Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A07-001066

BETWEEN:

B

Applicant

and

RBC GENERAL INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Maggy Murray

Heard: April 7, 8, 9, 10, 14, May 12, 13, 14 and 15, July 28, 29, October 27, 28, 29 and 30, 2008, at the offices of the Financial Services Commission of Ontario in Toronto.

Appearances: Hassan Fancy and Monica Chakravarti for Mrs. B on April 7 and 8, 2008
Monica Chakravarti for Mrs. B on April 7, 8, 9, 10, 14, May 12, 13, 14 and 15, July 28, 29, October 27, 28, 29 and 30, 2008
James Leone for RBC General Insurance Company

Issues:

The Applicant, Mrs. B, was injured in a motor vehicle accident on May 12, 2004. She applied for and received statutory accident benefits from RBC General Insurance Company of Canada, payable under the *Schedule*.[1] Mrs. B applied to RBC pursuant to section 40 of the *Schedule* for a determination that she sustained a catastrophic impairment ("CAT"). An assessment at an Insurer's Examination determined that Mrs. B did not sustain a catastrophic impairment. The parties were unable to resolve their disputes through mediation, and Mrs. B applied for

[1] The *Statutory Accident Benefits Schedule - Accidents on or after November 1, 1996,* Ontario Regulation 403/96, as amended.

arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

The issues in this hearing are:

1. Did Mrs. B sustain a catastrophic impairment within the meaning of clauses 2(1.2)(f) and (g) of the *Schedule*?

2. Is either party entitled to expenses of the arbitration proceeding pursuant to section 282(11) of the *Insurance Act*?

Result:

1. Mrs. B did not sustain a catastrophic impairment within the meaning of clauses 2(1.2)(f) and (g) of the *Schedule*.

2. The issue of expenses is deferred.

EVIDENCE AND ANALYSIS

Witnesses

I heard testimony on behalf of Mrs. B from herself, Mr. B (the Applicant's husband), Ms. B (the Applicant's daughter), Dr. Rolbin (anesthesiologist), Dr. Alpert (orthopaedic surgeon) and Linda Stewart (Applicant's co-worker). Dr. Oshidari (physiatrist) and Dr. Lawson (psychologist) testified on behalf of RBC.

Background

At the time of the accident, Mrs. B was 39 years old working approximately 10-15 hours per week as a personal support worker. She is married with two children, a 20 year old daughter and a 15 year old son. Mrs. B obtained her nursing diploma the month before this accident.

Although Mrs. B initially failed her Ontario and Michigan nursing licensing exams following this accident, she subsequently passed them. She began working full time as a registered nurse in Michigan in May 2005, within almost one year of the accident. Her job duties include charting the condition of patients and dispensing medication to them. Mrs. B continues to work full time as a nurse, up to 12 hours a shift. She claims that she sustained a catastrophic impairment within the meaning of clauses 2(1.2)(f) and (g) of the *Schedule*.

The accident occurred while Mrs. B was a passenger in a car driven by her husband. Mrs. B was taken to the hospital by ambulance. She was in the hospital for a few hours, x-rays were taken, she was given a sling for her elbow and painkillers and was discharged. Her initial injuries included injuries to her right knee, left shoulder, left elbow, lumbar spine and neck. Her family doctor also diagnosed her with depression.[2]

Mrs. B testified that before the accident, she traveled, cooked, snowboarded and swam. She also assisted her husband with the paperwork for his trucking business. Following the accident, she said she doesn't swim or snowboard because of her knee and shoulder injuries, as well as her neck pain and depression. She also doesn't go to the temple on Sundays because she can't sit for long periods of time. Her evidence was that in addition to headaches, neck pain, numbness and tingling in her left arm, back pain and right knee pain, she is also depressed, anxious, and has difficulty sleeping.

She testified that she lost consciousness after this accident and her next recollection is being in the hospital. Following this accident, she saw her family doctor, and was treated by Dr. Salama (psychiatrist) for over one year. She was also treated by Dr. Gilyard (orthopaedic surgeon), who recommended shoulder surgery to repair her rotator cuff and medial menisectomy surgery to her right knee. Her shoulder surgery was scheduled for May 2008 and her knee surgery was scheduled for September 2008. Mrs. B testified that the surgeries should improve her condition, otherwise she wouldn't undergo them.

[2] Exhibit one, tab 35

Mrs. B's evidence was that her employer accommodates her with respect to her job duties. She does not have to carry patients; nursing aids do her heavier jobs; the staff she works with know her limitations; and she works fewer hours than when she started working as a nurse.

When cross-examined, Mrs. B stated that she can only sit for 40-45 minutes. However, she agreed that she sat for over one hour on the first day of the hearing. She could not recall having jaw or thigh problems in 2003, low back pain in 2003, or anxiety prior to this accident in 2004. Mrs. B could not recall whether the chiropractor she saw after this accident performed spinal manipulations on her neck.

Mr. B, the Applicant's husband, testified that prior to this accident, Mrs. B used to do his bookkeeping for his trucking business. Following this accident, he does the bookkeeping. In addition, Mrs. B is irritable, depressed, complains, yells unnecessarily and only cooks once a week.

