Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

Ontario

FSCO A07-000297

BETWEEN:

DEAN FOURNIE

Applicant

and

COACHMAN INSURANCE COMPANY

Insurer

REASONS FOR DECISION

Before: Lloyd (J.R.) Richards

Heard: April 20, 21, 22, 23, May 25, June 15, 2009, in London, Ontario.

Appearances: Rodney Dale and Matthew Dale for Mr. Fournie
Jamie Pollack and Stacey Morrow for Coachman Insurance Company

Issues:

The Applicant, Dean Fournie, was injured in a motor vehicle accident on August 11, 2004. He applied to Coachman Insurance Company ("Coachman") for a Determination of Catastrophic Impairment under the *Schedule*.[1] Coachman concluded that Mr. Fournie did not suffer a catastrophic impairment as a result of the motor vehicle accident on August 11, 2004. The parties were unable to resolve their disputes through mediation, and Mr. Fournie 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 issues in this hearing are:

1. Has Mr. Fournie suffered a catastrophic impairment as defined by paragraph 2(1.2) (f) of the *Schedule*?

2. Has Mr. Fournie suffered a catastrophic impairment as defined by paragraph 2(1.2) (g) of the *Schedule*?

3. Is Coachman liable to pay Mr. Fournie's legal expenses in respect of this hearing, pursuant to subsection 282(11) of the *Insurance Act*?

4. Is Mr. Fournie liable to pay Coachman's legal expenses in respect of this hearing, pursuant to subsection 282(11) of the *Insurance Act*?

Result:

1. Mr. Fournie has suffered a catastrophic impairment as defined by paragraph 2(1.2) (f) of the *Schedule*.

2. Mr. Fournie has suffered a catastrophic impairment as defined by paragraph 2(1.2) (g) of the *Schedule*.

3. Mr. Fournie and Coachman may speak to me on the issue of expenses.

BACKGROUND

Mr. Dean Fournie is presently a 45 year old man who sustained injuries to his left heel and ankle as a result of a motor vehicle accident. On August 11, 2004 Mr. Fournie rode his bicycle to Petrolia from his home in Sarnia. This is some 30 kilometres away. While riding his bicycle back to Sarnia from Petrolia, Mr. Fournie was struck from behind by a pickup truck. He broke his left heel as well as his left ankle and left thumb and lost some teeth. He also suffered extensive bruising.

Mr. Fournie claims that he suffered a catastrophic impairment from the injuries he sustained as a result of the motor vehicle accident on August 11, 2004.

THE LAW

In determining whether Mr. Fournie suffered a catastrophic impairment he was assessed under section 2(1.2), paragraphs (f) and (g) of the *Schedule* as set out below:

> 2(1.2) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs after September 30, 2003 is,
> ...
> (f) subject to subsections (1.4), (2.1) and (3), an impairment or combination of impairments that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993, results in 55 per cent or more impairment of the whole person; or
>
> (g) subject to subsections (1.4), (2.1) and (3), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder.

The *Schedule* requires catastrophic impairments to be evaluated according to the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993 (the "*Guides*"). The *Guides* are a series of peer reviewed chapters, dealing with different organ systems, compiled by the American Medical Association to "bring greater objectivity to estimating the degree of long-standing or 'permanent" impairments.'"[2] Each chapter allows an assessor to translate impairments relating to each organ system into a percentage rating. After each impaired organ system is assessed and assigned a percentage rating, the assessor or assessors use a chart in the *Guides* to combine the percentages to calculate a Whole Person Impairment ("WPI"). The chart in the *Guides* does not provide for a straight addition of the percentages, but rather combines the percentages to reflect a more holistic view of how organ systems work together and how impairments reflect overall functioning. When combining

[2] American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th Edition, 1993, foreward.

impairments according to the chart, it would be impossible to have a WPI greater than 100%. In fact, any WPI close to100% would be a near death state.

Chapter 3 of the *Guides* deals with the Musculoskeletal System. In particular, section 3.2 addresses The Lower Extremity.

Chapter 4 of the *Guides* addresses The Nervous System. Chapter 4 assigns WPI ratings based on permanent impairments resulting from dysfunction of the brain, brain stem cranial nerves, spinal cord, nerve roots, and peripheral nerves. These are all impairments relating to brain injuries. Chapter 4 notes that brain injury impairments are very closely related to mental and emotional processes.

Chapter 14 of the *Guides* addresses Mental and Behavioural Disorders. These are mental disorders and behavioural impairments that may complicate any given condition. Chapter 14 does not assign WPI ratings, but rather looks at four areas of functioning, being:

- Activities of daily living;
- Social functioning;
- Concentration, persistence, and pace; and
- Deterioration or decompensation in work or worklike settings.[3]

"*Activities of daily living* include such activities as self-care, personal hygiene, communication, ambulation, travel, sexual function, sleep, and social and recreational activities."[4] An assessor is to assess not just the number of activities that are limited, but the overall degree of restriction or combination of restrictions. In assessing *social functioning* an assessor determines "…an individual's capacity to interact appropriately and communicate effectively with other individuals…. It is not only the number of aspects in which social functioning is impaired that is significant, but also the overall degree of interference with a particular aspect or combination of

[3] This area of functioning is often referred to as "adaptation".
[4] *Guides*, p. 294

aspects."[5] *Concentration, persistence, and pace* "refer to the ability to sustain focused attention long enough to permit the timely completion of tasks commonly found in work settings."[6] "*Deterioration or decompensation in work or worklike settings* refers to repeated failure to adapt to stressful circumstances. In the face of such circumstances the individual may withdraw from the situation or experience exacerbation of signs and symptoms of a mental disorder; that is, decompensate and have difficulty maintaining activities of daily living, continuing social relationships, and completing tasks."[7]

