Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A12-000632

BETWEEN:

D.B.

Applicant

and

ECONOMICAL MUTUAL INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Judith Killoran

Heard: April 23, 2013, in Brantford, Ontario, April 24, 29, 30, May 1 and June 25, and 26, 2013 at the Financial Services Commission of Ontario

Appearances: Albert Conforzi and Alexander Voudouris for D.B.
Lee Samis for Economical Mutual Insurance Company

Issues:

The Applicant, D.B., was injured in a motor vehicle accident on November 22, 2008. She applied for and received statutory accident benefits from Economical Mutual Insurance Company ("Economical"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and D.B. applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

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

The issue in this hearing is:

1. Is D.B. catastrophically impaired as defined in the *Schedule*?

Result:

1. D.B. is catastrophically impaired as defined in clause 2(1.2) (f) of the *Schedule*.

Background

D.B. has applied for a catastrophic designation under the *Schedule*. The relevant clause is 2(1.2)(f) which states the following:

> For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,
>
> (f) …. an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, results in 55 per cent or more impairment of the whole person …

D.B. was involved in a motor vehicle accident which occurred on November 22, 2008. She was travelling north on Highway 24 to Cambridge when a driver lost control of his truck while travelling south on the highway and hit D.B.'s vehicle head on. Her airbag was deployed and it hit her in the chest and abdomen area. She was shoved sideways so that her hip and left knee hit the door. She also hit the dash and the steering wheel while feeling her foot on the brake explode from the impact. The paramedics used the jaws of life to extricate her from the vehicle. She was transported by ambulance to Cambridge Memorial Hospital where she stayed for 10 days.

D.B. had multiple injuries to her neck, back, shoulders together with a pylon tibial fracture to her leg, which required 5 separate surgeries. D. B. spent significant periods of time in hospital. The pylon fracture was infected as a result of a non-union, which was permanent, to the distal end of her tibia. The fibular fixation failed and the fibular crown was broken. D.B. consumed

opioids daily to deal with her pain. She has chronic neck and back complaints together with abdominal discomfort due to a hernia.

Economical takes the position that D.B. requires a below knee amputation. It relies on its medical experts which support this position. Economical submits that the applicant's experts did not find a 55% Whole Person Impairment (WPI) under the *Guides to the Evaluation of Permanent Impairment* (4th Edition)[2] (the "Guides") but rather, a range below the 55% threshold. Not only did the experts not find a mental/behavioural impairment under the DSM IV[3] but it was not appropriate for them to use the Gait Derangement Table in their calculations with respect to physical impairment. Economical insists that D.B. be rated as the equivalent of an amputee, as she has declined to follow medical advice recommending a below knee amputation.

D.B. submits that there is no assurance that having a below knee amputation will increase her mobility. Drs. Lisa, Dory and Harold Becker testified about using the Gait Derangement Table when assessing D.B.'s impairment and the WPI rating, taking into consideration mental and behavioural issues. D.B. disputes the thoroughness and accuracy of the insurer's experts. She claims to be wheelchair dependant which results in a WPI rating of 80%. In the event that she is found not to be wheelchair dependent, she maintains that she, nonetheless, meets the definition of catastrophic impairment by choosing one of a range of options for calculating her WPI.

EVIDENCE AND ANALYSIS:

All of D.B.'s assessors found her to be credible and reliable when recounting her history. I, too, found no reason to question D.B.'s veracity. She testified in a consistent, detailed and straightforward manner.

[2]American Medical Association, 2004

[3]Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition), American Psychiatric Association, 1994

D.B. testified that she lives in a 2-storey townhouse with bedrooms upstairs and a living room, dining room and small kitchen on the main floor. There are 15 stairs from the main floor to the upper floor, which she manages by using a stair glide. D.B. has a large trapeze on her bed with a triangular bar, a 4-point walker to move from the bathroom to the stair lift and a lift chair in the living room which elevates her feet to assist in moving from the chair. From the top of the stair glide to the bathroom is 4 or 5 steps. From the bathroom to the bedroom is 8 or 9 steps, which she manages with a walker.

D.B. had a prior motor vehicle accident in January 2008 when she was driving on an icy road, stopped, and slid into the back of the vehicle in front of her. She testified that she had pretty much healed from the first accident when the second accident occurred. By September 2008, she had returned to doing her housekeeping, babysitting her grandchildren, fishing and travelling with her husband. D.B. testified that the month before the accident she was involved in an exercise program, was babysitting her grandchildren, and was experiencing some muscle soreness from exercise. She was chiefly responsible for housekeeping which included laundry, cooking, grocery shopping and cleaning. She had resumed driving and had no problems with being the driver or passenger in a car. D.B. weighed approximately 240-250 lbs. Her weight now exceeds 330 lbs. I accept D.B.'s evidence that she had almost completely recovered from the January 2008 accident before she was injured in the November 2008 accident.

When D.B. was discharged from Cambridge Memorial Hospital after the November accident, she was bruised on her legs from her knees to her ankles and her abdomen had purple bruises. She had a small fixator on her ankle with screws into her bones, and a large fixator on her leg. She had no ability to weight bear. She returned to the hospital for 2 surgeries on her ankles and for cleaning and flushing at the site of her injuries. She was sent via ambulance from the hospital to Brampton to see an orthopaedic specialist, Dr. Pradeep Alexander. She had surgery in the hospital in Brampton on December 10 and stayed in hospital for 7-10 days. She returned to her daughter's house to recuperate.

