Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

BETWEEN:

PG

Applicant

and

E INSURER

Insurer

DECISION

Before:	Louise Barrington
Heard:	In person at the offices of Cornell Catana Reporting Services, 170 Laurier St.West, Ottawa from January 11 to 19, 2016
Appearances:	Mr. L and Ms. F for Applicant Mr. P and Ms. S for Insurer

Issues:

The Applicant, Mrs. PG, was injured in a motor vehicle accident on March 17, 2010 while riding as a passenger on her husband's motorcycle, and sought accident benefits from E INSURER ("E INSURER"), payable under the *Schedule*.[1] The parties were unable to resolve their disputes through mediation, and Mrs. PG, through her representative, applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

[1]Effective September 1, 2010, the *Statutory Accident Benefits Schedule – Effective September 1, 2010* (the "new *SABS*") came into force. The transition rules in the new *SABS* provide that, subject to certain exceptions, benefits that would have been available pursuant to the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996* (the "old*SABS*") shall be paid under the new *SABS*, but in amounts determined under the old *SABS*.

The issues in this arbitration are:

1. Has Mrs. PG sustained a catastrophic impairment as a result of the accident?
2. Is Mrs. PG entitled to receive a non-earner benefit?
3. Is Mrs. PG entitled to receive a medical benefit of $140 for massage therapy?
4. Is Mrs. PG entitled to receive rehabilitation benefits of $1,835.23 for occupational therapy assessment, $8,246.74 for occupational therapy – hospital bed, and $5,849.08 for physiotherapy and $4994.90 for travel time and mileage of her physiotherapist?
5. Is E INSURER liable to pay a special award because it unreasonably withheld or delayed payments to Mrs. PG?
6. Is E INSURER liable to pay Mrs. PG's expenses in respect of the arbitration?
7. Is Mrs. PG liable to pay E INSURER's expenses in respect of the arbitration?
8. Is Mrs. PG entitled to interest for the overdue payment of benefits?

Result:

1. Mrs. PG has sustained a catastrophic impairment as a result of the accident.
2. Mrs. PG is entitled to receive non-earner benefits for:

   -the periodsbetween May 17, 2011 to January 3, 2012 in the amount of $185 per week, for 33 weeks, a total of $6,105; and for

   -the period from December 2, 2013 to the date of this award, being 122 weeks, at $185 per week, totalling $22, 570, (Total NEB $28,675) and ongoing.
3. Mrs. PG is not entitled to receive a medical benefit of $140 for massage therapy.
4. Mrs. PG is entitled to receive a rehabilitation benefits of $1,835.23 for an assessment, and $5,000.00 for a hospital bed, and $5,849.23 for physiotherapy.
5. E INSURER is not liable to pay a special award.
6. The following claims are denied:

   - medical benefit of $140 for massage therapy; and

   - medical benefit of $4,944.90 for physiotherapist's travel time mileage.
7. Mrs. PG is entitled to interest at the rate of 2% per month, compounded monthly, from the date each specific benefit became overdue until the date of this award.

8. The Applicant is entitled to her reasonable expenses of the arbitration. If the parties are unable to agree on the entitlement to, or quantum of the expenses of this matter, the parties or one of them may request an appointment with me for determination of same in accordance with Rules 75 to 79 of the *Dispute Resolution Practice Code.*

EVIDENCE AND ANALYSIS

Case History

Mrs. PG was born in1958. She completed Grade 10 and some Grade 11 courses, was married for several years and divorced in 1998, and raised as a single mother three children, all of whom had left home at the time of the accident. At the time of the accident she was fifty-one years old and had been living with LB, her common law husband, for at least eight years. Prior to the accident she had held a variety of jobs, including running her own baking business, managing a grocery store, and providing a children's daycare service. Her most recent job was as a seasonal employee in a restaurant induring the summers before the accident. Like Mr. LB, Mrs. PG was a passionate motorcycle enthusiast, who had for some years owned and ridden her own motorcycle. They lived in summer in a house in a small town outside Ottawa, and in a gated trailer community in Arizona each winter.

On March 18, 2010 Mrs. PG was a passenger on her husband's motorcycle during a road trip in Arizona with a group of friends. When a car in front suddenly slowed or stopped, Mr. LB was not able to swerve and struck the car. Upon impact, Mrs. PG was thrown from the motorcycle, hitting the car in front and then landing in an oncoming lane of the highway. Her physical injuries are not in dispute: she suffered a broken back, shattered humerus, fractured wrist, and shoulder damage. She was airlifted to the Las Vegas Trauma Centre and treated there for a week. Her left arm fracture was set in a cast, and her T12 spinal burst fracture required a full body "clamshell" cast which Mrs. PG wore continuously for six months. The wrist fracture was discovered and treated only when the arm cast was removed. Spinal surgery was performed a year later to insert a metal rod in her spine, when conservative treatment had failed to alleviate her suffering. She developed chronic pain, and has been diagnosed with a number of psychological disorders stemming from the accident. She applied to E INSURER, Mr. LB's Insurer, for benefits under the *Schedule*.

These facts were not disputed by the Respondent. The Parties have also agreed that Mrs. PG's physical impairment is at the level of 29% whole person impairment ("WPI"). The dispute concerns the evaluation of the combined physical and psychological consequences to Mrs. PG of the accident - whether her impairment is catastrophic. The Insurer's position is that it is not.

Has Mrs. PG sustained a catastrophic impairment as a result of the accident?

The Insurer contests the extent of the Claimant's impairment, arguing that her condition is not serious enough to satisfy the requirement of the *SABS*. Following on that argument, the Claimant would not be entitled to the non-earner benefits in excess of the non-catastrophic limit, which at the time of the accident was $100,000, for medical and rehabilitation benefits sought in this arbitration.

The concept of catastrophic impairment is a "gate-keeper"- to enhance compensation of those who have suffered such an impairment in their lives, while limiting compensation to those less seriously affected. A finding of catastrophic impairment is no guarantee of compensation, but only the gate through which an applicant must pass in order to advance a claim.[2]

In order to "pass through the gate" of catastrophic impairment under *SABS* clause 2.1.1(f) a claimant must have an *impairment or combination of impairments* that, in accordance with the American Medical Association *Guides to the Evaluation of Permanent Impairment*, results in an impairment of the whole person ("WPI") of at least 55%.[3] Clause 2.1.1(g) requires an impairment that, in accordance with the American Medical Association *Guides to the Evaluation of Permanent Impairment*, results in a class 4 impairment (marked impairment)… due to mental or behavioural disorder.

Citing the *Kusnierz v. Economical* case[4], Insurer's Counsel accepts that a combination of physical and psychological impairment can produce the 55% under clause (f), but contests that the extent of the combined impairment in this case reaches that level.

Put simply, Mrs. PG can pass through the gate only if she can demonstrate a severe enough psychological impairment that when combined with her agreed 29% physical impairment will yield a total WPI of 55%; or alternatively, if she can demonstrate a mental or behavioural disorder which causes a marked impairment.

Claimant's Counsel refers us to the Court of Appeal's case guidance in *Pastore v. Aviva*[5]:

1. Did the accident cause the applicant to suffer a mental or behavioural disorder?
2. If yes, what is the impact of the disorder on the applicant's daily life?
3. In view of the impact, what is the level of impairment?

The Court of Appeal provided guidance on the interpretation of the notion of catastrophic impairment, in light of its purpose. The Court referred to the legislature's intent to give the concept an inclusive and not a restrictive meaning.[6]

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[2] *Jaggernauth v. Economical Insurance Company*, FSCO A08-01413, Arb. Feldman at p. 14
[3] American Medical Association *Guides to the Evaluation of Permanent Impairment*,4th edition, 1993
[4] *Kusnierz v Economical*, 2011 ONCA 823
[5] *Pastore v. Aviva Canada Inc.*, 2012 ONCA 642 at p.46
[6] ibid

Counsel for the Insurer has helpfully set out the role of the arbitrator in a citation from *Taylor v Pembridge*[7]:

> "…the trier of fact has the responsibility to try to accurately express and estimate all of the impairments that an insured person has sustained as a result of the accident, and then to determine whether the insured person, on a balance of probabilities, has sustained a catastrophic impairment… The adjudicator must weigh expert evidence and determine its probative value. …The adjudicator may accept the expert evidence, reject it, or accept part of it and reject other parts of it. […] Adjudicators decide cases, experts do not."

