Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A16-003657

BETWEEN:

ABDIRAHMAN ABYAN

Applicant

and

SOVEREIGN GENERAL INSURANCE COMPANY

Insurer

DECISION ON A PRELIMINARY ISSUE

Before: Arbitrator Benjamin Drory

Heard: In-person at ADR Chambers on August 2 and 3, 2017

Appearances: Mr. Mohamed Elbassiouni and Mr. Essam Elbassiouni, licenced paralegals, for Mr. Abdirahman Abyan
Mr. Abdirahman Abyan attended
No appearances on behalf of Sovereign General Insurance Company
No appearances on behalf of the Attorney General of Ontario
No appearances on behalf of the Attorney General of Canada

Issues:

The Applicant, Mr. Abdirahman Abyan, was injured in a motor vehicle accident ("MVA") on June 19, 2015. He sought accident benefits from Sovereign General Insurance Company ("Sovereign"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and the Applicant, through his representative, applied for arbitration at the Financial Services Commission of Ontario ("FSCO") under the *Insurance Act*, R.S.O. 1990, c. I.8, as amended.

[1] *The Statutory Accident Benefits Schedule - Effective September 1, 2010*, Ontario Regulation 34/10, as amended.

The issues in this Hearing are:

1. Are sections 3 and 18 of the *Schedule* (i.e. the definitions and monetary caps related to the Minor Injury Guideline), or parts thereof, unconstitutional, as unjustifiably infringing upon sections 7 and/or 15 of the *Canadian Charter of Rights and Freedoms*?
2. If the answer to any part of the above is yes, what is/are the consequence(s)?
3. Is either party entitled to expenses arising from this proceeding?

Result:

1. Sections 3 (the definition of “minor injury”) and 18(2) of the *Schedule* are unconstitutional, as infringing upon section 15(1) of the *Canadian Charter of Rights and Freedoms* on the basis of physical disability. The infringements are not justifiable under section 1 of the *Canadian Charter of Rights and Freedoms*.
2. The definition “clinically associated sequelae” in the definition of “minor injury” in s. 3 of the *Schedule* is interpreted to exclude individuals who suffer from chronic pain among the sequelae to the injury.
3. The provision “that was documented by a health practitioner before the accident” in section 18(2) of the *Schedule* and also in section 4 of Superintendent’s Guideline No. 01/14 (“Minor Injury Guideline”) is severed.
4. If the parties are unable to mutually agree on the entitlement to and/or quantum of the expenses of this matter, either of them may request an appointment with me for determination of same in accordance with the provisions of Rules 75 to 79 of the *Dispute Resolution Practice Code*.

EVIDENCE AND ANALYSIS:

BACKGROUND

The substantive issues in dispute between the parties are whether the Applicant is entitled to $1,995.32 for a psychological assessment provided by Injury Management & Medical Associates,

and whether the Applicant is entitled to a Special Award because the Insurer unreasonably delayed payments of benefits to him. The applicability of the Minor Injury Guideline ("MIG") as a defence to the Applicant's case is also in issue.

The Applicant challenges the constitutionality of the MIG, and properly served notice of his intention to raise a constitutional argument upon both the Attorney Generals of Ontario and Canada, in accordance with Rule 80 of the *Dispute Resolution Practice Code* ("*DRPC*"). No response was received from the Attorney General of Canada. The Attorney General of Ontario advised that it did not intend to intervene in the challenge, and simply advised the Applicant that constitutional questions should only be heard as necessary and not in a factual vacuum. Sovereign also opted not to attend the Preliminary Issue Hearing, and left it to me to decide whether the Applicant met the onus of proving a constitutional infringement, and if so whether I have the authority to read down sections of the *Schedule* pursuant to s. 24 of the *Canadian Charter of Rights and Freedoms* ("*Charter*"),[2] but added its position that no other substantive issues ought to be considered.

The Applicant submitted that this is not the first time a case has come before a tribunal respecting the constitutionality of legislation, and referred to the Supreme Court of Canada decisions in *Martin*,[3] *Conway*,[4] and *Cuddy Chicks*.[5] The Applicant also submitted that, per *Cuddy Chicks*, the applicability of this decision is strictly limited to this particular case, and would not constitute a precedent of general effect. I orally indicated that I was satisfied that this tribunal appropriately has jurisdiction to hear and decide the *Charter* issues raised. I will elaborate on those reasons in the Analysis section.

The Applicant submitted that in constitutional litigation, it is incumbent upon the Applicant to first demonstrate that a *Charter* right has been infringed, and then upon the government to justify the infringement under s. 1 of the *Charter*. The Applicant acknowledged that no one was present

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[2] *Canadian Charter of Rights and Freedoms*, Part I of the *Constitution Act, 1982*, being Schedule B to the *Canada Act 1982* (UK), 1982, c. 11.

[3] *Nova Scotia (W.C.B.) v. Martin,* [2003] 2 S.C.R. 504, 2003 SCC 54.

[4] *R. v. Conway*, [2010] 1 S.C.R. 765, 2010 SCC 22.

[5] *Cuddy Chicks Ltd. v. OLRB*, [1991] 2 S.C.R. 5.

on behalf of the government, which all present agreed was unfortunate. However, all parties were served with proper notice of the Hearing on the constitutional question, and provided the opportunity to present argument.

The Applicant submitted that he requires ongoing medical treatment. Normally, ss. 15 and 16 of the *Schedule* respecting medical and rehabilitation benefits would be applicable, and the test would be whether such benefits sought by the Applicant from the Insurer are reasonable and necessary. If so, such benefits would presently be payable up to a monetary limit of $65,000 (also including attendant care benefits) over 10 years. However, the MIG creates a legislative exception to this typical $65,000 limit; for applicants subject to the MIG, as defined in the *Schedule*, the limit is reduced to $3,500.

The Applicant is 51 years old, and has been working full-time as a taxi driver with Airport Taxi Cab based out of Pearson International Airport in Toronto. The Applicant submitted that on June 19, 2015, he was involved in a three-vehicle accident; his vehicle was an “insurance write off” due to damage it sustained, and both of his vehicle’s airbags deployed due to the force of the collision. The Applicant experienced immediate onset of neck pain following the collision, and suffered injuries to his head, neck, shoulders, back, hips, thighs, and knees, along with headaches, flashbacks, difficulty sleeping, and fear of driving. His ongoing pain is aggravated by prolonged sitting, standing, bending forward, and ambulation. The Applicant followed up with his family physician within the first week of his injuries, who referred him to physiotherapy and provided him with medication. He continued physiotherapy for 6 months until his benefits ran out. He returned to work approximately 6 weeks after his injuries, but at reduced hours and capacity.

On June 21, 2015 (two days post-MVA), a cervical spine x-ray revealed a reversal of cervical lordosis. Prominent osteophytes and moderate degenerative facet disease in the lower cervical spine were noted. On October 15, 2015, Sovereign denied the Applicant’s request for a psychological assessment proposed by Dr. Jon Mills, stating there was no need for the proposed assessment and that the maximum amount payable pursuant to the MIG applied.

On April 1, 2017 (nearly two years post-MVA), x-rays of the Applicant's knees conducted by Dr. Tze Chia revealed osteoarthritis of the bilateral knees, along with enthesopathic changes of the distal quadriceps and proximal patellar tendons. On May 31, 2017, Dr. Krystyna Prutis noted that a MRI of the lumbar spine showed multi-level degenerative disc disease of the spine. She reported the Applicant's MVA aggravated pre-existing degenerative changes in his cervical spine and made them symptomatic, thus resulting in chronic neck pain. On June 8, 2017, Dr. Tajedin Getahun reported that the Applicant's injuries had not resolved within the expected time course for uncomplicated soft tissue injuries, and opined that the Applicant's injuries were consistent with chronic pain, which precluded the Applicant from achieving maximum medical recovery within the MIG. A June 15, 2017 follow-up with the Applicant's family doctor, Dr. Hanna Hinnawi, indicated that chronic neck and back pain continued to affect the Applicant, and he was also suffering from major depression, poor sleep, and restricted range of motion in his back and neck.

EVIDENCE

Dr. Tajedin Y. Getahun

Dr. Getahun testified on behalf of the Applicant; he is an orthopaedic surgeon with a full practice respecting acute and chronic conditions. I accepted that Dr. Getahun was an expert witness with respect to orthopaedic surgery and chronic pain. Dr. Getahun testified that he saw the Applicant in June 2017. He completed both an independent chronic pain assessment[6] of the Applicant and a medical-legal report[7] requested by the Applicant's counsel.

