PERSONAL INJURY SETTLEMENTS:

Resolution Oriented Case Management, Mediation and Arbitration

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> *Is it possible to improve estimates of the severity of human impairments, basing them on accepted medical standards? Can those estimates be used in comparing, evaluating, and adjudicating claims of ill health and impairment arising in workers compensation cases, Social Security Administration cases, and other types of cases?*
>
> *This book, Guides to the Evaluation of Permanent Impairment (Guides), began to take form during the 1950s under the premise that the answer to the first question is "yes…*[1]
>
> *The Guides provides a standard framework and method of analysis through which physicians can evaluate, report on, and communicate information about the impairments of any human organ system. The book uses up-to-date information on impairment and illness provided by knowledgeable clinicians and scholars.*[i2]
>
> *If two physicians who examine a patient and use the methods of the Guides do not obtain similar results and reach similar conclusions, then the book can be used to resolve discrepancies. Analysis of the records and reports in question will disclose the disparities which should be matters of fact rather than opinion. If the patient's medical condition is stable, then different physicians should reach the same general conclusion. If widely disparate evaluations occur, then the stability of the medical condition and the matter of permanent impairment would be in question*[3]

According to these introductory passages from the 4th Edition of the *AMA Guides to the Evaluation of Permanent Impairment*, objective assessments of impairment and low inter-rater variability can be achieved by clinician adherence to the structure and methodologies of the *Guides*, with the goal of improving the "quality and equity" [4]of adjudication when the *Guides* are

[1] American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th Edition, 1993, Page 1/1

[2] Ibid

[3] Ibid, page 2/7

[4] Ibid, page 1/5

used in a claims or litigation context. It was no doubt the promise of a straightforward and objective standard for evaluating impairment severity that led to the incorporation of the 4th Edition of the *Guides* into Ontario's statutory accident benefits legislation in 1996 as a basis for determining "catastrophic impairment" which in turn allows an injured insured to access enhanced levels of benefits available to those who qualify for "catastrophic" designation.

"Catastrophic Impairment" is defined at section 2 of the *Statutory Accident Benefits Schedule* as follows:

> *a. paraplegia or quadriplegia;*
>
> *b. the amputation or other impairment causing the total and permanent loss of use of both arms or both legs;*
>
> *c. the amputation or other impairment causing the total and permanent loss of use of one or both arms and one or both legs*
>
> *d. the total loss of vision in both eyes;*
>
> *e. subject to subsection (1.4), brain impairment that, in respect of an accident, results in,*
>
> > *i. a score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., Management of Head Injuries, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or*
> >
> > *ii. a score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett B. and Bond, M., Assessment of Outcome After Severe Brain Damage, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;*
>
> *f. subject to subsections (1.4), (2.1) and (3), an impairment or combination of impairments that, in accordance with that American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a 55 per cent or more impairment of the whole person; or*
>
> *g. subject to subsections (1.4), (2.1) and (3), an impairment that, in accordance with the American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.*

There has been little controversy surrounding the criteria set out at paragraphs a) through d) of the definition, given the generally objective nature of those criteria.

The various qualifiers contained at paragraph e) of the definition created some early litigation surrounding the issues of whether a GCS reading had been taken within a "reasonable" period of time by a person "trained for that purpose" and reflected the results of a head injury as opposed to confounding factors such as intoxication, medication or other types of injuries. While there are still controversies on these points, it appears to be generally the case that a GCS of 9 and under obtained during the course of urgent care evaluations in the presence of a head injury will trigger a catastrophic determination, even if there are issues of concern as to whether all of the qualifying clauses have been satisfied.[5] Further litigation on this aspect of the catastrophic threshold would only be expected in cases where an insurer might choose to seek a more favourable precedent based upon the facts of a particular case, such as where a clearly "non-catastrophic" outcome follows from a questionable GCS reading.[6]

By contrast, the criteria at sections 2(f) and (g) of the *Schedule* continue to create significant ongoing controversy and litigation.

By reference, sections 2(f) and (g) of the *Schedule* incorporate the 15 chapters of the 4th Edition to the *AMA Guides* in their entirety into the *Statutory Accident Benefits Schedule*.[7] Far from providing a clear and objective methodology for evaluating impairment for the purpose of determining whether the catastrophic threshold has been met, sections 2(f) and (g) are the basis of the current majority of contested catastrophic cases, and have spawned a multi-million dollar industry as catastrophic evaluation costs now routinely exceed $50,000 per case on a combined basis. Where multi-disciplinary rebuttals follow section 24 and section 42 catastrophic evaluations, insurer clients are reporting that the evaluation costs on a file may reach $100,000 before a penny of catastrophic level funding is available to the insured.