In order to assess the gravity of a claimant's impairment and decide this dispute, it is necessary to consider the activities of that claimant prior to the impairment, and then to compare the claimant's ability to participate in those activities after the accident which caused the impairment, as well as the causes of that impairment.

The Claimant's Case

Evidence of Mrs. PG

Mrs. PG, in her oral evidence,[8] testified that as a result of the accident, she has suffered from depression, anxiety including nightmares, flashbacks and panic attacks, and chronic pain. Six years after the accident, despite surgery, medication and therapy, she is substantially unable to work or pursue her former interests, depends on her husband for aspects of her personal care, cannot participate meaningfully in family and social and activities, and fears driving anything more than short familiar routes without traffic. Her physical limitations make it impossible to help with the care of her grandchildren, or even to play with them as she would like. She spoke of tensions in the relationship with her husband. And she described her psychological reactions to these limitations, of depression, feeling useless and socially isolated.

Expert witnesses who examined or treated Mrs. PG have provided reports and several have testified orally that as a result of the accident she suffers from severe major depression, adjustment disorder, post-traumatic stress trauma and debilitating chronic pain which is exacerbated by these psychological problems. Their assessments of the effect of these problems differ, and that is the critical decision that needs to be made in this arbitration. Making that determination calls for an examination of the evidence produced by both sides regarding Mrs. PG's physical limitations, her psychological condition, and their combined effect on her quality of life. To assess this effect, we must first form a picture of Mrs. PG's life prior to the accident, so that it can be compared with her life afterward.

In the years before the accident, Mrs. PG had had a busy life, caring for her growing children, and working at multiple jobs. At one period she operated her own baking business, and she baked and decorated wedding cakes. In her previous home, she had had a vegetable garden, a flower garden. Prior to the accident she did some of the outdoor home maintenance, and handled the

[7] (A12-004886)
[8] Evidence of PG, Hearing Day 2

housekeeping where she and Mr. LB lived. She enjoyed entertaining friends, and children were an important part of her life. She knitted and did crochet. She liked massages and visits to the hairdresser. She enjoyed ballroom dancing, bingo, dinner/dance evenings, educational courses, exercises such as yoga and Zumba, visiting the local patio grill and the swimming pool regularly. She had also assisted in decorating and coordinating themed events in their Arizona community. But perhaps the defining factor in the life Mrs. PG shared with Mr. LB was their shared passion for motorcycles. She and her husband would ride most days, taking summer bike trips in Ontario to visit friends. In winter they and their friends took trips from their Arizona base. They socialised with other bike owners, whether in Ontario or Arizona. Mrs. PG had owned her own motorcycle, although she sold it prior to the accident, and continued as a passenger on her husband's bike. As well as being a pastime for them, motorbikes provided the focal interest of their social network.

With the accident, all of that changed.

Mrs. PG testified about her injuries and resulting pain, how they had affected her physical enjoyment of life, and the psychological problems she has suffered since the accident. She testified that she no longer interacts socially as she did prior to the accident. She said that in 2012 she had gained 30 pounds over 3 months, and had been feeling really sad and unhappy around that time, but felt really horrible with the extra weight. She was distraught about not being able to work, not only for the money it would contribute to the family finances, but also because she missed the social interaction with customers at Le Gourmet.[9] She was also upset about being unable to respond to her husband and that, although he was generally supportive, family relations were strained. She felt unmotivated and in constant pain, was having panic attacks and flashbacks of the accident. Her participation in driver desensitisation was bringing back memories of the accident, when she thought she was going to die.[10] She was taking medications for depression, anxiety, pain, constipation and leg pain, and for nausea caused by the others. She was dependent on her husband for help with her personal hygiene and dressing, meal preparation, and for driving her everywhere except for occasional short distances. When they were with her grandchildren, it was Mr. LB who had to assume childcare tasks, as Mrs. PG could not. Her inability to continue the couple's shared motorcycling activities also took a toll: "My life with LB was all about motorbikes."

During her oral testimony over two days when she was present, the Applicant impressed me as an earnest and honest witness, troubled by her many physical and psychological limitations, but not exaggerating them. She spoke coherently, with occasional lapses of memory. She was clear about her situation, but seemed somewhat flat and emotionless as she described her l imitations. At intervals during her testimony she stood up, stating that sitting for prolonged periods caused her discomfort.

In addition to Mrs. PG's own testimony, counsel Mr. L offered the evidence of a number of professionals involved in her evaluation and treatment. Some of these attended the Hearing to give evidence in person.

[9] Evidence of PG, Day 2 of Hearing.
[10] ibid

Ms. M, Occupational Therapist

Ms. M graduated from Queen's University in Rehabilitative Therapy and has worked for 20 years full time in the field of Occupational Therapy. Her area of specialisation is chronic pain and psychiatric disorders. Ms. M's notes recorded her many interviews with Mrs. PG. She was assessing the physical capabilities, social, psychiatric and cognitive functions, and her living and social environment in order to make recommendations to help Mrs. PG achieve her goals of independence and safety, pain management, and psychological and physical well-being.

In testifying, Ms. M consulted her contemporaneous notes[11] of the many interviews she conducted with Mrs. PG. She noted Mrs. PG's complaints of elbow pain affecting her ability to keep house, back pain, intense migraines, ringing ears, fatigue and lethargy, shoulder pain with reduced mobility and strength, and aching and limited strength in her wrist.

As to functional tolerances, sitting caused pressure, and she was comfortable only when reclining. Yet she was uncomfortable lying down flat, and although she wanted to sleep in bed with her husband to be "normal", she could not find a comfortable position and suffered from interrupted sleep. Standing and walking were not functional, she was unable to crouch, kneel or bend, she needed assistance with her personal care such as showering, dressing and toileting, and her ability to lift or carry objects was restricted.

Ms. M found it difficult to comment on Mrs. PG's cognitive ability in light of the pain medication she was taking. She did note that Mrs. PG gave an adequate history, but seemed lethargic and complained of memory difficulties and being unable to organise her thoughts. Emotionally, she expressed frustration at the "wasted year" prior to her back surgery, and had hoped the surgery would alleviate her pain. She also mentioned the financial strain of not being able to work and contribute to family finances, and not knowing what her future capabilities might be. She also mentioned stress on her marriage, describing the relationship as "strained but supportive".

In April 2012, when Mrs. PG returned from her winter stay in Arizona, Ms. M formed the impression that rather than progressing, Mrs. PG was worse. Ms. M recommended the purchase of an electric bed. This was denied by the Insurer, who did later allow for a rental bed.

In July 2012, more than six months after her surgery, when Mrs. PG's clamshell back brace came off, Ms. M reported "more mobility, more pain". She noted that "PG wants to engage, to do as much as possible to become more functional. She pushes the limits, and then has to lie in bed for several days after to deal with a 'pain crash' caused by doing too much." She needed monitoring and guidance to avoid overdoing it. Mrs. PG had been able to do without morphine for some time, but had to resume it when the brace came off. Ms. M noted, "still struggling…problems with LB who is stuck inside to care for her…hope starting to dwindle about this ever getting better". Ms. M noted that the rental bed which Mrs. PG had been able to procure was "only partially meeting her needs" as it was not of adequate quality for nightly use and in additionally, did not permit her to sleep in the same bed as her husband.

