Strategies for Chronic Pain & Emotional Injuries: Coping With the OMPP Threshold

RICHARD M. BOGOROCH

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1. INTRODUCTION*

Chronic pain cases are challenging, difficult and complex. They are fraught with great risk to both plaintiff's and defence counsel. A chronic pain case represents "a roll of the dice", the outcome of which cannot be predicted with any degree of certainty. The objective of this paper is to assist plaintiff's counsel in taking the "roll" out of the dice.

The Ontario Motorist Protection Plan, which came into effect June 22, 1990, and which hereinafter shall be referred to as the OMPP, has, as a result of the Court of Appeal's decision in Meyer v Bright et al (hereinafter referred to as the "trilogy"), engendered a host of difficulties which require different strategic and tactical considerations. To provide perspective, I propose briefly to canvass strategies and tactics to employ in a chronic pain case arising from car accidents prior to June 22, 1990. (I use the paradigm of a car accident as opposed to a slip and fall or other mishap giving rise to personal injury since, in my experience, chronic pain following a car accident is more frequently encountered than from other traumatic events.)

* I acknowledge with thanks the helpful comments of my associate, Ms. Franceen Rogovein.

2. TACTICAL CONSIDERATIONS IN HANDLING THE CHRONIC PAIN CASE: PRE-OMPP

a. Definition of Chronic Pain

What is chronic pain? Chronic pain, quite simply, is pain which has not abated. It frequently arises in cases where the injured victim sustained soft tissue injuries to the neck or back. The injuries do not improve over time and indeed over a period of time the victim is immobilized by constant pain and discomfort which renders him or her dysfunctional or which severely affects his or her health and general well being. Dr. David Corey in his article "Chronic Pain Syndrome: Identification and Management", defines chronic pain as "pain persisting for more than six months from its onset."[1]

Chronic pain syndrome is indicative of a serious, vocational and psychological disability.[2]

[1] Corey, David: Chronic Pain Syndrome: Identification and Management 1988 9 The Advocates' Quarterly, 223

[2] Ibid. p 224

Corey defines chronic pain as follows:[3]

1. "The chief complaint is of severe and prolonged pain in excess of what could be expected on the basis of organic findings.
2. At least six of the factors listed below are exhibited:
   (a) Diagnosis of a soft tissue injury;
   (b) Multiple symptom complaints, e.g. headaches, fatigue;
   (c) An unsuccessful attempt to return to work;
   (d) Guarded movements or avoidance of many activities, e.g. an invalid like life style;
   (e) Ingestion of multiple analgesics, tranquilizers, etc.;
   (f) Frequent and multiple physician contacts;
   (g) Development of family and marital problems;
   (h) A reduction in or loss of libido;
   (i) Diffuse anger, frustration and irritability;
   (j) Anxiety and/or depressive symptoms;
   (k) Sleep disturbance."[4]

[3] Ibid.

[4] Ibid.

Chronic pain syndrome is not a psychiatric diagnosis such as post-traumatic neurosis, compensational neurosis, psychogenic regional pain or functional overlay.[5] It is a descriptive label for those who are vocationally and/or functionally disabled.

What makes the chronic pain case so difficult is that it affronts our conception of pain, disability and dysfunction. Many people simply do not believe that a motor vehicle collision resulting in minor or even moderate property damage can transform a previously functioning human being into a pain-plagued, medication ingesting and doctor dependent individual incapable of performing his or her usual and customary activities of every day life. Those of us who act for plaintiffs and who have witnessed the devastating effects that a car accident can have on an apparent functioning individual will know that chronic pain is very real and very prevalent. Plaintiff's counsel must understand the nature of chronic pain syndrome, must be able to marshall the evidence necessary to establish the legitimacy of the plaintiff's complaints and must be able to neutralize the force and impact of the defendant's experts in order to persuade the trier of the fact to award the plaintiff fair and appropriate compensation for all that he or she has lost.

Because these cases always present "tough sells" to a judge and jury there is a vast divergence of opinion regarding the value of these cases. If the accident has rendered the plaintiff unemployable and incapable of returning to his or her previous employment,

[5] Ibid. p. 225

and if the plaintiff comes across well, a judge or jury could award the plaintiff hundreds of thousands of dollars, depending, of course, on the nature of the job performed by the plaintiff and his loss of income and future loss of income as calculated by the actuary or other expert. Alternatively, if the plaintiff does not come across well, if the plaintiff's experts are not compelling, if the surveillance carried out on the plaintiff belies the plaintiff's complaints and vividly and illustrates the contradictions between the plaintiff's evidence on discovery and the histories imparted to his physicians, the case could result in the award of a paltry sum to the plaintiff.

Cases which arose prior to the enactment of the OMPP are now making their way through the courts. The comments listed below are applicable to those cases and indeed may apply equal force to chronic pain cases under Bill 164.

b. Establishing Credibility: Choosing the Right Expert

It is essential to have the plaintiff examined for medico-legal purposes by a competent physiatrist or rehabilitation specialist; in particular, one who as part of his practice examines patients at the request of both plaintiff's counsel and defendant's counsel. These specialists therefore bring with them an aura of objectivity and their reports should then be more readily accepted by the insurers and by the courts. If a doctor who does defence medical work examines the plaintiff at the request of a plaintiff's counsel and finds that the plaintiff is suffering from chronic pain, then the report of this doctor will

have greater weight with an insurer and with the court than a doctor who simply sees plaintiffs at the request of plaintiff's counsel and never does any defence medical work.

