"FAIR, LARGE AND LIBERAL" WHERE CAT IS AT

Jennifer Griffiths

There can be no doubt that our understanding of what constitutes a "catastrophic impairment", as set out at section 2 of the *Statutory Accident Benefits Schedule*, has enlarged considerably since the concept was introduced in 1996. In general, an increasingly "large and liberal" interpretation is being applied in the decided cases to the catastrophic definition. Whether this trend is a "fair" one depends very much on where the line is ultimately drawn.

THE STATUTORY LANDSCAPE

As always, it is helpful to begin by considering the statutory provision in question.

Section 2(1.2)(e) through (g) of the *Statutory Accident Benefits Schedule*[1] defines "catastrophic impairment" as follows:

> *(1.2) For the purpose of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is:*
> ....
>
> *(e) subject to subsection (1.4), brain impairment that, in respect of an accident, results in,*
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> > *(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;*

[1] O.Reg. 458/03 [*Schedule*].

> *(f) subject to subsections (1.4), (2.1) and (3), an impairment or combination of impairments that, in accordance with the American Medical Association's* Guide 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.*

Pursuant to the *Schedule*, a catastrophic determination expands first party coverage as follows:

- medical and rehabilitation limits are increased from $100,000 available for 10 years, to a lifetime maximum of $1,000,000[2];
- attendant care coverage is increased from a maximum of $3,000 per month for 2 years to $6,000 per month, to a lifetime maximum of $1,000,000[3];
- housekeeping coverage extends for life[4]; and
- case management services are covered for catastrophic claims[5].

Prior to October 1, 2003, precisely the same wording was used in the tort context, permitting recovery of health care expenses for individuals who had sustained "catastrophic" impairment.

The first four conditions described at subsections (a) through (d) of the definition refer to impairments that are readily diagnosed and can be identified by an expert and a layperson alike as "catastrophic" in their impact, such as quadriplegia, paraplegia, multiple limb amputation and total loss of vision. These impairments can be diagnosed using purely objective standards shortly after an accident. Once diagnosed, they immediately trigger a catastrophic designation.

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[2] O. Reg. 458/03, Section 18(3) and 19(1) *of the Schedule*.
[3] *Ibid*, Section 16(5) and 18(3).
[4] *Ibid*, Section 22(4).
[5] *Ibid*, Section 17(1).

The tests set out in parts (e)(ii) through (g) all incorporate by reference clinical assessment protocols, all of which involve at least some degree of subjectivity on the part of the assessor. Apart from the test set out at part (e)(i), these assessments are meant to evaluate outcome following an injury, and therefore attempt to measure the impact of an impairment on a particular individual's level of functioning. As such, there is always uncertainty as to precisely where the catastrophic threshold will be established in such cases.

It is suggested that the test set out at subsection (e)(i) constitutes something of a hybrid. Although it references a clinical assessment tool, the decided cases on this point indicate that there is little or no room for clinical judgment in deciding cases under this Section, suggesting that the Section is meant to provide an instant trigger of catastrophic coverage in the cases of severe head injuries.

Initially, it was presumed that there would be internal coherence to the various subtests set out in the catastrophic definition, such that impairments meeting the test pursuant to subsections (e) through (g) would be equally "catastrophic" in their impact as quadriplegia and paraplegia and the other impairments described in subsections (a) through (d). The decided cases to date suggest that this is not necessarily so, and indeed, the catastrophic definition is being interpreted ever more expansively over time.

THE DIRECTION OF DECISIONS TO DATE

The first cases examining the catastrophic threshold dealt with subsection (e)(i), which provides catastrophic coverage where a brain impairment results in a Glasgow Coma Scale score of 9 or under "according to a test administered within a reasonable period of time after the accident by a person trained for that purpose." In these cases, insurers alleged that particular Glasgow Coma Scale readings were not valid or the purpose of the *Schedule* on the grounds that the qualifying conditions of subsection (e)(i) were not met. Insurers have generally not been successful in these cases. Instead, the emerging direction from both FSCO and the Bench suggests that a GCS of 9 or under, recorded in the course of post-accident emergency treatment, will almost always trigger a catastrophic determination. Confounding factors will not invalidate a reading for the purpose of the *Schedule*. The reading does not have to prognosticate a catastrophic outcome to be valid. With that having said, it is not clear whether a purely transient loss of consciousness with little or no resulting impairment will trigger a catastrophic designation.

The second wave of catastrophic challenges has dealt with the test set out at subsection (f), which extends catastrophic where, as a result of the accident, a 55% or greater whole person impairment has been sustained, according to the 4th Edition of the American Medical Associations *Guides to the Evaluation of Permanent Impairment*.