[11] C Ex 7 Tab 1

In November of 2012, Ms. M noted a "complicated recovery" after the surgery, with a sensitive lump appearing at the site of the spinal surgery and decreased capability for exercise such as walking. Ms. M recorded that Mrs. PG was suffering from pain flare ups, still needed full-time care and homemaking assistance, and there was "no motorcycling, no knitting (no sitting), no baking, socializing, gardening, care of grandkids". She noted Mrs. PG could engage verbally with the Children, but could not take them to the bathroom, or outside to play, bake or prepare meals for them – all activities which she valued. She could not babysit the Children as she would be unable physically to deal with an emergency. She noted that Mrs. PG was "dejected", feeling the strain on her marriage, and wanted to be in Arizona. However, her attempts to sleep there, in a regular bed when no electric bed was available for rent had resulted more pain and a consequent deterioration in sleep. Ms. M noted that this experience precipitated the sale of the couple's Arizona home.

In July 2013, Ms. M noted that Mrs. PG's recent trip to Arizona had been "too much", and that there were very few activities in which she could participate. She was lonely and isolated when her husband went out to enjoy them without her. She noted various treatments, and attempts at pain management with various drugs. Mrs. PG was walking with a cane, but only ¼ to ½ a kilometer a day, instead of the full kilometer she had been able to manage prior to surgery, and was suffering frequent pain flare-ups.

By January 2014 she had made progress with mobility, and her ability to assume much of her personal care, but still depended on her husband for assistance. She found it difficult to balance her need to control "pain crashes" caused by too much activity with the expectations of her husband and family. This caused strained relations with her husband.

Mrs. PG participated in a Chronic Pain Management group, tried yoga, mindfulness and meditation for pain control, and was happy to be able to sleep in the same room with her husband, although in separate beds pulled together. Ms. M noted this, but was still concerned about her "alarming" dependence on the opiate pain medication, and noted that she needed support and assistance with personal care. Mrs. PG was trying to come to terms with her significantly changed life. She had participated in driver desensitization with Dr. L, which had "not been a huge comfort to her" according to Ms. M's observations, and was cautiously driving short distances. Her husband normally continued to drive her to their appointments.

Ms. M made a number of recommendations – for assistive devices, regarding home management over several years, ending in 2014 when another therapist took over the file. At that point she mentioned, "Pat [is] recognising that there is no cure for her pain; this how it's going to be." Ms. M testified that in October 2014, after another therapist had taken over the file, she received a call from LB, concerned about the pain medication, because Mrs. PG was "not coherent" and was talking "silly talk".

Ms. M did not make any recommendation that Mrs. PG attempt to do volunteer work as a way to increase her social interactions. As she said, placement opportunities in the area are very scarce, and besides, Mrs. PG cannot function well enough to do volunteer work. Her pain prevents her from making any firm commitment, her cognitive abilities are impaired, possibly by the heavy

pain medications she requires for it, and she would be more likely to need help, rather than be able to give it.

In assessing the evidence of Ms. M it is useful to remember that almost all Ms. M's information about Mrs. PG's life and feelings came from Mrs. PG herself. This however, is supported by Ms. M's continuing professional observations of her physical and capacities over the approximately four years she worked with her. At the hearing Ms. M acknowledged that as an occupational therapist she was not in a position to speculate about whether Mrs. PG's psychological state was actually making her pain worse and keeping her from getting better.

Dr. W, Psychiatrist

Dr. W has practised as a psychiatrist since 2000, both in his private office for psychotherapy and at Ontario Shores Psychiatric Hospital. His sub-specialities are forensic and geriatric psychiatry, and he frequently performs court ordered assessments in criminal cases. He treats psychological trauma, brain injuries. He frequently uses the AMA *Guides* in assessing patients for lawyers, working about 50:50 per cent for injured parties and for insurers. He used the AMA Guides[12] to assess PG. From his review of the voluminous documents[13] and from professionals treating Mrs. PG, Dr. W knew that her family doctor, Dr. K, wanted her to get psychiatric help and had prescribed Trazodone, an anti-depressant. Dr. W interviewed Mrs. PG for about two hours alone and with her husband, and then with her permission saw Mr. LB alone. He also used two screening tests, and relied on the findings of the other professionals working with Mrs. PG: "We work as a team. Others have different expertise that I don't have."

Dr. W testified that there are three categories of pain: pain caused by a physical or medical condition, pain caused by psychological factors only, without a physical cause, and -- most common – pain associated with a physical cause, with psychological factors playing a role to worsen or perpetuate it.

He also explained that post-traumatic stress disorder ("PTSD") is a reaction to significant trauma which the patient has witnessed or heard about. It produces symptoms including flashbacks, nightmares and hypervigilance, and may be either chronic, that is extended over a long period, or acute brief incidents, relating to a specific phobia or event.

He learned of Mrs. PG's childhood, including an abusive father and a mother left quadriplegic by a serious accident when she was five years old, her education and work history, and her current relationships with her children (healthy, enjoyed family contact) and her husband (loving, committed relationship but significant decline since the accident). Previous medical history

[12] *AMA Guides to the Evaluation of Permanent Impairment*, 4th edition, version in effect after Sept 1 2010

[13] Assessments, clinical notes of family physician, psychologist Dr. R, medications, CAT reports of SIMAC for Insurer up to February 14, 2013, copies attached to his Witness Statement, C Ex 5, Tab 3 at Appendix A

included knee surgery and a thyroid condition. Pre-accident function was normal with regular visits to the gym, social functions, travel, family activities, motorcycling and travel.

Dr. W noted that the trauma of the accident made Mrs. PG fear for her life. At the assessment, in 2013, he found that Mrs. PG, despite the passage of time, surgery and physiotherapy, was not improving. She showed signs of depression and hopelessness. His examination of her mental status revealed her as "tired, exhausted, sad, depressed, with flat affect even when describing emotional things, tearful at times, and with suicidal ideation. Although she admitted to having thoughts about suicide she told him she had never made a plan to do it.

Mrs. PG told him she had not returned to many of her pre-accident activities such as motorcycling. She was in constant pain, and felt her friendships suffered because of this. She needed help from her husband with everything. He quoted her as saying, "It's not the life we expected for ourselves." She described feeling useless and guilty as she had lost her independence, and her roles as wife, mother and grandmother. He administered the Hamilton and Montgomery Asberg depression rating scale structured interviews, noting that each scale alone is reliable, but together they have a very high degree of accuracy.

Interviewing Mr. LB, Dr. W learned, "he missed the person she used to be," as well as their many activities, and physical intimacy. Both spouses felt that the pain situation was critical and they had become hopeless about it ever getting better.

Dr. W had no concerns that Mrs. PG was malingering, that is, intentionally producing symptoms for a secondary gain. In his first report, he wrote, "It is evident from the medical legal records that Mrs PG tends to minimize her own complaints…"[14] Dr. W testified that he shared the conclusions of Dr. R, whose test reports he had read, that this was a hardworking lady who had lost her independence and her income, and found herself in a "devastating" situation. In his oral testimony[15] he spoke of "the distraction of pain" and he wrote, "Mrs. PG still has severe pain causing spasms, cognitive deficits, depression, fatigue and sleep disturbances… which physically impair her functioning…" In his first report he concluded, "The psychological difficulties she is, and has been experiencing as a result of the accident translate into marked functional limitations or activity restrictions, and according to the applicable AMA Guides are considered to result in a Class 4 impairment level."[16] There was no evidence from which to infer that these current problems would not continue in the long term.

Dr. W explained the Global Assessment of Functioning ("GAF") score, which measures the severity of impairment of social, psychological and occupational functions, including how well they adapt to life's problems. A score of 1 to 10 represents the non-functioning, even suicidal individual with 90 to 100 representing superior function, and most people in the 70 to 80 range. He found Mrs. PG scored 50, corresponding to serious symptoms including suicidal ideation, with moderate difficulty in social and occupational functioning.[17]

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[14] Ex 12 Tab 3 Report of Dr. W, May 28 2013 at p. 14
[15] Testimony of Dr. W, Day 4 of Hearing
[16] Ex 12 Tab 3 W, May 28 2013 at p.16
[17] Applicant's Authorities, Tab 18

He found Mrs. PG to have a Major Depressive Disorder of a severe degree[18], which would have significant impact on her ability to cope and on her life in general.

