# IN THE SUPREME COURT OF BRITISH COLUMBIA

Date: 20111116
Docket: M109975
Registry: New Westminster

Between:

**Julia Hanson**

Plaintiff

And:

**Tennille Lennie, Stephen Tuoc Tran and Shao Ping He**

Defendants

Before: The Honourable Mr. Justice Harvey

## Oral Reasons for Judgment

| | |
|---|---|
| Counsel for the Plaintiff: | A. Sandilands<br>A. Bayley |
| Counsel for the Defendants | M. J. Gibson<br>A. Meade |
| Place and Date of Trial: | New Westminster, B.C.<br>November 14-16, 2011 |
| Place and Date of Judgment: | New Westminster, B.C.<br>November 16, 2011 |

[1] THE COURT: This will be my ruling with respect to the admissibility of the report of Dr. Boyle.

[2] The plaintiff seeks to exclude the admission of the medical report of Dr. Mark Boyle, an orthopaedic surgeon. Dr. Boyle is the sole defence expert expressing an opinion as to the extent of the plaintiff's injuries. His report was served September 13, 2011, some 62 days before trial. The report was served, according to the defendants, in compliance with Rule 11-6(4) which provides:

> Rule 11-6 — Expert Reports
>
> Service of responding report
>
> (4) Unless the court otherwise orders, if a party intends to tender an expert's report at trial to respond to an expert witness whose report is served under subrule (3), the party must serve on every party of record, at least 42 days before the scheduled trial date,
>
> (a) the responding report, and
>
> (b) notice that the responding report is being served under this rule.

[3] No abridgment of Rule 11-6(3) was sought by the defendant until trial, despite the fact the plaintiff declined to attend an Independent Medical Examination ("IME") scheduled for August 31, 2011. The reason for the plaintiff's non-attendance was that, in counsel for the plaintiff's opinion, the resultant report would offend the time requirements of Rule 11-6(3), which provides for an opinion to be served some 84 days before trial.

[4] The defendant upon hearing this did not take an application requiring the plaintiff to attend the IME or to reschedule it perhaps because the defendant had cancelled two previously scheduled IMEs to which the plaintiff had agreed to attend.

[5] In any event, in the absence of the physical examination of the plaintiff, Dr. Boyle proceeded to perform a record review opinion. That is to say he prepared an opinion as to the extent and duration of the plaintiff's injuries based upon records and reports provided to him including the reports of the plaintiff's three experts, Dr. Crossman, Dr. Hassam, and Mr. Worthington-White, an occupational therapist.

[6] The plaintiff contends that the report prepared is not responsive as is contemplated by Rule 11-6(4) and should be excluded. It expresses, according to the submissions of Mr. Bayley, standalone opinions and speculation which are impermissible.

[7] As to the report itself, the major complaints of the plaintiff in this action relate to her neck and right shoulder. Other more minor injuries have resolved since the accident occurred in 2006.

[8] After setting forth the material relied upon, Dr. Boyle opines as follows:

> Cervical Spine
>
> The patient suffered a myofascial strain. This is an injury to ligaments, tendons and muscles. There is no evidence of injury to vertebrae, disc pathology or neurological compromise.
>
> The only investigation is a plain film x-ray of her cervical spine, which was normal. She has not had an MRI, CT scan or bone scan suggesting that her treating physicians were no [sic] entertaining any other diagnosis.

[9] I pause to note that Dr. Boyle, would appear, is wrong as to the extent of the diagnostic techniques, but that is not a matter that concerns me in determining the admissibility in the first instance of the report.

[10] As to the injury to her right shoulder, he goes on to say:

> Right Shoulder
>
> Some tenderness was noted over the AC joint on the right by Dr. Carlson. No other abnormality was noted. An ultrasound of the right shoulder was negative.
>
> This is likely to be at most a grade 1 to a minor grade 2 strain.
>
> She is unlikely to undergo late degenerative changes. She is unlikely to require surgery.
>
> ...
>
> As regards the right AC joint, a grade 1 or minor grade 2 strain has an overwhelming likelihood of resolution over time. Again, there is no objective evidence that I have seen to provide a reason for continued symptoms.

[11] I note there is no suggestion in either medical report filed by the plaintiff that the injury is other than a myofascial strain and there is no opinion there is a bony injury or possible future surgery.