In addition, prior to arranging for the consultation it is absolutely vital that you obtain the plaintiff's pre-accident clinical notes and records going back five years prior to the accident. These notes and records should be provided to your expert for his review. There is nothing worse than proceeding to trial when your expert has not been provided with a complete medical history of the plaintiff and his report therefore is based on a partial or inaccurate or incomplete medical history. In that situation there is a strong likelihood that your expert's opinion will be given less weight than the defendant's expert.

In addition, it is essential that once you are in receipt of any further defence medical reports that your expert review the defence medical reports and thereafter provide you with this or her comments, review and critique of the defence doctor's findings, opinion and conclusion. It is an ongoing process to ensure that your experts are provided with up-to-date information.

The family doctor should then be provided with a copy of your medical report for his assistance and for his comments and review. The family doctor should be asked whether he agrees with the specialist's findings, opinions and conclusions.

Recommendations regarding the ongoing treatment of the plaintiff should be canvassed with the family physician.

As can be seen, handling the chronic pain case requires plaintiff's counsel to be active, interventionist and innovative. Intervention should not involve directing the plaintiff's medical care, which is not ethically appropriate; however it does and should take the form of ensuring that there are no miscommunications between the various physicians involved with the plaintiff's case.

Conveying Credibility: The Importance of Lay Witnesses

In all cases, not only in chronic pain cases, it is essential that the plaintiff be found to be credible person worthy of the court's sympathy, compassion and generosity. How is this accomplished? The tried and true way is to lead evidence through friends, relatives and co-workers about what a good fellow or good woman your client is, how credible that he or she is, changes that the witnesses have observed in your client's personality since the accident, how the accident has affected your client, etc. It is absolutely essential that you call the family members, particularly if the plaintiff has a spouse and children. They must testify at trial as to the impacts of the accident on them and, as well, and perhaps more importantly their observations of the changes that have occurred to the plaintiff since the accident. Friends and relatives are also extremely important witnesses in this regard. You must elicit from the family doctor and any other treatingphysician the physician's views of the plaintiff as a credible and honest person

who is genuinely in pain. Each expert should reinforce the other. For example, you may ask the treating physiatrist whether he agrees with the family doctor who testified that the plaintiff is an honest and sincere individual who is genuinely experiencing pain. Extracts of an examination-in-chief of a plaintiff's treating physiatrist, together with extracts of a cross-examination of the defence doctor are appended to this paper to illustrate how these basic techniques are employed.

c. Effect of Surveillance

In virtually every chronic pain case there is surveillance. Not all surveillance is harmful. Harmful surveillance, in some cases, can be explained away. My advice to counsel and my advice to my client is not to be overly concerned unless the surveillance contradicts in a material way what the plaintiff said on discovery or what the plaintiff told his doctors. That does not mean that the surveillance is to be ignored. It all depends on what is depicted I the video. Obviously, if the plaintiff claims that he or she is suffering from the most excruciating back pain preventing him from doing any type of physical activity and the video shows him helping a friend load furniture onto a van, then you may have problems. You are not "dead" but the case may be on "life support", unless it is established, of course, that the plaintiff tried to do something that he should not have done, he was told not to do, and paid the price in "spades" for trying to be a good Samaritan. You need an extremely compelling explanation from your client; otherwise there is a good chance that if this case went before the jury it would be equivalent of Mitch Williams serving up his famous pitch to Joe Carter in Game 6 of the World Series.

However not all surveillance is harmful. Surveillance can be explained away as being a brief and inaccurate “snapshot” of a brief moment in the life of the plaintiff or it may not correlate with a precise day, month or year in which the plaintiff states he was so disabled. Much of surveillance is inconclusive. It shows the plaintiff walking and doing things that he normally can do. It does not, of course, depict or in any way portray the pain which the plaintiff may be experiencing. In chronic pain, the pain is subjective and is not really captured by the camera lens.

In addition, chronic pain plaintiffs are not generally invalids; they are able to function, albeit their function is limited, and their ability to function at their employment is restricted. Surveillance is a two-edged sword. Unless the surveillance is extremely damaging to the plaintiff by highlighting a blatant contradiction between the plaintiff’s evidence of Discovery and the histories disclosed to the physician, counsel should be concerned about but should not be panicked by the surveillance.

At trial, it is essential, of course, in the cross-examination of the videographer to establish the following:

1. whether the film was in any way edited;
2. whether the camera was running throughout the time of surveillance;
3. whether the operator of the video camera or the investigator filmed everything or filmed selective aspects of the plaintiff's movement;
4. when precisely was the surveillance taken;
5. why there are no close-ups of the plaintiff's face which may portray pain.

All of these questions may help to cast doubt on the credibility, reliability and objectivity of the surveillance video.

