varies in intensity. At its worst, it is debilitating.

(1) Negligence

(1.1) Liability in Negligence

[88] To succeed in a claim of negligence based on the alleged failure of a medical professional to obtain informed consent for a medical procedure, the plaintiff must prove three things. First, the plaintiff must prove that the defendant failed to inform him about the nature of the medical procedure and any material, special, or unusual risks that it entails. Second, the plaintiff must prove that a reasonable person standing in his shoes, properly informed of the nature of the procedure and the relevant risks, would not have consented to the procedure. Third, the plaintiff must prove that the particular risk or risks not explained to him were in fact the cause of the injuries for which he claims damages: *Brock v. Anderson*, 2003 BCSC 1359 [Brock] at para. 12; *Chen v. Ross*, 2014 BCSC 374 [Chen] at para. 308, *aff'd* 2015 BCCA 250.

(1.1.1) Whether Dr. Weaver Failed to Properly Inform Mr. Parhar about the Root Canal Procedure

[89] To obtain informed consent for a medical procedure, the doctor must inform the patient about the nature of the proposed procedure, its gravity, and any associated material, special, or unusual risks of the procedure: *Chen* at para. 302-303, citing *Hopp v. Lepp*, [1980] 2 S.C.R. 192 [Hopp] at p. 210. Material risks are those that might be expected to affect a patient's

decision. Special or unusual risks include those that might be less probable, that is, mere possibilities, but which carry serious consequences such as death or permanent injury: Hopp at p. 209-210; *Brooks v. Spencer*, 1991 CanLII 1951 (B.C.S.C.) at para. 32-33, aff'd [1993] B.C.W.L.D. 1400 (C.A.), citing *White v. Turner* (1981), 120 D.L.R. (3d) 269 (Ont. S.C.) at para. 53, aff'd [1982] 12 D.L.R. (4th) 319 (Ont. C.A.).

- [90] Thus, a doctor is "duty bound to disclose" to the patient the "nature of" the proposed treatment and "any material, special or unusual risks associated with it". The doctor is also expected to answer any questions in relation to the risks of the proposed treatment, and to explain the treatment options, including the option of doing nothing: Brock at para. 15.
- [91] In considering the materiality of a particular risk, expert medical evidence is relevant but not determinative. This is because, while relevant, expert medical evidence taken on its own could "hand over to the medical profession the entire question of the scope of the duty of disclosure, including the question whether there has been a breach of that duty". Expert evidence is relevant in identifying the risks associated with a particular procedure. It will also have "a bearing" on the "materiality" of the risks, "but this is not a question that is to be concluded on the basis of the expert medical evidence alone". Materiality of risk is ultimately a question to be determined by the trier of fact: *Reibl v. Hughes*, [1980] 2 S.C.R. 880 [Reibl] at p. 894-895.
- [92] Courts have taken an "expansive approach" in deciding whether risks that "carry serious consequences" are sufficiently material to require disclosure to the patient. The duty to disclose encompasses even a "statistically remote risk" where the potential consequences are sufficiently serious. In addition to informing the patient of the statistical probability or chance of a particular risk arising, the doctor must explain the nature and severity of the consequences: Chen at para. 303-304.
- [93] In the case at bar, Dr. Weaver was obliged to inform Mr. Parhar about the nature and gravity of the proposed root canal, along with any material, special or unusual risks associated with this procedure. He was also obliged to explain to Mr. Parhar the treatment options for tooth 46. The burden is on Mr. Parhar, as the plaintiff, to prove on a balance of probabilities that Dr. Weaver failed to do so.
- [94] With regard to the obligation to describe the nature and gravity of the root canal procedure, and the treatment options, I have no difficulty in concluding, based on the findings of fact set out at paragraphs 86(c), (d), and (f) above, that Dr. Weaver met his duty of disclosure. In particular, Dr. Weaver discussed the treatment options for tooth 46, recommended a root canal given the anatomical importance of that particular tooth, and gave a description of the root canal and the consequences. This included the likelihood of post-operative pain that is normally expected to resolve within one week. Leaving aside for a moment the issue of ongoing or chronic nerve pain, I accept the expert opinion of Dr. Nielson that Dr. Weaver obtained "adequate verbal informed consent" to perform a root canal on tooth 46.

- [95] The plaintiff's case is focused on the allegation that Dr. Weaver did not inform Mr. Parhar of the risk of chronic nerve pain. In assessing this allegation, the key question is whether chronic nerve-related pain qualifies as a "material, special, or unusual risk" associated with the performance of the root canal procedure on tooth 46. There is conflicting expert evidence on this point.
- [96] Dr. Nielson's report states that in his opinion, Dr. Weaver had previously advised Mr. Parhar of the "possible risk of pain after root canal treatment". However, it was clear in cross-examination that Dr. Nielson was referring here to normal post-operative pain of a sort that would be expected to last less than a week and could in unusual circumstances last for as long as several months. When pressed, Dr. Nielson acknowledged in cross-examination that this post-operative pain is distinguishable from "continuing" or "chronic" nerve pain arising from inflammation or damage to the trigeminal nerve. In another section of his report, Dr. Nielson stated that in his 46 years of clinical dental experience, training, and involvement in dental education, general dentists have not been advised to warn patients of a risk of developing trigeminal neuralgia as a result of a root canal. Nor has there been any notification from either the British Columbia College of Dentists or the Canadian Dental Association directing or recommending that dentists advise root canal patients about the risk of trigeminal neuralgia. In his addendum report, Dr. Nielson stated that over the course of his career he had not witnessed "chronic nerve pain" in connection with or following root canal treatment. Dr. Nielson would not anticipate it as a risk and therefore would not advise patients about it.
- [97] There are several reasons to question the value of Dr. Nielson's opinion evidence in assessing the materiality of the risk of chronic nerve pain in connection with a root canal procedure. First, the opinion that Dr. Weaver informed Mr. Parhar about a risk of pain was focused on conventional post-operative pain, as opposed to chronic nerve pain of the sort that is in issue in this case. Dr. Nielson seemed reluctant to come to grips with and engage in a genuine discussion concerning the risks of nerve-related, non-odontic pain in connection with root canal procedures. Second, while Dr. Weaver's opinion that dentists in this province have never been expected to inform patients about a risk of chronic nerve pain following a root canal is entitled to some weight, this evidence cannot be determinative of the question of materiality of risk. To hold otherwise would be to "hand over to the medical profession the entire question of duty of disclosure, including whether there was a breach of that duty" as discussed in Reibl.
- [98] Dr. Nielson was asked in cross-examination whether the pain experienced by Mr. Parhar, commencing a matter of hours after the surgery and persisting thereafter to the point of becoming chronic, could be indicative of nerve damage. Dr. Nielson acknowledged this as a "remote possibility" but in his opinion extremely unlikely given that Dr. Nielson had never encountered such a situation in 48 years of practice. Although at first blush this evidence might seem compelling, it must be approached with caution because it is really just the anecdotal experience of a single dentist. It is not of the same quality as an opinion based on

