CITATION: Kusnierz v. The Economical Mutual Insurance Company, 2010 ONSC 5749
COURT FILE NO.: 64834/02
DATE: 20101019

ONTARIO

SUPERIOR COURT OF JUSTICE

B E T W E E N:	)	
	)	
ROBERT KUSNIERZ	)	Harry F. Steinmetz, for the Plaintiff
	)	
	)	
Plaintiff	)	
	)	
- and -	)	
	)	
THE ECONOMICAL MUTUAL INSURANCE COMPANY	)	Lee Samis, for the Defendant
	)	
	)	
	)	
Defendant	)	
	)	
	)	**HEARD:** November 24 and 25, 2009, and January 28, 2010

REASONS FOR DECISION

LAUWERS J.

[1] On December 24, 2001, the plaintiff, Robert Kusnierz, was a passenger in a vehicle being driven by Cezary Kaczmarek proceeding eastbound on Albion Road. Mr. Kaczmarek lost control of the vehicle, which left the paved portion of the road and rolled over a number of times. Mr. Kusnierz suffered numerous injuries, the most serious of which required the amputation of his left leg below the knee.

The Issues in this Case

[2] The plaintiff sues his insurer, The Economical Mutual Insurance Company, for a declaration that, as the result of his injuries in the accident, he sustained a "catastrophic

impairment" and is therefore entitled to enhanced benefits under the *Statutory Accident Benefits Schedule – Accidents on or after November 1, 1996*, O.Reg 403/96 ("SABS"), as amended.

[3] Mr. Kusnierz was a credible and honest witness who did not embellish his evidence. He has suffered much and continues to suffer from the results of his injuries. He deserves the sympathy of the court.

[4] If the court finds that Mr. Kusnierz is catastrophically impaired within the meaning of the SABS, then Economical Mutual must pay for medical and rehabilitation benefits up to $1 million and attendant care benefits up to $1 million under section 19 of the SABS. If the Court finds that Mr. Kusnierz is not catastrophically impaired, it is common ground that his $100,000 medical and rehabilitation limits were exhausted by November 11, 2005.

[5] A person is catastrophically impaired under clause 2(1.1)(f) of the SABS if he or she has an impairment or combination of impairments that result in 55 percent or more impairment of the whole person ("WPI"), in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 (the "Guides"). For the reasons set out below, I conclude that Mr. Kusnierz has not proven, on the balance of probabilities, that he is catastrophically impaired under clause 2(1.1)(f) of the SABS.

[6] It is common ground that if Mr. Kusnierz' impairments assessed under clause 2(1.1)(f) were combined with his mental and behavioural impairments assessed under clause 2(1.1)(g) of the SABS, then his WPI rating would exceed 55% and he would be deemed to be catastrophically impaired. For the reasons set out below, I conclude that, as a matter of law, such a combination is not permissible. The action is therefore dismissed.

Mr. Kusnierz' evidence

[7] Mr. Kusnierz testified that the immediate aftermath of the accident was very difficult for him. As a result of an infection, the stump of his left leg required a number of revisions. He had great difficulty in finding a prosthetic leg that fit properly, given the tendency of his stump to develop cysts. Over the course of succeeding months, Mr. Kusnierz had more than ten socket replacements as the stump matured. The prosthetic devices did not fit properly.

[8] Within the last three years Mr. Kusnierz went to Sweden on a couple of occasions and was fitted with a new prosthesis that is much better. He testified that, as a result of his ongoing pain, including pain caused by the development of cysts on his stump, he wears his prosthesis about 50% of the time. When questioned about how he ambulates or moves around indoors if he is not using his prosthetic leg, he testified that he prefers to use his walker over his wheelchair because he finds it to be the quickest and easiest way to move around. He always uses the prosthesis when he is outdoors. On days that he has cysts and his stump is too big for the socket, he stays indoors and uses the walker. This happens about five days each month. There are also days on which he can wear the prosthesis "practically non-stop".

[9] Mr. Kusnierz testified that he continues to experience difficulty walking with his prosthetic leg. Since the left side of his body is weaker than the right side, he walks well only on a level surface. He has difficulty walking up or down a slope.

[10] Mr. Kusnierz testified that in the three-year period following the accident, he had a great deal of pain in his shoulders, his lower back and his upper back. He also had problems with his right hip because it was carrying the weight of his body.

[11] Dr. Arthur Ameis, a physiatrist, assessed Mr. Kusnierz on October 21, 2002, about ten months after the accident. Mr. Kusnierz reported daily headaches, sore shoulders, pain in his neck and lower back, visual disturbances, numb fourth and fifth fingers on his right hand, sore hips, knees and right ankle, and "phantom pain" in his left leg, including the sensation that his amputated left foot was twisted into a painful position. He reported withdrawing from others emotionally and socially.

[12] Mr. Kusnierz developed a narcotic dependency in dealing with the pain, but went through a detoxification process and is now stable on his medication. He is seeing a psychiatrist to assist with his depression.

[13] As a result of his disabilities, Mr. Kusnierz was no longer able to drive tractor trailers and lost his job. He relied and still relies on family for help day-to-day.

[14] At present, Mr. Kusnierz owns a condominium with his mother in Mississauga. He owns and operates a trailer park/marina in St. William, a town near Port Dover in Ontario. For the most part, he lives there with his wife whom he married in 2009. He is able to do some work around the trailer park and is assisted by his son, his mother and his wife.

The Agreed Statement of Facts and Issues

[15] The parties have filed an Agreed Statement of Facts and Issues, reproduced below:

1. Kusnierz is a person entitled to SABS (Ontario Regulation 403/96) benefits from Economical as a result of an accident which occurred on, or about, December 24, 2001.

2. Kusnierz has applied to be considered as a person who has sustained a "catastrophic impairment", as that term is used under the SABS.

3. Kusnierz has been assessed on behalf of both parties in order to determine whether or not he has sustained a "catastrophic impairment".

4. The assessors and the parties agree Kusnierz does not meet the definition of catastrophic impairment pursuant to section 2(1.1) (a), (b), (c), (d), (e), or (g) of the SABS and therefore that Kusnierz could only possibly be considered to have met the

definition of "catastrophic impairment" under clause (f) of subsection (1.1) of section 2 of the SABS.

5. The parties have identified two issues for determination by the Court:

   A. Whether it is permissible to assign percentage ratings in respect of Kusnierz's psychological impairments under clause 2(1.1)(g) of the SABS and combine them with percentage ratings in respect of Kusnierz's physical impairments under clause 2(1.1)(f) of the SABS, for the purposes of determining whether Kusnierz is catastrophically impaired pursuant to the SABS and the 4th Edition of the AMA's Guides to the Evaluation of Permanent Impairment?

      It is conceded by Economical that if Kusnierz's physical and psychological impairments are combined he will meet the definition of catastrophic impairment.

   B. Secondly, if the combining of physical and psychological impairment ratings is not proper, has Kusnierz nevertheless sustained a catastrophic impairment on the basis of 2(1.1)(f) of the SABS alone?

6. This agreement, the reports of assessors and experts related to catastrophic impairment and attendant care, as listed in the Joint Document Brief, and the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 constitute the entire record of these proceedings, without restriction on the ability of the parties to call the plaintiff and the authors of any of these reports as witnesses to also give viva voce evidence.

The task of statutory interpretation

[16] The determination of each issue requires the interpretation of Bill 59[1], the SABS, and the Guides. In carrying out this task, I am guided by the Court of Appeal's words in *Bapoo v. Co-Operators General Insurance Company* (1997), 36 O.R. (3d) 616, [1997] O.J. No. 5055 at pp. 620-21[2] [*Bapoo* cited to O.R.], which "calls on courts to interpret a legislative provision in its total context. The court's interpretation should comply with the legislative text, promote the legislative purpose and produce a reasonable and just meaning."

Purposive analysis

[17] The invariable first step in purposive analysis and interpretation is to consider the legislative history, to which I now turn.

[18] The legislative history is repeated in almost every decision concerning Part VI of the *Insurance Act*, R.S.O. 1990, c. I-8 or the SABS. Automobile insurance is a particularly intensive area of public policy, as the frequency of studies and changes shows. The Ontario system is a hybrid of no-fault insurance coverage and traditional tort law.[3] In the *Report of the Inquiry into Motor Vehicle Accident Compensation in Ontario* (Ontario: Queen's Printer, 1988), Commissioner Coulter A. Osborne noted the basic elements of the system in his comment at p. 46: "The legitimacy of the co-existence of no-fault and tort requires first that there be a substantial expansion of the quantum of no-fault benefits and the eligibility criteria for these benefits; and second, that the compensation plan be capable of being delivered through the automobile's insurance system at a reasonable cost."

[19] His work led to the introduction of the Ontario Motorist Protection Plan in 1990. In analyzing certain claims under the new legislation, the Court of Appeal in *Meyer v. Bright* (1993), 15 O.R. (3d) 129, [1993] O.J. No. 2446 at p. 134, para 6 [*Meyer* cited to O.R.], laid out the competing policy tensions and the policy thrusts in the legislation:

> In our view, the Ontario legislature enacted s. 266 and other related amendments to the Act for the purpose of significantly limiting the right of the victim of a motor vehicle accident to maintain a tort action against the tortfeasor. The scheme of compensation provides for an exchange of rights wherein the accident victim loses the right to sue unless coming within the statutory exemptions, but receives more generous first-party benefits, regardless of fault, from his or her own insurer. The legislation appears designed to control the cost of automobile insurance premiums to the consumer by eliminating some tort claims. At the same time, the legislation provides for enhanced benefits for income loss and medical and rehabilitation expenses to be paid to the accident victim regardless of fault.

[20] The Court added a corollary at p. 150, para 70:

> Because it is only a serious impairment which will qualify as an exception under s. 266(1)(b) it is apparent that the Legislature intended that injured persons are required to bear some interference with their enjoyment of life without being able to sue for it.

[21] These competing policy thrusts are endemic to the system; the legislative history shows constant adjustments affecting the interests of the participants.

[22] The transition from the Bill 164 regime[4] (which applied to accidents occurring between January 1, 1994 and November 1, 1996), to the Bill 59 regime (which applied to accidents occurring between November 1, 1996 and October 1, 2003), is of critical importance to this case since Mr. Kusnierz was hurt on December 24, 2001.

[23] In *Henderson v. Parker* (1998), 42 O.R. (3d) 462, [1998] O.J. No. 4389[5] (Gen. Div.) [*Henderson* cited to O.R.], Heeney J. explained the differences between Bill 164 and Bill 59 at pp. 470-71:

> **30** The right to sue existed at common law, but those rights were seriously truncated when the OMPP came into force in 1990. When Bill 164 came into force in 1994, the right to sue a protected defendant for pecuniary loss was eliminated altogether. That was the state of the plaintiff's legal rights when Bill 59 was passed into law. Bill 59 did not truncate the plaintiff's right to sue but rather it expanded it. It gave the plaintiff the full right to sue for economic loss, other than health care costs, without regard to a threshold. As to health care costs, it restored the right to sue to a plaintiff who is catastrophically injured.
>
> **. . .**
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> **32** In my opinion, Bill 59 is simply a reworked version of the OMPP which was under consideration in *Meyer v. Bright*. It is essentially remedial legislation, which restricts the right to sue in certain respects, but offsets that with first party benefits that are available regardless of fault. One of the objectives implicit in the title of the Act is to achieve stability in car insurance rates. It seems clear that one of the ways to do so was to reduce the extremely generous accident benefits provided for under Bill 164. The result may well be that some health care expenses, such as those that exceed the prescribed limits, may go unpaid. While that may seem unfair, that is what the legislature appears to have intended.

[24] The court explained in *Desbiens v. Mordini*, [2004] O.J. No. 4735 at paras. 231-32 (S.C.J.):

> **231** … Under Bill 164 a claimant who sustained a serious disfigurement or a serious impairment of an important physical mental or psychological function (serious threshold) could recover non-pecuniary damages but protected defendants were not liable for pecuniary damages regardless of the severity of the claimant's impairment. However, there were very generous benefits for income loss, medical, rehabilitation and attendant care available on a no fault basis: for example, attendant care benefits of $3,000 to $10,000 a month depending on the nature of the injury, with no overall maximum, and medical rehabilitation to a maximum of $l, 000,000.

> **232** The Bill 59 regime was introduced in 1996. . . . Under Bill 59, claimants are barred from recovering non-pecuniary damages from protected defendants unless the claimants' injuries meet a threshold similar to the Bill 164 threshold except that the permanent requirement was restored. Pecuniary damages are recoverable without meeting any threshold, except for health care expenses, which are not recoverable unless the injured person has sustained a "catastrophic impairment."

