SPIAO WORKSHOP

DECEMBER 1, 2017

RELIEVING THE PAIN FROM CHRONIC PAIN CASES

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INTRODUCTION –

It amazes me that the issue of chronic fatigue syndrome and fibromyalgia and chronic pain and so on have been the topic of discussion at numerous seminars. I happened to review some of the binders that I have kept from past presentations organized by various groups and this topic is always one of controversy and continued interest. Chronic pain cases have been a curse for many insurers both in the context of motor vehicle accident and long-term disability claims. Judges and arbitrators in the context of statutory accident benefit claims, have grappled with this issue. When reading the papers authored by Plaintiff counsel, we are usually advised that one has to create a theme and help the jury understand why this invisible condition is disabling. Flesh is put on the skeleton. The skeleton is dressed up so that it is appealing to the jurors. The trier of fact is inundated with information as to how this Plaintiff was a functioning individual before the traumatic event. They hear from lay witnesses and medical professionals and rehab specialists and so on.

On the flip side, the defence counsel has obviously a different approach. I am not certain if the approach is designed to dispel any notion that this subjective "condition" is disabling. These papers usually provide defence counsel with some pointers about how to defend such cases. Quite frankly, I am thankful that we have the chronic pain type of cases as they have provided all of us with plenty of work over the last number of years and will continue to do so. Certainly the controversy over the "disorder" or "syndrome" has provided monetary bounty for the medical profession and those in the rehabilitation network. It is somewhat of a symbiotic relationship.

Cynicism aside, I have had the pleasure of working not only on the defence side, but as well for Plaintiffs in respect of motor vehicle accident/statutory accident benefit/LTD type of claims and as well, as a mediator. After reviewing many decisions and authoring papers on the topic over of the years, I have come to accept the fact that there is something called "chronic pain" and the only way one can truly deal with such a claim is to not bury one's head in the sand and ignore it or pretend it does not exist. I firmly believe that based on the decisions of a number of judges, the condition, in the right circumstances, has been found to be a disabling problem. The challenge for the defence counsel is to figure out whether or not the specific claimant is truly suffering from chronic pain or fibromyalgia or whether the alleged disability is based on secondary gain on a conscious level. Proving the latter is not easy as we all know as certainly many claimants are quite astute and manipulative.

Another important consideration by way of introductory comment, is the blind adherence to the opinions of the doctors. The bottom line from my perspective is that one has to critically review the opinions of those who have put forth the diagnosis of chronic pain disorder, chronic pain syndrome or fibromyalgia. Certain doctors have their own agendas and biases. Certain doctors write reports that are designed to appease those who have retained them. To determine the medical expert's bias, one has to dig and dig deeper into the expert's past. More will be said about this further on in the paper.

I have noticed over the last almost 35 years of practicing and mediating in this area that rarely do counsel have much difficulty at arriving at a reasonable resolution of a case involving a paraplegic, quadriplegic or a moderate to severe traumatic brain injury.

The real problem cases which are the ones that judges grapple with on threshold motions and which cause insurers no end of indigestion are those that deal with chronic pain, post-concussive syndrome, mild traumatic brain injuries and the ones that have the usual labels attached to them such as Major Depressive Disorder, Adjustment Disorder and so on and so on.

Those who attend these programs are probably sick and tired of hearing about chronic pain disorder or syndrome, chronic fatigue syndrome, fibromyalgia and other labels. Most insurers and defence counsel take a dim view of these labels and feel that for the most part they are subjective in nature and difficult to prove as these are the "invisible" injuries.

If there has been any doubt that the concept of chronic pain and the label chronic pain syndrome and related conditions have been accepted by judges as being a legitimate basis for a claim, this has now been effectively disposed of by the Supreme Court of Canada. Most of you who have attended these programs will likely be familiar with the decision of *Nova Scotia Workers' Compensation Board* v. *Martin* [2003] 2 SCR 504. The words of Mr. Justice Gonthier, as far as I am concerned, will be quoted by Plaintiff's counsel when pursuing chronic pain cases under the new threshold scheme. In case you forgot, Mr. Justice Gonthier had this to say in the introduction portion of his reasons:-

> "Chronic pain syndrome and related medical conditions have emerged in recent years as one of the most difficult problems facing workers' compensation schemes in Canada and around the world. There is no authoritative definition of chronic pain. It is, however, generally considered to be pain that persists beyond the normal healing time for the underlying injury or is disproportionate to such injury, and whose existence is not supported by objective findings at

> the site of the injury under current medical techniques. Despite this lack of objective findings, there is no doubt that chronic pain patients are suffering and in distress, and that the disability they experience is real. While there is at this time no clear explanation for chronic pain, recent work on the nervous system suggests that it may result from pathological changes in the nervous mechanisms that result in continuing pain and non-painful stimuli being perceived as painful. These changes, it is believed, may be precipitated by peripheral events, such as an accident, but may persist well beyond the normal recovery time for the precipitating event. Despite this reality, since chronic pain suffers are impaired by a condition that cannot be supported by objective findings, they have been subjective to persistent suspicions of malingering on the part of employers, compensation officials and even physicians....".

Quite frankly, the words of Mr. Justice Gonthier are a springboard used by Plaintiffs' counsel to legitimize their client's claims. But, alas, in 2017 the Supreme Court of Canada once again solidified the legal foundation for advancing psychologically based claims in the decision of Saadati, by his Litigation Guardian, Sara Zarei v. Moorhead, et al (2017 SCC 28). The Court unequivocally stated that the trier of fact is not concerned with the diagnosis. The critical factors are the symptoms and their effects. The experts and/or treating doctors may have a professional disagreement about the diagnosis or lack thereof. The medical debate is not the Court's concern. It is the question of function. The impact on one's life, vocational and avocational.

Chronic pain has received its share of publicity. TV programs deal with the various forms of treatment when it comes to chronic pain (and its offshoots). One just has to read the introductory comments for the treatment of pain in a Time magazine article that was on the newsstands for the week of February 28, 2005. The article entitled "The Right and Wrong Way to Treat Pain" start off with the following comments:-

> "Chronic pain is a thief. It breaks into your body and robs you blind. With lightening fingers, it can take away your livelihood, your marriage, your friends, your favourite pastimes and big chunks of your personality. Left unapprehended, it will steal your days and your nights until the world has collapsed into a cramped cell of suffering".

In addition to the Time Magazine article, more recently, Newsweek ran a cover story on "The New War on Pain" which was in the June 4, 2007 issue. Once again, pain has received its share of publicity, and for good reason. It was noted in an article in the University of Toronto magazine (Spring 2007, Volume 34/No. 3) in a cover story entitled "The Problem of Pain", that:

> "The annual cost of chronic pain to the Canadian economy (including medical expenses, lost income and lost productivity) has been estimated at more than $10,000,000,000.00. Despite this elephant in the room, the funding and facilities for treating pain are, well, painfully limited. There are not enough multi-disciplinary clinics in Canada – one for every roughly 250 thousand people; Prince Edward Island and the Territories don't have any at all. University curricula haven't caught up to the need either; many medical students receive only a handful of hours of pain education."

This is not a new problem. It has been with us for quite a few years. For example, the College of Physicians and Surgeons of Alberta in a CPSA Guideline entitled "Management of Chronic Non-Malignant Pain" was published in February of 1993, more than fourteen years ago. The purpose of the guideline was to "aid practitioners in making decisions about appropriate care". It noted that "The College of Physicians and Surgeons of Alberta recognizes the important role served by physicians in relieving pain and suffering". Fourteen years before the article came out in the University of Toronto magazine dealing with The Problem Of Pain, the College of Physicians and Surgeons of Alberta had noted in their own Guideline that:

> "The scope of the problem of chronic non-malignant pain is staggering; the costs of annual lost productivity due to chronic pain in North America is measured in the billions of dollars.
>
> Other less easily measured parameters such as failed marriage or poor quality of life underscore the gravity of the situation".

Dr. Ricky S. Miller, a clinical psychologist, had noted the following in a paper that she wrote for the publication entitled "Personal Injury Litigation, Guidance from Health Care Professionals":-

> "Chronic pain is a serious health care problem which is becoming more prevalent and costly to both the individual and society. Traditional medical interventions often fail to alleviate pain after it has become chronic (defined as having persisted for more than six months). As time goes on, psychological factors become more important than physical factors less important and maintain the pain problem. The individual often comes to adopt the chronic pain lifestyle, characterized by some or all of:
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> a) Excessive rest and inactivity;
> b) Excessive use of analgesic medications;
> c) Dependence of health care professionals;
> d) Family and marital problems; and
> e) Distress and pain."[1]

Dr. Miller, in the same book, in a chapter entitled Toward an Unbiased Assessment of Personal Injury, at page 117, commented that-

> "It is a truism that medical tests help in the diagnosis of injuries caused by car accidents. These tests have their limitations and do not, by themselves, necessarily tell us anything about a patient's level of pain...We are far from understanding the physiological mechanisms that give rise to

[1] R.S. Miller, Psychological Approaches to Chronic Pain: Assessment and Treatment Personal Injury Litigation, Guidance from Health Care Professionals, The Honourable Ted Matlow, Editor, Canada Law Book Inc., 2000, at 99.

> chronic pain but, despite our lack of understanding, chronic pain is a very real problem. However, many assessors
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> conclude that a patient's pain problem is not genuine because its mechanisms or origin are not understood, are deemed to be "clinically impossible or do not appear to be consistent with the type of injuries sustained. This is an extremely presumptuous conclusion to make since it assumes that we possess an understanding of the impact of all injuries and the basis for chronic pain problems when we do not".

The above quotes certainly justify a review of medical concepts dealing not only with chronic pain but post-concussive syndrome and mild head injuries.

OVERVIEW OF THE MEDICAL CONCEPTS –

Despite the plethora of research that has been undertaken by the medical profession over the last number of years, from the perspective of the insurer and perhaps some defence counsel, there is still some skepticism about the prevalence and legitimacy of "chronic pain". All I can say is that one cannot turn a blind eye to what has become a significant problem in terms of health care expenses and the impact of chronic non-malignant pain (a label coined by the College of Physicians and Surgeons) on the economy and daily activities of a percentage of the population.

For example, one study, entitled "The Impact of Sampling and Measurement of the Prevalence of Self-Reported Pain in Canada" noted in one of the statistical tables that when dealing with activity limitation (the range was "prevents some activities to most activities"), relating to both sexes in the age group of between 35 and

64 years, the percentage that reported restrictions of some to most activities ranged from 21.3 to 25% for some activities and 16.2 to 19% for most activities.[2]

This particular paper cannot obviously deal with all studies and points relating to chronic pain. The other members of the panel are far more qualified in their respective disciplines to deal with the medical aspects. This particular paper will highlight some of the points in terms of the medical conditions, terminology and how the same can be used by the legal profession.

OVERVIEW –

When dealing with chronic pain files over the last number of years, one notes a common trend in terms of how the case should be presented and how one convinces either side that there is merit or lack thereof in terms of the claim.

