Date: 19990304
No. B961315
Vancouver Registry

IN THE SUPREME COURT OF BRITISH COLUMBIA

BETWEEN:

RONALD J. BRENNAN and MARCIA D. BRENNAN

PLAINTIFFS

AND:

BALJINDER SINGH, deceased, MARR CONTRACTORS LTD., and MIDTOWN TRUCK SERVICES INC.

DEFENDANTS

REASONS FOR JUDGMENT

OF THE

HONOURABLE MR. JUSTICE HARVEY

Counsel for the Plaintiffs, Ronald J. Brennan and Marcia D. Brennan:	J.N. Laxton, Q.C. and E. Lyszkiewicz
Counsel for the Defendants, Baljinder Singh, Deceased, and Marr Contractors Ltd.:	R.B. Lindsay and W.D. Mussio
Counsel for the Defendant, Midtown Truck Services Inc.:	M.D. Adlem and A.M. Ross
Place and Date of Hearing:	Vancouver, B.C. January 25 - 29, February 1 - 5, 8 - 12, February 15 - 19 and 22, 1999

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I. INTRODUCTION

[1] The plaintiffs claim damages for injuries suffered by them in a motor vehicle accident which occurred on August 16, 1995 on the Upper Levels Highway, North Vancouver, British Columbia.

[2] The accident occurred on the said highway as it descends in a southerly direction to the Second Narrows Bridge, in an area known as "the Cut". The plaintiffs, who at that time resided in Cambridge, Ontario, were in British Columbia for the wedding of one of their sons. Mr. Brennan was driving a rented vehicle, a 1995 Ford Contour. Mrs. Brennan was occupying the right front passenger seat.

[3] The accident was caused when the plaintiffs' vehicle was struck from the rear by a tractor-trailer driven by the defendant, Baljinder Singh, and owned by the defendant, Marr Contractors Ltd. The impact, described as horrendous, was such that it caused the plaintiffs' vehicle to be catapulted over the centre line concrete barrier and into the path of a northbound vehicle where a second collision occurred.

[4] The plaintiffs are not at fault for the accident. The defendants, Singh and Marr, admit fault for the accident but claim the defendant, Midtown Truck Services Inc., contributed to such fault. The issue of fault will be determined subsequently by me, the trial of that issue as between the defendants, commencing on March 22nd next, at Vancouver.

[5] The question of damages is in issue.

[6] As a result of involvement in the motor vehicle accident,

the plaintiff Marcia Brennan, now 61 years of age, suffered multiple severe injuries. The plaintiff Ronald Brennan, now 63 years of age, suffered less serious injuries.

[7] Following the accident, the plaintiffs were transported to the Vancouver General Hospital where they were examined, treated, and confined. They eventually returned to Ontario where Mrs. Brennan continued her hospital confinement for the purposes of treatment for approximately fourteen months, eventually being released to return to the family home.

[8] By agreement of counsel, medical reports, clinical records, hospital records, reports related to economic loss, research papers and studies and the reports of experts in the field of care and life expectancy were filed as exhibits. The materials are voluminous.

[9] The injuries allegedly suffered by the plaintiffs are set out in the Statement of Claim.

[10] The plaintiff Ronald Brennan is alleged to have suffered injury as follows: (a) Injuries to neck;

(b) Injury to back, including fractures of the L1 and L3 vertebrae;

(c) Injury to right scapula;

(d) Injury to right arm;

(e) Injury to ribs;

(f) Multiple lacerations including both knees, legs, and head;

(g) Multiple abrasions and contusions;

(h) Severe shock and upset.

[11] The plaintiff Marcia Brennan suffered serious and permanent personal injuries which have rendered her a quadriplegic. The injuries suffered by her have subsequently been particularized to allege she suffered as well a head injury, diagnosed as subdural hygroma (fluid in the brain) causing some dysfunction and leaving her in a coma for three to four days.

[12] In February 1995, Mrs. Brennan was diagnosed as suffering from Parkinson's Disease.

[13] Pursuant to the agreement of counsel, there are a number of matters which will not be addressed and dealt with in these Reasons. They are the application of a tax gross-up, whether there should be, and if so, the assessment of a management fee, and pre-judgment interest. Additionally, it has been agreed with regard to the claim for future care, I will give my decisions related to the items of such care presently in

dispute and the level and quantity of care, together with the life expectancy I find is applicable to the plaintiff Mrs. Brennan, from which counsel will make the necessary projections related to the present value of those expenses requiring such calculation.

[14] The damages to be assessed at this time and the amounts claimed in relation thereto, are:

Mrs. Brennan

(a)	Non-Pecuniary Damages	$ 262,000.00
(b)	Future Care:	
	(i) regarding a life expectancy of 17.7 years	$2,987,830.00
	(ii) regarding a life expectancy of 19.0 years	$3,067,932.00
(c)	Psychological Counselling	$ 32,940.00
(d)	"In Trust" Claims:	
	(i) Past Claim	$ 110,272.00
	(ii) Future Claim	$ 77,438.40

Mr. Brennan

(a)	Non-Pecuniary Damages	$ 100,000.00
(b)	Loss of Income	$ 12,080.00
(c)	Travel Expenses	$ 16,128.00
(d)	Subrogated Claim of Manulife	$ 33,345.50

II. NON-PECUNIARY DAMAGES:
A. MRS. BRENNAN

[15] It is agreed non-pecuniary damages should be awarded at the upper limit having regard to the catastrophic injury suffered being $262,000 and I award that sum.

II. NON-PECUNIARY DAMAGES:
B. MR. BRENNAN

[16] The amount claimed on behalf of Mr. Brennan as appropriate in the circumstances is $100,000, comprising, as Mr. Laxton put it, 50/50 between a conventional award for his injuries and as well the loss of his future in the perspective of a life planned with a partner in what has been described as the "Golden Years" of retirement.

[17] In relation to the first component, there is much common ground. In this regard, Mr. Brennan suffered significant injury as a result of the motor vehicle accident. The most serious injuries, were the burst compression fracture to the L1 vertebrae and the fracture at L3. He was hospitalized in Vancouver for about 11 days in relation to these injuries and, upon release, had to wear a Jewett brace for several months.

[18] The orthopaedic surgeon attending Mr. Brennan in Vancouver stated that he will have a permanent deformity of his L1 vertebrae and will definitely develop osteoarthritis which will

result in an interference and inability to do activities he could do normally.

[19] Mr. Brennan was attended to by an orthopaedic surgeon upon his return to Ontario. This specialist found Mr. Brennan to complain of tenderness and discomfort in his low back area with that pain being secondary to degenerative changes at L1-2. He commented that Mr. Brennan's symptoms are being exacerbated by the strenuous demands in relation to him involved in the day-to-day care of Mrs. Brennan.

[20] The orthopaedic surgeon retained by the defendants to examine Mr. Brennan essentially confirmed the opinions of the medical specialists having seen and treated him. He was of the further opinion Mr. Brennan "does have genuine symptoms which are likely to continue on an indefinite basis".

[21] Mr. Brennan suffered other injuries that included a stiffness in the neck. He says these symptoms have continued to trouble him periodically since involvement in the accident.

[22] Counsel for the defendants submit Mr. Brennan's complaints in relation to his neck are not attributable to the accident. As I understand the submission, this is essentially because there is no specific reference to neck discomfort in the Vancouver General Hospital records or in the attending orthopaedic surgeon's report, suggesting a late onset of the condition. I do not agree. Having regard to the nature of this accident, it is not unreasonable that this condition may have been given little if any significance at the time of initial treatment and in the perspective of the Brennans moving from hospitalization in Vancouver to Ontario. I agree, however, that the condition of the neck of which he complains is minor in nature.

[23] Mr. Brennan is an impressive witness in relation to his tendency to minimize his complaints of pain, discomfort and disability from the injuries he suffered. In relation to the fractures of the vertebrae, one would have expected much more by way of complaints. In my view, he does not do so at least in part because of the catastrophic injuries and attendant disabilities suffered by his wife and the inevitable comparison of their respective situations.

[24] In this perspective, I accept without reservation, the complaints he does make related to his injuries, including to his neck. While he agrees his injuries have gone on to a "more or less full recovery", he does have certain continuing problems. One of such problems, the development of osteoarthritis, is permanent in nature.

[25] Counsel for the defendants submits the range for non-pecuniary damages should be $30,000 to $35,000. He referred me to two unreported decisions of this court supporting his submission. In my view, the decisions are of limited assistance when related to the circumstances here which can properly be described as unusual.

[26] In the particular circumstances here, I take into consideration where and in what manner the injuries were sustained, the fact that there was a loss of consciousness for some appreciable period of time, and a hospitalization of 11 days. In my view, an appropriate conventional award of damages is the sum of $45,000.