[12] As to the plaintiff's neck injury, Dr. Boyle opined as follows:

> Cervical spine
>
> The patient suffered a myofascial strain. This is an injury to ligaments, tendons and muscles. There is no evidence of injury to vertebrae, disc pathology or neurological compromise.
>
> ...
>
> She is unlikely to undergo late degenerative changes. She is unlikely to require surgery.
>
> ...
>
> Dr. Crossman felt that she may have a right-sided C3-4 facet "irritation". He suggested the possible role of injections.
>
> There is no objective evidence of pathology involving the C3-4 facet joint. As stated previously, there has not been an MRI, CT scan or a bone scan (the latter being quite sensitive to the presence of inflammation). The physicians treating her obviously felt that there was no diagnostic or potentially therapeutic value in doing so. The diagnosis of soft tissue injuries is the only one entertained or consistent with the findings.

[13] These opinions, the plaintiff says, are not responsive to anything opined by Drs. Crossman, Hassam, or Gary Worthington-White, but, rather, the bare assertion that absent objective symptoms of injury to the facet joints or bone structures, the plaintiff's symptoms of myofascial pain ought to have resolved within six to nine months from the date of the accident.

[14] Both Drs. Crossman and Hassam attribute the plaintiff's ongoing symptomology to myofascial pain but suggest that it is chronic. Dr. Crossman tempers this with the opinion that the symptoms will "likely persist to some degree for the foreseeable future", not that they are necessarily permanent.

[15] Dr. Hassam describes her pain as chronic and says she will require treatments, specifically chiropractic and massage, indefinitely. Mr. Worthington-White has costed the various medical needs attended upon this diagnosis and the

ultimate cost of future care is said to be in the area of $100,000. In addition, loss of future earning capacity is claimed.

[16] Certain comments contained in Dr. Boyle's report specifically is reference to what other treating doctors thought by virtue of "not entertaining any other diagnosis" are clearly gratuitous and cannot reasonably be called responsive. They are argument, nothing more, nothing less.

[17] Some of what is contained is not disputed; specifically that the injuries are what are euphemistically referred to as soft tissue injuries and that no surgical intervention is required.

[18] Some of her injuries, specifically her low back, seem to have resolved shortly following the accident.

[19] Both Drs. Crossman and Hassam suggest ongoing treatment is necessary and that the plaintiff may anticipate further disruptions to her employment and recreational pursuits.

[20] In support of the plaintiff's position, I have been referred to *Palmer v. Kim*, 2007 BCSC 1868, a decision of Madam Justice Holmes, pre-dating the new civil rules, and to *Luedecke v. Hillman*, 2010 BCSC 1538, a decision of Mr. Justice Cullen.

[21] Counsel for the defendants acknowledges the law as correctly set forth in *Luedecke* and says that it, not *Palmer*, contains the proper analysis as to what is "responsive". In *Luedecke*, Cullen J. was considering Rule 7-6(1), not 11-6(4). He left with the trial judge the content of the proposed report to be prepared by the IME doctor and whether in fact it was responsive to the opinions of the plaintiff's medical experts.

[22] In *Palmer*, the matter of what was responsive was considered under the old rules where written notice was not required of rebuttal evidence. In determining the

defence reports tendered in *Palmer* were not responsive, Holmes J. referred at paragraph 21 to the test laid out in the Fraser and Horn, "The Conduct of Civil Litigation in British Columbia", where the author stated the test as follows:

> Determining whether expert evidence falls without the "responsive" category and therefore escapes the rigours of Rule 40A can be difficult. For example, if the evidence of expert No. 1 is that he tested something, using a certain procedure, it would seem that expert No. 2 might respond that the procedure used was inappropriate. However, if expert No. 2 refers to a different method of testing as part of the basis for the critique, it might well be argued that this is, as it were, free-standing evidence which is not responsive only. This exception to the requirement for advance written notice of the expert's view is limited strictly to true response evidence and does not permit fresh opinion evidence to masquerade as answer to the other side's reports.