Dr. Getahun testified that the MIG refers to "minor" injuries as defined by legislation—specifically, contusions, abrasions, lacerations, subluxations, and clinically associated sequelae. Any injury that is not one of those listed conditions is not a "minor injury". Dr. Getahun was asked to elaborate on his understanding of what "clinically associated sequelae" means. Dr. Getahun said that "clinically associated sequelae" is "anything that is a following sequel of" in the

[6] Exhibit 3—Independent Chronic Pain Assessment, Dr. Getahun, June 8, 2017 (Tab 16).
[7] Exhibit 4—Medical-Legal Report of Dr. Getahun, July 17, 2017 (Tab 17).

natural course of recovery from treatment of an injury. For example, ankle surgery could be minor, but a subsequent injury resulting from it would be a "sequelae". In the Applicant's case, his injuries were to his knee and neck, and he had a WAD/whiplash injury, which was projected to recover in 3 months.

Dr. Getahun said that chronic pain starts with some kind of stimuli. A reaction can become maladaptive—chronic pain is maladaptive behaviour to pain. Dr. Getahun referred to the American Medical Association's *Guides to the Evaluation of Permanent Impairment, Fourth Edition*[8] to describe accepted medical understandings of chronic pain; I reprint some of his highlights below from Chapter 15 entitled "Pain", which provide a sense of chronic pain's hallmarks and severity:

> Chronic pain *represents the nidus of the chronic pain syndrome. ... Pain of long duration is properly referred to as "persistent pain", with the term "chronic pain" being reserved for the devastating and recalcitrant type with major psycho-social consequences. In this chapter, the term "chronic pain" is synonymous with "chronic pain syndrome".*
>
> ...
>
> *Chronic pain represents a malevolent and destructive force and generally is considered to be useless. Chronic pain is a self-sustaining, self-reinforcing, and self-regenerating process. It is not a symptom of an underlying somatic injury, but rather a destructive illness in its own right. It is an illness of the whole person and not a disease caused by the pathologic state of an organ system. Chronic pain is persistent, long-lived, and progressive. Pain perception is markedly enhanced. Pain-related behaviour becomes maladaptive and grossly disproportional to any underlying noxious stimulus, which usually has healed and no longer serves as an underlying pain generator.*

[8] Exhibit 5—highlighted *Guides to the Evaluation of Permanent Impairment, Fourth Edition,* American Medical Association, (June 1993; Tenth Printing December 2010), Ch. 15, pp. 306-313; ISBN: 0-89970-553-7.

Chronic pain that is not recognized and properly treated results in a deterioration of coping mechanisms. Under such circumstances, limitations of functional capacity are apt to occur. The patient's maladaptive behavior may have medical, social, and economic consequences that greatly outweigh any somatic components of the illness. These consequences may include despair, alienation from family and society, loss of job, isolation, invalidism, and suicidal thoughts. Yet, chronic pain is not a psychiatric disorder.

Chronic pain may result from inappropriate management of acute pain. It is not possible to predict the course of a patient's condition from inception of the noxious stimulus to the development of the complete chronic pain syndrome.

…

Diagnostic Characteristics (the Eight Ds) of Chronic Pain

The presence of two or more of the following characteristics should be considered to establish a presumptive diagnosis of chronic pain syndrome:

1. Duration: *In the past, the term "chronic pain" has been applied to pain of greater than 6 months' duration; however, current opinion is that the chronic pain syndrome can be diagnosed as early as 2 to 4 weeks after its onset. Prompt evaluation and treatment are essential.*

2. Dramatization: *Patients with chronic pain display unusual verbal and nonverbal pain behavior. Words used to describe the pain are emotionally charged, affective, and exaggerated. Patients may exhibit maladaptive, theatrical behavior, such as moaning, groaning, gasping, grimacing, posturing, or pantomiming.*

3. Diagnostic Dilemma: *Patients tend to have extensive histories of evaluations by multiple physicians. The patient has undergone repeated diagnostic studies, despite which the clinical impressions tend to be vague, inconsistent, and inaccurate.*

…

5. Dependence: *These patients become dependent on their physicians and demand excessive medical care. They expect passive types of physical therapy over long time periods, but these provide no lasting benefit. They become dependent on their spouses and families and relinquish all domestic and social responsibilities.*

6. Depression: *The condition is characterized by emotional upheaval. Patients tend to have psychological test results that suggest depression, hypochondriasis, and hysteria. Cognitive aberrations give way to unhappiness, depression, despair, apprehension, irritability, and hostility. Coping mechanisms are severely impaired. Low self-esteem results in impaired self-reliance and increased dependence on others.*

…

The physician should suspect the presence of the chronic pain syndrome if a patient does not respond to appropriate medical care within a reasonable period of time, or if the patient's verbal or nonverbal pain behavior greatly surpasses the usual response to a given noxious stimulus.

…

The focus of treatment is on management rather than cure. Management requires a multidisciplinary effort that is carried out at a comprehensive pain centre on an inpatient or outpatient basis.

Dr. Getahun testified that even if the original injury recovers, a patient can still be left with chronic pain. Chronic pain is devastating and recalcitrant; a sustained and progressive illness of the whole person. The focus of treatment is on management, not care, and is always a multi-disciplinary effort. He testified that he regularly treats and makes referrals for chronic pain, and that the assessment process for chronic pain can take multiple assessors and its treatment can take a while.

Dr. Getahun was asked about his assessment of the Applicant. His impressions[9] were that the Applicant's MVA-related injuries were: chronic myofascial strain of the cervical spine and aggravation of pre-existing degenerative changes, as noted on his x-rays; left-sided arm symptoms consistent with nerve root irritation and possible left-sided radiculopathy and stenosis; and chronic myofascial strain of the lumbosacral spine. Dr. Getahun also noted the Applicant reported persistent headaches, sleep disturbance, and depressive symptomatology. Dr. Getahun recommended physiotherapy and enrolment in a multi-disciplinary chronic pain program utilizing multiple modalities, including counselling and physical therapy. Dr. Getahun also recommended MRIs of the cervical spine and lumbosacral spine, to rule out C4-5 disc herniation on the left side and left-sided L5-S1 disc herniation, respectively. Dr. Getahun's opinion was that the Applicant's injuries had not resolved within the expected time course for uncomplicated soft tissue injuries, and his presentation was consistent with the development of chronic pain with radicular symptomatology of the cervical and lumbar spine. His opinion was that these factors precluded the Applicant from achieving maximum medical recovery within the MIG. Dr. Getahun also noted that the Applicant had no notable previous history.

The Applicant's counsel asked Dr. Getahun about his medical-legal report dated July 17, 2017.[10] Dr. Getahun said it is not unusual for orthopaedic injuries to develop into chronic pain. The definition of "clinically associated sequelae" must necessarily include chronic pain. His opinion (strictly in the medical sense—not in the legal sense as defined) was that chronic pain is not a minor injury. He said it is a multi-faceted, devastating diagnosis, and self-perpetuates. The AMA Guides recognizes it as a serious problem leading to serious dysfunction, with increased mortality.

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[9] Exhibit 3, pp. 6-7.
[10] Note 7, *supra*.

His opinion was that chronic pain cannot be treated within $3,500. Treatments need to become more varied and take longer.

Dr. Getahun said he has not infrequently encountered patients with pre-existing medically asymptomatic conditions that were not documented in their health practitioners' clinical notes and records ("CNRs"). In his Report, Dr. Getahun noted it was not uncommon for patients to present with traumatic events such as a fall, who have no previous documentation of osteoarthritic pathology—including those who have previously asymptomatic knee, hip, ankle, and/or spinal osteoarthritis. Most often, the first time they encounter a health practitioner who identifies pre-existing osteoarthritis is subsequent to a traumatic episode—in his practice, he often explains to patients that while they had a traumatic episode from their fall, the osteoarthritis was pre-existing and asymptomatic, but was now aggravated and likely to continue to be symptomatic going forward. In other words, in their minds the patients usually attribute the arthritis to the incident, but that is not necessarily true—it was there before, but the trauma of the incident triggered it and worsened it.