From an insurer's perspective, some of the areas of concern surrounding sections 2(f) and (g) of the *Schedule* can be encapsulated as follows:

1. Which experts should comprise the catastrophic evaluation team, and how should a "consensus" opinion on the catastrophic question be developed?

2. Which evaluation methodology is "correct"?

3. What is the role of the expert?

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[5] See for example Young and Liberty Mutual (2005) O.F.S.C.D. No. 76, Holland v. Pilot Insurance Co. (2004) O.D. J. No. 2737 (Ont. C.J.), Tournay v. Dominion (2006) O.F.S..C.D. No. 137, Michalski (Litigation Guardian of) and Wawanesa Mutual Insurance Co. (20050O DF.S.C.D. No. 150

[6] Liu v. 1226071 Ontario Inc. (2007) O.J. No.1504 (Ont. S.C.J.), appeal pending

[7] Desbiens v. Mordini [2006] O.J. No. 4735 (Ont. S.C.J.)

4. How should psychological impairments be assessed in accordance with the *Guides*?

5. Where a catastrophic insurer's examination is incomplete or of poor quality, what remedy does an insurer have?

Based upon the kinds of issues we are seeing in our catastrophic file caseload, I will discuss each of these issues in turn.

1. Which experts should comprise the catastrophic evaluation team, and how should a "consensus" opinion on the catastrophic question be developed?

Prior to March 1, 2006, an insurer wishing to question an OCF-19 Application for Determination of Catastrophic Status was required to refer the insured to a Catastrophic DAC assessment. There were a limited number of accredited "CAT DAC" facilities. In addition to establishing that the assessors within the facilities possessed sufficient expertise to conduct catastrophic evaluations, accredited CAT DAC facilities were also required to follow certain assessment protocols in conducting catastrophic evaluations.

With the demise of the DAC system, there is no longer any formal accreditation process which must be completed before an assessment facility can undertake catastrophic evaluations. As a practical matter, evaluations based upon the *AMA Guides* do require specialized expertise, given that the *AMA Guides* are only generally employed in Ontario in the context of statutory accident benefits or workers' compensation claims, and therefore physicians not working within the context of these regimes would have no further occasion to use the *Guides*. The use of the 4th Edition of the *Guides* is, in addition, somewhat enigmatic, given that the 4th Edition was published in 1993 and has now been further revised twice. While some jurisdictions mandate the use of the "current" edition of the *AMA Guides*,[8] the *Statutory Accident Benefits Schedule* has incorporated by reference only the 4th edition, even though the *Guides* themselves caution against the use of any but the most current edition. Thus, if an assessor is to conduct a catastrophic evaluation for the purposes of the *Schedule*, he or she must be familiar with a comprehensive method of evaluation which is now 8 years out of date, and of limited utility in Ontario outside of the accident benefits context.

In addition, in the post-DAC era, there are no longer any formal assessment protocols to be followed in conducting a catastrophic evaluation. The prior assessment protocols attempted to promote consistency and neutrality in catastrophic evaluations by mandating how information would flow to and from the DAC facility, and by prescribing a set intake protocol. They also provided a degree of "quality control" in setting out a decision making structure to be followed in planning the evaluation process for any given insured, considering the applicability of each aspect of the catastrophic definition, in order to make sure that all components of the definition were addressed. Only once this evaluation process had been completed in its entirety (or appropriate "exit points" to the assessment process employed) would a catastrophic formulation

[8] See http://www.impairment.com/use of the_AMA_Guides.htm

be developed on a consensus basis. The "clinical co-ordinator" responsible for developing the consensus report would typically be an assessor who was very experienced in the use of the *Guides*, and who could assist other assessors in translating their clinical findings into a catastrophic formulation using the methodologies of the *Guides*.