As noted by two authors:

> "Chronic pain is a demoralizing situation that confronts the sufferer not only with the stress created by pain but with many other ongoing difficulties that compromise all aspects of his or her life. Living with chronic pain requires considerable emotional resilience as it depletes people's emotional reserves.
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> Moreover, chronic pain taxes not only the sufferer but also the capacity of significant others who provide instrumental or emotional support.
>
> On a societal level, unrelieved pain creates a burden in, health care expenditures, disability benefits, loss of productivity, and tax revenue. Third-party payors are confronted with escalating medical costs, compensation of payments, and frustration when patients remained disabled despite extensive and expensive treatments". [3]

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[2] E.G. Van den Kerkhof, Wilma M. Hopman and others. The Impact of Sampling and Measurement on the Prevalence of Self-Reported Pain in Canada, reported in Pain Research and Management, the Journal of the Canadian Pain Society, Volume 8, No. 3, Autumn 2003 (Pulsus Group Inc., Oakville) at 162.

[3] Dennis C. Turk and Robert J. Gatchel., Psychological Approaches to Pain Management A Practitioner's Handbook, Second Edition (New York: The Guilford Press, 2002 at 3).

Essentially, if one has a fundamental understanding in regards to the medical terminology and principles when dealing with the physical and psychological effects of soft tissue injuries then that knowledge can be used to present a strong case that the injuries are permanent and serious. Obviously one has to retain the appropriate experts in that regard and that would be a subject matter of a different paper. However, if one is going to embark on pursuing a claim on behalf of an accident victim or defending such a claim, it is critical to have the right experts deal with the type of claim that is being advanced.

This paper is not intended to a comprehensive and a definitive analysis of medical principles. I am not a licensed physician but a personal injury lawyer with an interest in understanding phenomenon of chronic pain. References will be extracted from a number of textbooks and other sources of material that I have consulted (actually invested money and purchased the same). The bottom line is that unless personal injury litigators have a basic understanding in regards to the phenomenon of chronic pain and soft tissue injuries, they are doing a disservice to their client, whether for a Plaintiff or the insurer.

MEDICAL RELATED CONCEPTS –

The starting point, of course, is dealing with some terms. From the perspective of the Threshold, we are dealing with the concept of "impairment". The World Health Organization differentiates between impairment and disability. According to the WHO, impairment is defined "as a loss or abnormality of psychological, physiologic or anatomic structure or function; these disturbances are at the organ or

system level, such as problems with hearing, vision or specific musculoskeletal movements".[4]

The other term of note is "disability". This is defined as "any restriction or lacked of ability to perform an activity in the manner or within the range considered normal for a human being".[5] It has been noted that if there is an impairment, this does not necessarily mean that there is a disability. The two are somewhat distinct. Individuals who have impairments can still be able to function.

Normally we have medical reports that list a number of "symptoms". A symptom is a subjective sensation of the pain that is allegedly felt by the individual. The medical doctor may refer to a "syndrome" and this is nothing more than a set of symptoms that are occurring together. From a medical perspective, there may be objective evidence (signs) of a disease that is perceptible to an examining medical doctor. This is different than the symptoms that are voiced by the patient. Therefore, the basis of the disability includes signs and symptoms.

From the medical perspective, the disability, if only defined by subjective symptoms is not necessarily a medical determination as one is only accepting the patient's subjective complaints. Strictly speaking, medical disability is the loss of function due to a measurable medical impairment. Accordingly, we routinely see reports from the defence which indicates that there is no "objective" impairment or anatomical abnormality which would account for the symptomology. To put it differently, the defence doctor (usually an orthopaedic surgeon or physiatrist) will conclude that there is no disability as one cannot just accept the symptoms that are complained of by the patient

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[4] World Health Organization., The International Classification of Impairments, Disabilities and Handicaps, (World Health Organization, Genova 1980).
[5] Ibid.

as the same are nothing more than a subjective sensation of pain. However, this position taken by the doctors is one that does not deal with the complete picture, particularly in the medical legal context. For example, there are different approaches to dealing with disability claims. For example, two authors, Drs. Anna R. Wright and Robert J. Gatchel have pointed out in a chapter dealing with occupational musculoskeletal pain and disability that –

> "There are several perspectives regarding the diagnosis and treatment of occupational musculoskeletal disabilities. The focus of this chapter is on the biopsychosocial model. This perspective of pain and disability concentrates on the complex interplay of variables – biological, psychological, medical legal, and social variables – that patients deal with when coping with a painful, persisting medical problem. This particular model permits one to understand the relationship between pain and emotional factors."[6]

The label "chronic pain" is often used, as we are well aware. As noted by two authors, -

> "Pain is essentially an unpleasant sensation leading to distress and suffering. It often occurs as a consequence of a noxious stimulus applied from without, such as physical variance causing injury leading to structural change in the body.
>
> Because pain is a subjective symptom, opinions on issues relating to pain are judgment-based and fall short of positive knowledge".[7]

The terminology that is commonly employed by medical doctors in the reports include "organic pain" versus "non-organic pain". According to Drs. Ogilvie-Harris and Lloyd, these terms are defined as follows:

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[6] Supra Note 2 at 351.
[7] Darryl J. Ogilvie-Harris and Geoffrey J. Lloyd., Personal Injury a Medico-Legal Guide to the Spine and Limbs, (Aurora: Canada Law Book Inc. 1999) at 335.

Organic Pain

> "While organic pain is unpleasant, causing distress and suffering, it does lead to an identifiable structural explanation. Usually objective findings will support the complaint of pain. When the cause of the pain is corrected the pain quickly decreases in severity and usually disappears".

Non-Organic Pain

> "Non-organic pain characterized by distribution which does not correlate to a recognized structural explanation. This is described as a non-anatomical distribution of pain. Supporting objective findings are absent. In addition, non-organic pain is seldom helped by the measures which decrease a severity of organic pain. It has a persistence and intractability which cannot be accounted for by identifiable clinical findings".[8]

The term "chronic pain" has been defined by the International Association for the Study of Pain (IASP) as "an unpleasant sensory and emotional experience associated with actual or potential tissue damage or described in terms of such damage".[9]

According to Drs. Robert W. Teasell and Manfred Harth, chronic pain "is best defined as pain which persists for longer than six months".[10]

From chronic pain, we move to chronic pain syndrome. According to one textbook, the definition of chronic pain syndrome is "disabling pain which exists three to six months beyond the normally acceptable recovery period.[11]

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[8] Ibid at 336.
[9] Giovanno Roccamo and John H. Haydon., Medicine in the Litigation Process, (Scarborough: Carswell Thomson Professional Publishing 1999) at 807.
[10] Ibid at 807.
[11] E. Lyle Gross, Injury Evaluation Medico-Legal Principles, (Toronto: Butterworths Canada Ltd. 1991) at 119.

In a different textbook, chronic pain syndrome has been described as follows:

> "Chronic pain syndrome is the stage in which the pain no longer acts as a symptom but actually becomes a disease in itself. Although many factors interact, the syndrome is often initiated by physical trauma.[12]

When dealing with chronic pain, it is important to have an understanding as to the principles associated with Whiplash Associated Disorders. This obviously is an important term as it has been routinely utilized by medical professionals in regards to treatment issues (statutory accident benefit claims) and issues relating to disability whether in the tort or statutory accident benefit context. As we know, with the amendments to the legislation, health care related expenses will be recoverable in non-catastrophic claims if the claim falls within one of the exceptions in terms of the Threshold. Therefore, from the perspective of personal injury counsel, it is of some importance that one has an understanding as to the approach taken by the medical profession when dealing with whiplash injuries and whether or not there is an acceptance that although a vast majority of patients do recover according to the "guidelines", there is a minority that do not follow the "timeline" for healing.

The term "Whiplash-Associated Disorder" has been defined as follows:

> "Whiplash is an acceleration-deceleration mechanism of energy transferred to the neck. It may result from rear-end or side impact motor vehicle collisions, but can also occur during diving or other mishaps. Impact may result in bony and soft tissue injuries (whiplash injury) which may in turn lead to a variety of clinical manifestations (Whiplash Associated Disorders). The following classification was proposed:...Grade 1: Neck complaints of pain, stiffness and tenderness only...; Grade 2: Neck

[12] Supra at Note 6, at 336.

> complaint and musculoskeletal signs, including decreased range of movement and pulling tenderness; Grade 3: Neck complaint and neurological signs, including
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> deceased or absent tendon reflexes, weakness or sensory deficits. Grade 4: Neck complaint and fracture of disc location.[13]

It is noted by Drs. Robert W. Teasell and Manfred Harth that –

> "The clinical syndrome of whiplash is dominated by head, neck and upper thoracic pain. There is also poorly explained syndromes such as tinnitus. Symptom complex is consistent from patient to patient and is complicated by psychological sequelae such as anger, anxiety, depression and concern over litigation or compensation.[14]

Despite the fact that there may be a delay in terms of the onset of the symptoms for a number of hours or even to the following day, this is noted as being a feature of whiplash injuries.[15]

The Quebec Task Force on Whiplash-Associated Disorders limits the term "whiplash" to the mechanism of the injury: during rear-end car collisions people are subject to an extension-acceleration force that may result in a ligamentous, nervous, muscular, and/or bony injury of the neck.[16]

It is noted in the textbook Psychological Approaches to Pain Management a Practitioner's Handbook, that –

> "A combination of symptoms and signs caused by the injury is currently labeled as Whiplash-Associated Disorders (WADs). The term 'whiplash' itself does not indicate a diagnosis. The diagnosis, or in other words, the anatomic lesion, is usually classified following the grading

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[13] Supra at Note. 2 at 106.
[14] Ibid at Note 8 at 810.
[15] Ibid at 811.
[16] Supra at Note 2, p.417.

> system proposed by the Quebec Task Force (*Spitzer, et al*, 1995). It should be emphasized that the Quebec classification is not a comprehensive classification. It only differentiates with regards to quality of the lesion in relation to neck pain.
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> After a Grade 1 and 2 (the least severe), the majority of people report neck pain. The pain often radiates from the occiput, at one end or both sides, into the shoulder along the trapezius muscle. Many of those suffer also from occipital headache. Some may have a frontal headache. Patients with a Grade 1 lesion may complain of neck pain and stiffness that usually occurs a couple of hours after the accident. This is the only symptom and that examination notes tenderness or reduced range of motion of the neck is observed. Patients with a Grade 2 lesion have neck pain and stiffness within a half hour or so. At examination positive signs of tenderness and muscle spasm of the trapezius muscles are present. Patients with a Grade 2 lesion may also report other symptoms, such as dizziness, jaw pain and even back pain.
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> In patients with a Grade 3 lesion, objective findings indicating neurological pathology such as a cord lesion, nerve root or cervical plexus lesion are observed. A Grade 4 lesion is characterized by a fracture, fracture disc location or a rupture of the cervical disc."[17]

An issue of some medical controversy is whether or not the Grade 1 and 2 injury results in a physical lesion as indicated by physical and/or radiological examination. It is beyond the scope of this paper to enter into a discussion in respect of that subject. However, a review of the different positions is set out in the text, Psychological Approaches to Pain Management, a Practitioner's Handbook.[18]

A common theme can be discerned when reviewing the cases dealing with chronic pain syndrome and soft tissue injuries. Whether one is dealing with statutory accident benefit or tort claims, the approach from the perspective of the defence

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[17] Ibid at 417.
[18] Ibid at Note 2, chapter 20 – Treatment of Whiplash-Associated Disorders.

is fairly predictable or linear. Reliance is placed on the Quebec Task Force Study. For the most part, the diagnosis would be either WAD I or II. Therefore, based on the guidelines, one would expect that the individual would have minimal if any symptoms after a specified period set out in the study. The usual timeframe would be less than six months. If the symptoms persist, then the position taken by the defence is quite simple. The professed disability cannot be proven and falls outside the "norm".