[25] The court addressed catastrophic impairment in *Henderson v. Parker*, *supra* at p. 471:

> **36** As already noted, s. 267.5(4) provides that s-s. (3) does not apply if the injured person has sustained a catastrophic impairment. The legislature appears to recognize that catastrophically impaired plaintiffs are a special case, and health care costs can be enormous. They dealt with this by increasing the SABS limits to $1 million for life, which is available to any catastrophically injured person regardless of fault, coupled with the restoration of the right to sue for health care costs in excess of the SABS limits, which would be available to the innocent party.

[26] In my view, the Legislature's actions in Bill 59 do not show a single purpose. As part of its goal to reduce insurance costs, Bill 59 and the new SABS it authorized actually reduced medical and rehabilitation benefits available on a no-fault basis for everyone from $1 million to $100,000, and for attendant care from $1 million to $72,000, except for victims who were catastrophically impaired. Their no-fault benefits were not increased or enhanced, but were merely preserved. This was the legislative and executive policy choice.

[27] In *Desbiens v. Mordini*, *supra* at paras. 233-35, the court reviewed the legislative debates to discern the purpose for Bill 59:

> **237** Indeed, a common thread runs through the remarks quoted above. That is, the intention to restore fairness to the system for the innocent victims of motor vehicle accidents. Thus a major purpose of section 275.5(5) of the Act is to ensure that those innocent victims who are in the most need are able to recover health care expenses, perhaps at the expense of those who have less need. The legislature appears to recognize that catastrophically impaired plaintiffs are a special case, and health care costs can be enormous. Another important purpose was to control premiums. In my view, however, insofar as health care expenses are concerned, this was to be achieved by the drastic reduction in the level of medical and rehabilitation benefits available on a no-fault basis. (footnotes omitted)

[28] Mr. Steinmetz adopted the language in *Arts (Litigation Guardian of) v. State Farm Insurance Co.* (2008), 91 O.R. (3d) 394, [2008] O.J. No. 2096 (S.C.J.)[6] at para. 14, where the court said that the purpose of the scheme was to "foster fairness."

[29] But I find, with the greatest of respect, that the policy thrusts are more disparate and acute. In *Chisholm v. Liberty Mutual Group* (2002), 60 O.R. (3d) 776, [2002] O.J. No. 3135 (C.A.), Laskin J.A. observed at para 7:

> Since 1990, the system of motor vehicle accident compensation in this province has been premised on an "exchange of rights" principle. In one way or another the Legislature has restricted the right of innocent accident victims to maintain a tort action against the wrongdoer in exchange for enhanced no-fault accident benefits from their own insurer.

[30] He went on to observe at para. 16, however, that the principle does not help where the government changes the previous arrangement:

> As I have said, this principle underlies the scheme of motor vehicle accident compensation that has been in place in Ontario since 1990. But the principle does not help Chisholm's appeal. In 1996, the government re-drew the balance between tort rights and accident benefits. It changed the rights being exchanged. One of the changes was to limit the number of incidents that called for the payment of accident benefits.

[31] In determining whether his interpretation of the SABS was "reasonable and just," Heeney J. said in *Henderson v. Parker*, *supra* at p. 473:

> **43** It may be argued that it is not just to deny the plaintiff the right to sue for health care costs in excess of the SABS maximums. However, the legislation must be looked at as a complete package. Something less than full recovery may be justified in exchange for providing benefits to all parties, regardless of fault. Similarly, the plaintiff who is less seriously injured may have to take less in order that the limits can be increased for catastrophically injured people who clearly have a greater need. These competing interests must also be considered within the budgetary constraints mandated by a stated desire to hold the line on insurance premiums. Looking at this legislation as an exchange of rights and a balancing of rights, I am not in a position to say that the result is unjust. It is certainly far from perfect, but it is not manifestly unjust.

[32] The hybrid system of no-fault insurance coverage and traditional tort law is a closed system; since the interests of people are differently affected by any adjustment, it is difficult to speak of fairness. I therefore have trouble agreeing that the changes Bill 59 brought about showed an "intention to restore fairness" or were aimed at "fostering fairness". Bill 59 made a person who was seriously but not quite catastrophically injured far worse off. For example, a catastrophically impaired person was left in roughly the same position as under Bill 164, at least in respect of medical rehabilitation and attendant care benefits; each would have quite a different view of Bill 59's fairness. While citizens may hope if not expect that fairness is one of the factors routinely considered in making legislation or subordinate legislation, there are often winners and losers. There certainly were as the result of Bill 59.

[33] Professor Ruth Sullivan expresses an apposite caution in her book *Sullivan on the Construction of Statutes*: "[D]escriptions of legislative purpose tend to be vague and incomplete while inferences of legislative purpose are subjective and prone to error. Furthermore, being able to identify the purpose(s) sought does not necessarily resolve the interpretive problem facing the court."[7] The purpose may be indeterminate, as Professor Sullivan points out:

> Purposive analysis is at its most indeterminate when the purposes of the legislation are mixed and point in different directions. Instructions about how to rank competing purposes are normally not found in legislation; at most the legislation offers only very general guidance, leaving it to interpreters to strike an appropriate balance.[8]

[34] Where the purposes of the legislation are mixed, as they are in the area of automobile insurance since the policy thrusts go in different directions simultaneously, a purpose like "fairness" can become a subjective standard of little guidance in interpretation. In my view, in this context the determination of purpose must be more provision-specific; this requires a very close look at the words of the legislation. Before turning to the issues, it is necessary to consider the admissibility of expert medical evidence in the interpretation of the Guides and the SABS.

The proper use of expert medical evidence in interpretation

[35] The plaintiff called Dr. Arthur Ameis, and the defence called Dr. Michel Lacerte. Despite the opposed positions of the parties who called them as witnesses, the two doctors agree on the first issue: the Guides, taken on their own, do not permit physical impairments, which are covered in chapters 3-13 of the Guides, to be combined with "mental and behavioural disorders," which are covered in Chapter 14 of the Guides, for the purpose of calculating whether the plaintiff has suffered a "catastrophic impairment" by reaching the threshold of 55% WPI.

[36] They part company on the second issue. Dr. Ameis gives the opinion that Mr. Kusnierz is catastrophically impaired under clause 2(1.1)(f) of the SABS, and Dr. Lacerte gives the opinion that he is not. The details of their evidence are set out below.

[37] It seems obvious that expert medical evidence is admissible on the second issue, since it raises a question of mixed fact and law. The first issue, however, raises a question of law; is expert evidence admissible on it?

[38] The determination of each issue must take into account the Guides. In *Snushall v. Fulsang*, [2003] O.J. No. 1493 (S.C.J.), Lax J. set out the origin and development of the Guides:

> **12** The AMA Guides originated in 1958 as a compilation of articles when the American Medical Association struck a committee on the rating of physical impairment. Over the next thirteen years, that committee and several subcommittees prepared papers on the evaluation of impairments for different body systems. The individual work products of the committees were published as thirteen separate articles and ultimately collected in 1971 as the first edition of the Guides to the Evaluation of Permanent Impairment. Subsequent revisions led to

> the second edition in 1984, the third edition in 1990, the fourth edition in 1993 and the fifth edition in 2000. Although the fifth edition of the Guides is the most current, the Regulation requires that whole person impairment of 55% or more be determined in accordance with the Guides fourth edition, published in 1993. (footnotes omitted)

[39] The Guides not only have a medical genesis, they also have substantial medical content. In *Niagara River Coalition v. Niagara-on-the-Lake (Town)*, 2010 ONCA 173, [2010] O.J. No. 937 at para. 44, the Court of Appeal found that the court below erred in relying on expert planning evidence in interpreting an official plan. I take the court's direction to be that it would be an error to defer to or to adopt expert opinion on a legal issue, and I do not do so. I find, however, that the expert evidence is admissible to set the context for the Guides and the way in which they ordinarily operate. It is also admissible to assist the court in navigating the Guides and in understanding the underlying medical judgments.

Issue One: Is it permissible to assign percentage ratings in respect of Mr. Kusnierz' psychological impairments under clause 2(1.1)(g) of the SABS and combine them with percentage ratings in respect of his physical impairments under clause 2(1.1)(f) of the SABS, for the purposes of determining whether he is catastrophically impaired pursuant to the SABS and the 4th Edition of the AMA's Guides to the Evaluation of Permanent Impairment?

[40] Answering this question obliges the court to analyze carefully the SABS and the Guides in the context of Bill 59. I extract from the purposive analysis the following relevant policy thrusts: Bill 59 was aimed at reducing no-fault benefits to most people, with the savings going to stabilize insurance premiums. The exception was for people who were catastrophically impaired, whose no-fault benefits were maintained and who also got the right to sue the tortfeasor for damages in excess of the maximum no-fault benefits. Thus it is fair to say that Bill 59, in the words of the court in *Desbiens v. Mordini*, *supra* at para. 237, had as another purpose, albeit exceptionally, to ensure that "victims who are in the most need are able to recover health care expenses."

[41] I set out the relevant SABS provisions.

The relevant SABS provisions

[42] Subsection 2(1) of the SABS provides that "'impairment' means a loss or abnormality of a psychological, physical or anatomical structure or function."

[43] Clauses 2(1.1)(a) through (g) define when a person is considered to have sustained a catastrophic impairment. It is common ground that Mr. Kusnierz has no claim under clauses 2(1.1)(a) through (e). These are set out here to give context:

> 2(1.1) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is,

(a) Paraplegia or quadriplegia;

(b) The amputation or other impairment causing the total and permanent loss of use of both arms;

(c) The amputation or other impairment causing the total and permanent loss of use of both an arm and a leg;

(d) The total loss of vision in both eyes;

(e) Brain impairment that, in respect of an accident, results in,

(i) A score of 9 or less on the Glasgow Coma Scale, as published in Jennett, B. and Teasdale, G., *Management of Head Injuries*, Contemporary Neurology Series, Volume 20, F.A. Davis Company, Philadelphia, 1981, according to a test administered within a reasonable period of time after the accident by a person trained for that purpose, or

(ii) A score of 2 (vegetative) or 3 (severe disability) on the Glasgow Outcome Scale, as published in Jennett, B. and Bond, M., *Assessment of Outcome After Severe Brain Damage*, Lancet i:480, 1975, according to a test administered more than six months after the accident by a person trained for that purpose;

(f) Subject to subsections (2) 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 (2) 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.

(2) Clauses (1.1) (f) and (g) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs before October 1, 2003 unless,

(a) the insured person's health practitioner states in writing that the insured person's condition has stabilized and is not likely to improve with treatment; or

(b) three years have elapsed since the accident.

(3) For the purpose of clauses (1.1) (f) and (g) . . . , an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

[44] Analytically, what is the relationship between the SABS and the Guides?

The Status of the Guides

[45] Subsection 2(1.1) of the SABS refers to the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993. Although the precise status of material to which legislation or subordinate legislation refers is a matter of the legislator's intention[9], I find that the words "in accordance with" in clauses 2(1.1)(f) and (g) incorporate the Guides into the SABS[10]. This amounts to incorporation by reference so that the Guides become "an integral part" of the regulation: *R. v. Sims*, 2000 BCCA 437, (2000) 148 C.C.C. (3d) 308 at para. 20; *Desbiens v. Mordini*, *supra*, at para. 227.

[46] Even so, it is obvious that the SABS must prevail over any provision of the Guides with which a SABS provision might be inconsistent. For example, in *Snushall v. Fulsang*, *supra*, the court commented at para. 58 that the Guides state "that impairment percentages derived according to Guides criteria should not be used to make direct financial awards or direct estimates of disabilities", but this is what the SABS does to some extent. This is a clear legislative choice.

[47] As an additional example, by setting three years as a date for evaluating the impairment in subsection 2(2), the regulation may diverge from the Guides in a specific case. The Guides are intended to apply to a permanent impairment, defined in section 1.1 at p. 1 as "one that has become static or stabilized during a period of time sufficient to allow optimal tissue repair, and one that is unlikely to change in spite of further medical or surgical therapy." It is possible that the regulation would require the assessment to be made before a date on which the Guides are designed to be used. The regulation, of course, prevails. This is the legislative choice.

[48] As I note below, the plaintiff argues that the SABS supersede the Guides on a number of critical points.

[49] The corollary of the primacy of the SABS, however, is that where the Guides take a position on an issue and the SABS is silent, the Guides apply. This is what the words "in accordance with" in clauses 2(1.1)(f) and (g) import.

