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In this issue:

MOTOR VEHICLE ACCIDENT VICTIMS CAN CLAIM ATTENDANT CARE EXPENSES INCURRED PRIOR TO SUBMITTING A FORM ONE

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An accident benefits insurer must consider retroactive attendant care claims advanced in an Assessment of Attendant Care Needs (Form 1) that is submitted to the insurer.

In *Kelly v. Guarantee Company of North America ("Guarantee Company")*, this issue was recently decided by Arbitrator John Wilson in favour of the insured, where the Guarantee Company argued that it was not required to pay attendant care expenses incurred prior to the submission of a retroactive Form 1.

The decision is important, as unrepresented and seriously injured accident victims who are in need of attendant care services are frequently unable to comply with the technical requirements for claiming attendant care expenses under the *Statutory Accident Benefits Schedule* (SABS).

In *Kelly*, the applicant, Stephanie Kelly, suffered a severe brain injury in a motor vehicle accident on April 6, 2009, from which she was found to be catastrophically impaired. Following the accident, Ms. Kelly was transferred to St. Joseph's Health Care in London, Ontario, where she remained until June 23, 2009, when she was discharged home with 24 hour supervision.

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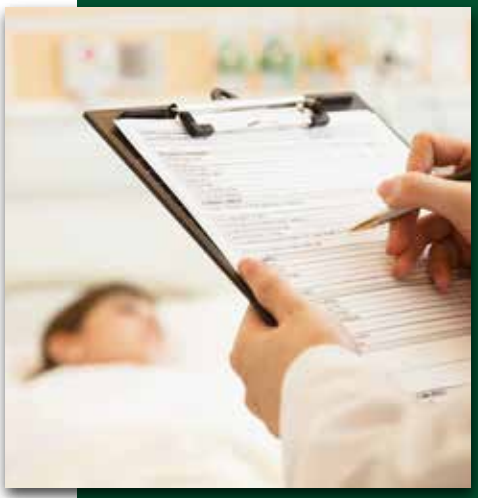

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Motor Vehicle Accident Victims Can Claim Attendant Care Expenses Incurred Prior To Submitting A Form One

Continued from cover story

It was not until February 1, 2013, that Ms. Kelly commissioned a retroactive attendant care report covering the period between April 6, 2009 and June 23, 2009, which assessed her Form 1 care needs during this period at $7,061.83 per month.

The SABS require an insurer to pay for all reasonable and necessary attendant care expenses. Section 42(1) of the SABS requires that an application for attendant care benefits be in the form of an Assessment of Attendant Care Needs (Form 1) and be prepared and submitted to the insurer by an occupational therapist or a nurse.

In Ms. Kelly's case no Form 1 covering the period of Ms. Kelly's hospitalization was submitted to the insurer until February 1, 2013 (almost four years after the attendant care expenses were incurred). The Guarantee Company refused to pay for the attendant care services provided to Ms. Kelly by her family members and the hospital. It argued that since no Form 1 was submitted to the insurer during the period of Ms. Kelly's hospitalization, it was not required to pay attendant care expenses during that period. The Guarantee Company relied upon Section 42(5) of the SABS, as set out below:

> **42(5)** "An insurer may, but is not required to, pay an expense incurred before an assessment of attendant needs that complies with this section is submitted to the insurer."

Arbitrator Wilson disagreed with the narrow approach taken by the Guarantee Company noting that, "given the seriousness of the situation and complexity of the accident benefit scheme, it is not surprising that Ms. Kelly or her treating physicians did not immediately turn their minds to obtaining a Form 1."

Arbitrator Wilson found that Section 42(5) allows insurers to pay attendant care benefits before the submission of a Form 1 and held that, at minimum, this section suggests that the absence of a Form 1 is not a bar to retroactive claims for attendant care services. Referring to the principle of statutory interpretation that requires insurance coverage exclusions to be applied narrowly, Arbitrator Wilson required significantly stronger statutory language than that which is set out in Section 42(5) before permitting the insurer to deny a retroactive attendant care claim.

That is not to say that retroactive attendant care benefits will always be payable upon submission of a Form 1. Arbitrator Wilson, relying on the authority of the decision of Arbitrator Bayefsky in *T.N. and Personal Insurance Company of Canada (FSCO A06-000399, June 26, 2012)*, held that once a Form 1 is submitted the question turns to, "whether the evidence prior to the receipt of the Form 1 reflects the analysis contained in the Form 1".

