SUPREME COURT OF NOVA SCOTIA

Citation: Hartling v. Nova Scotia (Attorney General), 2009 NSSC 2

Date: 20090112
Docket: Hfx No. 236705
Registry: Halifax

Between:

Helen Hartling, Melissa Gionet, Anna Marie MacDonald

Applicants

and

The Attorney General of Nova Scotia, representing Her Majesty the Queen in Right of the Province of Nova Scotia

Respondent

and

Insurance Bureau of Canada, an incorporated association

Intervenor

Docket: Pic No. 217706
Registry: Pictou

Between:

Saquoia McKinnon, an infant by her Litigation Guardian, Kathryn Jean McKinnon and John McKinnon

Applicants

and

Adam Thomas Roy

Respondent

and

The Attorney General of Nova Scotia, representing Her Majesty the Queen in Right of the Province of Nova Scotia

Statutory Respondent

Editorial Note

In paragraph 108, it should read: In **Arnold** v. **Teno**, [1978] 2 S.C.R. 287, Teno was a 4 ½ year-old little girl who suffered brain injuries with severe physical and mental impairment.

Judge: The Honourable Justice Walter R.E. Goodfellow

Heard: October 6, 7, 8, 9, 14, 15, 16, 20, 21, 22, 28, 29, 30 and 31, 2008, in Halifax, Nova Scotia

Counsel: Mr. Barry J. Mason and Mr. Glenn E. Jones, on behalf of the Applicants, Gionet and MacDonald

Mr. Janus Siebrits, on behalf of the Applicant, McKinnon

Mr. D. Geoffrey Machum, Q.C. and Ms. Christa M. Hellstrom, on behalf of the Respondent, Adam Roy

Mr. Alexander M. Cameron, on behalf of the Attorney General of Nova Scotia

Mr. Jeffrey W. Galway and Ms. Rahat Godil, on behalf of the Insurance Bureau of Canada

By the Court:

THE PLAINTIFFS:

[1] Anna Marie MacDonald was involved in a motor vehicle accident on November 20, 2003. She was a rear seat passenger and advances that she sustained injuries to her neck, shoulder and back and had resultant headaches. She advances that she had not recovered from these injuries when she was involved in a second accident in which she was the operator of her motor vehicle on October 30, 2004.

[2] With respect to the first accident, she was offered a settlement which included the cap amount of $2,500.00 for pain and suffering, bringing that accident within this application. The position with respect to her second accident has not yet been determined.

[3] Melissa Gionet was involved in a motor vehicle accident as the operator of her motor vehicle on December 17, 2003 and she was seven months pregnant at the time of this accident. She advances that she sustained injuries including an injury to her knee and back pain. She further advances that she was unable to return to her work as a cashier at Casino Nova Scotia for approximately two months. When she did go back she advances that she was unable to continue to work except, eventually, on a gradual basis. However, in October 2005, she changed employment to one that she found less aggravating of her injuries.

[4] Ms. Gionet advances that she was approached by an insurance adjuster wishing to settle her claim. That she was advised that there was a "cap" on claims for soft tissue injuries that would apply to her claim as it was put in place in November, 2003. She advances that she was advised she could not receive more than $2,500.00 and was offered $3,000.00 in total, which included her lost wage claim of $1,100.00. She accepted the offer and signed a release on November 29, 2004 and in her action she includes a claim to have the release set aside.

[5] For the purposes of this application, Ms. Gionet concedes that her claim would be categorized as a "minor injury" as defined under the *Insurance Act*, R.S.N.S., 1989, c. 231 (as amended). This concession is for the purposes of this application **only** and without prejudice to her right to advance alternate arguments in her actions against the defendant driver/owner.

[6] Saquoia McKinnon was born on April 10, 1990 and when she was 13 on the 25th of November, 2003 she was walking along the shoulder of a roadway in Coalburn, Nova Scotia with her father when she advances that her father was struck by the Defendant's motor vehicle. Ms. MacKinnon from her presence in viewing what happened to her father suffers Post Traumatic Stress Disorder (hereinafter referred to as "PTSD") and for the purposes of this application, her injury is considered to be one of serious unresolved PTSD as a result of witnessing the accident.

LEGISLATION:

[7] *Canadian Charter of Rights and Freedoms,* Sections 1, 7, 15 and 24:

Guarantee of Rights and Freedoms

Rights and freedoms in Canada

1. The Canadian Charter of Rights and Freedoms guarantees the rights and freedoms set out in it subject only to such reasonable limits prescribed by law as can be demonstrably justified in a free and democratic society.

Legal Rights

Life, liberty and security of person

7. Everyone has the right to life, liberty and security of the person and the right not to be deprived thereof except in accordance with the principles of fundamental justice.

Equality Rights

Equality before and under law and equal protection and benefit of law

15. (1) Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Affirmative action programs

(2) Subsection (1) does not preclude any law, program or activity that has as its object the amelioration of conditions of disadvantaged individuals or groups including those that are disadvantaged because of race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

Enforcement

Enforcement of guaranteed rights and freedoms

24. (1) Anyone whose rights or freedoms, as guaranteed by this Charter, have been infringed or denied may apply to a court of competent jurisdiction to obtain such remedy as the court considers appropriate and just in the circumstances.

[8] *Constitution Act*, 1982, Part VII:

Primacy of Constitution of Canada

52. (1) The Constitution of Canada is the supreme law of Canada, and any law that is inconsistent with the provisions of the Constitution is, to the extent of the inconsistency, of no force or effect.

[9] *Insurance Act* R.S.N.S., 1989, c. 231, (as amended), Section 113B(1):

Limitation on liability

113B (1) In this Section,

(a) "minor injury" means a personal injury that

(i) does not result in a permanent serious disfigurement,

(ii) does not result in a permanent serious impairment of an important bodily function caused by a continuing injury which is physical in nature, and

(iii) resolves within twelve months following the accident;

(b) "serious impairment" means an impairment that causes substantial interference with a person's ability to perform their usual daily activities or their regular employment.