Conclusion on the first issue

[50] I find that it is not permissible under the SABS to assign percentage values to mental and behavioural disorders under Chapter 14 of the Guides (which is referred to in clause 2(1.1)(g) of the SABS), and then combine them with the percentage values derived from impairments assessed under the other chapters of the Guides (referred to in clause 2(1.1)(f) of the SABS) in determining whether an individual meets the catastrophic impairment threshold of "55 per cent or more impairment of the whole person" prescribed by clause 2(1.1)(f) of the SABS.

[51] I reach this conclusion for the following reasons, in a nutshell:

(i) The Guides deliberately do not permit the mental and behavioural disorders in Chapter 14 to be assessed in percent terms and combined with the percentage values derived from impairments assessed under the other chapters of the Guides for the purpose of determining whole person impairment.;

(ii) The structure of the SABS reinforces the bright line demarcation between mental and behavioural disorders referred to in Chapter 14 of the AMA Guides – specifically referred to in clause 2(1.1)(g) of the SABS – from the impairments assessed under the other chapters of the Guides which are referred to in clause 2(1.1)(f) of the SABS; and

(iii) This interpretation is consistent with the purpose of the specific provisions of Bill 59 and the SABS that this issue engages.

[52] I address these reasons in sequence.

1. The Guides deliberately do not permit the mental and behavioural disorders in Chapter 14 to be assessed in percent terms and combined with the percentage values derived from impairments assessed under the other chapters of the Guides for the purpose of determining whole person impairment.

[53] The Guides deliberately do not provide a mechanism for translating mental and behavioural impairments into percentages that can be used in determining the WPI. The lack of a mechanism is not an oversight.

[54] The Guides explain this position at some length. The basic premise, stated at p. 300, is this: "There is no available empiric evidence to support any method for assigning a percentage of [psychiatric] impairment of the whole person. . . ." The results of such assessments are inconsistent and therefore unreliable. The Guides state at p. 301: "Translating these guidelines for rating individual impairment on ordinal scales into a method for assigning percentage of impairments, as if valid estimates could be made on precisely measured interval scales, cannot be done reliably."

[55] The Guides, at pp. 301-02, set out the reasons for this position and the process taken in reaching it, which I excerpt here at length because of their critical importance on this issue:

> **Comment on Lack of Percents in This Edition**
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> The decision not to use percentages for estimates of mental impairment in this fourth edition of the *Guides* was made only after considerable thought and discussion. The second edition (1984) provided ranges of percentages for estimating such impairment. Mental functions, such as intelligence, thinking, perception, judgment, affect, and behavior, were considered to fall into five classes, and the ranges were given as follows: normal, 0% to 5%; mild impairment, 10% to 20%; moderate impairment, 25% to 50%; moderately severe impairment, 55% to 75%; and severe impairment, more than 75%. Ability to carry out daily activities was estimated as follows: class 1, self-sufficient; class 2, needs minor help; class 3, needs regular help; class 4, needs major help; and class 5, quite helpless. From estimates of the individual's functioning, a whole-person impairment estimate could be made.
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> The procedure for the second edition was highly subjective. The third edition (1988) did not list percentages but instead provided the same classes of impairment as the fourth edition. There are some valid reasons to use ranges of percents for mental impairments. If this were done, the chapter on mental disorders would be consistent with *Guides* chapters for the other organ systems. Another point is that various systems for estimating disability have developed ranges of percentages; if such estimates were not provided in the *Guides*, the material in the *Guides* on mental disorders might be ignored. This would increase the likelihood that estimates would be made inconsistently in the various jurisdictions.
>
> A more persuasive argument is that, unlike the situations with some organ systems, there are no precise measures of impairment in mental disorders. The use of percentages implies a certainty that does not exist, and the percentages are likely to be used inflexibly by adjudicators, who then are less likely to take into account the many factors that influence mental and behavioral impairment. Also, because no data exist that show the reliability of the impairment percentages, it would be difficult for *Guides* users to defend their use in administrative hearings. After considering this difficult matter, the Committee on Disability and Rehabilitation of the American Psychiatric Association advised *Guides'* contributors against the use of percentages in the chapter on mental and behavioral disorders of the fourth edition.

[56] In view of this clear and clearly expressed logic, I do not accept Mr. Steinmetz' argument that by merely listing the old percents, the Guides give tacit permission to use them.[11]

[57] Dr. Ameis, who testified for the defence in *Desbiens v. Mordini, supra,* pointed out that where the Guides permit the rating of psychological problems in calculating WPI, they do so in the context of related physical problems. Chapter 4 of the Guides relates to the nervous system. Table 3 in Chapter 4, entitled "Emotional or Behavioral Impairments," provides impairment descriptions and associated percentage impairments of the whole person.

[58] Elsewhere Guides acknowledge that physical impairments may give rise to psychological problems, and the Guides permit adjustment of the WPI percentages. Skin is one such area, in view of related cosmetic issues. For example, in relation to a Class 2 skin disorder, example 5 at p. 284 of the Guides describes how to utilize the Combined Values Chart and then adds: "A mental and behavioral impairment (Chapter 14, Page 291) might further increase the estimate" for a woman who had lost all her fingernails. Similarly, in respect of a Class 3 skin impairment, example 1 at pp. 284-85 of the Guides addresses serious and visible dermatitis, and as a result: "Impairment: 30% impairment due to the skin disorder, which is to be increased by an amount that is proportional to the estimated mental and behavioral impairment (see Chapter 14)". The principle of interpretation known as "implied exclusion[12]" or, in Latin, "*expressio unius est exclusio alterius*", has obvious and reasonable application.

[59] Mr. Steinmetz relies indirectly on the evidence of Dr. Allan Finlayson, a neuropsychologist who testified as an expert witness for the plaintiffs in *Desbiens v. Mordini, supra*:

> **245** Dr. Finlayson testified that while the Guides do not to [*sic*] provide ranges of percentages for the psychological impairments set out in Chapter 14, they did recognize that a numeric or ordinal scale might be of use in certain circumstances. They also provided general information regarding how a clinician might determine what percentage is appropriate. They further made the decision to include the percentages from the second edition so that they would be available to clinicians for reference. Dr. Finlayson also stated that he did not think that clinicians had stopped using percentage impairments under Chapter 14. He opined that clinicians would use the percentages from the second edition to make their own estimates.
>
> **246** The authors of the Guides note that there are some valid reasons to use ranges of percents for psychological impairments. If this were done, the chapter on mental disorders would be consistent with Guides chapters for the other organ systems. Another point is that various systems for estimating disability have developed ranges of percentages; if such estimates were not provided in the Guides, the material in the Guides on mental disorders might be ignored.
>
> **247** In my view, given the purpose of the legislation as I have found it, these are powerful reasons for supporting the plaintiffs' interpretation.

> **248** The argument against providing percentages in the Guides focused on the fact that there are no precise measures of impairment in psychological disorders and the concern that percentages are likely to be used inflexibly by adjudicators, who then are less likely to take into account the many factors that influence psychological impairment. In the end it was this argument that prevailed.
>
> **249** Dr. Finlayson testified that there is a significant amount of overlap between Chapter 4 and Chapter 14. Although Chapter 4 is used when the disturbance or disorder is caused by dysfunction to the brain or central nervous system, the features of the disorder causing the impairment, for example, depression and anxiety, may be common to both chapters. The only essential difference is the cause of the impairment. The Guides state that emotional and behavioural disturbances, such as depression and anxiety disorders, "illustrate the interrelationships between the fields of neurology and psychiatry. The disturbances may be the result of neurological impairments but may have psychiatric features as well". In Chapter 4 clinicians are instructed to assign percentages to the impairment classifications within the designated ranges. The Guides state, "the criteria for evaluating these [emotional and behavioural] disturbances relate to the criteria for mental and behavioural impairments." According to Dr. Finlayson, the word "relate" implies some kind of similarity between the two sets of criteria. (footnotes omitted.)

[60] The court explained the logical basis of Dr. Finlayson's interpretation:

> **250** Dr. Finlayson was of the view that the psychological impairments should be combined with physical impairments to reach an overall percentage of whole person impairment. He stated that if psychological impairments are left out of the WPI% calculations then the individual does not get a fair representation of his whole person impairment. He expressed his disapproval of a situation in which if his patient had a brain injury he could quantify the resulting psychological impairment and include it in determining the patient's WPI but if he had no brain injury but had virtually the same psychological impairment there would be no mechanism for doing so.

This is result-selective reasoning, and I return to it below.

[61] The court in *Desbiens v. Mordini, supra*, noted the similarities in the descriptions between table 3 in Chapter 4 and the table in Chapter 14 entitled "Classification of Impairments Due to Mental and Behavioral Disorders". These are set out below:

Chapter 4: Emotional and Behavioural Disturbances			**Chapter 14: Mental and Behavioural Disorders**	
Impairment Description	WPI%		**Impairment Description**	Class
Mild limitation of daily social and interpersonal functioning	0-14		Mild impairment: Impairment levels are compatible with *most* useful functioning	2
Moderate limitation of *some* but not all social and interpersonal daily living functions	15-29		Moderate impairment: Impairment levels are compatible with *some*, but not all, useful functioning	3
Severe limitation impeding useful action in *almost all* social and interpersonal functions	30-49		Marked impairment: impairment levels *significantly impede* useful functioning	4
Severe limitation of all daily functions requiring total dependence on another person	50-70		Extreme impairment: *impairment levels preclude* useful functioning	5

[62] Dr. Ameis acknowledges the similarities, but he notes that the principal distinction between the two tables is that Table 3 in Chapter 4 requires organic and neurological deficiencies that are measurable. These must be demonstrated to be "permanent", as noted in the proper title to the Guides: "Guides to the Evaluation of Permanent Impairment". Mental and behavioural impairments that are not rooted in a physical difficulty are not normally understood as "permanent". Table 3 in Chapter 4 was "never intended for reading psychological disorders that lack an associated neurological diagnosis." There is, in his view, "no basis for determining a direct relationship of level of impairments between Chapter 4 and Chapter 14."

[63] Combining the two sorts of impairments would contradict the express purpose of the Guides, which is to provide a system for evaluating impairments that is objective and standardized:

> The major objective of the *Guides* is to define the assessment and reporting of medical impairments so that physicians can collect, describe, and analyze information about impairments in accordance with a single set of standards. Two physicians, following the methods of the *Guides* to evaluate the same patient, should report similar results and reach similar conclusions. Moreover, if the

> clinical findings are fully described, any knowledgeable observer may check the findings with the *Guides* criteria. (Page 7)

[64] The Guides go on to state at p. 7: "Without standardization of evaluations and reporting procedures, an individual reading these reports would have difficulty deciding which report to believe. This outcome is neither reasonable nor fair, and it tends to give rise to avoidable confrontation."

[65] The problem with mental and behavioural impairments is that such standardized assessments are not possible. Dr. Ameis testified that impairment is to be based on objective findings, not on subjective non-verifiable complaints. But this causes difficulty with respect to psychological complaints:

> The psychologist and psychiatrists look for key symptoms and try to apply them to reach a diagnosis but it's done in a, in a much looser way than the rest of the – the physical examination and the physical diagnosis is done. So, one ends up with descriptive diagnosis such as adjustment disorder as opposed to carpal tunnel syndrome, which is based on an actual finding of weakness and wasting.

[66] Combining the mental and behavioural impairments with the physical impairments would introduce the danger of creating an impairment rating system that is not based on consistent objectivity. As Dr. Ameis testified: ". . .There's far more variation in inter, inter-clinician observation and conclusion in the psychological realm. . . .[Y]ou can end up with two psychiatrists or a psychiatrist and psychologist giving substantially different ratings for the same condition. . . . So, you have two different levels of precision in play when you try and combine the two."

[67] I find that, with limited exceptions, the Guides do not permit the combination of mental and behavioural impairments with physical impairments, for reasons that are clearly stated.

2.The structure of the SABS reinforces the demarcation in the Guides

[68] The structure of the SABS reinforces the bright line demarcation between mental and behavioural disorders referred to in Chapter 14 of the Guides on the one hand, to which clause 2(1.1)(g) of the SABS specifically refers, and the impairments assessed under the other chapters of the Guides on the other hand, to which clause 2(1.1)(f) of the SABS refers, and does not permit their combination in determining WPI under clause 2(1.1)(f). I say this for a number of reasons.

[69] First, the policy position in the 4th edition Guides against combining them is so clear and so distinctive that the legislator must have been familiar with this position when that edition was selected as the standard for determining catastrophic impairment. As noted above, the corollary of the primacy of the SABS is that where the Guides take a position on an issue and the regulation is silent, the Guides apply. This is what the words "in accordance with" in clauses 2(1.1)(f) and (g) import.