In *Kelly*, the applicant's Form 1 and the report accompanying it disclosed a "plethora of documentary evidence", in circumstances where 24 hour care continued to be necessary once Ms. Kelly left hospital. In addition, the insurer filed

no evidence to contradict the findings in the Form 1 report despite having access to all of the medical evidence and the ability to conduct an insurer's assessment, which it did not do. These factors led to the Arbitrator's finding that the retroactive care expenses claimed by Ms. Kelly were reasonable and necessary.

An insurer cannot deny past attendant care claims solely on the basis that they are advanced retroactively in a Form 1 report. This finding is important as is the Arbitrator's unwillingness to take an overly technical approach to interpreting the SABS in circumstances where the benefits available under the SABS were clearly warranted. Accident victims can be comforted by the fact that insurers will not be able to rely solely on the timing of the Form 1 submission to deny critical post accident attendant care expenses and attendant care assessors should ensure their reports consider an insured's attendant care needs in the periods prior to the Form 1 assessment. ■■■

Robert M. Ben
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LOOSE LIPS CAN SINK SHIPS: WAIVER OF PRIVILEGE

Many of you provide treatment to people recovering from serious personal injuries. It goes without saying that confidential information entrusted to you by your patients within a professional relationship should be carefully guarded – confidential information should not be disclosed without the patient's authorization, unless otherwise required by law. Unfortunately, sometimes the most routine interactions with patients can jeopardize this confidentiality. This is particularly the case for patients who are involved in legal proceedings and who may forget to heed their lawyer's advice not to discuss the details of their lawsuit with their treatment providers. While it is certainly not a treatment provider's responsibility to prevent such inadvertent disclosures, an awareness of the potentially harmful ramifications on a patient's lawsuit can

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Loose Lips Can Sink Ships: Waiver of Privilege

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perhaps help preserve the patient's legal "zone of privacy" with their lawyer.

Consider the following scenario. You are treating a patient who suffered a brain injury in an accident. She is in the midst of a lawsuit to recover compensation. During your treatment session you innocently ask your patient how things are going with her case. She tells you about a recent meeting with her lawyer where he reviewed the results of testing he arranged by a non-treating expert neuropsychologist. Your patient tells you the test results came back in the "average" range, although she considered this a decline from her "above average" cognitive abilities pre-accident. You make a brief note about this in your clinical record but otherwise don't think much about it. Months after your session, your clinical records are produced to the defendant in the lawsuit. The defendant asks for a copy of the expert neuropsychologist's report referred to in your notes. Although you were never provided with a copy of the expert report, the defendant brings a motion against your client to obtain a court order requiring the report be produced.

Normally, the law requires that parties to a lawsuit disclose all documents and any information that is relevant to the issues in the lawsuit as part of the truth-seeking process. The problem with the above scenario, however, is that the expert report your patient told you about was obtained by her lawyer for the purpose of assisting with the litigation. It was not a report generated in the course of your patient's treatment. The lawyer does not want your patient's adversary in the lawsuit to have a copy of the report or to use the report as evidence at the trial of your patient's personal injury lawsuit.

There is nothing illegal, unethical, or improper about the lawyer wanting to withhold the expert report in this scenario. The report is privileged. Privilege is a rule of evidence and a substantive right that exempts certain documents and other communications from having to be disclosed in legal proceedings. Although the law requires fulsome disclosure of relevant documents, the law also recognizes there is an important public interest in preserving and encouraging confidentiality between a lawyer and their client. The right to consult a lawyer and confidentially obtain legal advice without fear of disclosure of those communications is recognized as essential to the proper administration of justice in our adversarial legal system.