[27] I turn next to the claim for loss of enjoyment of life in the perspective of the loss of a life planned with a partner and a loss of his "Golden Years" of retirement. It is to be understood that such a claim is in no way for loss of consortium.

[28] Mr. Laxton frankly concedes this is a matter of first instance and I should venture forth with a concept in mind the categories of negligence are never closed.

[29] In the course of an able submission, he invites me to consider, inter alia, the directness of the loss, that it is personal to Mr. Brennan, and has and will deprive him of his future as expected, and here, planned with his wife.

[30] I have much sympathy for this submission. I have no difficulty in understanding the nature and depth of the loss suffered by Mr. Brennan. The question here, however, is whether such a loss is compensable at law.

[31] In keeping with the conclusion I have reached with regard to this component of Mr. Brennan's claim for non-pecuniary damages, I do not consider it necessary to review Mr. Mussio's submissions and at length the authority to which I was referred supporting those submissions.

[32] The authority relied upon here by the defendants Beecham v. Hughes (1988), 27 B.C.L.R. (2d) 1, and the decisions following subsequently can be argued, as has been done here, not to support a claim such as Mr. Brennan's for the loss of enjoyment of his life related to a catastrophic injury suffered by his wife. While as I have stated, supra, it is not that difficult to understand how such a claim can be considered as relating directly to the injuries suffered by Mrs. Brennan, I am compelled to give effect to Mr. Mussio's "flood gates" submission if such is the case "virtually all individuals that may be affected by Mrs. Brennan's quadriplegia would have a compensable claim".

[33] In the result, I have concluded that while such a claim as it is submitted here can be readily understood as having "taken a toll on the enjoyment of his life", it has not as yet been recognized as one sounding in damages and therefore it is not compensable.

[34] The amount I award for non-pecuniary damages will therefore be the sum of $45,000.

III. LOSS OF INCOME: MR. BRENNAN

[35] At the time of the motor vehicle accident, Mr. Brennan in his retirement years had part-time employment with the local School Board marking papers, the income limited for pension purposes to $3,000 per annum. Mr. Brennan says it was his intention to continue with such employment to age 65. He says he was unable to continue with his part-time employment as a result of injuries he suffered in the motor vehicle accident and the time required to participate in the care of Mrs. Brennan.

[36] The amount claimed is $12,080 net after partial income loss replacement by an insurer.

[37] The defendants concede that as a result of injuries he suffered in the motor vehicle accident and partial disability thereafter, Mr. Brennan may have lost income from part-time employment - possibly a trimester - but for which he has since received payment. Following this loss, the defendants submit it was his choice whether to return to such employment and that he has chosen not to do so.

[38] In my view the answer to this claim lies in part with the manner in which Mr. Brennan is compensated by way of the past and future "in trust" claims and that he will not be precluded from pursuing part-time work in the future to age 65.

[39] For these reasons, I make no award for past and future income loss.

IV. FUTURE CARE:
LEVEL, QUANTITY AND COST OF CARE

[40] This issue occupied a substantial amount of the time at trial. Included in the evidence for consideration are the two models of care employed to date, four models of care for the future, together with the defendants' submission, in the alternative, that the court consider a hybrid model, depending upon the findings made related to a higher level of care being required than presently exists provided by Independent Living Centre.

[41] The defendants concede the number of hours of paid attendant care (presently provided by health care workers) should be increased to reduce but not remove Mr. Brennan from involvement in the ultimate care model. The defendants also concede Mrs. Brennan requires 24 hour care but not "a paid attendant for 24 hours a day, seven days a week, 365 days per year".

[42] In the course of their submissions, counsel have revisited the trilogy and more current decisions of the courts of this province, related to this issue.

[43] At the end of the day, Mr. Laxton submitted the issue comes down to whether in the circumstances here, the level and quantity of care provided 24 hours a day should be that

essentially provided by unregistered health care workers or by registered practical nurses. He submits further the expert opinions of Dr. C. McGillivray and Dr. O. Geisler, which should be accepted, answer the issue in favour of the position of the plaintiffs.

[44] Mr. Mussio, on behalf of the defendants, does not agree. He submits the issue is whether registered practical nurses, as opposed to unregistered health care workers, are medically necessary and reasonable in the circumstances. He comments from a cost perspective the difference in hourly rates between them, based upon 24 hours of paid service, is $39,682.80 per year.

[45] Mr. Mussio submits further "the very issue was tried by Mr. Laxton in Zapf and rejected by the learned trial judge in that case, despite the plaintiff being a C4-5 incomplete quadriplegic". The decision referred to is Zapf v. Muckalt (1995), 11 B.C.L.R. (3d) at 296. I will return to the Zapf decision later in these Reasons.

[46] In keeping with the conclusion I have reached, I will not review all of the evidence at trial bearing upon this issue.

[47] I consider it sufficient to say that in the main the evidence adduced and relied upon by the plaintiffs to support the position of the plaintiffs, is that of Dr. McGillivray. Dr. McGillivray, in turn, approves the model of care put forward by Mr. T. Pearce, a rehabilitation consultant.

[48] Dr. McGillivray is a physical medicine and rehabilitation medical specialist. She is presently, and has been for some time, a member of the active staff of Lyndhurst Hospital. As well since 1997, she has been acting head of the division of physiatry of the University of Toronto. She has had extended involvement with Mrs. Brennan. She attended and treated her while she was a patient in Lyndhurst Hospital.

[49] It is Dr. McGillivray's opinion that Mrs. Brennan requires this level and quantity of care provided by registered practical nurses for a number of "factors". They include the following:

(a) the quality of care provided in the management of areas such as bowel treatments and catheterization;

(b) early detection and notification of a physician of medical problems;

(c) problems which may arise from time-to-time, including wound dressings, administration of intravenous medication, bladder medication, or chest/respiratory care;

(d) the assessment of medical risks, such as a weak cough requiring an attendant to deliver an effective cough and to give chest physiotherapy to reduce the risk of

pneumonia.

[50] In the course of her testimony, Dr. McGillivray emphasized the importance of early detection of what she referred to as medical problems, emphasizing the necessity of the attendant having a certain level of skill to do that.

[51] Dr. J. Dornan, a physical medicine and rehabilitation specialist, stated that the level and quantity of care proposed on behalf of the plaintiffs, is not medically necessary. Dr. Dornan's major interest in the Rehabilitation Institute, a chronic care hospital, was in the management and rehabilitation of intercranial trauma, as he put it, "a few inches away from spinal cord injury trauma". He says that a "spin off" from that was when he was asked to see spinal cord injured patients. He went on to say the following:

> The reason being is that although spinal cord injury, high spinal cord injury, carries a lot of hazards to the patient by virtue of the injury, specific entities, which can cause their demise, a major factor within the equation is the immobilization that is engendered by a high spinal cord injury, or for that matter, a severe head injury.

[52] In this perspective, the first question asked of him in cross-examination is as follows:

> Q: Doctor, your primary experience is in brain injury rather than in spinal cord injury, is that so?
>
> A: Well, my current experience, yes.

[53] I mention in passing in this particular case, Dr. Dornan has offered an opinion in relation to Mrs. Brennan's life expectancy. I understood his expertise in this area to arise from seeing over the past ten years or so numbers of spinal cord injured patients, with a specific request to make estimations of their life expectancy.

[54] As I understand Dr. Dornan's opinion, while a registered nurse should monitor the care, and there should be from time-to-time the involvement of a medical doctor, insofar as the care itself, it could be something less than that provided by a registered nurse or nursing assistant. He agreed the lower level care would require the training of the unregulated health care workers, particularly in the functions of catheterization and the bowel routines, but comments that the subjects are not sophisticated and the workers do not require special qualification.

[55] On February 12th, counsel for the defendants informed the court he wished to call Dr. Geisler in rebuttal, in a particular sense, to rebut the testimony of Dr. McGillivray.

At that time, the introduction of Dr. Geisler's evidence was opposed by Mr. Laxton.

[56] Mr. Mussio, advancing the defendants' position at that time, informed the court that the rebuttal opinion was necessary because Dr. McGillivray, in her testimony, had at the very least expanded upon what she had expressed as opinions in her reports, particularly her earlier reports, to be the appropriate standard of care.

[57] I considered the submissions of counsel and delivered orally my ruling which was that the rebuttal of opinion of Dr. Geisler would be received and if he was to disagree with the opinions of Dr. McGillivray, he should be permitted to say why and that if an attempt was to elicit an opinion "having an affirmative character of its own", outside the ambit of proper rebuttal, I would deal with such a situation should it arise.