It is not as simple as one would imagine. Emotional or psychological factors do make a significant contribution to the issue of disability. Psycho-social factors can interact with physical symptoms to contribute to the disability. These factors need to be attended to as soon as possible. Plaintiffs are at risk of developing chronic pain syndrome if the factors are not recognized during the early stage. As time marches on, the severity and duration of symptoms become excessive in relation to what one would expect in the normal recovery process. The usual modalities of treatment do not diminish the symptoms.

There are a number of physical and psychological complaints that are associated with whiplash injuries and they have been enumerated as follows:

- neck and shoulder pain
- headache
- arm pain/parasthesia/weakness
- dizziness
- tinnitus
- fatigue
- low back pain

- sleep disturbance
- temporomandibular joint pain
- depression
- anger and frustration
- anxiety
- loss of job and income
- marital and family disruption
- drug dependency.

In respect of the psychological complaints, it is beyond the scope of this paper provide an in-depth analysis in regards to mental health issues that arise from traumatic events, such as motor vehicle accidents. It is recommended that certain textbooks can be referred to in regards to developing an understanding as to the various psychiatric classification systems for chronic pain disorders.[19]

Dr. Brian Hoffman had noted that when dealing with mental health issues and in particular, the "emotional consequences of personal injury", there are certain psychiatric diagnoses that are commonly considered. For the most part, one is referring to the DSM IV (American Psychiatric Association, 1994) classification system which is often referred to in the medical legal context, whether in statutory accident benefit or tort

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[19] Some suggested textbooks to consult include: Brian Hoffman et al, The Emotional Consequences of Personal Injury – A Handbook for Mental Health Professionals and Lawyers (Canada: Butterworths Canada Ltd. 2001, Second Edition); Dennis C. Turk and Robert J. Gatchel, Psychological Approaches to Pain Management, A Practitioner's Handbook., (New York, Guilford Press, 2002); Dennis C. Turk and Ronald Melzack, Handbook of Pain Assessments., (New York: The Guilford Press, 2001); Robert J. Gatchel and Dennis C. Turk., Psycho-Social Factors and Pain, Critical Perspectives., (New York: The Guilford Press, 1999); The Journal of the Canadian Pain Society – Pain Research and Management., (Oakville: Pulsus Group Inc.); Brian Smith., Report of the Chair of the Chronic Pain Panels for the Ontario Workplace Safety and Insurance Board, August 2002; The College of Physician and Surgeons of Ontario – Evidence-Based Recommendations for Medical Management of Chronic Non-Malignant Pain: Reference Guide for Clinicians; E. Lyle Gross., Injury Evaluation Medical-Legal Principles., (Butterworths Canada Ltd., 1991).

claims. This system is employed extensively for purposes of psychiatric classification in North America.

Dr. Hoffman notes at page 124 of his book that –

> "In the medical-legal context, it is important to distinguish conditions that were caused or aggravated by the accident in question, and conditions that were present before or not causally related to the accident (the) multi-axial system is especially useful when describing complications from injuries because of prognosis of emotional difficulties depends not only (on) the clinical psychiatric syndrome, but also on the patient's pre-morbid personality (Axis II), the extent and nature of the physical injuries (Axis III), and the wide variety of psycho-social environmental factors (Axis IV). With most psychiatric conditions, the best indication of future functioning, or prognosis, is, in fact, level of functioning in the past year (Axis V). Axis V is a measurement of psychological, social and occupational functioning".[20]

It is noted by Dr. Hoffman that one has to be careful about using the DSM IV in the context of litigation. He points out that this classification system was specifically designed for clinical use and not for forensic settings or the courtroom. He points out that-

> "In forensic and legal arenas, the usual protocols of medical practice do not apply, and examinations by the health care provider are subjected to legal principles that are primary. Not all sources of health information may be made available for the legal assessment. Lawyers may not have access to or may withhold vital medical information, sometimes to their detriment. Certainly the patient or client must be told that confidentiality of information is not possible and that the report and clinical records may be made available to other people. The detection of distortion and deception is one of the main

[20] Ibid at 124; The Honourable Ted Matlow, Personal Injury Litigation , Guidance from Health Care Professionals. (Aurora: Canada Law Book Info, 2000).

> purposes of the assessments for the Court and for the defence in a civil litigation or disability case."[21]

Chronic pain disorder does not fit into any specific diagnosis and treatment plan under what is known as the "acute medical model". The latter is essentially concerned with signs of objective assessment and treatment of disease. When dealing with chronic pain disorders, there are a few objective signs but a host of symptoms. Therefore, diagnostic tests do not confirm or substantiate any structural abnormalities. For that reason, the accident victim is normally faulted for their complaints and we end up with labels such as "malingering", "hysteria", "somatoform pain disorder", "secondary gain" or "litigation neurosis". In the medical legal report, we commonly see the term "Somatoform Pain Disorder". This is defined in the DSM IV as having the following diagnostic criteria –

a) Pain in one or more anatomical sites is the predominant focus of the clinical presentation and is of sufficient severity to warrant clinical attention;

b) Pain causes clinically significant distress or impairment in social, occupational, or other important areas of functioning;

c) Psychological factors are judged to have an important role in the onset, severity, exacerbation, or maintenance of the pain;

d) The symptom or deficit is not intentionally produced or feigned;

e) The pain is not better accounted for by mood, anxiety or psychotic disorder does not meet criteria for dyspareunia.[22]

When dealing with chronic pain, it is important to note that there are a number of psycho-socio economic risk factors which can possibly determine the

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[21] Ibid at 127.
[22] Supra, Note. 2, at 516 to 517.

development and severity of the disabled state. As noted by Drs. Robert J. Gatchel and Geoffrey Dersh, there are a number of risk factors and they include-

a. High self-reported pain and disability;

b. Elevation of MMPI scale 3 (hysteria);

c. Depression;

d. Somatization;

e. Poor coping skills/strategies;

f. Poor quality of social support;

g. Unresolved Workers' Compensation/personal injury cases;

h. Gender;

i. Reinforcement of Pain Behaviours;

j. Job Dissatisfaction;

k. Maladaptive attitudes and beliefs about pain;

l. History of childhood sex abuse.[23]

There are a number of negative predictive factors that may influence the successful reintegration back into the labour market. It is noted by one author that no one factor will carry more weight than the other, however, the greater the number of factors, the greater the extent of "competitive disability". Nineteen factors were identified and they are as follows:

1. More than ninety days off;

2. Doctor shopping;

3. No job to return to;

4. Job change or modification indicated;

[23] Supra, Note. 2 at 45.

5. Psychological/social stress;
6. Economic stress;
7. Substance abuse;
8. Multiple medical problems;
9. English as a second language;
10. Cultural adjustment;
11. Age;
12. Female;
13. Lack of education;
14. Previous claim with difficult rehabilitation;
15. Inconsistent with examination;
16. Missing appointments;
17. Not responding to treatment;
18. Pre-existing medical condition;
19. Third party litigation.[24]

It has been noted that there are factors which magnify the stress-pain cycle. The factors that can exacerbate the cycle which in turn leads to prolonged disability and the need for perhaps extensive treatment include the following:

a) Anxiety;
b) Depression;
c) Anger;
d) Guilt;
e) Family problems;

[24] Supra. Note 10, at 120.

f) Cognitive distortions;

g) Financial problems;

h) Medical uncertainty;

i) Job dissatisfaction.[25]

In regards to the interplay between the physical and the psychological components of chronic pain syndrome and the fact that there is a dichotomy of approaches taken by doctors who following different "schools of thought", it is not surprising that there is such a controversy in terms of dealing with the issue of disability arising from "soft issue" injuries. There is an interplay of variables that include biological, psychological, medical legal and social factors. The effect on the individual can be quite significant in terms of how they perceive themselves in the midst of multiple assessments and conflicting approaches. As noted by Dr. Dennis C. Turk –

> "When patients with chronic pain come to a mental health professional, they have received multiple evaluations and a range of treatments provided by a host of health care providers. A common feature cross all patients, regardless of medical diagnosis, is that the array of interventions did not adequately ameliorate their suffering. Thus, it is not surprising that when these patients are seen by a mental health professional, they feel demoralized and frustrated and believed that their situations are hopeless, yet they continue to seek the cure for their suffering."[26]

Measuring pain is problematic as it is based on complaints. Drs. Dennis C. Turk and Ronald Melzack noted the following:

> "There is no simple thermometer that can objectively record how much pain an individual experiences. As we have noted, all that can be determined about the intensity of the person's pain is based on what the person verbally or non-verbally communicates about his/her subjective experience....

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[25] Supra, Note 2, at 46.
[26] Supra, Note 2, at 142.

> There has been tremendous interest in developing, and efforts to develop, reliable and valid measures for quantifying pain intensity and for objectively quantifying the causes of pain. However, pain is a complex, multi-dimensional, subjective experience. The report of pain is related to numerous variables, such as cultural background, past experience, the meaning of the situation, personality variables, tension, arousal level, emotions and reinforcement contingencies....
>
> Considerable attention has been devoted to developing measures of physical functioning. A number of attempts have relied on people's self-reports of their abilities to engage in a range of functional activities...and the pain experienced upon performance of those activities...Although many investigators are skeptical of the validity of self-report measures and prefer more objective measures, studies have revealed a high level of concordance among self-report and disease characteristics."[27]

Further on, the same authors commented that:

> "Despite obvious limitations of bias, self-report instruments have several advantages. They are economical; enable the assessment of a wide range of behaviours that are relevant to the patients; permit emotional, social and mental functioning to be assessed. Investigators have also developed systematic procedures for a physical examination and evaluation of functional capacity that directly assesses the individual's physical limitations and capabilities."[28]

Drs. Turk and Melzack point out that objective physical findings do not necessarily support pain complaints and for that reason, one has to employ reliable measures to correlate the complaints of pain and the level of function or lack thereof.

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[27] Dennis C. Turk and Ronald Melzack, Editors, Handbook of Pain Assessments, Second Edition., (New York: The Guilford Press, 2001) – Chapter 1, The Measurement of Pain and the Assessment of People Experiencing Pain at 5.
[28] Ibid at 6.