There are two main types of privilege: (1) lawyer-client privilege; and (2) litigation privilege. Lawyer-client privilege (sometimes referred to as solicitor-client privilege) protects communications between lawyers and their clients, where those communications are for the purposes of giving or receiving legal advice. The requirements of lawyer-client privilege are that: (1) the communication is between a lawyer and his client; (2) the communication is made in confidence; and (3) the communication is made in the course of seeking or obtaining legal advice. The privilege belongs to the client and not the lawyer. Unlike litigation privilege

(discussed below), lawyer-client privilege is permanent and virtually inviolable. It survives even after the client's relationship with her lawyer is at an end. It even survives the client's death. Because the privilege belongs to the client, it generally cannot be waived by anyone other than the client. Lawyer-client privilege is justifiable because it encourages clients to make full, frank and honest disclosure of all information that a lawyer may require, in order to provide sound and helpful legal advice to a client in the course of litigation. Without the protection of privilege, clients would be reluctant to be candid with their lawyer for fear that whatever they said would be disclosed to their adversary to their detriment.

Litigation privilege is different than lawyer-client privilege in that it goes beyond mere communications between a client and her lawyer to protect from disclosure any work or documents that have been undertaken or prepared for the dominant[1] purpose of anticipated or pending litigation. The purpose of litigation privilege is to provide the client and her lawyer with what the courts have called a "zone of privacy" within which the case can be prepared to the client's best advantage. The courts recognize the importance of this "zone of privacy" because the adversarial system is based on the assumption that if each side presents its case in the strongest light, the court will be best able to determine the truth. Lawyers must be free to make the fullest investigation into a client's case without risking disclosure of opinions, conclusions, strategies or tactics to the client's adversary. The invasion of privacy of a lawyer's trial preparation might well lead to the lawyer postponing this preparation until the eve of, or during the trial, so as to avoid early disclosure of potentially harmful information, which the lawyer is not necessarily obliged to disclose to his client's adversary. This would be counter-productive to the goal of early and thorough investigation by lawyers.

In the scenario I outlined at the outset, the client's disclosure to a treating practitioner of the existence and contents of a privileged expert report can have potentially harmful consequences on the

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[1] In Ontario, the *Rules of Civil Procedure* narrow the "dominant purpose" test for litigation privilege insofar as expert reports are concerned. The rule allows a party at the discovery stage of litigation to obtain full disclosure of the findings, opinions and conclusions of an expert engaged by or on behalf of a party except where those findings, opinions and conclusions were made or formed in preparation for contemplated or pending litigation and for "no other purpose," and the party undertakes not to call the expert as a witness at trial.

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Loose Lips Can Sink Ships: Waiver of Privilege

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client's lawsuit. Privilege can be lost by what is called waiver. Generally, waiver occurs if the holder of the privilege makes a voluntary disclosure or consents to the disclosure of any material part of a privileged communication or document. Although waiver generally requires that the client be aware of the privilege and that the client demonstrates and intention to give up the benefit of the privilege, waiver can arise through careless, inadvertent or even implied disclosure of otherwise privileged information. Because lawyer-client privilege rests on a foundation of confidentiality, if a client discloses to a third party (such as a treatment provider) the substance of discussions she has had with her lawyer, this alone can amount to waiver and a loss of privilege. However, since litigation privilege rests on a different foundation (i.e., the "zone of privacy" in preparing one's case for litigation), mere disclosure of litigation privileged information or documents will not necessarily amount to waiver. Where, as in our scenario, the patient inadvertently disclosed litigation-privileged information, the courts will consider a number of factors in determining whether there has been waiver. These factors include:

1. Whether the disclosure was, in fact, inadvertent;
2. Whether after discovering the inadvertent disclosure an immediate attempt was made to retrieve the information or documents;
3. Whether there is still a legitimate interest to be protected notwithstanding the disclosure (this will depend in large part on the identity of the person to whom the disclosure was made, i.e. whether that person should be classed as a "stranger" to the litigation);
4. Whether maintenance of the privilege will result in unfairness or prejudice to the adversary and undermine the integrity of the administration of justice.

Going back to our scenario, it could be argued that there was no waiver of privilege. The patient disclosed only one finding in the expert report to her treatment provider. She did not provide a copy of the report itself to her treating practitioner. The treating practitioner did not appear to make any treatment decisions based on the disclosed information. There is still a legitimate interest to be protected because the report was prepared for the sole purpose of assisting the patient's lawyer with the lawsuit and for no other purpose, i.e. the patient is still entitled to a "zone of privacy" over the report particularly if her lawyer undertakes not to rely on it or call the expert neuropsychologist as a witness at trial. Lastly, there is no prejudice of unfairness to the patient's adversary in the lawsuit because the adversary is in no worse position than the patient in that neither will be able to rely on the neuropsychological test findings at trial.