[58] Finally, in the spirit of obiter in Kelley v. Crow (previously considered by me in other rulings), I suggested it might well be good practice for the defendants to inform the plaintiffs, insofar as that was possible, what was expected to be the opinion or opinions of Dr. Geisler in rebuttal.

[59] In due course, Dr. Geisler provided a letter report to counsel for the defendants dated February 14, 1999 (Exhibit 46). On February 16th last, Dr. Geisler was called as a witness in rebuttal.

[60] Dr. Geisler is now 73 years of age. He may properly be described as an eminently qualified medical specialist in his medical specialties of internal medicine and physical rehabilitation medicine related to spinal cord injury. He has written extensively on the care and management of patients with spinal cord injury, including the conducting of pioneer research work in Canada with colleagues in the area of life expectancy in traumatic spinal cord injury. For many years, he has been associated with the Lyndhurst Hospital, a spinal injury hospital, as its medical director and, later, its president. From 1991 to date, he has been Professor Emeritus, Department of Medicine (Rehabilitation Medicine, University of Toronto).

[61] Since 1952, Dr. Geisler has seen patients in the several thousands in consultation and in relation to their treatment and care, including after they have been discharged home. He continues to see such patients at this time. In relation to the patients that he has seen, and continues to see, he makes recommendations for their ongoing care.

[62] In this case, for the purpose of preparation of his opinions, he was provided with all of the reports previously filed by Dr. McGillivray and a transcript of her testimony at trial as well as two reports prepared by Mr. Pearce.

[63] In keeping with the importance placed upon the opinions of Dr. Geisler, and in the interest of accuracy, I quote from his

testimony:

Testimony in Chief

Q Now, I have asked you to comment upon the standard or the level of care that you think is medically necessary for a patient in that condition given your review of Dr. McGillivray's reports and evidence. Can you tell his lordship what, in your opinion, an attendant for Mrs. Brennan requires in the way of training and -- well, I'll leave it at that for now.

A Well, your honour, in my opinion, she requires care by an adult, mature, intelligent, compassionate person who is sensitive to the disability of the spinal cord patient but who has received special instruction in matters particularly of concern to the spinal cord patient and most likely to be problematic -- that includes problems with the skin, the bladder, bowel, joint mobility and airway clearing -- and that that care has to be around the clock.

Q Now, you're aware that Dr. McGillivray stated in one of her reports that she agreed with Mr. Pearce's recommendation for registered practical nurse care. In your opinion, is it medically necessary that Mrs. Brennan have registered practical nurse care?

A Well, let me put it this way. She's got to have care by persons who are appropriately trained, in whom she and her attending doctor will give approval, and these persons could be -- if they are intelligent and mature and adult and happen at the same time to be a registered practical nurse with training, that person would be appropriate. If she was intelligent and mature and adult and sensitive and it was a so-called health care person with appropriate training, then that person, too, would be appropriate. If it was a registered nurse who was mature and sensitive, she would also be appropriate but she, too, would have to receive special training.

Q Now, you've mentioned the appropriate training. Are you aware whether that training can be provided to attendants who are not registered practical nurses or registered nurses?

A Yes, I'm aware that that training can be applied to those persons.

...

Q We have heard evidence in this trial regarding the possibility of a patient who has quadriplegia developing autonomic dysreflexia.

A Yes.

Q Can you tell me whether an attendant in your opinion would -- who is not a registered practical nurse nor a registered nurse would be capable of dealing with a situation such as that?

A If she had been educated in the symptomology and what to do, the answer is yes.

...

Q Now, the other thing that we have heard some evidence of in this trial is Mrs. Brennan slipping into a listless or confused state, and I think you would have seen that in Dr. McGillivray's report.

A Yeah.

Q In your opinion -- well, what should an attendant do in that circumstance?

A Well, now you're introducing a symptom that's a very complex symptom, and if a person is suddenly found to be in coma, suddenly -- you go in to look at them at two o'clock in the morning, you go and look at them at eight o'clock in the morning, they are in coma. Coma means they are unconscious, they don't respond to stimuli of awareness. There's only one thing you can do under that circumstance. You pick up the telephone and you phone the doctor, say, "Dr. Jones, Mrs. Brennan is unconscious." You phone the doctor and he's not there, he's got an answering service, "Please leave your number and the doctor will call when he gets back to the office," three days later or five hours later. You pick up the telephone and you call the ambulance and you tell the ambulance to come and pick up your -- the patient you're responsible for who's unconscious and take them to hospital. Now, that's when the patient is unconscious. If you happen to get the doctor, the doctor is likely to say, "Well, is she breathing?" "Yes." "Okay, call an ambulance and send her to the emergency." Is she -- if she's not breathing, she may be dead. The unconsciousness may be so severe that she's dead, so he said, "I will be right over to see her." That's what I have done when they have called me. Okay.

...

A Now, to sort all of that [confusion, lethargy, slowness] out, at any moment in time if it's slowly seen to progress, you'd better have a doctor come and see that patient and make a decision about whether or not he's giving her too much Sinemet or not enough Sinemet, too much Lioresal, Baclofen, too much Dantrium, too much nocturnal hypnotic, or whether she's depressed and time is catching up with her and she's losing hope. Now, the best person to make that decision is the doctor who knows her better than anybody else, her specialist in spinal cord rehabilitation or her family doctor.

...

Q One last question, Doctor -- and I think you've touched upon it. In terms of bladder and bowel care in particular and the administration of the prescribed drugs as well, is an attendant capable -- an attendant who's not a registered practical nurse or a registered nurse, capable of performing those functions?

A With training, yes.

Cross-Examination

Q Doctor, you know Dr. McGillivray?

A Yes.

Q She works at Lyndhurst Hospital?

A Yes. She's a colleague of mine.

...

Q You have a high regard for her?

A Yes, indeed. Yes.

...

Q And she looked at all the lists of risks and problems that Mrs. Brennan had, and let me just quickly list them for you in case you haven't seen them all but there are perhaps nine in total, starting off with vulnerability to urinary infection; decubitus ulcers, which she's had at least in the acute stage; she's had bladder stones; she's got still uropathic pain, which she feels from one to four hours every

day; she's had the Parkinson's disease, of course, and she's had drug reactions from the Parkinson's medication and perhaps in combination with her other medication; she has from time to time been, not surprisingly, depressed; she has had a brain injury which has affected her cognitive function to some extent, at least in terms of memory; and, most importantly, Mrs. Brennan herself has expressed the need, for her own peace of mind, to have an attendant with a minimal medical training.

Given all those factors, it was Dr. McGillivray's opinion that it would be reasonable for Mrs. Brennan to have her attendant care provided by an attendant with some level of medical knowledge and, she said, an RPN.

Now, given that's the opinion of Dr. McGillivray, would you agree with it?

A Yes.

...

Q Can you elaborate a little bit?

A Yes. I think that -- as you well know, I watched these patients over more than a generation of mankind and I've been concerned about consequences in spinal cord injured patients of the fact that they have had a spinal cord injury and I -- as you well know, and I've studied life expectancy and, as a general statement, the quality of care is important. Persons who have better care, concerned care, live longer than persons who don't.

That having been said, I've seen patients who have had abysmal care who have out-distanced the life expectancy probability that I may have put to them, and I've seen patients with superb care who haven't reached those figures.

Q But generally, as a --

A As a general statement, yes.

Q The better the care, the better the prognosis?

A Mr. Laxton, nobody can tell you how long a person is going to live. I can't do it and whomever else you might look to to try and get an answer really can't. They can give you their best judgment based upon their experience and whatnot but I guess -- you know, I don't know what your philosophy of life is but the only person who can really tell is God.

However, that being said, yes, there have

been lots of experience with these patients, and the better the quality of care, the longer they are going to live.

Q Are the feelings of the patient about who they would prefer to have as an attendant important?

A Yes, they are.

Q Why?

A Because feelings of an individual impact upon your response to a circumstance in life. If you are fearful, under great anxiety and worried, you can be almost arrested in your performance, and if you are vivacious and pleased and happy and hopeful with things as they are happening at a particular moment in time, that will bow you up or buoy you up and support you in your ongoing trek along life's path but perhaps -- these patients are at great risk through a depression of spirit, and a depression of spirit is loss of hope and loss of hope can kill you.

...

Q Assuming that in this case Mrs. Brennan has expressed a preference for RPN's because she feels that a minimal amount of medical training puts her at ease, how much weight would you put on her preference?

A I think you'd have to give it a lot of weight.Re-Examination

Q Doctor, my friend asked you about the desires of the patient in terms of registered practical nursing care versus attendant care. In your opinion, is RPN care for Mrs. Brennan medically necessary?

A You mean if it was the only one that was available?