Dr. BM, the physiatrist who reviewed Dr. W's report in assessing Mrs. PG's assessment stated, considered that her accident-induced impairments met the requirements for Catastrophic Impairment according to the *SABS* criteria. He noted that a single "Marked" impairment in any of the spheres of function is sufficient to meet the criteria, and she had two spheres of function "Markedly" impaired plus two spheres "Moderately" impaired. [19]

One year later, Dr. W assessed Mrs. PG again and found serious problems, with her symptoms meeting the criteria for Major Depressive Episode. Despite all the medical interventions, therapy and counselling, the synergistic combination of the pain disorder and depression created a "perfect storm," feeding off each other and producing a catastrophizing cycle. Dr. W testified that, because Mrs. PG had repressed her 5-year-old emotions around her mother's quadriplegia, when her own accident destroyed a layer of protection, these emotions came to the surface. He concluded, based on the information from Mrs. PG and her husband, that psychological factors played an important role in exacerbating the pain in this cycle. The pain was not imagined or fictitious, and had produced a chronic condition for which the prognosis is poor. Dr. W also testified that sleep is extremely important for regeneration, and interrupted sleep can lead to further depression as well as being one of the first symptoms of depression.

Referring to the AMA Guides, Dr. W classified Mrs. PG's impairment of the activities of daily living as moderate. In the category Concentration Persistence and Pace he classified her impairment as moderate (Class 3) as a result of severe depression and the distraction of chronic pain.[20] Classifying her impairment as "Marked" (Class 4) in the categories of social functioning, adaptation and as her global impairment, he stated,

> "Ms. PG is currently disabled from working at her pre-accident or any other occupation. In my opinion given the extent of her depression, chronic pain and cognitive deficits she is substantially disabled from all employment that it is consistent with her education training and experience.
>
> Ms. PG also continues to suffer impairment to her mental and psychological functions…which show no sign of probable recovery. She does not have the memory or organizational kills she was able to utilize before the accident. She suffers from depression which have been exacerbated by what she perceives as an inability to return to her pre-accident condition…"[21]

Counsel for the Insurer argues that Dr. W, in view of his earlier statement that Mrs. PG could not return to work because of the prolonged standing and heavy lifting involved, was inconsistent in his evaluation above. I do not necessarily find this to be the case, as it is just as likely that the two causes were cumulative, rather than mutually exclusive.

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[18] See C Ex 12, Tab 3
[19] Ex 12 Tab 7 Dr. M's Report of June 24 2013 at p. 7
[20] C Ex 12, Tab 4 p 16
[21] Exhibit 12 Tab P page 14, 16

Dr. M, Psychologist

Dr. M received her degree in 1985, registered as a psychologist in 1987, and has a clinical practice specialising in rehabilitation. Many of her clients are victims of motor vehicle accidents, with chronic pain issues. When testifying she referred to her handwritten contemporaneous notes of interviews with Mrs. PG between her initial treatment assessment on March 2, 2012 and March 3, 2015.[22] She continued to treat Mrs. PG between March 2015 until the time of the Hearing.

In the initial interview, Dr. M noted Mrs. PG in a traumatic adjustment, with difficulty coming to terms with the changes in her life and complaints of pain and distress, and "horrid" sleep disturbances not helped by Trazodone because of its side effects. She testified at the Hearing[23] that she found in Mrs. PG a "totally depressed, totally dependent lady who had been very independent and now found it very hard to go from who she was to this." Her view was that depression was Mrs. PG's most serious issue.

Through March she noted that Mrs. PG had expected to feel better but did not. There was no improvement and her back surgery was not healing properly. She was very concerned about the lack of progress and they discussed possible medication changes. Mrs. PG was reluctant to go back on medications as she feared becoming dependent on them.

In May after a month in Arizona, Mrs. PG reported that the dry heat there reduced her pain to some extent, but by June she was again having disturbed sleep and trying different medications, had trouble coping with normal demands and felt very upset about her inability to cope. She knew she could never ride on a motorcycle again for both physical and psychological reasons, and was seeing the effects of her disability on her relationships. She felt there were too many barriers to her enjoying the activities she had done in the past, and this was affecting her friendships. She feared that she was losing a whole part of the life she had had. She was also concerned that despite the surgery, which she had expected to provide an 85% improvement in her condition, she wasn't even at 50%, and she felt hopeless. She mentioned driving for the first time and the anxiety that produced.

Into the autumn, Dr. M noted more sleep problems, and Mrs. PG's perception of a "scary future" with life moving and she not. She noted that Mrs. PG appeared very fragile and vulnerable. Her life had been "on hold for 3 years" and the surgery had not worked. She was facing the fact that she was not getting better. In Dr. M's words, she had "learned" depression from repeated failures to be independent, to enjoy life, to interact with others. She was having panic attacks, and in January was having flashbacks and would wake up screaming.

Dr. M encouraged Mrs. PG to go to Arizona, as she needed something positive to look forward to. However, it was very hard to make the trip and once there she couldn't do things with her husband

[22] Exhibit 10 Tab 13

[23] Testimony of Dr. M, Day 5 of the Hearing

and friends. She felt isolated, excluded, dependent, and anxious. Dr. M's described Mrs. PG as a stoic, and not a complainer. Nevertheless, when the couple decided to sell their Arizona home, she noted that it was a huge loss for Mrs. PG.

In May, Mrs. PG was very stressed by her daughter's wedding, to which she felt she could not contribute as she should. Her doctor had told her the pain would never go away and she could not accept this. She felt she had been "robbed, and was hopeless for the future, was sleeping in the living room on a hospital bed, and needed comfort but was isolating herself from her husband and from normalcy. Dr. M was concerned by the depression and suggested cognitive behavioural therapy in order to stop the catastrophizing which creates a further declining spiral.

The June note mentioned worse back pain, difficulty coping, more limitations, more sleep disturbances, and more "entrenched" in the depressive cycle. Socially, Mrs. PG was feeling more and more isolated and unable to do activities; psychologically, she was not connecting as she used to. Rather than coping with the stress of her condition, she simply just tried to get through the day.

In July Mr. LB went off biking and Mrs. PG said her life had "stopped". Since the accident she had never spent a night alone, and that night slept at her daughter's home, feeling very badly about imposing on her. Dr. M observed that when she does try to do something semi-normal things, she suffers terribly. And Mrs. PG had received news from her doctor that the pain would worsen over time due to arthritis. She was more and more fatigued, deconditioned, isolated, depressed, anxious and finding it harder and harder to go on.

By August Mrs. PG was "running out of the ability to cope" and experiencing passive thoughts of suicide. Her driving anxiety was unabated and she was going to try driver desensitisation. She realised that she had to break up every task, doing part and then resting in between. By the end of the year the pain worsened and Mrs. PG had difficulty putting on winter boots. Dr. L who did the initial driver desensitisation, noted clinically significant levels of catastrophizing and severe depression and anxiety, likely due to post traumatic stress disorder. Using indicators to test if a patient is being candid, Dr. L concluded that there was no evidence of Mrs. PG distorting her profile, but that she might be under-reporting her symptoms. Dr. L assigned a GAF value of 50 with which Dr. M "agrees completely". This was the same value assigned by Dr. W in his report of May 2013.

In February 2014 Dr. M noted "started driving reintegration, Cymbella anti-depressant" and Mrs. PG told her she felt like a mental breakdown, that she wasn't coping with any stress at all, and was overwhelmed by anxiety. In May she was still feeling overwhelmed by people's demands, declining, and experiencing more anxiety and depression. After a more positive period in June where Mrs. PG showed more motivation and seemed more hopeful, she again was depressed, when her husband wanted to go riding and she could not go. By August the pain was exacerbated by nightmares and she even heard people talking to her who were not there. In October, Dr. M noted a worsening of the PTSD, including nightmares and nausea, as Mrs. PG tried to work on her driving fear. She was reliving the accident and the feeling of lying on the road, helpless and in pain. The pain was worse, with bad headaches and she was concerned that this would be the rest

of her life. She was not actively suicidal, but could not cope with the idea that this would go on forever.