data published in peer-reviewed, critically-evaluated articles or studies.

- [99] In evaluating materiality of risk, I find the expert evidence of Dr. Mehta and Dr. Coil to be more helpful. Both gave opinions about the prevalence of nerve injury based on their training, practice experience, and academic research.
- [100] Dr. Mehta stated in his report that nerve-related pain following a root canal procedure is "considered unusual" in "general practice" but nevertheless "documented in the research literature and discussed in most continuing education courses". On this basis, Dr. Mehta opined that "ongoing" nerve-related pain can be "reasonably anticipated as a possible outcome" of a root canal procedure.
- [101] In an addendum report, Dr. Mehta summarized the literature he consulted in support of his assertion that ongoing nerve-related pain can be reasonably anticipated as a possible outcome of a root canal. That addendum report acknowledges a "lack of consensus in the academic literature" in the classification and assessment of the incidence of pain or sensory loss following injury to the trigeminal nerve. The literature does agree that "the most common dental procedures associated with iatrogenic trigeminal nerve injuries" are third molar surgery, local anaesthetic administration, implant replacements, and root canals. Dr. Mehta went on to cite several specific articles in support of his conclusions.
- [102] One article cited by Dr. Mehta identified a 3.4% incidence of non-odontic pain following root canal therapy. In cross-examination, Dr. Mehta testified that the article in question, written by Nixdorf et al. in 2010, was the most persuasive because it was a meta-analysis of nine earlier studies involving more than 3,400 patients. The authors concluded that "non odontic pain is not uncommon following root canal therapy", potentially representing half of persistent tooth pain cases.
- [103] Dr. Mehta's addendum report also referred to another "review article" suggesting that the incidence of "persistent pain after endodontics" ranged from 3.0 to 13.0% of cases. The article in question, written by Lewis et al. in 2007, was not itself a research study but rather a review of available data from other sources. The authors note the absence of a classification system for diagnosis and treatment of neuropathic orofacial pain. The article goes on to describe altered sensation and pain of varying types and degrees of severity. As far as incidence or prevalence is concerned, the relevant portion of the article states that "[p]ersistent pain after endodontics was found to occur in 3% to 13% of cases", listing the "[f]actors significantly associated with persistent pain" to include "long duration of preoperative pain, marked symptomatology from the tooth", and "previous chronic pain problems or a history of painful treatment". This list of factors suggests that many cases involving "persistent pain after endodontics" may in fact be cases where pre-existing pain has continued or gone unresolved following an endodontic procedure.

- [104] Dr. Mehta did not agree with the suggestion that Dr. Coil was in a better position to offer an opinion on this topic because he was an expert in root canal procedures. In Dr. Mehta's view, he was probably in a better position to opine on such things because he treats patients after they encounter such problems, whereas root canal specialists like Dr. Coil perform root canals but do not necessarily treat patients who experience post-operative complications or adverse outcomes.
- [105] Dr. Coil disagreed with the suggestion in Dr. Mehta's addendum report that the incidence of chronic nerve pain following endodontic treatment is 3.0 to 13.0%. In Dr. Coil's opinion, the incidence of non-odontic symptoms following a root canal is 1.5 to 2.0%, which includes patients presenting with pre-existing pain. Further, the vast majority of these patients report as having "altered sensation" in and around the affected tooth. In other words, they report that something "feels different" in or around the tooth that was the subject of the root canal. Only a "small portion" of the 1.5 to 2.0% of patients experiencing non-odontic pain following a root canal have pain that is moderate to severe. In cross-examination, Dr. Coil said the 1.5 to 2.0% incidence of "altered sensation" is an estimate from his own clinical experience, supported by colleagues at the American Association of Endodontics. As to the proportion of this 1.5 to 2.0% that involved moderate to severe pain, Dr. Coil could not quantify it, but based on his experience considered it rare as he has only seen perhaps two or three cases in 27 years.
- [106] Taking all of this evidence together, my conclusions regarding the materiality of risk are as follows:
- a) I find the reference in Dr. Mehta's addendum report to a "review article" stating that the incidence of non-odontic pain following an endodontic procedure ranges from 3.0 and 13.0% to be unhelpful, in light of two limitations identified by Dr. Coil. The first is Dr. Coil's point that many reported instances of non-odontic symptoms following endodontic procedures are cases of mere "altered sensation" as opposed to moderate to severe pain. The second is Dr. Coil's observation that the underlying data does not distinguish between the incidence of pre-existing and the incidence of resultant pain.
 - b) I agree with Dr. Mehta that the most persuasive source of data is the Nixdorf meta-analysis, which puts the incidence of chronic pain following root canal treatment at 3.4%. However, I also accept Dr. Coil's point that the 3.4% figure identified in the Nixdorf article includes cases of pre-existing non-odontic pain. The authors of the article expressly acknowledge that due to a lack of information about "baseline" conditions in the underlying data, their study could "not differentiate between patients whose non-odontic pain arose from pre-existing pathosis and patients whose pain arose from the procedure". Accordingly, the authors present the 3.4% figure as "a frequency of occurrence".

- c) I do not accept Dr. Coil's assertion that the incidence of adverse non-odontic symptoms following endodontic procedures is actually 1.5 to 2.0%. That figure appears to me to be an estimate based principally if not entirely on Dr. Coil's experience without any reliable statistical data. Dr. Coil asserted in cross-examination that his figures were supported by the American Association of Orthodontics, but did not specify the basis for that assertion.
 - d) I place some weight on the expert evidence of Dr. Coil that in the course of his practice and experience he has encountered no more than two or three instances of moderate to severe chronic nerve pain following a root canal. I also attach some weight to the evidence of Dr. Nielson that he has never personally encountered such a case in his many years of practice. This evidence must be treated with caution because it is largely anecdotal, although to be fair, it is evidence given by experts with considerable experience in the field who are also involved in the continuing education of other dental practitioners. In this context, it is fair to say that the expertise of these witnesses includes, but is not limited to, their accumulated knowledge based on practical experience.
 - e) Taking into account all of the aforementioned evidence, I find that the incidence of nerve-related symptoms following a root canal is something in excess of 3.0%. However, a significant proportion of such cases involve what Dr. Coil would characterize as altered sensation as opposed to chronic pain. I further find that the incidence of moderate to severe chronic nerve-related pain following a root canal is extremely low, to the point that the risk cannot be meaningfully quantified.
- [107] Against this factual backdrop, the question is whether Dr. Weaver was duty-bound to advise Mr. Parhar that there was a material, special, or unusual risk of chronic nerve-related pain in connection with the proposed root canal procedure on tooth 46. Dr. Weaver was not personally aware of any such risk, but that is not dispositive of the issue.
- [108] My conclusion is that the plaintiff has not established that non-odontic, nerve-related chronic pain is a material, special, or unusual risk associated with a root canal procedure. The evidence establishes that there is some risk, but the risk of moderate to severe nerve-related pain is extremely low to the point that it cannot be meaningfully quantified. The risk is certainly not as substantial as the one found to be material in *Rawlings v. Lindsay* (1982), 20 C.C.L.T. 301 (B.C.S.C). The decision in *Diack* demonstrates that even a very low but clearly ascertainable risk of chronic nerve-related pain could be found to give rise to a duty to disclose for the purposes of obtaining informed consent. I acknowledge that the consequences of chronic orofacial pain can clearly be quite dire. However, the plaintiff has failed to prove a material risk of moderate to severe nerve-related pain associated with the root canal procedure which Dr. Weaver had recommended for Mr. Parhar's tooth 46. Thus, despite the "expansive approach" to materiality of risk as recognized in the case law, I cannot conclude that the risk was sufficiently material to require Dr. Weaver to advise Mr. Parhar of it as a prerequisite to obtaining informed consent for the root canal procedure on tooth 46.

[109] I am mindful of the concern about handing the entire question of duty of disclosure over to the medical profession in a way that might place the actions of a physician beyond the scrutiny of the courts. Nevertheless, I find that on the evidence presented, the possibility of chronic nerve-related pain was simply too remote to warrant a finding that Dr. Weaver was negligent in failing to inform Mr. Parhar about it. I stress that this is a case-specific conclusion. It turns on the evidence presented at this trial.

[110] I must dismiss Mr. Parhar's negligence claim on the basis that he has not proven that Dr. Weaver failed to properly disclose a material, special, or unusual risk for the purposes of obtaining informed consent. In the event that I am wrong in this conclusion, I will go on to consider the other elements of the legal test for negligence based on an alleged failure to obtain informed consent.

(1.1.2) Whether a Reasonable Person Standing Mr. Parhar's Shoes Would Not Have Consented to the Root Canal Procedure

[111] The burden is on Mr. Parhar to show that a reasonable person in his position, fully advised of the relevant risks, would not have consented to the root canal procedure on tooth 46. This has been described as a "modified objective test", in that it focuses on what a "reasonable patient in the circumstances of the plaintiff would have done if faced with the same situation". The test relies on a "combination of objective and subjective factors". It includes "any 'particular concerns' of the patient and any 'special considerations affecting the particular patient' in determining whether the patient would have refused treatment if given all the information about the possible risks": *Arndt v. Smith*, [1997] 2 S.C.R. 539 [Arndt] at para. 6 and 17.

[112] In this modified objective test, the "plaintiff's circumstances" would include such things as age, income, marital status, along with any special considerations. It would also include the plaintiff's "reasonable beliefs, fears, desires and expectations": *Arndt* at para. 9. The test excludes purely subjective, idiosyncratic, or irrational fears and beliefs which are not related to the material risks and which would often be unknown to a physician: *Arndt* at para. 14.

[113] I consider the following factors to be relevant in assessing what a reasonable person would have done in the same circumstances as those faced by Mr. Parhar in deciding upon the appropriate treatment for tooth 46:

- a) At the time of the root canal procedure on tooth 46, Mr. Parhar was a 26-year-old single man, living at home with his parents. His prior dental health was poor. He has never been a particularly talkative or expressive person.
- b) Prior to seeing Dr. Weaver, Mr. Parhar had received treatment from other dentists. This included prior tooth extractions performed without incident or complication.

- c) When he began his treatment with Dr. Weaver, Mr. Parhar's principal dental concerns were time and money. He was not overly fearful of, or preoccupied with, pain associated with dental procedures. He did not have dental insurance at the time, although he later obtained coverage, prior to the root canal procedure on tooth 46. From this I infer that cost of dental treatment became less of a concern, though it would not have been completely irrelevant considering that most dental insurance policies do not cover the entire cost of odontologic procedures.
- d) When he first saw Mr. Parhar, Dr. Weaver recommended a treatment plan, which included root canals and extractions for specific teeth.
- e) At various points in time Dr. Weaver discussed with Mr. Parhar the treatment options for teeth with serious decay. These options included root canals, extractions, and prosthetic replacements or implants. Dr. Weaver and Mr. Parhar had previously discussed the pros and cons of a root canal to "save" a particular tooth, as opposed to extraction of the tooth.
- f) Dr. Weaver performed at least one tooth extraction for Mr. Parhar. Dr. Weaver obtained informed written consent for the procedure, which was uneventful and did not involve any complications.
- g) Dr. Weaver also performed a prior root canal procedure on one of Mr. Parhar's teeth. Dr. Weaver obtained oral consent for the procedure, which again was uneventful and involved no complications.
- h) Prior to any treatment of tooth 46, Mr. Parhar had generally followed Dr. Weaver's advice in deciding upon treatment options for various teeth.
- i) Tooth 46 became painful in January 2014 and was treated by Dr. Weaver with a filling. Dr. Weaver told Mr. Parhar that tooth 46 might require a root canal in the future.
- j) The pain in tooth 46 flared up again to the point of becoming acute some time in mid-September 2014. The pain was bad enough that Mr. Parhar went to the hospital in between appointments with Dr. Weaver.
- k) On 24 September 2014, Mr. Parhar went to Dr. Weaver's office with a subjective preference for extraction of the tooth causing the pain, i.e. tooth 46. Mr. Parhar had prior experience with tooth extraction, and had never experienced any notable complications. However, Mr. Parhar did not tell Dr. Weaver that he preferred to have the tooth extracted over a root canal.
- l) Tooth 46 was the last molar on the lower right side of Mr. Parhar's mouth. Aesthetically, tooth 46 was important because it was visible. Anatomically, tooth 46 was important for chewing. Losing it would make it difficult for Mr. Parhar to chew, and would place additional pressure on other teeth.

- m) Mr. Parhar previously had a root canal on a tooth that was arguably less vital in terms of its aesthetics and anatomical value, and arguably more costly and time consuming to "save" than tooth 46.
- n) Dr. Weaver fairly described the root canal procedure itself and informed Mr. Parhar about the likely outcome, including the expectation of post-operative pain that would normally last no more than a week. Mr. Parhar gave his consent to the root canal procedure.
- o) Dr. Weaver did not tell Mr. Parhar about any risk of non-odontic, nerve-related chronic pain following a root canal procedure.
- p) There is in fact a relatively small incidence, slightly in excess of 3.0%, of unresolved altered sensation following a root canal procedure. In very rare cases, this altered sensation can take the form of moderate to severe nerve-related, chronic pain. The risk of moderate to severe pain is too low to quantify. Moreover, similar risks are present with respect to other endodontic procedures, including tooth extraction.
- q) Tooth extraction is generally less time-consuming and less costly than a root canal. Extraction takes an hour or less and costs less than \$400. However, in some ways extraction is more invasive, because it involves complete removal of the tooth, and sometimes requires removal of the tooth in sections, and cutting of the surrounding gums and bone. Extraction can become even more complicated if the tooth cracks or breaks during the process. Also, while an extraction is cheap and can be done in a single procedure, installing a prosthetic replacement is costly and generally requires multiple follow-up appointments.
- r) Mr. Parhar's principal and most immediate concern in the treatment of tooth 46 was to resolve the severe tooth pain he had been experiencing in the days leading up to the root canal.
- s) Mr. Parhar was aware of the treatment options for tooth 46. He personally preferred extraction, but he did not express this preference to Dr. Weaver at any point prior to the root canal.
- t) Mr. Parhar subjectively believes that if he had been informed about a risk of chronic nerve pain associated with a root canal, he would not have consented. Rather, he would have opted for extraction of tooth 46. He believes extraction is less involved or less complicated than a root canal.
- u) When asked in examination for discovery what he would have done if told that - as between a root canal and an extraction - the risk of chronic nerve pain was equal for both procedures, Mr. Parhar's response was that he would "lean toward" extraction but if the tooth could be saved, then a root canal was "an option". He also conceded in his discovery testimony that it is hard to say for sure what he would have done, but if there were any risk at all he would have chosen to get an extraction.

- [114] In closing submissions, plaintiff's counsel cited five factors which he says, taken together, tend to show that a reasonable person standing in Mr. Parhar's shoes, fully informed of the material risks, would have declined root canal treatment in favour of extraction. Although there is some overlap between these factors and the considerations listed in the preceding paragraph of these reasons, for the sake of completeness, I will comment separately on each of counsel's five points.
- [115] First, counsel submits that the plaintiff has a "history of extracting teeth uneventfully". This is true. Mr. Parhar had at least one tooth extracted by another dentist, and at least one tooth previously extracted by Dr. Weaver. It is also correct to say that these procedures were uneventful and did not give rise to any complications or concerns. I agree with plaintiff's counsel that this evidence supports an inference that Mr. Parhar was "comfortable with this type of procedure". However, it must also be considered that Mr. Parhar had some prior history with root canal procedures, also without incident. All of this is relevant in assessing what a reasonable person standing in Mr. Parhar's shoes would have done when it came to deciding upon a treatment for tooth 46.
- [116] Second, counsel submits that the plaintiff, "as with all dental patients, had cost issues to consider". Even though Mr. Parhar did not give viva voce evidence that cost was a concern to him in deciding upon a treatment for tooth 46, defendant's counsel concedes that cost would be a relevant consideration in deciding what a reasonable person standing in the plaintiff's shoes would have done. I agree. In this regard, it is relevant that at the material time the cost of a root canal was around \$2,000, whereas the cost of extraction was something less than \$400. Of course, it is also relevant that a substantial portion of the cost of either treatment would likely be covered by Mr. Parhar's dental insurance. If cost were the only consideration, a reasonable person might have favoured extraction over a root canal. However, in my view, a reasonable person would very likely have balanced concerns about cost with other considerations, including the anatomical and aesthetic benefits of "saving" tooth 46, as opposed to having it extracted. A reasonable person would also take into account that if the tooth were extracted, serious consideration would have to be given to subsequently obtaining a prosthetic replacement which could be expected to involve additional cost.
- [117] Third, counsel submits that Mr. Parhar, being familiar with what is involved in both tooth extraction and root canal procedures, would have favoured extraction as the less complicated, less involved, and less time-consuming of the two options. On the one hand, a reasonable person may have been influenced by the fact that extraction takes less time and involves fewer appointments than root canal treatment. On the other hand, a reasonable person would also have considered that in some respects extraction is quite invasive, in view of the potential complications which include the possible need to section the tooth, the risk that the tooth could crack or break, and the possibility of having to cut away surrounding gums or bone in order to complete the extraction process. And while extraction itself involves fewer steps and appointments than a root canal, a reasonable

person would also have considered the possibility or likelihood of further dental appointments to obtain a prosthetic replacement for the extracted tooth. This would be particularly important in considering extraction of a tooth that is both visible and anatomically important.

- [118] The fourth factor cited by plaintiff's counsel is that Mr. Parhar was suffering from significant pain at the time. His principal concern was to obtain a treatment that would stop his tooth pain. In my view, a reasonable person standing in Mr. Parhar's shoes would have recognized that either of the two available treatment options, i.e. a root canal or a tooth extraction, could be expected to resolve the pain.
- [119] The fifth and final factor cited by plaintiff's counsel is that when Mr. Parhar went to see Dr. Weaver in late September 2014, his personal preference was to have the tooth that was believed to be the source of his pain extracted. I have found that Mr. Parhar had this preference, but did not communicate it to Dr. Weaver. Still, I accept that in applying the modified objective element of the test, one must proceed on the basis that the hypothetical reasonable person in Mr. Parhar's shoes had an unexpressed subjective preference for extraction as opposed to a root canal. The ultimate question for the court is whether a reasonable person, in light of that subjective preference and all of the other factors listed above, and properly advised of all of the material risks, would have accepted Dr. Weaver's advice that tooth 46 was an important tooth that should be "saved" with a root canal.
- [120] Taking all of the aforementioned considerations into account, I start from the premise that Mr. Parhar was in severe pain at the time that he sought out treatment for tooth 46 in late September 2014, so doing nothing was not a realistic option. He acknowledged this in his testimony. As for the choice between a root canal and an extraction, a reasonable person in Mr. Parhar's shoes, even one principally focused on stopping the pain from tooth 46, and appreciating that substantially the same risk of chronic nerve-related pain would apply to either extraction or a root canal, would have deferred to Dr. Weaver's recommendation. This is particularly so considering the aesthetic and anatomical benefits of saving tooth 46, as opposed to extracting it. I therefore find on a balance of probabilities that a reasonable person in Mr. Parhar's circumstances, fully informed of the relevant risks, would have opted for a root canal.
- [121] I would dismiss Mr. Parhar's negligence claim on the basis that he has failed to prove that a reasonable person in his circumstances would not have consented to the root canal procedure. In the event that I am wrong in this conclusion, I will go on to consider the final element required to make out the claim of negligence.

(1.1.3) Whether the Risk Not Explained to Mr. Parhar Caused His Injuries

- [122] The plaintiff must also prove on a balance of probabilities that the risk not explained to him actually materialized to become the cause of his injuries: Brock at para. 12; Chen at para. 308. In other words, the plaintiff must prove that the ongoing or continuing pain he has experienced since the root canal on tooth 46 is in fact a realization of the undisclosed risk of nerve-related chronic pain associated with the root canal procedure.
- [123] As a general rule, the test for causation requires proof on a balance of probabilities that the loss or damage would not have occurred "but for" the events underlying the plaintiff's claim. This is a factual inquiry, under which the "but for" test must be applied in a "robust common sense fashion": Clements v. Clements, 2012 SCC 32 at para. 9.
- [124] Causation "need not be determined by scientific precision". While the burden of proof always rests on the plaintiff, there are instances where "an inference of causation may be drawn from the evidence without positive scientific proof": Athey v. Leonati, [1996] 3 S.C.R. 458 at para. 16.
- [125] I would re-state the three findings of fact most relevant to the question of causation as follows. First, despite Mr. Parhar's honestly-held belief, the evidence as a whole does not support a finding that he experienced a sharp pain in or around tooth 46 during the root canal procedure. Second, within one day of the root canal, Mr. Parhar experienced pain that was more severe and debilitating than the tooth decay pain he had experienced in the past. Third, the pain was initially in the area of tooth 46, although more or less right away it moved around or shifted to different parts of the mouth. The pain continues to alternate between the right side and left side of Mr. Parhar's mouth.
- [126] In his main report dated 20 October 2017, Dr. Mehta offered an opinion that Mr. Parhar "most likely experienced some form of iatrogenic dental instrumentation" during the root canal on tooth 46, resulting in "trigeminal nerve neuropathic pain". Dr. Mehta's conclusion on this point would appear to rest heavily on Mr. Parhar's subsequent reports of a sharp pain in the course of the procedure, consistent with "over instrumentation" of one of the roots in tooth 46, causing damage to the nerve.
- [127] I do not accept Dr. Mehta's opinion for a number of reasons.
- [128] To begin with, I find the conclusion itself to be speculative, considering that earlier in the same report, Dr. Mehta wrote that Mr. Parhar's pain "could be" from instrumentation during the root canal procedure. Dr. Mehta noted a number of other concerns that had yet to be investigated at the point that he authored his report, including "hot and cold sensitivity" of the teeth and clenching of the teeth resulting in secondary jaw muscular pains. Dr. Mehta agreed in cross-examination that for a patient with a history of dental neglect, it would be important to rule out other sources of pain before making a diagnosis of neuropathic pain disorder.

- [129] Moreover, Dr. Mehta arrived at a diagnosis of "over instrumentation" despite his criticism of the absence of diagnostic quality x-rays in Mr. Parhar's dental records. When asked about this in cross-examination, Dr. Mehta responded that he was not commenting on the root canal procedure itself. However, he did comment on the root canal procedure, offering his opinion that Dr. Weaver likely over instrumented the root canals, without access to diagnostic quality x-rays.
- [130] Importantly, Dr. Mehta's opinion that the pain on the right side of Mr. Parhar's mouth was most likely the result of over instrumentation was based principally, if not entirely, on Mr. Parhar's delayed report of pain experienced during the procedure itself. In cross-examination, while avoiding a direct response to the suggestion that his opinion rested entirely on Mr. Parhar's subsequent report of pain, Dr. Mehta was ultimately unable to list any other factors supporting his "over instrumentation" conclusion. Dr. Mehta acknowledged that there was no report of Mr. Parhar experiencing any pain in Dr. Weaver's contemporaneous clinical notes of the root canal procedure. Dr. Mehta explained that he got that information from Mr. Parhar himself during an interview in preparation for his report. Because the evidence as a whole does not support a finding that Mr. Parhar experienced a sharp pain in or around tooth 46 during the root canal procedure, the plaintiff has failed to prove a key factual assumption underlying Dr. Mehta's over instrumentation opinion.
- [131] Finally, I find that Dr. Mehta's opinion draws an artificial distinction between Mr. Parhar's reports of pain on the right side of his mouth and reports of pain on the left side of his mouth. Dr. Mehta's opinion was that the pain on the left side of Mr. Parhar's mouth is "most likely unrelated" to the root canal procedure on tooth 46. This is because pain from a procedure resulting in nerve trauma to one side of the mouth is not likely to transfer or shift to the other side of the mouth. In Dr. Mehta's view, the pain on the left side of Mr. Parhar's mouth is likely related to recurrent decay in the teeth on that side of his mouth.
- [132] However, Dr. Mehta's distinction between right-sided and left-sided pain is inconsistent with the symptoms experienced by Mr. Parhar. Mr. Parhar testified that within one day of the procedure he began to experience pain, initially in the area of tooth 46, although more or less right away it began to alternate between the right side and left side of his mouth. Mr. Parhar estimates that the pain has been and continues to be on the right side about 60% of the time and on the left side the remaining 40% of the time. This pattern of symptoms is not consistent with Dr. Mehta's opinion.
- [133] I note that Dr. Mehta had earlier conducted a records review resulting in a report dated 14 July 2017. In that report, Dr. Mehta concluded that the tooth 46 root canal procedure was "not likely the cause of Mr. Parhar's ongoing pain". Reading that report as a whole, it seems to me that at least part of Dr. Mehta's reasoning for this conclusion was that Mr. Parhar reported pain on both sides of his mouth, and a dental procedure on the right side of his mouth "would not explain dental or neuralgia type pains on the opposite side".

- [134] Dr. Mehta's 14 July 2017 report was not originally disclosed to the defence, owing to confusion regarding the manner in which such reports are circulated. Although this miscommunication has no bearing on Dr. Mehta's objectivity as an expert or his credibility as a witness, the content of the 14 July 2017 report highlights a problem with the plaintiff's case. The pain experienced by Mr. Parhar alternates between the right and left sides of his mouth, when the expert consensus appears to be that nerve-related pain from an endodontic procedure on one side of the mouth is unlikely to transfer to the other side of the mouth.
- [135] The rationale for Dr. Mehta's revised opinion, as expressed in his report dated 20 October 2017, was Mr. Parhar's delayed report of pain experienced during the tooth 46 root canal procedure. When Mr. Parhar told Dr. Mehta in an interview that he experienced pain in the course of the root canal procedure, Dr. Mehta revised his opinion to conclude that the pain on the right side of Mr. Parhar's mouth was likely from "over instrumentation" during the tooth 46 root canal. However, the absence of sufficient reliable evidence that Mr. Parhar in fact experienced a sharp pain during the root canal procedure is fatal to Dr. Mehta's revised opinion. The problem highlighted by Dr. Mehta's original report remains, namely that nerve-related pain from an endodontic procedure on one side of the mouth would not be expected to produce pain that alternates between one side of the mouth and the other.
- [136] Two other expert witnesses, Dr. Coil and Dr. Nielson, concurred in the view that nerve-related pain from a dental procedure on one side of the mouth would not produce pain alternating between one side of the mouth and the other. Neither of these witnesses personally examined Mr. Parhar, so standing alone I would not give a great deal of weight to their opinions on causation. However, on this limited point, I find that their evidence corroborates the opinion of Dr. Mehta.
- [137] The only evidence that nerve-related pain can "transfer" or alternate from one side of the mouth to the other is found in the expert report of Dr. Medvedev. In his report, Dr. Medvedev opined that the pain on the right side of Mr. Parhar's mouth was most likely related to the 29 September 2014 root canal procedure. This conclusion is based on the "examinee's complaints pattern as documented in the reviewed records". Dr. Medvedev further opined that it was "possible" that the root canal procedure played "some role" in the pain in other quadrants of Mr. Parhar's mouth. Dr. Medvedev referenced a case report documenting traumatic neuropathic pain on one side of the body leading to "mirror pain" on the other side of the body. The case report also listed several "putative pathophysiological mechanisms" that could be responsible for such a process, which Dr. Medvedev did not further describe in his report.
- [138] It is of some concern that Dr. Medvedev offered an opinion on causation without conducting a physical examination or interview of the plaintiff. In cross-examination, Dr. Medvedev agreed that a physical examination is paramount in reaching clinical conclusions. He testified that he was "uncomfortable" offering a medical opinion without examining the patient, stating that if he were given a choice, he would have done so. With

respect, no one forced Dr. Medvedev to prepare and submit a report opining on causation. If he felt he was not in a position to do so without examining or interviewing the plaintiff, he could have said so. Just as Dr. Medvedev was admittedly uncomfortable offering an opinion on the issue of causation without conducting a physical examination of the patient, I am uncomfortable in placing much if any weight on his resulting report.

- [139] In any event, with respect to the pain on the left side of Mr. Parhar's mouth, Dr. Medvedev's opinion that it was "possible" that the root canal on tooth 46 played "some role" is in my view too equivocal to support a finding of causation. Although he later stated in cross-examination that the root canal "probably" triggered the pain in the "other parts" of Mr. Parhar's mouth, the language in Dr. Medvedev's report betrays a lack of confidence in that view.
- [140] With respect to the pain on the right side of Mr. Parhar's mouth, I agree with the defendant's counsel that Dr. Medvedev's initial report fails to set out the specific sources of information on which the conclusions were based. His addendum report did so, but in a summary way. The particular records Dr. Medvedev relied upon contained descriptions of Mr. Parhar's symptoms that are somewhat but not entirely consistent with the evidence adduced at trial. In the end, Dr. Medvedev's opinion on causation regarding the pain on the right side of Mr. Parhar's mouth is entitled to some weight. However, I do not consider it convincing given the manner in which it was prepared and presented to the court, and the fact that Dr. Medvedev based it on a review of records without any examination or interview of the plaintiff.
- [141] In final submissions, plaintiff's counsel chose not to rely on the opinion of Dr. Medvedev that traumatic neuropathic pain on one side of the face could lead to "mirror pain" on the opposite side. Rather, plaintiff's counsel rested his case exclusively on Mr. Parhar's complaints of pain on the right side of his mouth. Counsel expressly conceded that the evidence was "insufficient" to establish that the pain on the left side of Mr. Parhar's mouth is "related to" the tooth 46 root canal.
- [142] In my view, this tactical admission is not enough to overcome the problem with the plaintiff's case insofar as proof of causation is concerned. The pain Mr. Parhar experiences on the right side of his face is, on my assessment of the evidence, indistinguishable from the pain he experiences on the left side of his face. As Mr. Parhar put it, the pain effectively moves around or alternates from one side of his mouth to the other. The overwhelming weight of the expert opinion evidence is that nerve-related pain from an endodontic procedure performed on the right side of the mouth would not produce pain on the left side of the mouth. This causes me to question whether any of the pain suffered by Mr. Parhar in the wake of the root canal on tooth 46 was caused by the root canal procedure. Based on this concern alone, I am not satisfied on a balance of probabilities that a risk of nerve-related chronic pain associated with a root canal procedure actually materialized to cause the symptoms Mr. Parhar has experienced and continues to experience.

[143] If for some reason I am wrong on this point, even focusing exclusively on the pain on the right side of Mr. Parhar's mouth, I find the evidence is insufficient to prove causation on a balance of probabilities. For the reasons given above, I do not accept the causation opinion of Dr. Mehta, nor do I place much stock in Dr. Medvedev's opinion on this issue. While the law is clear that causation need not be proven with any degree of scientific precision, on the facts of this case, the existence of a temporal link alone is not enough to establish that the root canal procedure on tooth 46 was in fact the cause of the subsequent and continuing pain on the right side of Mr. Parhar's mouth.

(1.2) Damages in Negligence (in the Alternative)

[144] In closing submissions, plaintiff's counsel urged that even if I concluded the defendant was not liable in negligence, I should complete the analysis by making findings on damages "in the alternative". Presumably, the reason for making alternative findings on damages in negligence would be to avoid the need for a re-trial on the issue of damages in the event of a successful appeal of my decision on liability, as explained in *Awan v. Canada (Attorney General)*, 2010 BCSC 942 at para. 75.

[145] The decision to make findings "in the alternative" is "in the discretion of the trial judge" and is "inherently, case specific": *Recchia v. Co-operators Life Insurance Co.*, 2002 BCSC 712 at para. 63, *aff'd* 2003 BCCA 643. Some of the factors commonly considered in deciding upon the exercise of this discretion are listed in *Caplan Builders Ltd. v. Royal Bank of Canada* (1988), 25 B.C.L.R. (2d) 335 (S.C.) at para. 7, *aff'd* [1989] B.C.W.L.D. 1737 (C.A.). In the case at bar, I consider it appropriate to make alternative findings on damages, largely because I had the benefit of submissions on this issue from both parties, and because I am able to do so without making any findings inconsistent with the factual conclusions grounding my decision on liability.

[146] My analysis on damages will be brief. It is based on the evidence described in paragraphs 66 to 71 above, and the findings of fact set out at paragraph 87.

[147] I agree with plaintiff's counsel that Mr. Parhar's condition is accurately described as one of chronic pain. The claim is limited to chronic pain on the right side the mouth. I also agree with plaintiff's counsel that the pain was most severe and debilitating in the first year, and since then has been rendered more manageable with medication. Mr. Parhar's prognosis for full recovery is poor.

[148] With regard to non-pecuniary damages, I have considered the non-exhaustive list of factors discussed in the leading case of *Stapley v. Hejslet*, 2006 BCCA 34, the positions and submissions of the parties, and the case law cited by each of them. On the one hand, the plaintiff's relative youth, the nature of his chronic pain, his poor prognosis, and the effect of the condition on his lifestyle are all factors weighing in favour of an award at the high end of the range identified by the parties. On the other hand, Mr. Parhar's claim is focused exclusively on the pain on the right side of his mouth. The fact that he has also experienced and continues to experience pain on the left side of his mouth, and the corresponding

impact on his quality of life would lead me to reduce the award that he would otherwise have received by one third. In view of all this, an appropriate award to compensate the plaintiff for his loss had the defendant been found liable in negligence would have been \$93,300.

[149] With regard to loss of past income, the parties agree that the value of the earnings that Mr. Parhar lost in the year following the tooth 46 dental procedure is \$20,000. Left for my determination would be the extent to which Mr. Parhar was unable to work by virtue of chronic pain on the right side of his mouth, considering that he was concurrently suffering from serious pain on the left side of his mouth. To show an entitlement to damages based on hypothetical events, the plaintiff would have to establish a real and substantial possibility that the events would have occurred: *Hawkins v. Espiloy*, 2014 BCSC 1804 at para. 42. I find that there is a real and substantial possibility that the pain on the right side of Mr. Parhar's mouth would, on its own, have prevented him from working during this period. However, I would reduce the damages by 50% to account for the contingency that the pain on the left side of his mouth would have impacted his past earning capacity. I conclude that if the plaintiff had established liability in negligence, he would have been entitled to \$10,000 in damages for past loss of earnings.

[150] To summarize my findings on damages, if the plaintiff had successfully proven his claim in negligence, he would have been entitled to (a) \$93,300 in non-pecuniary damages, and (b) \$10,000 in damages for past loss of earnings, for a total of \$103,300.

Breach of Contract

[151] The plaintiff put forward a breach of contract claim as an alternative to his negligence claim. Counsel submitted that if the negligence claim failed on the basis that the plaintiff did not satisfy the modified objective element of the test for liability in negligence based on lack of informed consent, then the court should consider whether the defendant's alleged failure to disclose a material risk associated with the root canal procedure amounted to a breach of a contract.

[152] The plaintiff cites *De la Giroday v. Brough* (1997), 33 B.C.L.R. (3d) 171 (C.A.) [*De la Giroday*] at para. 34, which addresses breach of an implied term to exercise reasonable care and skill in the performance of a contract for professional services. Relying on *De la Giroday* and several other cases, the plaintiff submits that his breach of contract claim involves the following three elements: (i) a contract for services, that is, a contract in which Dr. Weaver agreed to perform a root canal procedure on tooth 46 in exchange for a fee paid by Mr. Parhar, (ii) an implied term of the contract under which Dr. Weaver would be expected to perform the root canal with "reasonable care and skill", and (iii) a breach of the implied term of the contract by virtue of a failure to advise Mr. Parhar of a material risk associated with the root canal procedure. The plaintiff submits that proof of these three elements would establish a breach of contract, which would be "actionable per se", without any requirement to prove either causation or damages. The plaintiff cites *Oliver v. Ellison*, 2001

BCCA 359 at para. 57 and Davidson v. Tahtsa Timber Ltd., 2010 BCCA 528 at para. 31 in support of the latter proposition.

- [153] On this approach to the case, there would be no requirement for the plaintiff to prove causation, and therefore no requirement to prove that a reasonable person in the plaintiff's shoes would not have consented to the root canal procedure. Thus in a contractual setting, the failure to advise of a material risk would be actionable per se, and the plaintiff would be entitled to a judgment in his favour for at least nominal damages. The plaintiff says this allows for a just result in cases where a defendant medical practitioner fails to properly advise of a material risk but the plaintiff is unable to prove the objective element of causation necessary to make out a case for negligence. In such circumstances, the plaintiff has done nothing wrong, and should be entitled to nominal damages and costs given that it was the defendant who failed to advise of a material risk before proceeding with a particular medical procedure. Plaintiff's counsel says this is not an invitation to establish "new law", but rather an effort to draw upon "old law". As counsel put it in his closing submissions, "the claim in contract has always existed", but has simply not been utilized.
- [154] The defendant counters by arguing, among other things, that even where there is a contract between a medical professional and patient for the performance of a particular medical service, there is no "implied contractual duty to obtain informed consent". The defendant says the duty to obtain informed consent is a function of the "special relationship" between physician and patient as described in the negligence jurisprudence, none of which supports an "implied contractual duty". This argument may well have some merit, but I do not need to address it because the plaintiff's breach of contract claim fails for other reasons.
- [155] To begin with, over the past three decades or so courts have shown a strong inclination to determine cases of alleged failure to obtain informed consent for a medical procedure under the law of negligence. This is because the modified objective test for causation takes into account the competing policy considerations engaged when courts are called upon to consider potential liability of medical professionals in connection with an alleged failure to obtain informed consent to a medical treatment: Reibl at p. 891-892; Arndt at para. 7, 15.
- [156] In Reibl, the Court held that despite the "temptation to say that the genuineness of consent to medical treatment depends on proper disclosure of the risks which it entails", absent misrepresentation or fraud, "a failure to disclose the attendant risks, however serious, should go to negligence rather than to battery": Reibl at p. 891-892. The Court went on to formulate what has since become known as the modified objective test for causation in the context of claims for negligence based on lack of informed consent to medical treatment.
- [157] In Arndt, the majority emphasized the "unique policy concerns" associated with the doctor-patient relationship, justifying a modification of the "usual approach to causation" in other actions for tort: Arndt at para. 7. Thus, the modified objective element of the test for causation initially articulated in Reibl "marks the rejection of the paternalistic approach to determining how much information should be given to patients". The test has been

calibrated to balance the patient's entitlement to a "high standard of disclosure" against the need to ensure that medical professionals have "some protection in the face of liability claims from patients influenced by unreasonable fears and beliefs": Arndt at para. 7, 15.

[158] The plaintiff's breach of contract claim seeks to avoid the requirement to prove causation, on the basis that a breach of contract is actionable per se. This approach would expose medical professionals to legal liability for failure to disclose a material risk in connection with a medical treatment, without any objective assessment of how the non-disclosure would have impacted the plaintiff's treatment decision, and without any requirement for proof of actual damages. In my view, this would upset the carefully calibrated balance between the competing policy considerations as discussed in the informed consent jurisprudence.

[159] At a more case specific level, even if it were appropriate to consider the plaintiff's breach of contract claim, it would fail in any event. Recall that the third element of the plaintiff's breach of contract framework as discussed in paragraph 152 above is proof that the defendant failed to advise Mr. Parhar of a material risk associated with the root canal procedure on tooth 46. At paragraphs 89 to 109 above, I held that the plaintiff did not prove that Dr. Weaver failed to disclose a material, special, or unusual risk for the purposes of obtaining informed consent for the root canal procedure. This finding is fatal to the breach of contract claim as formulated by the plaintiff.

Conclusion

[160] The plaintiff's action is dismissed in its entirety. Subject to further submissions as deemed necessary by counsel, the defendant is entitled to costs of the action at Scale B. If either counsel considers it necessary to make additional submissions on costs, arrangements may be made through the Scheduling Coordinators for submissions in writing or a further appearance before me.

"Riley J."

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