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2009 CanLII 5785 (ON S.C.)

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:	
JENNIFER HIBBERD	*Brian Brock Q.C.*, and *Pearl Rombis* For the Plaintiff
Plaintiff	
- and -	
WILLIAM OSLER HEALTH CENTRE AND ROBERT ALLDIS	*Simon A. Clements* and *Nyranne S. Martin* For the Defendants
Defendants	
	HEARD: June 2, 3, 4, 5, 6, 9, 10, 11, 12, 16, 17, 19 and August 1, 2008

L.A.Pattillo J.

Introduction

[1] Dr. Jennifer Hibberd is a highly regarded pediatric dental surgeon. On May 26, 2003, while in between surgical procedures, she fell and broke her left wrist in a corridor on the surgical floor of the William Osler Health Centre. The break did not require surgery to heal. Her wrist was placed in a cast for six weeks following which she underwent physiotherapy for five months.

[2] Although she was not able to perform surgery and other procedures requiring the use of her left hand during the period she had her cast and for a period of two to three months thereafter, Dr. Hibberd continued with those aspects of her practice which she could without interruption following the accident. By January 2004, she had resumed her practice full time. Although she experienced soreness in her wrist from time to time thereafter, she was able to endure it.

[3] Dr. Hibberd's practice is very successful financially. In the years before the accident, the revenues and net income from her practice increased year over year. In 2003, the year of the accident, in comparison to 2002, her revenues decreased by 1.72% and her net income decreased by 3.92%.

[4] Following the accident and her return to full practice, Dr. Hibberd's practice continued to grow financially. From 2004 through to 2006, the revenues and her net income from her practice rose significantly each year.

[5] In late 2006, Dr. Hibberd began to experience significant pain in her left wrist beyond what she had previously been experiencing. In 2007, she experienced a drop in her net income of 4.19% as compared with 2006. It was the first decrease in her net income year over year since 2003.

[6] This case raises issues relating to both liability and damages. The liability issues concern not only the defendants, but also Dr. Hibberd. The damage issues concern both non-pecuniary damages and pecuniary damages in the form of lost income prior to trial and in the future.

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Background

(1) Dr. Hibberd

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[7] Dr. Hibberd obtained her dental degree from the University of Toronto in 1982, followed by a specialty diploma in pediatric dentistry in New York City in 1984. She began working as an associate in a dentist's office in Toronto in 1984. In 1986, she started her own practice as a pediatric dentist in office premises at the William Osler Health Centre ("WOHC"). Dr. Hibberd also taught at the University of Toronto dentistry school from 1986 to 1991.

[8] Dr. Hibberd specializes in dealing with handicapped children including autistic and Down's syndrome children. Her patients range in age from approximately one week to 17 years of age. She receives referrals from many sources, including family members of past patients and more than a thousand dentists, pediatric dentists, doctors and emergency services personnel.

[9] Dr. Hibberd has a very busy practice. She sees between 4000-6000 patients a year. Each patient can involve between one and ten different dental procedures. Her working day begins at her office at 7 a.m. and normally finishes at 4:30 or 5 p.m., generally five days a week. In addition to the assessments, examinations and surgery she performs in her office, Dr. Hibberd also operates on patients in an operating room at WOHC one day a week. Because her patients are children, she also has constant interaction with the parents of her patients. Dr. Hibberd's practice is both demanding and stressful.

[10] In 2001, Dr. Hibberd hired an associate dentist, Dr. Shona Masse, to assist her in her practice.

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[11] Dr. Hibberd's offices consist of a large waiting room; five operatories; a laboratory; a private office; and a staff room. In addition to Dr. Masse, at the time of her fall, Dr. Hibberd employed a full-time and part-time hygienist, a dental assistant and two full-time receptionists.

[12] Dr. Hibberd's practice utilizes computers to manage appointments, keep track of patient flow in the office, record patient treatments and record all financial information. Computer stations are located in each of the operatories to enable Dr. Hibberd, Dr. Masse or the hygienists to enter the codes for the treatment provided to each patient immediately after the work has been done. The computer matches treatment codes with fees to generate an invoice and dental claim form, which are then provided to the patient. The computer provides daily reports detailing the work done for each patient, the individual doing it, the fees billed and the receipts collected.

[13] Dr. Hibberd is ambidextrous. Although she is left-hand dominant, as a young child, she was taught to use her right hand in her daily activities.

[14] Prior to the incident, Dr. Hibberd was in good health and had no prior problems with her left wrist. In 1991, she was diagnosed with breast cancer in her left breast. She had a lumpectomy followed by radiation and chemotherapy. She has had annual follow-ups and there has been no return of that particular cancer. In November of 2003, during a very detailed screening, a localized precancerous lesion was discovered deep within her left breast. Dr. Hibberd referred to this as a form of interductile cancer. As a result, in December 2003, a mastectomy was performed on her left breast followed in 2004 by reconstructive surgery.

[15] Dr. Hibberd is extremely dedicated to her practice. She describes herself as a perfectionist and a quick thinker who is very organized and precise.

[16] Dr. Hibberd is married to Klees van Winter and they have two children, ages eight and ten at the time of the trial.

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(2) The William Osler Health Centre

[17] WOHC is a not-for-–profit corporation. It owns and operates the facility where the incident took place (the "Hospital"). It was built in 1972 and was originally called the Etobicoke General Hospital. In 1999, its name was changed to WOHC.

[18] The surgical floor at WOHC is located on the main floor of the Hospital. It contains ten operating rooms, which are located on the west side of the building. They are bounded by corridors on the east and west sides. Operating rooms 1 to 5 are accessed from a corridor on the east side of the operating rooms, located in the interior of the main floor. Operating rooms 6 to 10 are accessed from a corridor, which runs along the western exterior wall of the building. In addition, there is a sterile corridor which runs between all of the operating rooms and provides access to each of them. The floors in the OR corridors have a smooth terrazzo surface.

(3) Robert Alldis

[19] The defendant Robert Alldis commenced employment with WOHC in September 1973, as a service assistant in the housekeeping department at the Hospital. He has remained continuously in that position ever since. His duties throughout the entire period of his employment have included cleaning the operating rooms and the surrounding corridors of the Hospital.

(4) The Fall

[20] On Monday, May 26, 2003, Dr. Hibberd was scheduled to conduct surgery on six patients in OR 6, which is located at the south west side of the surgical floor at the Hospital. Dr.

Hibberd arrived at the Hospital before 8 a.m. and changed in the nurses' locker room into surgical greens. She also put on a surgical cap over her hair, surgical booties to cover her flat-soled shoes and a mask. All of the above items were obtained from the locker room and supplied by WOHC.

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[21] Dr. Hibberd had six patients scheduled for surgery on May 26. Her first patient was scheduled to begin at 8 a.m. and the last was scheduled to end at approximately 3 p.m. Her first five appointments proceeded without incident, although Dr. Hibberd had fallen about one hour behind the schedule. Following completion of the surgery on her fifth patient at 2:34 p.m., Dr. Hibberd left OR 6 and proceeded to the parent waiting room at the north end of the surgical floor to speak with the parents of her patient about the surgery. Her sixth and last patient of the day arrived at OR 6 at 2:45 p.m.

[22] Following her discussion with the parents of patient number five, Dr. Hibberd left the parent waiting room and proceeded to return to OR 6 which, as noted, is at the south end of the floor. She walked along the OR north corridor. As she was turning the right angle corner to the OR west corridor (in the northwest corner of the floor), her legs went out from under her and she fell heavily to the ground. She put out her left arm to break her fall. Dr. Hibberd's recollection was that the fall occurred at approximately 2:35 p.m.

[23] On May 26, 2003, Mr. Alldis was working the 3 to 11 p.m. shift at WOHC. He started work at around 2:30 p.m. that day, which was the usual time he began his shift notwithstanding that he was not required to start until 3 p.m.

[24] Mr. Alldis' first task everyday, including on May 26, was to clean the hallway in the OR west corridor. The cleaning solution he used to clean the corridors was a product called Virox 5

which he mixed with water. He added six ounces of Virox 5 and approximately three gallons of water to his six-gallon wash bucket.

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[25] Mr. Alldis started mopping at the northwest corner of the corridor beside the men's change room. He proceeded south down the corridor, moving backwards. He had mopped approximately ten feet down the corridor when he said he heard Dr. Hibberd fall. He did not see the fall as he was moving a piece of equipment which was stored in the corridor in order that he could mop around it. Dr. Hibberd did not see him before she rounded the corner onto the OR west corridor.

[26] Normally Mr. Alldis used three "wet floor" signs when mopping the floor, one at the front where he commenced mopping, one in the middle by his bucket and one at the end of the hall. Although the floor dried in approximately one minute, he did not remove the signs for approximately five minutes. On the afternoon in question, he was not able to find the sign which he kept in the corridor where he started mopping, so he started mopping without it. He said that he had one sign at his bucket which was located further south, about 20 to 30 feet down the OR west corridor.

[27] Mr. Alldis estimated that about one minute had elapsed between the time when he had mopped the floor in the area where Dr. Hibberd fell and when he heard her fall. He said that the floor area where Dr. Hibberd fell was wet. Dr. Hibberd said that the surgical greens she was wearing at the time of the fall were wet on the side which was on the floor.

(5) The Injury

[28] When she fell, Dr. Hibberd hit the back of her head hard on the floor. She did not black out. When she tried to get up, she was unable to support herself with her left hand. Mr. Alldis helped her up.

[29] Dr. Hibberd went immediately to the x-ray department in WOHC, which was on the same floor. The radiologist advised her that her left wrist was broken. The surgery on her last patient was cancelled. After a short wait, she saw Dr. Robert Gordon, the orthopaedic surgeon who was on call at WOHC that day. Dr. Gordon repositioned her wrist and put it in a soft, temporary cast. Dr. Hibberd was in extreme discomfort. She returned to her office at the end of the day and, after dealing with an emergency patient who was waiting for her, she went home. She returned to the office the next day and remained in the office for the rest of the week, although she was in extreme discomfort.

[30] Dr. Hibberd remained in a cast until July 6, 2003. From July 7 to December 17, 2003, Dr. Hibberd attended 21 sessions of physiotherapy. She indicated that during this period, her wrist improved.

(6) The Impact of the Injury on Dr. Hibberd

[31] Immediately following her fall and for a week thereafter, Dr. Hibberd was in extreme discomfort. Her wrist continued to hurt, but improved during the healing process. Thereafter, she continued to suffer intermittent pain in her wrist at work.

[32] Beyond the initial pain that Dr. Hibberd experienced, the biggest impact from her injury in the months following the accident was in respect of her practice. Although she returned to work

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immediately, she was unable to perform to the level she had before the fall. When her cast was removed, it took a few months to resume her full activities at work.

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[33] When treating her patients in her office or in the Hospital, Dr. Hibberd uses her right hand for fine motor skills involving the use of instruments. Her left hand handles the gross motor movements such as holding the patient's head still while she is working.

[34] As a result of her injury, Dr. Hibberd was unable to perform any surgery during the six-week period that she was in a cast. She did, however, attend at her office every day and was able to do consultations with patients and examine patients after they had been seen by the hygienist. Once her cast was removed, she was able to perform procedures. It took a further two to three months, however, for her to be able to resume her full activities at work.

[35] By the end of 2003, however, Dr. Hibberd had returned to functioning fully in her practice as reflected in both the number of procedures she performed and the revenue her practice generated. From the end of 2003 through 2006, Dr. Hibberd continued to experience intermittent discomfort in her left wrist. She said that the pain came and went depending on the nature of her work. As a result of the pain, she said that she saw less patients and worked less hours than she had prior to injury. Notwithstanding, however, that she had intermittent pain in her wrist, she was able to accommodate it and to work through the pain in order to tend to her patients.