Of course the DAC system had many flaws. From an insurer's perspective, chief among these was the fact that the role of the DAC facilities was never fully developed. At the outset, it appeared that the DACS would have a neutral, quasi-adjudicative role. The results of a DAC evaluation were understood to be binding upon an insurer on an interim basis, subject to access to dispute resolution. Provided that the quality of the DAC evaluations was good, this should have served to limit the number of disputes regarding entitlement to accident benefits. What happened in fact was that the DACs were not perceived to be neutral. That they tended statistically to support the limitation or termination of benefits was used to argue that DACs were biased in favour of insurers and were not to be trusted by insureds or their representatives. It soon also became clear that an adjudicator would not give a DAC report any particular weight, notwithstanding the fact that DAC assessors were supposed to be trained and neutrally accredited to be conducting evaluations pursuant to the *Schedule*. An insurer relying upon a DAC that was later found to be incorrect in its conclusions would still be liable for extra-contractual damages even if procedural provisions of the *Schedule* had been followed to the letter, if that reliance was later found to have been unreasonable. At the same time, an insurer would not have a choice as to which DAC facility to use in a given case, and would have to fund the DAC report regardless of the quality of the work that was generated. Practically speaking, there was no mechanism for an insurer who wished to challenge a flawed DAC assessment, particularly a flawed CAT DAC.

According to information summarized on the Financial Services Commission of Ontario website in a chart entitled "Comparison of Designated Assessment Centre (DAC) System to Post-DAC System", the abolition of the DAC system was intended to "streamline" the assessment process and "avoid duplication" by minimizing the number of examiners where possible, and by combining broad benefit categories into a single examination. [9] Almost three years later, we are actually seeing the opposite occur, as the quantity of assessment pre-approval requests has increased enormously. Practically speaking, it is not often possible to "combine broad categories of benefits" into single assessments, given the tight timelines mandated for referring a disputed expense to a section 42 evaluation, and given that it is the insured person (or more often the service providers) who dictate the manner and timing of medical, rehabilitation and assessment applications, and not the insurer.

In the catastrophic context in particular, the assessment process has not been assisted by the move away from the DAC system. While the previously accredited CAT DAC facilities have carried on using more or less the same protocols as they did under the DAC system, an increased number of facilities now offer catastrophic assessments. An increase in the number of facilities offering catastrophic evaluations is potentially a very good thing, but there are still major

[9] See http://www.fsco.gov.on.ca/English/Insurance/auto/dacs/DACTransitionsChart.pdf

difficulties standing in the way of obtaining reliable, comprehensive, good quality catastrophic assessments, particularly in complex cases.

The first practical difficulty in any catastrophic assessment involves compliance with the timeframes set out in section 42 of the *Schedule*. More often than not, a catastrophic referral will be accepted by the assessing facility with the caveat that the *Schedule*–mandated time frames for seeing the patient and generating a report simply will not be met. Where the insured objects to any extension in these timeframes, precious time has already been lost in attempting to refer the matter to the first facility, and it will be even more difficult to find a second facility who can conduct the assessment in the even more limited amount of time that remains.

Once a referral has been made for the catastrophic evaluation, there is no longer a consistent intake protocol, or even a consistent approach to determining which experts will play which role in the evaluation process. In some cases, an appropriate intake will occur and a formal assessment protocol will be developed that is suitable for the case. In other situations, we have seen *ad hoc* assessments occur without any particularly reasoned approach to the selection of experts or even the order of the evaluations. If a co-ordinated approach is not taken at intake, it is highly unlikely that a comprehensive consensus report will result from the evaluations. If the referral or intake for a catastrophic evaluation is botched, it is very difficult to salvage the process.

Even in the case of catastrophic evaluations undertaken in the DAC era, there was little an insurer could do to obtain more reliable evidence when presented with a poor quality report, regardless of whether the error was in favour of the insurer or the insured person.[10] Now that the insurer is theoretically free to select any qualified assessor to complete an evaluation, it is likely that errors on the part of assessors will be attributed to the referring insurer. When initiating a catastrophic assessment, it is important to make sure that the receiving facility is in fact equipped to deal with the case and has a roster of experts which includes the specialties or subspecialties relevant to the case. Now that there is no longer a standard intake and assessment protocol, the insurer needs to be satisfied at the point of intake that an appropriate protocol will be developed for *this* case, and that a consensus report will result from the assessment. The author of the consensus report should be able to speak to the assessment protocol that was employed, and should be able to clearly explain how the clinical findings of the various individual evaluators were used to arrive at a formulation pursuant to the *Guides*. It is also incumbent upon the referring insurer to make sure that the referral questions appropriately direct the medical experts to the legal questions that their evidence will be used to answer. For example, each referral should appropriately direct the assessors to the proper legal test of causation, which they will need to answer in medical terms. It is important to remember that the assessors are qualified to give medical evidence and not legal opinions.