The textbook, Handbook of Pain Assessment is recommended reading for those interested in understanding the different concepts and the results of the research with respect to employing different tools for measuring pain.

In concluding this section, the following comments set the issues in their appropriate context –

> "Few issues in medicine are as fraught with more conflict and controversy than that of chronic "soft tissue" pain. "Soft tissue" pain appears to arise from muscle, ligaments, tendons, and joint capsules. The pathophysiology or biological mechanisms by which pain is perceived in the "soft tissues" has not been adequately elucidated. This has led to the paradox whereby these chronic pain conditions, which are the most prevalent and costly for society, are also the least well understood and accepted."[29]

When dealing with chronic pain claims, it must also be understood that certain symptoms that are complained of and noted by medical professionals early on may lead the health care practitioners and counsel down the wrong path. Far too often I have seen files when I am on for the defence where the wrong label is attached to the problem. To advise the Plaintiff that he or she has suffered a traumatic brain injury (or mild brain injury or post-concussive syndrome) may have a very startling and detrimental effect on the individual. As we are well aware, the phenomenon of Conversion Disorder which is a diagnosis under the DSM IV, can have dramatic effects on an individual who is provided with information to suggest that he has been brain injured! Trying to undue the damage is a daunting challenge at that point.

As noted by Professor Michael P. Alexander of the Harvard Medical School, early symptoms which suggest brain injury after whiplash are quite common but

[29] Supra, Note 8, at 106.

they do not corroborate the diagnosis of brain injury. In an excellent article entitled "The Evidence for Brain Injury and Whiplash Injuries", Professor Alexander reviewed the reliability of studies and diagnostic techniques to determine whether or not there is in fact evidence of brain injury following an acceleration/deceleration of the head and the neck. As he pointed out, the evidence does not support the proposition that the inertial forces in whiplash injury result in brain damage.[30] Certainly defence counsel are flooded with neuropsychological reports and even Spect Scan results which suggest that there are some organic and pathological basis for a traumatic brain injury following a simple whiplash injury. This particular article essentially discloses the flaws in that position and should be reviewed carefully. Dr. Alexander notes that common symptoms after whiplash often mirror the complaints associated with a brain injury and they include the following:

- impaired concentration
- forgetfulness
- mental fatigue
- impaired sleep
- sensory sensitivities
- dizziness
- headaches
- mental slowness

Dr. Alexander pointed out that the results from Spect Scans are the subject matter of controversy. Spect abnormalities are common. Dr. Alexander notes that at

[30] Professor Michael P. Alexander., The Evidence for Brain Injury and Whiplash Injuries., The Journal of the Canadian Pain Society – Pain Research and Management., Volume 8, No. 1 Spring 2003 (Oakville: Pulsis Group Inc.) at 19.

best, it is feasible that a fraction of patients after whiplash may suffer some transient brain dysfunction when the Spect Scan is used and this would only place him at the mildest end of the concussion spectrum.

The Professor further notes that neuropsychological tests in whiplash patients often show deficits compatible with the symptom complained of. Coupled with Spect Scan abnormalities that may show regional hypoperfusion, the Plaintiff's counsel is emboldened by such evidence. However, despite the fact that neuropsychological tests and symptomatic patients disclose deficits, the test results may be coloured by the effects of depression, anxiety and chronic pain which plague the chronic whiplash patient. The over attribution of symptoms to a recent event lead to an expectation by the patient that certain symptoms will flow. As noted by Dr. Alexander:

> "Patients with a whiplash injury frequently have cognitive symptoms. The general quality of the symptoms is quite consistent from patient to patient. The symptoms are very similar to patients who have "deemed" injuries, i.e., Grade 1 – the mildest-concussions. The symptoms are also very similar, although less frequent and usually less marked, to those of patients with classic concussions. A small number of patients with whiplash have persistent cognitive complaints, but they are embedded in a much more complicated collection of somatic and psychological symptoms. To assign them primary neurological causation underestimates their multi-factorial basis."[31]

In answer to one of the questions set out in the article as to whether or not brain injury best explains the reason for persisting cognitive symptoms after a whiplash, Dr. Alexander indicated that the answer is "no". Brain injury is regarded as an unsatisfactory explanation. The Spect Scan abnormalities are ambiguous in respect of

[31] Ibid at 22.

their interpretation as there is overlapping non-neurological disorders that bring into play other differential diagnoses in the patient population.

With respect to neuropsychological testing, this only illustrates that the patient is reporting his or her problems accurately. There may be some deficiencies on memory and attention tasks. However, we must not forget that any lack of performance can be due to pain, medication, depression, anxiety, sleep deprivation or poor motivation (whether conscious or unconscious for secondary gain). The latter factors may be accorded more weight to provide an explanation for the "cognitive deficits" that we always see in Plaintiff oriented neuropsychological reports.

When dealing with the issue of treatment and the whiplash-associated disorders with or without cognitive deficits, one should also take into account what was stated by Dr. Alexander in the same article. The following quote perhaps sets the tone for how these files should be regarded in terms of treatment issues:

> "It is also the case that pain, medication, depression, anxiety, and sleep disruptions are potentially highly treatable although it is uncertain if that can be claimed for stress or poor motivation. If there is lingering neurological dysfunction and cognitive inefficiency, there are no validated direct treatments. Compensatory programs using calendars, PDAs, schedules free of unpredictable interference, sleep hygiene and the like will surely help
>
> anyone but may require more effort than pain, medication, depression, anxiety, sleep disruptions, stress and poor motivation will allow. **Endlessly hunting for proof of brain injury is clinically detrimental and draws focus and energy from treatment up to disorders that can actually be treated. Failure to treat the treatable will only increase anxiety and prolong disability.**"[32]

[32] Ibid at 22. (emphasis added by author)

In an article entitled "Initial Assessment of Whiplash Patients", it was noted by the authors that –

> "In the long term, the incidents of neck pain is not different in WAD patients from the non-injured population. Yet, insurance claims are known to have a negative effect on the recovery rate after an accident. True malingering, however, is rare and chronic WAD patients are not cured by a verdict.
> Consequences of injury such as persisting pain, sleep disturbances, litigation etc., may induce secondary psychological factors that in turn participate in the chronicity of the symptoms while creating distress and illness behaviour (benoist). Psychological symptoms and post-traumatic conditions are not the cause but rather the consequence of somatic symptoms (Radanov).
> That the outcome of treatment strongly depends on the initial medical care is obvious for severe trauma. **This has now also been generally accepted for WADs, underlying the importance of a proper initial assessment on all cases of even less severe trauma.**[33]

The same authors note that the initial assessment of WAD is essential and once major injury has been ruled out, the initial treatment, which is usually started in the emergency department, should follow the basic four points:

- reassure patient about evolution
- no soft-collar
- NSAID
- early mobilization[34]

It is also noteworthy that the authors encourage the medical profession to provide reassurance and demystify the diagnosis of "whiplash". Further on it is stated that there is enough evidence to suggest that rest and a cervical collar may have a

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[33] Dr. R. Gunzburg, N. Szpalski, J. Van Goethem Initial Assessment of Whiplash Patients., the Journal of the Canadian Pain Society – Pain Research and Management., (Oakville: Pulsis Group Inc.), Volume 8, No. 1 Spring 2003 at 24.
[34] Ibid., at 25.

detrimental effect in the early management of WAD. The accident victim should be encouraged to embark on an early activation program. Not surprisingly, "early suffering and impairment to function may affect the later feeling of sickness behaviour".[35]

There are other interesting articles that should be reviewed when dealing with the whiplash injury phenomenon. This paper cannot obviously deal with all the interesting studies that have been done by I encourage the reader to consult the special issue published by the Pulsus Group Inc. entitled Pain Research and Management, Volume 8, No. 1, Spring 2003 and specifically refer to the articles entitled "An Evidence-Based Approach to the Treatment of Acute Whiplash Injury" authored by Dr. Les Barnsley and "Treatment Strategies for Chronic Cases" by Dr. Susan M. Lord. Both articles are of particular interest in regards to the usefulness of certain rehabilitative measures including traction, physiotherapy, soft collars, opiates and trigger point injections.

Once again, the usefulness of doing the research in terms of the medical literature, particularly as it relates to the treatment of the chronic pain patient/Plaintiff, is going to be almost mandatory if one is to properly address the issues of entitlement to a disability benefit.

THE QUESTION OF CREDIBILITY –

It is perhaps a daunting task to search for and retain the appropriate experts when dealing with personnel injury litigation. One is always conscious about trying to find an expert that will present well at court and create the appropriate impression. But in reality, the case really revolves around how the Plaintiff is going to

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[35] Ibid., at 26.

present and as we all know, one can never predict how members of the Jury or the Judge will approach the matter if they do not place the Plaintiff in a positive light.

When dealing with claims of a subjective nature, as defence counsel, we always mention that a good deal will depend on credibility. Not surprisingly, we commonly argue that in cases in which the symptoms of the injuries have continued well beyond the normal recovery phase and there is a lack of objective evidence to establish the source of the symptoms, the credibility of the claimant is of paramount importance. We highlight a number of examples of exaggerations by the claimant that were noted by the experts (e.g. such as the lack of effort during a functional abilities evaluation, pain magnification or lack of co-operation on examination and inconsistent behaviours).

The courts have made some general comments about credibility and the "judicial" approach. Mr. Justice Chamberlist in the decision of *Loretta Thiessen* v. *Shawn William Thomas Kover, et al*, (2008) BCSC 1445 at paragraph 122 noted:

> "The issue of the Plaintiff's credibility is central to this case because the accuracy, truthfulness and reliability of the Plaintiff's self-reporting is so important as the medical evidence relied on by the Plaintiff in the presentation of her case is either based entirely on the self-reporting of the Plaintiff, either directly or indirectly. Perhaps the best and most widely used statement regarding credibility in this province is found in *Faryna v. Chorney*, [1952] 2 D.L.R. 354, where at p. 356 O'Halloran J.A. stated:
>
> > ...Opportunities for knowledge, powers of observation, judgment and memory, ability to describe clearly what he has seen and heard, as well as other factors, combine to produce what is called credibility, and cf. *Raymond v. Bosanquet* (1919), 50 D.L.R. 560 at p. 566, 59 S.C.R. 452 at p. 460, 17 O.W.N. 295. A witness by his manner may create a very unfavourable impression of his truthfulness upon the trial Judge, and yet the surrounding

circumstances in the case may point decisively to the conclusion that he is actually telling the truth. I am not referring to the comparatively infrequent cases in which a witness is caught in a clumsy lie.

The credibility of interested witnesses, particularly in cases of conflict of evidence, cannot be gauged solely by the test of whether the personal demeanour of the particular witness carried conviction of the truth. The test must reasonably subject his story to an examination of its consistency with the probabilities that surround the currently existing conditions. In short, the real test of the truth of the story of a witness in such a case must be its harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions. Only thus can a Court satisfactorily appraise the testimony of quick-minded, experienced and confident witnesses, and of those shrewd persons adept in the half-lie and of long and successful experience in combining skilful exaggeration with partial suppression of the truth. Again a witness may testify what he sincerely believes to be true, but he may be quite honestly mistaken. For a trial Judge to say "I believe him because I judge him to be telling the truth," is to come to a conclusion on consideration of only half the problem. In truth it may easily be self-direction of a dangerous kind.