It may be flippant to say but surveillance videos may actually prove a drawback. In the United States, in the Rodney King trial, despite overwhelming video evidence, the jury acquitted the police officers at the first trial. In the Reginald Denny case arising from the Los Angeles riots, despite overwhelming evidence of the attempted murder of Reginald Denny, the defendants were acquitted of the most serious charges and were convicted only of relatively minor offences. There is a joke in New York which is a cynical but telling comment on the American criminal justice system, that the World Trade Centre bombers would have a good chance of being acquitted had their alleged actions and the alleged bombing of the Trade Centre been videotaped.

d. Neutralizing the Defence Expert

Mr. Justice Rand once said that the trial is “not a tea party”. Chronic pain cases are the most difficult, complex and hard fought cases and plaintiff’s counsel must be strong, courageous and vigorously pursue their clients’ cause. To paraphrase Ross Perot, “it is clear to anyone over the age of six years old” that there are doctors who are known as defence doctors and there are doctors known as plaintiff’s doctors. There are some doctors used by the defence counsel who invariably find that there is no such thing as chronic pain, who invariably find that the plaintiff is a malingerer, and who invariably find that the plaintiff is motivated by secondary gain. These doctors are not known to do any plaintiff’s work. Their objectivity may be compromised. It is submitted that it is perfectly appropriate to subpoena these doctors’ diaries to establish in cross-examination that these doctors are not independent medical experts as contemplated by Section 105 of the Courts of Justice Act, but are simply captives of the defence bar and whose practice consists only of examining injured victims at the request of defence. There may be vigorous and vociferous arguments in opposition to production of the diary, but in the war to secure justice for the injured victim I think it is a tactic worth taking. There is little left in the plaintiff’s arsenal to counter the overwhelming impact of OHIP summaries, clinical notes and records and costly and extensive surveillance and investigation carried out by the defence.

The courts have said time and time again that the clinical notes and records of the plaintiff’s treating health care providers are producible not only from the date of the

accident, but generally form one, two, three, four and five years pre-accident. Clinical notes and records secure the ends of justice, but at the same time, any pre existing medical condition, no mater how tenuous its relationship is to the injuries sustained in the car accident, are dredged up and thrown into the mix to qualify, weaken and otherwise belittle the extent of the plaintiff's claim, and used to delegitimize the plaintiff's claim for justice. Lastly, I recommend that computer searches be conducted to discover all cases in which the defendant's expert testified. Examine the cases. There may be instances in which the defendant's expert's opinion was not followed by the court. Indeed, there may be occasion when the expert was criticized and his or her objectivity questioned.

3. STRATEGIES FOR COPING WITH THE ONTARIO MOTORIST PROTECTION PLAN

IS CHRONIC PAIN PHYSICAL OR PSYCHOLOGICAL?

a. Is Chronic Pain Physical or Psychological?

Section 266 specifically excludes psychological injury. The symptoms may be physical or psychological or partly physical and partly psychological. Labels are used somewhat carelessly. The plaintiff may be diagnosed as suffering from chronic pain, posttraumatic stress disorder, fibrositis, fibromyalgia, psychogenic regional pain and depression. The diagnosis may vary but if the health care providers are of the view that what ails the plaintiff is depression and/or psychological distress or emotional stress and not

accompanied by any corresponding physical injury, the plaintiff's claims may likely not meet the threshold, or as the Court of Appeal prefers "may not fall" within the exceptions to Section 266 of the Insurance Act. In such situations the plaintiff is out of luck and out of court. The plaintiff who is exhibiting features of chronic pain and is suffering from depression, should not be defined by someone's labels. If he or she is in pain and incapable of functioning, then, it is arguable, the plaintiff suffers from chronic pain.

If the pain is persistent and if the pain totally prevents the plaintiff from performing the essential duties of his or her occupation, then adopting the reasoning of the Court of Appeal in the "trilogy" the chronic pain may be a "permanent serious impairment of important bodily function".

It is essential that you educate the health care provider. It is professionally proper to speak to them ask the physician whether the problem is also physical. Refer the plaintiff to physiatrists or rehabilitation consultants who have experience in chronic pain cases.

b. Financing the Lawsuit – Understanding the Risk Factors Involved

The OMPP has made it very difficult for chronic pain sufferers to receive justice. Prior to the passage of the OMPP, the chronic pain sufferer would have access to legal representation despite the cost of prosecuting a chronic pain case because the availability of compulsory automobile insurance made it certain that the plaintiff would

be compensation out of which he would be able to pay his lawyer. Make no mistake about it. If the plaintiff's lawyer were not willing to finance the case and spend, in many cases, tens of thousands of dollars over the course of many years, cases would never see the light of day. The OMPP changes things. Chronic pain cases are prohibitively expensive. Preparing a case competently and thoroughly costs upwards of $30,000.00 to $40,000.00 and this does not include the cost of taking the case to trial. Actuaries, psychologists, neuropsychologists, do not come cheaply. Their reports run into the thousands of dollars in lawyer times, clerk and student's times will have been expended. Most people are of modest means. Even those who are well off financially would be hard-pressed to afford the cost of taking a chronic pain case to trial. With the OMPP, few of these cases will make their way to court. There are few lawyers who can afford to take on these cases through the many years of the litigation parties. It is unlikely that there will be many chronic pain cases testing the interpretation of the threshold.

c. Using the Rehabilitation Consultant to Build your Case

Having said that, selectivity and care must be exercised by plaintiff's counsel. Clients should be advised every step of the way of the cost of the litigation so that he or she is appraised and not taken by surprise years later after having gone to trial unsuccessfully. If you desire to go forward with a chronic pain case it is absolutely critical to ensure that the right experts are chosen. Start preparing for trial as soon as it is apparent that the plaintiff is developing chronic pain syndrome. Generally, the plaintiff will have been unemployed since the accident. A useful source of information regarding the plaintiff's

condition can be obtained by obtaining the rehabilitation file from the rehabilitation consultant. Generally, the accident benefits insurer will retain the service of rehabilitation consultant in order to return the plaintiff to the work force.