The decisions on this point suggest that the *Guides* provide an imperfect and unwieldy tool to assess impairment in the context of an "all or nothing" threshold. This is in part because the *Guides* themselves call for a certain amount of estimation and reasoned improvisation on the part of the assessor. For example, where a precise impairment is not listed, the clinician is called upon to select a rating based upon the most analogous impairment that is listed in the *Guides*. For many impairments, a precise score is not allocated. Instead, the assessor is required to select a score from within a prescribed range. For many impairments, such as a lower extremity impairment causing gait derangement, one of several different assessment methods can be used, with different outcomes depending upon the approach employed. Finally, while the *Guides* do address impairments arising from psychological or behavioural issues, they do not provide a framework for incorporating such impairments into a WPI score. Thus, while two experts might (or might not) agree upon a general "ball park" whole person impairment rating for a given patient, it is highly unlikely that they would arrive at the precise same score, even if both of them used methods and assumptions that were defensible under the *Guides.* Thus, it is arguable that there is no such thing as an objectively verifiable single WPI score, making it very difficult to predict whether a given case will meet the 55% threshold, even assuming a generous margin for legitimate inter-rater variability.

Following the Superior Court ruling in *Desbiens*, decisions addressing the 55% WPI threshold to date clearly indicate that any uncertainty or perceived deficiency in the *Guides* or their use will be "fixed" by a decision maker and so resolved in favour of an insured, particularly if catastrophic-level coverage needs have been demonstrated

Although there is not yet a body of decided cases on this point, based upon files that are being referred for handling, it is anticipated that the third wave of catastrophic cases will address controversies arising from subsection (g) which addresses mental and behavioural disorders, and to a lesser extent, controversies regarding what constitutes a "severe disability" according to the Glasgow Outcome Scale, at paragraph (e)((ii) of the definition. Once again, it is anticipated that a liberal interpretation of these sections will be taken by FSCO and the Courts.

The First Wave - Glasgow Coma Scale of 9 or Under

As mentioned above, the first series of decided cases addressing the catastrophic threshold dealt with subsection (e)(i), which provides automatic catastrophic coverage where a Glasgow Coma Scale reading of 9 or under is recorded, "according to a test administered within a reasonable period of time after the accident by a person trained for that purpose" (section 2(1.2)(e)(i)). While this language initially seems straightforward, those familiar with the clinical use of the Glasgow Coma Scale within the urgent care context recognized a potential minefield of interpretive issues that could arise in applying this definition of catastrophic impairment.

Roughly these issues relate to the "what, when and who" of a given Glasgow Coma Scale reading as applied to a particular patient.

Because Glasgow Coma Scale readings are routinely taken by paramedics at the scene of an accident and before any diagnostic information is obtained, the initial figures contained on an ambulance call report simply constitute descriptive information about a patient's level of arousal based upon motor, verbal and eye responses. At the scene of an accident, factors such as intoxication, ability to speak English, emergency intubation, sedation, pre-existing disability (such as hearing impairment), facial injury or pre-existing medical condition (such as diabetes) could all effect a patient's Glasgow Coma Scale reading in the absence of a traumatic brain injury. Thus it would seem important to determine *what* a Glasgow Coma Scale reading describes, before relying on it for forensic purposes.

The timing of a Glasgow Coma Scale reading is also important, according to the definition set out in the *Schedule*. The reading must be "administered within a reasonable period of time after the accident" in order to be valid. No direction is provided in the *Schedule* as to what a "reasonable period of time" might be. Where there is transient loss of consciousness, a severely depressed Glasgow Coma Scale reading might be recorded minutes after an accident (assuming that there is someone "trained for that purpose" present at the scene at that time), followed by full recovery. Conversely, initially high Glasgow Coma Scale readings followed by a gradual deterioration in responsiveness some time later may reflect a severe underlying brain injury, prognosticative of a poor outcome. The question arises as to when a "reasonable period of time" has elapsed after an accident in order for a Glasgow Coma Scale reading to be valid for the purpose of the *Schedule*, and whether it is necessary for the reading to indeed prognosticate an ongoing brain impairment.

Finally, there is the question of "who" is a "person trained for (the) purpose" of administering the GCS. As the Glasgow Coma Scale is employed by paramedics, nurses and physicians, questions have arisen in situations where there are numerous different readings taken by various different health professionals in close temporal proximity to one another. Is a reading taken by a neurologist in an emergency room more reliable than one taken by an ambulance attendant five or ten minutes previously? Which score will be accepted in the case of inter-rater variability?

The cases addressing these questions to date suggest that, where there is at least some evidence of head injury, "a nine is a nine is a nine." In other words, where there is a GCS reading of nine or under, obtained during the course of emergency treatment, it will in all likelihood result in the catastrophic *threshold* being met. Apart from the private arbitration decision in *Unifund v. Fletcher*[6], in which a transient reduction in GCS scores was deemed not to meet the catastrophic threshold, there has been no other decided case in which an insurer successfully challenged a catastrophic application in the accident benefits context, where a GCS of 9 or under was recorded in the emergency records. In the *Unifund* case, Arbitrator Bruce Robinson stated that it was "clear" that the determination of "catastrophic impairment" with regard to "brain impairment" was intended to be based on a measure which would assist in predicting the outcome of brain injury, a view which has not been upheld in subsequent cases.

In *Young v. Liberty Mutual*[7], a FSCO decision which has since been affirmed on appeal and judicial review, Dr. Bruce Stewart, Neurologist, provided expert testimony for the insurer. It was his opinion that the GCS readings obtained were not "valid" in the presence of confounding factors which included intubation, sedation, and post-accident seizures. Arbitrator Beth Allen rejected this opinion in finding that the legislature was presumed to appreciate that in situations of trauma, Glasgow Coma Scale readings would often be influenced by these factors, and therefore the presence of post-traumatic complications could not be used to invalidate Glasgow Coma Scale readings for the purpose of the *Schedule*. She accepted that, in this case, a period of one hour was a "reasonable time after the accident" for the insured to have maintained a GCS of 9 or under, even though the scores were taken in the presence of intubation, medication and post-accident seizures and may not therefore have been the exclusive reflection of traumatic brain injury.

[6]January 18, 2000, decided pursuant to the Arbitration Act, S.O. 1991, c. 17, and the Insurance Act, R.S.O. 1990, c. I.8, as amended [*Unifund*].
[7](2005) O.F.S.C.D. No. 76.

In deciding the appeal of *Young v. Liberty Mutual*, Director's Delegate David Evans focused upon the wording of section 2(1)(e)(i) of the *Schedule*, rejecting the modifiers to the words of the Regulation that had been incorporated into the analysis undertaken by the CAT DAC in that case. For example, the DAC assessors had sought to determine whether the depressed Glasgow Coma Scale readings were "valid and reliable" and the "direct and exclusive" result of brain impairment. The Director's Delegate found that, in adding these modifiers to the test set out in the *Schedule*, the assessors were taking too demanding an approach. He additionally rejected Arbitrator Robinson's approach in *Unifund v. Fletcher*, stating "In my opinion, that predictive analysis is not called for in the definition."

In the case of *Holland v. Pilot Insurance Co.*[8], decided on a motion before Mr. Justice Keenan, the potentially confounding influences of alcohol and marijuana on an initial Glasgow Coma Scale reading were under consideration. Based upon written reports set out by way of affidavit evidence, Justice Keenan concluded on the evidence that the Glasgow Coma Scale readings of 9 or less had not been influenced by alcohol consumption. However, he did distinguish this from the cases of *Fletcher* and *Young* (supra.), in that the question of what constituted a "reasonable period of time" after the accident was not before the Court.

Of broader significance, however, were the following comments in *obiter*:

> *This type of regulation is adopted by the legislature after extensive consultation with interested parties, including insurers. If restrictive meaning is to be assigned to the regulation, it should be clearly recited in the regulation itself.*

In the case of *Tournay v. Dominion*[9], decided before FSCO in June 2006, the Arbitrator considered directly whether there was a distinction to be drawn between Glasgow Coma Scale scores depending upon whether they were to be used for forensic rather than clinical purposes. In this case, Ms. Tournay had suffered serious injuries, including a traumatic brain injury. Her daughter, who was present at the scene, reported that she had been unconscious and totally unresponsive for some minutes after the accident. However, the first recorded GCS was 14-15. During her emergency treatment, Ms. Tournay was becoming less responsive. A decision was made to intubate her, following which a score of 5 was obtained. This score was recorded without specifying that it was a score obtained in the presence of intubation, meaning that any kind of a verbal response would have been impossible. Dr. Harold Becker, who conducted the CAT DAC, was of the view

[8](2004) O.J. No. 2737 (Ont. S.C.J.).
[9](2006) O.F.S.C.D. No. 137.

that the post-intubation reading was not a valid GCS score and could not be relied upon to establish catastrophic status. This argument was rejected by the Arbitrator as follows:

> *…I find that there is no basis in law for any such distinction to be made, given the language of the current regulation, and it is that language which governs my decision here. Whether or not it would be appropriate for the government to review this section of the Schedule, given the concerns raised by Dr. Becker about the challenges associated with assigning a GCS score to an intubated patient, the current reality is that just the opposite conclusion which Dr. Becker draws is the most warranted one.*
>
> *The Schedule, in specifying the criterion for a catastrophic impairment determination under section 2(1.1)(e)(i), explicitly indexes the interpretation of the GCS score to the medical use of the test, as it is described in The Management of Head Injuries, by Dr. Jennett and Dr. Teasdale. There is no distinct "legal" or "insurance" or "forensic" interpretation of the GCS apart from its articulation in this text. It is not intended to be administered in the manner of an insurer's examination by someone retained to give the insurance company an independent opinion on neurological function. The GCS is a clinical test, pure and simple. This, if a medically appropriate GCS test registers a score of "9 or less" within a reasonable time after the accident, where the brain impairment as a result of the accident is not contested, then, in my view, that must be taken as satisfying section 2(1.1)(e)(i) of the Schedule. There is simply no further legal filter which the test needs to pass through to validate its results.*

Similarly, in *Michalski (Litigation Guardian of) v. Wawanesa Mutual Insurance Co.*[10], FSCO Arbitrator Alves noted that the insured person's GCS scores as recorded between the ambulance attendants, and then later by hospital personnel, were reported to be between 3 and 9. She stated:

> *In my view, absent disputes as to whether the scores were administered within a reasonable period of time post-accident, or as to whether the person or persons who administered the test were trained for that purpose, Mrs. Michalski's catastrophic impairment was immediately apparent.*

A special award followed the insurer's refusal to treat this claim as catastrophic until following a CAT DAC almost two years after the accident.

[10](2005) O.F.S.C.D. No. 150.

The one case that stands as an exception to the current trend on this point is the April 2007 ruling in *Liu v. 1226071 Ontario Inc*[11], in which the Plaintiff relied upon the determination of a CAT DAC to argue entitlement to the recovery of future care costs in tort. It would appear that no other evidence was led in respect of this issue. In a briefly worded judgment, Mr. Justice B.P. Wright found that, contrary to the conclusion reached by the CAT DAC, the Plaintiff was not catastrophically injured in accordance with the *Act*, on the grounds that his Glasgow Coma Scale score of 9 or under was not sustained for a "reasonable time" after the accident. In this case, a score of 3 was obtained 16 minutes after the accident. A score of 8 was obtained 28 minutes after the accident. By the time 40 minutes had elapsed, the score was 12. In a 12 paragraph ruling (which is not worded very clearly at that), Justice Wright appears to have concluded that 40 minutes was not a sufficient period of time to sustain a score of 9 or less, and further, that the Plaintiff's outcome was not consistent with a catastrophic determination. This was notwithstanding that the head injury was characterized in the material as "moderate to severe" or "moderately severe." The fact that the Plaintiff had traveled to China on two occasions, making all of his own travel arrangements, and was capable of managing his property and personal care were likewise felt not to be consistent with a catastrophic outcome.

While there is certainly a logic to an outcome-based analysis in deciding ambiguous cases under subsection (e) (i) (which logic may be more persuasive in the tort context), the reasoning behind this decision appears to be quite inconsistent with the decisions in the accident benefits context to date. However, the *Liu* ruling does suggest that there may be cases in which there is room for insurers to argue that a transient reduction or loss of consciousness followed by a non-catastrophic outcome should not attract a catastrophic designation under the *Schedule.*

Notwithstanding the cases of *Unifund v. Fletcher* and *Liu v. 1226071 Ontario Inc.*, it remains the case that insurers have generally been unsuccessful in arguing that GCS scores are "invalid" for the purpose of the *Schedule* by reason of the transience of reduced consciousness or the presence of confounding factors.

In addition, based upon the FSCO ruling in *Milson v. Aviva*[12], it would appear that arguments of assessor error based upon the relative expertise of persons "trained for the purpose" of administering the GCS are likewise not likely to succeed. In that case, the insurer attempted to challenge the appropriateness of a GCS score recorded by both a paramedic and a nurse based upon a file review conducted by a neurologist who felt that

[11](2007) O.J. No. 1564 (Ont. S.C.J.).
[12](2006) O.F.S.C.D. No. 67.

the scores were improper in light of somewhat contradictory narrative material contained in the emergency care chart. Arbitrator Rogers did not accept that the consulting neurologist in this case had superior training and experience as compared to the paramedic and the nurse whose assessments were under scrutiny, and noted that the paramedic had used the GCS test "hundreds, if not thousands of times", whereas the consulting neurologist rarely used the test in her clinical practice.

In conclusion therefore, although various factors may affect the validity and reliability of a particular Glasgow Coma Scale reading for clinical purposes, adjudicators have consistently refused to "read in" any qualifier to the language contained in the *Schedule*, and have suggested that the qualifying language in the Regulation itself will have extremely limited application.

The Second Wave - The 55% Whole Person Impairment Analysis

The Superior Court ruling in *Desbiens v. Mordini* demonstrated both some of the limitations of the *AMA Guides* as well as strategies that decision makers can use in addressing applications using the 55% WPI criterion. *Desbiens* was decided in the context of a trial for tort damages.

Mr. Desbiens was a paraplegic prior to a motor vehicle accident in which he sustained upper extremity injuries. Although he had previously been independent at the wheelchair level, the result of the accident was that he lost a great deal of his functional independence, and had significantly greater care needs as a result. The strict application of the "book value" of the separate impairments he sustained would not have accurately reflected the functional impact of these injuries in light of his pre-accident status. Instead, it was accepted that an assessment of Mr. Desbiens impairment could be undertaken based upon its' impact upon his residual capacity as it was prior to the accident. In accepting that Mr. Desbiens' accident-related impairment was "catastrophic" in light of his pre-existing disability Justice Spiegel stated:

> *On the record, it is impossible for me to decide that such an approach is in accordance with the Guides. However, I must say that there is certain common sense attractiveness to the concept and it certainly does provide a useful perspective on the inadequacy of the Guides in assessing the impairment of persons with pre-existing serious impairments.*

The ruling in this case serves as a precedent for evaluating other cases where there is a pre-existing disability and also demonstrates that decision makers may not feel bound to adhere strictly to the *Guides* in deciding whether a 55% whole person impairment has been sustained, where such adherence would not result in a "fair" outcome.

Of significance, Mr. Desbiens was also found to have met the catastrophic threshold on the grounds that his accident related psychological impairments could be translated into a WPI and added to his physical impairment rating score, to reach a global 55% WPI as a result of the accident. This approach was endorsed even though Chapter 14 of the *AMA Guides* specifically excludes percentage impairment ratings in respect of mental or behavioural disorders

While the particular fact situation in *Desbiens* highlighted some of the limitations in using the *AMA Guides* for the purpose mandated by the *Schedule*, the intellectual and logistical challenges in working with this section of the Regulation are set out much more extensively in the reasons provided by FSCO Arbitrator Blackman in the preliminary issue hearing in the matter of *G. v. Pilot Insurance Co.*[13] Arbitrator Blackman began his 39 page ruling by setting out perceived difficulties in applying the *Guides* to Section 2(1.2)(f) of the *Schedule.*

Beginning at paragraph 10, he stated as follows:

> *…An impairment percentage derived by means of the Guides is intended, among other purposes, to represent an "informed estimate" of the degree to which an individual's capacity to carry out daily activities has been diminished.*
>
> *The Guides note that they do not cover all conditions arising out of injuries. They further state that while medical information is essential for the decision process, the key is the interpretation and use of the medical information. The critical problem, state the Guides, is that there is no formula known by which to combine knowledge about a medical condition with non-medical information about one's personal, social, occupational and other activities of daily life. The Guides specifically state that while they can help in such areas as workers' compensation, they "cannot provide complete and definitive answers."*

[13](2006) O.F.S.C.D. No. 42.

> *The Guides further caution as to their reliability by strongly discouraging the use of any but the most recent edition of the Guides. The Guides are now more than a decade old, and have been replaced by further editions. The Schedule, however, dictates adherence to the outdated Fourth Edition, but with the proviso at paragraph 2(1)(3) that an "impairment that is sustained by an insured person but is not listed in the [Guides] shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person." The Guides strongly state that the impairment percentages derived from the Guides criteria should not be used to direct financial awards or make direct estimates of disabilities. However, as noted both in Desbiens v. Mordini [2004] O.J. No. 4735 and Snushall v. Fulsang [2003] O.J. No. 1493 (S.C.J.), "the insurance legislation in Ontario appears to require precisely what the Guides themselves discourage.*"

Having identified these multiple difficulties in using the *Guides* in deciding wether the catastrophic threshold has been met, Arbitrator Blackman went on to state his view that the use of the *Guides* in this context involved an adjudicative rather than a medical determination, and therefore:

> *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.*

In this case, the Arbitrator would appear to have thought so little of the competing evaluations before him, that he did not even outline the approach adopted or the conclusion reached by the CAT DAC, which found that the 55% WPI threshold had not been reached. Likewise, he did not refer in his reasons to the merits of the initial evaluation which had been undertaking by Ms. G's lawyer, resulting in a 62% WPI score being assigned. Instead, he undertook his own assessment based upon the medical evidence before him as well as the testimony of the claimant. Over the next 30 pages of the ruling, Arbitrator Blackman purported to conduct his own analysis pursuant to the *Guides*, adding scores for impairments which had not been assigned a score by the CAT DAC, including a right forearm scar, dental and dietary issues, the mental and emotional sequelae of the accident, headaches and a small facial scar. Ultimately, the Arbitrator's analysis yielded a WPI score of exactly 55%. He defended his approach as follows:

> *The search for the truth is crucially important. Finality and cost effectiveness is also important. Having had a chance to review the medical documentation and to examine Ms. G. and having failed to properly assess all of her impairments, the present applicable remedy in this particular case is not a "do over" by the CAT DAC, which may then require assessments by other practitioners, followed by recalling witnesses or calling new experts. Rather, in my view, the proper course is for an adjudicative assessment to be made as best one can on the basis of the available evidence.*

At the same time, it is very telling that the Arbitrator's truncated "search for the truth" in this case took 10 days of hearing and 10 months for a decision to be rendered. Notwithstanding that two of the province's foremost catastrophic assessors provided detailed testimony regarding what appeared on its' face to be a fairly straightforward case involving orthopaedic injuries to the heel and right forearm, the Arbitrator found the medical analyses before him were so inadequate that he had to perform his own. The length and complexity of the resulting decision suggests that the "search for the truth" using the criterion set out at subsection (f) is not a straightforward process. If medical specialists need to be retained to evaluate each body part and system potentially affected by an injury, the cost of the assessments alone becomes prohibitive, and, in marginal cases, may outweigh the value of benefits potentially at issue. It is hard to believe that this outcome was contemplated when this section of the *Schedule* was drafted.

Furthermore, if it is true that catastrophic status will be found where modest psychological impairments are added to moderate orthopaedic injuries, it is entirely conceivable that catastrophic applications may follow soft tissue injuries which cause chronic pain. This case would bear very little resemblance to the conditions described at Subsections (a) through (d) of the definition. Regardless of whether such applications are eventually successful, it would appear that WPI evaluations will be vulnerable to challenge where an assessor has not at least considered assigning an impairment score to each affected part of the body, even if that score is 0.

The Wave of the Future - Class 4 or Class 5 Impairment Due to Mental or Behavioural Disorder

Chapter 14 of the *Guides* addresses mental and behavioural disorders, directing that their impact be assessed in each of four functional realms being: activities of daily living; social functioning; concentration, persistence and pace; and adaptation to work or work-like settings. In each of these areas, the severity of an impairment is assessed as follows: class

1, no impairment; class 2, mild impairment; class 3, moderate impairment; class 4 marked impairment; and class 5, extreme impairment. Percentage ratings for these types of impairment were explicitly excluded from the 4th edition of the *Guides*. According to subsection (g) of the catastrophic definition in the *Schedule*, the definition is met in the case of an impairment that is classified as a class 4 or class 5 impairment due to mental or behavioural disorder.

The FSCO appeal decision in the case of *McMichael v. Belair*[14] (affirmed on Judicial Review) addressed the relationship between subsections (f) and (g) of the catastrophic definition. In that case, Mr. McMichael suffered a head injury as well as some orthopaedic injuries. The hearing arbitrator found that Mr. McMichael suffered a class 4 impairment due to head injury in three of the four domains under consideration, and therefore met the definition of catastrophic impairment set out at subsection (g). However, when Mr. McMichael's psychological problems were quantified pursuant to Chapter 4 of the *Guides*, the CAT DAC felt that his impairment fell within the range of 29-31 per cent. The arbitrator felt that the mental and behavioural problems were greater than assessed by the CAT DAC, and implicitly accepted that they fell within the 30-49% range. The insurer noted that, assuming a score at the top end of this range, the catastrophic threshold of 55% WPI would not be met, even with the addition of an 8% WPI due to orthopaedic injuries.

The insurer therefore appealed the Arbitrator's ruling in this regard on the grounds that "the *Guides* are intended to ensure consistency of results, and therefore the arbitrator's different conclusions with respect to paragraph (f) and (g) are irreconcilable, amounting to an error of law". This position was rejected by the Director's Delegate on appeal.

Indeed, it would appear that far greater divergences are possible between assessments under subsections (f) and (g), given that Mr. McMichael was found to have suffered a class 4 impairment in three of the four functional areas under consideration. While this point has never been decided, the hearing Arbitrator noted that the parties in *Desbiens v. Mordini* had agreed that a class 4 or class 5 impairment in only one functional area was sufficient to meet that catastrophic threshold under this test. If this is indeed the case, the catastrophic designation will apply in the case of individuals with far fewer functional limitations than Mr. McMichael, whose primary mental and behavioural impairment related to a crack cocaine addiction which was found to have been materially triggered by the accident.

Using this reasoning, it is not necessary for a catastrophic condition so found under subsection (g) to bear any quantitative relationship to the WPI evaluation of the same

[14](2005) O.F.S.C.D. No. 34.

impairment, further undermining any presumed coherence between the various tests for catastrophic impairment.

The CAT DAC in the McMichael case was also chastised for the manner in which they conducted their evaluation of Mr. McMichael. The arbitrator felt that the assessors had been overly clinical without considering other available information about Mr. McMichael, and perhaps more importantly, had failed to consider Mr. McMichael's adaptation to work. While it is true that Chapter 14 of the *Guides* does recommend that the evaluation of mental and psychological impairments should extend outside of the clinical context to include collateral interviews, including an inquiry into an individual's work and family life, such investigations are rarely seen. Further, in cases where an insured is disabled from working due to his or her injuries, the question of adaptation to work is routinely ignored as irrelevant. However, from the comments contained in the *McMichael* ruling and appeal, it would seem that an individual whose psychological fragility precludes a return to work without risking some form of decompensation can establish catastrophic entitlement on that ground alone. Given the enormous degree of subjectivity in such an assessment, it would appear that this argument, if accepted, could very significantly widen the scope of catastrophic coverage.

Score of 2 (vegetative) or 3 (severe) on the Glasgow Outcome Scale

Section (e)(ii) is the outcome based threshold for catastrophic designation where brain injury has been sustained. Like the assessment of mental or behavioural impairment pursuant to Chapter 14 of the *Guides*, clinical judgment will determine at what point an individual's outcome from head injury is "severe."

As outlined in an academic paper published in the *Journal of Neurotrauma*[15] in 1998 by Graham Teasdale and two colleagues, a series of guidelines for structured interviews has been developed to assist practitioners in making determinations under the Glasgow Outcome Scale. Such a structured interview was felt to be necessary in light of the fact that the categories under the Glasgow Outcome Scale are broad, and it was acknowledged that "the open ended format encourages impressionistic use of the Scale; the results are variable amongst individual assessors." It stands to reason that the determination of an individual's Glasgow Outcome Scale (or impairment due to mental or behavioural disorders) is also quite likely to vary between judicial decision makers, meaning that this aspect of the definition of catastrophic impairment is exceedingly open to interpretation.

[15]Graham M. Teasdale, J.T. Lindsay Wilson & Laura E.L. Pettigrew, *Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guildeilnes for Their Use"* (1998) 15 Journal of Neurotrauma. 573-585.

In the Teasdale paper, a series of guidelines were developed to identify patients in the upper and lower ranges of the various categories under the Glasgow Outcome Scale. The critical area for consideration in relation to determination of catastrophic status relates to the threshold between severe and moderate disability. According to the questions developed by Teasdale and his team, the threshold between severe disability and moderate disability turns on the patient's ability to live independently. According to the series of questions developed by Teasdale and his team, severe disability is found where "people may require actual assistance with activities of daily living, they may need to be prompted and reminded to do things, or they may need someone with them to supervise them because they would be unsafe otherwise. In all these cases, they are dependent."

Independence outside of the home is also a consideration. "Independence outside the house requires the ability to plan, to take care of money and behave appropriately in public."

If an individual is independent in all of these realms, but suffers a reduced capacity to work or study as well as interference with social or leisure activities and\or disruption of family and friendships, they will be deemed to be moderately disabled.

As noted in *McMichael*, assessors have failed to address adaptation to work under Chapter 14 of the *Guides* in situations where an insured remains disabled from working due to the accident. Similarly, it is likely that questions relating to the ability to be independent may not be being properly addressed currently under the GOS in situations where the insured person is living with family and may be quite reliant upon support and cuing received in the home, without having been found incompetent to manage their affairs. Where an assessor concludes that a claimant would not be able to cope with the demands of living independently due to the effects of a head injury, a GOS score of 3 and a catastrophic designation could follow. Given the subjectivity both in terms of reporting and assessing the degree of interdependence within a family, an application under the GOS provision could follow a relatively minor injury.

CONCLUSION

As the term "catastrophic impairment" as it is used in the *Schedule* is being interpreted ever more largely and liberally, the gap between the diagnosis based tests set out at subsections (a) through (e)(i) and the outcome based tests at subsections (e)(ii) through (g) is widening. There should no longer be an assumption of parity between the various kinds of impairments that will qualify for catastrophic designation. In all but the most serious (or minor) of injuries, it is difficult to predict the likelihood of a claim "going CAT."