By February of 2015 Mrs. PG had switched from morphine to methadone. She had managed to get to Arizona but getting there was hard. She was weepy and seemed to be sadder and sadder. With her husband still away, she had to stay with her daughter, and this was a constant reminder of how disabled and dependent she had become. She was asking herself what was the purpose of her continuing to live. In her last report, of March 2015, Dr. M said she was continuing to treat Mrs. PG for depression, anxiety and PTSD. She testified that her opinion at that time was that Mrs. PG was continuing to decline, her depression was severe, she was socially isolated, and unable to cope with the stresses of her life. "Any stress annihilates her; concerned re suicide." In a telephone session, with Mrs. PG in Arizona she noted that the better weather was easier on the pain, her mood improved and she seemed more stable. Yet travel was excruciating and she still felt isolated. At the Hearing, Dr. M testified that the situation was unchanged, that she was trying to help Mrs. PG to manage her thinking better to avoid the depressive spiral but that she was concerned because of the risk of suicide.

The Insurer's Case

Mr. P, Counsel for E INSURER, called as witnesses Dr. D, a psychiatrist, and Dr. S, Orthopaedic Specialist.

Dr. D, Psychologist

Dr. D obtained his PhD in 1981 at Western University and has been a practising clinical psychologist since then, with appointments at London Health Services Centre. He treats both in and out-patients for medical and neurological disorders and taught until 2010. He now supervises graduate students at Western, but remains an adjunct and plans to do some part time teaching there. He has received many research grants, mostly for his work on epilepsy. He has not concentrated his research on mental disorders or PTSD. All his peer reviewed journal articles relate to epilepsy, although he did his doctoral dissertation on depression, as well as a book chapter in 1980. He estimated the proportion of his practice dealing with brain injuries acquired through trauma at 5% and chronic pain from trauma at 10%.

Mr. L objected to the qualification of Dr. D as an expert witness, and after a brief discussion between counsel, I accepted Dr. D as an expert in psychology, but not as an expert in the fields of trauma-induced brain injuries, chronic pain or depression. Accordingly, his evidence is accepted on that basis and given appropriate weight.[24]

Dr. D assessed Mrs. PG on August 28 2013. His assessment[25] included a review of the documents made available to him, an interview with Mrs. PG, and a series of five tests, to arrive at his

[24] Testimony of Dr. D, on Day 7 of Hearing
[25] Ex 12 Tab Q2

clinical opinion. He referred to his computer-generated report during his testimony.[26] He stated that he did not consider it necessary to interview any other family member, though acknowledging it can sometimes be useful. During his testimony he stated, "I felt confident that her information was clear, consistent and credible. Therefore there was no need to obtain independent corroborative confirmation."

Dr. D referred to tests measuring effort, cooperation and motivation in three areas: memory, negative impression management, and pain profile. Mrs. PG "did well" on the memory section, and had a "good score" on negative impression management, and was within normal limits, not exaggerating her symptoms. A separate test ensures that the information provided by the patient is valid and not embellishing.

Dr. D noted Mrs. PG's depression and moods, concluding that she had symptoms of major depressive disorder and moderate anxiety. His conclusion was based on the administered tests, and self-reporting – her own presentation, and how she described her problems, her apparent ability to function. He described Mrs. PG's depression as mild at that time, considering the stress and frustration of attending the assessments. He noted no panic attacks at the time, although she spoke of "scary dreams". He found her to be intelligent and articulate and "not a complainer".[27]

He concluded that Mrs. PG had no psychological pain disorder, in that psychological problems are not making her pain worse. "She experiences pain, there's no doubt about that." Dr. D found Mrs. PG to be "a credible individual" but that she did not require treatment focused on pain management to help her cope and not feel more pain than she already does.

His conclusions regarding diagnosis and catastrophic impairment included four spheres:

1. Daily living activities – he found no psychological impairment;
2. Social functioning – he found she is still able to interact;
3. Concentration, Persistence, Pace – absent consideration of cognitive status, depression does not detract from these;
4. Ability to function at work and in work-like situations – a mild impairment.

Together these yielded a whole person rating of 5% disability. Thus, he found her Major Depressive Disorder to be at a "Mild" level. This is in marked contrast with all the others who assessed her, including Dr. P who calculated Mrs. PG's impairment at 29%.[28]

Dr. D testified that Mrs. PG's assessment lasted one hour, and that during this hour, a series of five tests was administered in another room. He personally would have spent about half an hour with her. His own notes were typed directly into his computer. When shown a report of Ms. DR, in which the summary was identical to the words in his own report, he stated, "I read the documents that were of particular relevance. They are not my words, they are hers." Also on cross-examination, it became apparent that Dr. D had not seen many of the documents of Mrs. PG's file. His own report listed 72 documents, while Dr. W's report listed 364 reviewed

[26] Ex 12 Q2 Report of Dr. D August 28 2013 at p.20
[27] ibid
[28] Ex 12 Q3 Report of Dr. P August 28 2013 at p.16

documents. He did not have Dr. M's notes, although he did speak with her. In that conversation they did not discuss the details of Mrs. PG's therapy. "I asked her about the focus of treatment and she told me, talk about pain and how she is coping. I didn't ask for details; it was important to know she is getting the treatment to address [her problems]." The tests administered at this assessment did not address PTSD.

Dr. D stated that Mrs. PG was not suffering from PTSD, as she did not appear to meet the symptom-based assessment criteria. On cross-examination, asked about this conclusion, he acknowledged that the accident had exposed her to a dramatic, traumatic experience. He did ask her questions, about it but did not administer any formal test for PTSD. Dr. D agreed with Mr. L that the accident was "a life-changing moment" and that Mrs. PG was not exaggerating. He had not seen the report of Dr. R[29], who had tested her for PTSD and found that she was suffering from it. He stated that he was unaware of Mrs. PG's driving phobia.

In answer to a question from Mr. L, Dr. D testified that he had never taken a course about the AMA Guide, but had read it, perhaps two or three years ago.

I found Dr. D's assessment of Mrs. PG to be remarkable. For whatever reason, he had not seen key documents in her file, he spent a very short time interviewing her, perhaps 30 minutes, did not discuss her case with any of her other treating professionals, and was unaware of some of her complaints. At the hearing, he agreed that he did not have much experience with trauma induced pain and depression, nor with the AMA *Guides* for assessing them. Despite Dr. D's impressive background as an epilepsy specialist, regrettably I am unable to give great weight to his conclusions on trauma-induced depression and its effects.

Dr. S, Orthopaedic Specialist

Dr. S has practiced orthopaedic surgery since 2008 and is on the staff of Queensway Carleton Hospital in Ottawa. He has worked with Bay Medical and Health Services for three years doing independent examinations. He has examined Mrs. PG on three occasions. On June 1 2011[30] he saw her in order to provide an independent evaluation at the request of her insurance company with respect to her eligibility for benefits, and her ability to perform home care, housekeeping duties. He noted her injuries: a broken arm above the elbow, a fracture at T12 (mid to low back), a fracture above the left wrist, and soft tissue injury to her left shoulder. With respect to the last, he had no imaging to show the tear, but observed the soreness of the area.

He agreed that the May 3, 2011[31] assessment of the occupational therapist JH provided a more functional assessment, but observed that Mrs. PG did suffer impairment with difficulty reaching overhead, squatting and lifting. He referred to the report of Bay Medical and Health Services, which concluded, after an in-home assessment, that Mrs. PG did not have an impairment due to the accident but was limiting herself by protecting her injured arm and over-compensating with her right hand, due to fear of re-injury or increased pain. There was however some impairment noted with respect to housekeeping tasks.