The plaintiff will also, even before retaining you, have seen the doctors at the request of the accident benefits insurer. Upon being retained, obtain the file from the rehabilitation consultant. Look at the reports from the doctors who have examined the plaintiff. You will learn the plaintiff's pre-accident history and vital information to assist you in making your determination to accept the case will be found within these reports. If the reports of the Rehabilitation Consultant are not harmful to the plaintiff's case, than you are halfway to deciding whether to take on the case on behalf of the plaintiff. It all depends on what the plaintiff. It all depends on what the plaintiff does, how much the plaintiff earns, what prospects of returning the competitive employment are.

Whether to proceed with the plaintiff's case is quite frankly, a gamble.

If the decision is made to take on the plaintiff's case and there are nothing preventing you, have the plaintiff's case managed by a rehabilitation consultant of your choosing. The plaintiff has a right to choose a rehabilitation consultant of his choice. The assistance of the rehabilitation consultant, together with the reports of physicians to whom the plaintiff has been referred and by the rehabilitation consultant, may provide a clear indication of the plaintiff's medical condition. Consultants and doctors may be in a

position to advise you whether in their opinion the plaintiff can return to his or her employment, or, if not, whether the plaintiff can be retrained. It must be borne in mind that in the "trilogy", the Court of Appeal indicated that the question whether the impaired bodily function is "important or serious" is a determination to be made with reference to the particular plaintiff. Although the court disapproved of a "subjective or objective approach" in essence a subjective analysis of the impact of the accident on the plaintiff's vocational functioning is precisely what must be conducted.

The Court indicated that the legislation is directed to bodily functions that play a major role in the general health and well being of the injured plaintiff. What must be looked at is the "injured person as a whole" and the effect the bodily function involved has on a person's way of life.

For example, a neck or back injury may prevent a bricklayer who loved his job, and who enjoyed being a bricklayer from working as a bricklayer. The inability to function as a bricklayer or as a general labourer is no less important than the inability of a concert violinist to perform as a violinist because of an injury to the little finger of the left hand.

A serious impairment is one, which causes a substantial interference with the ability of the injured person to perform his or her usual daily activities, which he does in his or her regular employment.

On-going back pain, neck pain, depression and headaches seriously impair a brick layer, a labourer, a construction worker, bulldozer operator, fork lift operator, taxi drive, assembly line work, printer, lithographer, etc. from performing his or her usual occupation.

If the evidence is that the injured person enjoyed his or her vocation, and even if the injured person can be retrained to a more financially lucrative career, the impairment will still be considered serious.

In the context of the chronic pain cases, if the plaintiff's physicians, the rehabilitation consultants, doctors retained by plaintiff's counsel for medical-legal examination, confirm that the plaintiff cannot perform the regular duties of his or her occupation, the plaintiff's chronic pain may constitute a serious impairment of an important bodily function.

What will limit the force of the plaintiff's argument, indeed, what will be potentially destructive of the plaintiff's case, is the surveillance which will belie the findings, opinions and conclusions of the plaintiff's doctors. Surveillance photographers or videos which portray a plaintiff engaging in strenuous physical activities which the plaintiff said he or she could not do may ultimately make the plaintiff's case a <u>gamble not worth taking</u>.

It is trite that chronic pain cases will engender much surveillance. It is therefore, prudent to advise your client early on in the process that he or she may be placed under surveillance and to expect that he or she may be followed by investigators hired by the insurer. I always tell my clients to live their life normally. There is nothing they can do. The insurer has a legitimate right to hire investigators in order to determine the legitimacy of the plaintiff's claim. The surveillance must not be oppressive or otherwise constitute harassment. Other than that the plaintiff must accept it.

If in fact the surveillance is damaging, the decision will be made whether to continue with the case to discovery, and plaintiff counsel should write to opposing counsel requesting details of any surveillance. The request should be repeated every few months. In keeping with its obligation under the Rules, all parties have a continuing obligation of disclosure. If surveillance has not been carried out at the time of discovery, but, if carried out subsequently, the defence has an obligation to disclose the surveillance.

4. CONCLUSION

Chronic pain cases are challenging, interesting and very difficult. Be prepared. They represent a “roll of the dice”. It is hoped that this paper will provide assistance to those trying the chronic pain case and that the recommendations and suggestions set out herein will help “even out the odds”.

5. APPENDIX

A. EXTRACTS FROM THE EXAMINATION IN CHIEF OF THE PLAINTIFF'S TREATING PHYSIATRIST

B. EXTRACTS FROM THE EXAMINATION IN CHIEF OF THE PLAINTIFF'S CONSULTANT ORTHOPAEDIC SURGEON

C. EXTRACTS FROM THE RE-EXAMINATION OF THE PLAINTIFF'S CONSULTANT ORTHOPAEDIC SURGEON

D. EXTRACTS FROM THE CROSS-EXAMINATION OF THE DEFENDANT'S ORTHOPAEDIC SURGEON

E. REPRINT OF COREY, DAVID: "CHRONIC PAIN SYNDROME: IDENTIFICATION & MANAGEMENT"
(1988) 9 THE ADVOCATES' QUARTERLY, 223

APPENDIX A. EXTRACTS FROM THE EXAMINATION IN CHIEF OF THE TREATING PHYSIATRIST.

in-ch (Bogoroch)

would bring that on?

A. A lot of causes. Simple activities, household activities can bring them on, to injuries from being in a car accident. There are numerous causes.

Q. On this occasion did you feel her ongoing symptoms were consistent with the mechanism of the accident and the injury sustained in the accident?

A. Yes.

Q. Did you feel her symptoms were caused by the accident?

A. Yes.

Q. Did you continue to see Mrs.

A. Yes.

Q. When was the next time?

A. She was seen on the 14th of June 1990, and that point she said throughout the past summer she had increasing symptoms of pain.