Instead of a percentage rating, Chapter 14 utilizes a classification table, assigning a "class of impairment" to each of the four areas of functioning, outlined as follows:

Class 1	–	no impairment.
Class 2	–	mild impairment, meaning the impairment levels are compatible with most useful functioning.
Class 3	–	moderate impairment, meaning the impairment levels are compatible with some, but not all, useful functioning.
Class 4	–	marked impairment, meaning impairment levels significantly impede useful functioning.
Class 5	–	extreme impairment, meaning impairment levels preclude useful functioning.[8]

The *Guides*, therefore, address impairments resulting from brain injury as well as from mental illnesses. Under the *Schedule*, an individual suffering from a "mental or behavioural disorder of Class 4 or Class 5" is considered catastrophically impaired. Although it is now settled law that mental or behavioural impairments can be combined with physical impairments to arrive at a WPI,[9] the *Guides* do not provide a mechanism to translate "Class" ratings into a percentage rating. This proves to be problematic. For example, an applicant might not meet the Class 4 or Class 5 definition of mental or behavioural disorder, but rather be classified as a Class 2 or 3.

[5] *Guides*, p. 294
[6] *Guides*, p. 294
[7] *Guides*, p. 294
[8] *Guides*, pp. 300-301
[9] *Desbiens v. Mordini* 2004 CanLII 41166 (ON S.C.), para. 252

However, the applicant might assert that when the mental or behavioural impairment class is combined with some other organ system impairment, the combined impairments meet the 55% or higher WPI threshold for catastrophic impairment. Some assessors address this issue by drawing a comparison between the mental and behavioural class ratings from chapter 14 of the *Guides* to the percentage ratings assigned to nervous system impairments in chapter 4 of the *Guides*.

PROCEDURAL MATTERS

Mr. Fournie and Coachman submitted numerous documents for my consideration. For ease of reference I marked the parties' document briefs as follows:

> Arbitration Document Brief of the Applicant - Exhibit "A"
> Curriculum Vitae Brief – Exhibit "B"
> Respondent's Arbitration Brief – Exhibit "C"

Within each of the above listed document briefs I marked submissions as exhibits as they were referred to during the hearing. Any submissions not specifically marked as exhibits do not form part of the record of this hearing.

In addition, all experts who gave evidence in this hearing were qualified and accepted as experts by Mr. Fournie and Coachman.

EVIDENCE AND ANALYSIS:

Physical Injuries

Mr. Fournie's position is that he requires two crutches and a short leg brace for pain relief, balance, stability and safety. According to Mr. Fournie, the *Guides* dictate that the WPI for an individual who routinely requires the use of two crutches and a short leg brace is 50%. In addition, Mr. Fournie contends that additional WPI amounts of 5% for skin disorder and 2% for adjustment disorder should be afforded him, thereby placing him within the range to be declared catastrophically impaired. Mr. Fournie also argues that he is catastrophically impaired by virtue

of his psychological impairments. Furthermore, if his physical impairment rating is combined with his psychological impairment rating, his whole person impairment rating easily exceeds the 55% threshold.

Coachman's position is that Mr. Fournie suffers from impairments to one lower extremity and that the *Guides* assign a 40% maximum WPI to such impairments. Coachman posits that in order for Mr. Fournie to surpass the 40% maximum WPI, he must have sustained bilateral impairments to his lower extremities. Further, the use of a brace and bilateral arm crutches is not sufficient for Mr. Fournie to surpass the 40% maximum. In addition, Coachman argues that Mr. Fournie is not catastrophically impaired by virtue of his psychological impairments and that even if his psychological impairments were to be combined with his physical impairments, his WPI would not meet the 55% threshold.

Dr. David Sanders, Steven Trujillo and Dr. Patrick Potter presented evidence on behalf of Mr. Fournie. Dr. Arthur Ameis, the clinical coordinator of the Multidisciplinary Assessment Centre ("MDAC"), and Demetrios Kostadopoulos gave evidence on behalf of Coachman.

Dr. David Sanders[10] treated Mr. Fournie at Victoria Hospital after the August 11, 2004 motor vehicle accident and stated that Mr. Fournie's lower leg injuries ranked among the three worst injuries he had witnessed in 10 years of practice. Dr. Sanders recalled that Mr. Fournie had fractured, among others, his calcaneous bone, which is the primary weight bearing bone in the lower body. According to Dr. Sanders, the swelling that arises as a result of injuries usually takes 10 days to 2 weeks to go down. However, Mr. Fournie's ankle swelling took approximately 4 weeks to go down after the accident. This, in his opinion, indicated more bone and soft tissue damage than an ordinary fracture. Dr. Sanders reconstructed Mr. Fournie's ankle and testified that his reconstruction was not successful as few of the bones in the joint were recognizable and the left ankle was "hopelessly fragmented." Dr. Sanders stated that Mr. Fournie's entire weight bearing on the left side of his body is now on a small spike of bone. This spike is not found in the normal course but grew during the healing process.

[10] Dr. Sanders is clinical associate professor at the London Health Sciences Centre, Victoria Hospital. He is an orthopaedic surgeon who specializes in lower leg and foot trauma. His report is at Tab 1 of Exhibit "A" (marked as exhibit 5).

Dr. Sanders further testified that Mr. Fournie's gait now causes him to walk on the outside of his foot. Mr. Fournie has atrophying, peroneal muscles[11] that are out of position, almost no side to side motion in his ankle and a limited ability to move his left foot up and down. In Dr. Sanders' opinion, it is obvious that Mr. Fournie should take the weight off his left ankle by using a cane and brace. It was Dr. Sanders' opinion that Mr. Fournie needs two crutches. On cross-examination, however, Dr. Sanders stated that he does not normally prescribe canes, nor does he recall ever prescribing canes. In his opinion, it is within the purview of an occupational therapist to prescribe canes.