Q Sorry. Is RPN care, as opposed to attendant care, medically necessary?

A I don't think it's medically necessary but --

MR. ROSS: Those are all my questions.

MR. LAXTON: You were going to say, but --

A If the other attendant care was appropriately trained, then it could be used excluding the necessity of the RPN.

[64] I return to Zapf.

[65] Mr. Mussio considers the issue of level of care was considered, determined, and rejected by the learned trial judge in that case, as submitted, supra. Mr. Laxton's reply was while the level of care put forward in that case was not accepted, the learned trial judge went on to say it would have been a good suggestion for an older, bedridden quadriplegic.

[66] In Zapf, the level of care sought was that to be performed by licensed practical nurses, which I understand is a status comparable to a registered practical nurse in Ontario.

[67] It is useful to consider what the learned trial judge actually said on this issue, in the perspective of the case before her. I refer to the judgment of Humphries J. at paragraph 128:

> Ms. Shulstad's level of care is more appropriate for an older, bedridden person who is incontinent and must be constantly turned, or for a quadriplegic who cannot do pressure shifts, is subject to pressure sores, and who has no bladder or bowel sensation. This level is not, in my view, justified or desirable for the plaintiff.

[68] It is also useful to consider the perspective of the case before her. Mr. Zapf was 18 years of age at the time he was rendered a quadriplegic, the quadriplegia being at the C4-5 level. In spite of the level of the lesion, Zapf had considerable sensory sharing, including his ability to shift his weight which was considered to be important in relation to his ability to prevent pressure sores.

[69] If, in addition to the factors referred to by Humphries J. in Zapf, most of which apply to Mrs. Brennan, is added the factor of loss of some cognitive function in the form of short-term memory and the risks to a quadriplegic of her age who cannot do pressure shifts, it seems to me rather than the learned trial judge's decision favouring the position of the defendants, it can be interpreted as supporting the position of the plaintiffs. In my view, upon any interpretation of the decision, it cannot be interpreted as a "rejection of the very issue".

[70] In relation to the quantity of care, I consider it of little or no value to attempt to make comparisons of Mrs. Brennan's situation in this case to those of the plaintiffs in cases such as Unruh, Jacobsen, and Zapf. Mr. Unruh was 17 years of age at the time of injury. It was the view of the learned trial judge in that case that it was probable Unruh would be able to operate a motorized van by himself. Mr. Jacobsen was 19 years at the time of injury, such being described as incomplete quadriplegia at the C4-5 level. Jacobsen was described by the learned trial judge as being able to feed himself, that he could stand, and walk with a walker,

which he did for 15 minutes a day. At the time of trial, he drove his own van.

[71] A study of these and other cases of quadriplegia arising from traumatic spinal cord injury, leads me to the view, care must be given to the age factor, sensory factor, the wishes of the injured person as to lifestyle (see, particularly, Zapf), before comparisons can properly be made. In my view, the statement of Humphries J. in Zapf quoted, supra, is most cogent in this perspective.

[72] It is submitted by counsel for the defendants, that the opinions of Dr. McGillivray should be viewed with caution "especially given the evolution of the opinions over time".

[73] Counsel for the defendants attacks the opinions of Dr. McGillivray, particularly those expressed in her most recent reports and in her testimony at trial, related to the necessity of 24 hour care, with that care being performed by RPNs. He submits such opinions were not expressed in her original reports and evolved over time to trial.

[74] I will not review the attack made upon the reports, culminating with the testimony of Dr. McGillivray at trial. In the result, it is submitted Dr. McGillivray was providing evidence to assist Mrs. Brennan in her claim, that she lacks the objectivity of an unbiased expert, the cumulative effect of the objections being that Dr. McGillivray should be considered as an advocate and her opinions disregarded.

[75] In his response to this attack, Mr. Laxton, inter alia, points out that in her earlier reports Dr. McGillivray was responding to Manulife, an insurer, by way of its adjusters, whose concept of care in all respects was limited to its contractual obligation to provide such care, and with Mr. Brennan playing a significant role in such care.

[76] I had the opportunity to observe the manner in which Dr. McGillivray gave her testimony at trial. I found her, in keeping with the regard Dr. Geisler has for her, to be a caring and competent medical specialist. I thought she gave her testimony in a direct, straight-forward manner, and in no way could or should be considered to be an advocate for Mrs. Brennan. It is apparent she has sympathy for Mrs. Brennan and has concern for the risks presented in relation to her future care. I would not have expected a competent medical specialist to think otherwise.

[77] The submissions of counsel for the defendants, in my respectful view, appear to overlook completely that the opinions of Dr. McGillivray now questioned, were considered as reasonable by an expert witness such as Dr. Geisler, who was called by the defendants on relatively short notice, for the purpose of rebutting those very opinions.

[78] In an historical perspective, here revisiting the trilogy, the test for the standard of care generally is whether a

reasonably-minded person of ample means would be ready to incur the expense. When measuring reasonableness, the expense should not be a squandering of money.

[79] Since the trilogy, the awards for the expense of future care have attempted to follow such directions.

[80] In the circumstances here, it is necessary to address the submission of the defendants that medical necessity, purporting to arise from Milina, is the appropriate test. I do not agree.

[81] This issue was addressed in Zapf. On appeal, 26 B.C.L.R. 201, where Donald J.A. stated:

> I think the proper test is reasonableness and that the psychological and emotional factors influencing the choice of where to live must be considered; Andrews v. Grand & Toy Alberta Ltd. (1978), 2 S.C.R. 229 at 238 and 245. Medical necessity is too stringent a test.

[82] While in a specific sense the court in Zapf was dealing with "the choice of where to live", it was considering the proper test in relation to the care of the plaintiff. There is nothing in the judgment of the Court of Appeal in Zapf to suggest there be a different test or tests applicable to the other components of care.

[83] I have revisited Milina.

[84] At page 78 of the decision, McLachlin J. (as she then was) reviewed the general principles governing the assessment of damages in the case before the court. I refer to the third such principle:

> The primary emphasis in assessing damages for a serious injury is provision of adequate future care. The award for future care is based on what is reasonably necessary on the medical evidence to promote the mental and physical health of the plaintiff.

[85] In Milina reference was made to what was described as the defendant's approach, referring to medical justification of the award for cost of future care. Following analysis of such a position, McLachlin J. at p.84 stated:

> These authorities establish (1) that there must be a medical justification for claims for cost of future care; and (2) that the claims must be reasonable.

[86] This passage from Milina has been quoted and applied since its delivery in 1985.

[87] I comment in passing that no where in Milina did

McLachlin J. use the words "medical necessity".

[88] Finally, I refer to the recent judgment of Low J. in Mann v. Ross, 1998, Vancouver Registry B50087, in which, after considering Milina, he stated:

> The award for future care is based on what is reasonably necessary on the medical evidence to promote the mental and physical health of the plaintiff. To that should be added that the plaintiff's preferences as to the type and level of care should be considered.

[89] In the last sentence of this statement, Low J. gives support to the concept of care encompassing, as it should do, the plaintiff's wishes as to the type and level of care. That concept is before me as well in the form of the opinions of Dr. Geisler, referred to, supra.

[90] Upon consideration of the evidence related to the issue of the level, quantity and cost of future care, I prefer and accept the expert opinions of Dr. McGillivray, supported by the expert opinions of Dr. Geisler, with regard to the appropriate level of care being that provided by RPNs with monitoring at appropriate times by registered nurses and a medical practitioner. In so doing, I take into consideration the preferences of Mrs. Brennan expressed in her testimony at trial for the type and level of care.

[91] In my view, such level of care is reasonably necessary; is what a reasonably-minded person of ample means would be prepared to incur as an expense; and cannot in the remotest sense be considered a squandering of money; and for which there is a medical basis.

[92] As to the quantity and cost of such care, in keeping with the findings made related to the level of care, I find that of the four models of care, the model provided by Para Med, with one important revision, is the most suited to be applied. In my view, the quantity of the care - the paid care - should be based upon 20 hours per day. I believe even with the catheterization procedure being required to be performed at four hour intervals, there are two periods in Mrs. Brennan's established regime which could be used to reduce the quantity of care to 20 hours per day.

V. "IN TRUST" CLAIMS

[93] In the circumstances of this case there are advanced on behalf of the plaintiff Mrs. Brennan, "in trust" for Mr. Brennan, substantial claims related to the services rendered by Mr. Brennan for her care, past and prospective. The claims are in the amounts of $110,272 and $77,438, respectively.

[94] The subject of "in trust" claims has been given considerable attention in recent years, including,

particularly, where the services in question have been rendered within the perspective of a husband/wife relationship or by a child or relative of the family. Here, the relationship is marital and brings into consideration the usual factors of such a relationship.