The trial Judge ought to go further and say that evidence of the witness he believes is in accordance with the preponderance of probabilities in the case and, if his view is to command confidence, also state his reasons for that conclusion. The law does not clothe the trial Judge with a divine insight into the hearts and minds of the witnesses."

In the decision of *Hrnic* v. *Fast*, 2004 BCSC 1411, Mr. Justice Scarth had this to say at paragraph 48:-

> "In assessing the Plaintiff's credibility I say at the outset that I found her a persuasive witness in the stand. She was articulate in giving her evidence, responsive to the questions in both her examination in chief and cross-examination, and not withstanding that English is not her native tongue she has a good command to the language. But personal demeanour is not determinative of the issue of credibility particularly where the witness has an interest in the outcome of the case. Her testimony must be subjected to scrutiny to determine if her story is in harmony with the preponderance of the probabilities which a practical and informed person would readily recognize as reasonable in that place and in those conditions": *Faryna* v. *Chorny*(1951 – 1952) 4 W.W.R. (N.S.) 171 (B.C.C.A.), at P.174 (per O'Halloran J.A.)
> At paragraph 52 of the same decision, Mr. Justice Scarth pointed out that:
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> "It must be borne in mind that the evidence regarding the Plaintiff's medical complaints is essentially subjective. There is little or no objective medical evidence. The dicta of McEahern C.J.S.C. (as he then was) in *Price* v. *Kostryba* et al, (1982), 70 B.C.L.R. 397 (S.C.), at pp. 398399 are relevant:
>
> > 'Perhaps no injury has been the subject of so much judicial consideration as the whiplash. Human experience tells us that these injuries normally resolve themselves within six months to a year or so. Yet every physician knows some patients whose complaint
> >
> > continues for years, and some apparently never recover. For this reason, it is necessary for a court to exercise caution and to examine all the evidence carefully so as to arrive at a fair and reasonable compensation. Previously decided cases are some help (but not much, because obviously every case is different).'
>
> ...In *Butler* v. *Blaylock*, decided 7th October 1981, Vancouver No. B781505 (unreported), I refer to counsel's

> argument that a Defendant is often at the mercy of a Plaintiff in actions for damages for personal injuries because complaints of pain cannot easily be disproved. I then said
>
> I am not stating any new principle when I say that the courts should be exceedingly careful when there is little or no objective evidence of continuing injury and when complaints of pain persists for long periods extending beyond the normal or usual recovery.
>
> An injured person is entitled to be fully and properly compensated for any injury or disability caused by a wrong doer. But no one can expect his fellow citizen or citizens to compensate him in the absence of convincing evidence – which could be just his own evidence if the surrounding circumstances are consistent – that his complaints are pain are true reflections of a continuing injury."

In the *Hornick* decision, Mr. Justice Thomson when dealing with the issue as to whether or not Mr. Hornick was a credible witness essentially pointed out that most of the complaints were subjective. The question from the judge's perspective was whether or not the Plaintiff was credible in his description of his pain and his limitations. Mr. Justice Thomson referred to the comments of Mr. Justice McKeown in *Victorov* v. *Davidson,* [1988] O.J. No. 190 at p. 15 who stated that the "best judicial test of credibility is a consistency and harmony or lack thereof with a preponderance of probabilities disclosed by the facts and the objective evidence". Mr. Justice Thomson indicated at paragraph 232 of his decision in *Hornick* that "I accept that statement as being a good judicial expression of how to test the credibility, believability and reliability of a witness's evidence".

As we know, judges have voiced their concerns about chronic pain cases as there is a significant reliance on testimony due to the subjective nature of the condition. Medical experts, to some extent, put forth their opinions based on what they

are told. From the perspective of the medical doctor, there is a combination of subjective and objective factors that have to be taken into consideration. There may be some significance to the response or lack of response, for example, to palpitation of the tender and control points. There is the argument put forth by some doctors that trigger and control points are purely subjective. Different clinicians may come up with different results on control point palpitations and this tends to undermine the objectivity of such testing.

Mr. Justice Thomson of the Ontario Superior Court of Justice in the case of *Pisciotto* v. *CAA Insurance Company (Ontario)* (2000), 21 C.C.L.L. (3d) 235, O.T.C. 621 (Gen. Div.) at 140 commented that one has to be quite cautious about accepting at face value the complaints of the Plaintiff and noted that:-

> "It seems to me that if a patient has a basic knowledge that a trigger and control point palpitation test....then it is open for a trier of fact to conclude that the tests were susceptible to manipulation and unreliable. The diagnosis may then be inaccurate".

It is not uncommon for insurers and defence counsel to approach a chronic pain claim with a high degree of skepticism. The buzzword is as usually coined is "malingering". That word has become somewhat unpopular. I do take note that over the last several years, reports from the medical experts on the defence side do not usually come out and boldly state that the individual is a malingerer. They raise the issue of malingering indirectly. They comment that the individual has signs of "symptom magnification" or "non-organic signs" and they tend to "embellish" their complaints. They leave it to the reader to read between the lines without explaining why they have come to this conclusion and more importantly, they do not provide any differential

explanation which would perhaps explain why the claimant is presenting in such a fashion (e.g. a vulnerable personality perhaps, or cultural issues).

Dr. Ricky Miller in the previously cited article entitled Toward an Unbiased Assessment of Personal Injury noted at pages 112 to 113 that:-

> "Malingering is conscious deception. Sometimes the term 'motivational distortion' is used instead....Conscious 'faking'...does occur and it is often difficult to assess...Instances of exaggeration are more common than outright malingering....Many insurance company adjusters and many assessors have become so worried about being duped that they are overly suspicious toward all victims of accidents. This, of course, results in serious injustices for the majority of clients whose complaints are genuine.
>
> Assessors have sought quick and easy ways of assessing malingering and a number of measures have been employed over the years. Unfortunately, there is no single measure or test for malingering that has validity in itself. Nothing can substitute for the task of analyzing the patient's behaviour and responses in light of all of the assessment data collected in
>
> order to explore the probability that malingering is or is not present. It is patterns of behaviour that lead to accurate conclusions, not single points of data, whether they arise from tests, other documents or behaviour. Malingering tests that have been used usually consist of easy tasks that are presented to the patient as if they were difficult. For example, a patient may be asked to remember a series of number or figures that only the most severely brain-damaged patient is unable to recall. The patient's failure on such measures has often been taken as an indicator of malingering. However, this is not necessarily a reliable indicator.
>
> Many factors can give rise to a poor performance on an easy test. A man who is depressed may not be motivated to try and/or may expect to fail, especially if he has correctly perceived the assessor's presentation that the test is difficult".

Essentially Dr. Miller, as well as a number of other psychologists, try to advise others that blind adherence to a specific test such as the Rey measure, is not

foolproof. One has to look at the complete picture in terms of analyzing the medical documentation, collateral source information, clinical observations and the employment of the number of tests that have validity indicies, such as the Personality Assessment Inventory, the Minnesota Multiphasic Personality Inventory (MMPI II) or the P3. Of course, there is no foolproof measure to determine if someone is a malingering. There is no iron clad proof that one can rely on to persuade the trier of fact that they should not believe the complaints of the individual. At the end of the day, it is going to come down to whether the jury likes the claimant or not. Unfortunately, in some cases, it is as simple as that.

Once again, I recommend to the reader that they review the papers authored by Dr. Brian Hoffman entitled "The Relationship Between Mind and Body and Chronic Pain" and Patrick Brown – "Defeating the Allegation of Exaggeration or Malingering", both of which are contained in the Oatley-McLeish Guide to Proof of Personal Injury Damages – Psychological Injuries and Chronic Pain – Part Two". Both papers discuss the diagnosis of Malingering (Law Society of Upper Canada, June 7, 2007).

Before leaving the question of credibility, it should be stated that the question of labeling the particular diagnosis is sometimes not the main issue from the perspective of the Judge. In the decision of *MacDonald* v. *Sun Life Assurance Company of Canada*, (2005) PESCAD 25 (Appeal Division), The Honourable Chief Justice G.E. Mitchell noted that a fair amount of time at the Trial was taken up with the dispute about whether or not the claimant fit the medically recognized criteria for fibromyalgia, chronic fatigue syndrome and multiple chemical sensitivity. In addition, there was an issue as to

whether or not "multiple chemical sensitivity" was even recognized by the medical community. His Honour quoted from the decision of Holmes J. in *Chaplin* v. *Sun Life Assurance Co. of Canada*, [2001] B.C.J. No. 350, 2001 BCSC 310, at paras. 41-42,

> "...the issue is not whether the claimant fulfulls the technical requirements of some particular diagnosis. The issue is whether the claimant is in a continuous state of incapacity due to bodily injury, disease, mental infirmity, or sickness which prevents him or her from performing the duties of their job or from engaging in a commensurate one. It is the fact of illness that is important not its name, cause, or explanation. It is true, as counsel for the respondent argues, that a person is not ill just because they say so but, on the other hand, a person may be ill even though there is little or no objective evidence to prove it. That said, the fact that a person suffers from an illness, even a chronic one, is not in itself sufficient to qualify for total disability benefits under the policy. The additional requirements that the resulting incapacity be continuous and that it be to such an extent that it renders the employee unable to perform their ordinary duties set a very demanding standard that is not easily satisfied."

TIPS FOR THE DEFENCE

From the defence perspective, it is important to stress the subjective nature of the complaints and to demystify any testing done on the Plaintiff side. One has to harp on the fact that people do work with aches and pains everyday and they do not have a traumatic incident to blame (that offers compensation).

There is no exhaustive check list as to what a defence counsel is supposed to do when defending its chronic pain case. Many papers have reviewed this topic. However, there are some points to consider such as the following:

1. Do you, as a defence counsel, feel that the description of the problems are credible;
2. Do the complaints seem consistent and make sense?