Dr. Getahun reported that pre-existing asymptomatic conditions are generally confirmed on history; such patients usually present after a triggering or traumatic event, so their histories would not indicate symptoms, treatment, or investigation. But findings from a radiographic examination would have taken months or years to develop—therefore, by definition they were pre-existing to the traumatic incident. Dr. Getahun reported it is certainly possible for a patient with asymptomatic pathology to be rendered symptomatic by the mechanism of a motor vehicle collision, and he has frequently encountered it in his practice.

Dr. Getahun testified that the Applicant was asymptomatic before the MVA. In his opinion, he didn't see how it would be fair to insist that he must have documentation for an asymptomatic pathology—it wouldn't be possible for him to go to a practitioner and say he had no pain, but ask to investigate. The Applicant wouldn't have had knowledge of his pre-existing pathology.

Dr. Getahun was asked to expand on his opinion of the MIG that he reported on, from a medical perspective. Dr. Getahun said in general he likes it—the MIG tries to expedite treatment for

people involved in MVAs. It tries to list specific injuries, and if you have one of those injuries then you'll get access to treatment to restore functionality. Dr. Getahun thought on its own that's a good idea, but like anything there are limitations. Dr. Getahun said some things he would think of as medically minor are not "minor" legally, and also vice-versa—i.e., some things listed as "minor" legally are, in his medical opinion, not minor. He felt the definition "clinically associated sequelae" leads to many proposals being denied; certainly chronic pain, but he also felt subluxations can be serious too—for example, a subluxation of a hip can be devastating. But conversely, Dr. Getahun noted that fractures are excluded from the definition of "minor injury"—many fractures he treats in orthopedics (e.g. fracture of a finger) are clinically minor, but if someone has such a fracture, it still takes them out of the MIG. Otherwise, Dr. Getahun's opinion was the rest of the MIG is reasonable.

Additional Evidence

The Applicant submitted a series of denials[11] from the Insurer based on reasoning that the limits in the MIG applied.

The Insurer later indicated[12] on June 20, 2017 that it would schedule s. 44 Insurer's Examinations ("IEs") in respect of proposals for chronic pain and psychiatric assessments, dated April 26, 2017 and May 11, 2017, respectively.

On July 13, 2017, the Insurer denied a treatment proposal by Dr. Hashi dated June 13, 2017, which had requested funding in the amount of $13,680.77 for a 20-week multi-disciplinary chronic pain program, based on Dr. Getahun's opinion of the Applicant's ability to reach maximum medical recovery.

The Applicant submitted a report by Dr. Krystyna Prutis, dated February 28, 2017.[13] She found that the Applicant's range of motion was decreased in extension and both rotations by 40%, and

[11] Exhibit 6—Correspondence from the Insurer (Tabs 1 to 13).
[12] Exhibit 6—Tab 8.
[13] Exhibit 8—Tab 14.

movements were painful. Examination of the lumbar spine revealed decreased lumbar lordosis, range of movement of the lumbosacral spine was decreased in forward flexion and extension by 50%, and there was pain during end range of these movements. Dr. Prutis found the Applicant's CNR history was suggestive of cervical and lumbar disc herniation, and to address the issue booked him for an MRI of the cervical and lumbar spine. The Applicant submitted that this was despite an asymptomatic history; but both Dr. Prutis and Dr. Getahun thought an MRI was reasonably needed. The Applicant also submitted that getting an MRI quickly is extremely difficult.

Following completion of the MRI, Dr. Prutis sent a follow-up letter on May 31, 2017.[14] She wrote, in part:

> *Mr. Abyan had an MRI of the cervical spine. There were disc osteophyte complexes at the C3-C4, C4-C5, C5-C6 and C6-C7 levels. There was multi-level neural foraminal stenosis. In conclusion, the MRI of the lumbar spine showed multi-level degenerative disc disease of the spine.*
>
> *Mr. Abyan had an MRI of the lumbar spine. The test was normal. There was no evidence of disc herniation or spinal stenosis.*
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> *In summary, Mr. Abyan's motor vehicle accident aggravated pre-existing degenerative changes in his cervical spine and made them symptomatic, thus resulting in chronic neck pain. This accident also contributed to chronic mechanical low back pain.*

The Applicant submitted that this MRI confirmed the result Dr. Getahun had originally suspected was possible, for which he had initially unsuccessfully recommended an MRI—Dr. Getahun felt an MRI was appropriate to try to rule out disc herniosis, which an MRI now showed is in fact the case.

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[14] *Ibid.*

The Applicant also submitted the CNRs of his family doctor, Dr. Hanna Hinnawi.[15] Her notes on April 11, 2017 indicated "neck and back pain"; "headache throbbing", "sleeping problems and stress out"; and "post traumatic stress disorders". Her notes on May 31, 2017 indicated "The pt presented with the following moods and symptoms which are triggered by his MVA and subsequent pain and his inability to return to his previous functional level pre MVA. DEPRESSION; PTSD; ANXIETY; AUTOMATIC NEGATIVE THOUGHTS"

The Applicant referred to an IE report prepared a year earlier by Dr. Margaret Russell (chiropractor) dated March 8, 2016.[16] In the Report Summary,[17] Dr. Russell concluded, in part:

> *Mr. Abyan presented well on physical exam in that his range of motion was full to all areas of injury as a direct result of the collision in question. He was somewhat self-limiting on examination. ... It is my opinion that this area of complaint is not directly related to the collision in question. ... His complaints are mainly subjective in nature.*
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> *It is my opinion that Mr. Abyan's injuries are of a predominantly minor nature and would fall under the Minor Injury Guideline (MIG) treatment protocol. There is no compelling evidence of pre-existing medical conditions that would prevent Mr. Abyan from achieving maximal medical recovery under the MIG.*

The Applicant submitted that when one looks at the 2017 MRI, it is understandable that Dr. Russell couldn't understand Mr. Abyan's "subjective complaints". The Applicant added the definition of "impairment" doesn't require objective findings.

The Applicant also referred to Dr. Murray's psychological IE report dated February 4, 2016,[18] wherein he opined that it would be appropriate for Mr. Abyan's psychological issues to be treated within the MIG.

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[15] Exhibit 9—Tab 15.
[16] Exhibit 11—Tab 6.
[17] *Ibid.*, p. 9.
[18] Exhibit 13—Tab 5.

The Applicant additionally referred to a second medical-legal report,[19] that of Dr. Ricardo Harris (psychologist), who did not testify at the Hearing but reported on the same medical-legal questions that were posed to Dr. Getahun in his medical-legal report.

Dr. Harris opined in his report that a “clinically associated sequelae” could be any psychological symptom of problem that arose as a result of the MVA—even if the physical injuries were minor. He confirmed he has encountered patients with pre-existing medical asymptomatic conditions that were not documented in their health practitioner’s CNRs. As an example, he stated “What is very common is women who were physically abused as children. They may have overcome this and may have been living a normal life at the time of the MVA, but the pain brings back all those memories, she becomes pain-focused and goes on to develop a somatic symptom disorder.” Dr. Harris said that in psychology asymptomatic medical conditions are not rendered symptomatic—what usually happens is the patient will have pre-existing conditions (e.g., insomnia) but lives with it, and after the MVA they become aggravated. Dr. Harris wrote that being subject to the $3,500 limit under the MIG could definitely prevent an insured person from achieving maximal medical recovery, but he opined that unfortunately few health practitioners will risk treating a patient if they do not think that they will get paid for it.

Legal Argument

The Applicant submitted that section 15(1) of the *Charter* provides as follows:

> *15(1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.*

The Applicant submitted that section 18 of the *Schedule* draws discriminatory distinctions that have the effect of perpetuating arbitrary disadvantage, in denying him reasonable and necessary medical and rehabilitation benefits respecting the MVA. The Applicant submitted that section 18

[19] Exhibit 10—Medical-Legal Report of Dr. Ricardo J. Harris dated July 18, 2017 (Tab 17).

of the *Schedule* fails to respond his actual capacity, and denies him benefits in ways that reinforce, perpetuate, or exacerbate his disadvantage based on physical disability—an enumerated characteristic in s. 15 of the *Charter*.

