

# DETERMINING CATASTROPHIC IMPAIRMENT FOR THE NEW SABS

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## DETERMINING CATASTROPHIC IMPAIRMENT FOR THE NEW SABS

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Courts and Arbitrators have helped us to understand how the definition of catastrophic impairment may apply to individuals who suffer very severe injuries in motor vehicle accidents. These same decisions have helped us to understand that clinical findings by treating and assessing health care professionals are integral to the process of evaluating whether a person has sustained a catastrophic impairment.

The goal of this paper is to provide health care professionals with further tools to assist them in conducting evaluations and providing detailed reports to assist in Catastrophic Impairment determination. This paper examines the definition of catastrophic impairment, legislative intent and provides a summary of all of the decisions concerning catastrophic impairment determination by the courts and by FSCO Arbitrators.

The paper analyzes key chapters in the American Medical Association Guides to the Evaluation of Permanent Impairment, 4<sup>th</sup> Edition<sup>1</sup>. For each Chapter, we identify key information and assessments by treating and assessing health care professionals that can be used to assist in CAT Impairment designation. The paper analyses the Glasgow Coma Scale and the Glasgow Outcome Scale in light of clinicians' assessments. We then address the legal meaning of causation as it relates to accident benefit impairments.

### A. CATASTROPHIC IMPAIRMENT

"Catastrophic Impairment" has been with us since November 1, 1996. The post-September 1, 2010 definition of catastrophic impairment follows:

- 3(2) For the purposes of this Regulation, a catastrophic impairment caused by an accident is,
- a) paraplegia or quadriplegia;
  - b) the amputation or other impairment causing the total and permanent loss of use of an arm or a leg;
  - c) the total loss of vision in both eyes;

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<sup>1</sup> AMA Guides To The Evaluation Of Permanent Impairment , 4<sup>th</sup> Edition, ed. Doege, T.C. © 1995, American Medical Association

- d) subject to subsection (4), 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;
  - e) subject to subsections (4), (5) and (6), 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
  - f) subject to subsections (4), (5) and (6), an impairment that, in accordance with the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4<sup>th</sup> edition, 1993, results in a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioral disorder.
- (3) Subsection (4) applies if an insured person is under the age of 16 years at the time of the accident and none of the Glasgow Coma Scale, the Glasgow Outcome Scale or the American Medical Association's *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, referred to in clause (2) (d),(e) or (f) can be applied by reason of the age of the insured person.
  - (4) For the purposes of clauses (2)(d),(e) and (f) an impairment sustained in an accident by an insured person described in subsection (3) that can reasonably be believed to be a catastrophic impairment shall be deemed to be the impairment that is most analogous to the impairment referred to in clause (2)(d), (e), or (f) after taking into consideration the developmental implications of the impairment.
  - (5) Clauses (2)(e) and (f) do not apply in respect of an insured person who sustains an impairment as a result of an accident that occurs after September 30, 2003 unless,

- a) in the case of an impairment that includes a brain impairment, a physician states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment;
  - b) in the case of an impairment that is only a brain impairment, a neuropsychologist states in writing that the insured person's condition is unlikely to cease to be a catastrophic impairment; or
  - c) two years have elapsed since the accident.
- (6) For the purpose of clauses (2)(e) and (f) 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.

The new SABS coming into effect September 1, 2010 contains only one substantive substantive change. A person suffering an amputation or complete and permanent loss of use of one arm or one leg will now be deemed catastrophically impaired.

There is also one procedural change. New section 45(2)1 of the SABS limits assessment or examination in connection with a determination of Catastrophic Impairment to "a physician". New section 45(2)2 of the SABS creates an exception to the "physician only" rule "if the impairment" is only a "brain impairment". In these cases, the assessment or examination "may" be conducted by a "neuropsychologist".

The section states:

45. (1) An insured person who sustains an impairment as a result of an accident may apply to the insurer for a determination of whether the impairment is a catastrophic impairment.

(2) The following rules apply with respect to an application under subsection (1):

- 1. An assessment or examination in connection with a determination of catastrophic impairment shall be conducted only by a physician.
- 2. Despite paragraph 1, if the impairment is only a brain impairment, the assessment or examination may be conducted by a neuropsychologist.

As these “rules” apply with respect to an “application”, it is likely that only the “application” itself must be completed by a physician or neuropsychologist. Arbitrators and judges rely heavily on other health professionals to help with catastrophic determinations such that evidence and reports from others will continue to be essential.

With respect to when an application for catastrophic impairment can be made, new subsection 3(5) now stipulates that the whole person impairment test and the marked or extreme impairment test can only be considered prior to the 2 year post accident mark if the impairment includes a brain injury and if the impairment is unlikely to cease to be a catastrophic impairment.

## **B. THE DEFINITION: THE DRAFTERS’ INTENT**

Arbitrators and courts have commented on the Legislature’s definition of catastrophic impairment.

One of the seminal decision considering the definition of catastrophic is *Desbiens v. Mordini* a decision of Justice Spiegel of the Ontario Superior Court in 2004.<sup>2</sup> In *Desbiens*, the Court commented that:

“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.”<sup>3</sup>

It is also important in interpreting the definition to remember that:

“the SABS are a remedial consumer protection legislation.”<sup>4</sup>

Typically, remedial consumer protection legislation is intended to be interpreted in a manner that assists consumers.

As the court noted again in *Desbiens* at paragraph 238 the text of the regulation itself indicates that the drafters clearly intended the definition of “catastrophic impairment” to be inclusive rather than restrictive.

As a result of *Desbiens* and a number of decisions following *Desbiens*,<sup>5</sup> when considering section (f) of the definition, Arbitrators and Judges have concluded that it is

<sup>2</sup> *Desbiens v. Mordini*, [2004] CanLII 41210 (ON S.C.)

<sup>3</sup> *Desbiens*, *supra* para 237- 234

<sup>4</sup> *Smith v. Co-Operators General Insurance Co.*, [2002] 129 S.C.R.

<sup>5</sup> *Desbiens*, *supra*, has been subsequently followed by: *Arts v. State Farm Insurance Company*, Can LII 25055 (ON S.C.), *McMichael and Belair Insurance Company* (2006) Appeal P)5-00006; *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); *Pastore v. Aviva*, [2009] O.F.S.C.O. No. 24, February 11, 2009

appropriate to assign a percentage rating to mental and behavioural impairments and to add that percentage, using the applicable tables, to the other percentage ratings of impairment to determine whole person impairment.

Apart from the legislative intention of the drafters, the Financial Services Commission of Ontario (FSCO) created Commission Guidelines dated October 2001 as a guide to Designated Assessment Centre's (DAC's) assessing catastrophic impairment.

As section 3 (2) (e) of the definition indicates that a person with a combination of impairments which results in fifty-five percent or more impairment of the whole person, it is not with any surprise that we note the Guidelines asked the CAT DAC to "ensure it evaluates the whole person".<sup>6</sup>

The definition of catastrophic was modified for accidents occurring after September 30, 2003 by Bill 198 when it allowed clauses (f) and (g) (now (e) and (f) for accidents after September 1, 2010,) to be used as a basis for determining catastrophic impairment when two years, as opposed to three years, had elapsed since the accident.

The other modification that occurred in Bill 198 was the inclusion of sections (1.3), (1.4) and (3). (s. 3(3) and 3(4) for accidents after September 1, 2010) Sections (1.3) and (1.4) acknowledged the difficulty of using the Glasgow Coma Scale, Glasgow Outcome Scale and AMA Guides to assess the impairments of a person under the age of sixteen. Sections (1.3) and (1.4) allow assessors who reasonably believe a person under the age of sixteen years to have suffered a catastrophic impairment to analogize that impairment to the impairment referred to in clause (1.2) (e), (f) or (g). (s. 2(d) (e) and (f) for accidents after September 1, 2010).

Section (3) (now 3 (4)) allows the assessor evaluating impairments that are not listed in the AMA Guides to deem the impairment to be the impairment in the Guides that is most analogous to the impairment sustained by the insured person.

The net effect of both of these revisions is to allow greater clinical judgment to be used in the assessment of impairments, including consideration of the developmental implications of an impairment.

### **C. AMA GUIDES 4<sup>TH</sup> EDITION – RULES FOR EVALUATION**

The Guides themselves recognize a significant role for physician discretion. Section 2.2 of Chapter 1 "Impairment Evaluation" indicates as follows:

"If in spite of an observation of a 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".

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<sup>6</sup> Catastrophic Designated Assessment Centre Assessment Guidelines October 2001, FSCO, page 4-2 paras 4-5.

## D. ARBITRATION AND COURT DECISIONS

Below you will find a summary of Court and FSCO arbitration decisions which address whether a person has sustained a catastrophic impairment.

### **Snushall v. Fulsang, [2003] O.T.C. 363, [2003] O.J. No. 1493**

The Plaintiff was seriously injured in a motor vehicle accident. She advanced a claim for catastrophic impairment on the basis of impairment of 55% or more of the whole person. Conflicting medical expert evidence was given and Lax J. found that she was not entitled to damages for future health care costs, as the conflicting evidence failed to establish that her injuries resulted in 55% or more impairment of the whole person. Although she suffered significant injuries, her functional abilities were still reasonably good.

### **Holland v. Pilot Insurance Co., [2004] O.T.C.544, [2004] O.J. No. 2737**

The Plaintiff was a 15 year old boy who sustained injuries in a motor vehicle accident after he had been consuming alcohol and marijuana. Medical experts were divided as to whether Plaintiff's GCS results at 7/15, 8/15 and 4/15 could be considered. Keenan J. found that the results could be considered and found that the status of catastrophic impairment is a creature of legislature. If restrictive meaning is to be assigned to the regulation, it should be clearly cited in the regulation itself.

### **Desbiens v. Mordini, [2004] O. J. No. 4735**

Landmark case in which Spiegel J. articulates the 'Desbiens approach' summed up as: **"It is in accordance with the *Guides* to assign percentages to [the Applicant's] psychological impairments and to combine them with his physical impairments in determining whether or not he meets the definition of catastrophic impairment under clause (f)"**. Further, Spiegel J. examines the history of the legislative scheme in this area and additionally does an individual assessment of each of the Plaintiff's impairments.

### **Lloyd Alison Villers and Pilot Insurance Company, [2005] O.F.S.C.O. No. 46**

The Applicant suffered from significant impairments before being injured in a motor vehicle accident. Arbitrator Bayefsky found that not enough had changed in the Applicant's health in order to indicate a catastrophic impairment caused by the accident.

### **Young and Liberty Mutual Insurance Company, [2005] O.F.S.C.O. No. 76**

The Applicant was involved in a car accident in which he was trapped in his car and unable to breath. His GCS was less than 9/15 just after the accident. He suffered from seizures and medical personnel intubated him. The Insurer argued that his GCS should not be considered. Director's Delegate Evans upheld the Arbitrator's decision and found

that the legislation only requires that there be a reading of 9 or less. As other factors are not considered in the legislation, they should not be considered determining catastrophic impairment. Therefore, the GCS was considered. The Applicant did meet the threshold to be determined catastrophically impaired.

**George and State Farm Mutual Automobile Insurance Company,**  
**[2005] O. F.S.C.O. No. 156**

The Applicant's appeal of an arbitration decision was overturned in this appeal as the Applicant's WPI did not exceed 30%. Director Delegate Evans reaffirmed the *Desbiens* approach and stated that the *Guides* do allow adding non-structural mental or behavioral impairment to the WPI. Additionally, the Multi Disciplinary Assessment Centre's (DAC's) assessment of the Applicant's level of impairment was found to be binding until an arbitrator determined that it was not.

**McMichael and Belair Insurance Co.,** [2006] O.F.S.C.O. No.17 - 8

The Applicant was injured in a motor vehicle accident. He had a prior history of cocaine use which became cocaine addiction after the accident. Director Delegate Makepeace reaffirmed the *Desbiens* approach. She also upheld the arbitrator's decision and found that:

"whether the [cocaine use] genesis was an effect of the mild traumatic brain injury that Mr. McMichael suffered, a vain and misguided attempt to self-medicate, or some combination of these two, the addiction is a direct consequence of the injuries sustained in the car accident."

**Lee and State Farm Mutual Automobile Insurance Co.,** [2006], O.F.S.C.O. No. 17

The Applicant was in a motor vehicle accident and sustained injuries. Medical experts for the Insurer claimed that the Applicant had a pre-existing history of abusing pain medication and suffered from post traumatic stress and thereby tried to assert that she contributed to her impairment. Arbitrator Ashby made reference to *McMichael*, in which the arbitrator found that the Applicant's pre-existing cocaine habit was not a significant pre-existing factor and that the mild brain injury from the accident materially and substantially contributed to his post-accident addiction. In this case Arbitrator Ashby decided that there was medical evidence to support that the accident had caused the Applicant's impairments.

**Tournay and Dominion of Canada General Insurance Co.,**  
**[2006] O. F.S.C.O. No. 137**

The Applicant was injured in a motor vehicle accident during which she was trapped in her car and had to be intubated. Her GCS was less than 9/15. The Insurer claims that because she was intubated her GCS should not be considered. Arbitrator Kominar found that the legislation is not restrictive, her GCS would be considered and therefore she met the threshold for catastrophic impairment.



**B.P. and Primmum Insurance Co., [2006] O.F.S.C.O. No. 202**

The Applicant was severely injured in a motorcycle accident and his lower right leg was amputated. Arbitrator L. Blackman reaffirmed the *Desbiens* approach and found that the *AMA Guides* state that impairments should not be considered separately in a vacuum but rather it is the unique individual that should be assessed. Additionally, he rejected the argument that the Arbitrator has discretion to find an Applicant suffers a catastrophic impairment on the basis that the cost of future care exceeds the non-catastrophic limit under the schedule. The “whole person” approach was followed and the Applicant was deemed to be catastrophically impaired.

**Cordeiro and Wawanesa Mutual Insurance Co., [2007] O.F.S.C.O. No. 64**

The Applicant had a pre-existing head injury. In the subject accident, he was injured when his car rolled over him. He suffered serious orthopedic, cognitive and emotional impairments. Arbitrator Muir found that the motor vehicle accident caused the impairments and thereby determined the Applicant to be catastrophically injured.

**Ms. G. and Pilot Insurance Co., [2007] O.F.S.C.O. No. 153**

The Applicant was injured in a motor vehicle accident and suffered both physical and mental impairments. Delegate Director Makepeace upheld the previous arbitration decision and found that the WPI percentages of physical and psychological impairments should be combined. Therefore the Applicant met the threshold for catastrophic impairment. Additionally, she also found that the trier of fact, and not medical experts, have the responsibility under paragraph 2 (1)(f) of the *Schedule* to capture and accurately estimate all of the impairments. Further, she noted that an impairment that is not listed in the *Guides* shall be deemed to be the impairment that is listed that is most analogous to the sustained impairment.

**H. and Lombard General Insurance Co. of Canada, [2007] O.F.S.C.O. No. 193**

David Payne, Thomson, Rogers for Applicant

The Applicant sustained physical and mental impairments in a motor vehicle accident. Arbitrator Renahan applies *Desbiens* approach. Arbitrator cites Spiegel J. in *Desbiens* and finds that because the *Guides* are referenced by the *Schedule*, it becomes an integral part of the incorporating instrument as if reproduced therein. The CAT DAC assigned a WPI of 1%. The arbitrator assigned a WPI of 79% based upon a rating of 52% for physical impairments and a rating of 55% for mental and behavioural disorders.

**Arts (Litigation Guardian of) v. State Farm Insurance Co. (2009), 91 O. R. (3d) 394, [2008] O.J. No. 2096**

The Plaintiff was involved in a motor vehicle accident that caused both physical and mental impairments. The Plaintiff argued that if his physical and psychological

impairment WPI percentages were combined he would qualify as catastrophically impaired. McKinnon J. accepted this argument and found that it is permissible to assign percentage ratings in respect of a person's psycho-emotional impairments and to combine them with percentage ratings in respect of the person's physical impairments for the purpose of determining whether the person is catastrophically impaired to pursuant to section 2(1)(f).

**Augello and Economical Mutual Insurance Co., [2008] O.F.S.C.O. No. 189**

The Applicant was injured in a motor vehicle accident that caused both physical and mental impairments. The Applicant argued that if her physical and psychological impairment WPI percentages were combined she would qualify as catastrophically impaired. Arbitrator John Wilson found that the *Desbiens* approach of permitting the combination the WPI percentages of physical and psychological impairments more closely corresponds with the underlying principles of the accident benefits scheme and that the approach that favours the insured should prevail.

**B. and RBC General Insurance Co., [2009] O.F.S.C.O. No. 5**

The Applicant was injured in a motor vehicle accident and made an application for determination of catastrophic impairment. Arbitrator Murray assessed each of the areas of impairment and found that they do not equal a WPI of 55% or more. Therefore the application was refused. Additionally, Arbitrator Murray finds that the Applicant's failure to obtain testimony or reports from some of her attending physicians calls the Applicant's credibility into question. Further Arbitrator Murray found that one of the Applicant's medical experts was evasive and unresponsive and this called his credibility into question.

**Pastore and Aviva Canada Inc., [2009] O.F.S.C.O. No. 24**

The Applicant was injured in a motor vehicle accident and sustained both physical and mental impairments. Arbitrator Nastasi reaffirmed the *Desbiens* approach but found that:

“*Desbiens* did not specifically decide or comment on the use of one prevailing methodology in assigning percentage ratings to psychological impairments... I find that given the lack of guidance offered in the 4th edition of the *Guides* that adopting a more holistic and flexible approach will result in the most fulsome and true picture of an individual's impairments.”

The Arbitrator accepted that Table 3 in Chapter 4 of the *Guides* provides the most accurate assessment of the Applicant's psychological impairment.

Further, the Arbitrator concluded that: “ I find that one marked impairment is adequate to meet the definition of catastrophic impairment under clause (g) [mental/behavioural disorder].”

**Knechtel and Royal & Sunalliance Insurance Co., of Canada,**  
**[2009] O.F.S.C.O. No. 70**

The Applicant sustained injuries in a motor vehicle accident. Medical expert for the Applicant claimed she suffers from psychological impairments. Arbitrator Sampliner concluded after considering surveillance evidence of the Applicant conducting normal daily activities that the nature and degree of psychological impairments that would lead to a determination of CAT status must be more substantial than the Applicant's.

**Liu v. 1226071 Ontario Inc. (c.o.b. Canadian Zhorong Trading Ltd.),**  
**2009 O.N.C.A. 571, [2009] O.J. No. 3014**

Appeal by the Plaintiff from a trial decision that he had not sustained a catastrophic impairment as a result of a motor vehicle accident and as such was not entitled to the jury award of damages of \$865,000.00 for health care expenses. He lost consciousness; the initial GCS administered by the paramedics was less than nine (9). MacFarland J. found that the fact that there might have been other higher GCS scores also within a reasonable time after the accident was irrelevant. It was a legal definition to be met by a claimant and not a medical test. As such the Plaintiff was deemed catastrophically impaired and was entitled to the jury award of health care damages.

**Fournie v Coachman,** [2010] O.F.S.C.D. No. 15

Applicant suffered comminuted injury to left ankle. Required two canes or crutches to ambulate outside home. Significant pain, 40 percent WPI for leg/ankle. Depression, anxiety, major depressive disorder and post traumatic stress disorder. FAE completed. Evaluated under Chapter 14 of Guides. Insurer examiner did not, finding that pain disorder was associated with foot injury and not with psychological factors. The assessing psychiatrist used Chapter 15 page 310 pain intensity frequency grid and assessed him as having a marked impairment under Chapter 14, finding that the four aspects of functioning (ADL, social functioning, concentration and adaptation) were significantly affected by pain.

**Ramalingam v. State Farm,** FSCO A08-001571, June 4, 2010

Accident January 9, 2002. In July 2007 insured applies for determination of catastrophic impairment. Result: There is no limitations defence for the claim for a determination of catastrophic impairment.

**Windsor v. MVAC Fund, FSCO A08-001383, May 10, 2010**

Injured applied for Catastrophic Determination under GCS. Had GCS of 13. There was no written record of GCS score of 9 or less for Mr. Windsor except for when he was sedated. Case revolves around question of whether Mr. Windsor was the person to whom they had previously assigned a GCS of 3. It was determined by the Arbitrator that Mr. Windsor was not the person to whom the ambulance attendants had previously assigned a GCS of 3.

**R. P. v. AllState, FSCO 106-001067, July 23, 2010**

Accident May 7, 2003. No treatment sought until ten months later. Didn't apply for accident benefits until 2004. Four and one-half years after the accident applied for Determination of Catastrophic Impairment. The Arbitrator found that R. B. was functionally psychologically impaired before the accident and the accident contributed very little, if anything to later psychological impairments. Therefore found not to be catastrophically impaired.

**Kusnierz v. Economical, 2010 ONSC 5749, October 10, 2010**

Amputated left leg to knee. Psychological disorders. Judge refuses to combine mental and physical impairments to determine "whole person impairment". Judge fails to distinguish Supreme Court of Canada decision **Smith v. Co-Operators** that SABs is consumer protection legislation; to be interpreted in a manner that favours consumers. The case is under appeal to the Ontario Court of Appeal. The Ontario Trial Lawyers Association is pursuing intervenor status.

**M.R. v. Gore Mutual Insurance Company, (2010) O.F.S.C.D. No. 149**

Applicant with a psychological disorder applied for catastrophic impairment determination developing within a few months of the accident. The Arbitrator rejected the insurer's assessment for failure to follow the procedures mandated in the AMA guides, most particularly for failing to gather and review the clinical records of the applicant's treating professionals. However, on the strength of other assessments, the applicant was found markedly impaired with respect to three of the four spheres functioning (activities of daily living, social functioning and adaptation to work or work-like settings), but only moderately to markedly impaired in concentration, persistence, and pace. The applicant was therefore found to have suffered a catastrophic impairment within the meaning of Clause 2(1.2)(g) of the SABS.

**Jaggernaut v. Economical Mutual Insurance Company, (2010) O.F.S.C.D. No. 140**

The applicant applied for catastrophic impairment determination on the basis of a psychological condition arising from an accident. The Arbitrator disregarded one assessor's opinion for failure to follow the procedures required under the guides for a valid assessment failure to gather and evaluate the complete medical history and review

the applicant's complete clinical record). The Arbitrator disapproved of another assessors downgrading of impairment classifications because of concerns of exaggeration indicated by surveillance evidence. The Arbitrator also disapproved of an assessor's refusal to assess any impairment that was not static (i.e., unchanging and recorded consistently by virtually every assessor). The applicant was found to be only moderately impaired and therefore not suffering from a catastrophic impairment.

The Applicant also applied for catastrophic impairment determination based on a Whole Person Impairment (WPI) rating. The Arbitrator determined that the applicant's mental and behavioural impairments, when combined with the WPI rating for all other impairments (in line with the *Desbiens* reasoning), rendered him catastrophically impaired. Importantly, the Arbitrator stated that the *Mrs. G. and Pilot Insurance Co.* decision continues to govern the approach at FSCO (i.e., mental or behavioural impairments are to be combined with other impairments).

## **E. CHAPTER 3 OF THE AMA GUIDES – MUSCULOSKELETAL SYSTEM – CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL**

Chapter 3 of the Guides includes sections which address the upper extremities, the lower extremities, the spine and the pelvis. These sections describe and recommend methods and techniques of determining impairments due to amputation, a restriction of motion, sensory motor deficits, peripheral nerve disorders and peripheral vascular disease.<sup>7</sup>

The upper extremity, lower extremity, the spine and the pelvis are each to be considered as a unit of the whole person. The upper extremity is four parts – hand, wrist, elbow and shoulder, the lower extremity is six sections – the foot, hind foot, ankle, leg, knee and hip, the spine is twenty-four vertebrae.

As the Guides note “examinations for determining musculoskeletal system impairments are based on traditional approaches for recording the medical history and performing a physical examination.”

As Chapter 3 notes: “Evaluating the range of motion of an extremity or of the spine is a valid method of estimating an impairment.”

A Clinician's assessment of musculoskeletal system impairments will likely include an evaluation of motion impairments and range of motion measurements. Historical range of motion measurements obtained through clinical records of treating physiotherapists and occupational therapists are of significant assistance to assessors evaluating impairment in this section.

Equally, notes with respect to vascular disorder, bone and joint deformities including crepitation in joint motion and joint swelling observations provide important information

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<sup>7</sup> Chapter 3 of the musculoskeletal system AMA Guides, fourth edition

for the purposes of evaluating the degree of impairment of musculoskeletal system. Musculotendinous impairments, tightness, grip and tension strength measurements help evaluate upper extremity impairments.

Notations of limb length discrepancy, gait derangement, muscle atrophy, joint crookedness or stiffness of joints also assists in evaluating the impairment.

In assessing persons who have suffered musculoskeletal impairments including amputations, the “whole person” approach leads to a multi system assessment of impairment. Ratings would be completed inside chapter 3 (Musculoskeletal System impairments) Chapter 13 impairments (The Skin) and Chapter 14 (Mental and Behavioural Disorders) and Chapter 4, (The Nervous System).

As the Guides note, the evaluation of an amputee’s impairments should be undertaken without the use of a prosthesis. Exacerbations caused by weather, stressful situations, humidity and sweating should also be taken into consideration. In the case of amputation, redness, rashes, blisters, skin peeling, affect a broad range of activities of daily living from the type of clothing to be worn to the ability to walk with prosthesis.

#### **F. CHAPTER 4 OF THE AMA GUIDES – THE NERVOUS SYSTEM – CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL**

Chapter 4 is an extremely important chapter in evaluating whole person impairment, especially in light of the *Desbiens* decision. The *Desbiens* decision used Chapter 14 to evaluate the mental and behavioural impairments a person has. By virtue of the fact that Chapter 14 does not assign mental or behavioural impairments a percentage of whole person impairment, in accordance with the *Desbiens* methodology, assessors rely upon tables contained within Chapter 4, to assign the appropriate percentage.

Chapter 4 is also an important chapter in relation to aphasia and communication disturbances, sensory disturbances and motor disturbances. Health Care Professionals such as psychologists, speech language pathologists and social workers will be able to provide helpful comment in relation to impairments related to aphasia and dysphasia.

Table 1 from Chapter 4 provides a description of the impairment and the correlating percentage impairment of the whole person, is included below (Chapter 4, page 141).

TABLE 1. IMPAIRMENTS RELATED TO APHASIA OR DYSPHASIA.

Description	% Impairment of the whole person
Minimal disturbance of comprehension and production of language symbols of daily living	0 – 9
Moderate impairment in comprehension and production of language symbols of daily living	10 – 24
Inability to comprehend language symbols; production of unintelligible or inappropriate language for daily activities	25 – 39
Complete inability to communicate or comprehend language symbols	40 – 60

In relation to the *Desbiens* methodology, Chapter 4.1 (c) Emotional or Behavioural Disturbances, provides two extremely important tables to help evaluate whole person impairment. Chapter 4 itself encourages use of Table 3 in that Chapter to assign percentage whole person impairment ratings to Mental and Behavioural Impairments.

As page 4/142 of the Guides state:

“These types of disturbances 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 which may range from irritability, outbursts of rage or panic and from aggression to withdrawal. These illnesses may include depression, manic states, emotional fluctuations, socially unacceptable behaviour and involuntary laughing or crying and other kinds of central nervous system responses. **The criteria for evaluating these disturbances (Table 3, below) relate to the criteria for mental and behavioural impairment (Chapter 14, page 291).**”

Table 3 is repeated below.

**TABLE 3. EMOTIONAL OR BEHAVIORAL IMPAIRMENTS.**

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

Review of Table 2, Mental Status Impairments, below suggests the interrelationship between assessment of attendant care, activities of daily living and Whole Person Impairment. A person who suffers “impairment that requires direct daily care under continued supervision and confinement in home or at a facility” suffers a Whole Percent Impairment of thirty to forty-nine percent (30 – 49%). Table 2 is repeated on the next page.

**TABLE 2. MENTAL STATUS IMPAIRMENTS.**

Impairment Description	% Impairment of the whole person
Impairment exists, but ability remains to perform satisfactorily most activities of daily living	1 – 14
Impairment requires direction and supervision of daily living activities	15 – 29
Impairment requires directed care under continued supervision and confinement in home or other facility	30 – 49
Individual is unable without supervision to care for self and be safe in any situation	50 – 70

Chapter 4 is also the chapter which deals with impairment criteria for sleep and arousal disorders. The observations of clinicians treating and assessing the candidate for



catastrophic impairment may helpfully include within their observations and narrative their comments on the degree to which fatigue interferes with the person's day-to-day activities. That information should assist catastrophic assessors in assigning appropriate percentages. Table 6 – Impairment Criteria for Sleep and Arousal Disorders is repeated below.

As the Guides note:

“The categories of impairment that may arise from sleep disorders (Table 6 below) relate to (1) the Nervous System, with reduced daytime attention, concentration and other cognitive abilities; (2) Mental and Behavioural factors including depression, irritability, interpersonal difficulties and social problems;...”.

**TABLE 6. IMPAIRMENT CRITERIA FOR SLEEP AND AROUSAL DISORDERS**

<b>Impairment Description</b>	<b>% Impairment of the whole person</b>
Reduced daytime alertness with sleep pattern such that patient can carry out most daily activities	1 – 9
Reduced daytime alertness requiring some supervision in carrying out daytime activities	10 – 19
Reduced daytime alertness that significantly limits daily activities and requires supervision by caretakers	20 – 39
Severe reduction of daytime alertness that cause the patient to be unable to care for self in any situation or manner	40 – 60

A review of the tables in Chapter 4:

- Table 1 - Impairments Relating To Aphasia
- Table 2 - Mental Status Impairments
- Table 3 - Emotional Behavioural Impairments and
- Table 6 - Impairment Criteria for Sleep and Arousal Disorders

reveals that observations by clinicians assessing all elements of physical, motor, emotional, psychological, behavioural function and activities of daily living, can provide helpful information to assist in the determination of Whole Person Impairment under Chapter 4.

Assessments by psychologists, social workers, neuropsychologists, physiotherapists, and occupational therapists may address the need for supervision, a person's ability to comprehend and communicate, the degree of limitation in daily functions and the presence of fatigue. These assessments provide extremely helpful information for the purposes of evaluating catastrophic impairment and assigning Whole Person Impairment under Chapter 4.

Obviously neurological functions associated with paraplegia or quadriplegia can also be evaluated under Chapter 4 of the AMA Guides.

Impairments resulting from spinal cord injuries include those related to station and gait, use of upper extremities, respiration, urinary bladder function, and sexual function.

It is important to note that those who have sustained diagnoses of incomplete paraplegia or incomplete quadriplegia do satisfy the criteria for catastrophic impairment under Section (3)(2) (a) of the Definition of Catastrophic Impairment in the SABS. Whether the descriptor is "complete" or "incomplete", catastrophic assessors have accepted the conclusion that by virtue of the fact that there are no qualifying adjectives which modify the term "paraplegia" or "quadriplegia" within the definition of catastrophic impairment, a claimant is catastrophically impaired whether or not his or her paraplegia or quadriplegia is complete or incomplete.

Once all of the impairments have been evaluated and assigned percentage ratings, the combined values chart is used to add the percentage values of whole person impairments to arrive at a total WPI for the individual.

#### **G. CHAPTER 13 OF THE AMA GUIDES – THE SKIN – CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL**

As the chapter indicates, the functions of the skin include providing a protective covering, participating in sensory perception, temperature regulation, fluid regulation, electrolyte balance, immunobiologic defences and resistance to trauma, and regenerating the epidermis and its appendages.

Permanent impairment of the skin is defined as any anatomic or functional abnormality or loss that persists after medical treatment and rehabilitation. In evaluating skin impairment, health care professionals can assist catastrophic impairment assessors by helping in characterization of disfigurement, ie. altered or abnormal appearance, scar, impairment of function and/or amputation. When clinicians comment on the effect that skin related impairments have upon ADL's this information can assist in determining whole person impairment.

In accordance with the Guides, there is impairment of the whole person from 0% – 10% when signs and symptoms of a skin disorder are present or are only intermittently

present and there is no limitation or limitation in the performance of activities of daily living, and no treatment or intermittent treatment is required.

A person suffers a Class 2 skin impairment of the Whole Person from 10% to 24% in relation to a skin impairment when a person has signs and symptoms of a skin disorder that are present or intermittent and there is a limitation in performance of *some* of the activities of daily living and intermittent to constant treatment may be required.

A person suffers Class 3 skin impairment of Whole Person from 25% - 55% when the person has signs and symptoms of the skin disorder that are present or intermittently present, and there is limitation in the performance of *many* of the activities of daily living and intermittent to constant treatment may be required.

A person suffers a Class 4 skin impairment of the Whole Person from 55% - 85% when the person has signs and symptoms of a skin disorder that are constantly present and 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 intermittent to constant treatment may be required.

A person suffers a Class 5 skin impairment of the Whole Person from 85% - 95% when the person has signs and symptoms of a skin disorder that are constantly present and there is limitation in the performance of *most* of the activities of daily living which *may include intermittent confinement at home or other domicile*, and intermittent to constant treatment may be required.

#### **H. CHAPTER 14 OF THE AMA GUIDES - MENTAL AND BEHAVIOURAL DISORDERS - CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL**

Mental impairment must be evaluated in accordance with each of the four categories provided in the Mental and Behavioural Disorder table on page 301, Chapter 14 of the Guides, which are:

1. Activities of daily living;
2. Social functioning;
3. Concentration, persistence and pace;
4. Adaptation to work or work-like settings.

In order to qualify as having sustained a “marked impairment”, the applicant must establish that:

“impairment levels significantly impede useful functioning”.

“Significantly” does not mean “totally”. It means “more than insignificant, more than minimally. For example, a twenty five percent contribution was found to be “significant” by the Supreme Court of Canada in *Athey v Leonati* [1996], 3 S.C.R. 458.

“Impede” does not mean “totally prevent”. It is defined to mean “obstruct”, “hinder” or “delay”.

A rating of “marked impairment” in one of the four categories is sufficient to be deemed Catastrophically Impaired.<sup>8</sup>

As such, if impairment levels more than minimally hinder, delay or obstruct a person’s ability to function in their ADL’s, social functioning, concentration or adaptation, the person has suffered one or more Marked impairments and are catastrophically impaired.

Occupational therapists, chiropractors, physiotherapists, psychologists, social workers and other health care professionals often evaluate one or more activities of daily living in the course of their assessments.

In the context of an occupational therapist’s assessment of function for a person suffering any impairment, consideration of all of the listed activities of daily living - and even those not listed - is critical to determine the extent of a person’s impairment.

Various chapters incorporate by reference the need to evaluate all ADL’s to determine impairment. Use of the ADL Table is central in evaluating Mental and Behavioural Impairments under Chapter 14 of the Guides. The Activities of Daily Living Table from page 317 of the Guides is reproduced below.

**Table - ACTIVITIES OF DAILY LIVING, WITH EXAMPLES**

Activity	Example
Self-care, personal hygiene	Bathing, grooming, dressing, eating, eliminating
Communication	Hearing, speaking, reading, writing, using keyboard
Physical Activity	<i>Intrinsic:</i> Standing, sitting, reclining, walking, stooping, squatting, kneeling, reaching, bending, twisting, leaning  <i>Functional:</i> Carrying, lifting, pushing, pulling, climbing, exercising
Sensory function	Hearing, seeing, tactile feeling, tasting, smelling

<sup>8</sup> *Pastore and Aviva*, [2009] O.F.S.C.O. No. 24

Hand functions	Grasping, holding, pinching, percussive movements, sensory discrimination
Travel	Riding, driving, travelling by airplane, train or car
Sexual function	Participating in desired sexual activity
Sleep	Having a restful sleep pattern
Social and recreational activities	Participating in individual or group activities, sports, hobbies

A Health Care Practitioner who considers activities of daily living in light of each of the impairments can provide helpful information for the purposes of accurate assessment of catastrophic impairment.

Narrative reports which identify the degree to which the individual is capable, or incapable, of initiating or participating in these activities or any other activities of daily living which are part of that unique individual's daily activities, independent of supervision or direction, will be instrumental in assisting counsel, evaluators, arbitrators and judges to determine whether the person has suffered impairments which significantly impede useful functioning in their activities of daily living.

In the course of their assessment, chiropractors, occupational therapists, physiotherapists, psychologists, social workers, neuropsychologists routinely consider activities of daily living, social functioning, concentration, persistence and pace in adaptation to work-like settings.

To the extent that records and reports from these treating professionals reveal impairments in these areas, it is important for those evaluations to include an indication as to *whether the impairment levels significantly impede useful functioning together with any examples which illustrate such a conclusion*. Should that be the case, whether it be in one or more of the spheres of activity of daily living, social functioning, concentration, persistence and pace or adaptation to work-like settings, the clinician's evaluation will assist in determining that the person has suffered a *marked impairment in one or more of the four spheres*.

Should the evaluation of the four spheres result in the assessor's conclusion that the person has suffered less than a marked impairment, such an evaluation will still enable catastrophic assessors, arbitrators and judges to assign percentage Whole Person Impairment using Chapter 4, The Nervous System's Table 3 – Emotional or Behavioural Impairments. The percent will be 0% - 14% if there is a mild limitation of daily, social and interpersonal functioning. 15% to 29% if there is a moderate limitation of some but

not all social and interpersonal daily functions and 30% to 49% if there is a severe limitation impeding useful action in almost all social and interpersonal daily functions.

Equally, evaluation of the attendant care requirements of a client will assist catastrophic assessors, arbitrators and judges to use Table 2 – Mental Status Impairments from Chapter 4 of the Guides, to evaluate whether the person requires direction and supervision of daily living activities, directed care or continued supervision in the home, or suffers an inability to be safe in any situation without supervision. When those determinations are made pursuant to Table 2 - Mental Status Impairments, the catastrophic assessor, judge or arbitrator may then assign the percentage of Whole Person Impairments between 1% and 70% under each of the four categories listed in Table 2.

### **(1.) Social Functioning**

As the Guides state, social functioning refers to an individual's capacity to interact appropriately and communicate effectively with other individuals. It includes the ability to get along with others, family, friends, neighbours, grocery clerks, landlords and bus drivers.

Social functioning may be demonstrated by a history -- ordinarily obtained through review of clinician's reports -- of altercations, social isolation, avoidance of interpersonal relationships and other examples of impaired functioning. It is also important to give context to the social traits which are exhibited. For instance, a hostile and uncooperative person may be tolerated by family but that person may have marked restriction and trouble functioning because antagonism and hostility are not acceptable in the work place or in a social context.

### **(2.) Concentration, Persistence and Pace**

According to the Guides, this refers to the ability to sustain focused attention long enough to permit timely completion of tasks, commonly found in work settings.

Activities of daily living and a person's ability to complete everyday household tasks should be considered. Where there are previous work attempts or observations in work-like settings, a person's concentration, persistence and pace may be evaluated in light of his or her success or impairment in the work setting.

As such, assessments and daily notes by those working closely with the injured person, including rehabilitation support workers, social workers, psychologists, attendant care providers, occupational therapists and physiotherapists, may assist in providing examples of the patient's incapacities, focus, fatigue or cognitive impairments. While psychological testing can also measure these impairments, the AMA Guides remind us that it is important to remember that concentration during psychological testing can be significantly different from the requirements for concentration in work-like settings.

### **(3.) Deterioration and Decompensation in Work or Work-Like Settings**

As the Guides indicate, this refers to a person's impairment and inability to adapt to stressful circumstances. Individuals may withdraw from the situation or express exacerbation of signs and symptoms of mental disorder – decompensation. This decompensation may come in the form of having difficulties in activities of daily living, continuing social relationships and or completing tasks. It is extremely useful to determination of mental and behavioural disorders for clinicians to provide examples of decompensation and stresses that might have occurred.

As a side note, there are several arbitration decisions that note the lack of formal occupational therapy situational assessments. These assessments assist catastrophic assessors, judges and arbitrators in determining Catastrophic Impairment. Clinicians who evaluate activities of daily living or perform situational assessments should also include within their report information which they have concerning the fall-out or effect of the assessment upon the person, emotionally, physically and behaviourally, following the situational assessment.

Consider the example of a person who is able to work four hours but then must sleep for an hour and one half in his truck before returning to work for a further two hours. On return home at the end of the day, the person is unable to perform household functions or interact with his family but instead must go to sleep to recover energy sufficient to work. The person in this example exhibits decompensation that is relevant in consideration of his adaptation in a work-like setting. Such a person, for example may even require attendant care if that person cannot be aroused during the night as a result of the extreme fatigue caused by overexertion. That need for attendant care may be relevant when considering Chapter 4, Table 2 – Mental Status Impairments and Table 6 – Sleep Disorders to determine Whole Person Impairment.

Situational assessments and those impairments that become apparent with situational assessment of activities of daily living, social interactions and adaptation to work-like settings are central to the evaluation of the depth and degree of mental or behavioural disorder. The person may be suffering decompensation apparent in these assessments whether it be as a result of physical, cognitive and/or purely psychological impairments.

If a person has attempted a return to work, it is important to obtain an occupational therapy assessment of her function in the work-place through contact with co-workers and supervisors in order to determine performance in those settings. This information can be pivotal in allowing assessors to determine the extent to which the person suffers mental/behavioural impairments in the work-like setting. A physical demands analysis of the work place is also integral to this evaluation in providing a baseline to compare the extent to which a person's impairments prevent a person from fully achieving her capacity in and/or the responsibilities of her work.

If a person has pre-existing psychological symptoms, the onus is on the applicant to prove that it is more probable than not that the contribution of the accident was more

than minimal and thereby made a material contribution to the development of the person's present mental and behavioural condition.

## CHAPTER 15 AMA GUIDES – PAIN

In the recent FSCO decision *Fournie and Coachman*, O.F.S.C.D. No. 15, 2010, the arbitrator accepted evidence by a psychiatrist, Dr. Merskey that in consideration of the Chapter 14 Mental and Behavioural Impairments could appropriately include an analysis of the degree to which pain from a physical injury was intertwined with the development of mental or behavioural impairments. Specifically, Mr. Fournie suffered depression, anxiety, plus traumatic stress disorder and a pain disorder. Dr. Merskey used the "Pain Intensity-Frequency Grid" on page 310, Chapter 15 of the Guides, Grid which is reproduced below, to conclude that the applicant suffered marked impairments in one or more of his activities of daily living, social functioning, concentration and/or adaptation.

Pain Intensity-Frequency Grid

		Frequency			
		Intermittent	Occasional	Frequent	Constant
Intensity	Minimal				
	Slight				
	Moderate				
	Marked				

"Marked" is defined:

"The pain precludes carrying out most activities of daily living. Sleep is disrupted. Recreation and socialization are impossible. Narcotic medication or invasive procedures are required and may not result in complete pain control."

### I. GLASGOW OUTCOME SCALE - CATASTROPHIC IMPAIRMENT ASSESSMENT AND THE ROLE OF THE TREATING OR ASSESSING HEALTH CARE PROFESSIONAL

Six months after the accident, brain injury survivors can be assessed using the Glasgow Outcome Scale which was developed in 1975 by Jennett and Bond.

The Scale is based on overall social compatibility or dependence of the client. It takes into account the combined effect of mental and neurological deficits without listing them as part of the definition.

There are four categories of survival:

- Vegetative State
- Severe Disability



- Moderate Disability
- Good Recovery

A person is Catastrophically Impaired if his or her score on the Glasgow Outcome Scale (GOS) is 2 (vegetative) or 3 (Severe Disability).

It is relevant to note that the determination of a GOS score must be based solely on the limitations imposed by traumatic brain injury, and the evaluator must discriminate these from any imposed by age, orthopaedic impairments, pain or other non-neurological problems.

A person with GOS 3 or Severe Disability is able to follow commands but unable to live independently. This indicates that a person is conscious but needs the assistance of another person for some activities of daily living every day. This may range from continuous total dependency (for feeding and washing) to the need for assistance with only one activity – such as dressing, getting out of bed or moving about the house, or going outside to a shop. Often dependency is due to a combination of physical and mental disability – because when disability is severe after head injury there is almost considerable mental deficit. The person cannot be left overnight because they would be unable to plan their meals or to deal with callers, or any domestic crisis which might arise. The severely disabled are described by the phrase “conscious but dependent.”<sup>9</sup>

In Chapter 13 of the text, Management of Head Injuries, by Bryan Jennett and Graham Teasdale,<sup>10</sup> the authors provide further elucidation of the meaning of Severe Disability. Comments within that definition include the following:

“The least affected of those in the category of severe disability are patients who are communicative and sensible, though usually with marked impairment of cognitive and memory function on testing, who are dependent for only certain activities on others – perhaps dressing, feeding, or cooking their meals [consider all ADL’s from previous tables] Such a person could not be left to fend for himself even for a weekend.  
**“He is not independent and must therefore be regarded as severely disabled on our classification.”**

Ready knowledge of this definition by treating and assessing health care professionals including psychologists, neuropsychologists, social workers, speech language pathologists, occupational therapists and physiotherapists and evaluation of the client in view of their ability to carry on activities of daily living, attendant care needs, and/or their complete or incomplete independence, will assist insurers, lawyers, judges and arbitrators in determining whether or not a person has suffered a Severe Disability under the Glasgow Outcome Scale.

<sup>9</sup> Jennett, B. Snoek, J. Bond, Mr. Brooks N., Disability After Severe Head Injury: Observation On The Use Of The Glasgow Outcome Scale, J Neurol, Neurosurg, Psychiat 1981;44:285-293

<sup>10</sup> Jennett, B, Teasdale, Management of Head Injuries 1981, F.A. Davis Company, USA

The need which a person has for attendant care is extremely relevant to the determination of whether the person is “not independent” and as such is “severely disabled”.

It is now well accepted that the Glasgow Outcome Scale suffers from a limitation involving inter-rater reliability, or IRR. Studies have shown that there is significant potential for the same patient to receive GOS scores differing by one or two points when different evaluators see the patient even where tests are administered in the same time period. In part, these limitations are a function of the GOS scale, which provides for only four incremental categories of disability. Too small a number of categories can lead to “forced choices,” in which bias, sympathy, inexperience, or other evaluator factors become overly significant influences on scoring decisions. Studies have indicated that, optimally, a measuring device should have five to seven categories in order to reduce forced choices and any effects of bias, sympathy or inexperience. For this reason, the more recently developed GOS-Extended, or GOSE, has become a more popular tool in recent times, although it is not legislated for use in catastrophic impairment determination.

Researchers have found that the IRR of the original GOS can be substantially enhanced by several measures. Adequate, reliable information about the patient is essential, and must be assembled as much as possible from direct assessment complimented by interviews by family or other caregivers. As one might expect, IRR may also improve when the cohort of evaluators is restricted to those with appropriate scopes of practice, and adequate experience with traumatic brain injury. Consistent, formal training of evaluators in the use of the GOS test can further improve IRR, as can experience in its use.

Substantial improvement in IRR can, however, be achieved by simply ensuring that the discriminators of the scale are more clearly described and systematically applied. In 1998, studies by Teasdale and by Wilson<sup>11</sup> demonstrated the importance of using a standard format involving a written protocol, and taking the form of a direct structured interview.

The structured interview set out by Wilson et al incorporates the following questions and guidelines:

Q1: *Vegetative state*: does the patient have the capacity to communicate?

If not, then the patient is GOS2.

[If yes, then the GOS must be 3, 4 or 5.]

Q2: *Independence in the home*: does the patient require actual assistance with ADLs, prompting or reminding to do things, or supervision to ensure safety? Does the

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<sup>11</sup> Wilson et al, “Structured Interviews for the Glasgow Outcome Scale and the Extended Glasgow Outcome Scale: Guidelines for Their Use”, Journal of Neurotrauma, August 1998

patient actually depend upon the assistance received (real need)? What are examples of minor domestic crisis? What would you do if a glass were dropped and broken, a tap were left running, a light went out, it begins to get cold, a stranger comes to the door...? Can the person use the telephone to report problems or summon help? Can the person be left alone for a 24-hour period?

Q3: *Independence outside the home* – shopping:

Q4: *Independence outside the home* – travel:

Can the patient plan, take care of money, and behave adequately in public? Is the person actually capable or just does not do it?

[Answers to Q2 – Q4 indicate whether the GOS is serious enough to be 3; if not, the GOS must be 4 or 5.]

Q5: *Work*: if the person was working previously, is there a reduced capacity?

Q6: *Social and leisure activities*: has there been an important change on the basis of loss of motivation or initiative, avoidance of social involvement, loss of mobility, cognitive problems such as poor concentration, or problems such as poor temper or impatience? How many occasions per week now versus previously? Is there at least one activity outside the home each week?

Q7: *Family and friendship*: how often is there a problem with relationships – Occasional (some problems but less than once per week, such as occasional bad temper that blows over); Frequent (problems at least weekly, with tolerable strains on relationships, such as temper outbursts resulting in modification of closeness of relationships); Constant daily problems (intolerable problems, with breakdown of relationships within family or friendship; has the family become socially isolated?)

[Answers to Q5 – Q7 indicate whether the GOS is 5 or is less than 5.]

## J. THE MEANING OF “CAUSATION” IN DETERMINING CATASTROPHIC IMPAIRMENT

At page 316 of the 4<sup>th</sup> Edition of The American Medical Association Guides to the Evaluation of Permanent Impairment, causation is defined:

“Causation means that a physical, chemical or biologic factor contributed to the occurrence of a medical condition. To decide that a factor alleged to have caused or contributed to the occurrence or worsening of a medical condition has, in fact, done so, it is necessary to verify both of the following:

- “(a) The alleged factor ***could have caused or contributed to worsening of the impairment***, which is a medical determination.
- (b) The alleged factor did cause or contribute to worsening of the impairment, which is a non-medical determination.”

On June 12<sup>th</sup>, 1996 The Supreme Court of Canada released its decision in *Athey v. Leonati*.<sup>12</sup> The Plaintiff suffered a disc herniation while working out following an accident. The Court stated:

“it is not now necessary, nor has it ever been, for the Plaintiff to establish that the Defendant’s negligence was the sole cause of the injury.”

Further from *Athey*:

“As long a Defendant is part of the cause of an injury, the Defendant is liable, even though his act alone was not enough to create the injury.”

In 2001 Director’s Delegate Naylor spoke in detail about principals of causation and adopted *Athey* in the *Correia and TTC* Arbitration Appeal.<sup>13</sup> Ms. Correia suffered an injury when bus doors closed on her. After physiotherapy sessions she felt ready to return to work. Her therapist wouldn’t allow her to return to work without a functional capacity evaluation. She was injured in the functional capacity evaluation. The Arbitrator found that Ms. Correia’s original injuries had substantially resolved and were not disabling but that her treatment-related injuries disabled her from work on an ongoing basis.

On Appeal, the Director’s Delegate Naylor upheld the conclusion that the injury related to the functional capacity evaluation was directly caused as a result of the accident and that the ongoing benefits were payable in relation to the disability arising therefrom.

The Ontario Court of Appeal released the decision *Monks v. Ing*<sup>14</sup> on April 15<sup>th</sup>, 2008. The Plaintiff was injured in three accidents. After the third accident, she became a complete quadriplegic. The Defendant did not dispute that the plaintiff was catastrophically impaired but claimed that her impairment was caused by a combination of the first and second accidents and said she was “a crumbling skull plaintiff”. The phrase “Crumbling skull” is used at law to describe a person who suffers impairments before an accident which would continue to worsen whether or not the accident occurred.

The Ontario Court of Appeal noted:

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<sup>12</sup> *Athey v. Leonati*, [1996] 3 S.C.R. 458 S.C.C.

<sup>13</sup> *Correia and TTC*, [2001] O.F.S.C.O. No. 106

<sup>14</sup> *Monks v. Ing* (2008), 90 O.R. (3d) 689 C.A.

“The trial judge did not err in finding that there is no room for the crumbling skull theory in accident benefit cases. Where, as here, a benefit claimant’s impairment is shown on the “but – for” or material contribution causation tests to have resulted from an accident...the insurer’s liability for accident benefits is engaged...”.<sup>15</sup>

Finally the Court of Appeal noted:

“The case law related to accident benefit claims is clear – that the principals enumerated in the Supreme Court of Canada decision of **Athey** are equally applicable in the context of an accident benefit claim.”<sup>16</sup>

In conclusion, if the accident made a material (more than minimal) contribution to the impairment or to the worsening of the impairment, then the impairment was directly caused by the accident and should be an impairment evaluated under one or more of the categories in the definition of catastrophic impairment.

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<sup>15</sup> Ibid, *Monks, supra*

<sup>16</sup> Ibid, *Monks, supra*