Steven Trujillo[12] has been an occupational therapist since 1971. He assessed Mr. Fournie by means of a three and a half hour functional abilities assessment on September 4, 2007. This is more than three years after the accident. Mr. Trujillo stated that Mr. Fournie requires two crutches for standing balance. He explained that when an individual has a foot that can only accomplish partial weight bearing, then that individual's stability requires a three point crutch pattern. In his opinion, walking is defined as losing and regaining balance and Mr. Fournie is at a disadvantage because he cannot rely on his left ankle. In addition, he opined that two crutches produce symmetry between the right and left sides of the body. In explanation he stated that it is better to carry 25 kilograms in each hand than 50 kilograms in one hand. He also stated that when using one crutch the disabled can carry the crutch up to 60° away from the body, leading to leaning over, which is particularly dangerous on slippery or loose gravel surfaces.

Dr. Patrick Potter[13], a physiatrist, examined Mr. Fournie on January 24, 2007. Dr. Potter spoke extensively about the effects of Mr. Fournie's walking pattern on the rest of his body. Dr. Potter stated that crutch use leads to forearm pain and shoulder pain because of support issues. With the use of crutches, back and neck pain are also common. Given Mr. Fournie's injuries, Dr. Potter recommended that Mr. Fournie put his injured foot into an orthotic (Dr. Potter recommended a Patellar Tendon Brace or "PTB", also called an Ankle Foot Orthosis or "AFO") to de-load his

[11] These are the muscles situated at the upper part of the lateral side of the lower leg.

[12] Steven Trujillo has his graduate certificate in occupational therapy and is a Professor in the Faculty of Health Sciences at the University of Western Ontario.

[13] Dr. Potter is a physiatrist at St. Joseph's Health Care London, Parkwood Site. His report is at Tab 2 of Exhibit "A" (marked as exhibit 13).

injured foot and allow him to stand and walk for short distances without crutches. Dr. Potter recommended that Mr. Fournie attempt the brace to promote a small amount of independence. According to Dr. Potter, two other options for Mr. Fournie would be amputation or a wheelchair. Dr. Potter is of the opinion that nothing further can be done to change Mr. Fournie's impairment and the obvious recourse is to accommodate the impairment.

In the opinion section of his report[14], Dr. Potter accepts that Mr. Fournie needs to walk with two crutches. He states "…it is probable that Mr. Fournie has experienced a permanent and severe impairment of the left foot and ankle function." In accordance with the *Guides*[15], Dr. Potter puts Mr. Fournie's impairment at 40% because of his need to ambulate using two crutches. At the hearing, Dr. Potter noted that since his assessment, Mr. Fournie had been prescribed a brace[16], and therefore according to the *Guides* a WPI for the use of two crutches and a brace is 50%. Dr. Potter went further and noted that from Mr. Fournie's medical records that he reviewed in his initial assessment, he would assign a further 4% WPI for Mr. Fournie's skin irritation and 2% WPI for pain. This would lead to a total WPI of 53%. The *Guides* allow that a final WPI may be rounded to the nearest values ending in 0 or 5.[17] In this case, Mr. Fournie's WPI of 53% rounded up would be 55%.

Mr. Fournie was assessed by assessors at MDAC as part of the determination of whether he is catastrophically impaired. In the executive summary of MDAC's report[18], the clinical coordinator states that each assessor prepares an individual report. He further states that at the end of the necessary data accumulation process, the assessors, with the assistance of the clinical coordinator, formulate a set of final, consensus conclusions about all identified impairments. The executive summary states that "the assessors formed the final consensus opinion that the Applicant's traumatic impairment is <u>not</u> a Catastrophic Impairment."[19]

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[14] Exhibit 13, p. 14

[15] Chapter 3, Table 36, p. 76

[16] Rehab First consultation reports found at Tab 6 of Exhibit "A" (pages 1 -11 and 53 -55 are marked as exhibit 4). Ms. Martha Korzycki, Occupational Therapist, in consultation with Dr. Potter, eventually prescribed a calf corset brace for Mr. Fournie instead of the PTB. Her rationale is that PTBs lead to instability in knee support over time and that Mr. Fournie's needs would be better served by offloading his weight into his calf area.

[17] *Guides*, p. 9

[18] Found at Tab 4d of Exhibit "C" (marked as exhibit 25)

[19] Exhibit 25, p. 2

Dr. Johnstone MacCallum[20]completed a report[21] on Mr. Fournie, dated August 10, 2006, as part of MDAC's assessment. Dr. MacCallum did not give evidence at the hearing. His report notes that at the time of assessment Mr. Fournie had significant atrophy of the muscles of the left leg.[22] Dr. MacCallum also reports that Mr. Fournie's complaints include "limited ambulation requiring bilateral axillary crutches" and "multiple anatomically distant musculoskeletal complaints, likely related to altered mechanics as a result of the utilization of crutches."[23] He further reports that Mr. Fournie is "below the sedentary level for strength."[24] Dr. MacCallum does not assign a WPI percentage to Mr. Fournie, but rather leaves the determination of Mr. Fournie's possible catastrophic impairments to what he terms "the consensus development process that will integrate all of the clinical findings, leading to a summary, catastrophic impairment report."[25] In my view, this means that Dr. MacCallum did not develop an opinion about whether Mr. Fournie is catastrophically impaired. Instead, he deferred forming an opinion to a time when MDAC was to arrange a consensus meeting.