THE COURT: What's the date?

A. June 14th, 1990.

Q. And in the past summer?

A. Last summer, referring to the summer of 1989, she had gradually increasing symptoms of pain. Around September she was in a lot of pain. She was treated mostly under the care of Dr. with conservative measures.

Two months prior to seeing me she stated her symptoms of pain had gotten worse and she experienced increasing symptoms of pain down to the right lower extremity, describing the pain from the buttock to the thigh, calf, foot and ankle joint. She reported numbness which has been quite significant, and she reported significant restrictions in the

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motions and could not sit for any length of time, bend forward, and these motions would aggravate the pain.

MR. BOGOROCH:

Q. Did you believe those symptoms were genuine?

A. I did.

Q. In your experience, have you ever come across malingerers or people who exaggerate?

A. Not uncommon.

Q. Had you regarded Mrs. at that time as exaggerating her symptoms in any way?

A. Not at all.

Q. Did you do any diagnostic tests, such as X-rays, to assist in your diagnosis?

A. Yes, we performed two tests. One was an EMG study to assess the state of the nerve, which has been affected, and I felt she would require what is called a CAT scan to assess the mechanical aspects of the spine.

Q. Were those tests carried out?

A. The EMG was performed on 5th July 1990, and the CAT scan performed later on, on August 10th, 1990.

Q. Can you tell us the results of those tests?

A. The EMG studies were essentially normal. There was no indication of nerve damage. The CAT scan was also normal in the sense it didn't show any surgical lesion.

Q. Is the fact that they were normal significant?

A. Significant in terms….

Q. Of your diagnosis?

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A. No.

Q. The fact they were normal didn't cause you to alter your diagnosis?

A. No.

Q. As a result of these diagnostic tests, what was your diagnosis?

A. Mechanical back pain.

Q. Did you continue to see Mrs.

A. Yes, she was seen on a few other occasions.

She was seen on the 12th of November 1990. She complained of marked pain and discomfort in the low back, and she continues to have pain to the right lower extremity and continues symptoms of numbness, and also noted cough, sneeze and bowel movement also aggravate the pain.

Q. Did you do an examination on that occasion?

A. Yes, and she demonstrated a positive straight leg raising test, and mildly positive bowstring sign on the right side, but the neurological examination was intact.

Q. Did it cause you on this occasion to change your diagnosis at all?

A. No. It basically reconfirmed my diagnosis.

Q. Did you continue to see Mrs.

A. Yes.

Q. When was the next time?

A. February 27th, 1992.

Q. What complaints, if nay did you make on that occasion?

A. On this occasion she had increasing symptoms of pain in the shoulder, but this was more prominent and specifically to the right shoulder area, and she continues to have pain to the lower part of the back. She reported recurrence of headaches, and she also

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commented Amitriptyline has allowed her to live with both the headaches and insomnia, and she also had been continuing the exercise program in the pool.

Q. Did you do an examination on this occasion?

A. Yes.

She continued to have persistent tenderness described as into her neck, shoulder, back area, and marked tenderness corresponding to the occipital nerve, and demonstrated positive impingement sign to the right shoulder.

Q. Did you relate those findings to the car accident?

A. Yes, I did.

Q. Of September 8, 1987?

A. Yes.

Q. Based upon your examination at that time and your examinations in the previous years, are you able at this time to advise us what your diagnosis was?

A. That she has suffered whiplash and continues to suffer recurring symptoms of myofascial pain following the accident and has recurring symptoms of pain to the right shoulder and pain to the back area.

Q. The trouble with the right shoulder, how can that result from this accident?

A. This is a very common known factor. People develop fibromyositic disorder and they develop myofascial pain syndrome, and it refers t specific points in the shoulders and elbows and heels.

Q. In terms of your diagnosis and prognosis, would it make any difference to your diagnosis that there may have been a gap in the experiencing of back pain, that it may have come earlier and improved and then disappeared and was quiet for several months, over about a year, would that change your diagnosis?

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A. Especially knowing the fact the CAT scan was normal, no.

Q. It doesn't mean it has disappeared?

A. No. It doesn't mean it has disappeared.

Q. Can you tell us, based upon your several years of treatment of Mrs. , the complaint she made to you and your own objective findings and your own examinations that you conducted, can you tell the court, first of all, whether her complaints are consistent with injuries sustained in the car accident of September, 1987?

A. Yes.

Q. In your opinion, are the current complaints and symptomatology caused by the car accident of September 8th, 1987?

A. Yes.

Q. Can you help us in terms of your prognosis for what the future will be for this lady, and it is now over four-and-a-half years?

A. I think she will continue to experience pain, as she has, in a fluctuating manner, and this can lead to what is described as a chronic pain syndrome, which means pain, plus the dysfunctional component, plus the emotional component.

Q. Do you agree with the diagnosis of chronic pain?

A. Yes.

Q. Do you agree that this lady has chronic pain?

A. I believe now, reviewing the history over the past four years, I think she is definitely at that stage now.

Q. Would there be any difference in your opinion that you found physical findings and some doctor would not find physical findings? Would that cause you to change your opinion with respect to your diagnosis?

A. No.

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Q. Why not?

A. There is a great deal of variability in observation and physical assessment, and it wouldn't influence my opinion.

Q. You are saying doctors can disagree?

A. Definitely, very commonly.

Q. During the four years since you started treating Mrs. and you started in 1988, can you tell us what your overall impression is of this woman now?