[70] Second, the impairments "due to mental or behavioural disorder" are separately and specifically referred to in clause 2(1.1)(g) of the SABS. The existence of indeterminacy in assessing mental and behavioural disorders is reflected in the clause since it considers only those who suffer "Marked impairment," that is, "Impairment levels *significantly impede* useful functioning," and "Extreme impairment," that is, "*Impairment levels preclude* useful functioning" (emphasis in Guides). One would reasonably expect fewer disputes about such distinctive impairments.

[71] Third, interpreting clauses 2(1.1)(f) and (g) just in terms of subsection 2(1.1), there is no indication that the impairments "due to mental or behavioural disorder" that are lesser than the two most serious categories were intended to be evaluated for inclusion with impairments assessed under clause 2(1.1)(f), unless that were permitted under the Guides themselves. Doing so would appear to be inconsistent with the design referred to in the preceding paragraph.

[72] Fourth, the original definition in subsection 2(1) of the 1996 SABS used the formulation: "'catastrophic impairment' means…". Professor Sullivan terms this the "exhaustive" definition, which she contrasts with the "non-exhaustive" definition that is "normally introduced by the verb 'includes'"[13]. An inclusive, non-exhaustive definition of "catastrophic impairment" was open to the legislator, but was not used. This suggests that the legislator's intent in this instance was to narrow the scope of the word and to ensure that it could not be enlarged except within the rules set by the SABS. The formulation in the current version of the SABS, which has been restructured somewhat as the result of changes in benefits attributable to different time periods over the years, now uses a different expression, which has the same import: "(1.1) For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is…" (emphasis added).

[73] Fifth, I note that the category of "catastrophic impairment" is meant to be exceptional in the SABS. Only those who suffer such an injury have the additional entitlements to benefits, which was one of the purposes of Bill 59 to restrict, and the right to initiate lawsuits, which was one of the purposes of Bill 59 to extend, but on a limited basis.

[74] Sixth, the things listed that qualify as catastrophic impairments under the definition are very serious and would, by their nature, be relatively rare. There is no indication of legislative intent that the list be expanded by the exercise of discretion.

[75] Seventh, the list of things that are identified as catastrophic impairments has the word "or" between the last two clauses 2(1.1)(f) and (g) at the end of a list of paragraphs. This is clearly a disjunctive use of the word (although it is possible for a very unfortunate accident victim to suffer from more than one of those injuries). Each of these injuries is a separate and distinct road to qualification under the definition. It also reinforces the conclusion in the previous paragraph.

[76] Finally, and perhaps obviously, if the legislator had wanted the mental and behavioural impairments contemplated by clause 2(1.1)(g) to be combinable with the impairments to be assessed under clause 2(1.1)(f), it would have been easy to say so clearly.

[77] These reasons, taken individually and together, lead to the conclusion that the mental and behavioural impairments contemplated by clause 2(1.1)(g) of the SABS are not combinable with the impairments to be assessed under clause 2(1.1)(f).

The definition of "impairment"

[78] The plaintiff submits that the definition of "impairment" in subsection 2(1) of the SABS and the application of subsection 2(3) of the SABS, which points to "analogous" impairments, effectively require the SABS to be interpreted to require or permit such a combination in determining whether a claimant can meet the catastrophic impairment threshold of 55 per cent WPI. I reject these submissions.

[79] Subsection 2(1) of the SABS defines "impairment" in the following way: "'impairment' means a loss or abnormality of a psychological, physiological or anatomical structure or function." This is technically an exhaustive definition[14]. Mr. Steinmetz argues that it is an expansive definition that must be read into the term "impairment" wherever it occurs in the SABS, including clause 2(1.1)(f). He relies on the words of the court in *Desbiens v. Mordini, supra* at para. 239 that the definition is "extremely broad" and that "it is difficult to conceive of a more inclusive definition."

[80] I disagree for two reasons. First, the actual use of the definition in the regulation must be considered. The term "impairment" is used more than 150 times in the SABS, and is cited more than one-third of the time in conjunction with the word "catastrophic". It takes its character from the specific usage in context. For example, in the definition of "health practitioner," the word is used, but is logically limited to the impairment that the particular practitioner is authorized by law to treat. A dentist, for example, would not be expected to treat a psychological disorder, nor would a psychologist be expected to treat a physiological injury. As another example, in terms of the specific impairments listed in clauses 2(1.1)(b), (c) and (e), the physical implications are obvious. Finally, in respect of clause 2(1.1)(g), the reference to "impairment" is highly specialized: "a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder." The particular meaning that is to be ascribed to a word ordinarily depends more on its specific use than on a general definition.

[81] It makes no sense to import the compendious definition of "impairment" in subsection 2(1) into every one of the specific uses of "impairment" in the SABS. As the Court of Appeal noted in *Jacobs Catalytic Ltd. v. International Brotherhood of Electrical Workers, Local 353*, 2009 ONCA 749, [2009] O.J. No. 4501 at para. 39: "It is a principle of interpretation that '[u]nless the contrary is clearly indicated by the context, a word should be given the same interpretation or meaning whenever it appears in an act:' *Thomson v. Canada (Deputy Minister of Agriculture)*, [1992] 1 S.C.R. 385 at 400 (per Cory J., for the majority)." And see *Bapoo v. Co-Operators General Insurance Company*, *supra*. The diverse uses of the definition in the SABS illustrate Professor Sullivan's observation that sometimes a definition may be used to do no more than "to create an abbreviation or other concise form of reference for a lengthy expression."[15] In my opinion, the compendious definition of "impairment" is nothing more than a drafting convenience.

[82] Second, in my view, Mr. Steinmetz is asking the compendious definition of "impairment" to do work for which it was not designed, and that is to override the inference imported by the words "in accordance with" the Guides in clauses 2(1.1)(f) and (g) of the SABS that the mental and behavioural disorders referred to in Chapter 14 of the Guides are not to be combined with the impairments assessed under the other chapters of the Guides in determining WPI. In my opinion, such an override would take a positive and clear direction by the legislator, and the definition does not suffice.

[83] Mr. Steinmetz submits that if it had been intended to limit the "impairment" referred to in clause 2(1.1)(f), it would have been simple to add the word "physical" or "physiological" before the word "impairment"[16]. I disagree for two reasons. First, that is not the way in which the drafting operates in the SABS. There is no other place in the SABS in which the word "impairment" is similarly qualified. Instead, the qualification comes from its specific local use, as noted above. In clause 2(1.1)(f), the qualifying reference is to "an impairment or combination of impairments that, in accordance with the . . . *Guides* . . . results in 55 per cent or more impairment of the whole person." Second, as noted above, the impairments assessed in the chapters other than Chapter 14 of the Guides do not encompass only physical injuries; some do permit adjustment to account for associated psychological factors.

[84] Mr. Steinmetz next submits that the Guides "do not provide any absolute prohibition on the use of percentage ratings for psycho-emotional impairments"[17]. While this is true, it rather reverses the ordinary understanding of judicial power. Courts cannot do what they like, but only what they are positively authorized by common law or legislation to do; if there is no such positive authorization, then the absence of a prohibition is of no assistance to empower the court.

"Analogous" impairments under subsection 2(3) of the SABS

[85] Mr. Steinmetz argues strongly that subsection 2(3) of the SABS gives clear direction that is inconsistent with the policy thrust in the Guides and therefore must override the Guides. It provides, to repeat for convenience:

> (3) For the purpose of clauses (1.1) (f) and (g) . . . , an impairment that is sustained by an insured person but is not listed in the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993 shall be deemed to be the impairment that is listed in that document and that is most analogous to the impairment sustained by the insured person.

[86] Mr. Steinmetz argues that subection 2(3) must result in psycho-emotional impairments being assigned percentage ratings for the purpose of determining WPI. He takes the position that that it directs the court to take the appropriate mental or behavioural impairment listed in Table 3 in Chapter 4 and utilize it in determining WPI.[18]

[87] In making this argument, Mr. Steinmetz relies on the reasoning in *Desbiens v. Mordini*, *supra* at paras. 260-62 where the court held that "it is proper to interpret the words 'not listed' as encompassing both impairments that are not identified and impairments that are identified but

not assigned any percentage." The reason for doing so was that "[t]o interpret the word 'listed' as only meaning 'identified' as urged by the defendants, could defeat this purpose and create a result that is neither reasonable nor just." The holding assumed that the court was "wrong in concluding that assigning percentages to psychological impairments is in accordance with the Guides."[19]

[88] I disagree, with respect. There is no definition of the word "listed" in the SABS or in the Guides. It is not a term of art. The definition in the Concise Oxford English Dictionary could not be simpler: "a number of connected item or names written consecutively." The definition raises the question: in what way are the items connected?

[89] The Guides describe and set out many impairments. But they divide into two major categories: those that expressly contribute to the calculation of WPI, and those that do not. The impairments in Chapter 14 of the Guides do not, as has been noted. There is nothing in the word "listed" that suggests that it was intended to erase the bright line between these categories.

[90] In my view, the more natural way to interpret the words in subsection 2(3) is by respecting the legislative concept that each of clauses 2(1.1)(f) and (g) is a separate and distinct road to qualification under the definition of catastrophic impairment. Those impairments that are not found in the respective categories are to be rated with those that are found which they most resemble, like to like.[20] To be even more specific, Chapter 4 and Chapter 14 of the Guides are not analogous to each other. Further, Chapter 4 requires a physical brain problem before resort can be had to the associated mental and behavioural impairments to calculate WPI; it too is not analogous. As will be noted below, Mr. Kusnierz does not suffer from such a brain problem.

[91] Reading subsection 2(3) as Mr. Steinmetz suggests would, in my view, undermine the delicate equilibrium among the purposes of Bill 59, which aimed at reducing no-fault benefits to most people with the savings going to stabilize insurance premiums, while creating a narrow exception for people who were catastrophically impaired. The introduction of subjective mental and behavioural factors on such a broad basis would undermine the objective approach to the assessment of impairments that contribute to the calculation of WPI required by the Guides, and through them, by the SABS. It would undermine the careful design of subsection 2(1.1) which I explicated above.

3. This interpretation is consistent with the purpose of the specific provisions of Bill 59 and the SABS that this issue engages.

[92] In my view, this interpretation is consistent with the purpose of the specific provisions of Bill 59 and the SABS that this issue engages.

[93] As noted, the purposive analysis established the relevant policy thrusts as reducing no-fault benefits to most people with the savings going to stabilize insurance premiums, and as creating an exception for catastrophically impaired people whose no-fault benefits were maintained and who also got the right to sue the tortfeasor for damages in excess of the

maximum no-fault benefits, so that, albeit exceptionally, those with the most need were more able to recover health care expenses.

[94] Where does "consequential analysis", as described by Professor Sullivan[21], lead? An interpretation of the SABS that would not permit the combination of mental and behavioural disorders with the other impairments would clearly create a kind of gap in eligibility for catastrophic impairment benefits. Mr. Steinmetz argues that any such gap would be unfair and unjust, so the court should avoid an interpretation of the SABS that would lead to it. He points out that there are victims who would qualify entirely because of physical impairments under clause 2(1.1)(f) and others who would qualify entirely in respect of mental or behavioural impairments under clause 2(1.1)(g). Those victims who had significant but insufficient physical impairments to reach the 55% WPI, but who also suffer from mental and behavioural impairments, would be denied the enhanced benefits.

[95] I acknowledge the gap. It was noted by the courts in *Desbiens v. Mordini*, *supra* at para. 257, in *Arts (Litigation Guardian of) v. State Farm Insurance Co.*, *supra* at para. 15, in *Snushall v. Fulsang, supra*, at para. 59 and in *Henderson v. Parker*, *supra* at p. 473.

[96] The existence of the gap was the logical basis of Dr. Finlayson's evidence in *Desbiens v. Mordini, supra*, excerpted above, that combining the impairments should be permitted to avoid it. Spiegel J. held:

> **252** On the basis of Dr. Finlayson's and Dr. Berry's evidence, and on my interpretation of the Guides, I find that it is in accordance with the Guides to assign percentages to Mr. Desbiens' psychological impairments and to combine them with his physical impairments in determining whether he meets the definition of catastrophic impairment under clause (f).
>
> **253** In my opinion this interpretation does not offend the legislative text and it gives effect to the purpose of the legislation. I must now consider whether it produces an outcome that is reasonable and just….
>
> **258** In my view, to deprive innocent victims of motor vehicle accidents the right to recover much needed health care expenses because their psychological impairments cannot be combined with their physical impairments in considering their overall WPI is unjust.

[97] I note that the gap also existed in the area of workers' compensation in Ontario, where the revised third edition of the Guides is used (which on this issue does not differ from the fourth edition used in the SABS). The gap has been bridged by a policy of the Workplace Safety and Insurance Board ("WSIB"), according to Dr. Lacerte. Some workers injured in a workplace accident do suffer both physical impairments, and mental and behavioural impairments. He testified that since the Guides do not provide a method for translating medical and behavioural impairments on a percentage basis so that they can be combined with physical impairments, the WSIB has created a policy that sets out a method for translating findings of mental or

behavioural impairments into percentage terms that can be combined with physical impairments under the Guides. Dr. Lacerte testified that there is no parallel in the automobile area.

[98] Consequential analysis, in the words of Professor Sullivan,[22] is a legitimate part of "every effort to apply legislation to particular facts."[23] It has its limits, however: "Clearly the courts are not allowed, under the guise of interpretation, to substitute their own notions of good policy for those of the legislature. Even the strongest proponents of consequential analysis do not suggest that courts can blithely disregard the clear intentions of the legislature."[24] This is the forbidden temptation of consequential analysis.

[99] Indeed, in *Gladstone v. Canada (A.G.)*, 2005 SCC 21, [2005] 1 S.C.R. 325, [2005] S.C.J. No. 20, the Supreme Court of Canada criticized "results oriented" reasoning (para. 24) and the effort to escape the plain meaning of a legislative provision on grounds of perceived unfairness (para. 12). The Court cited *Zaidan Group Ltd. v. London (City)*, [1991] 3 S.C.R. 593, aff'g (1990), 64 D.L.R. (4th) 514 (Ont. C.A.) at pp. 518-19, where Carthy J.A. said:

> The common thread of unfairness recognized by the common law breaks when a legislative body acts within its jurisdiction and stipulates, as here, that the municipality shall levy assessed amounts, the taxpayers shall pay those amounts, the municipality may use the money it has collected, and must refund it if adjusted downward on appeal, with interest if it has passed a by-law. The statute could equally have said that a taxpayer must pay the assessed amounts without any recourse by way of complaint. The unfairness of such a statute would be universally denounced but, if it were constitutionally competent to the legislature, the common law would have nothing to say on the subject. There is no question of a gap being left in the legislation for the common law to fill.

[100] Judges have occasionally chaffed at what they see as some unfairness in the regime: see the gap cases referred to earlier. Sometimes, on the other hand, the regime can provide benefits where the victim's current functioning might establish that there is no need; that is a necessary incident of the "bright line rule" that SABS establishes in determining catastrophic impairment: *Liu. v. 1226071 Ontario Inc. (Canadian Zhorong Trading Ltd.)* (2009), 97 O.R. (3d) 95, per MacFarland J.A. at para. 30 (C.A.).

[101] Changes in the automobile insurance regime result in claimants who are comparatively better off and worse off in relation to their predecessors and their contemporaries. This was the observation of the Court of Appeal in *Meyer v. Bright, supra,* at p. 150 and the observation of Heeney J. in *Henderson v. Parker, supra*, at para 43, p. 473. The references could easily be multiplied.

[102] The pertinent issue is whether that result was chosen by the legislator: *Chisholm v. Liberty Mutual Group, supra; Van de Vrande v. Butkowsky*, 2010 ONCA 230, 99 O.R. (3d) 641, [2010] O.J. No. 1239 (C.A.) at para. 11; *Niagara River Coalition v. Niagara-on-the-Lake (Town), supra* at para. 44.

[103] The Court of Appeal found in *Bapoo v. Co-Operators General Insurance Company*, *supra* at p. 620, that an appropriate interpretation is one that can be justified in terms of its compliance with legislative text, its promotion of the legislative purpose, and the reasonableness and justice of the outcome. I conclude that the interpretation here is consonant with the careful design of the legislative text, promotes the diverse legislative purposes, and, in that context, is reasonable and just in its outcome.

Issue Two: Has Mr. Kusnierz sustained a catastrophic impairment on the basis of section 2(1.1)(f) of the SABS alone?

[104] How should the Guides be interpreted and applied in determining whether Mr. Kusnierz' "impairment or combination of impairments . . . results in 55 per cent or more impairment of the whole person" under clause 2(1.1)(f) of the SABS?

Some Observations about the Court's Task

[105] My task is to consider whether the evidence of Mr. Kusnierz' impairments satisfy the criteria in the SABS and the Guides for catastrophic impairment on the balance of probabilities. The discussion of the first issue conveys some sense of the purpose and approach of the Guides. As the Foreword notes, the purpose of the Guides is "to bring greater objectivity to estimating the degree of long-standing or "permanent" impairments". The reason is to "help eliminate bias, and error introduced by selecting or encouraging one outcome over another" (page 3) and to prevent "avoidable confrontation" (page 8). But the Guides are realistic:

> Even though a rating or estimating impairments cannot totally be objective, use of the *Guides* increases objectivity and enables physicians to evaluate and report medical impairment in a standardized manner, so that reports from different observers are more likely to be comparable in content and completeness. The *Guides* helps minimizes abuses and unrealistic verdicts that may arise from unjustified claims. (page 5)

[106] While clinical judgment has some limited scope, as my review of the evidence will show, medical assessors are given no overriding discretion to substitute their views for the hard evidence required by the Guides. If anything, the Guides aim at reducing the scope for subjectivity and discretion. As I observed earlier in the context of the first issue, the exhaustive definition of "catastrophic impairment" in the SABS grants no overriding discretion to the court.

[107] Sympathy for a patient, while naturally human, is not to be permitted to influence the assessment, according to the Guides. This same stricture is binding on the court through the Guides and the SABs. My sympathy for Mr. Kusnierz, therefore, is not allowed to influence my assessment of his claim on the evidence.

[108] The SABS, through the use of the Guides, prescribe a highly structured framework that is quite precise and mathematical. The result of a bright line threshold like 55% WPI is that some people will meet it handily, others will fall far short, and some will come close. For those who come close, there is no discretion in the court, out of sympathy, to push the plaintiff over the

line. This is scheme that the legislator has adopted and that binds me in determining the second issue.

What the Guides Direct

[109] In order to determine a person's WPI, the Guides direct a physician to examine the impairment that is of most concern to the person. It is common ground that it is possible and legitimate to add other impairments and combine ratings together using the Combined Values Chart in the Guides to calculate WPI, but the impairments to be added must be significant and unrelated to each other.

[110] Section 2.2 (p. 8) of the Guides sets out the required steps in an assessment:

> **2.2 Rules for Evaluations**
>
> In general, the physician should estimate the extent of the patient's primary impairment or impairing condition, that is, the condition that seems to be of most concern to the patient. The estimate should be based on current findings and evidence. It may be necessary to refer to the criteria and estimates in several chapters if the impairing condition involves several organ systems. In that case, each organ system impairment should be expressed as a whole-person impairment; then the whole-person impairments should be combined by means of the Combined Values Chart (p. 322). The general philosophy of the Combined Values Chart is explained in Section 3.1, Chapter 3.1, Chapter 3 (p. 15).
>
> If the physician believes that the patient has two significant, unrelated conditions and that the extent of each should be estimated, this may be done. The whole-person impairment estimates for the two separate conditions then would be combined into an overall impairment estimate using the Combined Values Chart.
>
> Tests of consistency, such as the one described to check the patient's lumbosacral spine range of motion (Chapter 3, Section 3.3 j p.113), are good but imperfect indicators of patients' efforts. The physician must utilize the entire gamut of clinical skill and judgment in assessing whether or not the results of measurements or tests are plausible and relate to the impairment being evaluated. If in spite of an observation or test result the medical evidence appears not to be of sufficient weight to verify that an impairment of a certain magnitude exists, the physician should modify the impairment estimate accordingly, describing the modification and explaining the reason for it in writing.
>
> In this book, a 95% to 100% whole-person impairment is considered to represent almost total impairment, a state that is approaching death.

The Medical Experts

[111] I heard evidence from the respective medical experts, Dr. Ameis for the plaintiff and Dr. Lacerte for the defendant. I was also referred to medical reports in the document book, which the parties have agreed are admissible as reports under section 52 of the *Evidence Act*, R.S.O. 1990, c. E.23.

[112] Dr. Ameis is a qualified physiatrist. From 1996 to 2006 he was designated by the Financial Services Commission of Ontario as a catastrophic impairment assessor. For many years, he was the medical director of the Multi-Disciplinary Assessment Centre ("MDAC"), one of seven designated assessment centres. His evidence demonstrated a deep conversancy with the Guides. He has been qualified as an expert in the Guides on numerous occasions and his expertise is not disputed.

[113] Dr. Lacerte is a qualified physiatrist. He is an associate professor at the Faculty of Medicine and Dentistry at the University of the Western Ontario in the Department of Physical Medicine and Rehabilitation. Dr. Lacerte was the medical director of the ADAC Centre for Catastrophy, a designated assessment centre, for many years. He is on the Workplace Safety and Insurance Appeals Tribunal roster of health professionals by Order-in-Council appointment. He trains physicians in how to assess non-economic loss in WSIB claims. He is well-experienced in using the Guides. Dr. Ameis graciously acknowledged that Dr. Lacerte is "the one I go to when I want advice".

The Admissibility of Dr. Ameis' Evidence

[114] Dr. Ameis was initially retained by Jack Fireman, counsel for the plaintiff, to assist him in preparing a SABS claim. Dr. Ameis almost immediately moved from the status of an independent expert to something close to a treating physician. His first letter to Mr. Fireman of October 21, 2002 states: "In this case, the patient and I agreed that a physician patient relationship could exist, insofar as there were some elements of information that I felt important to impart to him about the nature of his condition, his prognosis and management." Dr. Ameis sent a copy of this letter to Mr. Kusnierz's family doctor. He later assisted Mr. Kusnierz in finding a new family doctor when his old family doctor retired.

[115] Dr. Ameis' report of October 28, 2004 concerning a visit on October 25, 2004 was perfunctory in part because, as a result of a recent plastic surgical procedure, Mr. Kusnierz' stump was infected and Dr. Ameis wanted to him to get to a hospital. He has, however, not seen Mr. Kusnierz since.

[116] Dr. Ameis was candid and clear, and I admire his commitment to his patient. In the same report, he notes in his concluding comments that: "I continue to advocate for Mr. Kusnierz to be deemed 'catastrophically impaired', as I genuinely believe that he meets the requirements of Catastrophic Impairment in terms of his severe long-term impairments of ambulatory function, chronic ill health and pain, as well as exceptional associated financial needs." Indeed, Dr. Ameis continues to be a passionate advocate for Mr. Kusnierz.

[117] But I was left in a quandary about the admissibility of Dr. Ameis' evidence as a result of recent concerns about the undue weight that trial judges sometimes give to experts who are not independent within the meaning of the amendments to Rule 53.03 and Rule 4.1.01 of the *Rules of Civil Procedure*, R.R.O. 1990, Reg. 194: see the recommendations of the Civil Justice Reform Project (2007)[25] related to the problem of "expert bias"[26]. It is important that trial judges take seriously the "gate keeping" function: see the Honourable Stephen T. Goudge, Commissioner, *Report of the Inquiry into Paediatric Forensic Pathology in Ontario*, Volume III, Chapter 18 (the Goudge Inquiry). While the new wording does not apply to this case, the underlying policy of due caution does.

[118] It would be reasonable in these circumstances, to consider the evidence of Dr. Ameis as one would the evidence of a treating physician like a family doctor. Such a witness does not seem to fall squarely within either Rule 4.1.01 or Rule 53.03, but is someone who has and exercises expertise routinely, and ought to be able to give relevant evidence about his or her patient. I will take into account that Dr. Ameis has been a passionate advocate for Mr. Kusnierz and has formed a therapeutic alliance with him. I must, therefore, take his evidence with the proverbial grain of salt that goes to its weight.

The Competing Approaches

[119] Dr. Ameis and Dr. Lacerte took quite different approaches to the assessment of Mr. Kusnierz' impairments.

Dr. Lacerte's evidence

[120] The defendant retained Dr. Lacerte to "provide a medical opinion" on "whether Mr. Kusnierz has sustained a catastrophic impairment" as a result of the accident. He prepared a 28-page report, dated December 21, 2006. He reviewed all of the medical reports and focused especially on the reports of Dr. Ameis and of Dr. Oshidari. His report and his testimony were occasionally scathing.

[121] Dr. Lacerte, however, did not examine Mr. Kusnierz. He testified that he was asked simply to do a "technical review". He explained that if the assessments of Mr. Kusnierz had been done in accordance with the standard methodology in the Guides, he would have been able to rate the impairments quite easily. He pointed out that the Guides contemplate the original assessment being done by a doctor but the ratings are done by another person, usually not a medical doctor. This is only possible if the results of assessments are objective and consistent, and the same no matter which doctor did them.

[122] Dr. Lacerte is a staunch defender of the straightforward approach to the Guides. He believes that the methodology in the Guides must be rigorously followed. This is, he testified, "very tedious work and, you know, you really need to be very precise and because this is very much scrutinized, that, you know, you need to have a very established methodology and it has to be in keeping with [the Guides]." The cogency of his evidence respecting Mr. Kusnierz suffers, however, because he did not examine him.

[123] Dr. Lacerte criticizes Dr. Ameis' assessment strongly because Dr. Ameis did not follow the generally accepted methodology for assessing a person as outlined in Guides. For example, in assessing the amputation, the length of the residual limb is critical. If it is less than three inches, the WPI rating is 32%, but if it is three inches or more, the WPI rating is 28%. In his initial assessment of Mr. Kusnierz, however, Dr. Ameis reported: "The stump is about three inches in length". Dr. Lacerte testified that the methodology requires a definitive measurement: "Don't put 'about' because it brings a degree of vagueness that is really not helpful when you're reviewing." Based on the measurements performed by Dr. Alborz Oshidari and Dr. Edward English, Mr. Kusnierz' residual limb is more than three inches in length. The Guides make the distinction, Dr. Lacerte explains, "because essentially the shorter your stump, the harder it is, essentially, to fit the prosthesis because you don't have as much leverage."

[124] Dr. Lacerte was also somewhat critical of Dr. Oshidari's approach, who assessed the range of motion in Mr. Kusnierz' cervical spine in terms of "per cent of normal". That is not the way in which the Guides require it to be done. The Fourth Edition requires the use of an "inclinometer", which provides precise range of motion measurements in terms of degrees. Dr. Oshidari also failed to assess the range of motion in Mr. Kusnierz' leg with his prosthetic on:

> So, basically, the thing is that he had zero, zero as it relates to objective, reliable, valid measurement using, you know, measuring instrument. So, basically, Oshidari can tell you that it is decreased - you just have to believe him. He doesn't give you data, okay, and that's the whole point of the AMA Guide is that you need to give data because [otherwise] it cannot be reproducible.

[125] In his testimony, Dr. Lacerte deplored assessments aimed at generating impairment numbers for the purposes of WPI calculation. As Dr. Lacerte put it: "Overall I found that, you know, in general, how people are doing impairment rating is really out of control and, you know, is really generally poorly done."

[126] In Dr. Lacerte's opinion, Mr. Kusnierz does not meet the 55% WPI threshold in clause 2(1.1)(f) of the SABS and is therefore not catastrophically impaired. Dr. Lacerte submits that for Mr. Kusnierz, "the patient's primary impairment or impairing condition, that is, the condition that seems to be of most concern to the patient" under section 2.2 of the Guides is obviously the amputation of his left lower leg. This impairment draws the assessor immediately to Table 63, entitled "Impairment Estimates for Amputations" in Chapter 3, "The Musculoskeletal System" . Since Mr. Kusnierz' stump is longer than 3 inches the listed WPI is 28%. This rating includes associated pain according to section 2.2, disfigurement and scarring since the scar is hidden by the prosthetic. Further, section 3.2i of the Guides imposes an absolute cap of 40% WPI on impairment of a lower extremity.

[127] I insert Dr. Lacerte's specific comments below where appropriate in reviewing the evidence tendered by the plaintiffs.

Dr. Ameis' Evidence

[128] Dr. Ameis repeated a number of times, both in his testimony and in his reports, his belief that any person who has suffered an amputation above the ankle, so that he or she is unable to stand without prosthesis, should be considered to be catastrophically impaired. In his letter of June 7, 2004 to Mr. Fireman, Dr. Ameis expressed the opinion that "[t]he additional and biomechanical burdens and associated losses of functions for a man with only one leg would be better ranked . . . at a score of 60%."

[129] Dr. Ameis took what I would call a "result-selective" or "results oriented" approach to the assessment of Mr. Kusnierz under the Guides. His stated belief is that the severity of the impairment and the financial need of the patient should both drive the determination of catastrophic impairment. In his testimony he called these "two parallel arguments for his being considered catastrophic." I find that there is no support in the Guides for financial need as an available argument to justify an impairment assessment.

[130] His strategy was to look for ways to interpret the Guides that are "logical and plausible" to find Mr. Kusnierz to be catastrophically impaired. In his letter to Mr. Fireman of June 16, 2004, he wrote: "I will remind you that the primary consideration in developing an estimated impairment score is that the approach and final score must be logical and plausible within the context of the medical condition in question proportionate to the losses of function actually sustained." Over the years, he has discussed with counsel various approaches to the Guides in assessing Mr. Kusnierz.

[131] Section 2.2 of the Guides refers to the requirement for "plausibility". In cross-examination, Dr. Ameis said that he was "trying to throw, throw more things into the mix." Elsewhere he said he was looking for "opportunities". Dr. Ameis took the position that, on the part of the provincial DAC Committee, "there was essentially a tacit permission to go ahead and do what you needed to do if you thought the patient should be catastrophic." He also admitted in cross-examination, however, that "the approach that you've taken in this case is an approach that has not been commonly seen previous to this case."

The Plaintiff's Approaches on the Evidence

[132] Based on the evidence, the plaintiff argues that there are two basic approaches: gait derangement alone and the cumulated impairments.

1). Gait derangement

[133] First, as provided in section 2.2 of the Guides, Dr. Ameis defines "the condition that seems to be of most concern to the patient" to be not the amputation, but Mr. Kuznierz' mobility. This is better assessed, Dr. Ameis submits, as "gait derangement" under Table 36 in Chapter 3 of the Guides; by means of this table alone, he assesses Mr. Kuznierz' WPI at 60%, over the 55% WPI threshold for catastrophic impairment.

[134] This approach has been consistent from the outset. Dr. Ameis completed Mr. Kusnierz' Application for Determination of Catastrophic Impairment form on November 27, 2003. In the Application he noted:

> Robert is a "failed" prosthetic rehab case, with significant nociceptive and neurogenic stump pain. He is walker dependent. He has exhausted his benefits without successful prosthetic fit, Therefore severity = catastrophic, financial need = catastrophic. WPI [Whole Person Impairment] score ~ 60-65% using Table 36, ch. 3 [of the AMA Guides].

[135] The Application that Dr. Ameis completed for Mr. Kusnierz, however, specifically referred to Table 36 in Chapter 3 entitled "Lower Limb Impairment from Gait Derangement". He explained his approach in the accompanying letter of October 29, 2003:

> The AMA Guides uses a simple scoring system based on length of residual limb. However, the resultant score does not draw a distinction based on variations in ability to use a prosthetic device, a spectrum spanning the polarities of loss of function, from at best walking all day to at worse being confined to a wheelchair all day. A better approach involves a use of Table 36, evaluating Gait Derangement.

[136] Since Mr. Kusnierz suffered a below-knee amputation, it seems natural for an assessor under the Guides to consider Table 63 in Chapter 3, entitled "Impairment Estimates for Amputations". This is what Dr. Alborz Oshidari, a physiatrist for Work Able Centres Inc., did in his report dated April 6, 2004, following an assessment of Mr. Kusnierz on February 15, 2004, a little more than 26 months after the accident.

[137] In his testimony, Dr. Ameis criticized Dr. Oshidari's approach. He argued that Table 63, which sets out "Impairment Estimates for Amputations" in the lower extremities, is not appropriate because it implicitly assumes a normal outcome for the amputee being evaluated. When he first saw Mr. Kusnierz on October 21, 2002, this is what he expected. By 2003, however, he considered Mr. Kusnierz to be a "failed prosthetic rehab case". If the outcome is abnormal, then Dr. Ameis testified that the assessor is free to look for other approaches within the Guides. Subsection 2(3) of the SABS provides that where an impairment is not listed in the Guides, an assessor can utilize the impairment that is listed in the Guides "that is most analogous to the impairment sustained by the insured person." Within the Guides, Dr. Ameis referred to section 3.2i, entitled "Diagnosis-based Estimates". It provides:

> Some impairment estimates are assigned more appropriately on the basis of a diagnosis than on the basis of findings on physical examination. A good example is that of a patient impaired because of the replacement of a hip, which was successful. This patient may be able to function well but may require prophylactic restrictions, a further impairment. For most diagnosis-based estimates, the ranges of impairment are broad and the estimate will depend on the clinical manifestations.

> The evaluating physician must determine whether diagnostic or examination criteria best describe the impairment of a specific patient.

He also relied on section 3.2c, entitled "Muscle Atrophy (Unilateral)": "The evaluating physician should determine which method and approach best applies to the patient's impairment and use the most objective method that applies."

[138] Dr. Ameis also referred to section 2.3, entitled "General Comments and Evaluation": "The *Guides* attempts to take into account all relevant considerations in estimating or rating the severity and extent of permanent impairment and the effects of the impairment in terms of the individual's everyday activities"

[139] Dr. Ameis testified that gait derangement is particularly well suited to Mr. Kusnierz because his problem is one of mobility. Dr. Ameis accepts that the limits in Table 36 must be respected. The associated text in section 3.2b provides:

> This part may serve as a general guide for estimating many lower extremity impairments. The lower limb impairment percents shown in Table 36 should stand alone and should *not* be combined with those given at other parts of Section 3.2. Whenever possible, the evaluator should use the more specific methods of those other parts in estimating impairments. (emphasis in original)

Section 3.2b "does not apply to abnormalities based only on subjective factors," such as pain.

[140] The "more specific" method would normally apply, and that would send the assessor to Table 63 relating to amputations. This is why Dr. Lacerte disputes Dr. Ameis' use of gait derangement.

[141] For Mr. Kusnierz, however, the problem with Table 63 is found in section 3.2i, which provides that: "The final lower extremity impairment must not exceed the impairment estimate for the amputation of the extremity, 100%, or 40% whole-person impairment." According to Dr. Ameis, if the focus is only on amputation, then the estimate would be capped at 40% WPI, which would not reflect Mr. Kusnierz' true level of impairment.

[142] But, Dr. Ameis testified, the example in section 3.2b shows that close attention must be paid to the specific problem manifested by the patient. In the example, the patient had moderately advanced hip arthritis that required part-time use of a cane. The comment makes it clear that the gait derangement table can be used even where other parts of the Guides are more specific:

> The patient's impairment might be estimated by using the estimates for gait derangement, those for arthritic degeneration (p. 82), or those for hip abductor muscle weakness (p. 77).

In this case, the evaluator believed the patient's use of a cane best reflected the basic pathologic process and that using the estimates related to gait disturbance was proper.

[143] Dr. Ameis testified that :

…gait derangement is something different than specific impairments because many things contribute to gait, to the ability to walk. The instructions go on to warn that firstly, Table 36 – which is the table that relates to this section – is a standalone table. Whatever score you get in it represents the lower extremities in total. It also goes on to advise that whenever possible, more specific methods should be used. This is not supposed to be the table of choice in all – in, in most cases and also there are certain areas of exclusion such as pain or giving way, which are behaviours rather than, than anything else. The table itself is based upon the extent to which an individual relies upon an assistive device. So, the table scores, which are found on page 76, Your Honour, lies in lock step – no pun intended – with the type of device being used. So, using a cane part-time would be considered a 15 percent impairment. Using two canes full-time would be 40 percent impairment. Using two canes and a long-legged brace would be 60 percent impairment and so on upward all the way to 80 percent. The reason I suggest that the 40 percent limit is not absolute is that an individual with a bad leg, so bad that he has a long-legged brace and is walking with two canes, if the leg alone is the source of the limitation, that's 40 percent, but here we see the Guides suggesting that 60 percent might be applicable. So, it's really a question of case by case individual circumstance by individual circumstance and the clinical example that's given is intended to help understand that. So, we don't need to get into the details of the clinical example other than it's an individual who has part-time use of the can because of hip disease.

[144] Dr. Ameis added:

The problem is the book itself has such limited explanation that it's very difficult to know what's intended and the point I'm making is that it may well – it may be that in some circumstances 40 percent isn't an absolute ceiling. That's the only inference I would like you to draw from that particular point. The sec – well, I said there's a second one which is that whereas the general guideline has always used the approach that gives the highest score, but that's always, of course, subject to reasonableness, proportionality. In this case the examples given – what they're saying is that when you use the table for arthritis or you use the table for muscle weakness, you don't get enough of the score to capture what this person is experiencing in terms of difficulty walking and the gait table is therefore chosen because it does seem to be more proportionate.