Dr. Arthur Ameis[26] is the clinical coordinator for MDAC and he gave evidence at the hearing. He stated that he has been practising since 1979 and has been using the AMA Guides for 20 to 25 years. Dr. Ameis gave evidence that he coordinates the summary of the reports sent to him by the various assessors. He stated that in Mr. Fournie's case he spoke to each practitioner and asked what their information meant. He maintained that the opinions in the executive summary are not solely his own. He stated that he had a discussion with Dr. MacCallum about Mr. Fournie's gait derangement. The *Guides* describe gait derangement as a component of many different types of lower extremity impairments and refers to full-time derangements of persons who are dependent on assistive devices.

[20] Dr. MacCallum is a physiatrist at St. Joseph's Health Centre in Guelph.
[21] Tab 4b of Exhibit "C" (marked as exhibit 19)
[22] Exhibit 19, p. 5
[23] Exhibit 19, p. 8
[24] Exhibit 19, p. 8
[25] Exhibit 19, p. 9
[26] Dr. Ameis has a staff appointment to North York Branson Hospital. He is the consulting physiatrist to a number of clinics and hospitals. His curriculum vitae is exhibit 24.

At the hearing, Dr. Ameis spent some time explaining the difference between using the Diagnosis Based Estimate portion of the *Guides* at section 3.2i and using the Gait Derangement section at 3.2b when assessing impairments. In determining the extent of impairments a practitioner has a number of options. One option is to use a Diagnosis Based Estimate, seen at section 3.2i of the *Guides*, which refers to assessments where impairments are rated based on a diagnosis derived from objective, observable criteria such as x-rays. Another option is to use the Gait Derangement table, seen at section 3.2b of the *Guides*. The Gait Derangement table differs from the Diagnosis Based Estimate section in that the Gait Derangement table relies on an assessor engaging in an examination or assessment of an individual to determine impairment. Dr. Ameis suggested that the Diagnosis Based Estimate section of the *Guides* assigns a maximum WPI of 40%. The Gait Derangement table does not appear to have a 40% maximum. Under cross-examination, Dr. Ameis stated that he "does not disagree that the pathological process here is severe, requiring the use of Table 36", which is the Gait Derangement table. Dr. Ameis went on to state he believes as a general rule that the ceiling on single, lower limb impairments is 40%. He derives this opinion from reading page 75 of the *Guides*.[27] It is his opinion that a maximum of 40% WPI is to be assigned for the amputation of one leg. If a WPI of 40% or greater is to be assigned, then an individual would need to have impairments in both lower limbs. The MDAC executive summary notes that using the Gait Derangement table Mr. Fournie's WPI is 20% because, even though Mr. Fournie uses two crutches, the orthopaedic disorder in question does not require two crutches. [28] In addition, MDAC assigned 5% WPI for skin scarring and 2% WPI for unaccounted for pain,[29] leading to a final WPI of 26%.

I have two concerns with MDAC's assessment of Mr. Fournie. Firstly, there was no evidence presented at the hearing to indicate that the MDAC assessors had consulted on the final opinion, had seen the executive summary or, in fact, agreed with the final opinion. The executive summary and final report did not indicate that the individual assessors had signed off on it. Dr. Ameis, who is the controlling mind behind MDAC, stated that before completing the executive summary he did not consult with the psychiatrist or occupational therapist who

[27] Page 75 explains that the maximum WPI for an above knee amputation of 1 leg is 40% and the maximum WPI for the amputation of 1 leg and hip is 50%.
[28] Exhibit 25, p. 7
[29] Exhibit 25, p. 8

assessed Mr. Fournie for MDAC. He gave evidence that he had consulted with Dr. MacCallum, but could not remember where or when and would not be able to provide proof of a consensus meeting with him. He gave evidence on cross-examination that he did not consult with the psychiatrist or occupational therapist when determining Mr. Fournie's final WPI percentage. Demetrios Kostadopoulos, the occupational therapist who gave evidence for Coachman, stated that he did not know if his assessment was provided to subsequent assessors. Furthermore, he was not provided with other assessors' reports, nor did he have any recollection of MDAC's executive summary being provided to him.

Secondly, Dr. Ameis' evidence on assigning a WPI of 26% to Mr. Fournie also causes me concern. Dr. MacCallum, in his report, clearly states that he leaves the determination of the final WPI to the consensus process. Dr. MacCallum does not give his opinion on Mr. Fournie's final WPI and Dr. Ameis provided no evidence that he ever got an opinion from Dr. MacCallum on Mr. Fournie's final WPI. Dr. Ameis stated that he did consult with Dr. MacCallum, but cannot remember when. For an issue as important as the determination of an individual's impairments and that individual's access to future benefits, one would think MDAC would have taken more care in keeping records of its assessments. I find that Dr. MacCallum did not give a final opinion on Mr. Fournie's WPI. Instead, I find that the final WPI percentage score is Dr. Ameis' opinion.

Section 3.2b of Chapter 3 of the *Guides* addresses gait derangement, which I find to be the most appropriate chapter to use when assessing Mr. Fournie's lower limb injuries. All the experts who gave evidence at the hearing on this issue, including Dr. Ameis, agreed that the Gait Derangement table is the most appropriate assessment tool. I find nothing in the Gait Derangement ratings at Table 36 in the *Guides* that would convince me that an individual requires impairments in both legs to be assigned a WPI over 40%. A plain reading of the table shows that a WPI of 50% is assigned to an individual who "(r)equires routine use of two canes *or* two crutches *and* a short leg brace (AFO)."[30] The table does not mention bilateral leg impairments as a requirement for a WPI over 40%.