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[29] Ex 8 Tab M3
[30] Ex. 6 Tab T2 Report of Dr. S
[31] Ex. 6 Tab C 5 Report of JH

In a follow-up report from January 2013,[32] about a year after the spinal fusion, he observed instability around the fracture, with the cast in place to prevent movement and stabilize the spine. He suggested an assessment by a chronic pain clinic. In his report he stated, "The Claimant has reached maximum medical recovery with regard to her left elbow and wrist. Etiology of the left shoulder pain was unclear." He then added that Mrs. PG had likely reached maximal recovery of her spine and would likely require physiotherapy. He concluded that she did not suffer a complete inability that prevented her from driving or using public transit. He was unaware of her driving phobia, or that she lived in a community without public transport.[33]

Dr. S found no significant change in her shoulder or wrist, except for a slight improvement in the elbow. The trunk however, after the insertion of the titanium rods, is less manoeuvrable, although there is still some motion in the lumbar region. At this point he was of the opinion she had reached a maximum point of recovery. However, there was still chronic pain, necessitating narcotics, which could impair her judgment and make driving unsafe. The narcotics could also impair cognitive function for driving and other activities, although many patients, he said, function very well at home. Still they must be watched carefully. At this time Dr. S found substantial impairment in walking and carrying objects. This was a deterioration from her prior condition.

He formed the opinion that Mrs. PG did not suffer from an impairment resulting in a complete inability to carry on a normal life. "She does however have substantial impairments in her life….She will have difficulty with prolonged standing, walking, carrying, crouching and forward bending.[34]

At the hearing, when questioned by Mr. L, Dr. S testified that he did not have a summary of the law applicable to the provision of benefits, and had no instructions about the definition of "complete inability to carry on a normal life". He stated, "My definition [of "complete inability"] was that the person required constant care, is not able to move on her own." This is not the proper test for catastrophic impairment. Dr. S did not see the films of Mrs. PG's burst T12 fracture, in order to be able to assess its gravity. He acknowledged that his report was to give a sense of the patient's functional abilities, rather than to address social interaction, hobbies, or ability to travel. He did not include in his conclusions any comparison of Mrs. PG's life before and after the accident. He was thus unaware, for example, of the importance of motorcycles to Mrs. PG's social life. He admitted that as he saw her only for three sessions, an hour at a time, he was not in a position to assess her progress on a continuing basis.

During the third assessment, in 2015, Dr. S noted that it was unclear what was causing Mrs. PG's pain. Her shoulder pain was worse and motion had deteriorated. The wrist was better, but her trunk was worse than in the second session.

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[32] Ex. 6 Tab 7
[33] Testimony of Patricia PG at Hearing Day 2
[34] Ex. 8 Tab M4 Report of Dr. S at p. 7-9

The Respondent submits that Mrs. PG's functional limitations arose mainly from her physical limitations and the psychological exacerbations of those limitations affect her in a mild to moderate level only, so that she has not sustained a marked impairment due to a mental or psychological disorder.[35]

Video surveillance

In his cross-examination of the Claimant, Mr. Pshowed surveillance video tapes taken in November of 2012 to Mrs. PG, showing her on a number of occasions walking, riding as a passenger in a car, and on one occasion driving. She is shown attending a medical appointment, eating at a restaurant, shopping, and waving goodbye after a visit from her grandchildren. The video shows her, usually supported or steadied on the arm of Mr. LB, with a slightly awkward gait, grasping things with her right hand and favouring her left which is usually immobile. In a grocery store, she reaches slightly above her head to take a bottle, then replaces it on the shelf. Bending, she moves gingerly and supports herself at times on the shelf in front of her. She exits the store pushing a cart full of bottles with her handbag on top. She does not touch the bottles but enters the car.

The video tapes, from my observation, show that Mrs. PG was able to do some errands, usually with assistance from Mr. LB who usually did the driving, and carried any large packages. All the witnesses who viewed the video, both Applicant's and Insurer's witnesses, testified that nothing in the video changed their previous reported conclusions. The video, while illustrative, did not show anything to contradict the factual testimony of Mrs. PG and those who had assessed her.

Conclusion – Mrs. PG has suffered a catastrophic impairment

Returning to the guidance of the Court of Appeal *Pastore v. Aviva*:

1. *Did the accident cause the applicant to suffer a mental or behavioural disorder?* Dr. G, the psychologist retained by the insurer in the tort action associated with this case, found evidence of pain disorder, with both a physical and a psychological aspects[36]. Dr. M reported Mrs. PG's panic attacks, occasional thoughts about suicide as well as her problems responding to stress. Dr. L, who treated Mrs. PG's driving phobia, found a severe major depressive disorder.[37] Dr. W found the disorder to be severe. Dr. G found the severe major depressive disorder to be moderate. Only Dr. D found the severe major depressive disorder to be a mild form. With respect to Post Traumatic Stress Disorder, Dr. G considered it to be moderate to severe, and both Dr. G and Dr. W considered it to be moderate to severe. Dr. D did not test for it. Dr. G found as well, an unspecified anxiety disorder. Having observed Mrs. PG over the two days she was present in the hearing, and having considered the evidence offered both orally and in the written reports, I am convinced by the evidence that Mrs. PG is suffering from a mental or behavioural disorder as a direct result of the accident.

[35] Insurer's post hearing submission p. 22-21
[36] Ex. 6 Tab 9 Report of Dr. G
[37] Ex. 18

Dr. W, in assessing Mrs. PG's Adaptation, stated that she "does not have the memory or organisational skills she was able to utilize before the accident. He recounted trials of various medications, none of which relieved her pain or depressive symptoms, and her disrupted sleep. Because of the severity of her depression interacting with her pain disorder, Mrs. PG was fragile and could not withstand stress. In his opinion, she would not be able to perform work outside of a shielded environment.[38]Recalling Dr. W's comments at the hearing[39] and considering the weight of other evidence, notably that of Drs. G, M and L , I am persuaded that the level of psychological impairment in Mrs. PG's case is "Marked" (useful functioning impeded) in the spheres of activities of social functioning and in concentration, persistence and pace, with moderate impairment in activities of daily living and adaptation yielding a global impairment rating of "marked". None is totally precluded, but all are to some degree impeded. The AMA *Guides* define marked impairment as significantly impeding useful functioning in a given sphere.

2. *What then is the impact of the disorder on the applicant's daily life?* Mr. L suggests that it was "devastating". As a result of the accident Mrs. PG suffers severe and unrelenting chronic pain, and as a result of that pain, is now deprived of what were the focal points in her life – the social life revolving around motorcycles, her activities such as baking and crocheting, her work in the restaurant, and her ability to care for and be helpful to her family, and her independence and her self-esteem. The pain, the drugs to deal with it and the deprivation of all her favourite activities have resulted in the depression and anxiety Mrs. PG suffers daily. To paraphrase Dr. W, the depression and hopelessness resulting from the realisation that her condition is unlikely to improve have then contributed to exacerbate her pain, in a vicious downward spiral. Rather than feeling better with the passage of time, now six years post-accident Mrs. PG's professional assessors have noted deterioration in her condition.

3. *In view of the impact, what is the level of impairment?*
A marked impairment in any of the four spheres takes Mrs. PG through the CAT gate via subsection (g).As noted above, she has demonstrated a marked impairment in two of the four spheres considered. One is sufficient, according to the law as set out in *Pastore*.[40]

   With respect to her eligibility under subsection (f), the parties have agreed that her level of physical impairment is 29%. This was the level assessed by the panel from SIMAC, including Dr. P, the orthopaedic surgeon who examined Mrs. PG. In the case of *Kusnierz v Economical*, the court decided that a claimant can combine the physical impairment with psychological impairment in order to reach the total of at least 55% WPI.

   How does one translate "Marked impairment" into a percentage that can be combined with the agreed 29% physical impairment? In this case Dr. W had found a 35 to 40 %

[38] Evidence of Dr. W at Hearing Day 4
[39] Ex 12 Tab 3 Dr. W, May 28 2013 at p.16: "[T]he synergistic combination of the pain disorder and depression created a "perfect storm," feeding off each other and producing a catastrophizing cycle."
[40] See note 4 above.

impairment on the psychological side. Using Table 3 (Emotional and Behavioral Impairments) of chapter 4 of the *AMA Guides* as a yardstick, Dr. BM, the physiatrist, working with his own conclusion of a 27% physical impairment, equated Dr. W's 35-40 (conservatively set in the middle of the "marked" range) to a WPI of 55%. For the reasons alluded to earlier, I leave aside Dr. D's outlying assessment of 7% impairment.