The better practice, of course, is for lawyers to remind their clients to avoid the inadvertent disclosure of privileged information and documents in the first place. Clients, however, sometimes forget. While it is certainly not a treatment provider's responsibility to guard against such pitfalls, an awareness of the potentially harmful ramifications on a patient's lawsuit can help preserve the patient's legal "zone of privacy." ■■■

Michael L. Bennett
PARTNER | THOMSON, ROGERS

CATASTROPHIC IMPAIRMENTS BY VIRTUE OF MENTAL AND BEHAVIOURAL DISORDERS

There is no more difficult patient or client to assist than those who suffer from mental and behavioural disorders. I am sure all lawyers and clinicians who are regular readers of the Accident Benefits Reporter have, or are currently dealing with, clients and patients who suffer physical injuries but their recovery is complicated due to psychological or psychiatric issues. It is also very common to see survivors of motor vehicle accidents succumb to anxiety, depression and outright despondence once the reality that some impairment will be permanent becomes obvious.

Helping clients and patients who suffer from accident related mental and behavioural disorders is difficult. Insurance companies find these injuries difficult to deal with because they do not fit neatly into their pre-conceived notions regarding the trajectory of a normal recovery. Lawyers, clinicians and insurers alike would all like to see survivors follow a straight line towards total recovery. However, once in a while, a survivors' recovery is complicated by a mental or behavioural impairment resulting in his or her condition actually getting worse, not better.

Proving a survivor has suffered a catastrophic impairment by virtue of mental and behavioural disorder is usually an uphill battle. While to the lawyer or clinician it may seem obvious the mental and behavioural disorder was caused by a motor vehicle accident, insurers are often slow to agree.

It is not uncommon for insurers to take a hard look at the survivor's pre-accident medical history and draw inferences from vague and

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Catastrophic Impairments By Virtue Of Mental And Behavioural Disorders

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dated medical records, suggesting that the mental and behavioural disorder pre-existed the relevant motor vehicle accident. Similarly, the credibility or truthfulness of the survivor is often brought into question. Questions of primary or secondary gain of the survivor often come to the forefront. Insurer evaluations often reach vague conclusions regarding "poor effort" on psychological and psychiatric testing and conclude that the survivor is not telling the whole truth. As a result, the application process may serve to exacerbate and entrench the mental and behavioural disorder. Lack of funding for further treatment and financial pressures may also worsen matters.

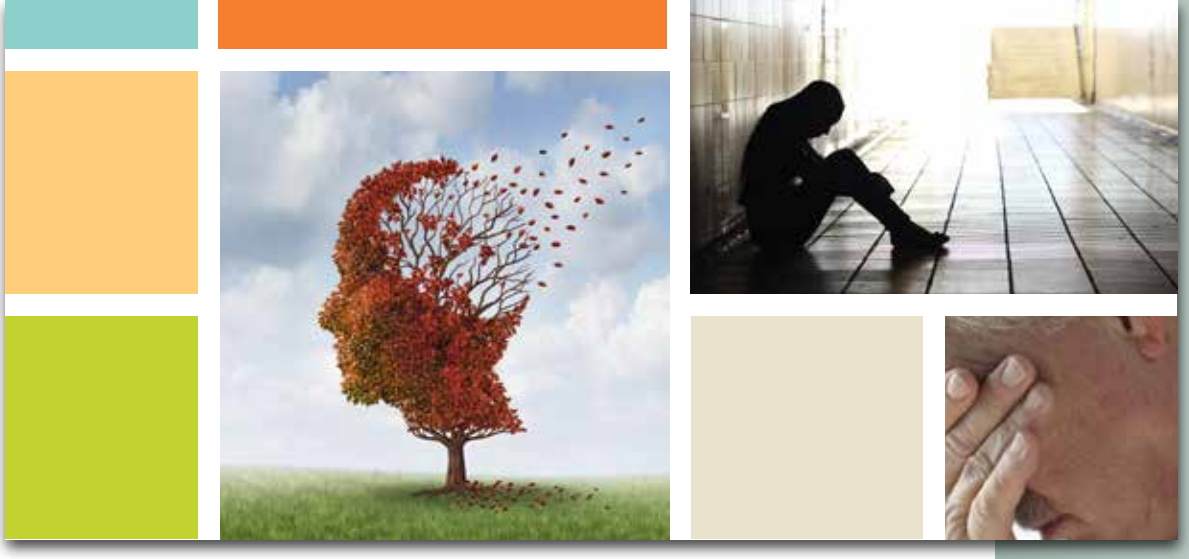
When faced with a survivor as I described above, it is important to remain level headed and clinical when attempting to prove the survivor has suffered a catastrophic impairment. At this point, it is important for the lawyer to arrange appropriate assessments to accurately determine whether the survivor is suffering a catastrophic impairment by virtue of a mental and behavioural disorder. Failing to arrange the appropriate assessments required, in some cases, can prove to be fatal.