[95] In my view, it is useful to review briefly the factors which are considered in the assessment of such claims. They are:

(a) where the services replace services necessary for the care of the plaintiff;

(b) if the services are rendered by a family member, here the spouse, are they over and above what would be expected from the marital relationship?

(c) quantification should reflect the true and reasonable value of the services performed taking into account the time, quality and nature of those services. In this regard, the damages should reflect the wage of a substitute caregiver. There should not be a discounting or undervaluation of such services because of the nature of the relationship;

(d) it is no longer necessary that the person providing the services has foregone other income and there need not be payment for such services.

[96] Here, it is not, strictly speaking, necessary to consider the facts of foregone income or opportunity because, at the material times, Mr. Brennan was retired from his full-time occupation as a teacher. He did, however, supplement his income by marking papers pursuant to contract with the local School Board, which he renewed from time-to-time.

[97] The amount claimed for past care is calculated by multiplying the hours when services were provided, 6,892 by $16, the amount the current care provider charges for services of a health care attendant.

[98] The future "in trust" claim is calculated by multiplying care for one hour per day projected, assuming a life expectancy of 19 years, at the same hourly rate, with that amount reduced to present value, being $77,438.40.

[99] It is common ground that when Mrs. Brennan returned to her home, she could not be left alone which is still the case. I mention in passing, with the acquisition of an environmental control unit enabling Mrs. Brennan to do many things with its assistance, for example, opening doors, making telephone calls, she is in that sense, more independent. Counsel for the defendants goes so far as to submit with its acquisition, she can be left alone for brief periods of time. While this may be so, realistically, I consider someone, whether Mr. Brennan or a health care attendant, must be in attendance, either in the home or on or about the property, or sufficiently close to

respond quickly in the event of an emergency.

[100] The models of home care (there have been two) which have been in place since Mrs. Brennan's release from Lyndhurst Hospital, have been those approved by an insurer, pursuant to what I have been led to understand is a contract of insurance, providing coverage for such care. In this regard, it is the insurer which ultimately controls, that is, determines the hours of attendant care provided weekly and the level of that care.

[101] The models of care have been based on something appreciably less than 24 hour care. It is essentially for this reason that Mr. Brennan has been, and continues to be, part of Mrs. Brennan's care regime. Indeed, one of the models of care prepared for submission at this trial, appears to be based upon Mr. Brennan providing thirty percent of such care.

[102] The objections of the defendants to the claims as presented here are:

(a) any award should be restricted to the form of care going beyond what one would consider to be the normal duties flowing from a husband and wife relationship, sometimes referred to as the natural affection, friendliness and interdependence of the usual marital relationship;

(b) in keeping with the routine established related to Mrs. Brennan, including particularly her sleeping regime, although Mr. Brennan was in the home in the presence of his wife for much of such time, he was not providing services which are compensable at law. In this regard, the defendants submit the actual time Mr. Brennan might have spent actually assisting his wife, would be in the range of twenty-five percent;

(c) with regard to the amount in relation to the hourly rate to be applied, the defendants submit it should be based upon what the home care attendants were actually paid which is "about $10 to $11 per hour";

(d) while Mrs. Brennan's Parkinson's Disease has not materially progressed up to this point in time, even before her involvement in the motor vehicle accident, Mr. Brennan was assisting his wife and therefore her Parkinson's Disease should be applied as a negative contingency.

[103] In keeping with the evidence at trial, I find that during this period Mr. Brennan performed numerous services that can properly be said to be nursing or attendant care services necessary for the care of Mrs. Brennan. Further, I find these services were substantially over and above what would be expected from the marital relationship.

[104] I do not consider it necessary to review the nature

of these services rendered, most of which, including turning, positioning, bathing, are found in Mr. Brennan's testimony, which I accept without reservation, and in the reports of doctors attending Mrs. Brennan.

[105] In my view, it is taking this claim in a too narrow perspective to attempt to limit it to the actual time Mr. Brennan spent assisting his wife, such as the twenty-five percent range suggested by the defendants. There are times when he rendered a service by being there ensuring his wife's safety which I consider would be compensable within the criteria for such compensation.

[106] I accept, however, that part of the defendants' submission to the effect there were times, having regard to Mrs. Brennan's established regime, when Mr. Brennan was not providing services in the form of actual care or otherwise, or alternatively, when what services he did perform, did not go beyond the normal duties flowing from a husband/wife relationship and are therefore not compensable.

[107] In relation to this claim, I do not consider the evidence taken as a whole supports the defendants position that before the motor vehicle accident, because of the onset of Parkinson's Disease, Mr. Brennan was already assisting his wife in the performance of services such as to allow the application of a negative contingency.

[108] Doing the best I can with the evidence, I find that a fair amount for the services provided during this time to be seventy percent of the hours claimed at a rate of approximately $12 per hour, being the sum of $57,892.80.

[109] I turn next to the future claim.

[110] In relation to the future claim, the assumption is made that Mr. Brennan will be required from time-to-time to provide some assistance in the form of care to either his wife or an attendant health care worker for one hour per day at a rate of $16 per hour for the remainder of her life expectancy, assuming that to be approximately 19 years, with a calculation of present value based upon Mr. Carson's report.

[111] I do not consider it necessary to review in detail the objections of the defendants to the claim as presented. I consider it sufficient to say they object submitting such claim is inconsistent with the submissions related to Mrs. Brennan requiring 24 hour care and that any contribution Mr. Brennan may make should not be factored into the future attendant care award.

[112] While I can understand that in the foreseeable future, Mr. Brennan may, voluntarily or otherwise, render a service related to the care of Mrs. Brennan which might meet the criteria of a compensable claim, I do not consider it appropriate to attempt to quantify such a claim, either as has been done or otherwise, for a number of reasons.

[113] First, in keeping with the model of care I consider to be appropriate in the circumstances of the case, it is hoped and expected Mr. Brennan will be relieved from any sense of obligation to provide care. I can appreciate, however, in the context of a marital relationship, he may wish or choose to provide, or be a participant in care, of his wife from time-to-time.

[114] Second, while the evidence, here expert opinion, cannot be particularly precise as to the progression of Mrs. Brennan's Parkinson's Disease and her need for assistance, commonly provided by a spouse, at a later time, I find some allowance for a negative contingency should be applied.

[115] I do consider it to be appropriate in the circumstances of this case to make some allowance for a contribution to the future care of Mrs. Brennan which is compensable. I consider such allowance should be in the range of approximately $20,000.

[116] In summary, I award the amounts of $57,892.50 and $20,000 to the plaintiff Mrs. Brennan impressed with a trust for the plaintiff Mr. Brennan.

VI. LIFE EXPECTANCY

[117] This was the second issue occupying a substantial amount of the time at trial, including as it did, consideration of numerous scientific studies containing statistical analyses, and the expert opinions of witnesses called on both sides.

[118] The issue is made more complex because Mrs. Brennan was diagnosed as suffering from Parkinson's Disease in February 1995.

[119] I refer first to the Parkinson's Disease factor in its relationship to this issue.

[120] It is common ground there are no studies in the literature dealing with the risk of death of persons suffering from both Parkinson's Disease and quadriplegia.

[121] In relation to this factor, I received the expert opinions of three eminently qualified medical specialists who have made the study, treatment and progression of the disease, their life's work. I refer to Dr. Rajput, Dr. Guttman, and Dr. Calne. I comment in passing that Dr. Rally also offered an opinion.

[122] For reasons which I will comment on later, I prefer and accept the opinions of Dr. Rajput and Dr. Guttman over those given by Dr. Calne and Dr. Rally.

[123] In general terms, Dr. Rajput, with whom Dr. Guttman agrees, says for the purpose of considering life expectancy, Mrs. Brennan's Parkinson's Disease is a "non-issue". He says

while the Parkinson's Disease is there, it is in the background and is "overridden" by the consequences of her spinal cord injury at this level.

[124] In particular, Dr. Rajput and Dr. Guttman consider what is relevant and material in this perspective, inter alia, are the following:

(a) she was diagnosed with a mild form of Parkinson's Disease (there are more serious forms);

(b) she has a relatively young onset disease;

(c) she had and has no dementia;

(d) in the course of treatment, (including by Dr. Guttman), her symptoms did not suggest the disease was progressing rapidly;

(e) the introduction of levodopa (a medication) and therapy available today, has materially affected the "staging" intervals of the progress of the disease;

(f) in the final stages, probably in her early 80s, while she may require some assistance around the home, institutionalization is not necessary in the majority of cases, and it would not necessarily require 24 hour care.