[30] *Guides*, p. 76

Under the circumstances, I prefer Dr. Sanders', Dr. Potter's and Steven Trujillo's evidence concerning Mr. Fournie's physical functioning. Dr. Sanders and Steven Trujillo both noted that Mr. Fournie requires two crutches. Dr. Potter gave evidence that Mr. Fournie requires two crutches as well as a foot brace to promote his independence. In assessing the evidence, I am not convinced that Mr. Fournie can safely ambulate without the use of two crutches, nor do I believe that Mr. Fournie's use of two crutches is a choice. Instead, I find that he requires the use of two crutches for his safety, to promote his independence and to improve his quality of life. The Gait Derangement table of the *Guides* assigns a 50% WPI to an individual requiring the routine use of two crutches and a short leg brace. Dr. Potter also assigned a further 4% WPI for skin impairment and 2% for pain.[31] When 50%, 4%, and 2% are combined using the combined values chart in the *Guides*, the WPI is 53% which, when rounded up, meets the 55% threshold. I find that Mr. Fournie's WPI based on his physical impairments is 55%.

Mental and Behavioural Disorder

Mr. Fournie maintains that he suffers from a mental and/or behavioural impairment at a Class 4 level, which is "marked" impairment. In the alternative, his position is that if his physical impairment is combined with any of the mental and behavioural ratings assigned to him by his assessors, then his WPI impairment rating would significantly exceed 55%.

It is Coachman's position that Mr. Fournie still suffers from the physical consequences of his accident but does not present with any psychiatric problems. Further, that while Mr. Fournie presents with a pain disorder, this disorder is not due to psychological factors and is directly related to his ankle and foot injuries. Coachman argues that Mr. Fournie has returned to a high level of activity and therefore does not qualify as catastrophically impaired under the criteria relating to mental and behavioural disorders.

[31] Although the *Guides* at page 304 state that, in general, the impairment percentages given in the tables make allowances for pain, Dr. Potter decided to assess Mr. Fournie primarily on his need for crutches and a brace, making small allowances for other factors.

Mr. Fournie filed Dr. Gayle Kumchy's report for my review.[32] In addition, Drs. Alvin Shapiro and Harold Merskey gave evidence on behalf of Mr. Fournie.

Mr. Fournie went to see Dr. Gayle Kumchy in July 2005. Dr. Kumchy reported that Mr. Fournie is positive for depression, likely at a clinical level. Further, that Mr. Fournie is in the average range for pain patients and is more depressed than the average patient. She reported that Mr. Fournie has difficulty with sleep, wakes feeling fatigued because of pain and is an excellent candidate for pain management. In a follow-up report to her initial assessment,[33] dated January 16, 2006, Dr. Kumchy noted that Mr. Fournie has been trying to socialize and that this is helpful as a means of pain and depression management. Dr. Kumchy assigned no WPI or Class rating to Mr. Fournie.

Dr. Alvin Shapiro[34] is a clinical psychologist who completed a psychological assessment of Mr. Fournie on February 14, 2007. [35] In his report, Dr. Shapiro noted that Mr. Fournie underreported his symptoms. As with all other assessors, Dr. Shapiro was of the opinion that Mr. Fournie answered questions honestly and passed the tests for feigning. Dr. Shapiro was of the opinion that Mr. Fournie was having a difficult time mentally coping with life since the accident. In reporting on his activities, Mr. Fournie told Dr. Shapiro that he works on mathematics puzzles, tends to watch television, tries to take care of himself, talks on chat lines and takes his dog for a walk every day while using his crutches.[36] Dr. Shapiro diagnosed Mr. Fournie with chronic pain and post-traumatic stress disorder. Dr. Shapiro rated Mr. Fournie as a Class 4 in his activities of daily living, Class 4 in adaptation to work, and Class 4 in social functioning. Dr. Shapiro did not rate Mr. Fournie in the area of concentration, persistence, and pace.

At Mr. Fournie's counsel's request, Dr. Shapiro completed a supplemental report dated January 23, 2008.[37] Coachman submits that Mr. Fournie made this request in order to have Dr. Shapiro conclude that Mr. Fournie suffers from a Class 4 impairment and therefore the report

[32] Exhibit 21
[33] Exhibit 22
[34] His curriculum vitae is found at Tab 3 of Exhibit "B" (which is marked as exhibit 9).
[35] The report is found at Tab 3 of Exhibit "A" (marked as exhibit 10).
[36] Exhibit 10, p. 10
[37] Exhibit 10, pp. 24 - 45

is evidence of Dr. Shapiro's lack of impartiality as an expert witness. In reading the supplemental report, I find that the request was for Dr. Shapiro to review his findings in light of information that was not available when he first assessed Mr. Fournie, including the MDAC report. As such, I find no reason to question Dr. Shapiro's impartiality.

In his supplemental report, Dr. Shapiro maintained that Mr. Fournie is catastrophically impaired from a mental and behavioural perspective. Dr. Shapiro noted the activities in which Mr. Fournie engages and as reported to the MDAC assessors, and stated that "[u]pon careful reflection, the original assignment of Class 4 concerning Activities of Daily Living needed to be upgraded to a Class 3 level,… [B]y self report, Mr. Fournie can complete his Activities of Daily Living with some, but not all useful functioning."[38] In the report, Dr. Shapiro reiterated that Mr. Fournie is a Class 4 in social functioning and Class 4 in mental adaptation to work stress. Dr. Shapiro also noted the issues concerning Mr. Fournie's concentration difficulties reported in the MDAC assessment report and concluded that Mr. Fournie suffers from a Class 4 impairment with regard to concentration, persistence and pace.

In giving evidence at the hearing, Dr. Shapiro stated that Mr. Fournie had a reduction in activity level after the motor vehicle accident and a high self-perception of pain. Dr. Shapiro was surprised to discover that Mr. Fournie had given evidence that since the motor vehicle accident he had resumed fishing and kayaking, had made new friends, and attends a chess club.[39] On cross-examination, Dr. Shapiro stated that given Mr. Fournie's evidence, his social life and functioning are "not impossible" and he does not require narcotics. As a result, Dr. Shapiro reversed his position and stated that Mr. Fournie was not suffering from a Class 4 impairment given Mr. Fournie's improved level of social functioning.