The first step is to find an appropriate treatment provider or assessor to complete the Application for Catastrophic Impairment (OCF-19). This form must be completed by a physician as it is assumed that there is more to the injury than "brain impairment only". Mental and behavioural impairment caused solely as a result of a brain impairment is outside the scope of this article. Generally, because there is usually a long gestation period for a mental and behavioural disorder, one should normally wait two years before making the application for catastrophic impairment under this criteria.

In terms of the assessment itself, whether conducting it for the first time or for the hundredth time, the assessor should read through Chapter 14 of the AMA Guides, 4th Edition, as a starting point. The evaluator should follow the basic steps set out in Chapter 14 which explains how to conduct an appropriate assessment. If the assessor does not follow the instructions set out in Chapter 14 of the AMA Guides, that assessor's opinion will not be accepted by an Arbitrator.

In the seminal decision of *Pastore v Aviva Canada Inc.* (2012), 112 O.R. (3d) 523, the Ontario Court of Appeal set out the necessary steps that an assessor must take before he or she may conclude that a person has suffered a catastrophic impairment by virtue of a mental and behavioural disorder. It involves a three-step approach. First, there must be a diagnosis of a mental and behavioural disorder. Second, the assessor must identify the impact of the disorder on a person's daily life. Third, there must be an assessment of the severity of those limitations in relation to the four spheres of functioning set out in Chapter 14.

With respect to the diagnosis of mental and behavioural disorders, Chapter 14 states



that the clinician must use the DSM-III-TR. Currently, most clinicians use the DSM-IV-TR to arrive at a diagnosis notwithstanding the fact that recently, the DSM-V is now in circulation. Whatever version of the DSM is used, there must be an actual formulation of a diagnosis of a mental and behavioural disorder based on whatever DSM edition is chosen.

Second, the assessor must consider the impact of the mental and behavioural disorder (if one is found) on that person's actual daily life. During this stage of the assessment, the clinician must consider how the mental and behavioural disorder affects the four spheres of a person's daily life, which are well described in Chapter 14. These four spheres are as follows:

1. Limitations on activities of daily living;
2. Social functioning;
3. Concentration, persistence and pace; and
4. Deterioration or decompensation in the work or work-like settings.

In the written report, the assessor is asked to provide examples of how the identified mental and behavioural disorder is affecting the survivor within each identified sphere.

The final step is to provide an opinion on the "severity" of the limitations that were found in the four spheres. At this point, the assessor should turn to page 301 of the AMA Guides 4th Edition and consider the table entitled "Classification of Impairments due to Mental and Behavioural Disorders". In this table, there are five classes of impairments starting with Class 1 (No Impairment) to Class 5 (Extreme Impairment). According to the Court of Appeal in the Pastore decision, if an assessor finds that the survivor has suffered a Class 4 or Class 5 impairment in any <u>one</u> of the four spheres, then,

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Catastrophic Impairments By Virtue Of Mental And Behavioural Disorders

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that survivor is to be deemed catastrophically impaired.

One of the most difficult aspects of rating this severity is deciding whether a person is suffering from a Class 3 (Moderate Impairment) as opposed to a Class 4 (Marked Impairment). There is no explanation in the AMA Guides 4th Edition as to the qualitative difference between these two categories. A Class 3 Impairment is described as "impairment levels are compatible with some, but not all, useful functioning". A Class 4 impairment is described as "impairment levels significantly impede useful functioning".