A. I think she truly is suffering from symptoms of pain and her symptoms I have always been able to verify with objective findings. I think there has never been a question on her honesty or truthfulness of the statements, and I believe she will continue to suffer form pain.

Q. Is she a person, in your opinion, who legitimately and sincerely wants to get better?

A. I think so. I definitely believe, yes. She has certainly followed all the recommendations and procedures we have recommended. She has been a very compliant patient.

Q. Do you believe what she is suffering from is temporary or permanent?

A. I think it would be long term permanent.

MR. BOGOROCH: Thank you, no further questions.

MR. EDWARDS: May I have an opportunity to review the doctor's file, your honour?

THE COURT: How long will that take?

MR. EDWARDS: It shouldn't take long.

THE COURT: Can we finish by about 5:00?

MR. EDWARDS: I hope so.

in-ch (Bogoroch)

--- Court recessed at 4:20 p.m.

--- Upon resuming at 4:30 p.m.

CROSS-EXAMINATION BY MR. EDWARDS

Q. You have prepared reports in this matter dated May 3rd, 1989, and October 24th, 1990. Those have been entered into evidence as part of Exhibit 1. Those are reports you provided to my friend, Mr. Bogoroch?

A. Yes, that's correct.

Q. In addition to those reports, you would have been providing written correspondence to Dr.

A. That's correct.

Q. And those letters or reports to Dr. would essentially be the same as what is contained in those letters to

APPENDIX B. EXTRACTS FROM THE EXAMINATION IN CHIEF OF THE PLAINTIFF'S CONSULTANT ORTHOPAEDIC SURGEON

- in-ch (Bogoroch)

Q. Tell me the results of the examination.

A. I found that the examination revealed no abnormalities of significance in physical terms.

Q. Did that cause you any concern?

A. Well, I think it strengthened my feeling that Mrs. pain was not based any further on any significant physical problem.

Q. Were you able at that time to come up with a diagnosis of what was bothering Mrs.

A. Well, I think that she was suffering from chronic pain, and this is very unusual diagnosis for me to make, but that's what I would call it.

Q. Do you have experience in chronic pain cases?

A. Yes.

Q. During the course of your years working for the Workmen's Compensation Board and your practice, have you seen many cases of chronic pain?

A. Yes.

Q. Describe what chronic pain is?

A. Chronic pain, by definition, is pain that lasts for an unduly long period of time. It may or may not be based on physical causes. In the absence of physical causes, it is based on the perception of pain by an individual, perception being that they feel the pain, they suffer the pain, but the pain is not being caused by conventional or orthodox ideas, disease.

Q. For example?

- in-ch (Bogoroch)

- in-ch (Bogoroch)

A. For example, a person can have a long period of chronic pain, or actual physical disease, like a chronic disk protrusion. On the other hand, a disk protrusion may have healed a long period o time before, but people continue to complain of the same type of symptoms, and there is no evidence that they are consciously magnifying or exaggerating their difficulties. They're feeling the pain and suffering the pain and they are winding up with the same disability they would have had had they the same organic or physical problems.

Q. Is it a recognized disease within the medical community, chronic pain?

A. Yes.

Q. You have seen many cases of chronic pain?

A. Yes.

Q. In your experience, do people suffer from chronic pain situations such as Mrs. Have you encountered that before?

A. Yes.

Q. It's not unusual?

A. I think it's a diagnosis I make rarely.

Q. Are you convinced of your diagnosis?

A. Yes, I am.

Q. What do you think the future holds for Mrs. It is now April, 1992.

A. My feeling is that Mrs. will continue to have the same symptoms basically that she has now, the same degree of disability, and that she will not deteriorate, and I do not feel she will improve.

Q. In other words, you think she is at a plateau?

A. Yes.

- in-ch (Bogoroch)

Q. Can you tell us or assist us how long you think she will be at this plateau?

A. I think it is going to be indefinite.

Q. Do you have an opinion whether this chronic pain is caused by the car accident of September 8th, 1987?

A. Yes, it is my view that the chronic pain was precipitated by the events of the 8th September, 1987.

Q. You have seen her on a number of occasions. Has your opinion of her believability, truthfulness, changed at any time during the course of the years you have examined her?

A. No.

Q. Today, what is your final opinion of Mrs. as a person?

A. I think she has been a credible witness to her dilemmas and that she is an honest individual who feels the problems she is suffering and feels the pain and is truly disabled because of it.

MR. BOGOROCH: Thank you, no further questions.

MR. EDWARDS: May I have a moment to review the Doctor's file?

THE COURT: Yes. Let's stretch our legs for five minutes.

--- Court recessed at 3:10 p.m.

--- Upon resuming at 3:15 p.m.

THE COURT: Cross-examination.

- in-ch (Bogoroch)

CROSS-EXAMINATION BY MR. EDWARDS:

Q. I take it you have seen countless patients similar to Mrs. over the years?

A. Yes.

Q. You have seen them both for the plaintiff's side and for the defence side?

APPENDIX C. EXTRACTS FROM THE RE-EXAMINATION OF THE PLAINTIFF'S CONSULTANT ORTHOPAEDIC SURGEON.

re-ex (Bogoroch)

In determining the nature of Mrs. ongoing pain?

A. None.

Q. Would the presence or absence of headaches in any way change your opinion about the chronicity of her pain?

A. No. I was concerned about musculoskeletal pain explicitly.

Q. You have mentioned one thing in cross-examination I want to discuss with you. There was evidence earlier that Mrs. had pain right after the accident in her back and on her neck. For a period of time, whether six months or twelve months or twenty months, she had no back pain, would that cause you any change in your opinion?