Applying the AMA *Guides'* Combined Values Chart, Dr. BM's calculation yields a combined WPI of **55% to 56%, or slightly higher** if one replaces Dr. BM's own assessment of the physical impairment with the slightly higher agreed figure of 29%.

There are other ways of approaching the conversion[41], none of them especially consecrated by the approval of the courts. In Mr. P's post hearing brief, he suggests the use of the *California Method for Conversion of GAF to WPI*. [42]Looking at the GAF scores given by Dr. R (55) Dr. W (50) and Dr. L (50), and citing the California Method Combined Values Chart, Mr. P arrives at a psychological WPI of between 23% and 30%, yielding a maximum combined WPI score of 50%, below the 55% minimum. However, given that doctors called by both parties used the *AMA Guides*, and the use of the California Method was never discussed during the hearing, either between counsel or with the medical witnesses, I see no reason for invoking it now. Neither Dr. W, Dr. BM nor Dr. D used it in their calculations. Given the admonition of the Court of Appeal to give the concept of catastrophic entitlement an inclusive and not a restrictive meaning, it is appropriate in a case of slightly differing results to use the more generous calculation.

As a result, I find on a balance of probabilities that the combined impact of the physical and psychological impairment of Mrs. PG resulting from the accident is between 55% and 57%, which is sufficient to satisfy the criteria of the *SABS* subsection (f).

As a consequence I find that Mrs PG has suffered a catastrophic impairment within the meaning of *SABS.* As a result, she is eligible to advance her claims for medical and rehabilitation benefits in excess of the usual $100,000 limit. Following is the analysis of her claims.

Is the Claimant entitled to non-earner benefits?

Mrs. PG is seeking non-earner benefits for the period between May 17, 2011 to January 3, 2012 (when she underwent spinal surgery), in the amount of $185 per week, for 33 weeks, a total of $6,105. She is also seeking non-earner benefits for the period from December 2, 2013, when the Insurer terminated her non-earner benefits, and ongoing. As of end of April 2016, this latter period claimed would yield $185 for 122 weeks, or $22,570, for a total of $28,675.

The Respondent takes the position that at the relevant times, Mrs. PG did not suffer from "a complete inability to carry on a normal life", an impairment which continuously prevents the

[41] As Mr. P points out at page 21 of the Insurer's post hearing submission, to quote Arbitrator Huberman, there is no specific methodology required by statute for converting mental and behavioural impairments into SABS ratings. Arbitrator Feldman in fact lists six such methods.
[42] Tab 6 Insurer's Brief of Authorities

person from engaging in substantially all the activities [she] ordinarily engaged in before the accident.

Unsurprisingly, Claimant takes the opposite positon.

Mr. P has again very helpfully pointed to the guidance of the Court of Appeal in the case of *Heath v. Economical Mutual Insurance Company.*[43] To paraphrase the Court, the starting point is to compare the claimant's activities and life circumstances before the accident to his or her activities and life circumstances after the accident. This requires more than a "snapshot" of the claimant's life immediately preceding the accident, but involves an assessment of the claimant's activities and circumstances over a reasonable time prior to the accident. It is up to the claimant to establish that she is continuously prevented from engaging in substantially all of her pre-accident activities, that is an incapacity which is serious enough to meet the criteria of the statute, and is and remains uninterrupted. "Engaging in" an activity is more than an isolated attempt, and the quality of the post-accident performance must be considered.

The Insurer terminated non-earner benefits in May 2011 after in-home assessment and functional assessments by occupational therapists Mc and Ga, who concluded that Mrs. PG had the ability to perform all of her pre-accident self-care, housekeeping and maintenance tasks. They also noted that she was not completely prevented from driving or from using public transportation. Her movements were reduced, but within normal range. Dr. S noted the decreased function of the left shoulder and spine, but this did not in his opinion qualify as a complete inability to carry on a normal life. Dr. K also stated that she did not suffer from a complete inability to carry on a normal life.

The Insurer re-instated benefits at the time of Mrs. PG's spinal surgery, and then terminated them in December 2013, about a year later, after re-assessments by Dr. R, Dr. S and occupational therapist Wi. Drs. R, S and K found that she did not suffer a complete inability to carry on a "normal life." Mr.Wi's report was inconclusive. Benefits were terminated as of December 2, 2013.

The difficulty in this case arises because the experts who assessed Mrs. PG had in mind the concept of "a normal life", while the Court of Appeal uses the yardstick of active participation in pre-accident activities. A "normal life" is a subjective concept, while the Court of Appeal has established a somewhat more objective, observable standard. The answer will to a great extent be determined by the question asked.

Let us suppose for a moment that prior to the accident, Mrs. PG's "normal life" had consisted of getting up in the morning, showering and brushing her hair, having a leisurely breakfast prepared by her husband, picking up a couple of small grocery items at a store close to home, and then several hours of television or reading or a bit of crochet, and chatting by phone with her daughter, grandchildren or friends. Dinner would again be prepared by her husband, at her direction, and then she would retire alone to sleep in her own bed. In such a case, clearly the accident would not have prevented Mrs. PG from living "a normal life"; post-accident she was not prevented from

[43] *Heath v. Economical* 2009 ONCA 391, at para 50

performing these personal, homemaking and social pre-accident activities. Effectively, in this hypothetical case, the post-accident activities would be the same, or nearly the same, as those engaged in prior to the accident and the "disability" less obvious. Anyone looking at her would say that Mrs. PG was living a "normal life". This was the stated standard applied by the professionals assessing Mrs. PG.

That however, is not exactly what the Court of Appeal has directed us to consider. We have a different standard to apply. Before the accident, Mrs. PG was an active, independent, outgoing and social person with a passion for motorcycles. Objectively speaking, what pre-accident activities have been continuously impaired or prevented, and how important was each of these activities to Mrs. PG? And what is a reasonable time period for which to consider these activities?

In the following chart is a list of the pre-accident activities in which Mrs. PG participated, drawn from Mrs. PG's testimony and behaviour, and from the notes of those treating and assessing her. It summarizes my findings regarding the degree of prevention and the importance of each activity. Degree of prevention is shown by "x "for mildly disabled through "xxxx" for total prevention from meaningful participation, and the level of importance to Mrs. PG shown by " *" for low importance through "****" for critically important to her. It is important to note that the chart covers physical disabilities, and with the exception of the driving phobia, does not include the psychological elements of Mrs. PG's disability referred to earlier.

Pre- Accident Activity	**Degree of prevention**	**Importance to Mrs. G.**	**Comments**
Self-care, hygiene	X	***	Important for independence, dignity. Now fairly self-sufficient but needs help with hair
Gardening	XXXX	*	No home garden for several years prior to accident
Baking	XXX	***	No longer an income job, but still an enjoyable hobby and way to contribute to family. Distress at not being able to decorate daughter's wedding cake after being "famous" for her cakes
Family Life and Playing/caring for children	XXX	****	Had run a day care, and loves children. Cannot physically play with grandchildren; cannot assist her daughter with caring, or be left alone

			with them in case of emergency.
Work at Le Gourmet	XXXX	****	Complete inability to work as before. Misses the social interaction and income from seasonal work. Had worked the summer before the accident and planned to return the summer following the accident.
Housekeeping and maintenance	XXX	**	Able to do light housekeeping but nothing heavy like painting, shovelling, yard work. "Left arm is still no use to me."
Cooking	XXX	****	Cannot stand for long periods, lift heavy dishes. Able to do some cooking with assistance, or supervises husband who cooks.