More specifically, the Applicant submitted that, together, sections 3 and 18 of the *Schedule* (i) preclude persons deemed to sustain "minor injuries" that continue beyond normal recovery times from receiving reasonable and necessary medical and rehabilitation benefits, including cases with chronic pain as a clinically associated sequelae; and (ii) preclude injured persons deemed to sustain "minor injuries" who had an asymptomatic pre-existing medical conditions that were not documented by health practitioners from achieving maximal recovery. The Applicant submitted that the legislative provisions impose burdens on applicants to prove pre-existing medical conditions documented by health practitioners before the MVA, despite the impossibility of documenting asymptomatic pre-existing medical conditions.

The Applicant submitted that in *Big M Drug Mart*,[20] the Supreme Court of Canada concluded that a law will offend the *Charter* if either its purpose or its effect abridges a *Charter* right. Where a violation of a *Charter* right is established, the onus then shifts to the government to establish reasonable justification for the infringement, under s. 1 of the *Charter*.

The Applicant submitted that the MIG provisions create an exception to the usual $65,000 medical/rehabilitation benefits limit—those subject to the MIG may only instead receive a maximum of $3,500. However, the MIG also allows an exception within its exception—if an insured can provide compelling evidence from his health care practitioner that he has a documented pre-existing medical condition that will prevent him from achieving maximum medical recovery if subjected to the $3,500 limit, then that $3,500 limit will not apply. The Applicant submitted that the phrase "documented by a health practitioner before the accident" was added to the MIG in February 2014,[21] and was not part of the original version of the MIG that was

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[20] *R. v. Big M Drug Mart*, [1985] 1 S.C.R. 295.
[21] Exhibit 1B—Minor Injury Guideline, Superintendent's Guideline No. 01/14 (February 2014) (Tab 18).

enacted in September 2010;[22] the Applicant submitted that the Guideline is silent as to what the purpose of the addition was.

The Applicant submitted that for individuals like himself who have pre-existing conditions undocumented before the MVA, they are prevented from taking advantage of the exception because their pre-existing condition didn't require intervention before the MVA. The provision also prevents those without doctors, without OHIP, or who were injured on the day before the MIG went into effect, from accessing the exception to the exception.

The Applicant requested two separate Orders—(1) to strike down or sever part of s. 18(1) of the *Schedule* so that it is not inconsistent with the *Charter*, and (2) to strike down or sever the requirement that pre-existing impairments be documented in physician records before an MVA. The Applicant submitted he had established by evidence that he had a pre-existing condition before the MVA, but the documentation was only obtained after the MVA.

In terms of remedies, the Applicant submitted that in cases where there has been a holding of unconstitutionality, but the infringement of rights only affected one or a few provisions of the challenged statute or regulation, those provisions were "severed" from the rest of the statute, enabling the rest of the statute to survive. Alternatively, where the language of a statute will bear two interpretations—one of which would abridge a *Charter* right, but the other of which would not, the *Charter* can be applied simply by selecting the interpretation that does not abridge the *Charter* right, which is known as "reading down".

The Applicant submitted that s. 15 of the *Charter* mandates equal protection to individuals under the law based on its enumerated grounds, or analogous grounds. The Applicant's focus was physical disability—an enumerated ground. The Applicant acknowledged the government is entitled to make rules or take away rights, but submitted that all accident victims must be subject equally to the rules.

[22] Exhibit 1A—Minor Injury Guideline, Superintendent's Guideline No. 02/10 (June 2010) (Tab 18).

The Applicant submitted that the Supreme Court of Canada has reinvented the analytical framework to s. 15 several times. The latest test, from *Quebec v. A.*,[23] was employed in the recent decision *Taypotat*.[24] The Court noted that courts should avoid a focus on government objectives and rationality under s. 15(1)—that inquiry belongs under s. 1 of the *Charter*. The Court also noted a trend towards more substantive equality than formal equality. In *A.*, the Court posited that where a violation of s. 15(1) is alleged, a court must ask the following questions:

1. Does the law create a distinction based on an enumerated or analogous ground?
2. Does the distinction have the effect of perpetuating arbitrary disadvantage?

In *Taypotat*, Abella J., for the Court, clarified this further. The first stage in the analysis is whether the impugned law "creates a distinction on the basis of an enumerated ground." She said:[25]

> *The focus of s. 15 is therefore on laws that draw discriminatory distinctions—that is, distinctions that have the effect of perpetuating arbitrary disadvantage based on an individual's membership in an enumerated or analogous group.*

The second stage in the analysis:[26]

> *…focuses on arbitrary—or discriminatory—disadvantage, that is whether the impugned law fails to respond to the actual capacities and needs of the members of the group and instead imposes burdens or denies a benefit in a manner that has the effect of reinforcing or perpetuating that disadvantage.*

At para. 21, Abella J. noted that "evidence that goes to establishing a claimant's historical position of disadvantage will be relevant."

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[23] *Quebec (Attorney General) v. A.*, [2013] 1 S.C.R. 61, 2013 SCC 5.
[24] *Kahkewistahaw First Nation v. Taypotat*, [2015] 2 S.C.R. 548, 2015 SCC 30.
[25] *Ibid*., para. 18.
[26] I*bid*., para. 20.

The Applicant submitted that the facts and merits of the present case are very similar to those from the Supreme Court's *Martin* decision.[27] There, the Court held that Nova Scotia's statutory workers' compensation scheme violated s. 15 of the *Charter* in providing only short-term benefits to sufferers from work-related chronic pain. The Court stated (emphasis Applicant's):[28]

> *Section 3(2) of the FRP Regulations deems chronic pain always to have been excluded from the operation of Part I of the Act, and provides that no compensation other than that provided by the FRP Regulations is payable for chronic pain with respect to injuries subsequent to February 1, 1996. The benefits available under the FRP Regulations are not determined with regard to the individual circumstances of each worker. Rather, the FRP Regulations establish a limited Functional Restoration Program. No worker may participate in the Functional Restoration Program if more than 12 months have elapsed since his or her date of injury, and participation in the Functional Restoration Program is limited to four weeks. No further benefits are available. Thus, injured workers suffering from chronic pain cannot receive earning replacement benefits (whether temporary or permanent), permanent impairment benefits, retirement annuities, vocational rehabilitation services or medical aid beyond the four-week Functional Restoration Program. They are also excluded from the duties to re-employ and to accommodate imposed upon employers by ss. 90 and 91 of the Act.*

The Court acknowledged that chronic pain was unlike other work-related injuries, in that it had no physical manifestations and there was no accepted method of diagnosis or treatment; it stated (emphasis Applicant's; **emphasis** mine):[29]

> ***For these reasons, I do not find it necessary to determine, based on the limited evidence before us, whether chronic pain sufferers have historically been subject to disadvantages or stereotypes beyond those affecting other injured workers. It will be sufficient to note that many elements seem to point in that direction. Most importantly,***

[27] Note 2, *supra*.
[28] *Ibid*., para. 68.
[29] *Ibid*., para. 90.

> ***the medical reports introduced as evidence often mention the inaccurate negative assumptions towards chronic pain sufferers widely held by employers, compensation officials and the medical profession itself. They identify the correction of negative assumptions and attitudes of this kind as a significant step in improving the treatment of chronic pain. The troubling comments made by some case workers in the Laseur file appear to betray such negative assumptions.*** *Thus, statements that Ms. Laseur had "fallen into the usual chronic pain picture" and that "[t]his is basically a chronic pain problem, perhaps even a chronic pain syndrome although she seems to be a very pleasant individual with not the usual features of this type of problem" were clearly inappropriate and suggest that Ms. Laseur's claim may have been treated on the basis of presumed group characteristics rather than on its own merits. Finally, the medical experts recognize that chronic pain syndrome is partially psychological in nature, resulting as it does from many factors both physical and mental. This Court has consistently recognized that persons with mental disabilities have suffered considerable historical disadvantage and stereotypes. … Although the parties have argued the s. 15(1) case on the basis that chronic pain is a "physical disability", the widespread perception that it is primarily, or even entirely, psychosomatic may have played a significant role in reinforcing negative assumptions concerning this condition.*

The Court dismissed problems of fully funding chronic pain cases, and held that the comparator group was "the group of workers subject to the Act who do not have chronic pain and are eligible for compensation for their employment-related injuries", which ensured that the claim of unequal treatment on the basis of physical disability was established:[30]

> *I agree with the Court of Appeal that the appropriate comparator group for the s. 15(1) analysis in this case is the group of workers subject to the Act who do not have chronic pain and are eligible for compensation for their employment-related injuries. The appellants are unlike these workers. Mr. Martin was deprived of temporary earnings loss and medical treatment benefits to which he would be entitled were he suffering from a condition other than chronic pain.*

[30] *Ibid.*, para. 71.

The Court added (emphasis Applicant's):[31]

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> *The relevant potential ground of discrimination in this case is "physical disability", a ground expressly included in s. 15(1). The question here is whether the differential treatment of chronic pain sufferers is truly based on this enumerated ground. While the Attorney General concedes that it is, the Board argues that since both the claimants and the comparator group suffer from physical disabilities, differential treatment of chronic pain within the workers' compensation scheme is not based on disability. Rather, argues the Board, the differential treatment must derive from some other basis.*
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> *In my view, this argument is without merit. This Court has long recognized that differential treatment can occur on the basis of an enumerated ground despite the fact that not all persons belonging to the relevant group are being equally mistreated.*
>
> *…*
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>
> *…Likewise, in the present case, it is no answer to say that all workers subject to the scheme are disabled. The second step of the* Law *test does not ask whether the claimant and members of the comparator group possess a certain characteristic. Rather, the inquiry is whether the basis of the challenged differential treatment is an enumerated or analogous ground. The distinction between the claimants and the comparator group was made on the basis of the claimants' chronic pain disability, i.e., on the basis of disability. The fact that injured workers without chronic pain have their own disability too is irrelevant. Distinguishing injured workers with chronic pain from those without is still a disability-based distinction.*

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[31] *Ibid.*, starting at para. 75.

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It can be no answer to a charge of discrimination … to allege that the particular disability at issue is not subject to particular historical disadvantage beyond those visited upon other disabled persons. Indeed, the contrary position could potentially relieve the state from its obligation to accommodate or otherwise recognize many disabilities that, despite their severity, are not subject to widespread stereotypes or particular historical disadvantage. Such a result would run contrary to the very meaning of equality in that context and cannot be condoned.

The Applicant submitted that in the present case, the MIG of June 2010[32] outlined the following as its objectives and purposes:

The objectives of this Guideline are to:

(a) Speed access to rehabilitation for persons who sustain minor injuries in auto accidents;
(b) Improve utilization of health care resources;
(c) Provide certainty around cost and payment for insurers and regulated health professionals; and
(d) Be more inclusive in providing immediate access to treatment without insurer approval for those persons with minor injuries as defined in the SABS and set out in Part 2 of this Guideline.

It further stated:

This Guideline is focused on the application of a functional restoration approach, in addition to the provision of interventions to reduce or manage pain or disability.

[32] Exhibit 1A.

In February 2014, the Superintendent replaced the MIG of 2010 with another MIG—Superintendent's Guideline No. 01/14.[33] The new Guideline applied to documents delivered on or after February 1, 2014, regardless of the date of the MVA to which they related. The new Guideline did not change or amend the objectives of the June 2010 MIG; but one of its few amendments added the following condition relating to pre-existing medical conditions. It now stated (February 2014 addition emphasized):

> *An insured person's impairment does not come within this Guideline if the insured person's impairment is predominantly a minor injury but, based on compelling evidence provided by his or her health practitioner, the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent the insured person from achieving maximal recovery from the minor injury if he or she is subject to the $3,500 limit referred to in section 18(1) of the SABS or is limited to the goods and services authorized under this Guideline.*

The Applicant submitted that in *Smith v. Co-operators*,[34] the Supreme Court of Canada held that consumer protection is one of the main objectives of insurance law. The Applicant submitted that the objectives and purposes noted in the MIGs of 2010 and 2014 provided no rational connection or explanation for the discriminatory monetary limit of $3,500, nor did the MIG of 2014 explain the arbitrary new condition of documenting pre-existing medical conditions before the MVA. The Applicant submitted that the purposes and effects of these provisions conflicted with the main objectives of the *Insurance Act* and the *Schedule*, which are consumer protection, and submitted that the provisions are silent about their true purposes. The Applicant submitted these distinctions are discriminatory both on their faces and in effect, and do not serve substantive equality.

The Applicant submitted that "substantive equality" indicates a theory of equality that covers both direct and indirect discrimination. Accordingly, s. 15 invalidates a law that is discriminatory in its

[33] Exhibit 1B.
[34] *Smith v. Co-operators General Insurance Co.*, [2002] 2 S.C.R. 129, 2002 SCC 30.

effect. In *Andrews*,[35] McIntyre J., for the majority of the Supreme Court, pointed out that "identical treatment may frequently produce serious inequality".

The Applicant reiterated Dr. Getahun's conclusion that a patient can have asymptomatic pathology that is rendered symptomatic by the mechanism of a motor vehicle collision, and his opinion that the Applicant's pre-existing asymptomatic pathology acted as a barrier to his recovery within the $3,500 limit offered by the MIG.

The Applicant submitted that sections 3 and 18 of the *Schedule* fail to respond to his actual capacities resulting from his impairment, and denies him medical benefits in ways that reinforce, perpetuate, or exacerbate his disadvantage. In the Alberta case *Morrow v. Zhang*,[36] Wittmann J. stated:

> *The evidence before me suggests strongly that Minor Injury victims, particularly those suffering from a whiplash associated disorder, are subjected to stereotyping and prejudice. In sum, they are often viewed as malingerers who exaggerate their injuries or their effects in an effort to gain financially. The fact that these injuries are often not objectively verifiable may contribute to this perception.*

The Applicant therefore submitted that chronic pain sufferers are a historically-disadvantaged group, treated differently in the provision of rehabilitation and treatment of their impairments compared to other MVA victims.

Section 7

The Applicant also advanced a separate argument that the impugned sections and Guideline violate section 7 of the *Charter*. The Applicant submitted that under section 7 of the *Charter,* he must show that:

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[35] *Andrews v. Law Society of British Columbia*, [1989] 1 S.C.R. 143.
[36] *Morrow v. Zhang*, 2008 ABQB 98.

1. The law interferes with, or deprives him, of his life, liberty or security of the person; and
2. That interference/deprivation is not in accordance with the principles of fundamental justice.

The Applicant submitted that section 7 of the *Charter* protects his physical and psychological integrity against any state action that causes physical or serious psychological suffering. In *Bedford*,[37] the Supreme Court of Canada stated:

> *The BC Motor Vehicle Reference recognized that the principles of fundamental justice are about the basic values underpinning our constitutional order. The s. 7 analysis is concerned with capturing inherently bad laws: that is, laws that take away life, liberty, or security of the person in a way that runs afoul of our basic values. The principles of fundamental justice are an attempt to capture those values.*

The Applicant submitted that a law is:

- arbitrary when there is no rational connection between the object of the law and the limit it imposes on life, liberty, or security of the person;
- overbroad when it takes away rights in a way that generally supports the object of the law, but goes too far by denying the rights of some individuals in a way that bears no relation to the object;
- grossly disproportionate when the impact of a restriction on the individual's life, liberty or security of the person is grossly disproportionate to the object of the measure.

The Applicant submitted that s. 18 of the *Schedule* deprived him of security of the person by causing physical and psychological suffering, and the law was arbitrary, overbroad, and grossly disproportionate in limiting his ability to access medical and rehabilitation benefits beyond an arbitrary $3,500 limit.

[37] *Canada (Attorney General) v. Bedford*, [2013] 3 S.C.R. 1101, 2013 SCC 72.

Section 1

The Applicant provided his understanding of the interpretation and application of s. 1 of the *Charter*, and his opinion of how it ought to be applied presently.

Section 1 of the *Charter* reads:

> ***1.*** *The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.*

The Applicant submitted that s. 1 makes clear that guaranteed rights and freedoms are not absolutes, and are subject to reasonable limits. Section 1 contemplates that judicial review of legislation should proceed in two stages. In the first stage, the court (or tribunal) must decide whether the challenged law has the effect of limiting a guaranteed right. If the challenged law has this effect, then the second stage is reached, the court must decide whether the limit is a reasonable one that can be demonstrably justified in a free and democratic society. There is a close relationship between the standard of justification required under s. 1 and the scope of the guaranteed rights.

In *R. v. Oakes*,[38] Dickson C.J. laid down the criteria that must be satisfied to establish that a law is reasonably and demonstrably justified in a free and democratic society. There are four criteria to satisfy that a law qualifies as a reasonable and demonstrably justifiable limit on rights:

1. *Sufficiently important objective:* The law must pursue an objective that is sufficiently important to justify limiting a Charter right.
2. *Rational connection:* The law must be rationally connected to the objective.
3. *Least drastic means:* The law must impair the right no more than is necessary to accomplish the objective.