A. It would if I was concerned about the physical aspect, but I think, as I have stated, that shows pain in her back and her leg which is not, on the whole, based on physical reasons and physical disease.

Q. In your opinion, if you can clarify it, has your opinion in any way been changed by any discrepancies in the doctor's reports, or anything else. You are an expert on orthopaedics. You have examined her on several occasions and spent one hour the first time and thirty minutes on subsequent occasions. That's a fairly lengthy period of time.

A. Correct.

Q. Dr. sees about 60 patients a day.

A. Really.

Q. Does that surprise you that there would be some mistakes in his notes?

re-ex (Bogoroch)

A. No.

Q. Based upon what you heard in terms of some changes in the history, or different factors in terms of the history, based on your own clinical findings, is there anything you have heard which would affect your opinion as to the causation of her problems?

A. No.

Q. What is your opinion as to the causation?

A. I feel the accident caused her back pain and sciatica.

Q. You have mentioned sciatica.

A. Sciatic-like pain.

Q. Do you have any opinion as to the neck area, what caused that?

A. The car accident, I feel.

Q. Do you wish to change your opinion based upon what came at you in cross-examination?

A. No, I don't.

MR. BOGORACH: Thank you.

THE COURT: Thank you very much, Doctor.

--- The doctor withdraws.

CERTTIFIED,

A. Black, C.S.R.

APPENDIX D. EXTRACTS FROM THE CROSS EXAMINATION OF THE DEFENDANTS' ORTHOPAEDIC SURGEON

cr. ex.

Doctor, isn't it true that on the 22nd of April, you were served with a subpoena by our office to attend in court on the 27th of April?

A. I can't remember. I get two or three subpoenas a week.

Q. Well, I'm showing you a subpoena. I'd ask you to identify it for the court.

A. Yes.

Q. Is that the subpoena that you were served with?

A. I presume so, yes.

Q. All right. And that subpoena ordered you to attend court on the 27th of April, true?

A. Yes.

Q. And you did not attend?

MR. EDWARDS: Well, Your Honour –

THE WITNESS: I was –

MR. EDWARDS: -- we all know what the situation here is. I'm not sure that this goes to the credibility of this witness's evidence.

MR. BOGOROCH: It –

MR. EDWARDS: My friend is at liberty to ask the questions, but I – really all he's doing is seeking to embarrass the doctor. And I'm not sure that we get anything from this, quite frankly.

THE COURT: Well, I don't know either but he's able to ask the questions. Cross-examination is broad. Broad reaching. Go ahead.

MR. BOGOROCH:

cr. ex.

Q. Doctor, you didn't attend in court on the 27th, did you?

A. No. I was in Berlin.

Q. You did not advise our office that you were not attending in court on the 27th, true?

A. I don't think I advised your office, no.

Q. Right. You didn't advise our office.

Doctor, take a look at the subpoena. If you'll note, it commands you bring your diary and appointment book for the 1991 calendar year.

A. Well, that's a new one.

Q. Do you have your 1991 calendar hear today?

A. No.

Q. Do you have your appointment book here today?

A. No.

Q. Doctor, this touches on professional obligation. And you've testified many times before the courts?

A. Yes.

Q. Subpoenas are to be obeyed?

A. Yes.

Q. They're not just for little people; you have to come – you have to obey the subpoena?

A. Yes.

Q. And you didn't obey the subpoena?

A. No.

Q. Doctor, it will be up to His Honour to decide about your professional responsibilities and how you discharge them, but isn't it a fact, doctor, when you've testified

before in the past, judges have brought to your attention or have made comments about your objectivity and your fulfillment of your function as an expert witness? True?

A. I beg your pardon?

cr. ex.

MR. EDWARDS: Well, Your Honour, before the witness answers, surely that's for Your Honour to decide, whether this witness is giving objective evidence.

MR. BOGOROCH: Well –

MR. EDWARDS: If my friend is intending to call evidence as to what other judges have said, then I certainly call upon him to do so.

MR. BOGOROCH:

Q. Well, let me read to you, Dr. What Mr. Said in a case called Samples and Wellesley Hospital.

A. Yes.

Q. You're familiar with Wellesley Hospital?

A. Yes.

Q. You gave evidence in the Samples case, didn't you?

A. I can't remember.

Q. That was the injury to the wife of the British High – the British trade commissioner, who injured herself in the Wellesley Hospital. Remember?

A. I vaguely remember the case, yes.

Q. Let me read what Mr. said.

MR. BOGOROCH: Your Honour, for your assistance, it's at page 10.

MR. EDWARDS: I'm objecting, Your Honour. I see no possible relevance, because you're the sole judge, I would respectfully suggest to Your Honour, as to the objectivity of this particular witness.

MR. BOGOROCH: This is –

THE COURT: I am at this time in this case. I agree with you there.

MR. BOGOROCH: I can put – Your Honour, it's my submission I can put to the witness questions raised about his objectivity in previous cases. That goes to the overall question of his credibility and his objectivity.

THE COURT: I agree. Go ahead.

MR. BOGOROCH: Thank you.

Q. Let me read what Mr. said on page 10:

> "I have no reason to not accept all that which Dr. said at trial or has written in his report. To my mind, he was an impressive expert witness; and I prefer his testimony over that of Dr.
>
> . I was not given any explanation as to why Dr. made no mention in his first report of post-polio syndrome. Rather he endeavoured to explain Mrs. Loss of considerable strength as being due to the 'passage of years', and 'the increasing weakness of old age'. He did allow that the fracture had speeded up 'this process'. But it was not until more than two years had gone by that Dr. reported on the 'so-called Post Polio Syndrome'. As I have noted above, he said then, the 8th of January, 1987:
>
> "This lady's biggest problem is her inability to walk. This is caused by the Post Polio Syndrome.'
>
> He concluded that report by repeating a portion of the summary contained in his first report that post-polio syndrome complicated 'the weakness that would come with increasing age'."

cr. ex.

This is what Mr. said:

> I would like to think that Dr. opinions from the outset have not been compromised by an application of a lesser degree of objectivity than is required of an expert witness."

Do you recall that doctor?

A. I'm not sure what you're asking me. Are you asking me whether the post-polio syndrome was valid or not?

Q. I'm –

A. Because there is considerable medical controversy as to whether there is such a thing as a post-polio syndrome.

Q. I'm asking – in that case you testified on behalf of the defence, correct?

A. I can't remember.

Q. Let me refresh your memory. You testified on behalf of the defence, Wellesley Hospital, which was being sued.

A. Maybe. Yes, if you say so.

Q. All right. Was it brought to your attention, the judge's comments about your objectivity?

A. This is the first I've ever heard of it.

Q. Do you know who Mr. is?

cr. ex.

A. No.

Q. It may interest you to know he was one of the senior partners in my friend's law firm.

MR. EDWARDS: What does that have to do with apples and oranges?

THE COURT: I'm not concerned with that.

MR. BOGOROCH:

Q. Doctor, I'm talking –

THE COURT: He's on our court. We're all aware of that.

MR. BOGOROCH:

Q. Dr. I'm concerned, too, about objectivity. I have had research done in terms of objectivity, because I understand the bulk of your practice is doing work for the defence. True?

A. Since –

Q. Defence medical work.

A. Since the Peterson – the no-fault insurance. Before that, it was 50 per cent plaintiff and 50 percent defence. As you well know, there is virtually no plaintiff's stuff available since Mr. Peterson cured chronic pain.

Q. I submit to you that the bulk of your work – answer the question, please.

A. Yes, now it is.

Q. The bulk of your work is for the defence?

A. Now, yes.

cr. ex.

Q. And I understand that you do defence medical work for the vast majority of the defence firms in Toronto, true?

A. Probably. I don't know.

Q. All right. Rarely do you do plaintiffs' work?

A. There is no plaintiff working going on about and hasn't been since no-fault insurance came in.

Q. Well, doctor, that's for somebody else to decide, and I submit to you – I'll put it to you that there is plenty of plaintiffs' work. This accident took place, doctor, before the application of the no-fault, correct?

A. Well, at that time, I was seeing 50 per cent plaintiff and 50 per cent defence. Just to protect myself from such an argument as you are bringing up.

Q. Be honest, doctor. You're telling me that prior to 1990, 50 per cent of your defence – of your consulting work was for the plaintiffs and –

A. It was indeed.

Q. And Dr. whom you respect, felt she has chronic pain?

A. Yes.

Q. You don't believe in chronic pain?

A. No, I do not believe in chronic pain. Mr. Peterson cured it.

Q. All right. You could be wrong, and Dr. could be right.

A. Yes.

Q. Do you accept that?

A. Yes.

Q. And Dr. K -- have you heard of Dr. K

A. Yes.

Q. He's the co-ordinator of the pain clinic at Scarborough Grace Hospital?

cr. ex.

A. Yes.

Q. He felt also that she has chronic pain.

A. Yes.

Q. He could be right, and you can be wrong?

A. Yes.

Q. Dr. has testified that she has chronic pain. You're familiar with Dr.

A. Yes. That's Dr. standard diagnosis.

Q. All Right. You're familiar with it?

A. Yes.

Q. He's a reputable psychiatrist?

A. He's a psychiatrist. I have no idea as to his reputation.

Q. All right. He says she has chronic pain. He can be right, and you can be wrong?

A. Yes.

Q. Now, you just don't believe in chronic pain period?

A. No. I have great difficulty in believing in it. It's like believing in fairies dancing on the head of a pin.

Q. All right. Now, you don't have your diary with you today, so you can't tell us how much time you spent with Mrs. can you?

A. No, I cannot. I can give you a rough estimate. Because I have three handwritten pages, so that would have taken me – I once worked it out. That would have taken me about 25 minutes. I have a standard time for medical/legal examinations of half an hour. Some take a lot less; some take a lot longer.

Q. It's possible it could have been less in this case?

cr. ex.

A. It's possible, but not likely.

Q. All right. So you spent about half an hour with her –

A. Yes.

Q. -- maybe?

Now, did you have occasion to see Dr. later report of March 25, 1992?

A. Yes. I think so.

Q. Do you know that Dr. says that his diagnosis of sciatica was a wrong and flimsy diagnosis?

A. Yes.

Q. You didn't mention that in your examination in chief, did you?

A. No.

Q. Now, doctor, you'll agree with me, as well, that you found Mrs. to be co-operative and pleasant woman?

A. Yes.

Q. She did not exaggerate at all?

A. I didn't think so, no.

Q. She was honest and truthful?

A. I thought so, yes.

Q. Now, you mentioned one thing which – you said she has degenerative disc disease.

A. That was my working diagnosis, yes.

Q. Doctor, it's my understanding if somebody has a pre-existing degenerative disc disease, assuming that to be true, then that person is more vulnerable for any trauma inflicted on the back. True?

A. It's possible, yes.