[10] *Automobile Insurance Tort Recovery Limitation Regulations* N.S. Reg. 182/2003, Regulation 2(1)(d), (f), (g) and (h):

2 (1) (d) “personal injury” does not include

(i) a coma resulting in a continuing serious impairment of an important bodily function,

(ii) chronic pain that

(A) is diagnosed and established as chronic pain by a medical specialist appropriately trained in the diagnosis and management of pain disorders,

(B) is a direct result of a physical injury sustained in the motor vehicle accident with respect to which the claim is brought,

(C) results in a continuous serious-impairment of an important bodily function, and

(D) is moderately severe or severe pain, as classified in the American Medical Association Guides to the Evaluation of Permanent Impairment, 5th edition,

(iii) a burn resulting in serious disfigurement,

(iv) an amputation of a major limb;

Clause 2(1)(d) added: O.I.C. 2003-486, N.S. Reg. 196/2003.

...

2 (1) (f) "resolves" means

(i) does not cause or ceases to cause a serious impairment of an important bodily function which results from a continuing injury of a physical nature to produce substantial interference with the person's ability to perform their usual daily activities or their regular employment, or

(ii) causes a serious impairment which results from a continuing injury of a physical nature to produce substantial interference with a person's ability to perform their usual daily activities or their regular employment where the person has not sought and complied with all reasonable treatment recommendations of a medical practitioner trained and experienced in the assessment and treatment of the personal injury;

Clause 2(1)(f) added: O.I.C. 2003-486, N.S. Reg. 196/2003.

2 (1) (g) "substantial interference" means, with respect to a person's ability to perform their regular employment, that the person is unable to perform, after reasonable accommodation by the person or the person's employer for the personal injury and reasonable efforts by the injured person to adjust to the accommodation, the essential elements of the activities required by the person's pre-accident employment;

Clause 2(1)(g) added: O.I.C. 2003-486, N.S. Reg. 196/2003.

2 (1) (h) "usual daily activities" means the essential elements of the activities that are necessary for the person's provision of their own care and are important to people who are similarly situated considering, among other things, the injured person's age.

Clause 2(1)(h) added: O.I.C. 2003-486, N.S. Reg. 196/2003.

> Section 2 renumbered subsection 2(1) and amended: O.I.C. 2003-486, N.S. Reg. 196/2003.

ISSUE ONE: Does Section 113B(1)(a) of the *Insurance Act* Infringe Section 15(1) of the *Charter* on the Basis of Physical Disability?

[11] Melissa Gionet and Anna Marie MacDonald assert that the definition of "minor injury" in s. 113B(1)(a) of the *Insurance Act* discriminates against individuals with certain types of pain and discomfort and thereby constitutes discrimination based on physical disability as defined in s. 15(1) of the *Charter*.

OVERVIEW

Section 15 of the *Charter*:

[12] Section 15 of the *Charter* guarantees to every individual the right to equal treatment by the state without discrimination. In **Law** v. **Canada (Minister of Employment and Immigration)**, [1999] 1 S.C.R. 497, Iacobucci, J. stated:

> There is nothing new in requiring a *Charter* claimant to establish that his or her right has been infringed in a manner which brings into play the purpose of the right in question. Both the principle that *Charter* rights are to be interpreted purposively, and the principle that the *Charter* claimant bears the onus of establishing an infringement of his or her right before the onus shifts to the state to justify the infringement, are fundamental and well established....

[13] The Supreme Court of Canada has consistently held that it would be inappropriate to attempt to confine analysis under s. 15(1) to a "fixed and limited formula". Iacobucci, J. indicated that in law the Court was articulating the principles under s. 15(1) as guidelines for analysis, and not as a rigid test which might risk being mechanically applied. The guidelines where labelled points of reference designed to assist a court in identifying the relevant contextual factors in a particular discrimination claim and in evaluating the effect of those factors in light of the purpose of s. 15(1). With the foregoing in mind, I proceed to address the contextual factors which the Supreme Court of Canada says may assist a court in determining whether the purpose of s. 15(1) has been engaged within the context of a particular case. In **Law**, *supra*, the question arose whether or not there was discrimination against widows and widowers under the age of 45 on the basis of age. If so, whether the infringement could be demonstratably justified in a free and democratic society under s. 1(1) of the *Charter*. The determination as to what constitutes

"discrimination" within the meaning of s. 15(1) is to be taken in a purposive way. The protection of equality of rights is concerned with distinctions which are truly discriminatory. Iacobucci, J. spoke at some length as to what is human dignity and his remarks included the following:

> ... Human dignity within the meaning of the equality guaranteed does not relate to the status or position of an individual in society *per se*, but rather concerns the manner in which a person legitimately feels when confronted with a particular law. Does the law treat him or her unfairly, taking into account all of the circumstances regarding the individuals affected and excluded by the law?

[14] Iacobucci, J. expressed assistance to trial judges quoting that:

> There is a variety of factors which may be referred to by a s. 15(1) claimant in order to demonstrate that legislation has the effect of demeaning his or her dignity, as dignity is understood for the purpose of the *Charter* equality guarantee...

Overview of Section 15(1) Analysis:

[15] In the recent Supreme Court of Canada decision in **R.** v. **Kapp**, [2008] 294 D.L.R. (4th) 1 (S.C.C.), McLachlin, C.J. and Abella, J. writing for the Court that was unanimous on this point, held that the *central concern* [italics added] of s. 15 of the *Charter*, as identified in **Andrews**, is one of combatting discrimination, defined in terms of perpetuating disadvantage and stereotyping.