Grocery shopping	XXX	***	Shopping inhibited by driving phobia and by inability to reach/lift /carry. Needs help.
Finances	N/A	***	Sedentary, no prevention, but difficulty concentrating
Knitting and crochet	XX	**	Pain prevents her from enjoying this former pleasant hobby which also was a contribution to family and friends
Travel	XX	****	Travel curtailed due to pain, inability to sit for long periods. Arizona house sold as it was "too much".
Socializing with friends	XXX	****	A very outgoing person who enjoyed entertaining friends and going out dancing swimming, to gym etc. Now feels

			isolated, lonely because of inability to participate actively in former social activities.
Motorcycling	XXXX	****	The focal point of her relationship with her husband and their social groups in Ontario and Arizona. Her inability to participate destroyed her former social network of social activities and connections.
Physical intimacy	XXX	****	Pain interferes; for a year the spouses could not even sleep in the same room. Husband's expectations, marital stress; a "life-altering change" in relations.
Personal autonomy	XX	****	Formerly active, engaged "take charge" now isolated, reduced to passive role. Cannot spend nights alone for safety reasons. Pain medication side effects. Physical and cognitive limitations, pain medication side effects, driving phobia preclude the independent, active life she enjoyed pre-accident and have impaired her self- esteem.

The Court of Appeal in deciding whether the necessary threshold has been satisfied, says that all of the pre-accident activities in which the claimant ordinarily engaged should be considered, but greater weight may be assigned to those activities which the claimant identifies as being important to his/her pre-accident life. The Court speaks of inability to participate in "substantially all," of pre-accident activities. This I interpret to include most, but less than 100% of her pre-accident activities.

Drawing on this guidance, and in light of the circumstances set out in the chart above, I find that the Claimant, over the six years since the accident, has suffered from the inability to engage in

substantially all of the pre-accident activities which were most important to her, and which defined her as a person and provided the focal points in her family and social life. I therefore find that she is entitled to the non-earner benefits as claimed, for the periods from May 17, 2011 to January 3, 2012 and from December 2, 2013 to the date of this award, and ongoing.

Is the Claimant entitled to medical and rehabilitation benefits?

The major point of contention under this heading is the claim for a king-sized bed with electric controls on one side. This was recommended by Ms. M in 2012, and the Insurer did recognise the need for a special bed, but would only approve the cost of a rental bed.[44] The Insurer paid out over $2500 for a rental bed. Ms. M testified that rental beds are of inferior quality as they are designed for short term use. [45] Mrs. PG's doctors have told her that she has reached maximum recovery and that the pain, far from diminishing, will probably worsen over time due to arthritis. That being the case, it is reasonable to assume that she will require the special bed for the rest of her life. Ms. M repeated her recommendation in 2013. After nearly a year of her sleeping on a single bed in the living room Mrs. PG and her husband cobbled together a solution with an electric bed and a regular single. They can sleep in the same room, but it is not unreasonable for the spouses to want to be in the same bed, to preserve whatever intimacy is possible in light of her chronic pain. I therefore find that the bed was a reasonable and necessary expense, and award the sum of $5000. The claim set out in the Application for Arbitration[46] was for $8256.74. However the balance of this amount has not been explained; the Claimant has not met the burden of proof to prove that this amount was reasonable and necessary. Consequently, the sum of $3,256.74 is denied.

Mrs. PG also claimed the amount of $140 for massage therapy by SG in Arizona. This was refused by the Insurer on the basis that it had not been approved in advance. This claim is denied.

Mrs. PG claimed the amount of [47] $1825.23 for a Treatment and Assessment Plan by JH dated June 8, 2011 to determine her occupational therapy needs. This was refused by the Insurer on the basis that it duplicated the assessment done by Ms. Ga and Ms. Mc in the previous month. [48] In fact the two reports are not duplicative, as they reach rather different conclusions. Ms. Mc and Ms. Ga found Mrs. PG's strength at "below sedentary", yet stated she might be self-limiting and that there was NO medical functional limitation.[49] One month later, Ms. JH answered YES in Part 8, Activity Limitations, in tasks of employment and activities of normal life.[50] The fact that the two assessments were close together in time but quite different in their observations, leads to the conclusion that the expense of the second opinion was reasonable and necessary.

[44] Ex 7 Tab 2, Letter from E INSURER of June 11, 2012
[45] Testimony of M at Hearing Day 3
[46] Ex 1 Tab A6j
[47] Ex 1 Tab C12 Treatment and Assessment Plan June 8, 2011
[48] Ex 1 Tab E1, Assessment done in May but completed June 27, 2011
[49] Ex 7 Tab K9 Report of May 8, 2011
[50] Ex 1 Tab C12 OCF-18 of June 8, 2011

Mrs. PG claimed physiotherapy expenses[51]provided by AC, in a treatment plan dated November 11, 2012, for $904.10 not covered by her collateral insurer SL and an additional $4944.90 in miscellaneous expenses. The Insurer agreed to cover and did pay the $904.10, and requested details of the $4,944.90 miscellaneous expenses. The sum of $4,944.90 was to cover Ms. AC's travel time of nearly 20 hours and automobile mileage. I do not find this expense reasonable, as there was no evidence before me that Mrs. PG was unable to travel to receive her treatments. Mrs. PG has not satisfied the burden of proving these expenses were necessary. Accordingly, I make no order in regard to $904.10 and deny the claim for $4,944.90.

Is the Claimant entitled to a special award?

The Claimant requested a special award, but did not pursue this issue or provide any particulars of reasons to justify a special award. The arbitrator has discretion to make a special award in cases where an Insurer has unreasonably withheld payment. Although it has been six years since the accident, and Mrs. PG has been successful in her claims, the issue of catastrophic impairment was genuine, and I do not consider the conduct of the Insurer to be unreasonable so as to warrant a special award. I thus make no order in this regard.

Is Mrs. PG entitled to interest on the amounts awarded?

The law entitles a successful applicant to interests on amounts awarded. The date of Mrs. PG's accident was March 17, 2010. Subsection 46(2) of the 1996 *SABS* (Ont. Reg. 403/96) required interest on overdue amounts at 2% per month, compounded monthly. Interest under the *Schedule* is recognized to be remedial, rather than punitive, and is intended to discourage insurers from delaying payment.[52] The interest rate is set by the date of the loss, not by the date the amount became overdue.[53] Therefore, for any accidents prior to Sept. 1, 2010 interest is calculated for each day the amount is overdue at 2% per month, compounded monthly, no matter when a specific benefit becomes overdue.

EXPENSES:

The Claimant has been successful in most issues, especially in the major issues of this arbitration, and I therefore see no reason that she should not have her expenses, having regard to the criteria set out in ss. 75.2 of the Dispute Resolution Practice Code. The Parties have not submitted any evidence or argument on their expenses. Rather than delay the publication of this award, I invite

[51] Ex 7 Tab 1

[52]*Attavar v. Allstate Insurance Company of Canada*

[53]*Federico vs. State Farm Mutual Automobile Insurance Co.*FSCO 1024 and *Subramaniam and Wawanesa* FSCO 3858.

the Parties to agree on a reasonable amount for the Applicant's expenses, failing which they may apply for an assessment under Rule 79 of the *Dispute Resolution Practice Code.*

Louise Barrington Arbitrator	Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

BETWEEN:

PG

Applicant

and

E INSURER

Insurer

ARBITRATION ORDER

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

1. Mrs. PG has sustained a catastrophic impairment as a result of the accident.
2. Mrs. PG is entitled to receive non-earner benefits for:

   -the period between May 17, 2011 to January 3, 2012 in the amount of $185 per week, for 33 weeks, a total of $6,105; and for

   -the period from December 2, 2013 to the date of this award, being 122 weeks, at $185 per week, totalling $22, 570, (Total NEB $28,675) and ongoing.
3. Mrs. PG is entitled to receive a rehabilitation benefits of $1,835.23 for an occupational therapist's assessment, and $5,000.00 for a hospital bed, and $5,849.23 for physiotherapy.
5. The following claims are denied:

   - medical benefit of $140 for massage therapy; and
   - medical benefit of $4,944.90 for physiotherapist's travel time mileage.

6. E INSURER is not liable to pay a special award.

7. Mrs. PG is entitled to interest at the rate of 2% per month, compounded monthly, from the date each specific benefit became overdue until the date of this award.

8. The Applicant is entitled to her reasonable expenses of the arbitration. If the parties are unable to agree on the entitlement to, or quantum of the expenses of this matter, the parties may request an appointment with me for determination of same in accordance with Rules 75 to 79 of the *Dispute Resolution Practice Code.*

Louise Barrington
Arbitrator

Date: