**Financial Services Commission of Ontario**

**Commission des services financiers de l'Ontario**

**FSCO A04-002496**

**BETWEEN:**

**ANNA PASTORE**

**Applicant**

**and**

**AVIVA CANADA INC.**

**Insurer**

# REASONS FOR DECISION

**Before:** Elizabeth Nastasi

**Heard:** April 14, 15, 16, 17, 18, 2008, at the offices of the Financial Services Commission of Ontario in Toronto.

Written submissions received on May 5, 2008

**Appearances:** Joseph Campisi Jr. for Ms. Pastore
Kevin Griffiths for Aviva Canada Inc.

**Issues:**

The Applicant, Anna Pastore, was injured in a motor vehicle accident on November 16, 2002. She applied for and received statutory accident benefits from Aviva Canada Inc. ("Aviva"), payable under the *Schedule*.[1] Disputes arose over the payment of various benefits and the parties were unable to resolve their disputes through mediation. Ms. Pastore applied for arbitration at the Financial Services Commission of Ontario under the *Insurance Act*, R.S.O. 1990, c.I.8, as amended.

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

The issues in this hearing are:

1. Has Ms. Pastore suffered a catastrophic impairment as defined by paragraphs 2(1.1)(f) and/or 2(1.1)(g) of the *Schedule*?

2. Is Aviva liable to pay Ms. Pastore's legal expenses in respect of this hearing, pursuant to subsection 282(11) of the *Insurance Act*?

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

## Result:

1. Ms. Pastore has not suffered a catastrophic impairment as defined by paragraph 2(1.1)(f) of the *Schedule*.

2. Ms. Pastore has suffered a catastrophic impairment as defined by paragraph 2(1.1)(g) of the *Schedule*.

3. The issue of the legal expenses claimed pursuant to subsection 282(11) of the *Insurance Act* may now be addressed in accordance with the provisions of the *Dispute Resolution Practice Code* (Fourth Edition, Updated - October 2003).

## Background

Ms. Pastore is presently a 66 year old woman who was involved in a pedestrian motor vehicle accident on November 16, 2002. Ms. Pastore initially suffered a fracture of her left ankle and underwent several surgeries related to this ankle. Ms. Pastore contends that during the period of time when she was unable to use her left ankle, she over-compensated on her right side which then caused pain in both her right knee and right ankle. In approximately September 2007, she underwent a right knee replacement. Ms. Pastore attributes the need for all of her surgeries to the motor vehicle accident of November 16, 2002.

Ms. Pastore claims that she now suffers a catastrophic impairment from the injuries she sustained as a result of the motor vehicle accident on November 16, 2002.

## The Law

In determining whether Ms. Pastore suffered a catastrophic impairment she was assessed under paragraphs (f) and (g) of section 2(1.1) of the *Schedule* as set out below:

> For the purposes of this Regulation, a catastrophic impairment caused by an accident that occurs before October 1, 2003 is,
> …
>
> (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. O. Reg. 281/03, s. 1 (5).

Both clauses (f) and (g) of the *Schedule* require the applicant's impairment to be evaluated in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition,1993 (the "*Guides*"). **"Impairment"** means a loss or abnormality of a psychological, physiological or anatomical structure or function.[2]

The *Guides* set out separate chapters that provide a means of translating an impairment of different body systems into a percentage rating. The *Guides* set out specific criteria for assessing impairments within each organ system. After assessing each separate body system, the *Guides* set out calculations and charts on how to combine various impairments to calculate a whole person impairment ("WPI") rating. Under part (f) of the *Schedule*, a WPI of 55 per cent or more is a catastrophic impairment.

If a mental or behavioural impairment is the result of a structural brain injury, then a WPI percentage rating can be assigned using the descriptions and tables found in Chapter 4 of the *Guides* dealing with the nervous system. Other types of mental and behavioural impairments are

[2] Section 2(1) of the *Schedule*.

dealt with in Chapter 14 of the *Guides*.[3] Chapter 14 however does not use percentage ratings to describe these types of impairments.

Using Chapter 14 of the *Guides,* assessors look at four areas or aspects of functioning:

1. activities of daily living;
2. social functioning;
3. concentration; and
4. adaptation.

A "class" of impairment, not a percentage, is assigned to each of the four aspects of functioning:

- Class 1 is *no* impairment.

- Class 2, mild impairment, means the impairment levels are compatible with *most* useful functioning.

- Class 3, moderate impairment, means impairment levels are compatible with *some*, but not all, useful functioning.

- Class 4, marked impairment, means impairment levels *significantly impede* useful functioning.

- Class 5, extreme impairment, means *impairment levels preclude* useful functioning.[4]

[emphasis in original]

[3] Note that I use the terms "mental or behavioural impairment" and "psychological impairment" interchangeably throughout this decision.

[4] American Medical Association, *Guides to the Evaluation of Permanent Impairment*, Fourth Edition (American Medical Association, June 1993), pages 300-301.

Under the *Schedule*, criterion (g) "mental or behavioural disorder of Class 4 or Class 5" is a catastrophic impairment. The 4th edition of the AMA *Guides* does not specifically provide a means of translating the "Class" ratings into a percentage WPI rating.

## The Parties' Positions

Both Ms. Pastore and Aviva asked me to consider several alternative arguments in making their respective cases.

### *The Applicant's Position*

The Applicant relies on the findings of the CAT DAC which found that Ms. Pastore met the definition of catastrophic impairment with respect to the (g) criterion. Ms. Pastore submits that only one marked impairment is required to meet the definition under clause (g) and relies on the Ontario Superior Court of Justice in *Desbiens v. Mordini*[5] *a*nd the FSCO arbitration decision of *McMichael and Belair*.[6]

With respect to the (f) criterion, the Applicant accepts the 30% WPI rating from the physical impairment of Ms. Pastore's right knee and left ankle as found by the CAT DAC. The Applicant also asked me to determine an impairment rating for Ms. Pastore's neck, back and scars as these impairments were not considered and rated by the CAT DAC.

In addition, Ms. Pastore contends that she suffered a 25-30% WPI based on a psychological impairment and that combining the physical and mental impairment ratings will result in a 55% WPI (after rounding up from 51%) according to criterion (f). The Applicant's position is that combining WPI ratings for physical and psychological impairments is well-settled law since the *Desbiens* decision which has been followed by *Arts* and several FSCO decisions.[7]

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[5] *Desbiens v. Mordini*, 2004 CanLII 41210 (ON S.C.).

[6] *McMichael and Belair Insurance Company Inc.*, (FSCO A02-001081, March 2, 2005) affirmed on Appeal (FSCO P05-00006, March 14, 2006).

[7] *Desbiens supra* has been subsequently followed by *Arts* v. *State Farm Insurance Company*, 2008 CanLII 25055 (ON S.C.), *McMichael supra*; *Ms. G. and Pilot Insurance Company*, (FSCO A04-000446, March 16, 2006), affirmed on Appeal (FSCO P06-00004, September 4, 2007); *Augello and Economical Mutual Insurance Company*, (FSCO A07-001204, December 4, 2007 and December 18, 2008).

***The Insurer's Position***

The Insurer challenges the CAT DAC results and asserts that the methodology used was not correct. In general, Aviva argues that the CAT DAC assessors misapplied the AMA *Guides* in coming to their assessment conclusions. Further, Aviva contends that the CAT DAC overstated her impairments.

Aviva argues that combining WPI ratings for physical and psychological impairments under clause (f) is not an appropriate interpretation of the legislation. Aviva argues that the AMA *Guides* recommend against the use of percentage ratings for mental/behavioural impairments. Further, Aviva argues that the decision in *Desbiens* was wrongly decided.

Aviva's position is that Ms. Pastore does not meet the (g) criterion for catastrophic impairment because her impairments do not fall within a Class 4 in any category. Aviva does not agree with the CAT DAC which found that Ms. Pastore suffers from a Class 4: Marked Impairment within the sphere of activities of daily living.[8]

In the alternative, Aviva argued that if I find that Ms. Pastore does have a Class 4: Marked Impairment in the sphere of activities of daily living, that one marked impairment alone does not give rise to a determination of catastrophic impairment.

## EVIDENCE AND ANALYSIS:

### Paragraph (f) of Subsection 2(1.1)

### Can the determination of whole person impairment under paragraph 2(1.1)(f) of the *Schedule* combine WPI ratings for both physical and psychological impairments?

[8] Exhibit #1, Tab 6, page 67, Dr. Salmon 's report; Exhibit #1, Tab 7, page 74. Dr. Rosenblat's report.

Since the decision of the Ontario Superior Court of Justice in *Desbiens v. Mordini*[9] it is clear that the combination of physical and psychological impairments is permissible under clause 2(1.1)(f) of the *Schedule*. This approach has been adopted in the recent case of *Arts v. State Farm* and in a number of FSCO decisions including the Director's Delegate's decision in *Pilot and Ms. G.*[10] I am bound by the decisions of FSCO's Director and Director's Delegates.

Both *Desbiens* and *Arts* begin with the proposition that the modern approach to statutory interpretation requires legislative purpose to be taken into account at each stage of interpretation and only an interpretation that is "consistent with or promote[s] the legislative purpose should be adopted."[11] In considering the purpose of the *Schedule*, the legislature's definition of "catastrophic impairment" is intended to foster fairness for victims of motor vehicle accidents and ensure that victims with the greatest health needs have access to expanded medical and rehabilitation benefits.[12]

The SABS are remedial consumer protection legislation.[13] "The text of the Regulation itself indicates that the drafters clearly intended the definition of 'catastrophic impairment' to be inclusive rather than restrictive."[14] To exclude psychological impairments from a WPI calculation would result in an incomplete and unfair representation of an individual's impairments and risk both an unfair and unreasonable outcome for motor vehicle accident victims in Ontario.[15]

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[9] *Desbiens supra*.

[10] *Arts v. State Farm Insurance Company*, 91 O.R. (3d) 394. Adopting the approach in *Desbiens*, Justice MacKinnon in *Arts* notes that arbitrators at FSCO have expressed approval of *Desbiens* in a number of decisions and appeals. FSCO decisions include: *Ms. G and Pilot Insurance Company*, (FSCO A04-000446, March 16, 2006). Aff'd on appeal (FSCO P06-000004, September 4, 2007); *B.P. and Primmum Insurance Company*, (FSCO A05-001608, December 21, 2006); *McMichael and Belair Insurance Company Inc.*, (FSCO A02-001081, March 2, 2005), aff'd on appeal (FSCO P05-00006, March 14, 2006), appl'n for judicial review dismissed, (2007), 86 O.R. (3d) 68 (Div. Ct.); *Augello and Economical Mutual Insurance Company*, (FSCO A07-001204, December 4, 2007 and December 18, 2008).

[11] *Desbiens supra*, paragraph 223.

[12] *Desbiens supra*, paragraph 237 and 240; *Arts supra*, paragraph 14.

[13] *Smith v. Co-operators General Insurance Co.*, [2002] 129 S.C.R.

[14] *Desbiens supra*, paragraph 238; *Arts supra*, paragraph 9.

[15] Note that in the recent decision of *Augello supra*, Arbitrator Wilson states: "It is more than just a question of whether or not I accept Spiegel J.'s approach in this matter. It is my understanding that, faced with consistent decisions on that very issue at the superior court level, I am bound to follow their lead."

### *Ms. Pastore's Physical Impairments*

Ms. Pastore was evaluated by the North Toronto Assessment Centre team from March 6, 2006 through May 25, 2007. The CAT DAC assessment was conducted by Dr. A. Oshidari (physiatrist), Dr. D. Salmon, Jr. (psychologist), Dr. H. Rosenblat (psychiatrist), and Ms. Jane Wong (occupational therapist who conducted an in-home assessment).

Dr. Oshidari was the clinical coordinator for the CAT DAC assessment.[16] It was only his assessment of the physical impairments that impacted on the (f) portion of the CAT determination. Dr. Oshidari concluded that as a result of the physical injuries sustained in the accident, specifically her left ankle and right knee, Ms. Pastore had suffered a 30% WPI (12% for the left ankle and 20% for the right knee). Although he assigned an impairment rating for the knee, Dr. Oshidari's position was that the impairment to Ms. Pastore's right knee was not caused by the accident. However, even with assigning an impairment rating for her knee, the CAT DAC concluded that Ms. Pastore did not meet the 55% WPI required under the (f) criterion.

Counsel for Aviva retained Dr. Brigham[17] to review the CAT DAC assessment. Dr. Brigham came to a different assessment for Ms. Pastore's left ankle. He concluded that she suffered a 2% WPI for the left ankle. Dr. Brigham agreed with the WPI rating of 20% with respect to Ms. Pastore's knee and, unlike Dr. Oshidari, initially found that the accident was the cause of her right knee impairment. However, in his testimony at the hearing his evidence was that he had changed his opinion and concluded that the motor vehicle accident did not cause Ms. Pastore's right knee impairment.

I find that a 2% WPI for Ms. Pastore's left ankle with the 20% WPI for her right knee are an accurate reflection of her physical impairments for the reasons that follow.

[16] Dr. Oshidari is a specialist in physical medicine and rehabilitation. He was a CAT DAC assessor for more than 6 years where he estimated that he conducted 50-60 CAT DAC assessments per year.

[17] Dr. Brigham is an American physician, Board-Certified in Occupational Medicine and a Certified Independent Medical Examiner. He is a prominent American advisor on disability issues.

(i) The Left Ankle

I agree with Dr. Brigham's analysis and the WPI rating of 2% with respect to Ms. Pastore's left ankle for the reasons set out below.

Chapter 3.2 of the *Guides* is the relevant section for a lower extremity problem. There are 13 different ways to look at a patient and the assessor has options in choosing which method is most appropriate in calculating an impairment rating.

Dr. Oshidari approached the assessment of the left ankle using several different methods. It was difficult to get a clear sense of Dr. Oshidari's assessment and WPI rating as he gave contradictory positions within the CAT DAC report and his testimony. The CAT DAC assessment of the left ankle notes that Ms. Pastore was "not rateable" (which would result in a 0% WPI), however it also provides a "worst case scenario" (or "severe") impairment rating due to arthritis of 12%.[18] Dr. Oshidari does not provide any explanation for assigning a "severe" as opposed to the "moderate" or "mild" impairment rating.

Dr. Oshidari's evidence at the hearing did not clear up any confusion on this point. During cross-examination he admitted that his report should have said that Ms. Pastore's physical impairment was not rateable and therefore assigned it 0%. When asked why he did not just stop his assessment at this point, he stated that he looked at other scenarios, however this was "idle speculation" and "academic" and of "no relevance to this case or the SABS." His evidence was slightly different again on re-direct, he said that to calculate an impairment for the ankle based on the structural abnormality assessment he conducted <u>was</u> an acceptable form of assessment in the CAT DAC process.

Dr. Brigham reviewed Dr. Oshidari's report and provided his own assessment of impairment. Contrary to Dr. Oshidari's assessment, Dr. Brigham found that the left ankle was in fact rateable according to the AMA *Guides* and assigned it 2% WPI. He found that Dr. Oshidari's WPI ratings of the left ankle and knee were not helpful in providing a reliable rating because he

[18] Exhibit #1, Tab 3, page 18.

provided ratings that were speculative and based on worst case scenarios. In Dr. Brigham's opinion, Dr. Oshidari's ratings were consistent with a total obliteration of the joint space and that Dr. Oshidari provided no basis for adopting this worst case scenario approach.

Dr. Brigham provided detailed evidence of the steps that he took in rating Ms. Pastore's ankle and clear reasoning for adopting the approach chosen. Dr. Brigham provided a detailed description of each of the possible methods that could have been used to evaluate Ms. Pastore and gave reasons for the ultimate choice made.[19] In Dr. Brigham's opinion, the medical records do not support Dr. Oshidari's choice of assigning the most severe rating of impairment for arthritis. This is based on Dr. Brigham's examination of a January 27, 2006 x-ray report.[20] The x-rays note "mild degenerative changes" but otherwise "unremarkable." Dr. Brigham notes that although the x-rays did not provide specific measurements, which are required by the *Guides*, Dr. Brigham felt that it was appropriate to assign Ms. Pastore the "benefit of the doubt" and assign her the "mild arthritic ankle impairment" which results in a 2% WPI.

I find Dr. Brigham's approach was a reasonable and informed exercise of clinical discretion as permitted by the *Guides*. I accept his evidence and rating of 2%. I find this rating appropriately captures and is representative of Ms. Pastore's left ankle impairment.

### (ii) The Right Ankle

In the CAT DAC report, Dr. Oshidari also notes that there was no active range of motion testing done on Ms. Pastore's right ankle either but passive range of motion testing was done. He provided a worst case scenario rating for the right ankle of 3%, which is "mild." However, he then notes that there is no documentation of right ankle pain and thus the 3% is not included in the overall WPI rating.

Dr. Brigham agreed with Dr. Oshidari that there are no rateable factors to consider for assigning a rating to the right ankle and that the only physical injuries that could be potentially rateable were the left ankle and right knee.

[19] Exhibit #1, Tab 13.
[20] Exhibit #3, Tab 3, page 20.

I find that based on the evidence presented, Ms. Pastore's right ankle is not rateable and as such assign a 0% WPI rating.

### (iii) The Right Knee

Dr. Oshidari and Dr. Brigham arrived at the same impairment rating for Ms. Pastore's knee of 20% WPI. Where their opinions diverge, at times, is with respect to the issue of causation.

In the CAT DAC report, Dr. Oshidari notes that the right knee was not rateable according to the AMA *Guides* because he found that the right knee was not caused by the accident. Dr. Oshidari's conclusion is based on the fact that "…there was no initial documentation of discomfort and pain in the right knee. Therefore there is no correlation between the car accident and the right knee. Initial x-rays also revealed some degenerative changes in the knee joint."[21] Dr. Oshidari does, however, acknowledge that there is a "… possibility that the way [Ms. Pastore] walked due to discomfort and pain in the left ankle caused pressure on the right knee, which exacerbated her pre-existing degenerative changes."[22]

In his March 12, 2008 report, Dr. Brigham disagrees with Dr. Oshidari's assessment of causation. Dr. Brigham specifically addresses the issue of causation and concludes as follows:

> Thus, considering the sequence of events that occurred after the accident, it appears that the treatment for the left ankle injury directly resulted in an aggravation of a pre-existing right knee arthritic condition. It is medically reasonable to believe that, as a result of increased loadbearing on the right lower extremity for such a significant period of time, a permanent aggravation would occur to the right knee.[23]

Slightly more than one month later, Dr. Brigham's position had changed significantly. During his oral evidence at the hearing, he took the position that the accident had not caused Ms. Pastore's right knee impairment. At the hearing, Dr. Brigham cited several reasons for his reversal on the

[21] Exhibit #1, Tab 3, page 17 of CAT DAC report.
[22] Exhibit #1, Tab 3, page 17 of CAT DAC report.
[23] Exhibit #1, Tab 13, page 3.

causation issue. He stated that in preparing to give evidence at the hearing he had additional records that he did not have when he reviewed the CAT DAC assessment. He initially considered the fact that Ms. Pastore favoured one side over the other and on re-examination he noted that he put too much weight on this factor. Further, he noted that there was no evidence that the right knee was directly injured in the accident and the x-rays showed degenerative arthritis in both knees.

The most significant concerns noted by Dr. Brigham were problems in terms of inconsistent examination, illness behaviour and credibility. He found Ms. Pastore "unreliable" and to have "very dysfunctional pain behaviour" as shown by the fact that she rated her pain as a 10. Finally, Dr. Brigham stated that the two significant risk factors of knee osteoarthritis are age and obesity and given Ms. Pastore's height and weight, it would not be uncommon for her to have knee problems.

Information with respect to Ms. Pastore's height and weight, her x-rays and the fact that her knee was not directly injured in the accident were all pieces of information that were available to Dr. Brigham during his initial assessment of the case. It is clear that the most significant new information that caused Dr. Brigham to change his position with respect to causation was in relation to Ms. Pastore's credibility and what he terms her "pain behaviour." To further explain his concern, he notes that Ms. Pastore exhibited "pain focused" behaviour and reported greater pain than one would expect to see from someone with her injuries. Given that pain is subjective it is not clear to me how this necessarily connects to the causation issue.

It would seem that Dr. Brigham viewed Ms. Pastore's pain complaints with some suspicion or disbelief which cast doubt on her level of impairment in general. It would seem that in this case Dr. Brigham was not only examining inconsistent medical evidence and information that related to Ms. Pastore's knee but he was assessing her overall credibility – a role reserved for the decision maker.

Despite several inconsistencies that were mostly related to Ms. Pastore's low back pain, I found that Ms. Pastore was a credible witness who gave clear and consistent evidence in relation to her left ankle and knee impairments and the affect that they have on her activities of daily living.

I find that there is sufficient evidence to support the claim that the accident caused or materially contributed to the impairment in Ms. Pastore's right knee. Having decided the issue of causation, the next step is to examine the evidence related to the impairment ratings of the right knee.

Dr. Oshidari and Dr. Brigham used different approaches in assessing the right knee, however, arrived at the same impairment rating of 20%. Similar to the assessment of the left ankle, Dr. Oshidari noted that the right knee was not rateable according to the *Guides*, but again also provided "worst case scenario" impairment ratings. Although the overall impairment rating is the same, I prefer the approach adopted by Dr. Brigham in arriving at the WPI rating for Ms. Pastore's right knee.

Dr. Brigham felt the appropriate assessment tool for Ms. Pastore's knee was section 3.2i of the *Guides*, Diagnosis-based Estimates, as this would address the total knee replacement that she underwent in September 2007. The calculations were based on a January 7, 2008 report of Dr. Tountas, Ms. Pastore's orthopaedic surgeon, which was the most recent available post-surgery report at the time.[24]

Ms. Pastore's operation condition was noted as "unremarkable" and her x-ray post surgery did not show any complications. On examination, she had improved flexion but there was not full recovery yet. Dr. Brigham stated that if he was only considering the objective parameters, her recovery looked good and he would have rated her as a "good" result. However, he also took her pain complaints into consideration. Factoring in Ms. Pastore's pain, Dr. Brigham arrived at a "fair" rating instead which results in an impairment rating of 20% for the right knee.[25] Dr. Brigham states that the impairment results may improve when Ms. Pastore reaches maximum medical improvement – one-year post operation.

I accept Dr. Brigham's evidence and impairment rating of 20%. I find this rating appropriately captures and is representative of Ms. Pastore's right knee impairment.

[24] Exhibit #3, Volume C, Tab 9, page 2.
[25] *Guides supra* Table 64, page 85.

### (iv) Back, Neck and Scarring

In his closing submissions, the Applicant's counsel asked me to also consider and assign a rating for Ms. Pastore's back, neck and scarring. In his words, I was to be the "ultimate impairment rater."

The CAT DAC did not assess Ms. Pastore's back, neck and scarring on her ankle and knee. Dr. Oshidari's testimony was that the CAT DAC assessment did not provide a rating for Ms. Pastore's back and neck pain because during the CAT DAC assessment she said she had no other pain.

Dr. Brigham gave evidence that Ms. Pastore's back pain was not rateable because the medical documentation contained only subjective reports. When specifically referred to the notes and assessment of the Toronto Polyclinic he stated that it was a "superficial report" that did not document any rateable impairment.[26] Further, he notes that a finding alone of tenderness does not constitute an impairment according to the *Guides*. Dr. Brigham came to a similar conclusion in regard to Ms. Pastore's neck pain and the reference to tenderness.[27]

There was scant medical evidence with respect to the scars on Ms. Pastore's ankle and knee. Ms. Pastore's evidence was that the scars were itchy and painful and prevented her from wearing shorts or skirts. The CAT DAC did not consider her scars in rating her overall impairment. In Dr. Brigham's opinion the scars were not rateable.

I find that there is very little medical documentation and evidence to allow me to adequately consider assigning an impairment rating for Ms. Pastore's back, neck and scars. I agree with the Insurer that if it was the Applicant's intention to have me assign a rating for these areas, they should have led specific medical evidence in support of this position.

I find that the Applicant did not lay an adequate evidentiary foundation to have me assign any ratings for the back, neck and scarring.

[26] Exhibit #3, Volume C, Tab 8.
[27] Exhibit #3, Volume C, Tab 8.

### *Ms. Pastore's Mental / Behavioural Impairments*

The 4th edition of the *Guides* does not use percentages for estimating mental / behavioural impairments in the same way that physical impairments are assessed. I heard extensive evidence with respect to the most appropriate method of assigning a WPI percentage rating to a psychological impairment. While a variety of approaches were explored, the central argument rested on whether to use the percentage ranges from the 2nd edition of the *Guides* or Table 3 in Chapter 4 (The Nervous System) of the 4th edition.[28]

In this case, I accept that the use of Table 3 in Chapter 4 of the *Guides* provides the most accurate assessment of Ms. Pastore's psychological impairment and results in a 22% WPI. A review of the methodologies and my findings are set out below.

I heard evidence with respect to this issue from Dr. Becker, Dr. Brigham and Dr. Leclair. Dr. Becker was asked by the Applicant to review the CAT DAC and to provide commentary with respect to the impairment ratings.[29] Dr. Brigham and Dr. Leclair conducted a similar review and analysis on behalf of the Insurer.

The common starting point of the rating approaches used in this case involved arriving first at a Global Assessment of Functioning (GAF) score and then using one of the editions of the *Guides* to convert the GAF score into a WPI percentage rating.

Global Assessment of Functioning is a widely used method to assess functioning. The GAF is part of a multi-axial diagnostic system. Adaptive functioning and impairments are recognized as important indices of mental health that are conceptually distinct from symptom severity. Functional impairment and adaptive functioning focus on what the person can do, the quality of their daily life and the need for assistance. The GAF assessment looks at to what extent the

[28] To a lesser extent using the 5th and 6th editions of the *Guides* in order to convert a GAF score into a WPI percentage rating were discussed.

[29] Dr. Becker is an Assistant Professor, Faculty of Medicine at the University of Toronto. His initial report is dated March 6, 2008 (Exhibit #1, Tab 8). In subsequent reports, Dr. Becker also reviewed the reports and findings of Dr. Brigham and Dr. Leclair. March 13, 2008 Report (Exhibit #1, Tab 9); April 2, 2008 Report (Exhibit #1, Tab 10).

psychiatric disorder experienced impacts a person's daily life.[30] The GAF is a numeric scale (0 through 100) used by mental health clinicians and doctors to rate the social, occupational and psychological functioning of adults. The scale is presented and described in the *American Psychiatric Association: Diagnostic and Statistical Manual of Mental Disorders*. (Fourth Edition, Washington, DC, American Psychiatric Association, 1994) (DSM-IV-TR).[31]

Drs. Salmon, Rosenblat and Leclair arrived at very similar GAF scores for Ms. Pastore – all within a range of 45 to 57.[32] A GAF score of between 51-60 indicates moderate symptoms. In order to convert this GAF score into a WPI percentage rating for Ms. Pastore's psychological impairments, the assessors used percentage ranges in either the *Guides* 2nd edition or 4th edition.[33]

### *Percentage Ranges from the Guides 2nd edition*

The 2nd edition of the *Guides* provided ranges of percentages for estimating psychological impairment. Mental functions fell into 5 classes with the following ranges given:

| | |
|---|---|
| Normal | 0% - 5% |
| Mild Impairment | 10% - 20% |
| Moderate Impairment | 25% - 50% |
| Moderately severe impairment | 55% - 75% |
| Severe Impairment | More than 75% |

The *Guides* 2nd edition, published in 1984, was the first edition to include the measurement of impairments associated with mental and behavioural disorders and a numeric rating scale. The 3rd edition of the *Guides* published in 1988 and revised in 1990 did not include numeric ratings.[34] These 2nd edition impairment ranges are included in Chapter 14 of the *Guides* 4th edition in a

[30] Exhibit #1, Tab 12, page 7.
[31] Exhibit #1, Tab 12, page 32.
[32] Exhibit #1, Tab 12, page 8 sets out the GAF scale. The reported GAF scores are as follows: Dr. Salmon (45-55); Dr. Rosenblat (55); and Dr. Leclair (57).
[33] The *Guides* 5th edition which employs the State of California Labor Code and the *Guides* 6th edition were also discussed.
[34] Exhibit #1, Tab 15

section entitled "Comment on Lack of Percents to This Edition." This section notes that the "…procedure for the second edition was highly subjective."[35]

Using the DSM-IV TR axial system, Dr. Rosenblat assigns a GAF score of 55. A GAF score of 51-60 is moderate symptoms or any moderate difficulty in social, occupational, or school functioning.

Dr. Rosenblat conducted the psychiatric assessment portion of the CAT DAC. He and Dr. Salmon concluded that Ms. Pastore meets the criteria for an Adjustment Disorder with Depressed Mood and that she suffers from a mild phobia. He notes that her psychological factors are playing a significant role in her chronic pain and he makes a diagnosis of Pain Disorder associated with Psychological factors.

Dr. Rosenblat refers back to the 2nd edition ranges to convert the GAF score into a WPI percentage rating. Using this approach, he concludes that Ms. Pastore has a WPI from a psychiatric perspective in the 25-30% range. Although he does not give extensive details with respect to his methodology in arriving at this conclusion, it would appear that he converts a "moderate" range on the GAF score into a "moderate" impairment from the 2nd edition *Guides*.

Dr. Becker arrived at a similar impairment rating using this approach. Dr. Becker was asked by the Applicant to review the CAT DAC and to provide commentary with respect to combining the (f) and (g) criteria ratings.[36] He authored a 1 ½ page report on March 13, 2008 concluding that Ms. Pastore meets the definition of catastrophic impairment under clause (f).[37]

Dr. Becker opined that although the 4th edition of the *Guides* does not quantify psychological impairments using WPI percentage ratings, it <u>does</u> review the percentage ratings from the 2nd edition of the AMA *Guides*. He concludes that it is therefore acceptable to use the 2nd edition impairment ratings in converting a GAF score. In addition, Dr. Becker testified that this is an

[35] *Guides supra*, page 301.
[36] Dr. Becker's initial report is dated March 6, 2008 (Exhibit #1, Tab 8). In subsequent reports, Dr. Becker also reviewed the reports and findings of Dr. Brigham and Dr. Leclair. March 13, 2008 Report (Exhibit #1, Tab 9); April 2, 2008 Report (Exhibit #1, Tab 10).
[37] Exhibit #1, Tab 9.

accepted practice in Ontario and that the task of providing an impairment rating for a mental/behavioural impairment "is an evolving process."

Dr. Becker accepts Dr. Rosenblat's GAF score and concludes that a rating of 51-60 on the GAF is the equivalent to a 20-40% WPI.[38] He then takes a midpoint score of 30% impairment rating for her mental impairment and combines it with the 30% impairment rating for Ms. Pastore's physical impairment as arrived at by the CAT DAC. Using the Combined Values Chart as required by the *Guides*, this amounts to a 51% WPI which Dr. Becker then rounds up to 55%.[39] I will address the issue of "rounding up" later in this decision.

Both Dr. Brigham and Dr. Leclair criticized the approach adopted by Drs. Becker and Rosenblat as there is no connection between the word "moderate" in the GAF scale and the ranges in the *Guides* 2nd edition psychological impairment ranges. They argue that the use of the word "moderate" in these two scales is not aligned. Aviva's position as articulated by Dr. Brigham is that the use of the 2nd edition of the *Guides* is not appropriate. Dr. Brigham and Dr. Leclair both take the position that the reference to 2nd edition ranges in the 4th edition is by way of background and merely an "historical reference."

I agree that the reference in the *Guides* to the 2nd edition impairment ranges is merely a historical reference. Further, the fact that it is included does not somehow automatically incorporate it into the 4th edition or mandate its use. The authors of the *Guides* refer to it after explaining why percentages have <u>not</u> been included in the 4th edition and caution against the use of assigning percentages for psychological impairments. However, the 2nd edition does provide physicians with "an approach" to determining a whole person impairment rating from the very qualitative descriptors in Chapter 14 of the *Guides*. [40]

I disagree with Dr. Becker's opinion that he is "precluded" from using any subsequent editions of the AMA *Guides* and newsletters in assigning impairment ratings. I find that where the

[38] The 2nd Edition percentage ranges actually rates a Class 3 Moderate Impairment at approximately 25-50% WPI.
[39] Page 322 of the *Guides*
[40] Exhibit #1, Tab 10.

4th edition of the *Guides* gives clear guidance about rating an impairment then it should be followed. However, in the case of assigning percentages to a mental or behavioural impairment, the 4th edition is silent. Reference to the 2nd edition of the *Guides* is one possible option but it is not mandated and there may be other approaches that are more appropriate given the specific circumstances of an individual's case.

Each edition of the *Guides* indicates that the reviewer can turn to other sources of information to help clarify an impairment rating if this additional information would lead to further clarity in the impairment rating process.[41] In light of all of the evidence presented, I find that it is then open to assessors to use not only previous editions of the *Guides* but also those subsequent to the 4th edition to assist them in determining the most accurate impairment rating for an individual.

### *Percentage Ranges from Table 3, Chapter 4 of the Guides, 4th edition*

Chapter 4 of the *Guides* provides percentage ranges for psychological impairments. Chapter 4 is used when the disturbance or disorder is caused by dysfunction to the brain or central nervous system. The features and characteristics of the mental disorders that fall within Chapters 4 and 14 may be the same, the difference however, is the cause of the impairment.[42]

Chapter 4 contains the following table in section 4.1c Emotional or Behavioural Disturbances:

**Table 3. Emotional or Behavioural Impairments**

| **Impairment description** | **% impairment of the whole person** |
|---|---|
| **Mild** limitation of daily social and interpersonal functioning | 0-14 |
| **Moderate** limitation of *some* but not all social and interpersonal daily living functions | 15-29 |
| **Severe** limitation impeding useful action in *almost all* social and interpersonal daily functions | 30-49 |
| *Severe limitation of all daily functions* requiring total dependence on another person | 50-70 |

[41] Exhibit #1, Tab 15, page 27.

[42] Spiegel J. uses this example in *Desbiens* stating that depression and anxiety are characteristics of various mental impairments. *Desbiens supra* paragraph 249.

In arriving at an impairment rating for Ms. Pastore, Dr. Leclair used Chapter 4, Table 3. He adopted this approach because he found that it is the only table in the 4th edition that is remotely similar and has the most common ground with the GAF scale. Although in Dr. Leclair's opinion the *Guides* do not provide a basis for assigning percentages to psychological impairments, he concedes that using Table 3 in the 4th edition chart is most in line with the *Desbiens* decision.[43] Dr. Leclair assessed Ms. Pastore at the mild bottom half of the moderate scale and assigned her 22% WPI which is the midpoint of the range. [44]

Dr. Becker opined that Chapter 4 was not appropriate for arriving at a psychological impairment rating because the chapter is intended for use in the case of a head injury. Further, Dr. Becker stated that Table 3 would overstate Ms. Pastore's impairment.

Dr. Brigham was firmly of the school of thought that it is not appropriate to assign a percentage rating to a psychological impairment, however his evidence was that if he had to choose an approach, he would use Chapter 4 as it is the "lesser of two evils" as compared to referring back to the 2nd edition of the *Guides*. He agreed with Dr. Becker that using Chapter 4, Table 3 would overstate the impairment.

### *Methodology Conclusion*

*Desbiens* did not specifically decide or comment on the use of one prevailing methodology in assigning percentage ratings to psychological impairments. In fact, one rigid formula or approach is not consistent with the general analysis adopted in *Desbiens*.[45]

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[43] Dr. Leclair gave evidence that if it were not for the *Desbiens* decision, that the 6th Edition of the *Guides* should be used because it would provide the most accurate rating as it is the most contemporary and most reflective of medical knowledge at this point in time. It also provides more of a range of impairment.

[44] Dr. Leclair's 34 page report dated March 12, 2008 provides detailed evidence explaining his approach.

[45] In *Desbiens*, the Plaintiff's expert approached the calculation of a percentage impairment rating first using Chapter 4, Table 3 and found that he would have assigned him a WPI of 25% as his impairments all fell within the description of "moderate limitation of some but not all social and interpersonal daily living functions." He also noted that the "percentages from the 2nd edition can also provide guidance for the appropriate percentage quantification of these impairments and a 25% WPI falls within the moderate category in the 2nd edition." In *Desbiens*, the Plaintiff's expert was of the opinion that either analysis would yield the same result and the same impairment rating.

I find that there should be some flexibility in the choice of assessment tool and method selected for rating impairments. The *Guides* themselves provide some flexibility in terms of options for rating impairments for the different body systems. Clinicians are encouraged to examine and assess impairments having considered the various sections in order to determine which assessment tool is most appropriate for a particular individual and impairment.

After reviewing the approaches and analyses of the various assessors in this case, the range of possible impairment scores for Ms. Pastore's psychological impairment spans from 10% WPI using the 6th edition of the *Guides* to 30% WPI using the 2nd edition of the *Guides*. Using Chapter 4 of the 4th edition of the *Guides* resulted in somewhat of a near midway score of 22% WPI rating.

I accept that the use of Table 3 (Chapter 4) will provide the most fair representation of Ms. Pastore's psychological impairment. The one area where there was some consistency among the assessors was in respect of Ms. Pastore's GAF score. I accept the evidence of Drs. Brigham and Leclair that Table 3 (Chapter 4) provides the most common ground with the GAF assessment and therefore a more accurate conversion into a WPI rating.

Further, until the *Schedule* mandates a specific approach or method, I find that given the lack of guidance offered in the 4th edition of the *Guides* that adopting a more wholistic and flexible approach will result in the most fulsome and true picture of an individual's impairments. Such an approach will produce the most fair and accurate results and is most in line with the true intent, meaning and spirit of the legislation.

As such, I find that Ms. Pastore's WPI rating for a psychological impairment is 22%.

### Ms. Pastore's Combined WPI Rating

According to the Combined Values Chart combining 2% WPI for the left ankle, 20% WPI for the right knee and 22% WPI for Ms. Pastore's psychological impairments results in a combined

impairment rating of 39% WPI.[46] As this falls below the 55% WPI threshold, I find that Ms. Pastore has not sustained a catastrophic impairment as defined by paragraph 2(1.1)(f) of the *Schedule.*

### Does the *Schedule* and the *Guides* allow for Rounding Up?

In reviewing the CAT assessments for Ms. Pastore, Dr. Becker arrives at a 51% WPI which he then rounds up to 55%. In rounding 51% to 55% Dr. Becker notes that although 51% WPI is below the CAT threshold, it is "well within the confidence limits derived from the methodology in the AMA *Guides* …" Dr. Becker's position is that a 51% WPI rating is statistically identical to a range of 46%-56% WPI as there is a +/- 10% confidence limit.

Given my finding that Ms. Pastore's combined WPI rating is 39% it is not necessary for me to make a finding on this issue as it would not affect the outcome of my decision.

## Paragraph (g) of Subsection 2(1.1)

According to clause (g) of the *Schedule*, an impairment is considered to be catastrophic if it results in a Class 4 impairment (marked impairment) or a Class 5 impairment (extreme impairment) due to mental or behavioural disorder. Chapter 14 of the *Guides* deals with mental and behavioural disorders. After identifying a mental or behavioural disorder, Chapter 14 directs clinicians to examine four areas of functioning to assess the severity of the impairment – activities of daily living, social functioning, concentration and adaptation.

The consensus opinion of the CAT DAC was that Ms. Pastore did meet the definition of catastrophic impairment under the (g) criterion of the *Schedule.* Drs. Rosenblat and Salmon, with the assessment of Ms. Jane Wong, OT, concluded that overall Ms. Pastore suffers from a Class 3 – Moderate Impairment, however she did achieve a Class 4 – Marked Impairment in the Activities of Daily Living sphere of function due to her recognized Pain Disorder.[47]

[46] AMA *Guides supra*, Combine Values Chart, page 322.
[47] Exhibit #1, Tab 6, page 67.

I agree with the CAT DAC assessors that although Ms. Pastore has difficulties in all of the four areas of function, it is only within the sphere of Activities of Daily Living that she suffers from a Class 4: Marked impairment. For this reason, it is the only area of function that I will discuss in detail.

Ms. Wong conducted a three-day Occupational Therapy Assessment in which she concluded that "there are physical and some emotional barriers that limit Ms. Pastore from functioning at her pre-accident status."[48] In addition to detailing the specific physical limitations Ms. Pastore experiences in carrying out her activities of daily living, Ms. Wong notes the following:

- constant knee pain;
- intermittent left ankle pain;
- guarded movements due to fear of injury and re-injury; and
- difficulty coping with the pain and frustration as a result of her limitation.

Ms. Pastore testified that in addition to her pain complaints she experiences the following:

- Difficulty sleeping;
- Fear in walking outside on her own;
- Anxiety;
- Depression;
- Extremely low energy;
- Fear while in a car; and
- Strained relationship with husband with limited intimacy since the accident.

Ms. Pastore's evidence was that prior to the accident she was an avid churchgoer who was also active in related church social events. She liked to play cards, bocci ball and bowling and was responsible for all of the housekeeping and cooking in the home. Ms. Pastore was also the primary caregiver for her husband of 38 years who was receiving chemo-dialysis three times a week.

[48] Exhibit #1, Tab 5, page 58.

Since the accident, Ms. Pastore has been dependent on her husband and daughter-in-law for housekeeping, personal care and mobility. During the day Ms. Pastore sits on the couch and watches TV, listens to the radio or reads the newspaper. She is not able to always sit comfortably on the couch and cannot sit for long periods of time without pain.

In terms of mobility, Ms. Pastore has limited ability both standing and walking and reduced balance. Ms. Pastore is only able to get around using a walker. She can no longer use public transportation and cannot walk long distances alone. Ms. Pastore cannot climb stairs except by going backwards and with assistance. Her bedroom is upstairs and since the accident she sleeps downstairs on the couch – in particular since her knee surgery. The bathroom is also upstairs and she is not able to go alone. She receives assistance from her husband if he is home and at other times she must use a portable commode downstairs.

Ms. Pastore is no longer able to do any of her housekeeping and is completely dependent on her husband and daughter-in-law to complete these tasks. Food preparation is also done by either her husband or daughter-in-law. Ms. Pastore no longer participates in any of her previous recreational activities and is no longer able to babysit her grandson. In terms of her personal care, Ms. Pastore needs assistance with the following: getting dressed, getting in and out of the tub, combing her hair and cutting her nails.

The CAT DAC concluded that "[g]iven the extent of interaction between [Ms. Pastore's] recognized physical and behaviourally based pain disorder, it is not possible to **factor out** the impact of any such discrete physical impairments, and associated pain limitations." The rating provided by the CAT DAC incorporates these factors on a "cumulative basis consistent with recognized Pain Disorder."[49] The CAT DAC found that the impact of these disorders on her daily functioning significantly impede her daily living tasks.

[49] Exhibit #1, Tab 6, page 66 of the CAT DAC. The DSM-IV definition of Pain Disorder is as follows: **307.89 – Pain Disorder Associated With Both Psychological Factors and a General Medical Condition:** both psychological factors and a general medical condition are judged to have important roles in the onset, severity, exacerbation, or maintenance of the pain, pages 499 and 503

Dr. Leclair disagreed with the CAT DAC's conclusion. Although he arrived at a GAF score within the same range as Drs. Rosenblat and Salmon, he concluded that none of the four spheres of function exceeded a Class 3 moderate level. In Dr. Leclair's opinion, the primary reason for Ms. Pastore's functional limitations was related to her physical impairments. In his March 12, 2008 report, Dr. Leclair concludes that "[p]sychological factors may contribute to her impairment in activities of daily living, but there is no documentation to support the point of view that it is the primary cause of her impairment."[50]

Dr. Leclair agreed with Dr. Rosenblat's assessment that Ms. Pastore suffers from mild depression and acknowledged that Ms. Pastore has been diagnosed with a "Chronic Pain Disorder." However, his position is that "…since chronic pain is considered by the *Guides* as not rateable because of the subjective nature of the pain, other psychological disorders such as depression and anxiety would need to be identified as contributing to difficulties in performing activities of daily living." Although he conceded that psychological factors may contribute to Ms. Pastore's impairment, he concluded that they are not the "primary cause."

In Dr. Leclair's opinion, assessing an impairment using Chapter 14 of the *Guides* requires examining the psychological aspects of the impairment and specifically the affect that they have on function. In doing so, it is necessary to examine how the mental disorder is independent from the physical disorder. He described this process in terms of layers – in order to properly assess mental and behavioural impairments you need to remove the layer of physical impairments.

Chapter 14 of the *Guides* directs that in assessing impairment, any limitation with respect to activities of daily living should be related to the mental disorder. The clinician is directed to determine the impact of the mental condition on "normal life activities."[51] "What is assessed is not simply the number of activities that are restricted, but the overall degree of restriction or combination of restrictions."[52] I do not interpret this as requiring a complete separation of physical and mental impairments nor do I think it is possible when you are considering an

[50] Exhibit #1, Tab 12, page 25.

[51] *Guides supra*, page 291.

[52] *Guides supra*, page 294.

impairment that also involves pain. The appropriate focus should be on how the mental part of an overall condition or impairment impacts the various spheres of function. The experience of pain and a diagnosis of Pain Disorder falls properly within this examination.

I find that Dr. Leclair's assessment overemphasized the need for the mental aspect to be the "primary" cause of the overall impairment as this overlooks the fact that Ms. Pastore's impairment has both a physical and mental component – it is complex with intertwined psychological and physical elements.

Dr. Leclair further opined that in assessing someone's physical impairments, the WPI rating includes a rating for pain and the psychological condition related to the pain within the rating itself. Therefore, pain should not be assessed and rated separately under the (g) criterion as this would result in double counting. I disagree with this interpretation and approach.

Chapter 15 of the *Guides* discusses pain. The *Guides* note that "[i]n general, impairment percents given in the tables and figures applicable to permanent impairments in the various organ systems include allowances for the pain that may occur with those impairments."[53] Although I agree with Dr. Leclair that it is important to avoid double counting, the chapter also notes that "the important task of evaluating impairment due to pain is difficult but not impossible."[54]

Chapter 15 discusses some of the challenges in the evaluation of pain and in doing so it sets out a very similar dilemma as that of Chapter 14 and the lack of percentages in rating psychological disorders. I do not find that this challenge leads to the necessary conclusion that pain should therefore be ignored in the assessment of impairment or that a comprehensive assessment and rating of pain is encompassed within the rating of other organ systems. Quite the contrary, Chapter 15 notes that traditional evaluation models are not appropriate for properly evaluating pain. It includes some of the assumptions that clinicians should be aware of when considering pain including:

[53] *Guides supra*, page 304.
[54] *Guides supra*, page 304.

1. Pain evaluation does not lend itself to strict laboratory standards of sensitivity, specificity, and other scientific criteria.

2. Chronic pain is not measureable or detectable on the basis of the classic, tissue-oriented disease model.

3. Pain evaluation requires acknowledging and understanding a multifaceted, biopsychosocial model that transcends the usual, more limited disease model.

4. Pain impairment estimates are based on the physician's training, experience, skill, and thoroughness. As with most medical care, the physician's judgment about pain represents a blend of the art and science of medicine, and the judgment must be characterized not so much by scientific accuracy as by procedural regularity. [55]

Ms. Pastore was diagnosed with a Pain Disorder Associated with Both Psychological Factors and a General Medical Condition. I regard this diagnosis as a separate aspect of Ms. Pastore's overall impairment which has caused her to suffer impairments that properly fall within Chapter 14.

Although perhaps a difficult task, it is necessary to consider all aspects of an individual's impairments in order to get a complete and accurate picture. Pain may be subjective and hard to quantify, but it is important to examine and consider the role of pain in relation to an individual's functional limitations.[56] I agree with the principle enunciated in both *McMichael and Belair* and *Ms. G and Pilot*[57] that it is important to deal with a person as a whole and not a mere list of quantifiable impairments. In doing so, it is necessary to take a step back to get a sense of the full picture of a person's impairments individually as well as how they interact with each other – the affect of pain is part of this picture.

Therefore, a complete assessment must consider the affect of pain and Ms. Pastore's Pain Disorder on her activities of daily living. The pain not only limits her physical abilities to do the

[55] *Guides supra*, Chapter 15 page 304.

[56] In *Desbiens*, Justice Spiegel considered and accepted that Mr. Desbiens' diagnosed psychological disorders, which included Chronic Pain Disorder, had caused him to suffer impairments that fell within the scope of Chapter 14 of the *Guides*. Spiegel J. considered evidence of how Mr. Desbiens' pain and related psychological distress played an increased role in his dysfunction. Spiegel J. found that Mr. Desbiens suffered from a "significant emotional disturbance" and "…significant psychological distress that further compromised his function." *Desbiens supra*, paragraph 123

[57] *McMichael supra*; *Ms. G supra*.

activity but it plays a role in the feeling of loss of meaningful activities or social relationships. This loss is noted as resulting in frustration, resentment or anger, which further increases pain.[58]

For Ms. Pastore, the combination of physical limitations and the associated pain are intertwined. They both play an integral part in having transformed her life from being a completely self-sufficient and independent individual and caregiver to her husband to becoming almost completely dependent on him and others for her most basic personal care needs. I agree with the CAT DAC conclusions that it is not possible to **factor out** the impact of any such discrete physical impairments and associated pain limitations, and that any impairment rating should incorporate both on a "cumulative basis."

Ms. Pastore's emotional, behavioural and mental difficulties are well documented.[59] Based on the medical documentation and evidence including the OT assessment and the testimony of Ms. Pastore, I conclude that the impact of these disorders on her daily functioning significantly impede her daily living tasks and the resulting impairment falls within a Class 4 marked level of impairment.

### Is one "marked" impairment adequate to meet the definition of catastrophic under 2(1.1)(g) of the *Schedule*?

Although Justice Spiegel in *Desbiens* did not have to specifically decide whether a Class 4 impairment in <u>one</u> area of assessment was sufficient to meet the definition of "catastrophic impairment", he did note that "[i]t is not disputed that it is sufficient for Mr. Desbiens to establish that his impairment in any one of the areas of functioning meets the requirements of clause (g)."[60] Arbitrator Muir in *McMichael and Belair* adopted this same approach, however, as in *Desbiens*, it was not specifically an issue before him.

There is nothing in the language of clause (g) to suggest that the approach taken by the Court in *Desbiens* is incorrect. If the provision is ambiguous and I find that it is, that ambiguity ought to

[58] Exhibit #1, Tab 5.
[59] Dr. Leclair's report reviews a number of previous assessments, Exhibit #1, Tab 12. Note also clinical notes and records of Dr. Castrodale and various specialists, Exhibit # 3, Volume A.
[60] *Desbiens* supra, paragraph 129.

be resolved, in the absence of anything pointing elsewhere, in a liberal manner having regard to the ultimate remedial purpose of the legislation.

The Superintendent's Guidelines ("CAT DAC Guidelines") for undertaking catastrophic DAC assessments are clear in dictating that two marked impairments are required to render a catastrophic determination under the (g) criterion. I find that they are merely guidelines and an assessment tool for clinicians, however they are not incorporated into the legislation. As such, I am not bound by this protocol.[61] Further, both *Desbiens* and *McMichael* note that the CAT DAC Guidelines used in undertaking catastrophic DAC assessments likely misinterpreted the terminology in clause (g) of the *Schedule* when they indicated that at least two (Class 4) marked impairments were required.

In Ms. Pastore's case, the CAT DAC assessors specifically note that in consideration of the *Desbiens* and *McMichael* cases that one marked impairment is adequate for a positive finding of catastrophic impairment under clause (g).[62]

Although Dr. Becker did not agree with the CAT DAC result with respect to the (g) criterion, he acknowledged that they are merely guidelines and that the DAC team must also be aware of arbitration and judicial decisions and that "[u]ltimately, it is about providing resolution for the individual's impairment definitions within the integrity of the SABS." [63]

Dr. Leclair noted that there is a strong basis for requiring more than one marked impairment for a determination of catastrophic impairment. He argued that due to the overlapping nature and interaction in the four areas of function, it would be very unusual to have only one marked impairment and thus it would not be a meaningful result.

I agree with Dr. Leclair that there is a strong interaction between the four areas of function described in Chapter 14. It is this very interaction that persuades me that a marked impairment in

[61] I accept the position of Arbitrator Muir in *McMichael supra* and Arbitrator Blackman in *Ms. G. supra* both of whom made similar determinations in terms of not being bound by the CAT DAC Guidelines.

[62] Exhibit #1, Tab 6, page 67. The CAT DAC assessors note that "… a classification of Class 4: Marked is required in only one domain (according to the *Desbiens* and *McMichael* decisions)..."

[63] Exhibit #1, Tab 8, page 2

one area of function alone is sufficient for a person to be deemed catastrophic for the purpose of Ontario accident benefits legislation.

In examining each of the four areas of functional limitation (activities of daily living, social functioning, concentration and adaptation), it is clear that these areas represent the most basic and core aspects of function – they are the things that define us. The four areas are interrelated with significant overlap between them. For example, it is highly unlikely that an impairment that affects activities of daily living will not also have related effects in the areas of social functioning and concentration, however not necessarily at a marked level of impairment.

If an individual has reached a marked level of impairment in any one area, then they are being deprived of a level of function in a basic and core area of life. This amounts to a serious loss. It is highly unlikely that in such a case the other areas of function would not also be negatively affected in some way. Given the importance of each area of function the loss of any one alone is significant and adequate to meet the definition of catastrophic impairment. To accept that one marked impairment is adequate is in line with a remedial approach to the *Schedule*.[64]

I find that one marked impairment is adequate to meet the definition of catastrophic impairment. On this basis, having accepted the assessment of the CAT DAC that Ms. Pastore has suffered a Class 4: Marked impairment in the sphere of activities of daily living, I find that Ms. Pastore has met the definition of catastrophic impairment pursuant to clause (g) of the *Schedule.*

## CONCLUSION:

For all of the reasons set out above, I conclude that Ms. Pastore has sustained a catastrophic impairment as a result of the accident on November 16, 2002 as defined by paragraph 2(1.1)(g) of the *Schedule.* Although I find that combining impairments is permitted under the *Schedule*, in this case Ms. Pastore's combined impairments do not result in a 55% whole person impairment and as such she does not meet the definition of catastrophic impairment pursuant to paragraph 2(1.1)(f) of the *Schedule*.

[64] *McMichael supra*.

**EXPENSES:**

I encourage the parties to settle the matter of expenses between themselves. However, if they are unable to reach an agreement, they may request a determination of the issue by writing to the Commission within 30 days of this order, as set out in Rule 79.1 of the *Dispute Resolution Practice Code*.

February 11, 2009

Elizabeth Nastasi
Arbitrator

Date

**Financial Services Commission of Ontario**

**Commission des services financiers de l'Ontario**

Ontario

**FSCO A04-002496**

**BETWEEN:**

**ANNA PASTORE**

**Applicant**

**and**

**AVIVA CANADA INC.**

**Insurer**

# ARBITRATION ORDER

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

1. Ms. Pastore has suffered a catastrophic impairment as defined by paragraph 2(1.1)(g) of the *Schedule.*

2. The issue of the legal expenses claimed pursuant to subsection 282(11) of the *Insurance Act* may now be addressed in accordance with the provisions of the *Dispute Resolution Practice Code* (Fourth Edition, Updated - October 2003).

February 11, 2009

Elizabeth Nastasi
Arbitrator

Date