[16] In **Granovsky** v. **Canada (Minister of Employment and Immigration)**, [2000] 1 S.C.R. 703, para 33, the Supreme Court of Canada described the purpose of s. 15(1) of the *Charter* as follows:

> The Charter is not a magic wand that can eliminate physical or mental impairments, nor is it expected to create the illusion of doing so. Nor can it alleviate or eliminate the functional limitations truly created by the impairment. What s. 15 of the *Charter* can do, and it is a role of immense importance, is address the way in which the state responds to people with disabilities. Section 15(1) ensures that governments may not, intentionally or through a failure of appropriate accommodation, stigmatize the underlying physical or mental impairment, or attribute functional limitations to the individual that the underlying physical or mental impairment does not entail, or fail to recognize the added burdens which persons with disabilities may encounter in achieving self-fulfilment in a world relentlessly oriented to the able-bodied. [emphasis added]

[17] McLachlin, C.J. and Abella, J. noted that the template created in **Andrews**, as further developed in **Law**, establishes in essence a two-part test for showing discrimination under s. 15(1): (1) does the law create a distinction based on an enumerated or an analogous ground? (2) does the distinction create a disadvantage by perpetuating prejudice or stereotyping? (see **Kapp**, above, at para. 17 (see also **Downey** v. **Nova Scotia (Workers' Compensation Appeals Tribunal**), 2008 NSCA 65, para 64)

[18] Each of the inquiries above proceeds on the basis of a comparison with another relevant group or groups. The test for identifying the proper comparator group was set out by the Supreme Court of Canada in **Hodge** v. **Canada (Minister of Human Resources Development**), [2004] 3 S.C.R. 357, para 23 as follows:

> The appropriate comparator group is the one which mirrors the characteristics of the claimant (or claimant group) relevant to the benefit or advantage sought except that the statutory definition includes a personal characteristic that is offensive to the *Charter*.

[19] In determining whether there is discrimination and not merely a distinction between the applicant and a comparator group, the Supreme Court in **Kapp** moved away from earlier jurisprudence of the Court which suggested that discrimination should be defined in terms of the impact of the law or program on "human dignity". While no longer defining discrimination in terms of the impact on "human dignity", McLachlin C.J. and Abella J. went on to identify the same four contextual factors enumerated in **Law**, that were formerly used to identify an impairment of human dignity, as the primary (but not exclusive) indicators of discrimination. The four contextual factors discussed in **Law** are: (1) pre-existing disadvantage, if any, of the claimant group; (2) degree of correspondence between the differential treatment and the claimant's reality; (3) whether the law or program has an ameliorative purpose or effect; and (4) the nature of the interested affected. (see **Kapp**, *supra*, paras. 19-23).

[20] In **Kapp**, McLachlin, C.J. and Abella, C.J. noted that factors one (pre-existing disadvantage) and four (nature of interest affected) and possibly three (ameliorative purpose) went to "perpetuation of disadvantage and prejudice" while factor two (correspondence) went to "stereotyping". (see **Kapp,** *supra* at para. 23)

[21] Iacobucci, J. in **Law** at para. 64 defined "stereotyping" in the following terms:

> A stereotype may be described as a misconception whereby a person or, more often, a group is unfairly portrayed as possessing undesirable traits, or traits which the group, or at least some of its members, do not possess. In my view, probably the most prevalent reason that a given legislative provision may be found to infringe s. 15(1) is that it reflects and reinforces existing inaccurate understandings of the merits, capabilities and worth of a particular person or group within Canadian society, resulting in further stigmatization of that person or the members of the group or otherwise in their unfair treatment.

[22] The four contextual factors in **Law** are meant only to be guides in determining whether there is discrimination and not all factors will be relevant in each case. In **Kapp**, McLachlin, C.J. and Abella, J. at para. 24 stated:

> The factors cited in *Law* should not be read literally as if they were legislative dispositions, but as a way of focussing on the central concern of s. 15 identified in *Andrews* – combatting discrimination, defined in terms of perpetuating disadvantage and stereotyping.
>
> *(*See also – *Nova Scotia (W.C.B.) v. Martin*, [2003] 2 S.C.R. 504, para. 85)

[23] The party raising a s. 15(1) *Charter* infringement has the burden of establishing that the legislation is discriminatory. The determination of the appropriate comparator group and the evaluation of the contextual factors described above in assessing whether there is discrimination is done both on an objective and a subjective basis. The perspective is that a reasonable person (objective), but one who shares the attributes and circumstances of the claimant (subjective). (see **Law,** *supra*, at para. 60**; Canadian Foundation for Children Youth and the Law** v. **Canada**, [2004] 1 S.C.R. 76, para 53)

Selection of Comparator Group:

[24] With respect to the first s. 15(1) *Charter* issue raised by Melissa Gionet and Anna Marie MacDonald (i.e. s. 113B(1)(a) of the *Insurance Act* violates s. 15(1) of the *Charter* on the grounds of physical disability), Melissa Gionet and Anna Marie MacDonald identify motor vehicle accident victims with a physical disability who meet the threshold as the appropriate comparator group. That is what the applicants have chosen.

Does the Law Create a Distinction Based on an Enumerated or Analogous Ground?

[25] Even if one accepts for purposes of argument that the definition of minor injury in s. 113B(1)(a) creates a distinction on grounds of physical disability. Any such distinction is not necessarily discriminatory.

Does the Law Discriminate?

[26] The fact that a distinction is based on an enumerated ground is insufficient on its own to prove discrimination. A contextual analysis is still required to determine whether a distinction is discriminatory. As noted by McLachlin and Bastarche, J.J. in **Corbiere** v. **Canada (Minister of Indian and Northern Affairs**), [1999] 2 S.C.R. 203, at para 7:

> ... the enumerated grounds must be distinguished from a finding that discrimination exists in a particular case. Since the enumerated grounds are only indicators of suspect grounds of distinction, it follows that decisions on these grounds are not always discriminatory; if this were otherwise, it would be unnecessary to proceed to the separate examination of discrimination at the third stage of our analysis discussed in *Law, supra*, per Iacobucci, J.