[125] The defendants submit that in keeping with Dr. Rally's comments related to Mrs. Brennan having a weak cough and some difficulty swallowing, she has thereby been put at increased risk related to the incidence of pneumonia. In this perspective, there was reference to Mrs. Brennan having some difficulty swallowing before involvement in the motor vehicle accident.

[126] The expert evidence generally is to the effect a difficulty swallowing can be a significant symptom of the disease. However, if it is related to the disease, it would be expected to progress and be evident to those entrusted with her care. Such was not the case.

[127] I find these latter submissions more relevant to the level of care than to life expectancy which I have taken into consideration in my decision on this issue.

[128] I turn next to the opinions of Dr. Calne.

[129] Counsel for the plaintiffs submits the process leading up to his giving evidence is relevant and material. The attack upon Dr. Calne commences with the submission he provided an ill-considered one page opinion in 1997 which he has tried to "cover" by the submission of a second report purporting to justify a difference of opinion on the basis of four highly technical points "cobbled together at the last minute".

[130] In the course of cross-examination at trial, Dr. Calne agreed that his initial opinion be disregarded and there was delay in the submission of what is referred to as his second opinion. Further, he agreed the additional material with which he was provided in the interim caused him to change his views.

[131] In the result, Dr. Calne has moved his opinion closer to that of Dr. Rajput and Dr. Guttman but postulates four points which he maintains supports his views and the present differences between them.

[132] I do not propose to review at length the four points of difference. In general terms, I will refer to them as:

(a) tremor as a factor;

(b) early development of dyskinesia (involuntary movement);

(c) wearing off or on/off reaction referred to by Dr. Guttman as response fluctuations and including hallucination;

(d) difficulty swallowing.

[133] In my view, the testimony of Dr. Rajput and Dr. Guttman in rebuttal, responded to the four points, and answered them. Dr. Guttman has a particular advantage in that for some appreciable time he was involved in the care and treatment of Mrs. Brennan with particular regard to, at any early stage, her medication.

[134] The testimony of both Dr. Rajput and Dr. Guttman answered from both a pragmatic and statistical basis, the point of tremor as a factor.

[135] Dr. Guttman described the dyskinesia which developed early in the history of the illness as being a side effect of levodopa in the form of the sinamet which she was receiving at that time together with certain other medications. Dr. Guttman described Mrs. Brennan as being "over medicated at first" when he was first involved in her care. The over medication problem was resolved and the dyskinesia disappeared.

[136] Dr. Guttman responded to the wearing off on/off reactions which in his terminology are better described as response fluctuations and the hallucinatory episodes recorded as not being related to her Parkinson's Disease. In the course of her treatment, Mrs. Brennan was administered a number of medications, including morphine, which have as side effects, hallucinations.

[137] Finally, with regard to the swallowing difficulty which has also been commented upon by Dr. Rally, I consider it useful to refer to Dr. Guttman's testimony:

Q What is your comment on that doctor?

A I did not have any record of her having swallowing problems when I saw her before the accident. This would be extremely unusual and would have sent out red flags or suggest to me that something else was going on. Typically, Parkinson's related swallowing problems are in the last few years of life and are very unusual earlier than that. So, I agree, if swallowing was an issue, which I do not believe it was, that could have had a prognostic factor, but I do not believe it was in this woman.

[138] In the result, in the circumstances here, I prefer the expert opinions of Dr. Rajput and Dr. Guttman over that of Dr. Calne and the observations of Dr. Rally with regard to the effect, if any, of the form of Parkinson's Disease from which Mrs. Brennan suffers to her life expectancy.

[139] The expert opinion of Dr. Rajput and Dr. Guttman, which I accept and give weight, supports Mrs. Brennan, notwithstanding her form of Parkinson's Disease, having close to a normal life expectancy. There will have to be some reduction in that life expectancy attributable to her Parkinson's Disease but it will be minimal.

[140] I turn next to the quadriplegia factor in its relationship to this issue.

[141] In relation to this factor I received the expert opinions of three medical specialists. I refer to Dr. Anderson, Dr. Rally and Dr. Dornan. In my view, Dr. Geisler, while not called specifically to consider life expectancy in relation to spinal cord injury, gave testimony bearing upon this factor.

[142] For reasons which I will comment upon later, I do not find Dr. Dornan's opinions to be of assistance, because of a misapprehension of a fundamental nature on his part, related to the nature of the injury suffered by Mrs. Brennan.

[143] The opinions of Dr. Anderson are reflected, in part, in the claims advanced for future care referred to, supra, which are based upon Mrs. Brennan having a life expectancy of either 17.7 or 19.0 years from the date of trial.

[144] The opinion of Dr. Rally, taking the Parkinson's Disease factor into consideration, is essentially that Mrs. Brennan has a life expectancy of approximately ten years from the date of trial.

[145] In relation to this subject generally, there are two studies which have been utilized to varying degrees by experts assessing life expectancy in relation to persons suffering from

spinal cord injury. As of 1998, there is a third study.

[146] In chronological order, they are:

1. Survival in Traumatic Spinal Cord Injury: W.O. Geisler & Associates, 1983 - 1,510 Persons;

2. Prognostic Factors for Twelve Year Survival After Spinal Cord Injury: DeVivo & Associates, 1992 - 9,135 Persons;

3. Long Term Survival in Spinal Cord Injury: A 50 Year Investigation: H.L. Frankel & Associates, 1998 - 3,179 Persons.

[147] The studies were referred to during the course of this trial as Geisler, DeVivo and Frankel.

[148] While these studies are part of the medical literature and are apparently used as such by interested parties, I conclude from consideration of the studies, their limited use by the experts in this case, reservations the authors have with regard to certain of their conclusions, the contents of the studies, particularly DeVivo and Frankel, must be used with great care.

[149] In relation to the Geisler study, because of its age, the study cannot reflect upon the improvements in the care and treatment of spinal cord injury patients since that time. Indeed, there is some evidence to indicate that Dr. Geisler and his colleagues have continued their research and that an updated form of such research will shortly be available.

[150] In relation to the DeVivo study, the experts were understandably, in my opinion, selective in what information and conclusions were relied upon for use by them respectively in the submission of their opinions.

[151] The DeVivo study concludes with a statement which I initially found difficult to understand and, thereafter, to reconcile. It is a statement at p.161 of the study, in reference to a "mean survival time" for a group average of 62 years of age, suggesting a relatively substantial reduction in life expectancy.

[152] It was Dr. Anderson's opinion the statement is not correct. Dr. Rally made no reference to it. I infer from that, he did not consider it appropriate in the sense of sufficiently accurate, to rely upon such a statement.

[153] In relation to the Frankel study, the authors, after commenting that caution should be exercised in interpreting the predicted life expectancies, since they are based solely on 1992 mortality data and do not incorporate the possibility of current and future medical advances that would improve the survival of individuals with spinal cord injury, make this interesting statement:

Finally, the lack of differences in mortality rates between individuals with C1-4 tetraplegia and those with C5-8 tetraplegia, are inconsistent with clinical experience. Further analysis examining the effect of different neurologic classification schemes for mortality risk, analysis appears warranted. In fact, the authors have conducted additional research to address this issue.

[emphasis mine]

[154] Where this statement refers to "tetraplegia" should be read "quadriplegia". The importance of this statement should be taken into consideration here because, among other factors, the level of Mrs. Brennan's spinal lesion falls within the second group or cohort.

[155] In my view, the difficulties presented when using such studies, include, of necessity, the authors placing the subjects in groups (cohorts) which are at times not segregated by gender and in age groups which are not always the same. The difficulty when contemplating their use in a case such as this, which in my view is most significant, is that there does not appear to be sufficient differentiation between the upper lesion quadriplegics which tends to distort average figures.

[156] Finally, as a general observation, the studies do not and cannot it seems to me, take into consideration the level and quantity of care in a given case, including the preference of the subject for such care. In this case, the experts who gave opinions related to the life expectancy of Mrs. Brennan, did not see her, and more importantly, did not, in a specific sense, refer to the level and quantity of her care in a hypothetical sense or otherwise.

[157] I turn next to the opinions of Dr. Anderson and Dr. Rally.

[158] Dr. Anderson was instructed not to include the Parkinson's Disease factor in submitting his opinion. Additionally, he did not take into consideration that Mrs. Brennan was a non-smoker and that she had considerable sensory sparing.

[159] Dr. Rally took into consideration the Parkinson's Disease factor in submitting his opinion. In the result, however, he concluded the Parkinson's Disease played only a slight role and caused him to increase a mortality rate of 6.5 times from the DeVivo study by .5 to a total rate of 7.