Ms. B, the Applicant's daughter, testified that before this accident she and her mother played volleyball and cooked together. Ms. B, who is away at university, returns home most weekends to help with the cooking and cleaning. She finds that her mother is less patient than prior to the accident. When cross-examined, Ms. B agreed that it's possible because she is away at university, she would not have done as much with her mother.

According to Ms. Stewart, a colleague of Mrs. B, the job duties of a registered nurse include pushing, pulling and lifting patients. Her evidence was that Mrs. B does not do any pushing or pulling and if Mrs. B is in pain, she can lie down. Furthermore, although other nurses work five days a week, 12 hours a day, Mrs. B only works three days a week.

Position of the parties

Among other things, Mrs. B argued that RBC's assessors: (a) reviewed fewer documents than the assessors retained by her and therefore her assessments are more accurate; (b) failed to take into account Mrs. B's injuries as they affected her activities of daily living; and (c) failed to assess all of Mrs. B's impairments.

With respect to the Applicant's argument regarding the number of documents that experts reviewed, the evaluation of a witness does not turn on the number of documents reviewed. Reviewing more documents does not necessarily mean more accuracy in reporting and understanding of a patient. In addition, it is not necessarily the case that difficulties with activities of daily living amount to a CAT impairment within the meaning of clauses 2(1.2)(f) and (g) of the *Schedule*.

RBC argued that: (a) Dr. Rolbin, the anesthesiologist who completed two CAT assessments on behalf of Mrs. B, is not qualified to assess orthopaedic and mental impairments; (b) Dr. Rolbin incorrectly inflated the Applicant's CAT impairment rating when he assessed her chronic pain and sleep disorder separately from her mental and behavioural disorder; and (c) following this accident, Mrs. B passed nursing exams in both Ontario and Michigan and is employed as a nurse, which requires a higher level of functioning than her work before the accident, when she was employed as a personal support worker.

Law

a) The *Schedule*

Under the *Schedule*, a person is eligible for increased benefits if their impairment falls within the definition of "catastrophic impairment" which is defined in clause 2(1.2) of the *Schedule* as:

(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 the *American Medical Association's Guides to the Evaluation of Permanent Impairment, 4th edition*,[3] 1993, results in 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.

b) Combining Physical Whole Person With Mental and Behavioural Impairment Ratings

In *Desbiens v. Mordini*[4] and *Arts (Litigation guardian of) v. State Farm Insurance Co.*,[5] it was found that an assessor could assign a Whole Person Impairment ("WPI") to a mental impairment and combine it with a physical WPI.

In the decision of *Pilot Insurance Company and Ms.* G,[6] the Director's Delegate agreed that it was appropriate to assign a percentage WPI to an impairment based on a mental or behavioral disorder and combine that with a percentage WPI due to a physical impairment. Pursuant to *Vo and Maplex General Insurance Company and Insurance Bureau of Canada*,[7] I am bound to follow the decisions of the Director and the Director's Delegates.

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[3] "*Guides*"

[4] "*Desbiens,*" [2004] O.J. No. 4735 (Ont. S.C.J.)

[5] "*Arts,*" [2008] O.J. No. 2096 (Ont. S.C.J.)

[6] (FSCO Appeal P06-00004, September 4, 2007)

[7] (OIC P-002777, December 12, 1997)

Catastrophic Assessments

Dr. Rolbin (anesthesiologist) completed two CAT assessments on behalf of the Applicant, one year apart. In the first CAT assessment, he concluded that the Applicant had a 67% WPI. In his second CAT assessment, he concluded that the Applicant had a 74% WPI.[8] He found that the Applicant had an upper extremity impairment, a gait disturbance, a cervical and thoracic impairment, a lumbar spine impairment, arousal and sleep difficulties, a chronic pain disorder and a mental and behavioural disorder.[9]

An Insurer's Examination to determine whether Mrs. B is catastrophically impaired was conducted in April and May 2007. Mrs. B was examined/assessed by Dr. Oshidari (physiatrist), Ms. Elyse Freedman (occupational therapist) and Dr. Lawson (psychologist).

Dr. Oshidari expressed the opinion that physically, as a result of this accident, Mrs. B sustained a WPI rating of 23%.[10] With respect to mental and behavioural disorder, Ms. Freedman thought that Mrs. B suffered a class 2, mild impairment, with respect to activities of daily living, social functioning and concentration.[11] According to Ms. Freedman, Mrs. B did not sustain any impairment with respect to adaptation to work environments.[12] With respect to mental and behavioural disorder, Dr. Lawson thought that Mrs. B suffered a class 2, mild impairment, with respect to activities of daily living and concentration and a class 3, moderate impairment, with respect to social functioning and adaptation to work environments. When clauses (f) and (g) of the *Schedule* are combined, Dr. Oshidari concluded that Mrs. B has a 31% WPI[13] and does not meet the *Schedule's* definition of catastrophic impairment (i.e., at least 55% WPI).

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[8] To put Dr. Rolbin's ratings into context, according to the *Guides*, at p. 301, a 100% WPI is considered to approach death; a 95% WPI or higher implies a state like that of coma

[9] Exhibit one, tab 9 at 4-7; tab 11 at 4-7

[10] Exhibit one, tab 73 at 14

[11] Exhibit one, tab 74 at 19

[12] Exhibit one, tab 74 at 19

[13] Exhibit one, tab 71 at 3

Analysis

It is open to an adjudicator to accept all, some or none of a witness's evidence.[14] The burden of proof rests with the Applicant. She must prove on a balance of probabilities that, as a result of the accident, she is catastrophically impaired. I have considered the whole of the evidence and for the following reasons I find that the Applicant has not discharged her burden. She did not provide reliable evidence that she sustained a catastrophic impairment.

Physical Whole Person Impairment

Pre-accident physical condition and causation

The Applicant saw a chiropractor between November 2003 and March 2004 as a result of a work related injury. In March 2004, she was on modified duties as a result of this work-related injury. This work-related injury had resolved by the time she was in this accident.

Dr. Rolbin stated in both his CAT assessments: "None of her symptoms were present prior to the (motor vehicle accident) of May 12, 2004. .. she suffers from anxiety ..."[15] This is incorrect because the Applicant's family doctor's notes[16] indicate that: on August 20, 2002, the Applicant was experiencing fatigue; on November 10, 2003, she had low back pain and her lumbar spine was x-rayed; she again had back pain on March 2, 2004; on March 30, 2004, she was experiencing anxiety.

The causation test is whether the motor vehicle accident of May 12, 2004 significantly contributed to the Applicant's impairment. I find that any of the Applicant's pre-accident physical and psychological injuries had resolved prior to this accident.

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[14] *TTC Insurance Co. v. Watson* (2008), O.J. No. 3820, 241 O.A.C. 131, QL at para. 19 (Ont. Div. Ct.)

[15] Exhibit one: tab 8 at 3, 12 and 27; tab 10 at 2

[16] Exhibit one, tab 31

i) Upper Left Extremity Impairment

In both his CAT assessments, Dr. Rolbin assessed the Applicant's upper left extremity impairment at 34% WPI based on a rotator cuff and nerve injury as well as grip strength. Dr. Oshidari concluded that the Applicant had a 10% WPI rating of the shoulder.

The Applicant was scheduled to have shoulder surgery in September 2008,[17] after she testified at this hearing. When cross-examined, the Applicant testified that her treating orthopaedic surgeon, Dr. Gilyard, said the surgery would improve her shoulder and chronic pain.[18] Dr. Alpert examined the Applicant the day after Dr. Rolbin did the second CAT assessment. However, Dr. Alpert concluded that the Applicant had an intact neurovascular status in her upper extremities.[19] Based on the opinions of Drs. Oshidari and Alpert, I find that the Applicant did not sustain a nerve injury.

When cross-examined, Dr. Alpert opined that shoulder surgery will not have any long-term effect in alleviating the Applicant's pain[20] because, in his opinion, the surgery was only addressing one component of the Applicant's shoulder problems. I place little weight on Dr. Alpert's opinion in this regard because: (a) he is not the Applicant's treating orthopaedic surgeon; and (b) he agreed that surgery is not recommended if it does not benefit a patient. I also prefer the Applicant's hearsay evidence[21] regarding the improvement of her shoulder following surgery because it is based upon her treating orthopaedic surgeon's opinion. Common sense suggests that the Applicant's treating orthopaedic surgeon would not subject her to intrusive surgery if he did not think it would do her any good. In addition, her family doctor opined that

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[17] Exhibit nine: Surgical Boarding Sheet

[18] Transcript, April 8, 2008 at 189, lines 15-18

[19] Exhibit one, tab 15 at 12

[20] April 14, 2008 at 820-821

[21] *Statutory Powers Procedure Act*, R.S.O. 1990, c. S-22, s. 15(1)(a)

although it is unlikely that she would have a "complete recovery," surgery "may improve her pain somewhat."[22]

The *Guides* state:

> Before a judgment regarding impairment is made, it must be shown that the problem has been present for a period of time, is stable, and is unlikely to change in future months in spite of treatment.[23]
> ...
>
> An impairment should not be considered "permanent" until the clinical findings, determined during a period of months, indicate that the medical condition is static and well stabilized.[24]
> ...
>
> An individual's impairment should be evaluated when the impairment has become stable after the completion of all necessary medical, surgical, and rehabilitative treatment.[25]
> ...
>
> Permanent impairment is impairment that has become static or well stabilized with or without medical treatment and is not likely to remit despite medical treatment.
>
> A permanent impairment is considered to be unlikely to change substantially and by more than 3% in the next year with or without medical treatment. If an impairment is not *permanent*, it is inappropriate to characterize it as such and evaluate it according to *Guides* criteria (emphasis in original).[26]

In reference to grip strength, the *Guides* state:[27]

> When evaluating strength, the examiner must have good reason to believe the patient has reached maximal improvement and that the condition is permanent.

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[22] Exhibit one, tab 35 at 2

[23] *Guides*, section 1.2 at 1/3

[24] *Guides*, section 2.3 at 2/9

[25] *Guides*, section 3.3j, at 3/112

[26] *Guides*, Glossary, at 315

[27] At 3/64

The *Guides* are clear that impairments are not assessable until a person's condition has stabilized and all necessary surgeries have occurred. However, Mrs. B's upper extremity was assessed prior to the completion of her shoulder surgery and possible rehabilitative treatment in respect thereof, contrary to the *Guides*. Despite this, however, Dr. Rolbin conducted two CAT assessments of Mrs. B, one year apart, with a 7% difference in WPI rating.[28]

For the above reasons, I find that the Applicant has not demonstrated that her left upper extremity is "unlikely to change in future months,"[29] "static and well stabilized"[30] or "unlikely to change substantially and by more than 3%."[31] In addition, the Applicant's grip strength should not have been evaluated based on the requirement in the *Guides* that a patient must have reached "maximal medical improvement." Therefore, pursuant to the *Guides*, it is inappropriate to rate the Applicant's upper left extremity until the completion of her surgery and her recovery there from.

ii) Gait Derangement

In both his CAT reports, Dr. Rolbin, assessed the Applicant's gait disturbance at 7% based on Table 36[32] of the *Guides*, which states at clause (a) that if a patient has an "Antalgic limp with shortened stance phase and documented moderate to advanced arthritic changes of hip, knee or ankle," the WPI rating is 7%.

Dr. Oshidari assessed the Applicant's knee impairment at 4%[33] based on her range of motion.

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[28] Note that according to the *Guides* (at 315) a person's condition has not stabilized if it will change by more than 3% within a year with or without medical treatment.

[29] *Guides*, section 1.2 at 1/3

[30] *Guides*, section 2.3 at 2/9

[31] *Guides*, Glossary at 315

[32] At 3/76

[33] Based on the rating at 3/78, Table 41 of the *Guides*

In Dr. Oshidari's report, he stated that the Applicant "walked with a normal gait pattern" and he was not able to detect any limping. Furthermore, she did not use an assistive device to walk.[34] Dr. Oshidari concluded that the Applicant's gait derangement is zero.[35] However, at p. 9 of Dr. Oshidari's report, he stated: "She had an elastic bandage on around the right knee, with a small patella brace." I place little weight on Dr. Oshidari's conclusion that the Applicant did not use an assistive device to walk because, as he noted, the Applicant used a knee brace, which is an assistive device.

The Applicant was scheduled to have medial menisectomy surgery to her right knee in May 2008,[36] after she testified at this hearing. When cross-examined, the Applicant testified that: (a) following knee surgery, she requires rehabilitation which includes exercises and physiotherapy; and (b) her treating orthopaedic surgeon, Dr. Gilyard, said the surgery would improve her knee.[37]

When cross-examined, Dr. Alpert opined that knee surgery will not have any long-term effect in alleviating the Applicant's pain[38] because, in his opinion, the surgery was only addressing one component of the Applicant's knee problems. I place little weight on Dr. Alpert's opinion in this regard because: (a) he is not her treating orthopaedic surgeon; and (b) he agreed that surgery is not recommended if it does not benefit a patient. I also prefer the Applicant's hearsay evidence[39] regarding the improvement of her knee following surgery because it is based upon her treating orthopaedic surgeon's opinion.

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[34] Exhibit one, tab 73 at 9 and 14

[35] Exhibit one, tab 73 at 14

[36] Exhibit nine: Surgical Boarding Sheet

[37] Transcript, April 8, 2008 at 189, lines 5-9

[38] April 14, 2008 at 819, lines 17-20

[39] *Statutory Powers Procedure Act*, R.S.O. 1990, c. S-22, s. 15(1)(a)

For the above reasons, I find that the Applicant has not demonstrated that her knee condition is "unlikely to change in future months,"[40] "static and well stabilized"[41] or "unlikely to change substantially and by more than 3%."[42] Therefore, pursuant to the *Guides*, it is inappropriate to rate the Applicant's knee condition prior to completion of her surgery and rehabilitative treatment.[43] However, in the event that I am incorrect regarding the above, for the reasons set out below, I conclude that the Applicant has not demonstrated that she has a gait derangement.

Dr. Rolbin concluded that the Applicant had "arthritic changes in her knee"[44] in his first CAT assessment. According to Dr. Alpert, the Applicant's right knee has "post-traumatic arthritic changes."[45] However, this is not reliable evidence of the *Guides'* requirement of "moderate to advanced arthritic changes."[46] That is, some arthritic changes do not necessarily amount to the *Guides'* requirement of "moderate to advanced arthritic changes."

I found that the Applicant's knee impairment is not assessable due to her future knee surgery. However, if I had found that the Applicant's knee impairment was assessable I would have agreed with Dr. Oshidari's assessment because, according to the *Guides*, an "evaluator should use the more specific methods of those other parts in estimating impairments"[47] before an assessor utilizes gait derangement.

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[40] *Guides*, section 1.2 at 1/3

[41] *Guides*, section 2.3 at 2/9

[42] *Guides*, Glossary at 315

[43] *Guides* at 3/112, section 3.3j

[44] Exhibit one, tab 9 at 5

[45] Exhibit one, tab 15 at 15 and 17

[46] At 3/76

[47] At 3/75

iii) Cervical and Thoracic Impairment

In Dr. Rolbin's first CAT report, he assessed the Applicant's cervical and thoracic impairment at 5%, stating the "cervical spine instability impairment rating by the use of digital motion x-ray and analysis ... could quite possibly result in a much higher impairment rating."[48] In his second CAT assessment, Dr. Rolbin relied on digital radiographic images taken by Dr. Baird (chiropractor) to measure loss of motion segment integrity. Dr. Rolbin assessed the Applicant's cervical and thoracic impairment at 25%.[49] Dr. Bennett (radiologist; retained by the Applicant) concurred[50] with Dr. Baird's assessment.

Dr. Oshidari reported that the Applicant had a 5% impairment of the neck. According to Table 73 of the *Guides*, this impairment rating is defined as a "minor impairment: clinical signs of neck injury are present without radiculopathy or loss of motion segment integrity." [51]

I place little weight on Dr. Rolbin's assessment of the Applicant's alleged cervical and thoracic impairment for the following reasons: (a) the *Guides* define what loss of motion segment integrity is and how to measure it. The cervical spine is radiographed in flexion and extension and the two x-ray films are superimposed to measure any slippage.[52] The Applicant's loss of motion segment integrity was not measured in accordance with the *Guides*. I do not find Dr. Baird's assessment, which was relied upon by Drs. Rolbin, Alpert[53] and Bennett (radiologist),[54] reliable evidence based on the *Guides'* methodology for assessment, that the Applicant suffered a

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[48] Exhibit one, tab 9 at 6

[49] Exhibit one, tab 11 at 5

[50] Exhibit one, tab 5, pp. 16-17

[51] At 3/110

[52] *Guides* at 3/98, Figure 63. *Masciarelli v. Allstate Insurance Co. of Canada* , QL at 6, para. 35 (FSCO A04-002444, August 16, 2006). See also *Guides* at 3/109

[53] Exhibit one, tab 15 at 18

[54] Exhibit one, tab 5 at 16-17

loss of motion segment integrity;[55] (b) Dr. French, an orthopaedic surgeon retained by the Applicant, opined in his report dated September 20, 2005 that the Applicant did not have any neck abnormalities;[56] (c) in treatment plans dated May 31, 2004[57] and June 14, 2005,[58]chiropractic and spinal manipulation were respectively recommended. I find that spinal manipulation is contraindicated for someone with loss of motion segment integrity.[59]

I accept Dr. Oshidari's assessment that the WPI rating is 5% for the cervical and thoracic impairment because the Applicant's impairment accords with the *Guides'* definition of a 5% rating.

iv) Lumbar Spine Impairment

Both Drs. Rolbin and Oshidari[60] agreed that the Applicant's WPI rating of the lumbar spine is 5%. In both of Dr. Rolbin's CAT reports[61] he relied upon Table 72, category II of the *Guides*[62] which states: "Minor impairment: clinical signs of lumbar injury are present without radiculopathy or loss of motion segment integrity." I find that Dr. Rolbin's reliance on category II of Table 72 of the *Guides*, in which a patient does not have loss of motion segment integrity, is inconsistent with his finding that the Applicant, in his second CAT report, sustained a loss of motion segment integrity. I find that the Applicant's WPI in relation to her lumbar spine is 5%.

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[55] *Masciarelli v. Allstate Insurance Co. of Canada* , QL at 7, para. 37 (FSCO A04-002444, August 16, 2006)

[56] Exhibit one, tab 45 at 7. See also Dr. Oshidari's report, Exhibit one, tab 73 at 10

[57] Exhibit one, tab 56

[58] Exhibit one, tab 51, Part 12

[59] Examination of Dr. Oshidari

[60] Exhibit one: tab 9 at 6, tab 11 at 6, tab 73 at 13 and 14

[61] Exhibit one: tab 9 at 6; tab 11 at 6

[62] At 3/110

v) Arousal and Sleep Disorder

In both Dr. Rolbin's CAT reports, he opined that the Applicant's WPI for arousal and sleep disorder is 5%. Dr. Oshidari did not rate the Applicant's arousal and sleep disorder.

I find that Dr. Rolbin's assignment of 5% for Mrs. B's sleep disorder is inconsistent with the *Guides*. In Chapter 14 of the *Guides* dealing with mental and behavioural disorders, sleep is one of the factors that are assessed under the topic Activities of Daily Living.[63] In the Applicant's case, according to the *Guides*, no WPI rating is given for arousal and sleep disorder, because, for example, she does not have a disorder of the respiratory system[64] and accordingly, the Applicant's rating for this is 0%.

vi) Chronic Pain Impairment

In both Dr. Rolbin's CAT reports, he opined that the Applicant's WPI rating for chronic pain is 5%. Dr. Oshidari did not provide a WPI rating for chronic pain.

The *Guides* state: "the impairment percents shown in the chapters that consider the various organ systems make allowance for the pain that may accompany the impairing conditions."[65] Chapter 15 of the *Guides* deals with pain. The *Guides* contain three examples[66] of various medical conditions accompanied by chronic pain, with discussion on WPI rating. However, in each of the three examples, no WPI rating is assigned for chronic pain. When asked where in the *Guides* the 5% WPI rating is contained, Dr. Rolbin stated: "percentages aren't given for chronic pain." In Dr. Rolbin's opinion, chronic pain "interferes with (the Applicant's) ... Activities of

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[63] Section 14.3 at 14/294. See also p. 317 of the Glossary of the *Guides* in which sleep is an example in the Table relating to Activities of Daily Living.

[64] *Guides* at 5/163. In Dr. Rolbin's reports, Exhibit one: tab 8 at 17 and tab 10 at 13, he concludes that her respiratory system was normal

[65] Section 2.2 at 2/9. See also section 15.1 at 15/304

[66] At 15/312-15-313

Daily Living."[67] However, the Applicant's Activities of Daily Living were assessed in the mental and behavioural component of the CAT assessments.

I find that Dr. Rolbin's WPI rating of chronic pain is inconsistent with the *Guides'* statement that "the impairment percents shown in the chapters that consider the various organ systems make allowance for the pain that may accompany the impairing conditions"[68] and the three examples given in the *Guides*. I find that in the Applicant's case, her WPI rating for chronic pain is 0%.

vii) Impairment due to mental or behavioural disorder

Under clause 2(1.2)(g) of the *Schedule*, a person satisfies the definition of "catastrophic impairment" if they suffer a class 4 impairment (marked impairment) or a class 5 impairment (extreme impairment) as defined in the *Guides*. A class 4 marked impairment is "Impairment levels significantly impede useful functioning." A class 5 extreme impairment is "Impairment levels preclude useful functioning."

Dr. Rolbin concluded in both his CAT assessments[69] that the Applicant has a class 3, moderate impairment and assigned the Applicant a 35% WPI rating. He states in his CAT reports that for a moderate impairment: "the 4th edition of the AMA *Guides* suggest a range impairment rating of 25-50%." The 4th edition of the *Guides* does not suggest any percentage rating, as outlined below. The percentages referred to in Chapter 14 of the *Guides*[70] are in reference to the *AMA Guides to the Evaluation of Permanent Impairment, 2nd edition.*

The Applicant completed for Dr. Rolbin various tests as part of her psychological assessment which, according to the descriptions contained in his reports, deal with her perceived pain, its interference with her life, and depression.

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[67] Transcript, April 9, 2008, at 394-395

[68] At 2/9

[69] Exhibit one: tab 9 at 4 and tab 11 at 4

[70] At 14/301

In both Dr. Rolbin's CAT assessments, he concluded that the Applicant's Global Assessment of Function ("GAF") score was 55,[71] which, according to Dr. Lawson's (psychologist) testimony, is "almost vegetative" and such a person should be hospitalized. However, in Dr. Salama's (treating psychiatrist) assessment, the Applicant's GAF score was 75.[72]

As part of the Insurer's Examination to determine whether the Applicant is catastrophically impaired, she underwent an assessment with an occupational therapist, Ms. Freedman.[73] According to the OT's report, the Applicant's daily routine consists of the following when she works: [74]

- She wakes up at 5:30 am, takes a shower, prepares tea and prepares self for work;
- Leaves for work around 6:15-6:30;[75]
- Either drives or is driven for 30 minutes with colleagues across the Michigan border to go to work;
- Works for two days a 12-hour shift and two days for an 8-hour shift;
- Returns from work between 8-8:15 pm;
- Showers
- Eats
- Sleeps around 10:00 pm

Ms. Freedman concluded that the Applicant has a class 2 impairment, mild impairment with respect to activities of daily living, social functioning and concentration, and no impairment with respect to adaptation to work environment.[76]

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[71] Scale is up to 100. The higher the score, the better one's function is.

[72] Exhibit one, tab 7 at 2

[73] Exhibit one, tab 74

[74] Exhibit one, tab 74 at 8. The Applicant's counsel was of the opinion that the OT's report was done in contravention of the *Guides* because it was not completed by a physician pursuant to 1/1 of the *Guides*. Without deciding whether the Applicant's counsel is correct or not, the OT's report provides a brief glimpse into the Applicant's life.

[75] The report incorrectly refers to the Applicant leaving for work between 6:15-6:30 pm

Dr. Lawson concluded that the Applicant has a class 2, mild impairment with respect to activities of daily living and concentration, and a class 3, moderate impairment with respect to social functioning and adaptation to work environments. Dr. Lawson assigned the Applicant a 10% WPI rating.[77] In his testimony, Dr. Lawson agreed that the Applicant's WPI rating could be slightly higher.

As part of the Insurer's Examination, the Applicant completed some of the same tests as she did for Dr. Rolbin, as well as additional tests which measure test engagement and test validity. According to Dr. Lawson's testing, the Applicant over-reported her psychological symptomatology. [78]

The following passages from *Guides*[79] are useful in putting mental and behavioural impairment ratings into context. A mild impairment:

> implies that any discerned impairment is compatible with most useful functioning.

A moderate impairment:

> Means that the identified impairments are compatible with some but not all useful functioning.

Mrs. B is not as active socially as she was before the accident. She claims to have suffered a loss of libido. She has some accommodations at work. However, she continues to work full time as a nurse.

Dr. Rolbin concluded that "it is not realistic to expect her to return to full-time employment because of the physical and psychological demands of employment."[80] However, for over one year thereafter, the Applicant continued to work full time.

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[76] Exhibit one, tab 74 at 19

[77] Exhibit one, tab 72 at 12

[78] Exhibit one, tab 72 at 3

[79] At 300

[80] Exhibit one, tab 10 at 23

Dr. Rolbin concluded that Mrs. B has reached "maximum medical improvement"[81] and that her physical and psychological injuries are not likely to improve with any treatment.[82] This is contrary to her family doctor's report that states: "With time it is anticipated that her symptoms of anxiety, stress and depression would improve and mentally she would be able to handle her day-to-day activities."[83]

Dr. Rolbin stated in his report of February 25, 2007[84] that the Applicant is unable to drive a car. This is incorrect.[85]

I found Dr. Lawson's insight, both in his report and testimony, credible[86] and useful. I prefer his assessment to that of Dr. Rolbin's assessment because: (a) as the parties agreed, Dr. Lawson is an expert in neuropsychology, whereas Dr. Rolbin is an anesthesiologist, who opined outside the scope of his expertise; and (b) his testing included an assessment of the validity of psychological tests, whereas Dr. Rolbin's testing did not.

I find that the Applicant has a class 2, mild impairment with respect to activities of daily living and concentration[87] because it is a level of impairment which is "compatible with most useful functioning." The Applicant has a class 3, moderate impairment with respect to social functioning and adaptation to work environments because her impairment levels are compatible with some, but not all, useful functioning.

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[81] Exhibit one, tab 10 at 18

[82] Despite this, however, he recommends that she go to a psychiatrist, see Exhibit one, tab 10, at 17

[83] Report dated February 25, 2008 at Exhibit one, tab 35 at 3

[84] Exhibit one, tab 8 at 5

[85] Pursuant to p. 317 of the Guides, travel is one aspect of Activities of Daily Living

[86] For example, Dr. Lawson acknowledged that although he did not review the Applicant's treating psychiatrist's report at exhibit one, tab 7, he should have. However, Dr. Lawson explained that if he had reviewed it, it would have strengthened his opinion of the Applicant's level of functioning because Dr. Salama assigned her a GAF score of 75.

[87] Which includes "the timely completion of tasks commonly found in work settings, Guides at 14/294

Table 3 in Chapter 4 of the *Guides* (which deals with the nervous system) provides impairment ratings for emotional or behavioural disorders. In addition, mental and behavioural disorders are addressed in Chapter 14 of the *Guides*.[88] Based on the aforementioned, I find that the Applicant's WPI rating is 20%.[89]

Combined WPI Ratings

According to the Combined Values Chart in the *Guides*, the combined value of the physical impairment ratings of 5 and 5 is 10% WPI. This does not meet the threshold of 55% WPI

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[88] See, for example *G and Pilot Insurance Co.*, QL at 17, para. 93 (FSCO A04-000446, March 16, 2006, upheld on appeal (FSCO P06-00004, September 4, 2007) regarding combining Chapters 4 and 14 of the *Guides* when assessing mental and behavioural disorders.

[89] 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 of interpretation where a non-statutory instrument, such as the *Guides*, is incorporated in a Regulation, Spiegel J. wrote in *Desbiens*:

> When material is incorporated by reference into a statute or regulation it becomes an integral part of the incorporating instrument as if reproduced therein (QL at 41, 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 certainty that does not exit ...

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 sight in one 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" (*Desbiens*, QL at 44, para. 242; *Arts*, 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 a physical WPI rating.

specified in clause 2(1.2)(f) of the *Schedule* which is required to satisfy the definition of "catastrophic impairment".

Mrs. B's impairment rating based on mental or behavioural disorder, which I have found is mild, is 20%. This does not meet the threshold of a class 4 impairment (marked impairment) or a class 5 impairment (extreme impairment) specified in clause 2(1.2)(g) of the *Schedule*. However, when the physical impairment rating of 10% is combined with the mental and behavioural impairment rating of 20%, this results in a WPI of 28%.

Based on the above, the Applicant did not sustain a catastrophic impairment within the meaning of clauses 2(1.2)(f) and (g) of the *Schedule*.

Additional Considerations

i) Dr. Rolbin

I have concerns regarding Dr. Rolbin's evidence. I find that he went beyond his area of expertise, which is anesthesiology,[90] when he conducted the CAT assessments which included: (i) assessing and evaluating orthopaedic injuries; and (ii) administering and evaluating psychological tests and diagnosing mental and behavioural disorders.[91] When asked to describe a Slap II lesion (an injury to the shoulder) by counsel for the Applicant, he deferred to Dr. Alpert (orthopaedic surgeon) and stated: "that's an orthopaedic terminology and classification. I understand there will be an orthopaedic expert testifying later on and he will have to explain the terminology to the court."[92]

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[90] He has treated patients with chronic pain.

[91] See, for example *G and Pilot Insurance Co.*, QL at 23, para. 137 (FSCO A04-000446, March 16, 2006, upheld on appeal (FSCO P06-00004, September 4, 2007) regarding area of expertise opinion evidence.

[92] Transcript, April 9, 2008, at 313, lines 14-18

In addition, Dr. Rolbin adopted the stance of an advocate for the Applicant, as opposed to providing objective evidence to this Tribunal.[93] For example, when asked whether given the Applicant's future surgeries and pre-accident medical history, he would change anything in his report, his testimony was "no."[94] He also testified that despite the Applicant's future surgeries, he would not alter his opinion regarding the permanency of the Applicant's injuries.[95] When cross-examined, he was often evasive and unresponsive.[96] As well, he referred to the Insurer's counsel as "heartless."[97]

ii) Applicant's Credibility

I have concerns regarding the Applicant's credibility and gave it little weight. In *Hawley v. Bapoo* some of the following factors were considered when assessing credibility:[98] (a) Apparent powers of recall: Although she reported to various assessors[99] and testified that she lost consciousness following this accident, the ambulance call report,[100] emergency record[101] and emergency notes[102] all indicate that she did not lose consciousness. I prefer the records made contemporaneously with this accident rather than Mrs. B's evidence following the accident;[103]

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[93] The role of an expert is discussed in *Ikarian Reefer*, [1993] 2 Lloyd's Rep. 68 at 81 as cited in *Fellowes, McNeil v. Kansa General International Insurance Co.* (1998), 40 O.R. (3d) 456, QL at 76, para. 450 (Ont. Gen.Div.)

[94] Transcript, April 9, 2008 at 522

[95] Transcript, April 9, 2008 at 523

[96] See, for example, the transcript of April 9, 2008 at 487-492

[97] Transcript, April 9, 2008 at 507

[98] [2005] O.J. No. 4328, QL at para. 6 (Ont. S.C.J.)

[99] Report of Dr. Salama, Exhibit one, tab 7 at 1; report of Dr. Alpert, Exhibit one, tab 15 at 7

[100] Exhibit one, tab 20

[101] Exhibit one, tab 21

[102] Exhibit one, tab 22

[103] An adjudicator is not "required to confront a witness if they are concerned that there is any possibility that, after hearing all of the evidence, they may not accept all of the testimony given by the witness." That is, "the rule in *Browne v. Dunn* is not suited for application to judges." *Vasilipoulos v. Dosanjh*, [2008] B.C.J. No. 1917, QL at 10, para.'s 35 and 36 (B.C. C.A.)

(b) Ability to resist the tug of self interest: When cross-examined, she had a selective memory. She could not recall matters which could impact on the causation test, such as her jaw or thigh problem in November 2003, anxiety in March 2004, her back problems in 2003 (in this regard she stated she's never had back problems), or whether her chiropractic treatment included spinal manipulations.[104] However, she was able to recall most everything else; (c) Inherent plausibility of her evidence within itself: She "denied any history of pre-existing medical conditions, and the use of medications prior to the mva"[105] despite taking Tylenol 3. When cross-examined, she said that she answered that way because she wasn't on the medication long-term. I find both her denial and her explanation of the denial disingenuous; (d) Consistency of evidence standing alone and as compared to other evidence: Although she testified that she could only sit for 40-45 minutes, she sat during the hearing, excluding the time she was testifying and times she sat outside in the reception area at FSCO and during breaks, for upwards of 1.5 hours without any apparent discomfort.[106] Dr. French (orthopaedic surgeon), who saw Mrs. B at her lawyer's request, noted that she sat comfortably for approximately 55 minutes.[107] Her evidence about her inability to sit, and the medical opinions based on that understanding, are not reliable. In addition, in a disability DAC assessment conducted in 2005,[108] her perception of herself was such that she was crippled,[109] bed-bound or exaggerating her disability. She is far from bed-bound.

iii) Adverse Inference

Mrs. B did not call any of her treating practitioners to give evidence, such as Dr. Gilyard, her orthopaedic surgeon, nor did she file a report by him. This issue was considered by the authors

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[104] Transcript, April 8, 2008 at 171-172

[105] Exhibit one, tab 75 at 2

[106] An arbitrator's assessment of evidence can include his/her observations during a hearing: *Rodrigues and State Farm Mutual Automobile Insurance Co.*, QL at 4-5, para.'s 21-25 (O.I.C.D. No. 140, August 26, 1996)

[107] Exhibit one, tab 45 at 7

[108] Exhibit one, tab 69 at 30

[109] Exhibit one, tab 69 at 31

of the text *The Law of Evidence in Canada* in which it is stated: "an unfavourable inference can be drawn when, in the absence of an explanation, a party ... fails to call a witness who would have knowledge of the facts and would be assumed to be willing to assist that party."[110] As well, this hearing continued past the dates that were scheduled for the Applicant's surgeries. However, the Applicant did not request that I consider additional evidence regarding those surgeries.

EXPENSES:

Expenses were not addressed at the hearing. If the parties are unable to agree on the issue of entitlement to or amount of the expenses, they may make submissions on both issues in accordance with Rule 79 of the *Dispute Resolution Practice Code - Fourth Edition.*

Maggy Murray
Arbitrator

January 16, 2009
Date

[110] Second edition, J. Sopinka, S.N. Lederman, A.W. Bryant, Butterworths Canada Ltd., 1999 at 297, para. 6.321

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A06-000209

BETWEEN:

B

Applicant

and

RBC GENERAL INSURANCE COMPANY OF CANADA

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c.I.8, as amended, it is ordered that:

1. Mrs. B did not sustain a catastrophic impairment within the meaning of clauses 2(1.2)(f) and (g) of the *Schedule*.

2. If the parties cannot agree on the issue of entitlement to or amount of the expenses of this Arbitration proceeding, they may request a determination of these issues in accordance with Rule 79 of the *Dispute Resolution Practice Code - Fourth Edition.*

Maggy Murray

Maggy Murray
Arbitrator

January 16, 2009

Date