Because of the need to exercise clinical judgment in the survivor's real world, it is essential that a multi-faceted approach to the assessment be adopted. Arbitrators at the Financial Services Commission of Ontario (including Appeal decisions to the Director's Delegate) have indicated a single assessment in a doctor's office is simply not enough.

In the decision *M.G. v The Economical Mutual Insurance Company* (FSCO A09-002443) November 23, 2012 (2) Arbitrator Feldman revisited the guidelines used by the CAT DAC's of yesteryear to determine what an appropriate mental and behavioural CAT assessment ought to look like. Based on the old CAT DAC guidelines, it is necessary for the assessor to consider each sphere set out in Chapter 14 of the AMA Guides separately and to comment on each sphere. Arbitrator Feldman also noted that, in most cases, it is necessary to have a psychiatrist, psychologist and occupational therapist work together before drawing any final conclusions.

Recently, Arbitrator Feldman's approach in the *M.G.* case, was accepted by Director Delegate David Evans in the *Allstate Insurance Company of Canada* and *T.S.* (FSCO Appeal P11-00032) September 25, 2014. In this decision, the survivor T.S. adduced evidence at her Arbitration from her treating family doctor, psychiatrist and psychologist regarding catastrophic impairment by virtue of a mental and behavioural disorder. At the Arbitration, these witnesses gave very general opinions on the issue whether T.S. was suffering from a marked impairment due to a mental and behavioural disorder, but the Arbitrator ruled in her favour. Sadly, because these treating professionals failed to follow the three step approach described in *Pastore* and the *M.G.* decision, the survivor lost on Appeal due to insufficient evidence of catastrophic impairment.

Since *Pastore*, it has become even more important to take a methodical approach to one's assessment of a survivor suffering from a mental and behavioural disorder. Before *Pastore*, most assessors were providing a more general overall opinion regarding the severity of the survivor's mental and behavioural impairment. Now an assessor needs to dig into the nitty gritty of the survivor's life and explain why the assessor has reached his or her conclusion with respect to the severity of the impairment (i.e. moderate impairment vs marked impairment) in each of the four spheres being evaluated. Therefore, in order to complete such an evaluation, an in-home assessment with an occupational therapist

is likely required. Naturally a psychiatrist and a psychologist ought to be involved in such an assessment as well.

Finally, the psychiatrist, psychologist and occupational therapist should all work together to reach a consensus on how these impairments are affecting the four spheres of activity along with a severity rating.

If all these steps are taken by the assessor involved in the Application for Catastrophic Impairment, the odds that an insurer will agree that the survivor has suffered a catastrophic impairment are greatly increased. At a minimum, reports that comply with what the Court and Arbitrators demand will have an influential effect on the assessors appointed by the insurer who will conduct their own assessment.

As far as proving catastrophic impairment at trial or arbitration, without reports from the involved assessors using the proper methodology, it is next to impossible for a survivor to prove his or her case. ■■■

ANNOUNCEMENTS

- We are pleased to announce three new associates to our firm: Denitza Koev (Municipal), Michael B. Gerhard (Municipal) and Jessica M. Luscombe (Family).
- We would also like to welcome back Adam Tanel.
- Thomson, Rogers, a proud member firm of the Personal Injury Alliance, is thrilled to announce the new association between PIA Law and MADD Canada.

  "PIA Law is proud to partner with MADD Canada. We have a shared belief that there is no excuse for impaired driving and are committed to working together to ensure that victims of impaired driving and their families have the best possible support during their time of grief and recovery."

  Alan Farrer, managing lawyer.
  MADD Canada's Press Release - October 28, 2014.

UPCOMING EVENTS

Thomson, Rogers will be in attendance at the following events - drop by and say hello.

- **Toronto ABI Network Conference 2014**
  November 20-21, 2014 | Allstream Centre, Exhibition Place
  For more information please visit:
  www.abinetwork.ca/abi-conference-2014

For more information on upcoming events, please visit:
www.thomsonrogers.com/upcoming-events-seminars

Thomson, Rogers holds various *Lunch & Learn seminars* throughout the year to assist health care providers, and other interested parties, in understanding the automobile insurance system. If you would like to arrange a *Lunch & Learn seminar* with Thomson, Rogers, please contact Joseph Pileggi at **jpileggi@thomsonrogers.com**.

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