[145] Dr. Lacerte's evidence on gait derangement is somewhat ambiguous. He testified that gait derangement was not appropriate where the underlying complaint was pain, which is understood to be a subjective problem that the Guides exclude in section 3.2b. He would, however, support using gait derangement where there is an "underlying pathology that is – objective – can be objectified and can be measured." Dr. Lacerte would, however, prefer to use a more specific method, which, in this case, is amputation.

[146] I find that using gait derangement is therefore a possible approach. In this case, the underlying pathology is the tendency of Mr. Kusnierz' stump to develop cysts to an unusual degree.

[147] I note that in Table 63, except for hemipelvectomy, none of the listed amputations exceed 40% WPI for lower extremity impairment, while Table 36 lists gait derangement values in a range from 7% WPI to 80% WPI. Dr. Ameis argues that the lower extremity limit of 40 % WPI set out in section 3.2i does not apply to gait derangement. I agree.

[148] The plaintiff notes that Table 36 assigns an estimated score of 40% WPI to a person who has two legs but requires assistive devices in the form of two canes or two crutches. In the opinion of Dr. Ameis, the additional biomechanical burdens and associated losses of functions faced by the plaintiff, who routinely uses a walker indoors for much of the time, would be similar to a person who requires routine use of two canes or two crutches and a long leg brace. This would yield a WPI score of 60% under Table 36.

[149] My difficulty is with the rating of Mr. Kusnierz' gait derangement at 60% WPI, which is in the severe range. I would accept that figure if the technique of hopping to the walker were Mr. Kusnierz' customary mode of walking indoors or outdoors – supplemented by a wheel chair – but it is not. Mr. Kusnierz uses a walker indoors, but not outdoors. He uses a prosthetic half of the time indoors, and all of the time outdoors.

[150] Dr. Ameis' report, dated June 7, 2004, states:

> Table 36 assigns a rank of (g.) and an estimate score of 40% to a person who has two legs but requires assistive devices in the form of 2 canes or two crutches. In my opinion, the additional biomechanical burdens and associated losses of function for a man with only one leg would be better ranked at (i.), at a score of 60%.

[151] To this, Dr. Lacerte responds in his report:

> The additional biomechanical burdens are not supported by the literature, thus Dr. Ameis' argument to arbitrarily give a 60% WPI rating does not rely on Table 36, which he has relied on up until now.

[152] Dr. Lacerte also points out that "Dr. Oshidari's examination of Mr. Kusnierz's left lower extremity and gait was basically normal". He added "It is my strong opinion that this [attributed hip disarticulation] is contrary to Dr. Oshidari's <u>own</u> objective findings that 'Today he walked

without a walking assistive device. There was no obvious limping in the lower extremity'" on his February 5, 2004 visit to Dr. Oshidari (emphasis in original). Dr. Lacerte concludes: "Finally, Dr. Ameis has not used Table 36 properly, which he relies upon heavily. In any case, when appropriate methodology is fully employed, Dr. Oshidari's description of Mr. Kusnierz's gait would preclude the use of this table."

[153] Based on the evidence of Dr. Ameis and Dr. Oshidari, I find that gait derangement is one possible approach to the assessment of Mr. Kusnierz' impairments, at no more, however, than 40% WPI.

2). Cumulating impairments

[154] Dr. Ameis' second approach was to assess all of Mr. Kusnierz' impairments and to combine them under the Combined Values Chart in the Guides to cumulate to a WPI that exceeds 55%.

[155] The plaintiff argues that this possible outcome starts with a base WPI of 40% and adds other impairments, specifically a skin impairment rating of 17-24%; a medication impairment rating of 5-10%; a cervicothoracic spine impairment of 5%; a lumbar spine impairment of 5%, and 7% impairment for the ulnar nerve entrapment, for a combined WPI of 60%, using the Combined Values Table of the Guides. I analyze each of these components.

The derivation of the 40 % WPI base

[156] The plaintiff argues that the base of 40% WPI can be reached by one of two routes. The first is the application of Table 63, which addresses impairment estimates for amputations, as scored by Dr. Oshidari at 40% WPI. In his report dated April 6, 2004, Dr. Oshidari explained his approach:

> Mr. Kusnierz also experiences severe phantom pain in his left lower extremity, which failed to respond to conservative treatment. Unfortunately, AMA Guidelines do not put any specific percentage for phantom pain or neuropathic pain in the lower extremity secondary to amputation. Therefore, I find it is very difficult to come to a specific calculation and measurement for impairment to the left below the knee amputation with neuropathic pain. If we closely follow the below knee amputation (Chapter 3, Page 83, Table 63) his impairment will be 32%. But, as mentioned before, there was a history of phantom pain and other medical condition. But, again, AMA Guidelines (sic) state that the maximum impairment in limb with other complications is not supposed to surpass amputation. Therefore, I decided to provide him with the maximum level of hip disarticulation to provide him with 40% impairment, which can cover not only below knee amputation, phantom pain and possibility of other deterioration of skin and arthritis in the left knee joint.

[157] Dr. Lacerte utterly rejects the proposition that Mr. Kusnierz' below-knee amputation is the equivalent of a hip disarticulation amputation. He explained that this particular impairment

involves taking the hip out of the socket so that the patient has no hip and no leg. It is very difficult to fit such a patient with a prosthesis. Patients with hip disarticulation amputation are not stable when they walk and usually use crutches. Most do not bother with a prosthesis. From the viewpoint of "an impairment and a disability impact and activity and everything else. I mean, it's night and day." I accept Dr. Lacerte's evidence that a hip disarticulation is far worse than a below-knee amputation, so that the latter cannot be rated as equivalent to the former.

[158] The plaintiff's second way to 40% WPI is the application of Table 36, addressing gait derangement, but scored at the moderate level of severity in which the patient "[r]equires routine use of two canes *or* two crutches" (emphasis in original). This rates at 40% WPI.

[159] Dr. Oshidari saw Mr. Kusnierz on February 18, 2005, and issued a report dated April 15, 2005. In this report, Dr. Oshidari commented on the gait derangement approach but used a different table than Dr. Ameis, not Table 36, but Table 13 in Chapter 4, which describes "Station and Gait Impairment Criteria":

> There is another way to calculate the impairment due to gait derangement not due to musculoskeletal injury but with the neurological condition. In this category the patient can rise to a standing position and can maintain it with difficulty but cannot walk without assistive device or patient cannot stand without help of others, mechanical support, and prosthesis. If we decide to use this category, this one fits more with the end of 20-39% or early of 40-60% (Chapter 4, Page 148, Table 13.). Therefore, in this case if also I decide to use this criteria, his impairment would be 40%.

Skin impairment rating

[160] Skin impairment is addressed in Chapter 13 of the Guides and particularly in Table 2 of that chapter, entitled "Impairment Classes and Percents for Skin Disorders." Skin impairment as a specific focus was first raised by Dr. Oshidari in his report of April 6, 2004, quoted above, where he referred specifically to "deterioration of skin" as a reason for scoring the amputation at 40%.

[161] In his testimony, Dr. Ameis differentiated between musculoskeletal problems and skin problems:

> The musculoskeletal system for the leg really is gait. Remove the leg, whether you paralyze it, amputate it and you remove the musculoskeletal functions but you're still left with skin and that skin, that stump, is still creating significant burdens for him and those burdens, I believe, are to be scored in a separate organ system – an organ system chapter, which is Chapter 13.

[162] In his comment on Dr. Oshidari's report dated June 7, 2004, Dr. Ameis took issue with this analysis. In his view skin requires a separate assessment. In commenting on the Guides' chapter on amputation, he noted:

> [T]here is one specific, deliberate omission: the overlying skin. This is because the skin in a separate organ system, the Integumentary System, which has a set of functions (heat regulation, protection from injury or infection, non-verbal communication etc) quite distinct from the neuromusculoskeletal organ system's component structures.

[163] These are addressed in Chapter 13 on skin. Dr. Ameis gave the opinion that "injuries to the Skin which require special protective measures, therapies or other attention because of vulnerability to one or more external factors (e.g. heat/cold/bites/physical blow/sun etc), must be separately impairment scored from the other systems." Consequently, he concluded that: "In regard to skin, [Dr. Oshidari] has been over-inclusive in 'lumping' it in with musculoskeletal impairments."

[164] Dr. Ameis went on to note that:

> Mr. Kusnierz suffers from multiple stump skin problems and must take special precautionary measures. Some of his time each day must be spent on managing the chronic skin problems. He faces the likelihood of plastic surgical interventions for the deeper, more complicated skin problems.
>
> His stump skin problems are greatly in excess of those minor conditions which are 'average' for the below knee amputee, and which would be expected to be captured within Table 36.

[165] Dr. Ameis testified that: "My argument would be that the "40% [limit for lower extremity impairment] is idiosyncratic to the musculoskeletal organ functions of the body and that anything to do with skin will be over and above that unless it, in some specific way, conflicted with what was already scored under musculoskeletal." In his view, "Chapter 13 would create opportunities for additional scores over and above what could be created out of Chapter 3." He referred specifically to the examples at page 283 of the Guides which show that skin impairments can be combined with other impairments under the Combined Values Chart. He noted that Chapter 13 also allows for some form of recognition of disfigurement and the associated psychological issues, and "amputation, in my view, is a disfiguring condition". He added that: "The parameter which the Guides Chapter recommended was social rejection, poor self-image, anything of that sort, and the means by which disfigurement would be scored as anticipated to be as supplement to whatever score is given for the skin impairment itself." The example on page 285 specifically refers to this approach, and providing for: "30% impairment due to the skin disorder, which is to be increased by an amount that is proportional to the estimated mental behavioral impairment." The example on page 284 takes the same approach, and provides that "a mental and behavioural impairment (Chapter 14, p. 291) might further increase the estimate."

[166] Dr. Ameis has not, however, been consistent in his rating of Mr. Kusnierz' skin problem. Dr. Ameis concluded in his report of June 7, 2004 that Mr. Kusnierz' circumstances place him in the Class 3 level of impairment (25%-54% WPI) described in the Guides at p. 284

as follows: “signs and symptoms of the skin disorder are present or intermittently present; *and* (2) there is limitation in the performance of *many* of the activities of daily living; *and* (3) intermittent to constant treatment may be required” (emphasis in original).

[167] In his later report of October 28, 2004, he amended his view of his estimate of skin impairment to increase it to Class 4 with a rating of 55% to 84% WPI, described in the Guides at p. 286 as follows: “signs and symptoms of skin disorder are *constantly* present; *and* (2) there is limitation in the performance of *many* of the activities of daily living, which may include intermittent confinement at home or other domicile; *and* (3) intermittent to constant treatment may be required” (emphasis in original).

[168] At trial, Dr. Ameis testified that he had again changed his opinion on the class of impairment for the skin disorder and instead now believes that Class 2, with a 10-24% WPI is more appropriate for Mr. Kusnierz. According to the Guides, this requires “signs and symptoms of skin disorder are present or intermittently present; *and* (2) there is limitation in the performance of *some* of the activities of daily living; *and* (3) intermittent to constant treatment may be required” (emphasis in original). He testified that where Mr. Kusnierz is placed within Class 2 depends on the severity of his psychological problems.

[169] The position of the Guides, Dr. Ameis testified, is that “if you have a skin disorder, you have a score for the actual disorder as a burden of care and then have regard to the disfigurement and you may increase the score proportional to whatever social withdrawal, self-image problems you encounter.” In Dr. Ameis’ opinion, these problems mentioned in the medical reports suggest that there should be a “significant shift upward”. A psychiatrist could assess these problems, or one could simply move to the top of the range for skin in this class, or at 24% WPI, which Dr. Ameis recommended.

[170] As noted earlier, Dr. Lacerte objects to the use of the chapter on skin because this violates section 2.2 of the Guides, which permits only the combination of unrelated impairments. The skin issues, he notes, are all related to the amputation. Further, the amputation table is the more specific method called for in section 3.2b of the Guides. At the same time, however, I note that section 13.2 of the Guides recognizes that skin impairments may be associated with the impairment of other body systems and permits their combination.