The site of D.B.'s leg injury became infected and she returned to see Dr. Alexander. She was put on an intravenous antibiotic and was admitted to hospital on January 14, 2009. D.B. was hospitalized for many months and received intravenous antibiotics. D.B. testified that she had 5 surgeries on her right leg and ankle area. The plates and screws were removed from the area and a larger, longer air cast was applied, which remains today. She used a wheelchair, and continues to use it, as she cannot bear any weight.

D.B. took daily doses of opioids, which helped with her pain levels. D.B.'s principal areas of pain were the following: her leg, foot, ankle, back, neck, shoulders and jaw. She also had headaches 2 to 3 times a week with jaw pain. She wore a splint in her mouth to keep her jaw in place. She had a smaller range of movement when she tried to turn her head sideways due to neck and shoulder pain. She could not walk due to foot pain and pain down the back of her legs. She had pain on her left sacral joint and across the top of her left knee. Her abdomen was painful on the right side with a bulge from the hernia. On her right side and hand she experienced pain when she used the walker a lot. Sometimes, she relied on a brace on her hand. Her right knee, leg and ankle were particularly painful. Pain runs down her back in many different places. Her right knee was x-rayed disclosing a small fracture. The neck, back and shoulder pain she experienced was completely different from any pain experienced before the accident according to her testimony. She testified that formerly the pain was muscular but now it is deep in the bones of the back and feels like a knife because it is so sharp. When D.B. gets up, most of her weight is taken by the left leg and the ankle feels as though it is going to give out. The air cast keeps the bones in place so that they shift less.

D.B. had three large sutures in 1993 for a hernia. After the accident, she had 6 purple bruises over the site of the sutures. She noticed the reappearance of the hernia after the accident.

Emotionally, D.B. feels terrible, sad and depressed. She often doesn't want to get out of bed. She feels useless. She feels it has affected her relationships with her husband and the rest of her family. She can no longer do things with her family, such as fishing and going to the beach. She feels like a burden to everyone and feels like she has lost her freedom. She cannot escape

from these feelings and finds every day a struggle. She can no longer hop in a car but instead is always dependent on someone else. She feels like a prisoner in her own house.

D.B. sometimes eats for comfort and does not get any exercise so she cannot keep her weight down. She feels embarrassed about her weight and her appearance. She has difficulty sleeping and wakes up every 2 hours at least. She continues to have nightmares about car accidents every week or every other week. She feels scared in a car and her heart beats quickly from anxiety.

D.B. testified that she spends 99% of her day in a wheelchair. The only time she is not in the wheelchair is when she transfers to the stair lift and uses the walker for a few steps to the bathroom. She takes 8 to 9 steps from the bathroom to the bedroom. She has pain in her right foot at a level of 8 when she uses the walker to take a few steps. With any activity, her pain increases. Even sitting in her wheelchair, she has a pain level of 2-5 in the right leg.

Dr. Alexander always raised the possibility of amputation of the leg after the non-union of the fracture. He advised D.B. that when she was ready for an amputation, she should come to see him for a below knee amputation. She last saw Dr. Alexander in November 2011. D.B. does not know what to do. Prosthetics and physiotherapy are not possible because she cannot afford them and no one can assure her that she will be able to walk after an amputation.

SUMMARY OF CAT ASSESSMENTS

D.B. was assessed at Omega Medical Associates (Omega) by Dr. Lisa Becker, physiatrist, and Dr. Dory Becker, psychologist, on November 25, 2010. Dr. Harold Becker completed the Summary Report and OCF-19 application dated December 7, 2010. He concluded that when physical and mental/behavioural impairments are combined, D.B. rated a 41-59% WPI. Dr. Lisa Becker issued another report, based on a more comprehensive file review, on August 29, 2011. Dr. Dory Becker conducted another assessment and issued a report on January 8, 2013. Dr. Harold Becker wrote a Summary Report on January 8, 2013 and a follow up opinion on January 11, 2013. Based on an updated clinical evaluation by Dr. D. Becker, he concluded that D.B. demonstrated 8-23% WPI under a mental/behavioural evaluation but she did not

demonstrate any marked or greater scores. Based on a clinical evaluation by Dr. L. Becker, he concluded that D.B. demonstrated a minimum of 30-42% WPI under the physical criterion. However Dr. L. Becker provided alternatives where D.B.'s impairment score could meet and exceed the 55% WPI threshold.

In Dr. L. Becker's report dated August 29, 2011, she raised the following possibilities:

> Interestingly, if one were to combine Dr. Paitich's rating for lower extremity impairment (28%) with the other whole person impairment ratings provided by myself as listed above, total combined ratings would equate to 41-51% whole person impairment. If one were to combine the 10% whole person impairment provided for Class I or II impairment under the (g) criterion according to the Insurer Examiner's psychiatric report, total ratings for combination of (f) and (g) criterion would be 47-55% whole person impairment. If Class II impairment for her abdominal hernia was accepted, which provides 10-19% whole person impairment, her combined impairment ratings under the (f) criterion would exceed 55% alone.[4]

When Dr. Harold Becker combined impairments, he concluded that D.B. demonstrated at least [(30-42) + (8-23)] or 36-55% WPI, a score which meets the catastrophic threshold at the upper end of the range. However, he added that D.B. clearly surpasses the 55% threshold under several other scenarios discussed, most notably, a finding of wheelchair dependency which would result in an 80% WPI rating.

D.B. underwent a multidisciplinary insurer's examination through SOMA Medical Assessment Corp. (SOMA) in March and April of 2011. Assessments were conducted by Dr. Bruce Paitich, orthopaedic surgeon, Dr. Lawrie Reznek, psychiatrist, and Ms. Elyse Freedman, occupational therapist. The Executive Summary was prepared by Dr. Paitich. The SOMA report concluded that D.B. did not meet the definition of catastrophic impairment under any of the criteria listed under section 2 of the *Schedule*, even when impairments were combined. On March 6, 2012,

[4]Exhibit 3, Tab 6, pg. 5

Dr. Paitich issued a response to Dr. L. Becker's second report in which he did not alter his original opinion.[5]

ASSESSMENTS OF PHYSICAL IMPAIRMENTS AND WPI RATINGS

There were two expert witnesses at the hearing who testified, based on their observations and reports, about the issue of D.B.'s physical impairments and possible WPI ratings under the Guides. Dr. Lisa Becker, a physiatrist, was called as an expert witness by D.B. and Dr. Bruce Paitich, an orthopaedic surgeon, was called as an expert witness by Economical.

Dr. Lisa Becker is an expert in physiatry qualified to offer opinion evidence in her field with respect to the Guides. She testified that she uses the Guides for the majority of her assessments and was taught to use them by Dr. Harold Becker. Dr. H. Becker is the Clinical Coordinator of the multidisciplinary assessments, including catastrophic assessments, performed at Omega. Dr. Harold Becker was appointed the Ontario Medical Association representative to the Minister's DAC Committee in 1997. He served for almost five years on the committee and held the position of Vice-Chair in 2000-2001. He was also Chair of the Catastrophic DAC Guidelines subcommittee that rewrote the Catastrophic DAC Guidelines introduced in Ontario in April 2001. It is Dr. Harold Becker who conducts an initial review of the files for assessment by Omega. He estimates that he rejects 40% of files. If a file is accepted, he appoints members of the assessment team who consult with him after the preliminary review. He takes the final step of writing the summary.

Dr. Bruce Paitich was qualified as an expert in orthopaedics. Dr. Paitich is certified to be a coordinator for CAT assessments. In his first report dated April 27, 2011, Dr. Paitich acknowledged he was unable to examine D.B. properly as she could not access the examining table. In his opinion, amputation is the only solution for D.B. Dr. Paitich testified that the use of the wheelchair was not consistent with D.B.'s injuries and a single point cane and air cast could be used. However, Dr. L. Becker testified that this involves looking at the ankle injury in isolation which should not be done. D.B.'s injuries are a combination of multiple factors which

[5]Exhibit 3, Tab 7

interplay with each other. Together with the severe injury to the ankle is bilateral knee pain resulting in a feeling that the knees are going to give out. Also, D.B. is obese with an abdominal hernia and is restricted to a wheelchair.

On November 25, 2010,[6] Dr. Lisa Becker assessed D.B. for the first time. She noted that D.B. was seated in a wheelchair as her major problem was mobility. She could only walk a few steps. She looked at 3 methods for rating the lower extremity:

1. Diagnosis Related Estimate (DRE)
2. Range of Movement (ROM)
3. Gait Derangement Table (GDT)

Dr. L. Becker testified that it is appropriate in the case before me to use the GDT to rate the lower extremity. Wheelchair dependency is not defined in the Guides but signifies someone who relies on a wheelchair. Dr. L. Becker testified that it is D.B.'s lack of mobility which is fundamental. She is unable to perform a tandem gait, which requires moving with one foot in front of the other. In fact, D.B. cannot stand independently. Although Dr. Paitich insisted that D.B. requires a below knee amputation, Dr. L. Becker questioned why an amputation is recommended and what would be achieved with an amputation. She doubts that D.B. could ambulate with a prosthetic as she is obese. Her prognosis is that with an amputation, D.B. would more likely than not remain wheelchair dependent.

Dr. Paitich testified that amputation is preferable with possibly better functional outcomes than having an infected non union. That D.B. is obese should not be a concern with respect to the outcome. He suggested that more fat on the limb provides more padding so that the functional outcomes are equal or better than for thin people. On an emotional level, it takes time for people to cope. However, if function improves, then the emotional outlook improves also.

[6]Exhibit 3, Tab 1

It was unexpected by Dr. Paitich that D.B. would be in a wheelchair. Dr. Paitich suggested that she should use a single point cane and some stabilization such as an air cast or brace. Under the GDT, he would assess her with a 30% WPI requiring a short leg brace or air cast. However, he believed that it was most reasonable to assess her based on amputation of her lower limb. The loss of a limb equals 28% WPI.[7] In his opinion, nothing should be rated higher than the amputation of the limb which would lead the infection to disappear. If she were more mobile, she could walk unaided and go to the gym for exercise.

D.B. reported constant pain in her neck which radiated to the digits of her right hand. The pain was described as sharp and burning. The weakness in her right arm was greater than in her left arm. With respect to the neck pain and the back pain, Dr. L. Becker relied on a DRE (diagnosis related estimate) method of evaluation with a non-uniform loss of ROM (range of motion) in the neck and non-verifiable radiculopathy in both the neck and the back.[8] For each of the neck and the back, she attributed a 5% WPI based on a DRE II, which is for minor impairment. Dr. Paitich did not rate for the neck or the back. He found 0% WPI impairment as he observed no true radicular symptoms. Dr. L. Becker did not agree with Dr. Paitich's methodology. In her opinion, D.B. had clear evidence of non-uniform range of movement and non-verifiable radicular complaints.

Dr. Paitich noted the following complaints: right-sided lower leg, neck pain with associated shoulder pain and lower back pain. In his opinion, D.B.'s compromised function in her limb should not affect her neck, shoulders and back. He found that there was no radicular pain as there was no nerve pain. He diagnosed D.B.'s variable intensity of mechanical back pain as non-pathological. Although he noted neck and back pain, he concluded it had been 90% resolved.

Dr. L. Becker found that D.B. had shoulder injuries with some limited range of movement which was restricted to the right shoulder. There were slight limitations in the range of movement in the right shoulder abduction and both shoulders had some pain and limitations. There was diffuse

[7] *AMA Guides* (4th ed.), *Guides to the Evaluation of Permanent Impairment*, Table 64, pg. 83

[8] *Ibid*, Chapter 3, pg. 110, Table 73

tenderness around both shoulders, which she found to be consistent with the accident. The force of the impact could have caused injury to the shoulders and D.B. lacked mobility as she was dependent on the wheelchair. The shoulder pain could have resulted from repeated pushing up from the wheelchair. The range of movement limitations resulted in a 1% WPI rating for each shoulder.[9] With respect to Dr. Paitich's examination of D.B.'s shoulder, there is no evidence of the use of a goniometer. He did not isolate each specific movement and he had no specific numbers for ROM. Elyse Freedman, the occupational therapist at SOMA, in her April 28, 2011 report noted the restricted ROM of the shoulder. Dr. Paitich gave no rating and he did not discuss it in his report.

Dr. L. Becker testified about D.B.'s bilateral knee injuries. She found crepitation, that is crunching, grinding and tenderness in both the right and left knees from the joint line outside to the bursa inside, which she found was consistent with the accident. The knee smashed the dashboard causing femoral pain in the patella and a fracture to the fibula head. Also, D.B. gained 90 pounds after the accident and extra weight can cause this sort of discomfort. Dr. L. Becker gave a 2% WPI rating to each knee which amounted to 2% combined with 2%. Dr. Paitich gave no rating for the knees although he commented on the range of movement in the knees. Dr. Paitich testified that evidence of direct trauma was necessary to allow a 2% WPI rating. There was no direct trauma to the lower leg in his opinion rather, this was an example of exploded bone.[10]

With respect to D.B.'s abdominal hernia, there was a hernia repair 15-20 years prior to the accident with no intervening hernia problems. Dr. L. Becker testified that the hernia could have resulted from the slow progression of muscle weakness or tearing. It recurred after the accident in the right upper quadrant and she was given a hernia support in March 2009. Dr. L. Becker found it consistent that the force of the accident involving the lap belt would cause injury to the abdomen. A repair to muscle causes scar tissue which is not as strong and predisposed D.B. to injury. She rated the hernia as 0-9% WPI, a Class I impairment initially. Later she re-evaluated

[9] *Guides*, Chapter 3, pp. 43, 43, Figures 36-39

[10] *Ibid.*, Chapter 3, pg. 83, Footnote Table 62

and moved to Class II, which results in a 10-19% WPI, because it popped out whenever D.B. strained to have a bowel movement.[11]

Ms. Elyse Freedman, the occupational therapist at SOMA, documented that by March 2009, the hernia could be palpated in the same area as the earlier hernia. D.B.'s complaints started almost immediately after the accident. As a bedside ultrasound showed no gross abnormalities according to the notation from the nurse, Dr. Paitich did not causally connect the hernia to the accident and gave no rating.

D.B. had scarring and deformity at the right ankle which was consistent with the accident and multiple ankle injuries and surgeries. Dr. L. Becker rated this as a Class I impairment with a rating of 0-9% WPI, which she later increased to 10-19% WPI.[12] Intermittent treatment was required and the daily application of cream. Dr. Paitich noted the skin condition but he did not rate it. In Dr. Paitich's opinion, as he had rated according to right lower extremity limb loss through amputation, there could be no additional rating for scarring.

D.B. took several large doses of opioids daily with unrelated medications. Dr. L. Becker rated this as 3% WPI.[13] In her words, medications may be masking pain and there are medical side effects from taking medications. These medications were highly addictive with side effects of dizziness and constipation. Dr. Paitich offered no rating related to the use of medications.

D.B. had an open pilon fracture with a comminuted tibial bone which required multiple surgeries. She had constant pain in the ankle and a severe hindfoot impairment such that no weight could be put on her right foot. Dr. L. Becker's impairment rating was 12% WPI for a severe ankle motion impairment and 2% WPI for a severe hind foot impairment.[14]

[11] *Ibid*, Chapter 10, pg. 247, Table 7

[12] *Ibid*, Chapter 13, pg. 280, Table 2

[13] *Ibid*, Chapter 2, pg. 9

[14] *ibid*, Chapter 3, pg. 78, Tables 42, 43

Dr. L. Becker testified that she is of the opinion that it is necessary to rate what you observe in the present. Her original combination totalled a WPI of 30 to 42% but when she added a rating for the abdominal hernia and a range for medications, she arrived at a total rating of 36 to 48% WPI.

There was an in-home assessment on March 31, 2011. A review of Ms. Elyse Freedman's report disclosed that D.B.'s walking ability was extremely limited, perhaps 4 to 5 steps. The evidence is that she used the wheelchair almost exclusively in the house other than the few steps between the bathroom and the bedroom. There was a finding that D.B. was dependent on the wheelchair indoors and outdoors. The report found that 99% of the time, D.B. was in a wheelchair or in a sitting position.

I prefer the testimony and ratings of D.B. provided by Dr. L. Becker to those of Dr. Paitich. Dr. L. Becker's findings were consistent with other reports and were the result of detailed observations. Dr. Paitich made no actual measurements and found that D.B. could stand independently although she had one hand on the examining table for support and was vertical for a very short time. The foundation of Dr. Paitich's WPI rating was flawed in that he refused to assess D.B. as she appeared in his office but instead, persisted in treating her as an amputee, which is not in keeping with the Guides. He compounded his error by not rating D.B.'s chronic neck, shoulders and low back pain, her scarring and skin condition, her hernia and daily use of opioid medications.

MENTAL/BEHAVIOURAL ASSESSMENTS AND WPI RATINGS

Dr. Lawrie Reznek was qualified as an expert in psychiatry. He commented on the dangers inherent in the DSM which has definitions of psychiatric impairments based on subjective symptoms. He emphasized the importance of exercising good clinical judgment. In his opinion, it is wise to exercise caution when taking a patient's history as it is subjective. It is important to observe whether a patient has flat affect or walks in an animated way and responds to humour. None of the psychiatric tests can substitute for clinical judgment. One of the dangers is that of

over reporting which can give a distorted picture so that clinical judgment must be exercised to make a diagnosis; that is perception, expertise and training come into play.

Dr. Reznek testified that he asked D.B. open-ended questions in order to obtain spontaneous complaints. D.B.'s mood was not down or flat. She behaved appropriately and became tearful when talking about her losses. She had normal levels of distress which do not necessarily characterize a mental disorder as people are expected to grieve for their losses. Dr. Reznek applied the Falstein Mini Mental State Examination to D.B. It tests not only for mood but also for word-finding problems. This test took 5 to 10 minutes. According to Dr. Reznek, D.B. displayed no cognitive abnormalities. If patients are depressed, all their cognitive functions are affected. They concentrate poorly and have memory problems.

Dr. Reznek characterized Post Traumatic Stress Disorder (PTSD) as extreme intense, protracted distress which is over diagnosed in psychiatry by being applied to much milder symptoms. As part of his clinical assessment, his assistant knocked on the door. Hyperarousal is a feature of PTSD with an exaggerated startle response and D.B. was not startled by the knocking.

Although the Beck inventories showed a severe range of depression, Dr. Reznek testified that lists should not be applied in a mechanical way but rather, the psychologist should exercise clinical judgment from impressions gathered. He applauded Dr. D. Becker for not slavishly adhering to the results of the tests. According to Dr. Reznek, D.B. had pain and emotional distress with an expectable reaction to her loss of a level of functioning but she was not suffering from a psychiatric impairment. D.B. was overweight prior to the accident. In his opinion, D.B. gained 90 pounds as she was not able to be active after fracturing her right ankle. Dr. Reznek was not able to perceive any diagnosable disorder based on what D.B. told him. He concluded that she had no mental/behavioural disorder and did not meet the definition for catastrophic impairment. Dr. Reznek agreed that he had no problems believing D.B. and he had no suspicions of malingering.

Dr. Reznek admitted there had been no discussion with D.B. about physical symptoms associated with her being in a vehicle. D.B. had extreme mobility issues and consequent sadness about the loss of her leg and ability to do things. She started crying when she talked about how the accident had changed her life. Dr. Reznek was asked whether her weight gain could also be seen as a response to sadness and as a functional expression of depression. In his opinion, the weight gain was not a symptom of depression. It was attributable to inactivity. Also, she could not sleep due to shooting pains which were waking her up so her sleeping difficulties should not be seen as a symptom of depression.

Dr. Reznek conferenced with Ms. Freedman, but not Dr. Paitich, about the discrepancies in their findings. In his opinion, her findings should be restricted to physical findings and her findings about domains of functioning were of a mild disorder not generated by a psychiatric disorder but rather were the result of a physical impairment. In Dr. Reznek's opinion, D.B.'s limitations have their source in her physical disabilities. Dr. Reznek gave her a 0% WPI rating for mental and behavioural disorders.

Dr. Dory Becker was qualified as an expert in psychology and in interpreting and analyzing the Guides, which she uses almost every day in her practice. She assessed D.B. on November 25, 2010[15] as part of a multidisciplinary assessment by Omega for a catastrophic impairment designation. She later conducted a follow up assessment of D.B. on December 18, 2012.

D.B.'s subjective complaints to Dr. D. Becker were that she was sad and felt that everything she dreamed about was gone. She scored in the severe range in the Beck Depression Inventory as she demonstrated a loss of interest and a loss of pleasure together with feelings of worthlessness and fatigue. On the Beck Anxiety Inventory, she also scored in the severe range as she had an inability to relax, her heart was pounding, and she was nervous and frightened. D.B. also had accident related dreams and nightmares with flashbacks making it difficult for her to travel in a vehicle. Although D.B. experiences whole body pain, the focus was on her right lower extremity. Her back, neck and abdomen were other focal points of pain. Cognitively, she had problems with

[15]Exhibit 5, Tab 8

distractibility. Based on all of the information gathered, Dr. D. Becker diagnosed D.B. with a Major Depressive Disorder, a Pain Disorder and Post-Traumatic Stress Disorder.

In Dr. D. Becker's opinion, all D.B.'s activities were affected by her emotional disorders. She did not get as much pleasure from anything. Her self-care and her social and recreational activities were negatively affected. Also, her weight gain affected her ability to ambulate and nightmares had an impact on her sleep. Dr. D. Becker testified that D.B.'s psychological condition resulted from the motor vehicle accident. She assessed her under the 4 parameters for mental/behavioural evaluations; that is, Activities of Daily Living (ADL), social functioning, concentration and adaptation.

Activities of daily living include self care, personal hygiene, ambulation, and travel. D.B. had a diminished interest in self care such as showering and even getting out of bed. She was not experiencing pleasure from activities. She turned to eating more which in turn was affecting her ability to ambulate. She suffered from anxiety as a passenger, let alone a driver, in a vehicle and this inhibited her ability to travel. She had a diminished interest in sex and suffered from nightmares when she slept. Dr. D. Becker estimated that D.B. suffers from a moderate impairment in this category which is compatible with some but not all useful functioning.

The category of social functioning measures one's capacity to interact appropriately and communicate effectively. D.B. has a good relationship with her spouse and her children but the quality of her relationships have changed. D.B. described withdrawing from social functions. Dr. D. Becker rated this as a mild to moderate impairment which is compatible with some useful functioning.

Under the category of concentration, persistence and pace, D.B. complained of more difficulty concentrating, heightened distractibility and problems with decision making. Dr. D. Becker rated her impairment levels as mild to moderate which again is compatible with some useful functioning.

The category of adaptation deals with repeated failure to adapt to stressful circumstances. Dr. D. Becker stated that D.B. was coping reasonably well but she was struggling. She rated her impairment as moderate, which reflected that she would likely have difficulty adapting to repeated stressful circumstances. Dr. H. Becker fixed the WPI impairment rating at 15-29%.

Dr. D. Becker assessed D.B.'s psychological functioning for a second time.[16] This assessment consisted of a clinical interview and a more comprehensive psychometric battery of tests.

At the second assessment, D.B. continued to be wheelchair dependent, only able to walk a few feet or less. She experienced severe pain in her right ankle if she put weight on it. She was more fearful and focused on how dependent she was on others. She reported problems falling asleep and napped more than 2 hours every day. Her pain was interrupting her sleep and she needed to sleep more. She had gained at least 90 lbs. because she was eating for emotional reasons. She could not control her appetite and she was inactive. She exhibited a depressive mood and symptomatology. She was sad and frustrated with a diminished interest in most things. She expressed frustration because she could not do activities with her grandchildren. She had some suicidal ideation, unlike in 2010. She reported states of hyperarousal in the car where her heart races and she shakes from fear. She suffered from tension and memory problems and had difficulty multitasking and prioritizing. She was withdrawing more from her intimate relationships and the quality of her relationships had deteriorated. She continued to be physically impaired as far as personal care and housekeeping.

D.B. was not under or over reporting according to her tests which revealed a clean profile. Primarily, she was sad and depressed, anxious and nervous with panic and depressive symptoms. Dr. D. Becker's diagnosis was PTSD, in partial remission, an Eating Disorder Not Otherwise Specified and a Major Depressive Disorder, Single Episode, Moderate, Chronic.[17]

[16]Exhibit 3, Tab 8

[17]Tab 8, pg. 24

Dr. D. Becker, in a painstaking fashion, identified the major symptoms of PTSD, Depression and an Eating Disorder as itemized in the DSM IV and the ways in which D.B. displayed most of the symptoms associated with the identified disorders. She calculated a GAF score of 55-65 which, based on the California conversion methodology[18], corresponds to a WPI of 8-23%.

Ms. Elyse Freedman, the occupational therapist from SOMA, assessed D.B. on March 31, 2011 and obtained information which was consistent with what Dr. D. Becker reported.[19] Some of her questions were more detailed in some areas and some not as comprehensive, although she talked of D.B.'s sad and depressed mood. She noted her cognitive impairments and her hypervigilance.

Dr. D. Becker summarized her findings by concluding that D.B.'s current daily routine involves coping and compensating strategies. She is physically reliant on her daughter and her husband. She gets things mixed up which goes to attention and concentration, with some word-finding difficulty and grammatical errors. She exhibits common symptoms, that is, depression, pain and anxiety.

Dr. D. Becker questioned the clinical significance of Dr. Reznek's observation that D.B. was able to smile and laugh. It would be expected that D.B. would still be able to laugh and enjoy some things even if she had a moderate/major depressive disorder. Also, one must take into consideration the power differential. D.B. knows that it is polite to laugh at doctor's jokes. Although Dr. Reznek commented that she did not have anhedonia, a loss of pleasure, he does not specify how he came to that conclusion. Dr. D. Becker concluded from both her assessment and psychometric measures that D.B. suffered from anhedonia. In Dr. D. Becker's opinion, Dr. Reznek's test with the door knocking is not an accepted method for testing for PTSD. D.B. was wheelchair bound. Of course she did not jump. It could be expected that with her daily opioids her responses would be sedated. It was also pointed out that D.B. may have become desensitized to such noises after being in hospital for months at a time.

[18] *Schedule for Rating Permanent Disabilities* under the Provisions of the Labor Code of the State of California, January 2005, pp 1-12 to 1-16

[19] Exhibit 3, Tab 4, pp 7, 8, 9

During her second assessment, Dr. D. Becker spent more time with D.B. and used more psychometric measures and tests. She questioned why Dr. Reznek said D.B. was capable of taking care of herself. Ms. Freedman's report agreed that she could not travel, was distractible, and had compromised sleep. With social functioning, Dr. Reznek also thought D.B. was not impaired. He claimed no lapses of concentration because she watched her favourite TV programs. Dr. D. Becker's opinion is that D.B.'s physical problems have triggered a psychological reaction. She is not confident that amputation would improve D.B.'s mobility. The resulting depression could be more debilitating.

I prefer the testimony, reports and ratings provided by Dr. D. Becker to those provided by Dr. Reznek. Dr. Reznek relied on such improvisations as having his assistant knock on the door to test for PTSD. He ignored the findings of his colleague, an occupational therapist, and he generalized too much with the result that he arrived at conclusions which were not reasonable.

WHOLE PERSON IMPAIRMENT RATINGS

Dr. Paitich calculated SOMA's overall WPI rating for D.B. In Dr. Paitich's opinion, D.B. does not qualify for the catastrophic impairment designation. He assigned her a WPI rating of 35%. Dr. Reznek found no impairment in his mental/behavioural evaluation while Ms. Freedman, the occupational therapist, rated it a mild impairment. Dr. Paitich determined 10% based on the report of Ms. Freedman, the occupational therapist. By choosing 10%, he appeared to have rejected his own psychiatrist's opinion about D.B.'s impairments. Dr. Paitich disagreed and testified that 10% was a compromise between the two findings.

Dr. Harold Becker was qualified as an expert witness in interpreting and applying the Guides. In this case, he took the GAF (Global Assessment of Function) findings and calculated a WPI rating with respect to the mental/behavioural evaluation.[20] The methods used under Chapter 14 involve converting mild/moderate/severe to a WPI. The actual method for GAF conversion to

[20]See Exhibit 1, Tab 1, with 4 reports See Tab 8

WPI is found in the DSM IV.[21] Dr. H. Becker has applied a GAF conversion which appears to be consistent with the Guides.

Dr. H. Becker pointed out that D.B. was in her mid fifties and was morbidly obese which complicated her case. He highlighted three sections in the *Guides* which encourage a progressive approach to evaluation; that is, if there is more than one possible rating, the higher rating should be used.[22]

In her first assessment, Dr. L. Becker did not rate D.B. on the Gait Derangement Table (GDT). The higher rating would be 80% for wheelchair dependency. Dr. Paitich states in his report that the GDT is restricted to rare situations and Dr. H. Becker disagrees. The important question is whether use of the GDT is consistent with a diagnosis. According to Dr. H. Becker, it is not appropriate to rate D.B. as an amputee when she is not. D.B. cannot simply strap on a prosthetic and walk. She weighs more than 330 pounds and is 53 years old. Also, five years have elapsed since the accident and she is deconditioned.

Amputations are in the DRE section of the Guides and the Guides specify that one must not exceed the rating for an amputation. Dr. H. Becker testified that the GDT stands alone and D.B. qualifies for more than 28% on many levels. She is not subject to the limitation of amputation which is too simplistic an approach to her impairments. An examiner cannot ignore the entire basket in this case which includes D.B.'s weight and emotional issues. If D.B. is in the wheelchair 99% of the time, then she is wheelchair dependent. It is possible that D.B. could have an amputation and continue to be wheelchair dependent.

Dr. H. Becker addressed the insurer's argument about the failure of D.B. to obtain treatment. He directed our attention to a section of the *Guides* which specifies that a patient may decline treatment and such a decision should not decrease the patient's rating.[23] If one is paralyzed, one

[21]Pp. 1.12-14

[22]See *Guides*, pp. 3/84, 3/99, 4/140

[23]*Guides*, pg. 2/9

may choose not to have surgery and continue to be assessed as catastrophic. In his January 8, 2013 report, he concluded that, based on a clinical evaluation by Dr. L. Becker, D.B. demonstrated a minimum of 30-42% WPI under the physical component. However, she provided scenarios where D.B.'s impairment score could meet and exceed the 55% threshold. Based on an updated clinical evaluation by Dr. D. Becker, D.B. demonstrated a 8-23% WPI under the mental/ behavioural evaluation but she did not demonstrate any marked or greater categorical scores. When Dr. H. Becker combined the impairments, he concluded that D.B. demonstrated at least [(30-42) + (8-23)] or 36-55% WPI, a score which meets the catastrophic threshold at the upper end of the range. This score is clearly surpassed under several other scenarios discussed, particularly, a finding of wheelchair dependency and use of the Gait Derangement Table to arrive at an 80% WPI.[24]

CONCLUSION

The Guides are an imperfect tool for determining whether an applicant is catastrophically impaired from a motor vehicle accident. Catastrophic impairment relates to multiple impairments which must be distilled to a single impairment score. I disagree with Economical's argument that D.B. has adopted a "smorgasbord" approach in order to "bump up" her impairment rating and has erroneously offered me a buffet of options for calculating whole person impairment. My interpretation of D.B.'s approach is somewhat different. I view the differing calculations by Omega as a valiant approach by a team of dedicated professionals to address the complexities of the *Guides* in a fashion designed to be fair and balanced toward the applicant, while recognizing that the ultimate decision is a legal issue to be determined by an arbitrator or a judge. The Omega team implemented a wholistic approach while exercising good clinical judgement in a sensitive and thoughtful manner.