3. Did the Plaintiff attempt to mitigate by trying to help himself or herself at any point (e.g. by engaging in active treatment, a work trial or even an attempt to go back to the job even if it is modified);

4. Are the complaints so incredibly ridiculous that the evidence does not have a ring of truth? For example, the use of common sense is a great weapon. When I examine a Plaintiff, I ask about the most mundane activities of normal living. If the Plaintiff is going to suggest that they cannot even take out the garbage, put in some laundry, make a sandwich or a cup of coffee and so forth, then I do have some problems with accepting this individual's claim. I highly recommend a review of the decision of *Brennand* v. *Sun Life Assurance Company of Canada* [2012] BCSC 972. The claimant in that decision alleged that he suffered from chronic pain. On behalf of the Plaintiff, a number of experts were called to testify including an "expert" in chronic pain as well as the treating psychiatrist. The defence called a psychiatrist as well as an occupational health consultant. What is interesting about this case is not so much the "battle of the experts" which was of some interest, but the approach taken by the defence counsel in regards to a microscopic analysis of the claimant's activities of daily living and recreational interests versus his alleged inability to work. For example, the Plaintiff was an avid motorcyclist who rode his motorcycle for a sustained period with friends. He would have to

wear the appropriate bulky clothing, together with a helmet and heavy laced boots. This stood in stark contrast to the opinion of the "expert" in chronic pain who was of the opinion that Mr. Brennand had "significant impairments" that included severe low back pain, moderate depression and anxiety and chronic insomnia which lead to daytime fatigue. The defence counsel was able to persuade the trial Judge that the opinions of the Plaintiff's experts were totally inconsistent with the activities engaged in by the Plaintiff. The credibility of the Plaintiff was brought into question which obviously effected the outcome of the case;

5. Surveillance is helpful but one cannot delve into the individual's mind. The investigator does not know how to measure pain either. Regardless, if someone is operating a motor vehicle or walking, shopping, engaging in some type of social activity and their evidence on discovery suggests that they are housebound, then obviously there is a problem. The fundamental issue is whether or not the activities observed are inconsistent with the physical or psychological nature of the injuries. Serial surveillance is crucial. It makes no sense to have surveillance done on one day and then wait a few days as the Plaintiff will usually indicate that it took him a few days to recover. We commonly hear about the "good and bad" days. We just happen to catch them on their good days.

Do consecutive days of surveillance alternate between weekdays and weekends?

6. Critically review the Plaintiff's experts in terms of their qualifications;

7. Did the Plaintiff's expert consider differential diagnoses? Is their opinion based on the subjective complaints only and nothing else? Did the Plaintiff disclose all their pre-accident issues to the expert?

8. Obtain the complete chart from the family physician for the pre and post accident timeframe is an obvious consideration;

9. The seven years of the decoded OHIP list is helpful but should be cautiously reviewed in light of the diagnostic codes as the same can be misleading. For example, there may be a reference to pre-accident "anxiety" or some similar label. If the practitioner is a family physician, this does not necessarily mean the individual had a psychological disorder under DSM IV. The person may have been complaining about their children or spouse and the family physician simply used the most appropriate code for billing purposes only. Blind adherence to OHIP summaries can create some difficulties for defence counsel (or defence doctors);

10. Are the lay witnesses persuasive and credible?

11. As a student of history, I firmly believe that a person's premorbid personality traits and vocational/educational and family related history is of some importance. A person's reaction to a traumatic

event can be significant if that individual is vulnerable. In addition, if the person has a stellar work history with minimal complaints preceding the accident, then that spells trouble for the defence;

12. When dealing with the choice of experts, everyone has their favourites. Some defence counsel like to use psychiatrists. Others they use an orthopaedic surgeon. Quite frankly, I shy away from psychiatrists and orthopaedic surgeons when it comes to subjective cases such as chronic pain/fibromyalgia and so forth. I believe that one has to have physical and psychological assessments done. I prefer to have a clinical psychologist who has an expertise in chronic pain type of claims. I like physiatrists as part of their specialty is rehabilitation medicine. Even if the individual does suffer from chronic pain, it is not fatal (hence the College of Physician and Surgeons description of chronic pain as – "**Chronic non-malignant pain**"). Even if the person has difficulties working, the fundamental question is for how long and what efforts are being made in terms of mitigation. I would want my experts to make recommendations as if the individual was their patient. I want the recommendations made in the report. I would then be most pleased if the Plaintiff sits back and does absolutely nothing. The couch potato Plaintiff is the one I love and the one that is detested by jurors.

COMMENTS REGARDING INDEPENDENT ASSESSMENTS

As personal injury litigators, one would assume that in the context of a personal injury case, we would always want to have the appropriate expert. The search for the unbiased expert is of critical importance from the perspective of the insurer. Quite frankly, one would have thought that the choice of the appropriate expert would have always been of paramount importance. The proliferation of punitive and aggravated damage claims over the last few years would have been the wake up call for the insurance industry in terms of cautiously adjusting files.

Needless to say, as defence counsel, we are routinely told by the Plaintiff's bar that the policy is a "peace of mind" contract or policy. The British Columbia Court of Appeal had confirmed this "label" in *McIsaac* v. *Sun Life Insurance Co. of Canada* (1999), 9 C.C.L.I. (3d) 155 (B.C.C.A.). The court, at page 158, quoted from the *Thomson* v. *Zurich Insurance Co.* (1984) 7 D.L.R. (4th) 664 (Ont. H.C.J.) and stated:

> "Few contracts could affect one's personal interest more than a contract for medical and rehabilitation benefits. In my judgment, both insured and insurer would contemplate that a failure of the insurer to pay medical and rehabilitation accounts on a timely fashion will foreseeably occasion mental distress and emotional upset. The predominant, if not the sole object of the contract was to provide ease of mind to the insured that his medical accounts would be taken care of by timely payments during the period of rehabilitation".

The importance of investigating and evaluating a disability benefit claim routinely involves the obligation on the part of the insurer to search out for the appropriate expert advice. It is trite to state that the duty of good faith necessitates that the accident benefit carrier undertakes an assessment which is both objective and fair. This duty extends to the selection and use of medical experts. Of course, the use of

expert medical evidence has become so routine in our litigation process that it is not surprising that most of the medical professionals earn a considerable sum of money from providing opinions for both sides of the claim. Some doctors are used routinely by the insurer and by the same token, certain medical experts are the favourites of the Plaintiff's bar.

It is not surprising that certain experts retained by the insurer or its Defence counsel (or Plaintiff's counsel for that matter), may have a certain perspective which obviously supports the position of the party that retains them. The opinion is well known to the person who retains the particular expert and, quite frankly, the counsel or the insurer does not have to be concerned about the threat of sanctions if it is shown that this particular expert has a very selective opinion. The downside, of course, is that the bias of the expert will be unmasked during cross-examination and the repercussions of the same will be felt in terms of the monetary judgment.

The use of such experts is not acceptable in a disability benefit case where the insurer is under an obligation to objectively evaluate the claim.

Therefore, the insurer must search out and find an expert who is unbiased and competent in the area that is of relevance. The expert should be provided with the available documentation. The insurer must avoid the temptation to influence the expert's perspective.

Clearly astute Plaintiff's counsel will carefully investigate the factors that went into the selection of an expert by the insurer. The fact that a specific doctor may routinely be used by the insurer or defence counsel does not necessarily translate into a finding of bias.

The insurer, has an obligation to approach the matter with an open mind and should attempt to shield itself from the sanctions set out in the legislation or incur the wrath of a Judge and/or Jury. Accordingly, the company or its counsel must be quite certain that the medical expert that is retained is clearly going to be one who is not going to be adversarial and essentially turn a blind eye to other possible diagnoses or explanations as to why the individual continues to be disabled or need medical treatment.

COMMENTS RE SELECTION OF EXPERTS –

It is, of course, trite to state that the role of the expert has to be considered by counsel in the litigation process. It is incumbent on counsel to ensure that the expert is "independent" and puts forth an unbiased opinion. Although this may sound obvious, far too often the experts prove to undermine the position of counsel by assuming the role of advocate. Perhaps the comments of Mr. Justice Preston in the decision of *Sebastian* v. *Nuefeld* (1995), 41 C.P.C.(3d) 354 (B.C.S.C.) at page 358 should be considered by counsel when he stated:

> "In personal injury cases arising from motor vehicle accidents, the Plaintiff and defence bars, have, in recent years, developed 'stables' of expert witnesses whose opinions predictably favour one side or the other in the litigation". There has been a tendency, of concern, to this Court, for experts to combine the role of expert and advocate. This is encouraged where experts approach their tasks with an unrestricted mandate and are given, by instructing counsel, material which is admissible but calculate the bias to the expert in the formation of his or her opinion".

While the comments of Madam Justice E. MacDonald in *Perricone* v. *Baldassarra* (1994), 7 M.V.R. (3d) 91 deal with the issue of Threshold, they still have some relevance in regards to how at least one Judge approached the role of the expert

when dealing with a Section 266(1) threshold motion. At page 97, her Honour observed that:

> "On motions such as this, and in the face of apparent conflict among the experts' reports, it is important that the reports be viewed for what they truly are. In personal
>
> injury cases, there has developed a tradition of exchanging and relying on competing 'expert reports', which, in my view, has eroded the legal basis for the acceptance of experts' reports into evidence either with or without cross-examination...Once a Judge is aware, as I am in this case, that an expert is hired by one of the parties to provide the Court with an opinion that is supportive of that party's case, the Judge must take this factor into account in weighing the credibility of the expert's report. When the report is overwhelmingly directed to advancing the position of the person engaged in the expert's report, the report must be viewed accordingly."

Additional comments about experts are contained in a lengthy decision called *Hornick* v. *Kochinsky* [2005] O.J. No. 1629. This decision is quite helpful in regards to not only dealing with experts but as well the treatment of damages. At this point the focus is on experts and at paragraph 226 and following of the decision, Mr. Justice Thomson quoted from an article authored by Vern Krishna, the former Treasurer of the Law Society of Upper Canada. Mr. Krishna was discussing the role of experts in long trials. The comment is quite insightful and Mr. Krishna had this to say:-

> "...The purpose of expert testimony is to assist those trying cases to make an informed judgment by providing special knowledge that the ordinary person would not know.
>
> In theory, the expert is an impartial witness and not beholden to the party who retains him or her. In fact, some experts are partisan and beholden to their retainers. This minimizes their value as assistants to the court.
>
> Courts generally allow expert testimony based on relevance, necessity and the qualifications of the expert.

> The cornerstone of such testimony is the independence of the expert. Where the court cannot rely on the impartiality of the expert, the trial becomes a battle between opposing experts, each carrying the banner for their retainers.
>
> An expert is not a hired gun. Regardless of who pays the expert, his or her primary duty is to the court and not to the client. Unfortunately, it is difficult for the expert to eradicate from his or her mind exactly who was doing the feeding. There are no easy solutions to resolving the hired gun problem".

In the *Hornick* decision, Mr. Justice Thomson had to deal with the battle of the experts in regards to the physical and medical related impairments. I recommend to the reader that they review this decision as it does provide some insight as to how the judge dealt with the evidence of the various experts and found flaws in regards to some of the approaches taken by the experts retained by the defence.

LOOKING FOR THE RIGHT EXPERT -

There are a number of factors that contribute to the selection of the right expert. Care should be taken in making the appropriate choice. How should you pick the expert? Perhaps the first question is what kind of expert do you need and what do you need him or her to do? Perhaps it is more fitting to step back for a moment and decide what type of expertise would be required. In order to make an informed decision, the counsel has to understand the theory of the Plaintiff's case, identify the basis that underlines it and decide which area of expertise will be necessary to counter the other side's theory and position. From the Plaintiff's perspective, obviously when dealing with a chronic pain type of case or a case based on the label fibromyalgia, it is helpful to consult with someone in the medical profession for some guidance in terms of the right type of expert to deal with the issues of disability. The most common experts used when

dealing with chronic pain and fibromyalgia type cases are physiatrists, psychologists and in some cases psychiatrists, rheumatologists and to measure function, perhaps an occupational therapist. Functional Ability Evaluations are some times employed to measure a function as well but they are somewhat artificial in terms of the context in which they are used. There have been enough cases which have criticized the usefulness of Functional Abilities Evaluations in relation to their rather artificial setting and the limited amount of time that one is testing someone and thereafter attempting to extrapolate the results.