[171] Dr. Lacerte was not prepared to agree that Dr. Ameis had properly valued Mr. Kusnierz’ skin problems. In his report, Dr. Lacerte stated that it would be appropriate to provide an additional 2% WPI rating to account for the neuroma (by analogy) from Table 68 in Chapter 3, entitled: “Impairments from Nerve Deficits”. In examination in-chief, Dr. Lacerte agreed that the section on amputation made no reference to using Chapter 13 on skin. But, he noted, every amputee, by definition, would have a scar. Given that fact, “the question is that how much more do you want to give. Well, what I’m going to say to you is that, I mean, it’s a good question. I mean, certainly not 50%. I have a hard time to give, you know, more than probably 4% because, you know, clinically what can happen if your stump is not working well, okay.”

[172] In cross-examination, Dr. Lacerte testified that "[e]ssentially every amputee . . . has skin problems". He clarified his evidence that he could justify a 4% WPI impairment for skin in relation to the stump, which qualifies as a class 1 impairment under Table 2 in Chapter 13, entitled "Impairment Classes and Percents for Skin Disorders". The associated description is: "Signs and symptoms of skin disorder are present or only intermittently present; **and** [t]here is no limitation or limitation in the performance of *few* activities of daily living, although exposure to certain chemical of physical agents might increase limitation temporarily; **and** [n]o treatment or intermittent treatment is required" (emphasis in original).

[173] I find that Dr. Lacerte's concession on the appropriateness of including skin impairment at some level is important. Dr. Lacerte stated in cross-examination that "[a]s a result of the skin problem, one is unable to wear the prosthetic device more than 50% of the time, it would have a negative impact on one's activities of daily living." He came close to conceding that Mr. Kusnierz has a class 2 impairment, although he criticized Dr. Ameis for failing to properly detail the evidence of skin problems.

[174] Considering the differences in the descriptions in Table 2 between a class 1 and a class 2 impairment, the evidence is clear that Mr. Kusnierz suffers from a class 2 impairment, which has a range of between 10 and 24% WPI. I therefore accept Dr. Ameis' trial evidence that class 2 is appropriate.

[175] But I do not accept Dr. Ameis' evidence on the proper location of the impairment on the range within the class. Chapter 13, which deals with skin, pays some attention to scarring and disfigurement as psychological factors to be accounted for. In the case of an amputation, I agree with Dr. Lacerte that the disfigurement is subsumed in the primary impairment, as is the scar. Rather than using psychological factors to bump the score to 24%, in my view it would be more reasonable to take Dr. Ameis' usual approach in the absence of more compelling evidence, and go to the mid-point of the range at 17% WPI for skin. That must be rounded to the nearest 0 or 5% under section 13.2, which takes it to 15% WPI. I am somewhat supported in this determination by section 13.5, which provides that: "If other chapters were also used to estimate the impairment from the patient's skin disorder, the skin disorder evaluation would *exclude* consideration of the components evaluated with those chapters (emphasis in original)."

[176] Finally, I do not agree with Dr. Ameis' approach that would combine percents from gait derangement and skin, simply because it is the problems with skin, and particularly neuromas, that led Dr. Ameis to abandon the amputation table and go to the gait derangement table. It would be inappropriate to count skin twice in assessing WPI. Section 13.5 also has some application here.

Medication impairment rating

[177] In his report of June 7, 2004, Dr. Ameis was critical of Dr. Oshidari for failing to rate Mr. Kusnierz' medication impairment. He said:

> In addition, it is appropriate to factor in the additional impairments that are imposed by medication, particularly when the dosage is exceptionally high and the side effects marked. Dr. Oshidari noted that Mr. Kusnierz was consuming 10 Percocet per day. Percocet is potent narcotic analgesic that generates as complications a significant set of side effects including constipation, sweating, tremulousness, itchiness and cognitive blunting. Essential remedial measures include a special diet and a combination of stool softeners and laxatives. Under Chapter 10, Digestive System; Table 3: Colonic and Rectal Impairment, it is evidence that the requirement for bowel-regulation medication and dietary changes would place Mr. Kusnierz is GI impairment Class 2 (range = 10 – 24%).

[178] In his testimony, Dr. Ameis considered Table 3 and reduced his estimate to 0-9% WPI, described in the Guides at p. 241 as follows: "Signs and symptoms of colonic or rectal disease are infrequent and of brief duration; **and** [l]imitation of activities, special diet, or medication is not required; **and** [n]o systemic manifestations are present and weight and nutritional state can be maintained at desirable levels; **or** [t]here are no sequelae after surgical procedures" (emphasis in original).

[179] Dr. Lacerte did not testify about the medication impairment rating. In his report, he commented: "The use of Percocet is not a permanent impairment, as other analgesics could be substituted. It is unclear to me why Dr. Ameis, who completed the Catastrophic Impairment application, had not recognized Percocet dependence earlier nor addressed the drug's side effects." Since it is clear, however, that Mr. Kusnierz is a long term user of medication, I find that recognition of this impairment is warranted.

[180] Dr. Ameis testified that he would now "be content to take the medium score of 5% for the constipation" and "because of the narcotics [Mr. Kusnierz is] taking." I accept Dr. Ameis' evidence on this issue.

Cervicothoracic spine impairment lumbar spine impairment; and impairment for the ulnar nerve entrapment

[181] Dr. Ameis testified that he otherwise supported the additional impairments reviewed in the CATDAC report of April 6, 2004.

[182] Dr. Oshidari's report of the physical examination states:

> In sitting position the range of motion of his cervical spine revealed forward flexion about 90% of normal and extension about 60% from normal. Rotation was about 95% of normal and lateral bending about 50% from normal. In all

movements he complained of discomfort and pain in his neck but not upper extremity.

Spurling's test (cervical intervertebral foramina stress test) did not produce pain in the upper extremities.

Active range of motion of both shoulders revealed forward flexion and abduction about 170°. Adduction, extension and external rotation were bilaterally within normal limits. During internal rotation the right side was about 80° and the left side was about 75°. There was no discomfort and pain in his shoulder only in the neck area. Impingement syndrome was negative in both shoulders. Stress test to the rotator cuff muscle did not produce any discomfort. Resistance against forward flexion of the upper extremity also did not show any sign of biomechanic weakness.

The cervical neurotension test for the right upper extremity remained within normal limits. The thoracic outlet syndrome test for the right upper extremity also remained unremarkable.

Tinel's test to the wrist was unremarkable bilaterally. Tinel's test to the right elbow was positive but to the left elbow was negative.

With his prosthetic on, his lumbosacral range of motion was decreased to the knee area due to discomfort and pain in his back. Extension, rotation and lateral bending were maintained but produced pain in his back not lower extremity. Straight leg raise was negative in sitting and lying position bilaterally. Femoral stretch test was negative.

[183] Dr. Oshidari then reached the following formulation:

With respect to definition [SABS section 2(1.1)] (f), AMA Guides rating for 55% Whole Person Impairment in accordance with the American Medical Association Guides to the Evaluation of Permanent Impairment, 4th Edition:

> There is history of discomfort and pain in the cervicothoracic spine. There was no sign of any radiculopathy or segmental instability of spine. Therefore, his maximum impairment will be due to cervical discomfort DRE II that provides him with 5% impairment. (Chapter 3, Page 110, Table 73.)
>
> There is discomfort and pain in the lumbar spine. There is no radiculopathy or segmental instability. His maximum impairment will be DRE II. (Chapter 3, Page 110, Table 72.) The maximum impairment will be 5%.

> There is numbness and tingling in the right forth and fifth digits. The physical examination also revealed positive Tinel's test in the right elbow as well as sensory abnormality in the nerve distributed by ulnar nerve. No sign of weakness of the muscle was present. His maximum impairment will be 7% of upper extremity due to ulnar nerve entrapment; 7% of upper extremity provides him with 4% of whole body impairment. (Chapter 3, Page 54, Table 15.)

[184] In his report, Dr. Lacerte stated: "I am not prepared to give Mr. Kusnierz a DRE [diagnosis-related estimate] for either his neck or back, given that there was no documented trauma to these regions at the time of the December 24, 2001 MVA. He reiterated in testimony his opposition to valuing these injuries on the basis that there was no causal link between these alleged injuries and the motor vehicle accident. He did, eventually, admit that there was no apparent pre-existing injury that would account for these injuries. He contested the methodology of Dr. Oshidari's assessment as noted above. I accept Dr. Oshidari's assessment nonetheless.

[185] With respect to the ulnar nerve, in his report Dr. Lacerte stated: "The left ulnar sensory loss represents a maximum of 4% WPI if the sensory loss was total. EMG confirmation would have been desirable." Again, I accept Dr. Oshidari's assessment. I note in passing that Mr. Kusnierz' complaint was about the right ulnar nerve entrapment, not the left. I assume this was a typographical error by Dr. Lacerte.

[186] Based on the evidence presented to me, I find on the balance of probabilities that the plaintiff has established cervical thoracic spine impairment at 5% WPI, lumbar spine impairment at 5% WPI, and numbness and tingling in the right fourth and fifth digits leading to 4% WPI.

3). Conclusion on the second issue

[187] On the evidence, there are two different routes to the calculation of WPI for Mr. Kusnierz, set out below:

Item	% WPI	Item	% WPI
Amputation	28	Gait Derangement	40
Skin	15		n/a
Medication	5		5
Cervical Spine	5		5
Lumbar Spine	5		5
Ulnar Nerve	4		4

The Guides require me to apply the Combined Values Table. Doing so by way of the amputation route reaches the result of 50% WPI, and by way of the gait derangement route reaches the result of 51% WPI. According to section 2.2 at p. 9 of the Guides, the result must be rounded up or down to the nearest value ending in 0 or 5. The final value, regardless of the route, is therefore 50% WPI.

[188] I find, in answer to the second issue, that Mr. Kusnierz does not meet the threshold of 55 per cent or more impairment of the whole person in order to be considered catastrophically impaired under clause 2(1.1) (f) of the SABS.

[189] The action is dismissed with costs if demanded. If the parties cannot agree on costs then I will accept written submissions on a 10 day turnaround starting with the defendant.

_____"P.D. Lauwers"_____
Justice P.D. Lauwers

Released: October 19, 2010

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[1] Entitled: "An Act to provide Ontario drivers with fair, balanced and stable automobile insurance and to make other amendments related to insurance matters", also known as the *Automobile Insurance Rate Stability Act, 1996*, S.O. 1996, c. 21.

[2] Application for leave to appeal dismissed [1998] S.C.C.A. No. 62.

[3] The public policy development process has become institutionalized in section 289 of the *Insurance Act*, which obliges the Minister to table a report every two years on the adequacy of statutory accident benefits, the changes made to SABS and the changes that are proposed to SABS, and section 289.1, which obliges the Superintendant of Insurance to undertake a review of Part VI of the *Insurance Act* and any regulations made under Part VI at least every five years.

[4] Also known as the *Statutory Accident Benefits Schedule - Accidents after December 31, 1993 and before November 1, 1996.*

[5] Approved [2001] O.J. No. 1868 (C.A.) per Osborne ACJO.

[6] Leave to appeal dismissed, [2008] O.J. No. 5740

[7] Ruth Sullivan, *Sullivan on the Construction of Statutes*, 5th ed. (Markham, Ont.: LexisNexis, 2008) at 292.

[8] *Ibid*. at 294.

[9] I use the term "legislator" to avoid having to distinguish between the Legislature and the regulation-making body, which in the case of the SABS is the Lieutenant Governor in Council.

[10] Sullivan, *supra*, at 404.

[11] See *Desbiens v. Mordini*, *supra*, at paras. 245-47.

[12] Sullivan, *supra*, at 243-52.

[13] *Ibid*. at 62-63.

[14] *Ibid*.

[15] *Ibid*. at 62.

[16] See the decision of the court in *Desbiens v. Mordini*, *supra* at para. 242 and in *Arts (Litigation Guardian of) v. State Farm Insurance Co.*, *supra* at para. 9.
[17] See *Desbiens v. Mordini*, *supra*, at para. 242.
[18] Relying on *Desbiens v. Mordini*, *supra*, at paras 249, 250, 262 and 263.
[19] See also *Arts (Litigation Guardian of) v. State Farm Insurance Co.*, *supra*, at para. 13.
[20] See *Snushall v. Fulsang*, *supra*, for such an application of the subsection.
[21] Sullivan, *supra* at ch. 9.
[22] *Ibid*.
[23] *Ibid*. at 317-18.
[24] *Ibid*. at 309.
[25] The Honourable Coulter A. Osborne, Q.C., *Summary of Findings & Recommendations, Civil Justice Reform Project*, November 2007 at pp. 71, 75-76.
[26] See *Beasley v. Barrand*, 2010 ONSC 2095, [2010] O.J. No. 1466.