On re-examination, Dr. Shapiro noted that Mr. Fournie's depression, anxiety, concern about his future, and low level of activity due to pain management were consistently reported by a number of assessors. Dr. Shapiro also noted that Mr. Fournie had only met one new person since the motor vehicle accident. When giving evidence on Mr. Fournie's mental and behavioural status

[38] Exhibit 10, p. 33

[39] Mr. Fournie was very active in the outdoors prior to the motor vehicle accident. Since the accident he had purchased a modified kayak that allows him to sit atop it and paddle.

during cross-examination, it appears Dr. Shapiro grew confused as to the correct section of the *Guides* to be used in assessing mental and behavioural disorders. For example, Dr. Shapiro noted that Mr. Fournie did not meet the definition of marked impairment as set out in chapter 15 of the *Guides*.[40] It is clearly noted in the *Guides* that Chapter 15 refers to pain and Dr. Shapiro had not comprehensively assessed Mr. Fournie for pain. On re-examination, Dr. Shapiro noted that he had indeed assessed Mr. Fournie using Chapter 14 of the *Guides*,[41] which is the chapter relating to mental and behavioural disorders. When directed to the assessment tool in Chapter 14, Dr. Shapiro agreed that Mr. Fournie meets the definition of Class 4 – "marked" impairment. Dr. Shapiro did not assign a percentage WPI rating to Mr. Fournie.

Coachman submitted that Dr. Shapiro's confusion during cross-examination nullifies his evidence regarding any mental and behavioural disorder affecting Mr. Fournie. I disagree. Dr. Shapiro's report is clear and addresses all the pertinent criteria in the *Guides* relating to mental and behavioural disorders. While giving evidence Dr. Shapiro clearly articulated his opinion until he became confused about sections of the *Guides* that are fairly closely related. On re-examination, Dr. Shapiro correctly noted the sections of the *Guides* under which he had examined Mr. Fournie. Dr. Shapiro also clarified his position on Mr. Fournie's social functioning. I find that Dr. Shapiro's evidence is credible and he remained sufficiently clear throughout the totality of his testimony.

Dr. Harold Merskey[42] is a psychiatrist who examined Mr. Fournie and completed a report dated July 5, 2008.[43] In his report, Dr. Merskey diagnosed Mr. Fournie with Major Depressive Disorder as well as symptoms of Post-Traumatic Stress Disorder. Dr. Merskey's report noted that Mr. Fournie's pain is unlikely to improve significantly and that "his established chronic leg pain at the present time is not going to change greatly unless radical measures are undertaken such as amputation which carries its own additional risks."[44] Dr. Merskey reported that:

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[40] Dr. Shapiro referred to the Pain Intensity-frequency Grid on p. 310 of the *Guides*.
[41] Dr. Shapiro then referred to the Classification of Impairments Due to Mental and Behavioural Disorders on p. 301 of the *Guides*.
[42] His curriculum vitae is found at Tab 7 of Exhibit "B" (which is marked as exhibit 14).
[43] The report is found at Tab 7 of Exhibit "A" (which is marked as exhibit 15).
[44] Exhibit 15, p. 8

> Looking at the 4th edition of the AMA "Guides" (chapter 14, p. 301) I consider that the psychological disabilities, difficulty in focus, difficulty in concentration etc. as outlined by Dr. Shapiro, reflect a Class IV – Marked Impairment level which significantly *impedes* useful functioning. Domestic care, ordinary pleasures in every respect, recreation, establishment of relationships with a suitable partner, ability to travel and shop are all significantly impaired. Mobility and work are significantly impaired. On these grounds alone, in my view, he would be Catastrophically Impaired.[45]

At the hearing Dr. Merskey stated that he used the pain assessment guide, fibromyalgia impact questionnaire and hospital anxiety depression scale ("HADS") to assess Mr. Fournie. He also noted that Mr. Fournie reported pain levels that are consistent with chronic pain and that Mr. Fournie uses pain avoidance behaviour. He also noted that pain affects Mr. Fournie's sleep which leads to more problems and concentration issues by the end of each day resulting in "wretchedness." On the fibromyalgia questionnaire, Mr. Fournie scored 71%. It was Dr. Merskey's evidence that 80% of people scoring 80% or more on this questionnaire do not go back to work. Mr. Fournie also scored 15 on the HADS anxiety scale and 15 on the HADS depression scale, which is where chronic pain patients usually score. Dr. Merskey further noted that Mr. Fournie suffers from substantial residual chronic pain and major depressive disorder reactive to his pain with symptoms of post-traumatic stress disorder.

Dr. Merskey was of the opinion that where an assessor cannot find an assessment tool that precisely addresses an impairment, the *Guides* mandate that trained observers should use all resources at their disposal to arrive at a conclusion. Dr. Merskey believes that Mr. Fournie is severely afflicted by pain, and because of this he assessed Mr. Fournie according to the Pain Intensity-frequency Grid in the *Guides*.[46] Dr. Merskey noted that Mr. Fournie can participate in recreation and socialization, but that he is precluded from carrying them out adequately and in full. Dr. Merskey believes that, according to the Pain Intensity-frequency Grid, Mr. Fournie's pain should be described as "marked." The Pain Intensity-frequency Grid, similar to the Mental and Behavioural Impairment Table, assigns the following ratings to impairment: minimal; slight; moderate; and marked. Dr. Merskey concluded that Mr. Fournie's pain and its consequences, being of a "marked" nature according to the Pain Intensity-frequency Grid, can be compared to

[45] Exhibit 15, p. 10
[46] Located at p. 310

the bottom end of Class 4, which is "marked" impairment, in the Mental and Behavioural Table in Chapter 14. As such, he believes that Mr. Fournie qualifies as catastrophically impaired because of pain. Dr. Merskey did not specify which of the four aspects of functioning (Activities of Daily Living, Social Functioning, etc.) are affected by Mr. Fournie's pain.