When canvassing the candidates, regardless of the discipline, one should consider the following:

1. Consult with other colleagues who have been involved in cases dealing with similar issues and find out who they retained in the past. This should no longer be a problem. With the Ontario Trial Lawyers Association and the Canadian Defence League, the two leading armed camps, one has access to the "chat line" for assistance;

2. Retain the expert who has the appropriate training experience. Perhaps this should obvious. However, far too often I have been shocked by the lack of appropriate experience when reviewing the expert's Curriculum Vitae. The latter must be closely scrutinized. For reasons I do not understand, the Curriculum Vitae is never requested until late in the day. It should be requested right away and someone should critically review the research that has been

done by the expert and which area he or she has focused on during their years as a medical professional;

3. Does the expert have the appropriate background? Does he or she have a particular interest in the area in question?

4. Has the expert authored any leading papers or publications?

5. Does the expert have the ability to express his or her opinion which is "jargon free". Can they communicate technical information in simple terms that a trier of fact can understand?

6. Will the expert commit himself or herself to the investment of time that is required to review documentation, examine the Plaintiff, prepare a report and work with counsel during the course of the litigation? This may sound obvious but I am certain many counsel will agree with the proposition that even if an expert is willing to write a report, is he prepared to return calls from counsel and be readily available. The expert must be a "team member" in regards to cooperating with counsel;

7. Does the expert have experience in conducting independent evaluations?

8. What has the expert's experience been at trial or at arbitration? Has his or her evidence been accepted? Has the expert's opinion been criticized by Judges or Arbitrators in the past? In order to find out, the counsel will have to question the candidate as to his or her past experiences at trial or arbitration. Certainly the Internet is

a handy tool. By checking the FSCO Website and inputting the name of the expert, it is quite startling as to how often a specific expert may have been referred to in the past by arbitrators. The question, of course, is whether or not the expert's reports were accepted and how did the expert perform in terms of cross-examination? Was the expert criticized? Was his or her evidence dismissed as being of little use when dealing with the issue at hand? Can someone provide you with the transcripts of prior cross-examinations which may have a useful tool?

9. What is the candidate's employment history? What agencies or employers was his affiliated with? Putting it differently, how many i.e. facilities is he or she associates with? What is the percentage of work that he does for the Plaintiff's bar versus the Defence bar? Does the potential candidate see patients on a regular basis?

10. Does the candidate adhere to a minority viewpoint?

11. Does his or her opinion follow the mainstream of views that would be contained in the authoritative text or publications?

12. One must carefully examine the candidate's educational and professional qualifications. Are they embellished upon?

13. Did the candidate author papers in recognized and peer reviewed publications? Is he or she held in high regard by his or her peers? Are his or her writing cited as being authoritative?

14. How familiar with the candidate with writings in that particular field? Is he or she prepared to acknowledge that there are differences of opinion and if so, how will the candidate deal with such questions? Is he or she prepared to concede that there are differences of opinion and if so, how will this witness convince the Court that his or her opinion is the preferable one? Is he prepared to put forth differential diagnoses and account for why his particular opinion should be accorded the most weight?

15. What professional organizations and societies does this candidate belong to? Has he or she participated in seminars organized by the professional organizations? Is he a frequent speaker at OTLA or the Canadian Defence League? Has he presented papers for the Advocacy Society or the Ontario Bar Association? Has he presented papers for insurers? The papers should be retrieved to find out if he or she presents consistently in terms of the theories.

16. Has the candidate been cross-examined at a prior trial or arbitration by the other counsel? What happened?

17. Is the candidate still affiliated with a hospital or teaching institution? Does he have any association in terms of teaching responsibilities at the local university? What rank does he hold? How often does he teach? What are his duties at the university? Is he still responsible for research at the university and if so, how

much time does he or she spend conducting research? Does he or she supervise residence at the hospital?

18. Does the candidate subscribe to well-known accepted medical journals?

19. Consult with other medical professionals in the same field to find out whether this candidate has a good reputation.

20. Do not be shy and request a number of references so you can check up on the candidate.

21. Sometimes it is helpful to meet with the candidate and quickly judge this individual's demeanor. How will he or she present?

In the final analysis, locating the right candidate is not a simple task. It may be challenging and time consuming. However, the consequences of not being careful in the selection process may have dire consequences when dealing with the Threshold issue.

THE PREPARATION OF THE EXPERT'S REPORT –

It is going to be critical to have the appropriate medical documentation to support the Plaintiff's case.

It is incumbent upon counsel to advise the expert that he or she has the obligation to prepare a report that is even-handed and that the opinion should be based on an objective analysis of the facts. The report must be crafted in order that it is clearly dealing with the germane issues.

It is important that the expert include a caveat that his or her opinion was based on the medical material provided at the time of the examination and the presumed

truthfulness of the individual. This allows the expert to review the matter in the future and if necessary, alter the opinion if new facts arise which may have a bearing on the credibility of the individual or the appropriate diagnosis.

Perhaps it is trite but if someone is going to rely on the medical report in support of one's position, form can be as important as substance. When dealing with the format of the report, it may be helpful to ensure that the report is written in plain English and sets forth a history in a structured and comprehensive fashion. A number of authors have noted that it is advisable if the report includes the following:

- The date of the examination (although this seems obvious, some times doctors never bother to put the date that they saw the individual but simply assume that the reader understands that the date of the report is also the date that the assessment was done and the report was dictated on the same day).
- The length of time for the interview and the actual examination.
- Confirmation that the nature of the assessment was explained to the individual and that his or her consent was secured.
- A list of the documentation that was received and reviewed.
- The writer's comments should be set out after each document is identified. The relevance of the document should be noted and the pertinent facts set out therein.
- A comment regarding whether or not all relevant information was provided and what should be obtained.

- A description as to the physical or psychological examination that was conducted by the expert. If someone else was present, this should be noted.
- The history of the accident as told by the Plaintiff and whether it was based on personal information or as told by others.
- A separate heading dealing with a discussion as to the treatment that was received from the date of the accident up to the date of the examination and comments on whether the treatment was reasonable and appropriate under the circumstances.
- A separate heading for the medical history that predated the motor vehicle accident and the relevant facts in respect thereof.
- A description of the injuries sustained by the Plaintiff.
- The Plaintiff's current health and complaints.
- The physical examination component of the report includes a statement as to who was present at the time. This would be from the point that the Plaintiff walks into the examining room. There should be a complete description as to what exactly was done during the examination process together with details as to the findings.
- The expert should only comment on matters within his or her area of expertise. Sometimes experts cannot help themselves and tend to meander off into areas outside their scope of practice.

- Any conclusions reached by the experts should be supported by information received from the Plaintiff in terms of the history and the resulting symptomology as well as the review of the documents.
- If appropriate, the expert should provide a differential diagnoses and comment on each one separately. The expert can then rule out which of the diagnoses should be disregarded as being less viable explanations of the problem.
- The expert should avoid a legal conclusion. It is not his or her role to interpret the law.
- Any conclusions dealing with issues of credibility should be avoided.
- Criticism of other involved health care providers should be avoided as sometimes it appears that they are personal attacks. There is a professional way of setting out one's difference of opinion.
- Any gaps in the Plaintiff's history or observations made by other treatment providers that contrast with the expert's own findings and observations on examination should be duly noted.
- If the expert makes references to studies or authoritative publications, the same should be listed in the report. The expert must ensure that his or her research is current.

MAKING MEDIATION WORK: MASTERING SUCCESSFUL TECHNIQUES FOR RESOLVING YOUR DISPUTES THROUGH MEDIATION

The topic of dispute resolution, particularly from the perspective of counsel, is one which has become quite popular over the last number of years. The litigants and their counsel are encouraged under past and current Statutory Insurance Regimes and the *Rules of Civil Procedure* to focus their energies and resources towards the mediated resolution of the dispute. Conflict resolution is the buzzword.

The concept of mediation stresses a more pragmatic, open-minded and common sense approach. However, motor vehicle (personal injury) litigation does have its share of potholes in the road that creates a more bumpy experience than mediations involving other tort related claims (e.g. occupier's liability) or contractual based claims (e.g. long-term disability). This is partly as a result of a more positional approach adopted by the Defence, which is rooted in the changes to the Insurance Regime (e.g. Threshold issues/and the ever evolving deductible). The push to use Roster Mediators is becoming more prevalent. While it may be a cost saving measure to some extent, one wonders whether the underlying message to the Plaintiff's counsel is more of a reflection of how the Defence views the merits, or lack thereof, of the claim.

However, the mediation process serves a purpose. At the very least, it does allow the parties to put forth their positions and outline the risks associated with proceeding with the litigation. With respect to dispute resolution techniques and maximizing the benefits of the process, there are certainly ample texts and publications covering this topic, some of which are referred to in the body of this paper.

This paper cannot obviously discuss all aspects of negotiation techniques. The panel discussion will review some of the problems that can arise during the mediation process and suggest some "creative solutions" to overcome the barriers.

GENERAL COMMENTS REGARDING THE APPROACH TO THE ADR PROCESS:

Essentially, there are two approaches to negotiating a settlement. The first approach is known as "positional bargaining". The negotiator does not focus his or her attention on the interests of the other litigant. The counsel, as a matter of habit, adopts a narrow, one-sided focus. The achievement of victory is at all costs and one adopts an uncompromising stance. Little time is spent trying to develop options which satisfy or at least acknowledge the interests of both parties.

One of the flaws of this approach is the suppression of one's creativity. It may cause more harm to the relationship between the parties as it becomes a "contest of wills". The alternative method of dealing with dispute resolution is to adopt an "interest-based" stance. A number of authors have endorsed this particular approach.[36] It is not the author's intention to review in detail mediation techniques. However, it is important to have some understanding as to the different approaches as this forms an integral part to maximizing the benefits of the ADR process itself. From the counsel's

[36] Examples of authors who endorse the problem solving approach are : Robert Fisher and William Ury., Getting to Yes, (Penguin Books U.S.A. Inc., 1991); William Ury, Getting Past No (Bantam Books, 1993); Robert Fisher and Scott Brown, Getting Together - Building Relationships as we Negotiate. (Penguin Books U.S.A. Inc., 1988); William Ury., Getting To Yes With Yourself (Harper Collins, 2015) – the prequel to Getting to Yes

perspective, if the approach proves to be a cost saving measure and facilitates the discussions, then why not adopt it?