[160] Mrs. Brennan is an incomplete quadriplegic at C6-7. There is an issue as to the extent of the incompleteness. This became relevant in relation to the issue of life expectancy in the manner in which the experts used statistics. For example, Dr. Anderson, after describing her by definition as incomplete,

goes on to say he treated her as though she was complete because in the use of the statistics available, "it makes the arithmetic, I think, more reliable and so forth".

[161] Dr. Rally agrees Mrs. Brennan is by definition incomplete. Indeed, in his report dated March 13, 1998 at p.6, he states:

I do think that Dr. Dornan is incorrect in stating that Mrs. Brennan's lesion is complete, that is, Frankel Grade A. The consensus of opinion would appear that there is some sensory sparing and, if so, the correct classification would be Frankel (or Asia) Grade B.

[162] This latter classification is in relation to an incomplete quadriplegic. In the same report, Dr. Rally goes on to state that because he views her sensory impairment as being very marked, it is his opinion her life expectancy is similar to that of Frankel Group A - a complete quadriplegic. When this subject was pursued in the course of submissions, Mr. Laxton directed my attention to the testimony of Dr. Anderson, supplementing what he had said in his reports in relation to sensory sparing. I refer to Dr. Anderson's testimony at trial:

Q Whatever sensory sparing is there, isn't going to assist her in terms of life expectancy?

A Well, yes, in this case, my instinct was that the presence of sensation was not going to assist since she had in fact already experienced a couple of pressure sores, but I understand since then she has not experienced any more, so maybe I was being a little over pessimistic about that.

[163] I also consider it appropriate to keep in mind that when Dr. Anderson prepared his first report, the medical information he had available at that time was that of the report of Dr. Schweigel and potentially hospital records related to her initial hospitalization in Vancouver immediately after the accident.

[164] In coming to my conclusion with regard to the life expectancy of Mrs. Brennan in the circumstances here, I am unable to accept without reservation the opinions of either Dr. Rally or Dr. Anderson.

[165] With regard to Dr. Rally's opinions, I have the following specific reservations:

(a) the mortality rate he has extracted from the DeVivo study (Table 6) upon which he has based his opinion, adding .5 for the Parkinson's factor, is 6.5, which relates to complete quadriplegia which, in my view,

is too pessimistic a basis upon which to base such a position. Further, this mortality ratio includes the whole group from C1 to C8 and does not differentiate as to gender. The importance of inclusion of the C1-4 cohort cannot be underestimated;

(b) Dr. Rally has underestimated the sensory sparing of Mrs. Brennan and in that sense the true state of the incompleteness of her quadriplegia;

(c) Dr. Rally is not aware of the level and quantity of care now ordered, nor has he contemplated such a level hypothetically in assessing, for example, the observation and attention to problems which may arise and the manner in which they are dealt with in relation to such a standard of care.

[166] In addition to my specific reservations, I have as well, those commented upon, supra, with regard to the contents particularly of the DeVivo and Frankel studies. These reservations also are applicable to the opinions of Dr. Anderson insofar as his reliance upon contents of those studies.

[167] With regard to Dr. Anderson, I have the following specific reservations:

(a) the manner in which Dr. Anderson arrives at a mortality ratio, as low as it is, appears to be inconsistent with the tenor of any of the studies under consideration or as counsel for the defendants submitted - it is clearly not representative and is far too optimistic;

(b) the mortality rate Dr. Anderson has found appears to be inconsistent with certain aspects of the studies upon which he relies in part for his calculations.

[168] Dr. Anderson, however, appears to have given consideration to the incompleteness of Mrs. Brennan's quadriplegia more so than has Dr. Rally.

[169] Finally, I return to the fact that neither expert related their opinions to the level and quantity of care which I have found reasonable and medically justified in the circumstances of this case.

[170] While strictly speaking, Dr. Geisler's testimony at trial was primarily directed to the level and quantity of care, it touched upon life expectancy in certain material respects, notably where he stated in that perspective:

The quality of care is important ... persons who have better care, concerned care, live longer than persons who don't ... the better the quality of care, the longer they are going to live ... feelings of an individual impact upon your response to a

circumstance in life. If you are fearful, under great anxiety and worried, you can be almost arrested in your performance ... These patients are at great risk through a depression of spirit, and a depression of spirit is loss of hope and loss of hope can kill you.

[171] These opinions are from a medical expert who has watched and cared for these persons over more than a generation and who is the author in conjunction with associates of studies related to life expectancy in spinal cord injury which are recognized throughout the world medical community.

[172] I accept these opinions in this perspective and have given them great weight.

[173] In the result, upon consideration of the factors and evidence bearing upon this issue and, particularly, having regard to the standard of care I have found to be reasonable and medically justified, I find Mrs. Brennan's life expectancy to be 15 years from the date of trial.

VII. MANULIFE CLAIM

[174] The plaintiffs claim the sum of $33,345.50 paid to them or on their behalf by Manulife, pursuant to the provisions of a policy of insurance between it and the Waterloo Regional District School Board, the employer of Mr. Brennan.

[175] There is no dispute as to the amount of such benefits and that they were paid under the extended health care portion of the policy in relation to injuries suffered by the plaintiffs in the motor vehicle accident.

[176] The defendants object to the claim on two grounds:

(a) the policy is not in the nature of a private insurance policy; and,

(b) the plaintiffs have not established that a right of subrogation exists on behalf of Manulife.

[177] The defendants here seek to avoid payment of the claim which they submit would result in a double recovery on the part of the plaintiffs. They rely in substantial part on two relatively recent judgments of the Supreme Court of Canada:

- Ratych v. Bloomer (1991), 1 S.C.R. 940;
- Cunningham v. Wheeler (1993), 88 B.C.L.R. (2d) 273.

[178] The evidence at trial bearing on this question is essentially that of a local representative of Manulife, Ms. Cleve, together with an extract from the policy related to the subject of subrogation (Exhibit 23) which reads as follows:

Subrogation

If an insured person suffers personal injury or loss for which he has a right to bring action for damages against a third party, Manulife Financial shall be subrogated to the insured person's rights to recover damages to the extent that it may be obligated to pay benefits to the insured person.

Upon judgement [sic] or settlement for damages, the insured person shall reimburse Manulife Financial for benefits paid or payable. Unless notified to the contrary, the insured person's solicitor shall also represent Manulife Financial's interests in such a recovery.

[179] The testimony of Ms. Cleve is found at Volume 9 of the transcript, pages 680-687 inclusive.

[180] Ms. Cleve's evidence is to the effect that Manulife intends to subrogate if judgment is given for the amount of this claim.

[181] Canadian courts have long held that payments received for lost wages or extended medical coverage pursuant to a private insurance policy should not be deducted from the damages claim of the plaintiff. The insurance exception derives from Bradburn v. Great Western Railway Co. (1874), [1874-80] All E.R. Rep. 195 (Ex. Div.) and has recently been reaffirmed by the Supreme Court in Cunningham, supra.

[182] The plaintiff has led evidence that Mr. Brennan has paid, and continues to pay, premiums for the extended health benefits of the Manulife policy. The policy explicitly covers his spouse. In Cunningham, Mr. Justice Cory, stated at pp.286:

It is my opinion that what is required by the Ratych decision is that there be evidence adduced of some type of consideration given up by the employee in return for the benefit. The method or means of payment of the consideration is not determinative.

[183] Mr. Brennan's continuing payments constitute consideration for the benefits received. As a result, the disability payments are the result of a private insurance policy and pursuant to the insurance exemption are not deductible from any damage award.

[184] Further, if it should be necessary so to do, it is possible to dispose of this issue by reference to the right of subrogation. In Cunningham, at p.293, Mr. Justice Cory, for the majority, stated that:

Generally, subrogation has no relevance in a consideration of the deductibility of the disability benefits if they are found to be in the nature of

insurance. However, if the benefits are not "insurance" then the issue of subrogation will be determinative. If the benefits are not shown to fall within the insurance exception, then they must be deducted from the wage claim that is recovered. However, if the third party who paid the benefits has a right of subrogation then there should not be any deduction. It does not matter whether the right of subrogation is exercised or not. The exercise of the right is a matter that rests solely between the plaintiff and the third party. The failure to exercise the right cannot in any way affect the defendant's liability for damages.

[185] The contract at issue here, between Manulife and his employer, contains the following term:

Upon judgement [sic] or settlement for damages, the insured person shall reimburse Manulife Financial for benefits paid or payable.

[186] The Brennans have agreed to comply with the terms of the contract. As a result, they are obligated, under this term, to repay any benefits received. This term represents a right of subrogation for Manulife which, whether exercised or not, prevents the deduction from the damages award of the value of any benefits received by the Brennans.

[187] I award the plaintiffs the sum of $33,345.50.