Dr. Merskey went further to assign Mr. Fournie a WPI rating of 37.5%. He based this on percentage values that were historically attached to mental and behavioural disorders in past editions of the *Guides*.[47] Dr. Merskey combined the 37.5% with the 40% WPI attributed to Mr. Fournie by Dr. Potter[48] for a combined WPI of 63% on rounding up.[49]

Mr. Fournie gave evidence on his own behalf. He chronicled his pre-accident life which seemed to be exceptionally active. He routinely made a 60 kilometre bicycle round trip from Sarnia to Petrolia and back. He enjoyed canoeing, fishing, driving both on and off road, working on cars, hiking and camping. The list of his pre-accident activities is extensive. Since the accident, Mr. Fournie cannot sit properly in a canoe. He has purchased a special kayak that allows him to elevate his foot while sitting on top of it. He now has to fish in areas where he can drive up to the water. He only hikes on tame trails because of his trouble walking. He no longer cycles and is only able to camp with his father, whom he claims "does everything." Mr Fournie gave evidence that he tries to be as independent as possible with his activities. He also tries to be social by attending a chess club, having coffee with friends and fishing with a buddy, who unfortunately was killed in 2008. Mr. Fournie stated that he suffers from pain. He claimed that his pain is humiliating and depressing and things that seem minor cause him great difficulty. He is humiliated because he has trouble with simple tasks and has cried because of his inability to do the things he used to.

[47] In Chapter 14 at page 301 of the *Guides*, the authors note that the second edition of the *Guides* provided ranges of percentages for mental and behavioural disorders. However, the Committee on Disability and Rehabilitation of the American Psychiatric Association advised *Guides'* contributors against the use of percentages in the fourth edition as the use of percentages imply a certainty that does not exist.

[48] Dr. Potter's 40% assessment was given to Mr. Fournie before Dr. Potter discovered that Mr. Fournie was using crutches **and** a brace.

[49] Exhibit 15, p. 12

Demetrios Kostadopoulos completed an Occupational Therapy assessment of Mr. Fournie on July 25, 2006 on behalf of MDAC. In his report[50], Mr. Kostadopoulos noted that Mr. Fournie was sociable with humourous affect and no emotional issues observed. He stated that Mr. Fournie did not present any difficulty in relation to concentration or problem solving and that he demonstrated intact cognitive/behavioural/social skills. Mr. Kostadopoulos reported that Mr. Fournie's independence with household management could be enhanced if he transitioned into subsidized housing. However, if Mr. Fournie did not, then further barriers would develop. Mr. Kostadopoulos noted that Mr. Fournie reported depressive tendencies, but appears emotionally and cognitively able to meet the demands of social situations. Mr. Kostadopoulos concluded that "…in relation to the 4 spheres of function, from a behavioural, mental and cognitive perspective; no impairment was noted by this assessor."[51]

Dr. John Mount[52] is a psychiatrist who assessed Mr. Fournie in August of 2006[53] as part of the MDAC assessment team. Dr. Mount gave evidence that he does not rely on the objectivity of tests, but on his own subjective analysis. He noted that on assessment Mr. Fournie had bright affect and had a normal mood. In addition, that Mr. Fournie responded with a sense of humour and that humour is usually not a presentation with major depressive disorders. He noted that Mr. Fournie could go fishing and walked around the house without his crutches. He gave evidence that he believes Mr. Fournie is compromised by physical limitations, not by psychiatric ones. His diagnosis is that Mr. Fournie has no psychological disorder and no phobic disorder. However, Mr. Fournie has a pain disorder, but the disorder is associated with his foot injury and not with psychological factors. He assessed Mr. Fournie as a Class 1 in activities of daily living, Class 2 in social functioning, Class 2 in concentration, persistence, and pace and Class 1 in adaptation. Overall he rated Mr. Fournie as Class 1.

No assessor who assessed Mr. Fournie found him to be a malingerer. They all reported that Mr. Fournie was forthright and honest, and in some instances underreported his symptoms. All assessors addressed Mr. Fournie's depression. I find Dr. Gayle Kumchy's assessment of

[50] Exhibit "C", Tab 4A (marked as exhibit 28)
[51] Exhibit 28, p. 4
[52] His curriculum vitae is at Tab F6 of Exhibit "C" (which is marked as exhibit 16)
[53] His report is at Tab 4C of Exhibit "C" (which is marked as exhibit 17)

Mr. Fournie's depression to be credible. Dr. Kumchy's diagnosis of Mr. Fournie seems to be consistent throughout the assessments Mr. Fournie attended.

I do not accept Dr. Mount's and Demetrios Kostadopoulos' evidence on Mr. Fournie's overall mental and behavioural status. Dr. Mount found that Mr. Fournie suffers from no psychological disorder. Considering the physical toll of the motor vehicle accident and the fact that his depression is noted consistently throughout his assessments, I find that Mr. Fournie suffers from a depressive disorder. Both Dr. Mount and Mr. Kostadopoulos appeared fixated on the fact that Mr. Fournie remained sociable throughout his assessments and expressed humour at appropriate moments. In their opinion, this indicated that Mr. Fournie would have little or no difficulty in social functioning. On the contrary, I find that Mr. Fournie's ability to remain upbeat in the face of his many difficulties coloured these assessors' opinions regarding his areas of functioning. In listening to the evidence in this case and observing Mr. Fournie at the hearing, I simply cannot accept that he would rank as a Class 1 or 2 in concentration, persistence, and pace, in adaptation, or in activities of daily living. It is clear to me that Mr. Fournie's life has been profoundly affected by his impairments. Mr. Kostadopoulos noted that Mr. Fournie could become independent were he to move into subsidized housing. Perhaps what Mr. Kostadopoulos meant was that Mr. Fournie would benefit from moving to an assisted living community. Subsidy relates to the price one pays for housing. Mr. Fournie struggles with his day to day activities and requires more than a price reduction. In any event, Mr. Kostadopoulos' assessment of Mr. Fournie's independence is speculative in this regard as no assessment of Mr. Fournie in an assisted environment was ever completed.