THE PRE-MEDIATION PROCESS:

A number of points should be considered before participating in the mediation itself. Some of the factors that may contribute to a successful resolution include:

- Evaluating the tactics that you would use during the negotiation process itself.

- Consider the various scenarios that may be played out during the course of the mediation.

- Ensure that your client is "kept in the loop". It is important that the insurer has a full understanding as to the "worst and best case scenarios".

- It is important to consider your walk-away alternative. The phrase "Best Alternative To Negotiated Agreement (familiarly known as **BATNA**) was quoted by Roger Fisher and William Ury in their two books, Getting to Yes - Negotiating Agreement Without Giving In and Getting Past No - Negotiating Your Way From Confrontation To Co-operation.[37]

- Prior to the commencement of any mediation, one should consider the various alternatives to the negotiated agreement. In order for the negotiation to be considered a success from

[37] Ibid, Note 1

your client's point of view, the option that is arrived at should be at least as good as your **BATNA**.

- If you formalize your objectives before the mediation, you are forcing yourself to consider the possible outcomes. This assists you in making concessions and compromises as the negotiation process proceeds.

- Problem solving requires you to have an understanding of the interests that lie behind each side's position. Interest are the tangible motivations that lead one to take a specific position. What are the other side's needs, concerns and fears?

- Although perhaps difficult to do, it is important that you put yourself in the other side's shoes. How can you possibly modify their way of thinking if you do not understand their perspective of the dispute.

- Consideration should be given to not just the nature of the claim, but understanding the likely approach taken by the other side. Specifically, in cases involving a corporation with a large self-insured retention (e.g. a grocery store chain, a trucking company or a Municipality), there are added challenges. Simply stated, it is their money and accordingly, the approach taken will likely differ from that of a property and casualty insurer. At the mediation, you will likely be dealing with an independent claims adjuster who has limited authority from the corporation. It is important to alert the Plaintiff, before the mediation, to the added challenge. The crucial question is whether or not the claims adjuster has the ability to make a phone call or send an email to the decision

maker during the course of the mediation. In some cases (particularly dealing with claims against a City), the resolution of the matter is held in abeyance until the Claims Review Committee approves the recommended settlement. Again, it is important that the Plaintiff is advised that the matter will not be finalized on the date of the mediation. From past experience as a mediator, it is surprising that the Plaintiff (and in some cases the Plaintiff's counsel), are unaware of the process of trying to obtain final approval.

- It is a mystery to me why there continues to be a practice of late delivery of expert reports. Mediations are routinely booked at least six to ten months ahead of time. The process of obtaining authority is not one that takes 24 hours. In the "good old days," it was a simple process to walk over to one's Claims Manager and discuss the case and obtain authority. That does not happen now. The fact remains that there are committees or levels of authority that have to be considered. At the very least, Plaintiff's counsel should seriously consider serving the expert's report **at least** one month before the mediation. The Defence counsel may not be able to review the report the minute he or she receives it. It takes time to actually sit down and digest the contents of the report and then formulate an opinion and send it to the Claims Representative. That person has many files to deal with on any given day and not surprisingly, it may take a few days for the Claims Representative to actually review his counsel's opinion and look at the report. Time and again, I have been advised by the Defence that receiving an expert's report a week or less before the mediation does not help the process.

The expert's report is not even considered when the Claims Representative tries to obtain authority before the mediation.

- The actual drafting of the Mediation Summary is an extremely important step in the dispute resolution process. The purpose of the summary is to set out counsel's perspective. In reality, the Summary provides counsel with an opportunity to set out the strengths of the case and the risks that the other side faces. Mediation Summaries which just regurgitate what is contained in medical reports is of minimal value. The Summary should highlight not only the opinions of the treating doctors and experts, but as well provide a critique of the other side's position and its experts. The role of the Defence counsel is to obviously explain to the insurer why there may be weaknesses in their position. This is partly designed to ensure that proper reserves are in place. However, there is no harm in reinforcing the position of the Plaintiff by setting out the pitfalls of the other side's position. By the same token, the Defence counsel will do the same. Clearly, the expectations of the Plaintiff must be tempered with the realities of the case. The role of the Defence counsel is to ensure that the Plaintiff understands the risks as well. **Once again, it helps the process if the Mediation Summary is delivered at least one week to ten days before the mediation so that both counsel have an opportunity to report to their respective clients.** In most cases, Plaintiff's counsel does meet with the client at least a few days before the mediation.

THE MEDIATION ITSELF:

What strategies and techniques are implemented during the course of the mediation itself from the counsel's perspective? One consistent theme in the various publications dealing with negotiating skills is the "Art of Listening".[38] As noted by George Fuller:

> *Although failing to be a good listener brings few consequences for most people, that cannot be said as negotiators. For them, listening isn't a social nicety it is a necessity, since there is no room for giving lip service to listening when you begin to bargain.*[39]

Although it may be difficult to do so, it is important for the insurer's counsel to have some understanding as to the other side's feelings and concerns. It is important to begin to address them after their position has been set forth at the opening. An attempt to explore areas of agreement helps to narrow the issues and focus the energies on the more contentious points. One is in a better position to persuade the other side if the latter feels that they have been heard. They are more inclined to listen to you. Simply stated, it costs little to listen and acknowledge the other side's position without making any commitments. Opening the lines of communication and developing a rapport is sometimes half the battle.

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[38] George Fuller, The Negotiator's Handbook, (Prentice Hall, Inc. 1991); Windel Turley, Creating the Right Settlement Environment, Trial Magazine, June, 1994, at 28; Jerry Spence, How to Argue and Win Everytime, (St. Marten's Press, New York, New York, 1995), at 67;

[39] Supra, Note 3, at 55. Mr. Fuller sets out a number of steps that increase your listening skills at the bargaining table. I refer you to page 55 which provides the reader with a number of helpful suggestions.

Normally after the opening statements, it is tempting to react to the position that has just been set out and from your perspective it appears to be irrational or patently unacceptable. One approach noted by William Ury in Getting to Yes, is to step back and "collect your wits, and see the situation objectively".[40]

As noted by Mr. Ury:

> *Imagine you are negotiating on the stage and then you imagine yourself climbing onto a balcony overlooking the stage. The "balcony" is a metaphor for mental attitude of detachment. From the balcony you can calmly evaluate the conflict almost as if you were a third party. You can think constructively for both sides and look for a mutually satisfactory way to resolve the problem. Going to the balcony means distancing yourself from your natural impulses and emotion.*[41]

How can you establish that your negotiation position is a reasonable one? George Fuller has suggested there are certain techniques that can be of assistance when trying to persuade the other side that your point of view is a sensible one:

1. Be positive to persuade - being negative is counter-productive. Act, look, think and talk like you believe in your negotiation objective.

2. Know your facts and present them in a knowledgeable manner.

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[40] Supra, Note 1 at 37.

[41] Ibid, at 37.

3. Make sure you are understood. Talk on a level the other party can understand.

4. Talk to the decision-makers.

5. Never engage in personally attacking your adversary, either directly or indirectly.

6. If possible, support your arguments with reference to third parties as this adds credibility (e.g. experts' reports).

7. Show the other side you can solve the problem they have.

8. Appearance counts. Whether it is a well-prepared written proposal, or neatly addressed negotiator, people are influenced by appearance.[42]

The focus should be on the task of identifying interests and creatively searching for options. One method that has been adopted requires the advocate to search for options by posing questions. This approach allows the counsel to hopefully understand what motivates the other party. One should avoid the use of confrontational and direct questions. As noted by William Ury, the framing of the question should be done in an indirect manner. A number of common questions that facilitate discussion include:

- "Why is it that you want that?"

- "What is the problem?"

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[42] Supra, Note 3 at 70.

- "What you are concerns?"

- "I am not sure I understand why you want that."

- "Help me see why this is important to you."

- "You seem to feel pretty strongly about this - I would be interested in understanding why."[43]

Every negotiator has his or her own style. However, if one approaches the dispute resolution process with an open mind, ears unplugged and employ some common sense, the resolution of the problem is achievable.

SOME BED TIME READING

There have been many books published dealing with the topic of negotiation. It is interesting to note that the authors of the seminal book, Getting to Yes continue to publish further books dealing with the topic. For those of you who have the time to read, here are some books that you may want to consider adding to your library:

- Roger Fisher and Alan Sharp., Getting it Done (Harpercollins Publishers, Inc., New York, 1998). The authors state in the introduction that "The goal of this book is to enable you to achieve high-quality collaboration with your colleagues – collaboration that produces high quality results".

- Roger Fisher and Daniel Shapiro., Beyond Reason – Using Emotions as you Negotiate, (Viking Penguin (USA) Inc., 2005). In the introduction, the authors state that this

[43] Supra, Note 1 at 84.

particular book offers the reader with a way to deal with the problem of controlling one's emotions during the course of negotiation. They point out that emotions can be "distracting, painful, or the cause of a failed agreement". They offer the reader "a strategy to generate positive emotions and to deal with negative ones".

- William Ury., The Power of a Positive No, (Bantam Books, New York., 2007). In this particular book, the author notes that he decided to complete the trilogy that began with Getting to Yes and Getting Past No. He pointed out that the focus of Getting to Yes is on both sides reaching an agreement. The focus of Getting Past No was on the other side and offering strategies as to how to circumvent objections and resistance to cooperation. The third book, The Power of a Positive No, deals with "your side of negotiation" and teaches you how to "assert and defend your interests". This book is described as a life skills and negotiation workbook.

- Gain the Edge: Negotiation Strategies for Lawyers (Latz Negotiation Institute, 2002).

- Getting More – How to Negotiate to Achieve Your Goals in the Real World by Stuart Diamond (Crown Business, 2010).

- The Power of Nice: How to Negotiate So Everyone Wins – Especially You! by Ronald Shapiro and Mark A. Jankowski (Wiley 2001, 3rd Edition, January 27, 2015).

- The 7 Triggers to Yes: The New Science Behind Influencing People's Decisions by Russell H. Granger (New York: McGraw-Hill, 2007).

- How to Win Any Argument: Without Raising Your Voice, Losing Your Cool, or Coming to Blows by Robert Mayer (Career Press, 2005).

- How to Win Any Negotiation by Robert Mayer (Career Press, 2006).

- The 8 Essential Steps to Conflict Resolution: Preserving Relationships at Work, at Home and in the Community by Dudley Weeks, PHD (Penguin Putnam Inc., 1992, New York, New York).

- Bargaining for Advantage: Negotiations Strategies for Reasonable People by G. Richard Shell (Penguin Books, Revised Edition May 2006).

Certainly, there are many books written on this topic. Seminars are routinely organized dealing with negotiation practices. At the end of the day, while it is helpful to have the "tips" from the experts, it really comes down to how you use these tips and deal with the human psychology of negotiation and mediation. It should not be a robotic and mechanical type of process. If both sides attend the mediation with a view to compromise and reasonably assess the risk, then that bodes well for potential resolution. Every case has its own particular challenge. If one adopts an approach that is Realistic, Rational and Reasonable, then perhaps the chance of success will be enhanced.