[38] *R. v. Oakes*, [1986] 1 S.C.R. 103.

4. *Proportionate effect:* The law must not have a disproportionately severe effect on the persons to whom it applies.

The government must rely on the legislative intent at the time of enactment, not a new or "shifting" objective. In *Big M*,[39] Dickson, C.J. rejected the notion that the purpose of a law might change over time with changing social conditions, as that would create uncertainty. He held "purpose is a function of the intent of those who drafted and enacted the legislation at the time, and not of any shifting variable."

The Applicant submitted that the Supreme Court of Canada has rejected claims of cost and administrative expediency as grounds to justify a program to deal with "chronic pain" (i.e., pain without any physical manifestations). In *Martin*,[40] the Court held that the program in question violated the equality rights of workers who suffered from chronic pain, and could not be justified under s. 1 on the basis of cost or administrative expediency or anything else. Regardless of cost, individualized assessment of chronic pain cases was required by the *Charter*.

The "minimum impairment" ("least drastic means") requirement requires that the chosen legislative approach must be the least restrictive manner of accomplishing the objective of the impugned provisions. The law should impair rights no more than is necessary to accomplish the desired objective. It requires a demonstration that the government considered the full range of alternatives and found them either less effective or more restrictive of *Charter* rights. The Applicant submitted that the requirement of least drastic means is generally the heart and soul of s. 1 justification.

The "proportionate effect" requirement requires balancing the objective sought by the law against the infringement of the *Charter*. It asks whether the *Charter* infringement is too high a price to pay for the benefit of the law. A legislative objective may, in principle, be sufficiently important to justify limiting claimants' rights, but even the least drastic means of accomplishing the

[39] Note 23, *supra*.
[40] Note 2, *supra*.

objective may still have too drastic an effect on claimants' rights for the law to be a reasonable limit under s. 1.

In *Andrews*,[41] Wilson J. held that the *Oakes* test "remains an appropriate standard for s. 15 cases", but added "given that s. 15 is designed to protect those groups that suffer social, political and legal disadvantage in our society, the burden resting on government is appropriately an onerous one."[42]

In *Martin*,[43] the Supreme Court addressed s. 1 of the *Charter* as follows (emphasis Applicant's):

> *107 ... [T]he proper focus of enquiry under s. 1 is the limit itself. In the case at bar, the Nova Scotia government has the burden of demonstrating that the exclusion of chronic pain from the purview of the Act and the substitution of very limited, structured benefits for those normally available under the worker's compensation system, is so justified.*
>
> *...*
>
> *109 The first concern, maintaining the financial viability of the Accident Fund, may be dealt with swiftly. Budgetary considerations in and of themselves cannot normally be invoked as a free-standing pressing and substantial objective for the purposes of s. 1 of the Charter. ...*
>
> *110 Likewise, the second objective, developing a consistent legislative response to chronic pain claims, could not stand on its own. Mere administrative expediency or conceptual elegance cannot be sufficiently pressing and substantial to override a Charter right. In my view, this objective only becomes meaningful when examined with the third objective, i.e., avoiding fraudulent claims based on chronic pain. That objective is consistent with the general objective of the Act, as avoiding such claims ensures that the resources of the workers' compensation scheme are properly directed to workers who are*

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[41] Note 38, *supra*.
[42] *Ibid.*, para. 154.
[43] Note 2, *supra*.

<u>genuinely unable to work by reason of a work-related accident. It my view, it is clearly pressing and substantial. As I believe this is the strongest s. 1 argument raised by the respondents, I will first apply the Oakes test to this objective. I will then briefly consider the fourth and last objective alleged by the respondents.</u>

111 The challenged provision of the Act and the FRP Regulations are rationally connected to this objective. There can be no doubt that, by excluding all claims connected to chronic pain from the purview of the Act and, in the case of workers injured after February 1, 1996, providing strictly limited benefits in the form of a four-week Functional Restoration Program, s. 10b of the Act and the FRP Regulations virtually eliminate the possibility of fraudulent claims based on chronic pain for all other types of benefits.

112 The same reasoning, however, makes it patently obvious that the challenged provisions do not minimally impair the equality rights of chronic pain sufferers. On the contrary, one is tempted to say that they solve the potential problem of fraudulent claims by pre-emptively deeming all chronic pain claims to be fraudulent. ... <u>s. 1 requires that the legislation limit the relevant Charter right "as little as is reasonably possible". ... However, even a brief examination of the possible alternatives, including the chronic pain regimes adopted in other provinces, clearly reveals that the wholesale exclusion of chronic pain cannot conceivably be considered a minimum impairment of the rights of injured workers suffering from this disability.</u>

113 ... <u>Even recognizing the Nova Scotia legislature's constitutional entitlement to select from a range of acceptable policy options, it is impossible to conclude that the blanket exclusion it enacted was necessary to achieve a principled response to chronic pain and avoid fraudulent claims.</u>

114 Since I conclude that the challenged provisions cannot survive the third stage of the Oakes test on the basis of this objective, it is unnecessary to consider the general proportionality stage.

...

> *116 This being said, assuming, without deciding the point, that the objective of early return to work is pressing and substantial and that the challenged provisions are rationally connected to it, I am of the view that they fail the minimum impairment and general proportionality tests. No other evidence indicates that an automatic cut-off of benefits regardless of individual needs and circumstances is necessary to achieve the stated goal.*

The Applicant submitted that in the present case, all that can be identified as the purpose for the MIG is within the MIG itself. The government must show that the MIG minimally impaired rights to meet its objectives. The Applicant submitted that the MIG makes no effort to take into account the actual individual capacities of applicants, as required by *Martin*, which could be achieved, for example, by allowing individualized assessment. The Applicant submitted that regardless of cost, individualized assessment as chosen by chronic pain sufferers is necessary to bring the law in line with the *Charter*.

ANALYSIS

Jurisdiction

I begin by considering whether or not this Tribunal has jurisdiction to decide in this matter. The determinative cases on point are *Cuddy Chicks*,[44] *Martin*,[45] and *Conway,*[46] all issued by the Supreme Court of Canada.

In *Cuddy Chicks*, the Court considered the jurisdiction of the Ontario Labour Relations Board to determine the constitutionality of a provision of its enabling statute. The Court, per LaForest J., said as follows:

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[44] Note 4, *supra*.
[45] Note 2, *supra*.
[46] Note 3, *supra*.

> *The power of an administrative tribunal to consider* Charter issues *was addressed recently by this court in* Douglas/Kwantlen Faculty Assn. v. Douglas College, *[1990] 3 S.C.R. 570. … In ruling that the arbitrator did have such jurisdiction, this Court articulated the basic principle that an administrative tribunal which has been conferred the power to interpret law holds a concomitant power to determine whether that law is constitutionally valid. This conclusion ensues from the principle of supremacy of the Constitution, which is confirmed by s. 52(1) of the* Constitution Act, 1982:
>
> > ***52.*** *(1) The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.*
>
> *Distilled to its basics, the rationale for recognizing jurisdiction in the arbitrator in the* Douglas College *case is that the Constitution, as the supreme law, must be respected by an administrative tribunal called upon to interpret law. In addition, the practical advantages of having constitutional issues decided at first instance by an expert tribunal confirm if not compel this conclusion.*

In *Martin*, LaForest J., for the Court, wrote as follows:

> *The Constitution is the supreme law of Canada and, by virtue of s. 52(1) of the* Constitution Act, 1982, *the question of constitutional validity inheres in every legislative enactment. From this principle of constitutional supremacy flows, as a practical corollary, the idea that Canadians should be entitled to assert the rights and freedoms that the Constitution guarantees them in the most accessible forum available, without the need for parallel proceedings before the courts. To allow an administrative tribunal to decide* Charter *issues does not undermine the role of the courts as final arbiters of constitutionality in Canada. Administrative tribunal decisions based on the* Charter *are subject to judicial review on a correctness standard.*

The Supreme Court further confirmed in *Conway*, per Abella J.:

> *[80] If, as in the Cuddy Chicks trilogy, expert and specialized tribunals with the authority to decide questions of law are in the best position to decide constitutional questions when a remedy is sought under s. 52 of the Constitution Act, 1982, there is no reason why such tribunals are not also in the best position to assess constitutional questions when a remedy is sought under s. 24(1) of the* Charter.

Accordingly, I am satisfied that this tribunal has jurisdiction to consider *Charter* issues. The Financial Services Commission of Ontario is empowered to make determinations of law, and there is no evidence the legislature did not intend for it to decide *Charter* issues. I am empowered to make decisions respecting constitutional remedies, although *Cuddy Chicks* and *Martin* both make clear that any decision I reach does not create any general precedential value, and the ruling is strictly limited to the present case itself.

Section 7

I am not satisfied from the submissions that the MIG violates s. 7 of the *Charter*. The Applicant suggested that the MIG threatens his security of person, without accordance to the principles of fundamental justice. I cannot agree. I find from reading section 7 is that it prohibits inappropriate actions by the government in the course of matters that affect the life, liberty, or security of the person of individuals. I presume that matters that would tend to implicate the liberty and security of the person of individuals would predominantly occur in the criminal law context, such as incarceration, arrest powers, and procedures for collecting evidence. In addition, under s. 7 it is the government that must directly not interfere with individual rights. I am not satisfied that the MIG constitutes direct government action—it is a set of rules for how benefits should be paid out by private companies. The government itself does not "act", in this capacity. I also do not accept that rights to accident benefits are akin to liberty or security of the person rights; but in any event, it shall be sufficient to say the submissions on point did not establish it.

My analysis with respect to section 15 is quite different, though.

Section 15

I start by noting I find *Martin* extremely compelling and directly applicable to the present case, both with respect to section 15 and section 1.

I am satisfied from the evidence in this case that chronic pain is a debilitating condition that is poorly understood. It is a whole-person impairment encompassing both physical and mental impairments. The Supreme Court in *Martin* was concerned by evidence of inaccurate negative assumptions towards chronic pain sufferers widely held by employers, compensation officials, and the medical profession itself, some of whom identified that the correction of negative assumptions and attitudes of this kind would be a significant step in improving the treatment of chronic pain. Justice Wittmann in Alberta described that similarly injured victims are subjected to stereotyping and prejudiced, and are often viewed as malingerers who exaggerate their injuries or effects in an effort to gain financially.[47] The Supreme Court in *Martin* acknowledged that chronic pain had no physical manifestations, and there was no accepted method of diagnosis or treatment, which is also consistent with Dr. Getahun's evidence of the published opinion of the American Medical Association.

The Supreme Court found in *Martin* that distinguishing injured workers with chronic pain from those without was a disability-based distinction, on the ground of "physical disability"—an expressly enumerated ground in s. 15(1) of the *Charter*.

The legislative mechanism of the MIG works in the following way. "Minor injury" and the "Minor Injury *Guideline*" are defined in s. 3 of the *Schedule*, as follows:

> *"minor injury" means one or more of a sprain, strain, whiplash associated disorder, contusion, abrasion, laceration or subluxation and includes any clinically associated sequelae to such an injury;*

[47] Note 39, *supra*.

"Minor Injury Guideline*" means a guideline,*

> *(a) that is issued by the Superintendent under subsection 268.3(1.1) of the Act and published in* The Ontario Gazette*, and*
>
> *(b) that establishes a treatment framework in respect of one or more minor injuries;*

Sections 15 and 16 establish entitlements to medical and rehabilitation benefits for those injured in automobile accidents in Ontario; but those entitlements are limited by the caps for cases of "minor injuries" in section 18. Those sections currently read as follows (**emphasis** mine):

Medical benefits

15. (1) ***Subject to section 18, medical benefits shall pay for all reasonable and necessary expenses incurred by or on behalf of the insured person as a result of the accident for,***

(a) medical, surgical, dental, optometric, hospital, nursing, ambulance, audiometric and speech-language pathology services;

(b) chiropractic, psychological, occupational therapy and physiotherapy services;

(c) medication;

(d) prescription eyewear;

(e) dentures and other dental devices;

(f) hearing aids, wheelchairs or other mobility devices, prostheses, orthotics and other assistive devices;

(g) transportation for the insured person to and from treatment sessions, including transportation for an aide or attendant; and

(h) other goods and services of a medical nature that the insurer agrees are essential for the treatment of the insured person, and for which a benefit is not otherwise provided in this Regulation.

(2) ***Despite subsection (1), the insurer is not liable to pay medical benefits,***

(a) for goods or services that are experimental in nature;

(b) ***for expenses related to goods and services*** *described in subsection (1) rendered to an insured person* ***that exceed the maximum rate or amount of expenses***

established under the Guidelines, *other than for expenses related to the services described in clause (1) (g); or*

(c) for transportation expenses other than authorized transportation expenses.

Rehabilitation benefits

16. (1) ***Subject to section 18, rehabilitation benefits shall pay for all reasonable and necessary expenses*** *incurred by or on behalf of the insured person in undertaking activities and measures described in subsection (3) that are reasonable and necessary for the purpose of reducing or eliminating the effects of any disability resulting from the impairment or to facilitate the person's reintegration into his or her family, the rest of society and the labour market.*

…

(4) ***Despite subsection (1), the insurer is not liable to pay rehabilitation benefits,***

(a) ***for expenses related to goods and services*** *described in subsection (3) rendered to an insured person* ***that exceed the maximum rate or amount of expenses established under the Guidelines****, other than for expenses related to the services described in clause (3) (k);*

Monetary limits re medical and rehabilitation benefits

18. (1) ***The sum of the medical and rehabilitation benefits payable in respect of an insured person who sustains an impairment that is predominantly a minor injury shall not exceed $3,500 for any one accident,*** *less the sum of all amounts paid in respect of the insured person in accordance with the Minor Injury Guideline.*

(2) ***Despite subsection (1), the $3,500 limit in that subsection does not apply to an insured person if his or her health practitioner determines and provides compelling evidence that the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent the insured person from achieving maximal recovery from the minor injury if the insured***

> ***person is subject to the $3,500 limit or is limited to the goods and services authorized under the Minor Injury Guideline.***
>
> *(3)* ***The sum of the medical, rehabilitation and attendant care benefits paid in respect of an insured person*** *who is not subject to the financial limit in subsection (1)* ***shall not exceed, for any one accident,***
>
> ***(a) $65,000;*** *or*
>
> *(b) if the insured person sustained a catastrophic impairment as a result of the accident, $1,000,000. O. Reg. 251/15, s. 8 (1).*

The "Minor Injury *Guidelines*" defined in s. 3 are the Superintendent's Guidelines Nos. 02/10 and 01/14, released in June 2010 and February 2014, respectively. Those Guidelines are 15 and 16 pages long, respectively, and set out the policy of the MIG in more detail—such as impairments that do and don't come within the Guideline, providers able to deliver services, timing of the initial visit, the "treatment phase", and appropriate fees at each phase. By virtue of the definition of "Minor Injury *Guideline*" in s. 3 of the *Schedule*, and the reference to that term in s. 18 of the *Schedule*, the entire contents of the Superintendent's Guidelines are incorporated into the *Schedule*, by that reference.

I acknowledge the Applicant's submission that at p. 5 of the 2014 Superintendent's Guideline, "Impairments that do not come within this Guideline" includes as follows:

> *An insured person's impairment does not come within this Guideline if the insured person's impairment is predominantly a minor injury but, based on compelling evidence provided by his or her health practitioner, the insured person has a pre-existing medical condition that was documented by a health practitioner before the accident and that will prevent the insured person from achieving maximal recovery from the minor injury if he or she is subject to the $3,500 limit referred to in section 18(1) of the SABS or is limited to the goods and services authorized under this Guideline.*

I also acknowledge that the phrase "that was documented by a health practitioner before the accident" was not part of the 2010 Guideline, and no purpose for this change is ostensibly noted

anywhere within the 2014 Guideline. I also note that the same wording has been directly added to s. 18(2) of the *Schedule*, as well.

The Superintendent's Guidelines include, at page 4, definitions of "minor injury", "sprain", "strain", "subluxation", and "whiplash associated disorder", which match the definitions of those terms in s. 3 of the *Schedule*. Of note, though, "clinically associated sequalae" are not defined anywhere in the Superintendent's Guidelines, nor in the *Schedule*. It is left to determine the meaning of that term from other sources. I accept Dr. Getahun's testimony that "clinically associated sequelae" simply means "anything that is a following sequel of" in the natural course of recovery from treatment of an injury. Dr. Getahun was clear that chronic pain can be, and often is, a sequel of an injury. Therefore, individuals who suffer chronic pain resulting as a sequel from an MVA become caught in the MIG, and subject to the $3,500 cap, in ways that many other accident victims do not—including some who arguably suffer from less severe conditions. It is unclear if the drafters of the legislation intended for chronic pain sufferers arising from an MVA to be captured within the MIG; but regardless, it is clear that the way the definitions in the *Schedule* read, that is a result.

The Supreme Court has made clear that substantive equality is different from formal equality. Substantive equality covers indirect as well as direct discrimination, and leads to the invalidity of a law that is discriminatory in its effect. I am satisfied that the effect of the MIG arbitrarily discriminates against MVA victims who suffer chronic pain as a clinically associated sequelae to the MVA, in ways that those who do not suffer from chronic pain resulting from an MVA do not.

The Applicant argued that the phrase "that was documented by a health practitioner before the accident" has discriminatory effect, as it means people without a doctor, without access to OHIP, who had asymptomatic pre-existing conditions, or who were involved in a MVA shortly before that provision came into effect, do not have access to the usual $65,000 medical/rehabilitation/attendant care cap, and are subject instead to the $3,500 MIG cap for medical and rehabilitation benefits simply because they did not have their conditions documented before the MVA took place. I agree that this wording clearly creates discriminatory effects, and there is no clear purpose elaborated for it.

Accordingly, I find that the MIG violates section 15 of the *Charter* on both of the two grounds argued—it discriminates against those who suffer chronic pain as a clinically associated sequelae to the MVA, and against those who did not (and frequently could not) have their pre-existing conditions documented by a health practitioner before the MVA.

Section 1

Having found that the MIG violates section 15 of the *Charter*, it is necessary to analyze whether these limitations on insureds' rights are demonstrably justifiable in a free and democratic society, in accordance with section 1 of the *Charter*. Normally the onus at this stage of the litigation is incumbent upon the government, but nobody represented either the government or the Insurer in this proceeding, despite being invited. It was not incumbent upon either the Applicant nor the adjudicator to make their argument for them. However, I was provided with sufficient information to make an informed decision on this point.

Martin is the obvious starting point. There, the Supreme Court made clear that budgetary considerations, in and of themselves, cannot normally be invoked as a pressing and substantial objective for the purposes of s. 1. However, even when the Court took a further step of assuming that the objective of the Act was avoiding fraudulent claims based on chronic pain—which it found was the Nova Scotia government's strongest argument—it still found it was "patently obvious" that the challenged provisions did not minimally impair the equality rights of chronic pain sufferers. The Court found that despite the fact chronic pain may become sufficiently severe to produce genuine and long-lasting incapacity to work, the provisions made no effort to determine who was genuinely unable to work and who was abusing the system. The Court found that the law in question failed the minimum impairment test.

I find the same in the present case. The MIG does not minimally impair the rights of individuals who suffer chronic pain as clinically associated sequelae of a motor vehicle accident. The legislation can surely be worded in many different ways that do not have the effect of drawing chronic pain sufferers within the ambit of the MIG and its $3,500 cap on medical/rehabilitation

benefits. I accept the testimony of Dr. Getahun, as well as the medical-legal report of Dr. Harris, that $3,500 is insufficient in most cases to treat or manage chronic pain, and that the $3,500 cap would prevent such insured persons from achieving maximal medical recovery. This is inconsistent with the MIG's stated legislative objective of focusing on a functional restoration approach, and also the Supreme Court's decision in *Smith*, where it held that consumer protection is one of the main objectives of insurance law. The definition of "minor injury" does not minimally impair the rights of chronic pain sufferers, and that infringement of s. 15 is not justified by s. 1.

I also found earlier that the wording "that was documented by a health practitioner before the accident" in the MIG violates s. 15 of the *Charter*. That violation is also not justified under s. 1. It is not even clear what the purpose behind this terminology is. Even if I assume that it is intended to reduce fraud with respect to benefits claims, that is insufficient, per *Martin*, to stand as support for infringement of a *Charter* right. People without a doctor, or who (seemingly like the Applicant) had pre-existing but asymptomatic conditions that might later prevent them from achieving maximal medical recovery from injuries, are functionally prevented from accessing the usual $65,000 cap. I accept Dr. Getahun's testimony that it is not infrequent for people to have asymptomatic conditions that get triggered by trauma, and then become symptomatic. Such people could not possibly get medical documentation of those asymptomatic conditions during the time they were asymptomatic—firstly they would not even know about them (which would not alter the factual existence of the condition), and secondly it does not make logical sense to require an individual to go to a doctor to get documentation for a condition displaying no symptoms—the doctor would not find it. The requirement of previous documentation by a health practitioner is arbitrary and discriminatory, and falls well short of meeting the minimum impairment test.

Remedies

Having found that the MIG infringes on rights protected under s. 15(1) of the *Charter*, and that those infringements are not justified under s. 1 of the *Charter*, the sole remaining question is of the appropriate remedies.

The Applicant submitted that in cases where there has been a holding of unconstitutionality, but the infringements of rights affected only one or a few provisions of the challenged statute (or regulation), those provisions were "severed" from the rest of the statute, enabling the rest of the statute to survive. Alternatively, where the language of a statute will bear two interpretations, one of which would abridge a *Charter* right but the other one of which would not, the *Charter* can be applied simply by selecting the interpretation that does not abridge the *Charter* right—which is known as "reading down".

In the case of the wording "that was documented by a health practitioner before the accident", I cannot determine any other way of reading that provision other than how it reads on its face. The wording is clear and only supports one interpretation. It cannot be read down; accordingly, it must be severed from the provision.

In the case of "clinically associated sequelae", which from the evidence in this case I am satisfied captures accident victims who suffer chronic pain arising from a motor vehicle accident, I believe this provision can survive if it is interpreted in a way that excludes those who suffer from chronic pain as among the sequelae. The provision extends too far in cases where the sequelae includes chronic pain—which is a whole person impairment of great severity, as has been recognized by the Supreme Court, and I am also satisfied, based on the evidence, cannot be treated within the $3,500 MIG cap.

In accordance with the Supreme Court's judgments in *Cuddy Chicks* and *Martin*, this decision is only of application to the present case between the parties, and is not a declaration of general invalidity applicable to any other cases.

EXPENSES:

If the parties are unable to mutually agree on the entitlement to and/or quantum of the expenses of this matter, either of them may request an appointment with me for determination of same in accordance with the provisions of Rules 75 to 79 of the *Dispute Resolution Practice Code*.

September 14, 2017

Benjamin Drory — Date
Arbitrator

Financial Services Commission of Ontario | **Commission des services financiers de l'Ontario**

FSCO A16-003657

BETWEEN:

ABDIRAHMAN ABYAN

Applicant

and

SOVEREIGN GENERAL INSURANCE COMPANY

Insurer

ARBITRATION ORDER

Under section 282 of the *Insurance Act*, R.S.O. 1990, c. I.8, as it read immediately before being amended by Schedule 3 to the *Fighting Fraud and Reducing Automobile Insurance Rates Act*, 2014, and Ontario *Regulation 664*, as amended, it is ordered that:

1. Sections 3 (the definition of "minor injury") and 18(2) of the *Schedule* are unconstitutional, as infringing upon section 15(1) of the *Canadian Charter of Rights and Freedoms* on the basis of physical disability. The infringements are not justifiable under section 1 of the *Canadian Charter of Rights and Freedoms*.
2. The definition "clinically associated sequelae" in the definition of "minor injury" in s. 3 of the *Schedule* is interpreted to exclude individuals who suffer from chronic pain among the sequelae to the injury.
3. The provision "that was documented by a health practitioner before the accident" in section 18(2) of the *Schedule* and also in section 4 of Superintendent's Guideline No. 01/14 ("Minor Injury Guideline") is severed.
4. If the parties are unable to mutually agree on the entitlement to and/or quantum of the expenses of this matter, either of them may request an appointment with me for determination of same in accordance with the provisions of Rules 75 to 79 of the *Dispute Resolution Practice Code*.

September 14, 2017

Benjamin Drory
Arbitrator

Date