It is clear that decision makers are treating determinations pursuant to section 2(1.2) of the *Schedule* as adjudicative rather than medical determinations. Although the various clinical assessment tools referred to in subsections (e) through (g) presume a high level of medical expertise on the part of the user, judges and arbitrators alike are not feeling bound to accept one or another of the medical opinions presented, but are reaching their own conclusions about such things as how long a period of time after the accident is "reasonable" for the purpose of obtaining a GCS reading, or how to ascertain a WPI rating under the *Guides* for a particular injury, for example. Where the test set out in the *Schedule* does not adequately speak to the fact situation presented (as in *Desbiens*), it has been suggested that the script can be left *opiso* altogether, in order to bring about a "fair" result.

While there are several identifiable trends in the decided cases to date, these trends are unfortunately not sufficient to provide clear guidance to those who are attempting to administer claims on the ground. The case of *B.P. v. Primmum*[16] demonstrates how challenges easily arise. Mr. B.P. was involved in a tragic accident as a result of which he sustained an amputation of his right leg at the knee. In addition, he suffered some orthopaedic injuries above the site of the amputation, along with some other minor orthopaedic injuries throughout his body . His psychological outcome was not bad in light of the severity of his injury.

As a single limb amputee, Mr. B.P. did not meet the catastrophic threshold set out at subsections (b) or (c). Because Chapter 3, paragraph 3.2h of the *Guides* provides a maximum impairment rating of 40% for a single lower limb amputation, the CAT DAC concluded that 40% was the highest figure that could be applied in respect of the leg amputation, and concluded that the catastrophic threshold was not met. However, Arbitrator Blackman did not accept that a maximum rating of 40% adequately captured the extent of the impairment. Instead, he considered different functional implications of the amputation according to the *Guides*, combining scores for loss of mobility and skin impairment resulting from the amputation, for a combined impairment of 50% arising from the amputation alone. When this was combined with the other ratings, a WPI score of 62% was obtained.

While this outcome may not have been predictable even to physicians and experts well versed in this area, it is hard to argue that it was unfair, given Mr. B.P.'s clear need for funding in excess of $100,000 to cover the continuing costs associated with his prosthesis. When the issue of future costs was raised before him, the Arbitrator stated as follows:

[16](2006) O.F.S.C.D. No. 202.

> *I am not persuaded by the Applicant's argument that I have discretion to make a finding of catastrophic impairment where the cost of future treatment exceeds the non-catastrophic limits under the Schedule. That, in my view, simply defeats the intent of the legislation that a requisite designation of impairment, in addition to reasonable and necessary need, determines entitlement at a certain monetary level.*
>
> *I have significant doubt that, in the absence of some direction from the Guides, I can exercise my discretion to make a finding of catastrophic impairment where I think that an impairment which does not meet the 55% WPI threshold (upon a proper, individualized and thorough assessment under the Guides), in my view, is as significant as another, this time hypothetical impairment, which does meet the threshold.*

Although future care needs may not in and of themselves trigger a catastrophic designation, it seems disingenuous to suggest that they are of no relevance in assessing catastrophic status. Indeed, but for future care needs, the catastrophic designation would be irrelevant.

In searching for coherence in the catastrophic coverage scheme and in the cases to date, the issue of future care needs is central. As suggested in the introduction, the different catastrophic criteria can be characterized broadly as "objective/ immediate" or "subjective/outcome based." The objective conditions giving rise to immediate catastrophic status at subsections (a) through (d) are associated with absolutely certain care needs required on an immediate and ongoing basis. Although less "objective" than a diagnosis of paraplegia or quadriplegia, it would appear that a GCS of 9 or less was included in the *Schedule* to provide immediate and automatic access to enhanced benefits (particularly attendant care) without having to wait and assess the outcome in the presence of a moderate to severe head injury.

The balance of the catastrophic at subsections (e)(iii) through (g) cannot be met until a prognosis is established either through the passage of time, or through a medical report stating that the condition will not cease to be catastrophic. At that point, the impact of the impairment can be assessed in more detail and will include information relevant to future care needs. If a person still requires attendant care at the two year mark due to head injury or mental or behavioural issues, that need itself will not justify a positive determination. However, the need for ongoing care will speak to the lack of a return to independence, and will be highly relevant for the purpose of determining the level of impairment pursuant to Chapter 14 of the *Guides* or the GOS. Thus, it is impossible to assess these impairments without some direct or indirect information speaking to the need

of catastrophic level coverages, and it would indeed seem counter-productive to all concerned if this information did not form part of the basis for a determination.

To suggest that care needs cannot be considered in a catastrophic determination is to reduce the process to a very costly and not terribly honest intellectual exercise. Further, the purpose of the legislation would be defeated if the catastrophic definition were to be interpreted so "largely and liberally" that it no longer bore any meaningful relationship to care needs. On the other hand, as long as rulings on catastrophic applications correspond to the reasonable and necessary need for services, the trend in the cases can be defended as fair.