[23] Further, at paragraphs 25 through 27 of the judgment in *Palmer*, Holmes J. describes her reasons for concluding the report of Dr. Jones, one of the defence experts, was inadmissible. She stated:

> [25] Dr. Robinson has given the opinion that the plaintiff's headaches were caused by the accident and, at this point, are not treatable except by the methods she currently uses. Dr. Jones would give the opinion that Mr. Palmer's headaches are caused by stress, and are treatable. Dr. Jones' proposed evidence would thus go to the heart of the issue between the parties, standing, simply, in flat opposition to Dr. Robinson's evidence. In the language of the authors of *The Conduct of Civil Litigation in British Columbia*, quoted above, Dr. Jones' proposed evidence would be "free-standing" evidence as to the key matter in issue. As such, it is not truly responsive, in the sense that would take it outside the requirements of Rule 40A. It would respond more to Mrs. Palmer's position in the trial than it would to Dr. Robinson's evidence.
>
> [26] If the situation were otherwise, one would have expected specific and focussed cross-examination of Dr. Robinson in the areas to be addressed by the proposed defence expert evidence, so as to expose the point of difference between the experts and allow for consideration of Dr. Robinson's evidence in that light.
>
> [27] However, as to the treatment of Mrs. Palmer's headaches, Dr. Robinson was cross-examined only in very general terms about classes of drugs that he chose not to recommend to Mrs. Palmer; he explained that some of them are not effective in cases of headache arising from trauma, as distinct from headache arising from other causes, and that some of them have adverse side-effects that outweigh their benefits. Some classes of drugs and particular drugs were suggested in general terms to Dr. Robinson, as potentially useful for treatment of headaches such as Mrs. Palmer's; he indicated that he would have prescribed them if he had considered that they

would have been helpful. However, he was not asked to elaborate for Mrs. Palmer's specific situation the balancing analysis (potential benefits vs. adverse effects) to which he had referred in only general terms.

[24] In *Luedecke*, Cullen J. was considering by way of appeal Rule 7-6(1), the requirement for an independent medical examination. There the plaintiff introduced for the first time the issue of the plaintiff's knee injury some 84 days before trial. The defendants sought and obtained an order that the plaintiff attend Dr. Reebye for an independent medical examination. The plaintiff appealed, submitting the Master had made an order which conflated the nature and purposes of responsive evidence governed by Rule 11-6(4) with that governed by Rule 11-6(3), that is an initial expert's report.

[25] After reviewing the law, Cullen J. concluded at paragraph 49:

> 49 Although the plaintiff submits Dr. Reebye should be limited in his report to "criticizing the methodology or the research or pointing out facts apparent from the records which the other examiners may have overlooked", based on Justice Savage's apparent reliance on *C.N. Rail, supra*, I do not take from Savage J.'s judgment that responsive opinions are invariably limited to a "critical analysis of the methodology of the opposing expert."
>
> 50 In *C.N. Rail, supra*, Henderson J. was dealing with rebuttal evidence in the classic sense described by Southin J. in *Sterritt v. McLeod, supra*, as simply evidence responsive to some point in the oral evidence of the witness called by the defendant.
>
> > 51 What is at issue in the present case is a different form of responsive evidence, recognized in *Stainer v. Plaza, supra*, as distinct in paragraph 15, where Finch J.A. (as he then was) noted:The third condition in the order is directed to the third party calling an independent medical examiner "for rebuttal evidence" I understand from counsel that this refers not to rebuttal evidence as generally understood, but to evidence that is purely responsive to medical evidence which the plaintiff has led as part of her case. It would not apply to opinion evidence offered by the third party on subject matters not adduced in the medical evidence adduced by the plaintiff. [underlining added]
>
> 52 I thus conclude that what is referred to in Rule 11-6(4) is not akin to rebuttal evidence such as that called by a plaintiff in response to a defendant's case, with its consequent limitations. Nor is it akin to expert evidence that responds generally to the subject matter of the plaintiff's case. Rather, it refers to evidence that is "purely responsive" to the medical evidence which the other party has called.

[26] Unlike in *Palmer*, Dr. Boyle's report advances no new theory explaining the plaintiff's symptoms. The thrust of the report is that, absent bony injury or neurological involvement, he would expect "the overwhelming majority of patients to have substantially recovered within a six-to-nine-month window." He diagnosed the plaintiff's shoulder complaints as a grade 1 to minor grade 2 strain, all of this without having seen her.