[36] Dr Hibberd experienced a 3.92% drop in net income from her practice in 2003 as compared to 2002. While there is no question, in my view, that a large part of the drop can be attributed to the impact of her injury on her ability to practice, it is conceded by Dr. Hibberd that a

portion of the decrease is attributable to the fact that she missed three days of work in December 2003 in order to undergo testing and treatment for cancer.

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[37] From 2004 to 2006, Dr. Hibberd suffered no income loss in her practice when compared with the prior year. Both the general revenues and her net income from her practice continued to rise in each successive year, as it had prior to 2003.

[38] In the later part of 2006, Dr Hibberd began to experience increased pain in her wrist beyond the pain she had been tolerating. She termed it “extreme”. She went to her family doctor and subsequently to medical specialists. She testified that as a result of the increased pain, her practice was affected. She had more difficulty using her left hand and wrist to stabilize her patient’s head, particularly with conscious children. She termed it “challenging”. She began having her dental assistant help her in stabilizing the patient’s head. Her assistant said that she began to assist in holding the child’s head on a more frequent basis in 2007 and by the end of 2007 and the start of 2008, it was with practically every single patient. Dr. Hibberd also said that she was required to take time off when the pain became too great at times. As a result, she was unable to adhere to a fixed schedule and saw fewer patients. She said that at the time of trial, there had been no change in her wrist.

[39] In 2007, the revenue from her practice dropped 2.87% and her net income 4.19%, when compared with 2006. There is no evidence of the financial results of her practice for the first five months of 2008, leading up to the trial.

[40] The following summarizes Dr. Hibberd’s revenue and net income from her practice, for the years 2000 to 2007. These numbers are drawn from Dr. Hibberd’s annual financial statements:

YEAR	REVENUES	% CHANGE	NET INCOME	% CHANGE
2000	$1,400,520.00		$929,638.00	
2001	$1,913,365.00	36.61%	$1,069,279.00	15.02%
2002	$2,286,311.00	19.49%	$1,384,484.00	29.48%
2003	$2,247,407.00	(-1.70%)	$1,330,126.00	(-3.93%)
2004	$2,697,061.00	20.00 %	$1,725,100.00	29.69%
2005	$2,738,578.00	1.54%	$1,760,555.00	2.06%
2006	$2,899,980.00	5.89%	$1,903,852.00	8.14%
2007	$2,816,498.00	(-2.88)	$1,823,975.00	(-4.20)

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[41] Although Dr. Hibberd experienced some personal inconvenience during the period she had her cast on and afterwards, she suffered no real disruption at home. Given her busy practice schedule, the household duties and the daily activities of the children were supervised by Mr. van Winter prior to her injury and afterwards. The family has the services of a full-time housekeeper who also did the cooking, a nanny, and employed a company to look after outside maintenance. Beyond some difficulty doing minor tasks around the house such as cutting bread or cheese or opening jars or bottles which had tight lids, she did not testify that her injury has caused her any significant inconvenience at home.

[42] Prior to the accident, Dr. Hibberd's recreational activities consisted mainly of occasional swimming, tennis games and working out in the gym. During the period she had her cast on and for a while thereafter, she was unable to engage in some of these activities. Subsequent to 2003, however, Dr. Hibberd has been able to continue all of the recreational activities which she enjoyed pre-accident.

[43] WOHC conducted video surveillance of Dr. Hibberd in May and November 2007, and again in April 2008. The videos show Dr. Hibberd meeting a friend for lunch in downtown Toronto, shopping, assisting in her children's tennis lesson, playing tennis, attending a meeting in downtown Toronto and taking her children and their friends to a movie. The videos show Dr. Hibberd enjoying a normal, active lifestyle with unrestricted use of her left hand. She uses her left hand without restriction and without any indication of difficulty in opening a heavy door; in carrying children's downhill skis with bindings; in lifting a tennis tube with a number of tennis balls in it; in holding a tennis racquet flat with a number of tennis balls sitting on the strings; and in picking up and carrying, at one time, in her left hand two to three tennis balls. She plays tennis right-handed and is seen hitting a two-hand backhand during a tennis game.

The Medical Evidence

[44] A CT scan of Dr. Hibberd's wrist on May 29 revealed a comminuted intra-articular fracture of the distal radius. There was no evidence of fracture of the carpal bones. The alignment was noted as satisfactory. Further x-rays of the left wrist were taken on June 2 and 6, 2003. On June 2, she received a permanent cast. The cast was removed on July 7, 2003. An x-ray at that time showed the position and alignment to be maintained and the healing to be progressing well. She was seen that day by Dr. Cartan, another orthopaedic surgeon at WOHC.

(i) Dr. Steven Cartan

[45] On July 7, 2003, Dr. Cartan noted that her radiographs demonstrated fracture union. Although there was no swelling about the wrist whatsoever, she was quite stiff. He gave Dr. Hibberd a referral for physiotherapy.

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[46] On July 16, 2004, Dr. Cartan issued a report to Dr. Hibberd's solicitors. He stated that he had reviewed both the x-ray taken at the time of the break and the CT scan taken on May 29, 2003. He noted that they demonstrated a comminuted left Colles' fracture of the wrist. Dr. Hibberd described to him some continuing stiffness and ache in her left wrist with repetitive use and infrequent episodes of subjective decrease in sensation. She also indicated that she had some reduction in her grip strength. Dr. Hibberd advised him that following her cast removal, she was able to resume performing surgery, although the number of cases she was able to perform was "markedly restricted" for two to three months. Although she had previously complained of tingling in the palm of her left hand which was painful to the touch, an earlier study demonstrated no evidence of carpal tunnel syndrome.

[47] Dr. Cartan felt that Dr. Hibberd's symptoms were completely in keeping with the injuries sustained. He noted that in his view, given the nature of the fracture suffered, there was a "somewhat remote" possibility of the development of post-traumatic degenerative arthritis as a result of the injury. He further noted that when he last examined her, she had satisfactory range of motion in her wrist, lacking only the final five degrees of wrist extension which likely accounted for the reduction in grip strength. He concluded that the overall result was, in his view, satisfactory.

[48] In a subsequent letter dated December 6, 2004, Dr. Cartan clarified his statement concerning the restriction in Dr. Hibberd's wrist extension and corresponding loss of grip strength by indicating that in his opinion, they were of a permanent nature.

[49] In 2006, Dr. Hibberd noticed what she termed as a radical change in her wrist. She said she started getting shooting pains in her left arm and wrist. She heard a clicking sound in her wrist. She described the pain as so debilitating that at times she had to stop what she was doing. On

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December 4, 2006, she went to see Dr. Brail, her family doctor who referred her to Dr. Cartan. Dr. Hibberd saw Dr. Cartan on December 18, 2006. Dr. Cartan referred her to Dr. Stewart Wright. She also saw Dr. James Mahoney at the request of her solicitors.

(i) Dr. James Mahoney

[50] Dr. Mahoney is a plastic surgeon who practices at St. Michael's Hospital and is a specialist in hands and wrists. Dr. Mahoney received his medical degree from McMaster University in 1974. In 1980, he became a Fellow of the Royal College of Surgeons in Canada as a specialist in plastic surgery. He joined the staff at St. Michael's Hospital in Toronto in 1981 and from 1986 to the present has been chief of the division of plastic surgery at the hospital. In 1992, Dr. Mahoney became a member of the American Society for Surgery of the Hand, an organization dedicated to the treatment of both the hand and wrist. He runs the Hand Clinic at St. Mike's. He is generally involved in surgery of the hand as well as most soft tissue-related injuries of the arm. Dr. Mahoney has written many articles and spent a lot of time looking at and dealing with carpal tunnel syndrome, which he described as involving increased pressure on the median nerve and tendons in an envelope on the palm side of the wrist in the area of the carpal bones, which in turn causes tingling and numbness in the thumb, index and long fingers of the hand.

[51] Dr. Mahoney initially reviewed Dr. Hibberd's records from William Osler Health Center and the two reports prepared by Dr. Cartan dated July 16 and December 6, 2004. Based on his review of the material provided, Dr. Mahoney prepared a report dated August 25, 2005. It was his opinion that Dr. Hibberd had suffered a fracture to her disco radius which had healed with some functional limitations consisting of some restriction in the range of motion and grip strength. It was also his opinion that Dr. Hibberd's loss of grip strength as noted by Dr. Cartan would be permanent.

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As a result of the injury and her symptoms, it was his opinion that Dr. Hibberd had a higher risk of developing both arthritis and carpal tunnel syndrome in her wrist in the future. He was unable to say what the risk was that she would develop osteoarthritis. In respect of carpal tunnel syndrome, he viewed the risk of Dr. Hibberd developing it to be greater than that of the general female population. Dr. Mahoney's opinion based on his experience and a review of the literature was that the risk of Dr. Hibberd developing carpal tunnel syndrome was 10%.

[52] Dr. Mahoney first saw Dr. Hibberd on January 25, 2006. On examining her, he noted decreased grip strength in her left wrist and limitation in range of motion of 20-30% in all dimensions (as compared with the right). He was able to diagnose carpal tunnel syndrome but stated that it was stable (no symptoms) and therefore he felt it was not clinically significant at the time he saw her.

[53] Dr. Mahoney saw Dr. Hibberd again on March 28, 2007. He noted a significant change in Dr. Hibberd's left wrist from the time he last saw her. She complained of increased pain in the back of her left wrist. She told him she was having difficulty performing some of the activities of daily living and was also having some symptoms at work. There was no swelling, but there was tenderness on the back of her left wrist. There was a significant loss of range of motion in her left wrist, as well as a decrease in grip strength from the grip strength he measured in January 2006. He suspected there was tendonitis or inflammation of a tendon or tendons in her wrist and ordered an MRI to confirm his diagnosis. The MRI showed a marked thickening and abnormal signal of the extensor carpi radialis longus tendon (the "ECRL tendon") in the second extensor compartment for a distance of approximately 3.5 cm from the distal radius to the mid-carpus. That tendon appeared macerated or shredded and was abnormal. The adjacent extensor carpi radialis brevis tendon (in the

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same compartment) appeared normal. While the MRI confirmed Dr. Mahoney's initial diagnosis that Dr. Hibberd had tendonitis, he said he was surprised to find that it also confirmed tendinosis, which is an abnormality within the tendon.

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[54] It was Dr. Mahoney's opinion that the change in Dr. Hibberd's ECRL tendon as shown by the MRI was consistent with the pain she was experiencing in her left wrist, and that it was directly related to the accident. The ECRL tendon overlies the area of the fracture. As a result of abnormalities in the bone caused by the healing of the fracture, the ECRL was rubbing against the bone causing the damage to the tendon and the pain. In Dr. Mahoney's view, the damaged tendon would cause ongoing pain and limitation of motion in Dr. Hibberd's left wrist.

[55] Dr. Mahoney stated that the treatment for Dr. Hibberd's problem is to limit the use of the wrist through rest or modification of aggravating activities. Dr. Mahoney also testified that in his opinion, it was "quite likely" that at some point in the future, Dr. Hibberd could rupture or break her left ECRL tendon. He classified the risk as "relatively high". Such an event would result in further loss of grip strength as well as a loss of power. In Dr. Mahoney's opinion, the only treatment is surgery. While the prognosis with surgery is better than if it is not done, it was also his opinion that even with surgery, Dr. Hibberd's wrist would not return to the state it was in prior to the rupture.

[56] Dr. Mahoney agreed that there was no evidence as a result of his examinations that the carpal tunnel syndrome which he had diagnosed was either symptomatic or affecting Dr. Hibberd in her ability to practice dentistry. Further, if the carpal tunnel syndrome became symptomatic, the surgery required to alleviate the pain is relatively straightforward day surgery involving, at the most, six weeks of recuperation, with a 90% success rate. Finally, he stated that when he examined her,

there was no evidence that Dr. Hibberd had developed or was developing osteoarthritis in her left wrist.

(ii) Dr. Stewart Wright

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[57] Dr. Wright is an orthopaedic surgeon with a subspecialty in upper extremity surgery involving the wrist and hand. Dr. Wright obtained his medical degree from Memorial University in Newfoundland in 1975. He did his residency training in orthopaedic surgery in Toronto at various hospitals and post-residency fellowships in hand surgery at Sunnybrook Health Science Centre in Toronto and at Raymond M. Curtis Hand Centre in Baltimore. He became a Fellow of the Royal College of Physicians and Surgeons of Canada in 1981. He has published numerous articles dealing with injuries associated with the wrist and hand. Dr. Wright has been on the staff of Sunnybrook Health Sciences Centre, Holland Orthopaedic and Arthritic Centre (formerly the Orthopaedic Hospital) continuously since 1982.

[58] Dr. Wright saw Dr. Hibberd on July 23, 2007. He confirmed from the prior x-rays he reviewed that Dr. Hibberd had suffered a fracture at the end of her left radius and into her left wrist joint. The fracture was at the distal or terminal end of the radius and went across the end of the radius and also into the wrist joint. He further confirmed that the force of the fall caused soft tissue injury to the area. In his experience, both the care provided and the time involved for Dr. Hibberd's treatment – six weeks in a cast, followed by five months of physiotherapy, was typical and appropriate for someone with her injury.

[59] Dr. Hibberd told Dr. Wright that her biggest concern was the weakness in her dominant left upper-extremity insofar as it affected her work. She told him that she had a daily ache in her

wrist, which he described as mild. She also advised him that the pain could become as severe as 6 to 7 out of 10.

[60] On examination, Dr. Wright found that while Dr. Hibberd had a significant loss of range of motion in her left wrist, in his opinion, while it was not the same as it was before the fracture, it was still a very functional range. He noted some inflammation of the lining of the tendons that bend the fingers down in both index fingers as well as along the palm surface of the left thumb. He was unable to find anything significant in terms of arthritis in the joint. He was also unable to find any symptoms of carpal tunnel syndrome.

[61] Following tests, Dr. Wright determined that Dr. Hibberd had a significant decrease in grip strength and a reduction in “pinch strength” in her left wrist. He said that the fracture was not a classic Colles’ fracture, as described by Dr. Cartan, because it went into the wrist joint as well. He described the fracture as a comminuted fracture (many pieces), which was not particularly displaced, which is to say that there was not much movement of the pieces away from each other.

[62] Dr. Wright confirmed based on his review of the MRI done in May 2007, that Dr. Hibberd had an inflation of the ECRL tendon on the thumb side of the back of her left wrist. In his opinion, it was caused by an irritation of the tendon over the top of the radius where there is a bony prominence that resulted from the healing of her fracture.

[63] It was Dr. Wright’s opinion that Dr. Hibberd had a healed wrist fracture. She had lost some range of motion in her wrist, probably due to the soft tissues around her wrist not getting fully stretched out following the break. She had a problem on the back of the wrist in terms of the ECRL tendon and diminished his grip and pinch strength.

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[64] Dr. Wright was of the opinion that the continual ache and intermittent pain which Dr. Hibberd described with her wrist would continue. With respect to the abnormal finding in the ECRL tendon in the back of her wrist, he stated that in his opinion, it was possible that tendon could break in time. There was no way of knowing whether it will rupture or not. If that occurred, it would likely result in immediate pain and swelling, which would cause soreness for four to six weeks and possibly some further diminution in grip strength and range of motion. He spoke of two treatment options. If after six weeks the pain was gone and the wrist was functional, it would be treated conservatively. If, however, the pain continued or there was a loss of strength, it is likely that surgery would be required to repair the tendon and that Dr. Hibberd would have to spend another four to six weeks in a cast, followed by physiotherapy. It would generally take approximately six months to get the range and strength back to where it was before the injury. Further, in his experience, the outcome of such surgery is generally very satisfactory.

[65] On the possibility of arthritis developing in the future, Dr. Wright's opinion was that while Dr. Hibberd had not yet developed significant arthritic changes in her wrist, because the fracture was in the wrist, she had an increased risk of it occurring in the future.

[66] In relation to carpal tunnel syndrome, although Dr. Wright was aware from the prior medical reports that Dr. Hibberd demonstrated those symptoms in 2003, she had not demonstrated any symptoms since and did not have any symptoms during his examination. Given the time that had elapsed since her injury, it was Dr. Wright's opinion that it was unlikely Dr. Hibberd would have a recurrence of carpal tunnel syndrome based solely on the fracture.

Liability

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[67] Dr. Hibberd submits that WOHC is liable for the injuries she suffered from her fall based on the law of occupier liability, and further, that both WOHC and Mr. Alldis, by their actions, are liable in negligence. WOHC and Mr. Alldis deny any liability to Dr. Hibberd for her fall and further submit that, if they are held liable, by her actions, Dr. Hibberd was contributorily negligent.

(a) Occupiers' Liability

[68] The common law obligations of an occupier of premises to persons who enter onto their premises have been replaced by the *Occupiers' Liability Act*, R.S.O. 1990, c. O.2 (the "Act"). The Act defines "occupier" in s. 1 to include, among other things, a person who is in physical possession of premises or who has responsibility for and control over the condition of the premises or the activities there carried on. WOHC, as the owner of the Hospital, is clearly an occupier within the meaning of the Act.

[69] The duty owed by an occupier to persons allowed onto its premises is set forth in section 3(1) of the Act, which provides:

> An occupier of premises owes a duty to take such care as in all the circumstances of the case is reasonable to see that persons entering on the premises, and the property brought on the premises by those persons are reasonably safe while on the premises.

[70] In *Waldick v. Malcolm*, [1991] 2 S.C.R. 456 (S.C.C.), Iacobucci J., on behalf of the Court, described the statutory duty of care on an occupier of premises as follows, at p. 472:

> After all, the statutory duty on occupiers is framed quite generally, as indeed it must be. That duty is to take reasonable care in the circumstances to make the premises safe. That duty does not change but the factors which are relevant to an assessment of what constitutes reasonable care will necessarily be very specific to each fact situation – thus the proviso 'such care as in all the circumstances of the case is reasonable'. [Emphasis added.]

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[71] In cases subsequent to *Waldick v. Malcolm*, *supra*, in situations where a known danger is present, the courts have held that reasonable care requires that policies and procedures be in place for inspection, maintenance, cleanliness and safety, and that these policies and procedures be followed. See: *Gardiner v. Thunder Bay Regional Hospital*, [1999] O.J. No. 833 (Gen. Div.), affirmed [2000] O.J. No. 141 (C.A.); *Fragomeni v. 1080486 Ontario Corp*., [2006] O.J. No. 1630 (Sup. Ct. J.); Linden, *Canadian Tort Law*, 8th ed. (Markham: Butterworths, 2006) at p. 755.

[72] WOHC, as an occupier, therefore had a duty to take reasonable care in the circumstances to make the Hospital and, in particular, the corridors on the surgical floor safe for all persons using them.

[73] There is no question in my view that the application of a liquid cleaning solvent to a smooth terrazzo floor in a hospital corridor which is used by surgeons and hospital staff in circumstances where the floor remains wet and slippery after application, constitutes a danger to those people who may be walking in the corridor.

[74] WOHC does not argue that the cleaning of the floor in the corridor does not constitute a danger. Rather, it submits that it had established and implemented reasonable policies and procedures for maintenance and cleaning. Further, the hospital had trained Mr. Alldis on its cleaning procedures.

[75] WOHC has approximately 100 employees engaged directly or indirectly in the cleaning of the Hospital on a daily basis and an annual cleaning budget of approximately $5-million.

[76] At the time of the accident and for sometime before, WOHC had in place specific standards and procedures in respect of the maintenance and cleaning of the Hospital. These

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procedures were contained in WOHC's Housekeeping Manual. In particular, there were specific procedures for cleaning the operating rooms both between procedures and at the end of each day. WOHC also had in place a procedure for cleaning all corridors in the hospital, regardless of where they were. The cleaning procedure for all corridors in the Hospital is very comprehensive and provides at the outset that protective equipment be worn "as required", and that "wet floor" signs be placed around the work area "as required". The procedure deals with all areas of the corridors, including walls, doors, door frames, railings, ledges, lights, vents, *etc.*, and sets out the process to be followed for each item, the frequency with which it is to be cleaned and the standard to be attained. With respect to hard-surface floors and baseboards, the procedure requires, in part, that they be dust mopped with a clean, treated mop, wet mopped as required with germicidal solution, and air dried on a daily basis.

[77] Ms Pauline Douglas, the manager of environmental services at WOHC testified that "as required" in respect of the use of "wet floor" signs meant that if a person was going to be working in an area, he or she needed to put up a floor sign. Ms. Douglas did not restrict the use of the floor signs to wet floors. She said that if a person was working in an area vacuuming or cleaning walls, he or she would still be required to use the "wet floor" signs. Specifically, she stated: "So when we do the training, we instruct them to put up a 'wet floor' sign prior to starting any work and then we collect the floor sign when the work is complete, the floor is dry, the wax is dry, whatever."

[78] In addition, WOHC had a job description in place for Mr. Alldis and others who cleaned the operating rooms and corridors in the surgical area setting out the times and duties to be undertaken. The procedure begins at 3 p.m. with the cleaning of the first available operating room,

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and continues throughout the evening until the conclusion of the shift at 11 P.M. The procedure involves, among other things, a dust mop, sweep or wet mop of the entire floor area.

[79] WOHC also does periodic training sessions with, among others, its cleaning staff, where they are instructed on various procedures including the placing of “wet floor” signs prior to starting any work. There is no record that Mr. Alldis attended any training sessions between 1996 and 2003. Mr Alldis said that he did not attend monthly housekeeping meetings at the Hospital. Notwithstanding, in the 30 years Mr. Alldis had been doing his job at the Hospital, he had never received a complaint about his work.

[80] In my view, the evidence clearly establishes that WOHC had in place a comprehensive and thorough system for maintenance and cleaning of its hospital corridors and for training its employees. This system was, in my view, reasonable in the circumstances. The problem for WOHC is that on the day in question, it was not being followed. The evidence clearly establishes that Mr. Alldis did not place the “wet floor” signs in the area where he was working at the time of Dr. Hibberd’s fall. The failure to do so was a breach of the procedure. I turn now to whether it was also a breach of the statutory duty.

[81] Despite the fact that Mr. Alldis failed to put up the “wet floor” signs, contrary to WOHC’s policy and procedure, WOHC submits that it was not in breach of its duty to take reasonable care in the circumstances. Departure from a policy is not *prima facie* evidence of negligence. A policy can, however, be used as a factor to evaluate the applicable standard of care. Any departure from a policy must be viewed in light of what was reasonable and prudent conduct in the circumstances. See: *Latin v. The Hospital For Sick Children*, [2007] O.J. No. 13 (Sup. Ct. J.) at

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paras. 60-61. WOHC submits that Mr. Alldis' conduct in not utilizing the "wet floor" signs was reasonable and prudent in the circumstances.

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[82] In support of its submission, WOHC points to the fact that the OR west corridor was sparsely travelled at the time of day when the accident took place; that Mr. Alldis was using a fast-drying cleaning solution, which dried within one to two minutes of application; that he had mopped the corridor at or about that time for 30 years without incident; and that WOHC had in place a mirror in the ceiling at the corner of the corridor to allow people to see around the corner prior to reaching the corridor.

[83] Dr. Hibberd, who used the OR west corridor often to travel to her operating room, testified that, while it was not crowded, it was used by surgeons, other operating personnel and patients. Ms. Alida van Vliet, the manager of the operating rooms at the time, said that at 2:24 p.m., there normally would have been no traffic in the corridor. I do not accept her evidence in this regard based on the very fact that Dr. Hibberd was using the corridor to return to her operating room, as she had done many times.

[84] There were only three routes back to OR 6 from the parent waiting room – the OR east corridor which is the longest route and which Dr. Hibberd said was crowded with people and equipment; the sterile corridor which could only be accessed through three adjoining rooms which comprised the nurses' lounge and locker room; and the OR west corridor. On the evidence, the OR west corridor is both the most direct and quickest route to take to get to OR 6. It was the logical route for Dr. Hibberd to take.

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[85] Even if, as WOHC submits, the OR west corridor was sparsely used, the fact that operations were still going on in OR 6 and OR 10, two operating rooms which access the corridor, meant that it was conceivable that someone could be using the corridor at that time of day. It was therefore foreseeable, in my view, until all operations had been completed in ORs 6 to 10 that a surgeon, an anaesthesiologist, a nurse or other operating room personnel would be using the OR west corridor.

[86] Further, notwithstanding that Mr. Alldis was using a fast-drying solution, the evidence is that there is a period of between one and two minutes after the cleaning solution is applied, when the floor remains wet and, as Mr. Alldis described, “slippery”, depending on one’s footwear. It is precisely for this one- to two-minute period when the floor is wet that “wet floor” signs are required.

[87] The mirror on the ceiling is located in the northwest corner of the corridor and is convex. Its function is to alert a person approaching the corner to any patients or equipment which may be around the corner in the corridor and which cannot be seen because of the right angle corner. No one asked Dr. Hibberd if she looked in the mirror prior to her fall. Even if she had, I am not satisfied based on Mr. Alldis’ evidence that Dr. Hibberd would have seen anything that would have alerted her to the danger of the wet floor at the corner.

[88] Mr. Alldis said that when he heard Dr. Hibberd fall, he was approximately ten feet down the corridor moving a piece of equipment. His cleaning bucket was approximately 20 to 30 feet down the corridor. Mr. Alldis moving equipment would not have been unusual. The corridor was a storage area for a lot of unused equipment. Given the distance, I doubt Dr. Hibberd could have seen the cleaning bucket in the mirror with the “wet floor” sign beside it further down the corridor. Even if she had seen the bucket, in the absence of a “wet floor” sign at the corner, she would have

assumed that the danger of the wet floor was further along the corridor, at the bucket, where the sign was, and not at the corner.

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[89] I am also of the view that the presence of the mirror would not have alerted a person approaching to the danger of a wet floor at the corner. In fact, it could do just the opposite. In order to look in the mirror, which is on the ceiling, Dr. Hibberd would have had to look up, away from the floor. By so doing, she would have greatly reduced her chances of seeing the wet floor ahead of her.

[90] In my view, therefore, the circumstances to which WOHC points do not establish that Mr. Alldis' breach of the floor cleaning procedure was reasonable and prudent in the circumstances.

[91] The procedure established by the hospital, including the use of "wet floor" signs, is reasonable and necessary to ensure the safety of people who may be using the corridors of its surgical floor, having particular regard to the slippery nature of the solution which is used to clean the floors. In the present case, by not placing a "wet floor" sign at the northwest corner of the corridor on May 26, 2003, Mr. Alldis failed to follow that procedure. Such failure constituted, in my view, a breach by WOHC of its duty to take reasonable care to ensure that persons such as Dr. Hibberd were safe on its premises. As a result, WOHC breached its statutory duty under the Act.

(b) Negligence

[92] It was further submitted by Dr. Hibberd that Mr. Alldis was negligent in that he applied too much cleaning solution to the floor when he was mopping, making it more slippery than it would otherwise have been. In support of this submission, Dr. Hibberd relies on the fact that immediately after her fall, the surgical greens she was wearing were wet from the floor. Dr. Hibberd also relies on a conversation that took place between herself and a Ms. Claire Gorman, an operating

room nurse at WOHC who was on duty on the day of the accident. Dr. Hibberd made a note of the conversation the day after the accident.

[93] Dr. Hibberd's evidence was that she had a conversation with Ms. Gorman in the area of the OR Desk. Ms. Gorman approached her after her wrist had been x-rayed and while she was waiting to see a doctor. Ms. Gorman told Dr. Hibberd about an incident involving Mr. Alldis in the operating room. Ms. Gorman was not happy that the floor in the operating room was wet and had words with Mr. Alldis that he was using to much water. She told Dr. Hibberd that "someone could fall and break their bones if he doesn't stop using so much water".

[94] Ms. Gorman's statements to Dr. Hibberd are hearsay. Over the objections of WOHC, I admitted the evidence on the basis that it met the threshold tests of both necessity and reliability: *R. v. Khelawon*, [2006] 2 S.C.R. 787 (S.C.C.). At the time of trial, Ms. Gorman was a former employee of WOHC. Her whereabouts, however, were unknown. Further, the circumstances surrounding her statements, including when they were made and the somewhat contemporaneous recording of them by Dr. Hibberd the following day, made her statements trustworthy. Finally, there was other evidence which in my view could test the evidence.

[95] Having considered the evidence of Ms. Gorman's statements to Dr. Hibberd in relation to all the evidence, I have concluded that it should be given no weight whatsoever. When viewed in light of the evidence of Mr. Alldis and WOHC's OR schedule for the day in question, Ms. Gorman's statements, in my view, are of no assistance in determining whether Mr. Alldis was negligent. Ms. Gorman was the operating room nurse in OR 1 on May 26. The OR schedule indicates that she was engaged in surgery in OR 1 from approximately 2:15 to 3 p.m. on that day. Mr. Alldis' evidence, which is accepted by all parties, is that he began his duties that day in the OR

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west corridor, shortly after 2:30 p.m. and moments before Dr. Hibberd fell. Accordingly, Ms. Gorman's observations of Mr. Alldis' alleged improper mopping could not have taken place before Dr. Hibberd's fall. The conversation between Ms. Gorman and Dr. Hibberd took place sometime between 4 and 5 p.m., one-and-a-half to two-and-a-half hours after Dr. Hibberd's fall. It follows that Ms. Gorman's comments concerned something that happened either prior to May 26 or sometime later on May 26, after 3 p.m., and after Mr. Alldis finished cleaning the OR west corridor.

[96] Whether Ms. Gorman saw Mr. Alldis mopping with too much water in an operating room sometime before May 26 or after 3 p.m. on May 26, that evidence is of no assistance, in my view, in determining whether Mr. Alldis was applying too much cleaning solution while mopping the OR west corridor prior to when Dr. Hibberd fell on the afternoon of May 26, 2003.

[97] In my view, there is no evidence that Mr. Alldis was using too much cleaning solution on the floor of the OR west corridor on May 26, 2003. Nor am I prepared to draw such an inference from the evidence. The fact that Dr. Hibberd's surgical gown was wet after her fall indicates nothing more, in my view, than that the floor was wet at the time of her fall.

[98] In summary, it is my view that the evidence does not establish that Dr. Hibberd's fall occurred because Mr. Alldis was using too much cleaning solution. Rather, it occurred because he failed to put out the "wet floor" signs in a hallway used by surgeons and hospital staff in circumstances where the floor was wet and slippery.

(c) Contributory Negligence

[99] WOHC submits that if I find it liable in respect of Dr. Hibberd's fall, then I should also find her contributorily negligent, and accordingly responsible, in part, for any damages she suffered.

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WOHC submits that Dr. Hibberd's negligence consisted of her walking too fast, failing to keep a proper lookout, and wearing improper footwear at the time of her fall.

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[100] In support of its submission that Dr. Hibberd was walking too fast at the time of her fall, WOHC relies on the evidence of Ms. Alida van Vliet, who was the manager of the operating rooms, recovery rooms and pre-admission at WOHC at the time. Part of her duties included managing the operating rooms at the Hospital. She testified that, in order to avoid overtime costs, the operating room committee at WOHC had mandated that if a surgeon could not complete his or her last operation by 3:30 p.m., then the last operation had to be cancelled. From this rule, WOHC submits that I should infer that at the time of her fall, Dr. Hibberd was rushing back to the OR to ensure that she could finish her last operation by 3:30 p.m. I am not prepared to draw such an inference. While the OR schedule for the day indicates that Dr. Hibberd was running behind schedule, there is no evidence that she could not have completed her last operation within the required time limits. She estimated that her fall occurred at approximately 2:35 p.m. Her last patient arrived in OR 6 at 2:45 p.m. Dr. Hibberd stated that there was ample time for her to return to the OR in advance of her last patient. She said she had no concern about her last case being cancelled because the patient had already been accepted to go through to the operating room and had been placed in OR 6.

[101] In addition, Dr. Hibberd testified that after speaking with the parents of her previous patient, she walked back to OR 6. She did not say she was rushing or proceeding at an inappropriate rate of speed. She denied in cross-examination that she was traveling too quickly. I accept Dr. Hibberd's evidence on this point.

[102] WOHC further submits that while there was a mirror on the ceiling in the corner of the corridor, Dr. Hibberd failed to keep a proper lookout and failed to see the danger lurking around the

corner in the form of Mr. Alldis, his mop and cleaning bucket. As noted, Dr. Hibberd was never asked if she looked in the mirror prior to her fall. As I have already commented, based on Mr. Alldis' evidence, it is my view that even if Dr. Hibberd had looked in the mirror, what she would have seen would not have alerted her to the danger of a wet floor at the corner. I am unable to find on the evidence that Dr. Hibberd failed to keep a proper lookout.

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[103] Finally, WOHC submits that Dr. Hibberd was wearing improper footwear at the time of her fall. In order to provide a sterile environment in the surgical area, WOHC supplied sterile clothing including surgical greens, head gear, masks and booties. It was the practice of the majority of doctors, nurses and other staff who frequented the surgical floor of the Hospital to wear dedicated rubber-soled shoes that they kept in their lockers for use in the surgical area exclusively. Dr. Hibberd did not participate in that practice. She preferred to utilize the surgical booties which were supplied by WOHC to the operating room personnel. The booties were made available by WOHC along with the other items of sterile clothing, free of charge, in the change rooms for the doctors and nurses.

[104] At the time of her fall, Dr. Hibberd was wearing flat soled shoes over which she had placed the green surgical booties.

[105] WOHC relies on the evidence of Jeff Archbold, a forensic engineer, who tested the slip resistance of the floor in the OR west corridor of the Hospital in the area where Dr. Hibberd fell using a machine called an English XL Tribometer. Mr. Archbold testified that, as a result of his testing, the floor, even when wet, met the ``threshold of safety`` with a co-efficient of friction rating of greater than 0.5 when a rubber soled shoe was tested on the wet floor.

[106] Over the strenuous objection of Mr. Brock, I permitted Mr. Archbold to give evidence as an expert engineer qualified to provide an opinion on the slip resistance of the floor at the Hospital where Dr. Hibberd fell. Having heard all his evidence, however, I am not prepared to accept it in respect of the tests he performed. Beyond the concerns raised about the reliability of the machine used by Mr. Archbold to conduct his testing and whether his certification from the manufacturer had expired at the time, I had fundamental concerns about the accuracy of the tests performed by him. In attempting to determine the slip resistance of the floor in a wet condition, he admitted that he did not know what the ingredients of the solution were that Mr. Alldis used on May 26, 2003 or the quantity of solution he put on the floor. Further, while he used a surgical bootie for his test, he did not replicate the bootie on a shoe similar to the one Dr. Hibberd was wearing at the time of her fall. As a result I am not prepared to rely on any of Mr. Archibald's evidence in respect of the tests he performed.

[107] Even if I accepted Mr. Archbold`s evidence, it established that, by wearing the surgical booties, a person would not slip walking in a straight line on the floor of the OR west corridor if it was wet from mopping but would have the potential to slip if they were making a sharp turn while walking, which is exactly what happened to Dr. Hibberd.

[108] Given that WOHC both supplied and permitted the use of surgical booties by the operating room personnel, Dr. Hibberd cannot be criticised for using them on the day in question. Nor was it improper for her to have the surgical booties on while walking in the OR corridors of the surgical area. At all material times, she was within the surgical area, carrying out surgical functions.

[109] I am therefore unable to find that Dr. Hibberd was negligent in any manner by wearing surgical booties over her shoes at the time of her fall.

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[110] Accordingly, WOHC has failed to establish that any of Dr. Hibberd's actions prior to her fall constituted negligence.

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Damages

(1) Pecuniary Damages

(a) Loss of Income

[111] Dr. Hibberd claims damages for loss of income arising from her injury, from May 26, 2003, to the date of trial, in the amount of $290,745.00.

[112] In addition, Dr. Hibberd claims damages for future loss of income in the amount of $114,724.00 per year. Assuming Dr. Hibberd retired at age 65, her claim for future loss of income, discounted to present value, is $1,725,453.00. If Dr. Hibberd retires one year later at 66, the present value amount of the loss alleged is $1,834,441.00.

[113] I was also provided with scenarios in which, as a result of her injury, Dr. Hibberd would be required to reduce her working capacity at age 60 but would still retire at age 65, and in which she would be forced to retire completely at age 60. The loss of future income in these scenarios, again discounted to present value, would be $5,789,637.00 and $10,414,824.00, respectively. Assuming Dr. Hibberd would have retired at 66 were it not for the injury to her wrist, the lost income using the above two scenarios would be $6,688,191.00 and $12,211,931.00 respectively.

[114] Dr. Hibberd's claim for both past and future income loss was calculated by Mr. Ian Wollach and Mr. Daniel Giovannone of the firm of Rich Rothstein LLP, chartered accountants. Mr. Wollach is a chartered accountant and is responsible for the litigation accounting practice at Rich

Rothstein. He was designated by the Canadian Institute of Chartered Accountants as a specialist in investigative and forensic accounting in 2001. He has significant experience in the preparation of damage reports dealing with economic loss. Mr. Wollach provided the calculations with respect to Dr. Hibberd's income loss and the basis of the calculations. Mr. Giovannone, who is an actuary and a Fellow of the Society of Actuaries, carried out the computer analysis of the financial and other data received from Dr. Hibberd which data was used by Mr. Wollach to support his calculations.

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[115] Mr. Errol Soriano from the firm of LECG Canada Ltd. reviewed Mr. Wollach's calculations on behalf of WOHC and Mr. Alldis. LECG provides expert opinions on a variety of matters, including damages and forensic accounting. Mr. Soriano is also a chartered accountant. He became a Chartered Business valuator in 1993. He has been engaged exclusively in damage quantification and business valuation since 1991.

(i) <u>Past Loss of Income</u>

[116] Mr. Wollach's estimates of Dr. Hibberd's lost income are based on his assessment of her income loss in 2003, 2007, and the first five months of 2008.

[117] In computing the income loss in 2003, Mr. Wollach compared the number of dental procedures performed by Dr. Hibberd in 2003 with the number performed in 2004, and applied the 2003 fee charged by Dr. Hibberd for each procedure to determine whether there was a net gain or loss of fees. The resulting calculation was a total net loss of fees of $108,152.00. Mr. Wollach then deducted variable expenses in the amount of $10,815.00 (estimated to be 10% of fees). He also deducted $19,633.00 as an allowance for the three days Dr. Hibberd missed in December 2003, while undergoing treatment for cancer. Mr. Wollach determined the allowance utilizing the average

number of procedures in a day and the average fee per procedure in 2003. The end result was a net past income loss to Dr. Hibberd in 2003 of $77,704.00.

[118] The hygienists in Dr. Hibberd's office perform services such as teeth cleaning and taking x-rays to assist Dr. Hibberd in her assessment and treatment of patients. When Dr. Hibberd is not able to work, the hygienists' work is affected, as well. Accordingly, utilizing the same methodology applied to Dr. Hibberd's procedures, Mr. Wollach determined there was a loss of hygienist revenue in the amount of $77,917.00 arising from Dr. Hibberd's unavailability. From that amount, Mr. Wollach deducted 30%, which he estimated as both variable and direct expenses attributable to the hygienists. This resulted in his estimate that Dr. Hibberd had what he characterized as "additional business losses" in 2003 in the amount of $54,542.00. The total amount of business loss for 2003, as calculated by Mr. Wollach was $132,246.00 ($77,704.00 + $54,542.00).

[119] Mr. Wollach carried out a similar exercise to determine Dr. Hibberd's income loss in 2007. This time, Mr. Wollach compared the number of procedures performed in 2007, with the number performed, on average, in the years 2004, 2005 and 2006. After factoring in Dr. Hibberd's 2007 fees and again deducting variable expenses of 10%, Mr. Wollach determined that Dr. Hibberd had a loss in 2007, of $85,586.00. A similar exercise was carried out in respect of the hygienists. This time, Mr. Wollach calculated a net business loss of $25,268.00. Accordingly, Dr. Hibberd's total loss of income for 2007 was estimated by Mr. Wollach to be $110,854.00.

[120] With respect to the five-month period ending May 31, 2008, Mr. Wollach did not review any 2008 financial or billing information from Dr. Hibberd's practice. Rather, he determined that Dr. Hibberd had increased her fees in the years 2004 to 2006 at an average rate of 3 to 4% per year. Assuming a similar fee increase in 2008, and that Dr. Hibberd otherwise lost income at the same

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rate as in 2007, Mr. Wollach estimated that in the first five months of 2008, Dr. Hibberd had an income loss in the amount of $36,864.00, and an additional business loss in respect of the hygienists of $10,781.00, for a total loss of income of $47,645.00.

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[121] In conclusion, Mr. Wollach estimated that Dr. Hibberd's total loss of income prior to trial was $290,745.00, composed of the 2003 income loss ($132,246.00); the 2007 income loss ($110,845.00); and the estimated income loss for the first five months of 2008 ($47,645.00).

[122] Mr. Soriano did not take issue with Mr. Wollach's use of procedures to compute Dr. Hibberd's income loss. He reviewed the procedure code data provided by Dr. Hibberd, compiled by Mr. Giovannone and used by Mr. Wollach. With relatively minor exceptions, Mr. Soriano agreed with the data concerning the number of procedures performed by Dr. Hibberd. Mr. Soriano also agreed with the deductions of 10% and 30% for variable and direct expenses in respect of Dr. Hibberd's practice, albeit reluctantly, since he was not satisfied that the quantum of the deduction had been established by Mr. Wollach. In the absence of production of additional financial information concerning Dr. Hibberd's practice, he was unable to determine what the costs of Dr. Hibberd's practice actually were.

[123] In respect of the loss in 2003, Mr. Soriano disagreed with Mr. Wollach that the appropriate comparison year should be 2004. Instead, Mr. Soriano compared the number of procedures performed in 2003 to the average number performed in 2001, 2002, and 2004 to 2006. He calculated Dr. Hibberd's loss of revenue in 2003 to be $79,500. After detecting the variable costs of 10% and the allowance for the December medical treatment as determined by Mr. Wollach, Mr. Soriano calculated that Dr. Hibberd's net income loss for 2003 was $51,917.00. In respect of the lost hygienist revenue, utilizing the same annual comparisons, Mr. Soriano's calculated a loss of

gross revenue in the amount of $37,831.00, and after deducting variable costs of 30%, a net revenue loss of $26,482.00. Combining the figures for both Dr. Hibberd and her hygienists, Mr. Soriano concluded that Dr. Hibberd's total net income loss in 2003 was $78,399.00.

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[124] To determine Dr. Hibberd's 2007 loss, Mr. Soriano multiplied the average number of procedures undertaken in the years 2001, 2002 and 2004 to 2006, by the average fee for each specific procedure. The result was an estimated loss of $98,253.00. After deducting 10% in respect of variable costs, he calculated a net loss of $88,400.00. In respect of the hygienists, using all data years, Mr. Soriano concluded that there was no loss of income in 2007.

(ii) 2003

[125] I agree that in determining Dr. Hibberd's loss of income in 2003 arising from the injury, one must take into account both Dr. Hibberd's direct loss as a result of her inability to perform and the impact that her unavailability had on the income generated by her hygienists. Dr. Hibberd's net income from her practice is made up not only of the income she generates directly but indirectly too.

[126] I also accept, as both parties have, that in order to determine Dr. Hibberd's income loss for the 2003 year, the procedures performed both by Dr. Hibberd and her hygienists is a proper measure. The real issue to determine is what is the base year or years against which the 2003 procedures should be compared?

[127] In explaining why he chose to compare 2003 with 2004, Mr. Wollach said that based on information available to him, 2004 was most representative of what would likely have happened in 2003, were it not for Dr. Hibberd's fall. Mr. Wollach did not elaborate on the information he used to reach that conclusion.

[128] Mr. Soriano felt it was more appropriate to use the average of what he termed the "normal" years, namely 2001, 2002, and 2004 to 2006. He also referred to these as the "non-loss" years.

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[129] Dr. Hibberd's revenues grew in each of the years prior to 2003 for which financial information was provided. Given this history, it is reasonable to assume, in the absence of any unusual event or events in Dr. Hibberd's practice during 2003, that 2003 would have been at least as good, and, in fact, better than it was in 2002. In 2003, apart from her fall, Dr. Hibberd missed three days at work in December on account of the treatment she received for cancer. As Dr. Hibberd concedes, that event, unrelated to her injury, resulted in a reduction of her income in 2003.

[130] It is not appropriate, in my view, to consider averages from the "normal" years, both before and after 2003, as Mr. Soriano has proposed. The use of such information and particularly the 2001 year which had fewer procedures, can easily distort the comparison by reducing the number of procedures against which 2003 is compared.

[131] Damages are assessed as at the time of the injury. In the usual case, the assessment of lost income arising from an injury begins with a review of the financial information prior to the event. In order to determine the lost income, if any, following the event, it is then necessary to consider the contingencies that apply, including whether the plaintiff would have earned more following the injury than he or she did before. Notwithstanding that the lost income is being determined based on procedures performed in this case, I see no reason to deviate from such an approach.

[132] In 2003, Dr. Hibberd performed 1,244 fewer procedures than in 2002. When the revenue gain or loss for each procedure is determined using the relevant 2003 fee, the total revenue loss for Dr. Hibberd in 2003 amounts to $158,413.00. From that number, one must deduct 10% in respect of variable expenses ($15,841.00), and $19,633.00 in respect of the three days of work Dr. Hibberd lost in December 2003 for medical reasons, resulting in a net income loss to Dr. Hibberd in 2003, as compared to 2002 of $122,939.00. In respect of Dr. Hibberd's additional business loss in 2003, there were more procedures performed by the hygienists in 2003 than in 2002. Accordingly, Dr. Hibberd suffered no additional business loss in respect of her hygienists in 2003 when compared with 2002.

[133] In the result, based on procedures, Dr. Hibberd's loss of net income in 2003 as compared to 2002 is $122,939.00. But as I have already noted, in my view Dr. Hibberd would have made more in 2003 than 2002. Accordingly, it is not appropriate to simply conclude that the comparison with 2002 by itself reflects Dr. Hibberd's income loss in 2003.

[134] Mr. Wollach concluded, when comparing the procedures performed in 2003 with those in 2004, that Dr. Hibberd's total loss of income in 2003, after allowing for her cancer treatment in December, 2003 was $132,246.00. Having regard to the loss of income when compared to 2002 and the fact, as I have found, that Dr. Hibberd would have made more in 2003 than 2002, it is my view Mr. Wollach's calculation of the loss in 2003 is a reasonable estimate of what Dr. Hibberd's income loss would have been as a result of her injury.

[135] Accordingly, I find that Dr. Hibberd's loss of net income in 2003 arising from her injury is $132,246.00.

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(iii) 2007

[136] Mr. Wollach found that Dr. Hibberd suffered a net loss of income in 2007 of $110,854.00. Mr. Soriano, using a formula that considered the average of number of procedures in 2001, 2002 and 2004 to 2006, determined that Dr. Hibberd's net loss of income for 2007 was $88,400.00.

[137] Compared with 2006, which was her most successful year financially, Dr. Hibberd's financial statements indicate that her 2007 general revenues declined by $83,482.00, and her net income declined by $79,877.00. When compared with the averages for both general revenues and net income for the period 2004 to 2006, her 2007 revenues were $31,292.00 greater and her 2007 net income was $27,473.00 greater.

[138] No matter how it is determined, when compared with her overall income, the loss of income which Dr. Hibberd suffered in 2007 as compared to 2006, which was her best year financially, is not that large.

[139] I accept Dr. Hibberd's evidence that during the years 2004 to 2006, she suffered intermittent pain in her wrist relating to her work. There is no question, however, that during those years she was able to accommodate any discomfort in her wrist and continue with her practice. Notwithstanding that she saw fewer patients and worked less hours in those years as compared to before her injury, Dr. Hibberd suffered no income loss in her practice in any of those years. In fact, her income went up substantially during this period.

[140] I also accept Dr. Hibberd's evidence that the pain in her wrist increased towards the end of 2006, and that it was of a higher intensity than what she had previously been experiencing. It is

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my view, however, based on the evidence that the increased pain which she has experienced and continues to experience has not resulted in an income loss to her. I have reached this conclusion for a number of reasons.

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[141] First, notwithstanding the increased pain, I am unable to find that it interfered with her work to the extent that it caused an income loss anymore than the intermittent pain she had been experiencing prior to 2007 caused an income loss. As with the pain she experienced before 2007, and while it has been difficult, she has been able to accommodate it in order to carry on her practice. Dr. Hibberd uses her left hand to steady the head of her patient. The evidence of both Dr. Hibberd and her assistant Anne Esterbrookes is that as a result of the increased pain, Ms. Esterbrookes began assisting Dr. Hibberd in holding the patients head.

[142] I also have trouble accepting Dr. Hibberd's evidence that she saw less patients in 2007 than 2006 based on the evidence. Mr. van Winter prepared a financial review of Dr. Hibberd's practice as part of an initial attempt to determine Dr. Hibberd's income loss. For the first six months of 2007 (the only period the information was provided), Mr. van Winter calculated that Dr. Hibberd saw 685 non-hygiene patients and 1,780 patients who first saw a hygienist. During the same period in 2006, she saw 628 non-hygiene patients and 1,882 hygiene patients. The hygiene patients generally require an examination and assessment as opposed to surgery. I conclude, therefore, to the extent that there is evidence on the number of patients Dr. Hibberd saw in 2007, there appears to be no reduction in the number of patients requiring surgery or other procedures beyond examination and diagnosis. In fact, those patients, the non-hygiene patients seen by her actually increased by 57 for the first six months of 2007 when compared with the same period in 2006.

[143] There is also other evidence that Dr. Hibberd was able to accommodate the increased pain she was experiencing in her wrist. In July 2007, Dr. Hibberd advised Dr. Wright that she had a daily ache in her wrist, which he described as mild. She told him the pain was sometimes as severe as 6 or 7 on a scale of 1 to 10. Further, Dr. Hibberd is shown in the surveillance videos in May and November of 2007 and again in April of 2008 effortlessly utilizing her left hand in activities which require some use of strength in the hand and wrist. While the activities are recreational and do not involve her practice, they are a strong indication, in my view, that the pain in her wrist was neither constant nor severe at the time the videos were taken.

[144] Further, and even if the increased pain which Dr. Hibberd experienced in her wrist resulted in her seeing fewer patients or taking extra time off, the evidence establishes there were other factors which occurred in her practice during the 2007 year unrelated to her injury that would have caused a decrease in her practice income for that year when compared to 2006.

[145] Those factors are that Dr. Hibberd's associate Dr. Masse was required to take substantial time off during 2007, including the entire month of December, for medical reasons; Dr. Hibberd reduced her part-time hygienist's work week from two or three days, down to one; she gave up seeing public-health patients in the summer of 2007; and she took six more vacation days in 2007 than in 2006, and ten more days than she took on average in the years 2004 to 2006. I consider each of these factors in more detail, below.

[146] Dr. Masse had been practicing with Dr. Hibberd since 2001. She saw patients referred by Dr. Hibberd and utilized the hygienists as part of her practice. Prior to 2007, in addition to seeing patients referred by Dr. Hibberd, Dr. Masse had developed her own busy practice. The loss of Dr. Masse periodically during 2007, including for the entire month of December, would have had a

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double impact on Dr. Hibberd's practice. First, the loss of Dr. Masse would have resulted in lost income to Dr Hibberd, which Dr. Masse would have generated from her practice both directly and from the hygienists. More importantly, in the absence of Dr. Masse, Dr. Hibberd was required to assume a greater workload than she otherwise would have in order to maintain her practice. Dr. Hibberd's practice was already demanding. The absence of Dr. Masse for the periods of time in question made it even more demanding and, in turn, would have caused additional stress on Dr. Hibberd, particularly given her injury.

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[147] Dr. Hibberd had, prior to and during 2007, both a full-time and a part-time hygienist working in her practice. She indicated that in 2007, as a result of the pain in her wrist, she had to reduce the part-time hygienist's employment from two to three days a week to one day a week. At the end of 2007, the part-time hygienist was let go completely. In my view, the reduction of the hygienist's hours did not result solely from problems with Dr. Hibberd's wrist. It was also attributable to Dr. Masse's reduced practice. The reduction in the hygienist's hours of work would have resulted in a reduction in the revenues of the practice.

[148] In the summer of 2007, Dr. Hibberd stopped taking public-health patients for reasons unrelated to her wrist. According to the fee guideline for these services, Dr. Hibberd was only able to charge her public health patients 30% of her normal fees. No evidence was presented as to what the loss was either in number of patients or revenue. Notwithstanding that the loss of the public health portion of her practice may not have represented a significant revenue loss when compared with her gross revenues, it nevertheless represents a loss of revenue in 2007 when compared to 2006.

[149] In 2007, Dr. Hibberd took 47 vacation days, six more than in 2006, and ten more than she averaged in 2004, 2005 and 2006. While I have no doubt that the vacation days were therapeutic in the sense that she was able to rest her wrist, I do not accept Dr. Hibberd's testimony that they were taken because of the increased pain in her wrist.

[150] The evidence in respect of the 2007 vacation days establishes that they were not days taken randomly or on a sporadic basis that would tend to corroborate Dr. Hibberd's evidence. Rather, all of the vacation days were planned vacations with her family during specific school breaks and the summer months, to visit family in Europe, California and Alberta, and to take her children on holidays to Disney World, Whistler and Antigua in the West Indies.

[151] When Mr. van Winters did the financial review of Dr. Hibberd's practice, he determined that each day that Dr. Hibberd spent away from her practice in 2007 cost her $12,285.00. Accepting that number for the purpose of determining the loss to Dr. Hibberd in taking six additional vacation days in 2007, the lost revenue to her would have been $73,714.26 as a result of the additional vacation days.

[152] While none of the factors I have raised may, on their own, account for Dr. Hibberd's income loss in 2007, in combination, they more than account for it.

[153] For the above reasons, therefore, I am unable to find that Dr. Hibberd's loss of income for 2007 as compared with 2006 was attributable to the injury to her wrist.

(iv) 2008

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[154] As noted, Mr. Wollach's estimate of Dr. Hibberd's lost income for the five months ending May 31, 2008, was reached by extrapolating. Based on a rate of loss similar to what he had calculated for 2007, and factoring in a fee increase of 3-4%, Mr. Wollach estimated that as a result of her injury, Dr. Hibberd lost $47,645.00 in the first five months of 2008. No actual analysis was conducted of Dr. Hibberd's practice records for this period.

[155] Because I have found that Dr. Hibberd did not suffer any loss of income in 2007 arising from the injury to her wrist, there is no basis in the evidence for finding that she suffered a loss in 2008 arising from the injury. As a result, I find that Dr. Hibberd suffered no loss of income for during the first five months of 2008 as a result of the injury to her wrist.

(b) Out-of-Pocket Expenses

[156] In 2003, Dr. Hibberd spent $1,706.55 on taxis and $1,750.00 for her physiotherapy, for a total of $3,456.55 in out-of-pocket expenses relating to her injury. WOHC takes no issue with these expenses.

(c) Future Income Loss

[157] Dr. Hibberd's claim for future income loss is based on Mr. Wollach's estimate that her annual income loss from the date of trial to her retirement would be $114,724.00. That figure is based on Mr. Wollach's calculation of Dr. Hibberd's loss of income in 2007, adjusted for rate increases in 2008 of an amount similar to those employed by Dr. Hibberd in the past.

[158] In order to calculate her total future income loss, Mr. Wollach developed various scenarios based on different dates when Dr. Hibberd might retire. From the date of trial until age 65,

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based on an annual income loss of $114,724.00, Mr. Wollach calculated the present value of Dr. Hibberd's income loss to be $1,725,453.00. If Dr. Hibberd worked until age 66, the present value of the loss would be $1,834,441.00.

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[159] Mr. Wollach also developed additional scenarios based on the assumptions previously described – namely, that Dr. Hibberd's working capacity would be reduced by 50% from age 60 until retirement at age 65 or 66. Based on retirement at 65, the present value of the loss would be $5,789,637.00 and at 66, $6,688,191.00. If Dr. Hibberd is forced to retire early at age 60 as opposed to at age 65, the present value of her future loss of income is $10,414,824.00; if retirement would have been at 66 and she is instead forced to retire at 60, the present value of the loss is $12,211,931.00.

[160] Because I have determined that Dr. Hibberd did not suffer an income loss in 2007 resulting from her injury, I am unable to accept the submission that she will suffer any annual income loss in the future, let alone one of $114,724.00 for each year until her retirement, whenever that may be.

[161] The evidence indicates, however, that Dr. Hibberd may have some future problems in relation to her wrist injury, which may in turn impact on her practice and ability to earn income.

[162] The courts have noted that the task of determining whether the plaintiff will suffer future pecuniary loss and if so, the amount of such loss, is, by its very nature, a speculative exercise. To be entitled to such compensation, a plaintiff must establish on the evidence that there is a "real and substantial risk" that future pecuniary loss will occur.

[163] In *Graham v. Rourke* (1990), 75 O.R. (2d) 622 (C.A.), Doherty, J.A. summarized the law relating to the assessment of future pecuniary loss at p. 634:

> A trial judge who is called upon to assess future pecuniary loss is of necessity engaged in a somewhat speculative exercise: *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229, 8 A.R. 182, 3 C.C.L.T. 225, 83 D.L.R. (3d) 452, 19 N.R. 50, [1978] 1 W.W.R. 577, at pp. 249-50 S.C.R. The ultimate questions to be determined -- will the plaintiff suffer future loss and, if so, how much? -- cannot be proved or disproved in the sense that facts relating to events which have occurred can be proved or disproved. A plaintiff who seeks compensation for future pecuniary loss need not prove on a balance of probabilities that her future earning capacity will be lost or diminished or that she will require future care because of the wrong done to her. If the plaintiff establishes a real and substantial risk of future pecuniary loss, she is entitled to compensation: *Schrump v. Koot* (1977), 18 O.R. (2d) 337, 4 C.C.L.T. 74, 82 D.L.R. (3d) 553 (C.A.), at pp. 340-43 O.R.; *Giannone v. Weinberg* (1989), 68 O.R. (2d) 767, 33 O.A.C. 11 (C.A.) [leave to appeal to S.C.C. refused (Wilson, La Forest and Cory JJ.), February 8, 1990]. Messrs. Kenneth D. Cooper-Stephenson and Iwan B. Saunders, the authors of *Personal Injury Damages in Canada* (Toronto: Carswell, 1981), aptly describe the task involved in assessing future pecuniary loss claims, at p. 84:
>
>> The different standard of proof which governs most of a damage assessment may be termed “simple probability”. It involves the valuation of possibilities, chances and risks according to the degree of likelihood that events would have occurred, or will occur. This contrasts with “the balance of probabilities”, more familiar in civil actions, which involves an “all-or-nothing” approach. [Footnotes omitted]
>
> A plaintiff who establishes a real and substantial risk of future pecuniary loss is not necessarily entitled to the full measure of that potential loss. Compensation for future loss is not an all-or-nothing proposition. Entitlement to compensation will depend in part on the degree of risk established. The greater the risk of loss, the greater will be the compensation. The measure of compensation for future economic loss will also depend on the possibility, if any, that a plaintiff would have suffered some or all of those projected losses even if the wrong done to her had not occurred. The greater this possibility, the lower the award for future pecuniary loss: *Personal Injury Damages in Canada*, *supra*, at pp. 91-92.

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[164] Accordingly, in order for a court to conclude that there is a “real and substantial risk” of a future loss of income occurring, the plaintiff need not prove the loss on a balance of probabilities, but must establish that it is more than mere speculation. See too: *Athey v. Leonati*, [1996] 3 S.C.R. 458 (S.C.C.), at para. 27.

[165] Further, even if a plaintiff establishes that there is a “real and substantial risk” of future pecuniary loss, the measure of such loss depends upon an assessment of the degree of risk or contingencies, both general and specific, which might impact on such future income: *Graham v. Rourke*, *supra*, at para 42 to 47.

[166] Notwithstanding my finding that the evidence does not establish Dr. Hibberd will suffer an annual income loss into the future as a result of her injury, the medical evidence indicates that Dr. Hibberd may suffer possible complications at some point in the future arising from her injury. These possible complications are carpal tunnel syndrome, tendonitis, the rupture of her ECRL tendon and osteoarthritis. As a result, it is necessary to determine whether there is a “real and substantial risk” that Dr Hibberd will suffer pecuniary loss from some or all of the possible future complications and, if so, the amount of such loss.

Carpal Tunnel Syndrome

[167] The evidence of both Dr. Maloney and Dr. Wright establishes that it is unlikely that Dr. Hibberd will suffer carpal tunnel syndrome as a result of her injury.

[168] Although Dr. Maloney was able to diagnose carpal tunnel syndrome when he examined Dr. Hibberd, he did not find any evidence during his examinations that it was symptomatic. Further, he only assessed the risk of Dr. Hibberd becoming symptomatic in the future at 10%.

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[169] Dr. Wright was unable to find any evidence of carpal tunnel syndrome when he examined Dr. Hibberd in July 2007. It was his opinion, based on an examination of Dr. Hibberd, that it was unlikely, given her history and the time that had elapsed since the injury, that she would develop carpal tunnel syndrome in the future as a result of her injury.

[170] Accordingly, the evidence does not establish that there is a real and substantial risk that Dr. Hibberd will suffer a future income loss by developing carpal tunnel syndrome as a result of the injury to her wrist. There is therefore no basis for finding that Dr. Hibberd will suffer any future loss of income as a result.

Tendonitis

[171] Both Dr. Mahoney and Dr. Wright were of the opinion that Dr. Hibberd had developed tendonitis or an inflammation of the ECRL tendon as a result of the injury. Further, they found that it was the tendonitis that was causing the pain in her wrist. Both doctors were of the view that the increased pain she complained of would continue.

[172] Although this increased pain is clearly an annoyance to Dr. Hibberd and is painful to her from time to time, I have already found that it is not significant enough to prevent her from practicing, nor has it contributed to any income loss to date. Further, while the evidence establishes that the intermittent pain will continue, there is no evidence that it will get any worse or that Dr. Hibberd may be required to take time off from her practice beyond what she is already taking.

[173] Accordingly, I am unable to find that there is a real and substantial risk that Dr. Hibberd will suffer any future income loss as a result of tendonitis in her injured wrist.

Rupture of the ECRL Tendon

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[174] Apart from the continued pain in her wrist, the real problem facing Dr. Hibberd in the future is that her ERCL tendon could rupture or break. Dr. Maloney's opinion was that it was "quite likely" at some point in the future that Dr. Hibberd's ECRL tendon could rupture or break. Dr. Wright's opinion, given the injury, was that it was "possible" that her ECRL tendon could break in time.

[175] Doctors Maloney and Wright also differ with respect to the treatment and prognosis for Dr. Hibberd in the event that her ECRL tendon ruptures.

[176] It was Dr. Mahoney's evidence that in the event of a rupture, surgery will be required and Dr. Hibberd's wrist will not return to its pre-rupture state. Dr. Wright, on the other hand, said that if the tendon ruptured, two treatment options were available. Initially, the injury would be treated with rest and immobilization for a period of four to six weeks. If at the end of that period, there was no pain and the wrist was functional, it would continue to be treated conservatively. If, however, the pain remained or there was a loss of wrist function, surgery would be required which would result in a period of recovery similar in length to the period Dr. Hibberd took to recover from her initial injury. Dr. Wright's opinion was that such surgery had a high probability of success in repairing the injury and returning the wrist to its pre-rupture state.

[177] I was impressed with the evidence of both Dr. Mahoney and Dr. Wright. They are both very well qualified and experienced in the area of hand and wrist injuries. On balance, however, I prefer the testimony of Dr. Wright as it relates to both the possibility of the injury occurring and its treatment as well as the prognosis in the event Dr. Hibberd's ECRL tendon ruptures. Dr. Mahoney's expertise and experience is more in the area of carpal tunnel syndrome. Dr. Wright indicated that in

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his 26 years of practice, he had seen many injuries similar to Dr. Hibberd's. I found Dr. Wright's approach to the issues to be more plausible generally and in particular with respect to the various treatment options and outcomes which might result.

[178] The evidence of Dr. Wright establishes that there is a possibility that, as a result of the injury to her wrist, Dr. Hibberd could rupture her left ECRL tendon at some point in the future. Further, having regard to Dr. Wright's evidence concerning both the treatment and prognosis if Dr. Hibberd's ECRL tendon does rupture at some point in the future, it is my view that there is a real and substantial risk that she will suffer some amount of pecuniary loss as a result.

[179] In order to determine the amount of pecuniary loss which Dr. Hibberd might suffer, it is necessary to assess the degree of risk to Dr. Hibberd in the event her tendon breaks. As noted, in so doing it is necessary to assess both the general and specific contingencies which apply in this case : *Graham v. Rourke*, *supra*, at para. 42 to 47.

[180] In my view general contingencies do not operate in the circumstances of this case to affect consideration of the amount of Dr. Hibberd's future income loss from a ruptured ERCL tendon. The evidence establishes that Dr. Hibberd will continue in her practice until she retires, whenever that may be.

[181] In dealing with the issue of future income loss, the parties addressed both evidence and argument towards the issue of when Dr. Hibberd will retire. That question becomes relevant if the determination is the annual future income loss or forced early retirement of Dr. Hibberd. Where the issue involves a determination of when her ECRL may rupture, however, a determination of whether Dr. Hibberd will retire at age 60, 65 or 66 is not necessary.

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[182] As noted, Mr. Wollach presented scenarios based on the assumption that Dr. Hibberd would either be forced to retire early at age 60 due to her injury or would be required to reduce the level of her practice between age 60 and her retirement age, be it 65 or 66. In my view, neither assumption comes into play when assessing Dr. Hibberd's future income loss from a ruptured ERCL tendon. If she suffers a rupture, Dr. Wright's prognosis does not require her to either retire early or reduce her practice. Further, Dr. Hibberd has a very busy and demanding practice. She works a long and very busy day. While she currently has no plans to slow down or retire, given the demanding nature of her practice it is possible in my view, even in the absence of the injury, that she could begin to slow down or even retire by age 60.

[183] WOHC submits that Dr. Hibberd's her pre-existing medical condition (breast cancer) is relevant in calculating Dr. Hibberd's life expectancy. In fairness, WOHC's submission was made in respect of Dr. Hibberd's claim for loss of income to retirement. In my view, it is not applicable to a determination of future pecuniary loss arising from a rupture of her ERCL tendon. In any event, it is my view that because Dr. Hibberd's breast cancer has been in remission since 1991, it should not result in any form of deduction in the determination of future income loss arising from a rupture of the ERCL tendon.

[184] Having regard to the evidence, it is my view that the specific contingencies that must be taken into account in determining the amount of Dr. Hibberd's future income loss in the event her ERCL tendon ruptures are when, if at all, it may occur and assuming it does, what is the period of time Dr. Hibberd will be prevented from earning income, directly or indirectly through her practice?

[185] Neither Dr. Mahoney nor Dr. Wright could say when a rupture of Dr. Hibberd's ECRL tendon might occur. It may happen tomorrow, next year or never.

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[186] Further, having regard to the alternate treatment options outlined by Dr. Wright, the likely period of Dr. Hibberd's recovery from a ruptured ERCL tendon is difficult to assess. The best case will be that she will lose some income from her practice for a four- to six-week period. During that period, her wrist will be immobilized, preventing her from performing surgery. She will, however, still be able to carry on some of her practice, as she did when her wrist was in a cast in 2003. The worst case scenario is that she will require surgery and a further four to six weeks in a cast, followed by physiotherapy and reduced use of her wrist for between three and six months.

[187] From a financial point of view, the best case will result in an income loss of less than the income loss she suffered in 2003. The worst case will result in an income loss slightly greater than in 2003. In either case, what will be lost is Dr. Hibberd's ability to do surgery for a period of time. She will still be able to work, but at a reduced level. Further, her associate or associates and hygienists will also be able to work.

[188] Accordingly, utilizing the 2003 income loss of $132,246.00, and recognizing that it occurred in 2003, when her revenue and income were smaller than they are now, based on the above best case, worst case analysis, it is my view that the range of potential income loss to Dr. Hibberd in the event she ruptures her ECRL tendon will be somewhere between $75,000.00 and $175,000.00.

[189] Considering the above noted contingencies, and in particular the issue of whether a rupture will occur at all, it is my view that the proper assessment of Dr. Hibberd's future pecuniary loss resulting from a potential rupture of her ECRL tendon is $100,000.

[190] The parties spent much time arguing over the discount rate that should be applied to any future loss, in order to determine present value. Given that it is not known when the future income

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loss will occur, it is not appropriate, in my view, to apply a discount rate in respect of any future income loss. The fact that Dr. Hibberd is being compensated in today's dollars for a loss which will occur in the future is accounted for, in my view, in the contingencies I have considered.

Osteoarthritis

[191] The last possible future complication is that osteoarthritis will develop in Dr. Hibberd's wrist.

[192] Dr. Cartan's opinion was that the possibility of Dr. Hibberd developing post-traumatic degenerative arthritis in her left wrist as a result of her injury was somewhat remote. Dr. Mahoney's opinion was that as a result of the break, Dr. Hibberd had a higher risk of developing arthritis in her left wrist. Dr. Wright's opinion was that there was an increased likelihood of arthritis occurring in the joint because of the fracture.

[193] At the time Dr. Wright examined Dr. Hibberd in July 2007, and when he wrote his report, his opinion was that arthritis had not yet developed in her left wrist. He found no indication of any degenerative change on examination. At trial, however, Dr. Wright testified that in preparing his report, he failed to note that a recently prepared radiologist's report, which was based on an x-ray taken at the time of Dr. Hibberd's visit to his office, had indeed indicated some evidence of early arthritic changes in Dr. Hibberd's wrist.

[194] The evidence establishes, in my view, that there is a real and substantial risk that Dr. Hibberd will develop arthritis in her left wrist as a result of her injury. I am not prepared to find on the evidence that it has already begun to occur. None of the doctors confirmed it had, except Dr.

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Wright, who was basing his view, not on his examination, but on a radiologist's report which he misread back at the time he received it.

[195] Although the evidence establishes that there is a real and substantial risk that Dr. Hibberd will develop arthritis in her wrist at some point in the future, there is no evidence of when it will occur and if it does what the impact would be on Dr. Hibberd's ability to practice.

[196] To the extent that it may occur after Dr. Hibberd reaches the age of 60, as I have noted, it is possible, given the stressful nature of her practice, that she would have reduced her practice in part or entirely even in the absence of developing arthritis in her wrist.

[197] While I acknowledge that the future onset of arthritis may have an impact on Dr. Hibberd's ability to practice, in the absence of any evidence as to the effect it may have on her practice, any determination of future pecuniary loss would be purely speculative. In the circumstances, I am unable to find that there is a real and substantial risk that Dr. Hibberd will suffer any future pecuniary loss as a result of arthritis developing in her wrist.

[198] In summary, therefore, I assess Dr. Hibberd's future pecuniary loss arising from her injury at $100,000.00.

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(2) Non-Pecuniary Damages

[199] Non-pecuniary damages are intended to compensate the injured party for past and future physical and mental pain and suffering, as well as loss of amenities and enjoyment of life.

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[200] The assessment of non-pecuniary damages differs from that of pecuniary damages. As was stated by Dickson J. (as he then was) in *Andrews v. Grand & Toy Alberta Ltd.*, [1978] 2 S.C.R. 229 (S.C.C.) at p. 261:

> The monetary evaluation of non-pecuniary losses is a philosophical and policy exercise more than a legal or logical one. The award must be fair and reasonable, fairness being gauged by earlier decisions; but the award must also of necessity be arbitrary or conventional. No money can provide true restitution. Money can provide for proper care: this is the reason that I think the paramount concern of the courts when awarding damages for personal injuries should be to assure that there will be adequate future care.

[201] Dr Hibberd submits that, as a pediatric dental surgeon who uses her left hand in a dramatic and regular way and experiences ongoing pain, she is entitled to non-pecuniary damages for past, present and future pain and suffering in the amount of $100,000.00. Dr. Hibberd further submits that the case law with respect to non-pecuniary awards in other cases is not useful because the impact of an injury on an individual depends on that person’s particular circumstances.

[202] By contrast, WOHC submits that the case law is highly relevant, and that in cases involving similar facts and injuries, plaintiffs have been awarded non-pecuniary damages in the range of $10,000.00 to $15,000.00. WOHC submits, given the evidence of Dr. Hibberd’s injury and the effect it had on her that non-pecuniary damages should be assessed in this case at the low end of the range.

[203] I agree that the result in each case should depend on individual circumstances. In my view, however, non-pecuniary damages cannot be awarded in a vacuum. As noted above in *Andrews*, *supra*, at p. 263, the determination of what is fair and reasonable should be guided, in part, by earlier cases across Canada involving similar injuries. Accordingly, the cases which have assessed non-pecuniary damages for broken wrists are a starting point in determining the range within which non-pecuniary damages should fall.

[204] In *Dally v. London (City)* (2004), 50 M.P.L.R. (3d) 133 (Sup. Ct. J.), the plaintiff, a 40-year-old female, broke her right wrist in a rollerblading accident. No surgery was required and the wrist was in a cast for six weeks, followed by physiotherapy for three months. The plaintiff resumed employment two weeks after the fall, notwithstanding significant pain and discomfort. She continued to suffer discomfort in her wrist on a near continuous basis. The discomfort was characterized as nuisance variety with normal use, but more significant with strenuous activity. Non-pecuniary damages were assessed at $25,000.00.

[205] In *Starr v. Ojibway Pic River First Nation*, [1997] O.J. No. 3671, 37 O.T.C. 13 (Gen. Div.), the plaintiff was a 49-year-old female who suffered a Colles' fracture of her left wrist, was in a cast for eight weeks, off work for 21 weeks, and had a decrease in strength in her left hand and some decrease in her ability to rotate the hand. Her wrist was painful on occasion. The court awarded non-pecuniary damages of $22,000.00.

[206] In *Simms v. Conestoga College of Applied Arts & Technology*, [1995] O.J. No. 902 (Gen. Div.), the 28-year-old plaintiff suffered a serious fracture of her left wrist, which had potential negative future consequences. The court assessed non-pecuniary damages at $10,000.00.

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[207] In *Tomczyk v. British Columbia (Ministry of Environment, Lands & Parks)*, [1998] B.C.J. No. 1877 (S.C.), the plaintiff was a 42-year-old female who fell and broke her wrist. She was in hospital for a day and had continuing problems with her wrist following the fracture, resulting in a permanent disability. Non-pecuniary damages were assessed at $25,000.00.

[208] In summary, based on the above cases, the range of general damages awarded by courts in cases involving broken wrists where the recovery period is between three to six months and the injured party continues to have discomfort in their wrist, falls between $10,000.00 and $25,000.00.

[209] Turning to the circumstances of the present case, as I have noted Dr. Hibberd's left wrist fracture was a closed fracture which was not particularly displaced and did not require surgery to resolve. It was not a serious break. She was affected for the six-week period she was in a cast and then for a maximum of five months while she underwent physiotherapy.

[210] There is no doubt that she suffered pain at the time of the accident and during the healing process. She also had a concern for her livelihood, which caused her anxiety. The impact of the injury on Dr. Hibberd's work and home life was lessened, however, by the fact that she is ambidextrous.

[211] Beyond the recuperation period through the latter half of 2003, and during the period from 2004 to 2006, Dr. Hibberd continued to suffer intermittent discomfort in her wrist. While the pain had some affect on her ability to attend to her patients, she was able to accommodate it, such that it did not affect her practice economically or her general enjoyment of life.

[212] As I have stated, I accept her evidence that beginning in late 2006, the pain she had been intermittently experiencing in her left wrist increased. For the reasons already noted, however, I

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have difficulty accepting that it is as debilitating as she says it is. Although she says it has had a great impact on her practice, she continues to practice at a very high and demanding level. In my view, apart from the six month period following her injury, her income has not really been affected. On a personal level, Dr. Hibberd did not testify that she has been significantly impacted from the injury or restricted from performing any of the activities she enjoyed before her injury. It is therefore my view that the impact of the injury on Dr. Hibberd has not been life-altering, either in respect of her practice or her personal life.

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[213] In determining the quantum of Dr. Hibberd’s non-pecuniary damages, I have considered whether the award should be increased to an amount above the range because, as a highly trained and skilled dental surgeon who relies on her hands to carry out her profession, Dr. Hibberd’s injury would have had a greater impact on her than it would have had on someone else who did not depend on their hands to earn a living. It is my view, however, as noted in *Andrews*, *supra*, that to the extent that Dr. Hibberd’s injury impacts her vocation, the law entitles her to be compensated for such impact in the form of lost income and not by way of increased non-pecuniary damages.

[214] Having regard to the range of damages awarded in cases involving broken wrists and the circumstances of this case, including impact of the injury on Dr. Hibberd to date and its likely impact in the future, I assess Dr. Hibberd’s non-pecuniary damages in respect of her injury at $25,000.00.

Conclusion

[215] In the result therefore, I find that WOHC and Mr. Alldis are liable to Dr. Hibberd for the injuries she suffered as a result of her fall in the OR west corridor of the Hospital on May 26, 2003. Dr. Hibberd was not contributorily negligent.

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[216] Further, I assess Dr. Hibberd's damages arising from her fall at the WOHC on May 26, 2003, as follows:

Special Damages:

1. Pecuniary Loss

(a) past loss of income: $132,246.00

(b) out-of-pocket costs: $3,456.55

General Damages:

1. Pecuniary Loss

(a) future loss of income: $100,000.00

2. Non-pecuniary Loss: $ 25,000.00

[217] Dr. Hibberd is entitled to pre-judgment interest on her past lost income at the pre-judgment rate provided in the *Courts of Justice Act*, R.S.O. 1990, c. C.43, from January 1, 2004, to the date of this judgment. She shall have pre-judgment interest at the same rate from July 31, 2003, to the date of trial, in respect of her out-of-pocket taxi expenses, and from January 1, 2004, to the date of trial, in respect of the physiotherapy costs. Finally, in respect of the non-pecuniary loss, in accordance with s. 128(2) of the *Courts of Justice Act*, *supra*, and R. 53.10 of the *Rules of Civil*

Procedure, R.R.O. 1990, Reg. 194, Dr. Hibberd is entitled to pre-judgment interest at the rate of 5% per annum calculated from May 26, 2003, to the date of this judgment. If the parties cannot agree on the calculations in respect of pre-judgment interest, I can be spoken to.

[218] In the event that the parties are unable to agree on costs within 30 days from this date, Dr. Hibberd shall file a brief written submission of no more than five pages, including a costs outline for the action, within five days after the failure to agree or 30 days, whichever comes first. WOHC and Mr. Alldis shall have a further seven days to provide reply submissions of no more than three pages, excluding a costs outline, if required.

L. A. Pattillo J.

Released: February 13, 2009

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DATE: 20090213
DOCKET: 04-CV-272922CM3

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ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:

JENNIFER HIBBERD

Plaintiff

- and -

WILLIAM OSLER HEALTH CENTRE AND ROBERT ALLDIS

Defendants

REASONS FOR JUDGMENT

PATTILLO J.

Released: February 13, 2009