I find Mr. Fournie to be a very determined individual who was very active before the motor vehicle accident and who has attempted to return his life to normal. To his credit, he researched and bought a modified kayak so that he could get outdoors again. He also researched and bought a truck that would allow him easy entry and exit from the vehicle, thereby improving his independence. Mr. Fournie's attempts to improve his condition do not necessarily lead to the conclusion that he is free from mental or behavioural impairments.

Mr. Fournie spoke at length about his pain and how it has impacted his life. Neither Dr. Mount nor Mr. Kostadopoulos, as part of the MDAC team, addressed Mr. Fournie's pain. I still have difficulty understanding why Dr. Mount attributed pain to Mr. Fournie's foot, yet did no assessment of the impact of Mr. Fournie's pain on the rest of his functioning. In addition, Dr. Mount and Demetrios Kostadopoulos gave evidence that they did not consult with the rest of the assessors when MDAC determined Mr. Fournie's final WPI rating. Had Dr. Mount or Mr. Kostadopoulos consulted with the physiatrist or others, it would have been possible for them to better determine Mr. Fournie's overall functioning.

I accept Dr. Merskey's evidence in two ways. Firstly, in his very thorough report, he notes that Mr. Fournie is catastrophically impaired in focus and concentration, domestic care, recreation and mobility and work. In my view, Dr. Merskey's report concluded that Mr. Fournie is a Class 4 or higher in activities of daily living, social functioning, adaptation and persistence and pace. At the hearing, given Mr. Fournie's evidence, Dr. Merskey downgraded Mr. Fournie's impairment in social functioning to below the catastrophic level and I accept that.

Secondly, Dr. Merskey very plainly articulated what the *Guides* suggest, which is for assessors to find the most appropriate assessment tool when assessing impairments. Pain profoundly affects Mr. Fournie and I find it appropriate for Dr. Merskey to have compared the Pain Intensity-frequency Grid to the Mental and Behavioural Impairment Table in arriving at a determination of how pain affects Mr. Fournie's overall mental and behavioural functioning. I also agree with Dr. Merskey that even though Mr. Fournie is able to engage in social functioning, it is clear from the evidence that he is greatly affected and cannot carry out his social functioning adequately and in full.

Neither Mr. Fournie nor Coachman made any submissions on whether the *Schedule* requires a marked impairment in more than one area of functioning in order to have an individual declared catastrophically impaired. In this case, I find that a Class 4 impairment is required in only one area of functioning to meet the definition of "catastrophic impairment." Justice Spiegel in *Desbiens*, while not called on to determine the issue, noted that "[it] is not disputed that it is sufficient for Mr. Desbiens to establish that his impairment in any one of the areas of functioning

meets the requirements of clause (g).”[54] Arbitrator Nastasi in *Pastore and Aviva Canada Inc.*[55] notes that the Superintendent’s Guidelines for undertaking catastrophic impairment assessments state that two marked impairments are required to render a catastrophic determination under the (g) criterion. She determined that the Guidelines are an assessment tool for physicians and are not incorporated into the legislation and therefore she is not bound by them. I agree with her. In light of this, I find that Mr. Fournie only requires one marked impairment to be deemed catastrophically impaired.

Drs. Shapiro and Merskey both determined that Mr. Fournie suffers from a Class 4 impairment in more than one area of functioning. In fact, Dr. Merskey’s assessment appears to indicate that because of pain, Mr. Fournie is a Class 4 impairment in all four areas of functioning. Based on the opinions of Drs. Shapiro and Merskey, I find that Mr. Fournie meets the definition of catastrophic impairment as defined by paragraph 2(1.2) (g) of the *Schedule*.

Combining Impairments

Mr. Fournie argued that his physical impairment rating combined with his psychological impairment rating exceeds the 55% WPI threshold. Dr. Merskey, in his report and at the hearing, combined Mr. Fournie’s physical and psychological impairment ratings. While I accept that it is well settled law that combining physical and psychological impairment ratings is permissible, as I have determined that Mr. Fournie is catastrophically impaired both physically and psychologically, I do not need to consider combining the two elements

CONCLUSION

For all the reasons set out above, I conclude that Mr. Fournie has sustained a catastrophic impairment as defined by paragraphs 2(1.2) (f) and 2(1.2) (g) of the *Schedule.*

[54] *Desbiens,* paragraph 129
[55] (FSCO A04-002496, February 11, 2009), confirmed on appeal (FSCO P09-00008, December 22, 2009)

EXPENSES:

The parties made no submissions on expenses. They are encouraged to resolve the issue. If they are unable to do so, they may schedule an expense hearing before me according to the provisions of Rule 79 of the *Dispute Resolution Practice Code*.

February 12, 2010

Lloyd (J.R.) Richards
Arbitrator

Date

Financial Services Commission of Ontario

Commission des services financiers de l'Ontario

FSCO A07-000297

BETWEEN:

DEAN FOURNIE

Applicant

and

COACHMAN 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. Mr. Fournie has suffered a catastrophic impairment as defined by paragraph 2(1.2) (f) of the *Schedule*.

2. Mr. Fournie has suffered a catastrophic impairment as defined by paragraph 2(1.2) (g) of the *Schedule*.

February 12, 2010

Lloyd (J.R.) Richards
Arbitrator

Date