[27] The absence of any physical examination of the plaintiff by Dr. Boyle is a matter the jury would undoubtedly consider. With all of that in mind, I conclude, after review of the two medical reports to which Dr. Boyle purports to respond, that his opinion that the right shoulder injury suffered by the plaintiff is either a grade 1 or grade 2 strain is responsive to the opinion of Dr. Crossman that the origins of the injury is a "irritation of the acromioclavicular, (AC), joint" and, as such, is properly admissible.

[28] As well, his opinion as to the majority of patients suffering similar injuries recovering over time is admissible.

[29] I will hear further from counsel as to a replacement for the adjective "overwhelming". I consider the adjective argumentative or at the very least overstated absent statistical information referencing studies of patients diagnosed with grade 1 - grade 2 AC strains.

[30] As to the diagnosis of the neck injury, all experts agree that the injuries are not to bony structures but to soft tissues of the plaintiff's neck. To include reference to that fact does not, in my mind, offend the principle in Rule 11-6(4) that the report, if delivered within the 42-day timeline contemplated by the Rule, must include only a critique or response to the opinions tendered by the plaintiff. They are entitled to a full narrative. It is the opinion which must be responsive.

[31] The bigger issue is the question of Dr. Boyle's opinion as to the duration of the injury. Dr. Hassam, whose report was delivered in 2009, stated that the injury was chronic and of an indefinite if not permanent nature. Dr. Crossman, his report

was delivered July 2011, mitigated this somewhat by stating that the injury to the neck would likely improve but would persist indefinitely.

[32] I assume counsel for the defence are equipped with any empirical data to cross-examine the plaintiff's experts on the statistical likelihood of recovery in soft tissue injury cases where investigation reveals no pathology to the bony structures of the patient, where other pathology exists such as neurological involvement.

[33] The Boyle report is responsive as it relates to there being no objective evidence of pathology involving the C3-C4 facet joint (albeit this I assume would be agreed to in cross-examination), Dr. Crossman "suspects" that the plaintiff has an irritation of the right greater than the left C3-4 facet joints. Dr. Boyle disagrees and provides the opinion the injury would appear from the records and history available to be simply of a soft tissue origin.

[34] The opinion is responsive to the extent that it disagrees that the injury is chronic. While this may be at the heart of the issue between the litigants, the burden is on the plaintiff to prove it. Upon receiving the totality of the plaintiff's expert's report, the defendant is entitled to provide responsive opinion to those matters where the plaintiff has that burden.

[35] In *Kroll v. Eli Lilly Canada Inc.* (1995), 5 B.C.L.R. (3d) 7 (S.C.), a decision approved later by the B.C. Court of Appeal in *Sterritt v. McLeod*, 2000 BCCA 318, Saunders J. (as she then was) stated:

> 7 In my view, Rule 40A(3) was not intended to prevent the court's receipt of evidence from expert witnesses which is in response to the opinion of experts presented by other parties to the action. While it will often be desirable that notice of such evidence be provided to a party prior to commencement of trial, and this will often be agreed by parties in litigation in which the action is subject to case management, such notice is not required, in my view, by the new Rule. I consider that the law as enunciated in *Pedersen v. Degelder* is still applicable to response to expert reports, and note that this exception to the requirement for advance written notice of the expert's view, limited strictly to true response evidence, does not permit fresh opinion evidence to masquerade as answer to the other side's reports.

[36] Rule 11-6 (3) and (4) recognize the concerns expressed by previous courts and extended the window for the delivery of expert reports to 84 days prior to trial and provided responsive reports must be served 42 days before trial. That has been done here.

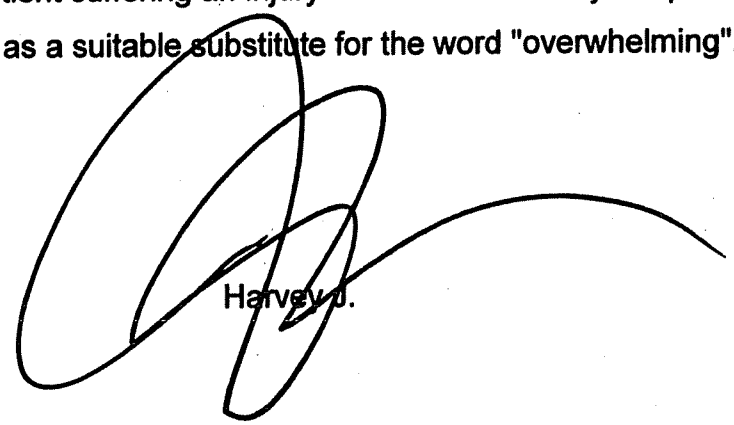
[37] That is not to say that the report is admissible as tendered. References to what was on the minds of the plaintiff's attending doctors are, in my view, impermissible by way of response. Those references should be expunged.

[38] Similarly, self-congratulating remarks such as those contained at the end of the report, specifically "This affirms the writer's belief in the above impression" ought to be removed.

[39] I also consider the word "overwhelming" to be hyperbole and potentially prejudicial to the jury absent reference to empirical studies relating to the recovery rate of patients of like gender, age, physical make-up as to this particular plaintiff. It needs to be removed from the report wherever it appears. Counsel may make submission as to another adjective to use in its place if they deem it appropriate.

[40] Both counsel would be aware of the Rule in *Pederson v. Degelder* (1985), 62 B.C.L.R. (253) (S.C.) and will limit their direct examination of experts called in accordance with that Rule.

[41] I will at the end of the case consider a limiting instruction concerning the use the jury might make of statistical information or standalone opinions unsupported by reference to empirical data or data obtained by Dr. Boyle through his practice as to likely recovery of a patient suffering an injury like that suffered by the plaintiff here. I will hear submissions as a suitable substitute for the word "overwhelming".



Harvey J.

# APPENDIX

August 24, 2011

ICBC
800-808 Nelson Street
Vancouver, B.C.
V6Z 2L5

Attention: Mark Gibson, Counsel, Litigation Department

Dear Sirs:

Re: HANSON, Julia
File #426963
Claim #M642125-4
Date of MVA: November 18, 2006

For the purpose of this report, I was asked to review material provided to me. I was not asked to, and did not, interview and examine this patient.

PLEASE NOTE: Re: Rule 11-2:

1. I am not an advocate for any party to this action.

2. I am aware of my duty to assist the court.

3. My report is in conformity with my duty to the court and I will, if called upon to give oral or written testimony, give that testimony in conformity with this duty.

4. I have prepared my report in response to instructions provided by defence counsel to review material provided to me regarding Julia Hanson and provide my opinion with respect to any injuries Julia Hanson sustained in a motor vehicle accident of November 18, 2006.

QUALIFICATIONS: B.A., M.D., F,R,C,S,(C), ORTHOPEDICS

I am a duly qualified Orthapedic Surgeon, licensed to practice in the Province of British Columbia under the Medical Practitioners' Act. I was a graduate of the University of Ottawa Medical School in 1973 and completed a fellowship in Orthopedic Surgery in 1979. I carried out a general orthopedic practice and for 22 years at M.S.A. General Hospital. For eight years prior to this, I was on the trauma

service at Vancouver Hospital. I did retire from general orthopedic practice in May 2009.

A curriculum vitae is available on request.

I am the person principally responsible for the preparation of this report.

The opinion expressed was formulated mainly from the facts obtained from review of accompanying documentation.

The material that I was asked to review include items 3, 12 and 13, accompanying a letter from Mark Gibson dated August 17, 2011.

**REVIEW OF ACCOMPANYING DOCUMENTATION**

Medical report from Dr. Hassam dated August 10, 2009.
Review of the records indicates the first visit was 1 week post-MVA.
Areas of complaint are the neck and mid-back.
Therapy was with Naproxen.

There is an entry of December 6, 2006 which is just short of 3 weeks post-MVA when the patient attempted to return to work but lasted only three hours.
The suggestion was that she remain off work until January when she would attempt 1-2 hours per day.

Entry of January 15, 2007 suggests the patient has chronic pain.
Treatment includes amitriptyline.
The accident report indicates she was a back seat passenger in a Volkswagen Jetta which was struck on the right side. The vehicle was written off. It states she did not go to the hospital.

Medical-legal report of August 10, 2009
He lists her past history with an MVA in April 2005 in which she suffered a grade 1 cervical strain from a motor vehicle accident. Her complaints resolved.
She presented on November 14, 2006 with mild musculoskeletal sacroiliac pain thought to be multifactorial in origin possibly due to posture, exercise and stressors.

It is noted that she was seatbelted and had an appropriate headrest.

The impact was from the right side. It is noted that she struck the left side of her head against the deployed air bag. At the scene, she had right-sided discomfort including her face. She exited the vehicle independently. There was no loss of consciousness. There does not appear to be any amnesia.

She had neck, back, leg and shoulder stiffness and pain. She had headaches. She had superficial bruising to her face and legs.

When she presented to the clinic on November 20, she had significant reduced range of motion of her neck. She had low back discomfort. There was paracervical and paralumbar tenderness.

She was referred to chiropractic and rehab treatments and prescribed Naproxen.

Neurologically, she was intact.

Diagnosis was multiple soft tissue strains.

She was attending chiropractic care and massage therapy through December 2006 and January 2007.

She was referred to ARC Rehab in the latter part of January.

A 6-week program was initiated.

In March, it would appear that she was working. She did white collar work at a desk at a computer.

She was planning as of April to switch work to that of a project manager/coordinator with a construction company requiring less sitting and computer work.

She was referred to Dr. Condon.

In May, she was back to work full-time.

A bone scan in June 207 at St. Paul's was normal.

In June 2007, she was working as an interior designer and project manager for a construction company.

It would appear that she travelled extensively over the winter of 2008-09 and she was last seen in February 2009. She had ongoing neck pain and stiffness, poor sleep, decreased energy levels, depressed mood and recurrent headaches.

She was unable to work at times and had difficult working on computers.

She had diminished capacity for exercise.

She used pain medication.

As regards prognosis, it was felt that it was guarded and that she would require treatment in the future, i.e. physiotherapy, massage, chiropractics or acupuncture. It was felt this would be required indefinitely.

It was felt that she had some restrictions re: advancing her career.

He commented on the possibility of increased susceptibility to exacerbations and recurrences.

There is a report from Providence Health Care which is incomplete regarding neurological examination and EMG studies. Only the first page is available. This writer would value the opportunity to review the entire document.

C-spine report and right shoulder ultrasound are from Dr. Patel dated April 27, 2009. No abnormality is noted in either.

Progressive Rehab Work Capacity Evaluation is dated September 27, 2010. It was carried out by an OT, Gary Worthington-White. The issue that was encountered was of neck and right upper extremity discomfort.

It was felt that she was capable of limited light and some occasional medium strength work. She required the ability to move around and change positions during the work day.

She was working full time as an architectural technician with Rafii Architects.

She worked sitting at a computer. This position resulted in increased neck pain and headaches.

She eventually left this position.

Her work for Home Sweet Home Improvements was then reviewed. She had more regular opportunity to change positions and move around.

It is then indicated that she started her own design and project management company known as AKAO Design and Management.

They reviewed the activity involved.

In further describing her work requirements, some of it was classified as medium and, in some cases, heavy strength work requiring standing, walking, kneeling, crouching, stooping and multiple limb coordination.

It was felt that she was poorly suited for exposure to such positioning.

It was therefore felt that she would likely continue to experience aggravation of her symptoms performing some of the job demands required of running her own interior design project management company. Continued symptoms would likely have some degree of impact on her work durability in this line of employment.

As regards ongoing studies in interior design, discomfort caused difficulties in meeting deadlines.

Discussion concerning an ergonomic review of her work space was made and recommendations done.

Report of Dr. Crossman, Physiatrist, is dated June 13, 2011.

In Diagnostic Considerations, page 3, line 15, there was an indication that the patient did have issues prior to the MVA.

On January 26, 2005, a medical history form was filled out by the patient when she saw a massage therapist in which she stated she had "constant pain in my back and neck."

She stated it had "been a problem for years but sitting at work all day has made it worse, last 6 months sitting, working out."

He reviews outside stressors.

He felt she had soft tissue injuries of her cervical, thoracic and lumbar spines.

He feels that her history of neck pain and associated headaches was exacerbated by the MVA.

He felt she had inflammation of her right greater than left C3-4 facet joints. He felt her headaches were cervicogenic.

He felt she had some acromioclavicular joint irrigation.

There was no evidence of thoracic outlet syndrome.

He suggested C3-4 blocks.

He felt she could then participate in an exercise program.

He felt an injection into the right AC joint would benefit her.

He suggested the use of Gabapentin or Lyrica.

He suggested an ergonomic evaluation at the work place.