[10] See Murray and Aviva (FSCO A07-000015)

2. Which evaluation method is "correct"?

Chapter 1 of the *Guides* states as follows:

> *It should be understood that the Guides does not and cannot provide answers about every type and degree of impairment.…The physician's judgment and his or her experience, training, skill and thoroughness in examining the patient and applying the findings to Guides criteria will be factors in estimating the degree of the patient's impairment.*[11]

The role of an assessor's experience and use of discretion is emphasized as well in Chapter 2.2 which sets out the "Rules for Evaluation," including the following passage:

> *The physician must utilize the entire gamut of clinical skill and judgment in assessing whether or not the results of measurements or tests are plausible and relate to the impairment being evaluated. If in spite of an observation or test result the medical evidence appears not to be of sufficient weight to verify that an impairment of a certain magnitude exists, the physician should modify the impairment estimate accordingly, describing the modification and explaining the reason for it in writing.*[12]

Within the chapters dealing with the evaluation of various systems, there are again judgment calls to be made between different methods for evaluating the same impairment, as well as for the selection of a particular impairment rating within ranges offered in the *Guides*. Consistent impairment ratings thus depend upon different evaluators making the same or similar judgment calls in employing the *Guides* for the purposes of arriving at a whole person impairment rating or an assessment of mental or behavioural impairments using chapter 14 of the *Guides*. To the extent that different approaches to certain aspects of the *Guides* have been espoused by different medical experts, there is inevitably going to be lack of consistency in employing the *Guides*, and an increase in litigation on these issues until they are resolved at an adjudicative level.

Ultimately, in the context of litigation or arbitration, the "correct" approach to evaluating impairment will be the one which is accepted by the trier of fact. Beginning with *Desbiens v. Mordini*, decision makers have made it clear that they will not be bound to follow one of two or more competing expert approaches to conducting a whole person impairment, but see the determination of impairment in accordance with the *Guides* to be an adjudicative rather than an expert function.

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[11] Guides, page 1/3

[12] Guides, Page 2/8

3. What is the role of the expert?

In the first level decision in *Ms. G and Pilot*, Arbitrator Blackman (as he was then) commented as follows:

> *The trier of fact is not simply reduced to choosing between expert medical opinions. The trier of fact, rather, has the responsibility under paragraph 2(1)(f) of the Schedule to endeavour, in accordance with the rules of statutory interpretation, to capture and accurately estimate all of the impairments that an insured person has sustained as a result of the accident.*[13]

In the more recent case of *Sharma and Allstate Insurance Company*, Arbitrator John Wilson declined to admit a "paper review" catastrophic report by Dr. Christopher Brigham, stating:

> *I am not convinced that Dr. Brigham's report necessarily provides information that is outside the experience and knowledge of an arbitrator in an accident benefits matter. Sifting the evidence and interpreting the AMA guidelines in the context of the Ontario accident benefits scheme are precisely the core functions of an arbitrator and not that of an expert witness.*[14]

Arbitrator Wilson also expressed concern that admitting Dr. Brigham's report might offend the rule in *R. v. Mohan,*[15] in that the necessity of expert evidence is only established when that evidence speaks to issues which are outside of the knowledge or experience of the trier of fact. In *Mohan,* the Supreme Court of Canada warned against the use of expert evidence where the effect of that evidence would be to "distort the fact finding process" and to "usurp the functions of the trier of fact". In *Mohan*, there was concern that the testimony of a psychiatrist regarding the "disposition" of the accused (and therefore his likelihood of having committed the crime in question) went to the central issue that was before the trier of fact.

At the same time, in the personal injury context, any medical expert opinion will necessarily speak to the central issue before the trier of fact, whether it is disability crossing he threhold, catastrophic impairment or the reasonable necessity of goods and services. To restrict an expert from offering an opinion on the central issue in dispute (i.e. whether an insured crosses the catastrophic threshold) would be counter to common sense and to the defined role of the expert set out in the assessment procedures mandated in the *Schedule.* In the catastrophic context, the issue is further complicated by the fact that the structure of the *Guides* themselves clearly

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[13] (FSCO A04-000446)

[14] (FSCO A07-001223)

[15] R. v. Mohan [1994] 2S.C.R.9

indicate that there is a specialized role for the medical expert in assessing a patient "in accordance with" the *Guides.*

> *The physician's judgment and his or her experience, training, skill and thoroughness in examining the patient and applying the findings of the Guides criteria will be factors in estimating the degree of patient's impairment. These attributes compose part of the "art of medicine", which, together with a foundation in science, constitute the essence of medical practice.*[16]

This passage and others speaking to the role of the medical judgment in conducting an assessment pursuant to the *Guides* are incorporated by reference into the *Schedule.* As Justice Spiegel stated in *Desbiens v. Mordini*:

> *The question of whether something is "in accordance" with the Guides also requires an interpretation of the Guides. Non-statutory instruments that have been incorporated by reference are considered part of the regulation.*[17]

Taking the evidence of an expert out of the broader context of the *Guides* can result in somewhat problematic reasoning as in the recent FSCO case of *Pastore and Aviva* [18]. In that case, unlike the cases of *Sharma* and *Angello* [19], the evidence of Dr. Christopher Brigham was accepted and Dr. Brigham's testimony formed an important part of the foundation of the Arbitrator's ruling. However, she commented on Dr. Brigham's testimony on the Applicant's "pain focused" behaviour as follows:

> *It would seem that Dr. Brigham viewed Ms. Pastore's pain complaints with some suspicion or disbelief which cast doubt on her level of impairment in general. It would seem that in this case Dr. Brigham was not only examining inconsistent medical evidence and information that related to Ms. Pastore's knee but was assessing her overall credibility – a role reserved for the decision maker.*

And yet, in the passage from Chapter 2 of the *Guides* "Rules for Evaluations", the assessing physician is specifically directed to determine whether or not results are "plausible" :

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[16] Guides, page 1/3

[17] Desbiens v. Mordini, Para 227

[18] (FSCO A04-002496)

[19] (FSCO A07-001204)

> *Tests of consistency….are good but imperfect indicators of patient's efforts. The physician must utilize the entire gamut of clinical skill and judgment in assessing whether or not the results of measurements or tests are plausible and relate to the impairment being evaluated. If in spite of an observation or test result the medical evidence appears not to be of sufficient weight to verify that an impairment of a certain magnitude exists, the physician should modify the impairment estimate accordingly, describing the modification and explaining the reason for it in writing.* [20]

Thus, when a physician has conducted an assessment in accordance with the *Guides*, it would appear that there is a dual but unequal role for the expert and the adjudicator in assessing credibility. The physician assessor is directed to determine whether results are "plausible" and relate to the condition being evaluated, based upon his or her clinical expertise. The trier of fact will ultimately determine credibility, and may be informed to some degree by the opinions of the experts as to whether the insured person presented credibly within the context of the medical assessment. Ultimately, however, the trier of fact will draw his or her own conclusion regarding credibility which may cause some or all of the opinion of the expert to be rejected if the conclusions are different. However, the fact that the adjudicator is ultimately charged with the responsibility of determining credibility does not remove from the expert's job the task of determining whether the assessment results are plausibly related to the impairment being assessed.

There remains a defined note for the expert who is called upon in the "*Guides* to employ experience, training, skill and thoroughness in examining the patient" and to integrate previously gathered medical information with the results of a current evaluation." An evaluation in accordance with the *Guides* then requires a three part process. First, medical evidence must be gathered in accordance with Chapter 2 of the *Guides*. Second, the *Guides* chapters on organ systems are to be used in evaluating a particular potential impairment, and third, the tables in the *Guides* are used to arrive at a whole person impairment. There is a role for medical expertise in each of these steps and in each decision that needs to be made to arrive at a whole person impairment in accordance with the *Guides*.

In order for this expertise to be useful to the trier of fact, however, the expert must be mindful of the fact that an adjudicator is free to accept all, none of some of the expert testimony. Expert testimony should ideally present a clear analysis of the process followed, and the basis for each decision, a description of the alternatives available and reasons for rejecting the alternatives, providing a "road map" for the adjudicator to follow in considering the experts' testimony. This "road map" if persuasive, will lead the trier of fact to a determination on the catastrophic issue, without usurping the role of the Judge or arbitrator.

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[20] Guides, page 2/8

I would therefore submit that a proper approach to the use of the *Guides* in an adjudicative context would begin with the role of the expert as that role is defined in the *Guides*, and would end with the decision of the trier of fact, informed by the medical evidence. The fact that the medical evidence is going to be subject to the ultimate decision of the trier of fact makes the medical expert's role more important, not less so. The trier of fact will be called upon to make a determination that is "in accordance" with the *Guides* without necessarily having any specialized medical training or any specialized training or experience in the use of the *Guides*.

The failure of either experts or adjudicators to appreciate the proper role of an expert in the adjudicative process will undermine the stated goal of the *Guides* to promote equity and quality in decision making.

4. How should psychological conditions be assessed in accordance with the Guides?

In December 2007, then Director of Arbitrations at FSCO, David Draper, rejected Economical's request in *Economical and Augello* to have a stated case put to the Divisional Court, addressing the question of whether or not psychological and physical impairments can be combined for the purpose of arriving at a whole person impairment that is in accordance with the *Guides.* In reasons for his decision, Director Draper rejected Economical's central submission that there were grounds to doubt the correctness of the approach taken in the *Desbiens* decision, and added that this was not a situation in which the decisions before FSCO were either "internally inconsistent or out of step with judicial decisions." He nonetheless acknowledged that the "issue is important" and concluded as follows, "…it is my view that the complexities of the definition of "catastrophic impairment," particularly the references to the *AMA Guides*, make it preferable that the issue proceed with a full evidentiary record to inform the decision." [21]

The matter came back for a hearing before Arbitrator John Wilson on September 9, 2008, the same day upon which leave to appeal was denied in the Superior Court matter of *Arts v. State Farm,*[22] on the same issue. Arbitrator Wilson issued reasons for finding that the catastrophic threshold was met in this case on the grounds that physical and psychological impairments could be combined to reach the 55% whole person threshold, both on the grounds that he was bound to follow *Desbiens*, and on the grounds that it was correct in any event. However, he also found that there were grounds for finding issue estoppel regarding the question of whether psychological and physical impairments can be combined for the purpose of reaching the catastrophic threshold. He found that there was no reason not to apply issue estoppels as, "There is no confusion in the jurisprudence as to the correct procedure to be followed in calculating a whole body impairment."

Although it is the case that each decision to date addressing the combining of physical and metal impairments has followed *Desbiens* and now *Arts*, there remains controversy as to whether this is

[21] (FSCO A07-001204)

[22] Sec 91, O.R. (3rd) 394

the correct approach, as reflected in the decisions which have dealt with this question substantively.

In the FSCO decision in *H. and Lombard*[23] the manner in which psychological and physical impairments were to be assessed under the *Schedule* was considered. In that case, the evidence supported the conclusion that the insured's physical injuries were overall, less disabling than her post-accident psychological problems. Arbitrator Renahan reviewed his prior comments in *George and State Farm* [24], in which he had noted the explicit exclusion of percentage impairments for mental and behavioural conditions from the 4th edition of the *AMA Guides*. On this point, he made the following statement:

> *The authors of the Guides considered that one valid reason for assigning percentage ratings for mental impairments was to make the chapter on mental disorders consistent with the Guides chapters for the other organ systems. They decided against it for the reasons I have described. The direction in the Guides not to convert a mental or behavioural impairment into a percentage WPI is clear to me. However, in the recent decision of Pilot Insurance Company and Ms. G, (FSCO Appeal P06-00004, September 4, 2007) Director's Delegate Makepeace agreed that it was appropriate to assign a percentage WPI to an impairment based on a mental or behavioural disorder and combine that with a percentage WPI due to a physical impairment.*

The Arbitrator went on to find that Ms. H. met the catastrophic threshold on the basis of a "marked" impairment in social functioning alone, and added that if he had to arrive at a whole person impairment rating, the allocation for mental and behavioural impairment would be "at least" 55%, although an analysis supporting this figure is not provided in his decision. Likewise, there was no discussion surrounding the question of whether there must be a Class 4 or 5 impairment in more than one sphere in order to establish catastrophic status pursuant to subsection (g) which addresses mental and behavioural impairments alone. Implicitly, however, the Arbitrator accepted that it was sufficient for a marked impairment to be found in only one sphere.

In the recent decision of Arbitrator Maggy Murray in *B. and RBC General Insurance Company*, she was called upon to address the question of combining physical and psychological impairments. She concluded that she was bound to follow *Desbiens*, but included the following footnote 89: [25]

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[23] (FSCO A06-0000209)

[24] (FSCO A03-001062

[25] (FSCO A07-001066)

Assigning percentages to mental and behavioural disorders leads to practical difficulties, for example, in the instance where an individual has different impairments of the four different areas of functioning. With respect to the principle interpretation where a non-statutory instrument, such as the Guides, is incorporated in a Regulation, Spiegel J. wrote in Desbiens:

> *Where material is incorporated by reference into statute or regulation it becomes an integral part of the incorporating instrument as if reproduced therein (OL.at para.227).*

In the introduction of the explanation of the rating system for mental and behavioural disorders the Guides authors write at page 300:

> *There is no available empiric evidence to support any method for assigning a percentage of impairment of the whole person....*

At page 301:

> *The decision not to use percentages for the estimates of the mental impairment in this fourth edition of the Guides was made only after considerable thought and discussion....unlike the situations with some organ systems, there are no precise measures of impairment in mental disorders. The use of percentages implies a certainly that does not exist....*

The use of the word "or" between clauses (f) and (g) suggests that each of the clauses contained in clause 2(1.2) of the Schedule are distinct and separate categories of catastrophic impairment.

For example, loss of sight in one eye can be combined with other physical injuries because it is not a standalone category in clauses (a)-(g) and a patient who loses an eye would have a 24% WPI rating (*Guides*, Table 6 at 8/218.)

It is not necessary for the legislature to exclude psychological impairments from clause (f) by the inclusion of the word "physical" before the word "impairment" (*Desbines* , QL, at 5, para 9) because the *Guides* are incorporated into the *Schedule*. Since the *Guides* do not assign a percentage WPI rating to mental and behavioural impairment, it cannot be combined with physical WPI rating.

In the case of *Pastore and Aviva*, [26] Arbitrator Nastasi followed the *Desbiens /Arts* combining approach and endorsed it as correct.

[26] (FSCO A04-002496)

Although there is consistency in the cases following *Desbiens*, it is anticipated that further litigation will follow on this point, pending a determination of this issue by the Ontario Court of Appeal.

In addition to the controversy regarding the "combining of physical and psychological impairments, there is also ambiguity relating to the use of Chapter 14 of the *Guides* for the purpose of determining whether a class 4 "marked" or class 5 "extreme" impairment had been sustained due to mental or behavioural disorders.

Section 2(g) of the *Schedule* indicates that catastrophic designation will follow a finding of "marked" or "extreme" impairment pursuant to Chapter 14 of the *Guides*. Chapter 14 instructs the assessor to evaluate psychiatric impairment based upon consideration of four separate areas of functioning being: activities of daily living, social functioning, concentration and desperation. The commentary then defines "marked" and "extreme" as follows:

> *"marked" is a level of impairment that significantly impedes use or functioning. Taken alone, a marked impairment would not preclude useful functioning, but together with marked limitation in another class, it might limit useful functioning. "Extreme" means that the impairment or limitation is not compatible with useful function.* [27]

The same section goes on to state:

> *In the ordinary individual, extreme impairment in only one class would be likely to preclude the performance of any complex task, such as one involving recreation or work. Marked limitation in two or more spheres would be likely to preclude performing complex tasks without special support or assistance, such as that provided in a sheltered environment.* [28]

Until recently, the question of how many areas of functioning needed to be "markedly" impaired for a "marked" impairment overall to apply had not received much attention. In *Desbiens* the parties **agreed** that it was sufficient to have a marked (class 4) impairment in only one realm for a class 4 impairment to apply.

This same approach was followed in *McMichael and Belair,* [29] with the hearings arbitrator finding that a FSCO guideline which stipulated that a class 4 or 5 impairment be identified in two or more functional areas for catastrophic designation to follow as not binding on him.

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[27] Guides 14/300.

[28] Guides 14/300-301

[29] (FSCO A02-001081)

In *H. and Lombard*, the issue was not addressed in the arbitrator's reasons for decision, although it was accepted in that case that a marked impairment in one sphere was sufficient to trigger catastrophic designation.

In *Pastore and Aviva*, the question of how many spheres need to be markedly or extremely impaired to reach the catastrophic threshold was considered in more detail.

In this case, the arbitrator accepted that the Appellant suffered a marked impairment in her activities of daily living. In addition to her physical restrictions, she suffered from a pain disorder. The psychologist testifying for Aviva felt that the pain was secondary to the physical injuries and....

> *further opined that in assessing someone's physical impairments, the WPI rating includes a rating for pain and the psychological condition relating to pain within the rating itself. Therefore, pain should not be assessed and rated separately under the (g) criterion as this would result in double counting.*

The arbitrator disagreed, and found that a marked impairment in activities of daily living which was due to the intertwined effects of physical injury and psychological reaction was sufficient to trigger catastrophic status.

Thus, with *Pastore*, we have a case where the physical impairments translated into only a 22% WPI. When the pain complaints were rated, the aggregate WPI was 39%. And yet, the insured's psychological response to her physical injuries was sufficient to trigger a catastrophic designation pursuant to clause (g). Following this ruling, there is no reason to believe a soft tissue injury followed by chronic pain cannot cross the catastrophic threshold.

Further litigation regarding this issue will certainly follow.

5. Where a catastrophic insurer's examination is incomplete or of poor quality, what remedy does an insurer have?

There is mixed authority as to which evidence an insurer can obtain when it wishes to challenge a CAT DAC, or when presented with a problematic insurer's examination.

In the case of *Murray and Aviva*[30], argued before Arbitrator John Wilson, the insurer sought to have a CAT DAC reopened. In that case, the CAT DAC was favourable to the insurer's position, but the insurer wished to have a further assessment conducted before being put to the cost of a hearing on the issue, given Aviva's concern that the CAT DAC may not have been sufficiently comprehensive in its scope. Arbitrator Wilson refused the insurer's request, stating that it would not be appropriate to "reopen" the DAC once a final opinion had been rendered. He went on to

[30] (FSCO A07-000015).

add that the DAC was obviously so flawed as to render its first determination of questionable value, because psychological issues had not been identified and addressed. Given that this was the outcome in the case of positive DAC determination, it seems highly unlikely that an unfavourable DAC would be "reopened" by certain FSCO arbitrators at an insurer's request. At the same time, the conclusion that the DAC was so flawed as to be useless (as suggested in the *Murray* case) would obviously not sit well with an insurer who has paid handsomely for the DAC and is now bound by its unfavourable outcome.

In contrast to the ruling in *Murray* which suggest that an insurer has no way to obtain evidence to challenge a CAT DAC, in the case of *Baron v. Kingsway*[31] the Court took the opposite approach in ordering contested defence medicals. In that case, the insurer was permitted to conduct medical assessments under section 105 of the *Courts of Justice Act* in respect of a contested catastrophic claim. This was after the insured person's refusal to attend similar section 42 assessments subsequent to the commencement of litigation. The insurer had discontinued attendant care benefits subsequent to the section 42 non-attendances, a remedy that the Court agreed was available under the *Schedule*. Justice Pardu made the following observations:

> *[37] A CAT DAC assessment further cannot be conclusive for all time as to an insured's entitlement to SABS, as an insurer may stop payment of benefits where an insured refuses to attend an insurer's health professional or vocational rehabilitation expert examination under s.42. Section 42(3) gives an insurer the right to schedule these examinations as often as is reasonably necessary. An insured and insurer may well disagree to the necessity and the propriety of any refusal. These disputes need resolution, again in the face of DAC assessments*
>
> *[38] It would be artificial to conclude that an insurer could argue that attendant care needs were nominal, yet deny the ability to argue that there was no catastrophic impairment. DAC assessments may be contradictory. Here one concluded that the insured could work and the other that he was catastrophically impaired. There must be a venue to resolve these issues.*[32]

Justice Pardu's "common sense" approach in recognizing the need to resolve conflicting assessments has not been applied often in the context of FSCO rulings. The availability of defence medical examinations in litigation pursuant to the *Courts of Justice Act* and the *Rules of Civil Procedure* provided a procedural means of resolving the issue that was before the Court in *Baron*. Yet the issues identified in the paragraphs of the judgment quoted above really have not been perceived as a problem to be remedied in cases before FSCO, likely in part because the *Dispute Resolution Practice Code* provides no remedy and arbitrators lack the inherent jurisdiction to order assessments.

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[31] (2006), 80 O.R. (3d) 290.

[32] *Ibid*.

In light of the fact that there is no right to a "defence medical" or its equivalent in proceedings before the Financial Services Commission of Ontario, insurers frequently turn to "paper reviews" in order to obtain foregoing expert input on a case, or where a matter proceeds to a hearing, expert testimony.

In *Borowski and Aviva*[33], the insured challenged the admissibility of a report by Dr. Chris Brigham, which had been based upon a paper review only. The Applicant argued that, as the report of Dr. Brigham was not sanctioned by the *Schedule*, the exchange of information between Aviva and Dr. Brigham constituted an invasion of no privacy. The arbitrator rejected this submission and ruled the reports to be admissible. However, the arbitrator indicated that the fact that Dr. Brigham had not assessed the claimant in person would go to the weight of his evidence, as would any comments in the report that fell outside of the scope of an expert witness.

In *Pastore*, the evidence of Dr. Brigham and Dr. Leclair was submitted and considered on its merit without regard for the fact that these experts were retained by an insurer for the purpose of challenging a CAT DAC evaluation.

The use of paper reviews or additional assessments following a catastrophic evaluation is expected to generate further litigation.

Trendspotting

There has been an unmistakable trend in the cases towards expanding the scope of catastrophic designation. Although this trend has discouraged insurers to some degree from litigating or arbitrating catastrophic claims, it is expected that the issues discussed in this paper will continue to generate further litigation until currently contentious issues are resolved by the Ontario Court of Appeal.

[33] (FSCO A07-002593)