VIII. TRAVEL EXPENSES

[188] Mr. Brennan claims the sum of $16,128 related to travel expenses incurred by him in visiting Mrs. Brennan four times weekly during the fourteen month period of time she was confined in the Lyndhurst Hospital from October 2, 1995 to December 20, 1996.

[189] The calculation of the expense is simply the distance travelled in kilometres by motor vehicle multiplied by a rate of 30› per kilometre. I comment in passing this rate is taken from the Rules of Court related to witness expense items.

[190] The defendants' objection to these expenses was originally twofold, being related to the number of trips weekly, and to the rate of expense.

[191] In the course of argument, the defendants withdrew their objection to the four trips per week not being reasonable. As I understood the remaining objection it is that the travel was by way of the use by Mr. Brennan of two older model motor vehicles and as such the costs incurred in their operation would in no way be represented by the rate per kilometre claimed.

[192] In my view, had Mr. Brennan chosen to visit Mrs. Brennan daily, his reasonable expenses in so doing would have been recoverable. Here the expenses relate to visiting her four days per week, are limited only to the distance travelled, at a rate per kilometre which does not include other expenses. The claim is appropriate and reasonable. I round it off at $16,000 and award this amount as special damages.

IX. MISCELLANEOUS CLAIMS

[193] There are a number of areas of future care involving expenditures of consequence which are in issue. I will now consider them essentially in the order addressed by counsel in their submissions.

A. HOME RENOVATIONS

[194] Mrs. Brennan is claiming the following additional renovations to the home:

(a)	installation of an elevator for access to the basement:	$20,000
(b)	construction of an exercise room in the basement:	$ 5,000
(c)	garage alteration to access her van without going outside:	$10,000

[195] In keeping with the recommendations of virtually all of the medical specialists and rehabilitation counsellors that exercise is desirable, I award Mrs. Brennan the amount of $5,000 to provide for the acquisition of exercise equipment. In this regard, I do not consider it necessary, as is submitted by the defendants, that a formal assessment be made to determine whether such exercise equipment in the home will help to maintain her strength.

[196] I accept that in the circumstances of this case, the exercise equipment be placed in the basement area of the plaintiffs' home. In this regard, I consider it reasonable that Mrs. Brennan be awarded the cost of construction of an exercise room in the basement at a cost of $5,000.

[197] The claim for garage alteration is not seriously questioned in the sense of necessity for access to her van. Some alteration will be required. The difficulty I have here is that there is no evidence of the actual renovation costs. In my view, $10,000 appears high for what is actually required. I award the amount of $5,000 for such alteration.

[198] I accept that access to the basement be provided by an elevator which is to be preferred for a number of reasons, not the least of which is the safety of the occupant when that person is Mrs. Brennan.

[199] I award the amount of $20,000 for installation of an

elevator. I will leave to counsel calculation of the present value of an amount appropriate to be considered for elevator maintenance.

B. TRANSPORTATION

[200] A van, duly modified, has been acquired for the plaintiffs by Unifund.

[201] I understand the issue here is when should replacement of the van, including modification costs, be made - every five years as opposed to every eight to ten years.

[202] Upon consideration of the actual and anticipated use of the present van, its cost and other relevant factors, I conclude replacement should reasonably be at eight year intervals. Further, I consider the values of $15,000 and the $17,000 for the cost of conversion and modification are in order.

C. EQUIPMENT/AIDS

[203] There has been general agreement with respect to the vast majority of these items. In the course of counsels' submissions, there were five items remaining in dispute, the nature of the dispute being whether a discount should be applied due to the ADP subsidy and whether the item is necessary at all.

[204] I have dealt with three of the five items, supra.

[205] With regard to computer and software, upon consideration of the evidence related to the purpose for acquisition of this equipment, while I can appreciate the needs and the abilities of Mrs. Brennan, it is my view, at least in substantial part, it is to make her life more bearable, more enjoyable and as such, it should be regarded as an amenity.

[206] I make no award for the acquisition of or payment for this equipment.

[207] With regard to the electric wheelchair, having regard to the evidence before the court with respect to the ADP, particularly that there is no guarantee that it will continue to be in existence in the future, I consider Wipfli relied upon by the defendants is distinguishable. I do not consider that what I am to consider as the viability of the ADP is properly comparable to free hospital care and services in this province which the Court of Appeal in Wipfli considers it is inconceivable will ever be substantially modified.

[208] Finally, I consider the comments made by Levine J. in Jacobsen at p.103 to be of assistance:

I do not consider that the principles on which Wipfli and Semenoff were decided are generally applicable to all government subsidies for health care costs. In

the absence of evidence that the subsidy provided for long term care subject to the same legislative safeguards and universality as was the case with the medical and hospital costs at issue in those cases, I am of the view the plaintiff would not be adequately compensated for the cost of his future care, if the award were reduced because a subsidy may be available.

[209] For these reasons, I decline to apply a discount to the agreed upon amount for the costs of this equipment.

D. MEDICATION

[210] The rehabilitation consultants on both sides are in agreement that medicine costs will be $3,894 per annum.

[211] The position of the defendants is that such expenses or most of the expenses will be paid on Mrs. Brennan's behalf by Manulife and after age 65, by OHIP, pursuant to the program in Ontario. The defendants refer to and rely upon Wipfli.

[212] With respect to Manulife, the plaintiffs say that since Mr. Brennan continues to pay the premiums for the policy, it is in the nature of private insurance and non-deductible and, alternatively, in any event, Manulife has a right of subrogation.

[213] With respect to OHIP, the plaintiffs submit there is no evidence before the court with respect to OHIP's plan, the extent of the coverage provided, and whether it is universally available to a person such as Mrs. Brennan. Finally, they submit a review of the applicable legislation indicates the plan may have a right of subrogation.

[214] I am not satisfied upon consideration of the evidence before the court that it would be appropriate to make either the reduction sought or any reduction of the medication costs as agreed.

E. HEAVY HOUSEKEEPING

[215] The rehabilitation counsellor retained on behalf of the plaintiffs has recommended $1,650 per annum be allowed for heavy household cleaning.

[216] The defendants' position is that amount should be reduced because, before the accident, Mrs. Brennan was having some difficulty with performing her household duties related to the onset of Parkinson's Disease, that in any event in due course she would have been limited in her abilities to perform heavy household cleaning because of the said disease. There is also submitted the fact that before involvement in this motor vehicle accident, Mrs. Brennan had been having neck and back problems for years, with a reasonable expectation those problems would continue and interfere with her ability to

perform household duties.

[217] As I understand the defendants' position, having regard to these factors, that at the very least, a substantial negative contingency should be applied to this head of damages.

[218] The plaintiffs do not agree that Mrs. Brennan was experiencing difficulty performing any housekeeping duties before involvement in the motor vehicle accident because of her Parkinson's Disease or any other physical problems. They also make reference to the evidence of Dr. Guttman and Dr. Rajput with regard to the mild nature of the Parkinson's Disease and, particularly, that it was not a rapidly progressive type.

[219] Upon consideration of the relevant factors which, in my view, have been submitted in the course of counsels' submissions, I consider it reasonable to apply some negative contingency to this head of damages and, in so doing, I would reduce the annual amount for heavy household cleaning to the sum of $1,200.

F. CRANIAL THERAPY/OT ASSESSMENT
PSYCHOTHERAPY/PSYCHIATRIC TREATMENT

[220] In relation to these heads of damages relatively substantial amounts are claimed for treatment, particularly psychotherapy.

[221] I comment in passing that to date there has been no psychotherapy or psychiatric treatment and that there is apparently a difference of opinion whether such treatment should be from a psychologist or a psychiatrist.

[222] In my view, the short answer to these claims is that I am not satisfied there has been properly established a medical basis for such treatment. In this regard, Mrs. Brennan has been seen in consultation and for treatment and in case management by a number of medical specialists, including those dealing with her Parkinson's Disease. Included in that group is Dr. Guttman.

[223] I do not understand any of them to have directly or otherwise recommended such treatment or any of it. If such treatment or any of it was necessary, I would have expected to see recommendations accordingly and that such treatment was necessary.

[224] I have had the opportunity to observe Mr. and Mrs. Brennan in the course of giving their testimony at trial. Nothing in their testimony, in my view, suggests a need for the therapy or treatment advanced in these claims.

[225] Finally, they are members of the Canadian Paraplegic Association which Association I was led to understand provides counselling.

[226] I make no allowance for the therapy and treatment

proposed.

[227] In keeping with the discussions which took place with counsel on February 18th last, the 19th consecutive day of this trial, and the undertaking I made at that time, these Reasons have been prepared under a compression of time. I have attempted, in the Reasons, to encompass all issues requiring determination. Counsel may apply to speak to any matters I may have omitted or requiring further direction.

"R.B. HARVEY J."