AS REGARDS PROGNOSIS:

He felt that she would not be able to work in jobs that required sustained cervical flexion or extension, repetitive overhead activity, heavy lifting and heavy, frequent pushing and pulling. He felt that the position of an architectural technician is not appropriate.

He discussed how she could work as an interior designer. She should restrict herself to more of a management position.

She is likely to be able to do her own domestic duties and it was noted that she was working on her own home renovations. The latter would suggest an activity greater in Intensity than that which she would be performing in her work environment. He discussed the possibility that heavy yard work would result in some difficulties.

**IMPRESSION**

Cervical Spine
The patient suffered a myofascial strain. This is an injury to ligaments, tendons and muscles. There is no evidence of injury to vertebrae, disc pathology or neurological compromise.
The only investigation is a plain film x-ray of her cervical spine, which was normal. She has not had an MRI, CT scan or bone scan ~~suggesting that her treating physicians were no entertaining any other diagnosis~~.

~~She is unlikely to undergo late degenerative changes. She is unlikely to require surgery~~.

Medical management should be in the form of stretching and strengthening exercises and over-the-counter anti-inflammatory medication.

It has been recommended by others, and this writer agrees, that an ergonomic evaluation of her work space and accommodations to minimize the flexed cervical position should be carried out.

Dr. Crossman felt that she may have a right-sided C3-4 facet "irritation". He suggested the possible role of injections.

There is no objective evidence of pathology involving the C3-4 facet joint. As stated previously, there has not been an MRI, CT scan or a bone scan (the latter being quite sensitive to the presence of inflammation). ~~The physicians treating her obviously felt that there was no diagnostic or potentially therapeutic value in doing so. The diagnosis of soft tissue injuries is the only one entertained or consistent with the findings~~.

Taking into consideration her age, gender, prior history, absence of prior pathology and the events surrounding the MVA, it is acceptable to consider that her symptoms would have been of a longer lasting nature than the norm. However, resolution over time of the symptoms attributable to the MVA is the ~~overwhelming~~ likelihood. There is no objective evidence of pathology that would explain a failure to follow this course.

She was well enough to travel extensively in the year post MVA. she is well enough to have undertaken renovations in her home.

Right Shoulder
Some tenderness was noted over the AC joint on the right by Dr. Carlson. No other abnormality was noted. An ultrasound of the right shoulder was negative.

This is likely to be at most a grade 1 to a minor grade 2 strain.

~~She is unlikely to undergo late degenerative changes~~. ~~She is unlikely to require surgery~~.

Medical management should be in the form of stretching and strengthening exercises.

Over-the-counter anti-inflammatories are appropriate. There is a possible role for an intra-articular injection.

**PROGNOSIS**

As regards the cervical spine, the ~~overwhelming~~ likelihood of such an injury is for resolution over time.

There is no objective evidence of pathology to suggest that this outcome would not occur. There is no objective evidence of pathology to explain her ongoing complaints.

As regards the right AC joint, a grade 1 or minor grade 2 strain has an ~~overwhelming~~ likelihood. Again, there is no objective evidence that I have seen to provide a reason for continued symptoms.

**RECOMMENDATIONS**

Passive modalities of therapy are not appropriate, i.e. massage therapy or chiropractic care.

Active therapy in the form of a regular exercise program that emphasizes stretching and strengthening exercises is appropriate. To that end, I would recommend that she be provided with a 1-year membership at a gym. The first 4 months should be under the guidance of a physiotherapist/kinesiologist to gradually increase her program.

It is this writer's opinion that the events surrounding the motor vehicle accident would have resulted in difficulties in daily living, i.e. work, leisure and home, for 6 to 9 months. Gradual resolution over that time would occur such that, by 9 months or so, some residual discomfort would be present but would not be inhibiting.

Long term resolution of the symptoms attributable to the MVA should be complete. The patient would have freedom of participation in any and all activities at work, leisure and home that she enjoyed previously. I feel that this is evident now as the

patient does use her sport motorcycle. As outlined by Dr. Crossman, this requires positioning of the cervical spine and shoulders and arms in such a way that, according to the patient, would bring on limiting symptoms. In addition, the jarring of the motorcycle would contribute to these. Despite this, the patient is ~~quite capable~~ of participating in this.

~~This affirms this writer's belief in the above impression~~.

Yours sincerely,

M.R. Boyle, M.D.
MRB/dvt