I prefer the approach and findings of Omega to that of SOMA, except for the helpful information found in the report of Ms. Elyse Freedman, the occupational therapist at SOMA. Omega adopted a rigorous framework for conducting its evaluations in accordance with the Guides. Each professional acted as a member of a team which consulted and conferred with the coordinator,

[24]Exhibit 3, Tab 8

gathered as much medical information as possible and followed the protocols and tables found in the Guides for evaluating each body part or system. Omega's creativity best reflected the case law from the courts and FSCO which has emphasized that a large and liberal interpretation of the Guides is justified, based both on the underlying philosophy of the Guides themselves and given that the *Schedule* is consumer protection legislation. It is important to remember that a determination that an insured has suffered a catastrophic impairment simply permits that person to make claims for an enhanced level and duration of benefits. It remains necessary for the insured to qualify for the particular benefits by meeting the tests for entitlement.

Dr. Paitich applied no objective tests to rate D.B.'s mobility. He accepted that she used a walker indoors but he never asked her how far she used it. Ms. Freedman, the occupational therapist, was far more specific in her examination and noted D.B.'s inability to adopt a single leg stance, tandem gait, and her inability to stand independently. D.B. was not asked by Dr. Paitich about the walker and there was no demonstration by D.B. of her mobility using a single point cane. Instead, Dr. Paitich chose to treat D.B. as analogous to an amputee with a 28% WPI rating. There also was no acknowledgement of D.B.'s functional limitations in her knees, neck, shoulders and back which should have been rated. However, the Guides speak to evaluating impairment of different body systems by rating the scores for each system independently.[25]

Dr. H. Becker pointed out that Chapter 2 of the Guides specifies that whether someone does or does not have surgery should not affect their rating. No doctor, insurer, arbitrator or judge can dictate to D.B. that she must have an amputation as a remedial procedure. I am mindful that D.B. has had 5 remedial surgeries as a result of the accident and has suffered from the non-union of a fracture. No one can assure D.B. that she will increase her mobility if she consents to an amputation.

In Dr. Harold Becker's report of January 11, 2013, he addressed the causation issue, in a manner which I found persuasive, with respect to D.B.'s wheelchair dependency:

[25] i*bid*, Chapter 13, pg. 278

> As I discussed in my recent report of January 8, 2013, Dr. Paitich was of the opinion that [D.B.'s] use of a wheelchair was not "consistent with her diagnosis." That diagnosis, is in fact, a complex one related to an open pilon fracture of the right distal tibia which required multiple surgeries and which essentially has gone on to non-union likely as a result of underlying infection. Even without consideration of [D.B.'s] excessive weight, Dr. Paitich's commentary appears simplistic in that his suggestion of the use of a single point cane would be fully sufficient to manage her mobility issues. Beyond the strictly orthopaedic issues, one must consider her significant weight gain and associated deconditioning on her physical ability to walk independently. Furthermore, factoring in the effect of the mental and behavioural issues involving Major Depressive Disorder, Post-traumatic Stress Disorder in partial remission as well as Eating Disorder, would reasonably be expected to impact this as well ....
>
> What may not be appreciated in an orthopaedic opinion, however, is the fact that there is associated mental and behavioural impairment including depression and anxiety issues, as well as excessive weight gain, and other residuals including a potentially accident related hernia, which all come together now to result in her wheelchair dependency.[26]

Dr. Harold Becker has also answered the unspoken question as to why Omega devoted so much care to assessing and calculating D.B.'s discrete impairments if the ultimate conclusion is that she is wheelchair dependent. The answer is that the constellation of D.B.'s impairments, both physical and mental/behavioural, created a perfect storm of impairment which resulted in her wheelchair dependency. For that reason, each of her discrete impairments must be evaluated and appreciated. I do not agree with Economical's position that D.B. must be either paraplegic or quadriplegic to qualify as wheelchair dependent. No such requirement can be found in the Guides.

D.B. was a credible, forthright witness who was consistently observed by all her assessors to be an honest and trustworthy person. I believed her when she said she was wheelchair dependent and unable to walk more than a few steps independently. I also believed her when she testified that she spends 99% of her time in a wheelchair. I endorse the Omega approach which was to assess D.B. as she presented herself rather than speculate about the effect of an amputation.

[26]Exhibit 11

It is understandable that D.B. is reluctant to consent to a lower limb amputation when she is uncertain about the result. I attach no weight to the WPI rating assigned by SOMA, which was based on an amputation D.B. has not had. Dr. Paitich also insisted that D.B. could walk with a single point cane and an air cast but I was presented with no evidence to support that assertion.

I find, based on the evidence, that D.B. satisfies the definition of "catastrophic impairment" under clause 2(1.2)(f) of the *Schedule*. She qualifies for a greater than 55% WPI rating in many different ways. The most obvious is that D.B. is wheelchair dependent and qualifies under the Gait Derangement Table for an 80% WPI rating. As D.B. cannot bear any weight and she is unable to walk as a result of the accident, the conclusion is inescapable that she is wheelchair dependent and her whole person impairment should be calculated under the Gait Derangement Table.

EXPENSES:

The parties are encouraged to resolve the issue of expenses. If they are unable to reach agreement, they may apply for an expense hearing, within 30 days, under the *Dispute Resolution Practice Code*.

Judith Killoran Arbitrator	October 2, 2013 Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A12-000632

D.B.

Applicant

and

ECONOMICAL MUTUAL INSURANCE COMPANY

Insurer

ARBITRATION ORDER

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

1. D.B. is catastrophically impaired as defined in clause 2(1.2) (f) of the *Schedule*.

Judith Killoran
Arbitrator

October 2, 2013
Date