[27] In **Law**, as noted above, Iacobucci, J. identified four contextual factors which should be considered in determining whether s. 15(1) has been infringed: (1) pre-existing disadvantage, stereotyping, prejudice or vulnerability experienced by the individual or group at issue; (2) the correspondence, or lack thereof, between the ground or grounds on which the claim is based and the actual need, capacity, or circumstances of the claimant or others; (3) the ameliorative purpose or affects of the impugned law upon a more disadvantaged person or group in society; and (4) the nature and scope of the interest affected by the impugned law.

Factor One: Pre-Existing Disadvantage/Stereotyping/Prejudice.

[28] Dr. Lynch's evidence on behalf of the Plaintiffs is that a negative social stigma has historically attached to persons suffering from chronic pain and soft tissue injury and that there has been a trend towards denying the reality of chronic pain. Dr. Lynch goes on to state that many of her patients are concerned about the stigma in society that they are faking their injuries and are the cause of high insurance premiums, particularly those who are labelled as suffering from "sprains or strains" or "minor

soft tissue injury". At this point I want to review and comment on the evidence before me.

Evidence of Doctor Mary Lynch:

[29] Dr. Lynch is a licensed medical doctor and psychiatrist with extensive experience in the area of chronic pain. Currently she is the director of research and director of the pain management unit at the Queen Elizabeth II Health Science Centre and a professor at Dalhousie University in the department of psychiatry, anaesthesiology and pharmacology. Dr. Lynch filed an affidavit, a supplementary affidavit and gave evidence in the application. Dr. Lynch expresses her views both in her affidavits and her evidence with great conviction. When the Court has a knowledgeable, experienced expert with the depth of concern for patients exhibited by Dr. Lynch such experts' views warrant the most careful of examination and assessment. Very clearly Dr. Lynch advances on the basis of her research and experience that there exists a negative social stigma that has historically been attached to persons suffering from chronic pain and soft tissue injury and a trend toward denying the reality of chronic pain. Dr. Lynch fortifies her views by referencing press releases, newspaper articles, studies, etc., which in her professional opinion contribute to what she concludes exists a stigmatizing and discrimination of accident victims who have suffered soft tissue injuries or so-called minor sprains and strains. In her supplementary affidavit, she clearly disputes the evidence filed on behalf of the Attorney General of Nova Scotia and the Insurance Bureau of Canada that takes the position there is no or only very limited negative social stigma attaching to persons who have sustained soft tissue injuries and/or who are suffering from chronic pain. She expresses this as follows:

> In my experience, that is simply not the case.

[30] Dr. Lynch's view is that pain is considered a subjective experience and cannot be externally validated. In cross-examination it was acknowledged by Dr. Lynch that one of the articles she cited is the Holloway article indicating stigmatization of people with chronic back pain. Dr. Lynch acknowledged that it was a United Kingdom study.

> **Q.** It talks about the sample of people who are the subject of the study, okay?
>
> **A.** Yes, I'm with you.

Q. And about four lines down, it says – or three lines:

> The sample consisted of 12 male and 6 female patients all of whom had recently been assessed as new referrals at one of two pain clinics in the south of England.

A. Correct.

...

Q. And it's the second paragraph. It begins with the words, "these participants"?

A. Yes.

Q. It says:

> These participants were at the point of entry into a service that is often regarded by those with chronic pain as their last resort.

Do you see that?

A. Yes, I do.

Q. Is it fair to say that by and large the – your pain management unit, the pain clinic is the last resort for patients?

A. For many patients, we are the last resort. They have seen on average five other sub-specialists before seeing us.

Q. Okay.

A. Not the case with everybody, but with many.

Q. Okay. And you talk about the wait list. I think you said it's a two or perhaps even three-year wait list now?

A. Yes.

Q. And would it be the case that many of those patients, having seen the number of physicians you just mentioned, would actually have been dealing with pain for some considerable time even before they get referred to the pain clinic?

A. Yes, many would have been.

Q. Okay. So we're talking about patients who typically have a history of pain which is prolonged, many years?

A. Yes. I should also mention we have, however, a fast tract. We're talking about the regular referral stream.

[31] Dr. Lynch was asked specifically about Ms. MacDonald and Ms. Gionet and confirmed that she had not assessed them and, further:

Q. Okay, that's fine.

A. If they had been referred, they would have unfortunately waited an extended period of time to be seen.

Q. It's fair to say though that not all patients with chronic pain are referred to your clinic?

A. This is true.

Q. Okay. A great many would not be referred to your clinic?

A. Correct.

[32] Dr. Lynch went on to agree with the comments in the Holloway report that with respect to credibility it is necessary to consider the trustworthiness of the data obtained through unstructured narrative interviews. Dr. Lynch went on further to say that the bottom line is that you have the physical examination and that you follow the patients for three years and you get to know that person and how they function. The cross-examination with respect to the Greco article relied upon by Dr. Lynch acknowledged the limitations of the article and that it made reference to peer interactions that cause pain which Dr. Lynch pointed out referenced contributing to pain.

Q. "Frequent abdominal pain may be in – at part – at least in part a reaction to chronic or daily stressors, for example, family related stress and so on."

And they talk about —

A. Right.

Q. — basically bullying.

A. So again, you'd have to go back to the term, "At least in part."

Q. Sure.

A. And I'm – I'm quite willing to acknowledge that psycho social issues can contribute to the experience of pain —

Q. Okay, thank you.

A. — and the overall suffering of pain.

Q. Thank you. And that – I actually wanted to bring that out.

I'm glad you've clarified that, because in your affidavit, when you read them, one doesn't get the sense that you are a wholehearted endorser of the bio-psycho-social approach to chronic pain.

But, in fact you do agree that there are many causative factors related to the chronic pain?

A. That the bio-psycho-social model is correct, and that one has to address the whole person.

[33] Dr. Lynch was cross-examined on an article referred to by her which is referenced the IWK article. The article references a group of six female children between the ages of 13 to 18 who were brought together for a one day focus group in which the children told their respective stories. Dr. Lynch, after further cross-examination, acknowledged there was no victimization on the part of the teachers and the report, I conclude, is not a description of stigmatization. Dr. Lynch acknowledged that in this focus exercise that teachers were being compassionate and were not advancing stigmatization or victimization. Further cross-examination is informative.

A. I would – I'm basically agreeing with you that not everybody who's had a minor sprain or bump is going to be stigmatized by society.

Q. Your professional opinion with respect to stigmatization relates to the classifications that you're familiar with, which are those in your tertiary care physician relationship.

A. Which are those patients that we see in the Pain Management Unit. Correct.

Q. Yes.

...

Q. Okay. Dr. Cassidy in his report says that this assertion of yours is – and I'm quoting him at page 14 of his report is:

> "In disagreement with the findings of the Decade of the Bone and Joint, 2000 to 2010 Task Force on Neck Pain."

Which he describes as the state of the art. Do you agree or disagree with that?

A. I haven't seen the publication. It is the – repeat it again?

Q. It's the report or the findings of Decade of the Bone and Joint, 2000 to 2010 Task Force on Neck Pain.

A. Right. I —

Q. You're not familiar with that, Ms. Lynch?

A. I haven't read that document myself so I can't tell you if it's congruent with what the state of the art is or not.

...

Q. And with respect to the situation that existed in Nova Scotia in 2002 and 2003, I take it you're not in a position to comment as to the factors that contributed to high automobile insurance premiums in the province during that period, are you?

A. Correct.

Q. That would be outside your area of expertise?

A. Yes.

[34] Dr. Lynch was referred to paragraph 10 of her affidavit indicating in her view that certain articles contribute to continued stigmatization and discrimination and with respect to the Newfoundland and Labrador article press release she commented as follows:

Q. And if you could look at the fifth paragraph, it states:

> "Studies on closed claims released in both Nova Scotia and New Brunswick show the primary factor linked to automobile insurance cost is the number of soft tissue injury claims, sprains and strains."

Do you see that?

A. Yes.

Q. Dr. Lynch, I take it you have no basis to disagree with that statement?

A. That's correct.

Q. And, Dr. Lynch, when I read these articles – and I think Mr. Forgeron is quoted in a number of the articles – he's not saying anywhere in these articles, is he, that the insurance industry considers everyone with a soft tissue injury to be a fraudster or a malingerer?

A. Correct. He's not saying that.

[35] With respect to Mr. Forgeron's comment with respect to fraud in the system, Dr. Lynch was cross-examined as follows:

Q. In fact, if I look at one page over, there is a statement by Mr. Forgeron – there's an interview where he states – he goes on to state:

> "There's no question that fraud is part of our system."

Do you see that?

A. Yes, I do.

Q. And I take it you have no basis to disagree with that statement either, do you?

A. I have – that's correct.

Evidence of Doctor Mahar:

[36] Dr. Mahar, like Dr. Lynch, is a highly respected professional. He has been involved in physical medicine and rehabilitation for almost 29 years. In his report he references and describes soft tissue injuries and whiplash. He outlines in his report how physicians go about trying to evaluate people who have soft tissue injuries given there is a paucity of objective measures to evaluate that type of injury. He outlined that there is objective testing where the outcome of the test is outside the control of the person you are examining, i.e., blood pressure, how much you weigh, reflexes, *et cetera*. Patients are subject to subjective tests which rely upon the subjective reporting of the individual.

[37] In between objective and subjective testing is a range of motion testing. Dr. Mahar referred to the example "bring your arm up as far as you can over your head". This is capable of measurement and provides some degree of specificity and reliability and some degree of objectivity. His report references the Quebec Task Force study in the mid-nineties which reviewed a great number of clinical studies then tried to come up with guidelines in terms of descriptors of "whiplash injury", the clinical outcome of whiplash and they tried to come up with some treatment suggestions. Dr. Mahar did reference an article which did not agree with the Quebec Task Force which shows that there exists some controversy and acknowledging that there was some potential for bias based on the fact that the Quebec study was conducted by an insurer. Dr. Mahar reviewed factors relating to chronic pain, that it can be from mild to excruciating.

Q. Then, Dr. Mahar, you begin a discussion specifically about chronic pain. You talk about there being no clearly accepted definition. I'm on page 5, of course. And you talk about chronic pain being mild to excruciating, and then you talk about the causes of chronic pain. And could you elaborate that discussion?

> **A.** Basically, chronic pain is pain that goes on for a long time. And someone who has chronic pain can have chronic pain that's mild. Someone can have chronic pain that's excruciating.
>
> Someone who has chronic pain may have a disability, and someone who has chronic pain may or may not – may not be disabled.
>
> So, there are modifiers, I guess, or within the big umbrella of the term chronic pain that people would stand under that umbrella, and they could have a wide range of severities of pain and disability.
>
> Similarly, I mean, chronic pain can occur from a number of other causes, other than motor vehicle collisions, and even in other organ systems.

[38] Dr. Mahar went on to indicate that in the real world of practice they do not have any way to assess central facilitation. In addition, those in practice encounter psychological and social factors. He stated at the bottom of page 450 of the trial transcript:

> So I guess I go on to try to say that what causes one injury to become chronically painful in one person and not chronically painful in another may not have a lot to do with the specific initiating traumatic event.

[39] Dr. Mahar in his report dated June 26, 2008 was asked certain questions. Following are the questions and the answers with respect to what is chronic pain and what are the causes of chronic pain:

> **What is chronic pain? Is there, in the medical community, a widely accepted definition of what chronic pain is? If so, what is that definition. How long must pain endure to be considered chronic?**
>
> There is no clearly accepted definition of chronic pain. The most commonly utilized definition would be "pain that has lasted a long time". It is variably described as pain that has lasted a long time for "more than three months" or "more than six months."
>
> Chronic pain can be range from mild to excruciating.
>
> Chronic pain may or may not be associated with a report of disability.
>
> Chronic pain can be attributed to any organ system and is not confined to Whiplash Associated Disorder or soft tissue injury (eg., chronic gallbladder pain, chronic kidney pain, chronic pain from shingles, etc.)

What are the causes of chronic pain? What makes chronic pain "chronic"? How does pain or chronic pain usually or typically resolve, or does it resolve?

The causes of chronic pain, therefore, are obviously many.

Chronic pain may occur as the result of an ongoing noxious or painful stimulus (eg., an unhealed fracture, a chronic pancreatitis, a bone spur in the heel).

It can also occur as the result of "central facilitation". By that, it appears that the experience of pain, in and of itself, leads to actual alteration in pain modulating circuits in the spinal cord and brain resulting in a magnification, exacerbation and perpetuation of chronic pain state even after the noxious stimulus is resolved. This is not the case in all patients. In some cases, other factors may exist: We do not clinically evaluate patients for "central facilitation". Although it has been shown to be validated in research studies, it is not clinically possible to ascertain this via any objective means in day to day clinical practice. In some cases, this may be a factor in the maintenance of a chronic pain state. In other cases, it may not be a factor in continued reports of chronic pain.

Chronic pain can also be rendered chronic by virtue of psychological factors. These include pre-injury factors such as tendency to catastrophization, anxiety, depression or traumatic experiences (previous physical or sexual abuse).

What makes one noxious stimulus become chronically painful in one individual and not in another (assuming the painful stimulus is "the same") is difficult to evaluate and ascertain.

Whether pain usually resolves, to a large extent, relies on the nature of the underlying impairment and individual factors as noted above. There is no "typical resolution" for chronic pain. By definition, it tends to be ongoing.

[40] Dr. Mahar was also asked to express his opinion on the very issue I am now addressing, namely, allegation of stigmatization or discrimination and his response is as follows:

Is it within your expertise as a physician, to discuss whether sufferers of chronic pain experience "negative social stigma" or "discrimination"? What is your experience respecting such alleged stigmatisation or discrimination?

I would indicate that I see individuals with chronic pain every day in my practise. I have been a practising physician for 29 years.

Most of these patients report negative consequences as the result of chronic pain.

> The negative social factors or discrimination appears to be largely related to stressors in dealing with employers and third party payers. That is to say, they feel marginalised by lack of remuneration or acceptance of disability by third party payers or their employer and a sense that there subjective report of pain and disability is not understood or accepted. They also commonly report a loss of personal sense of control over their life situation. I am uncertain as to whether this meets the criteria for "negative social stigma" or "discrimination".
>
> I also encounter many situations in which suffers of chronic pain are in conflict with immediate family members ie., spouse as the result of ongoing pain experience. I would feel that this would not be characteristic of "*negative social stigma*" or "*discrimination*".
>
> It is very uncommon for me to encounter sufferers of chronic pain who feel that they are marginalised or discriminated against by their neighbours, friends, family or co-workers as the result of a chronic pain experience.
>
> Therefore, within the context, I do not identify sufferers of chronic pain as experiencing significant negative social stigma or discrimination with the possible exception of issues relating to employers and third party payers.

[41] Dr. Mahar was subject to vigorous cross-examination by Mr. Mason. Mr. Mason endeavoured to have Dr. Mahar disagree with the opinion of Dr. Cassidy in his report.

> **Q.** You cited it, I think.
>
> **A.** Yeah
>
> **Q.** You didn't necessarily accept the opinion in Dr. Cassidy's report, correct?
>
> **A.** Well, I mean I think the methodology in the study was accurate. I don't have any problems with the results of the study.
>
> ...
>
> **Q.** And that's not always the case, is it?
>
> **A.** I guess the original question was whether I accepted Dr. Cassidy's study as being valid I guess, right? Was that what the question was?

Q. Well, I'm just asking you questions about the methodology right now.

A. Okay. So yeah, he identifies limitations within the study.

Q. Sure

A. Yeah.

Q. And that's a fairly significant limitation, isn't it, Doctor?

A. Yes.

Q. Yes. I mean if every count that he's using to come down to some conclusions here is based on WCB patients or victims that are cut off, they're all better, that's a significant limitation, correct?

A. He's talking about not WCB patients.

Q. I'm sorry, Saskatchewan Government Insurance; a no-fault system similar to WCB. And it is a significant limitation, correct?

A. A limitation in what regard?

Q. In the strength of the conclusion that people get better and faster in a no-fault system versus a tort-based system?

A. I don't think Dr. Cassidy says people get better.

Q. Improve.

A. If you look at – if I go back to where we started here, he said there was a decrease in the number of whiplash injuries. What Dr. Cassidy showed in his study was that the incidence of people coming forward with whiplash injury was lower when the system changed. I don't – I'm not aware of the data that talks about that people got better faster or they didn't have any symptoms after.

Q. Sure.

A. So I guess I'm a little uncomfortable with where we're going from that.

Q. Sure. What I'm asking you though at this point doctor is that the study here, the methodology being used for this study is based on the assumption that people have gotten better once their claim is terminated with Saskatchewan Government Insurance, correct?

A. I'm not being difficult. You're going to have to say that again.

Q. Okay. What I'm saying is the methodology used in forming the conclusions in this report —

A. What's the conclusion of the report?

Q. The conclusion of the report – I believe Doctor, you cite it in your report.

A. Yeah.

Q. Conclusion:

> Elimination of compensation for pain and suffering is associated with a decreased incidence and improved prognosis of whiplash injury.

A. Yeah.

Q. That's his conclusion.

A. Yeah, I accept that.

Q. Well, let's be – let me –

A. Okay.

Q. I'll hold you just for a second before you jump to your conclusion on that.

A. I guess when I say that is that this – the – Dr. Cassidy, the limitation of his study is that it doesn't identify the issues of continued pain or ongoing symptoms. All Dr. Cassidy seems to indicate to me when I read that study is that there were fewer people who had the disease of whiplash when that system changed. Fewer people went to doctors, fewer people you know – and so – and those people, but in terms of whether they got better or not, I don't think Dr. Cassidy says that in his report.

[42] Dr. Mahar went on to acknowledge a limitation dealing with the manner in which claim closure times are determined.

Q. Sure.

A. — but he wasn't looking at people who were in one system and then all of a sudden they're – they were – they would carry through from one system into another. So that in Dr. Cassidy's study he's just looking at what happens to people who live in a province where there's a no-fault versus a tort system.

[43] Dr. Mahar went on to acknowledge that he heard the view expressed that some people are faking, some people are committing fraud. He was asked if this was from insurers and third party payors and employers. His acknowledgment that he has heard such does not contradict the opinion expressed in his report.

Q. Yeah. And you would agree that if you were one of the few being blamed for costing the many additional premiums, that that would have a negative impact or stereotype of stigma on you, correct?

A. Yeah, if I was being blamed for that.

Q. Yes.

A. I'm not – again, I'm not sure that – anyway, if I was being blamed for the cost of high insurance, I would feel stigmatized.

Q. Thank you. Perfect. We'll move to Tab 2, doctor. And this is "A Select Committee Ignores Consumers in Auto Insurance Report", about halfway down, I guess, the third or fourth paragraph, "The committee results", do you see that, doctor?

A. Yes.

Q. "The committee results are extremely disappointing. Forgeron says..."

Mr. Forgeron is an official with the Insurance Bureau of Canada.

"... the reasons for higher rates are crystal clear, but the committee has chosen to focus on the symptoms

> of the problem instead of solving the larger issues behind the increases, namely soft tissue injury awards."
>
> Would you agree with me, doctor, when you read that, that what's happening here is soft tissue injury awards are being blamed clearly for high rates? Is that how you read that?
>
> **A.** Yeah. We're getting outside – I mean, this is clearly outside my area of expertise, but that seems like what that paragraph is saying.
>
> **Q.** Yeah. And that would have the impact of marginalizing or stigmatizing an accident victim, correct?
>
> **A.** It would stigmatize me if someone – if it was directed personally toward me.
>
> **Q.** Sure.
>
> **A.** If I read it on a piece of paper or in the newspaper, I don't think I'd feel stigmatized.
>
> **Q.** All right. But your patients would. Correct?
>
> **A.** If they were reading it —
>
> **Q.** Yeah.
>
> **A.** — maybe, yeah. I mean, I don't know what they'd think.

[44] Mr. Mason showed Dr. Mahar a video which was on the Insurance Bureau of Canada's website for an unidentified period of time. Mr. Mason, I noted, commented "I see you smiling and I saw you actually laugh a bit when you initially saw that video". When he was asked how he would describe the video he stated:

> **A.** Well, what's the purpose of the video? What – put it within some context for me I guess. I mean I – it almost looks like a skit to me. It's sort of ludicrous but please go ahead.

[45] Dr. Mahar expressed his view that to most people they would not take the video personally.

> **A.** I guess so. I mean to me most people that I see wouldn't take that personally I guess. But they'd say well, that's not my situation. I'm not out to rip off the system. I'm not pretending to have a neck collar on and act like that guys acting.
>
> Most people – in the real world, most people would sort of say well, that's just not me. They wouldn't – now if the insurance company is saying this is what everybody's like, sure, that would be an affront.
>
> **Q.** Yes.
>
> **A.** And I'm not sure what they're saying or why it's on the website but – so not all of my patients would feel horrified if they saw a video such as that.

[46] I note that while it is indicated in the affidavit of Don Forgeron, the Vice President of IBC sometime between July 1993 and May 2008, that the video in question was on the IBC website, at the request of Mr. Mason, Mr. Galway undertook to advise when the video went on the website and at page 1513 of the transcript he related to the court and Mr. Mason that the video went on the IBC website in May of 2005. It went on the website in tandem with a second video, I have no evidence of the time frame the video was displayed. No evidence of how many people saw it, 10?, 2000?. No evidence as to how many persons who saw the video were insurance adjusters or insurance personnel or sufferers of chronic pain, or whatever. The same applies to the other "positive" video which in Forgeron's affidavit is stated to depict another victim of a sprain / strain injury who resists the efforts of the staff in a massage therapy clinic to submit claims to her insurance company for additional treatment after she has already recovered from the affects of her injury. The evidence of Ms. Riis is to the effect this is an area of concern with respect to fraud in the treatment arena.

[47] Mr. Forgeron indicates the purpose of the two videos in paragraph five of his affidavit as follows:

> The purpose of the two videos was to serve as part of an ongoing effort by IBC to raise public awareness of all types of insurance crime (e.g. liability, automobile and property) and its impacts on the price of insurance to all policy holders....

[48] And further in his affidavit:

> **Conclusion**

> The videos that have been entered into evidence via Dr. Lynch's and this affidavit respectively, depict two fictional incidents of insurance crime: one depicts a claimant as the initiator of the crime and, in the other, the crime is being promoted by clinic staff and resisted by the claimant. The purpose of the videos was to illustrate that, in the fact of an opportunity to defraud an insurance company, individuals have an ethical choice to make. These videos were part of IBC's and the insurance industry's ongoing efforts to raise public awareness of insurance crime, reduce its incidence and protect the affordability of insurance.
>
> In my view, neither of the two videos referenced above or the fraud prevention programs implemented by insurers within their respective organizations stigmatize automobile accident victims with minor injuries. Insurers know that most of the people that they see have been injured and need assistance in processing their claims and obtaining the necessary medical assistance.

[49] It is interesting to note that neither Dr. Lynch, Dr. Mahar, Dr. Rosenberg nor Ms. Riis gave evidence that any one of their patients reported to them actually seeing the video or that they were impacted by the existence of the video. Clearly the evidence does not establish that it was a best seller.

[50] Mr. Mason asked Dr. Mahar to comment specifically on the opinion expressed by Dr. Lynch.

> .... She answers:
>
> "Well, most patients feel that they are being negatively judged in some way. This comes out in relationships with family and friends, colleagues. If they happen to be involved in any sort of litigation, there's additional stigma with relation to the whole claims process.
>
> **Q.** Do you agree with that portion of her answer, doctor?
>
> **A.** What was the very first two words? I couldn't quite hear what they were.
>
> **Q.** "Well..."
>
> **A.** Most patients.

Q. "...most patients feel that they are being negatively judged in some way. This comes out of..."

Comes out, sorry:

"... in relationships with family and friends, colleagues. If they happen to be involved in any sort of litigation, there's additional stigma with relation to the whole claims process."

You would agree with that?

A. No.

Q. You wouldn't? Okay.

A. I would say it's not common for them to be negatively judged by friends and family. I would say it's common for them to be negatively judged by some of their colleagues.

I would say that if they're involved with legal —

Q. Yes.

A. — issues then they're more likely to be —

Q. Sure.

A. – negatively whatever the word she used was.

[51] Dr. Mahar went on to say that he sees most family and friends as being enablers. Consistently he says that there may be difficulties with respect to insurers and payors, otherwise his views are in direct contrast to the views expressed by Dr. Lynch.

[52] The observation by Dr. Mahar of acknowledging the existence of an adverse attitude that some injured parties face from insurance and the payor personnel is just that, an acknowledgement. Some of this exists but by no means does he in his acknowledgement suggest it is significant or widespread and, indeed, his professional opinion is, I conclude to the contrary.

[53] In re-examination Dr. Mahar commented as follows:

> **Q.** My Friend – Dr. Mahar, Mr Friend asked you about Dr. Cassidy's article in the New England Journal of Medicine.
>
> **A.** Yes.
>
> **Q.** And in the medical community what sort of respect is accorded to an article in that journal?
>
> **A.** That's probably the top two prestigious medical journals in the world.
>
> **Q.** Okay. Now, in terms of publishing an article in the New England Journal of Medicine, you just write in and they publish or is there any sort of scrutiny involved?
>
> **A.** No there are editors that – so typically what would happen would be when you submit an article to a journal the editors review it. If there's – and then if they have any suggestions or criticisms or questions they – so then they will revise or submit data or answer questions.
>
> So typically there's correspondence back and forth between the editors and the authors. Ultimately then if it's accepted it's published.
>
> **Q.** Okay. That process is typically called peer review is it not?
>
> **A.** Yes.

[54] I am able to state a preliminary assessment of the relative weight to be attached to the opinions of Dr. Lynch and Dr. Mahar on this question of stigmatization and stereotyping. I begin by saying that if I ever have a problem with chronic pain of a particularly lengthy duration, ie., two to three or more years, I would without reservation seek out the assistance of Dr. Lynch.

[55] I would relate their respective evidence to a basic pyramid where the sides of the pyramid reflect the length of time the patient suffers chronic pain. Dr. Lynch is a highly respected specialist who, in my assessment, deals primarily with people who had chronic pain over a prolonged period which would place her mostly (but not exclusively) at and near the top of the pyramid with the base of the pyramid representing the time of injury. Dr. Mahar who would have a much broader

professional practice and experience, permitting him to express, in my opinion, views more reflective of the situation as it relates to stigmatization and stereotyping.

[56] In **Hernandez** v. **Palmer** (1992), 15 C.C.L.I. (2d) 187 at para 194, Stayshyn, J. rejected the argument that the Ontario threshold infringed a. 15(1) of the *Charter*. The Ontario threshold at the time precluded all claims for damages (pecuniary and non-pecuniary) where the nature of the injuries were not serious enough to pass the threshold. In discussing whether automobile accident victims are a traditionally afflicted group who have been disadvantaged, Stayshyn, J. stated:

> I am also of the view that automobile accident victims do not constitute a traditionally afflicted group of the type that s. 15(1) is meant to protect. Thus, automobile accident victims are not "discrete and insular minority" that has suffered political, social and legal disadvantage in Canadian society. Rather, automobile accident victims are a diverse collection of individuals without any common characteristics or history linked only by the chance occurrence of having been injured by a motor vehicle. In essence, everyone is a potential member of this class. The phrase "insular and discrete" is a legal category which has its genesis in United States jurisprudence and has a specific legal meaning of being stigmatized historically and subject to prejudice. [emphasis added]

[57] Second, the fact that certain individuals who suffer chronic pain as a result of an automobile accident may feel disbelieved or stigmatized on the basis that they are exaggerating their injuries for personal gain does not establish that as a group, this is in fact the way that society perceives or treats chronic pain sufferers.

[58] The evidence of Dr. Mahar, a specialist in physical medicine and rehabilitation, is that it is very uncommon for him to encounter sufferers of chronic pain who feel that they are marginalized or discriminated against by their neighbours, friends, families or co-workers as a result of their chronic pain (although they may have issues with employers or third party payors in certain cases). Similarly, the evidence of Ms. Riis (a physical therapist with may years of experience in treating patients who have suffered traumatic musculoskeletal injuries) is that she disagrees that there is general disapproval attached to victims of soft tissue injuries and chronic pain. Since she began practising as a physiotherapist, she has seen significant growth in the amount of publicity around the prevalence of these conditions. Dr. Lacerte is a physical medicine and rehabilitation specialist with broad experience in the area of medical management and rehabilitation of trauma. I specifically note that Dr. Lacerte is certified as a rehabilitation counsellor. This is amongst his very extensive qualifications and I also specifically note that he is responsible for the training of the Ontario Workplace Safety Insurance Board Roster of Physicians who perform non-

economic loss medical assessments. Dr. Lacerte was accepted by all parties as an expert witness with his expertise stated as being a medical doctor with expertise in physical medicine and rehabilitation of trauma injuries. His opinion that most automobile accident victims who sustain a soft-tissue injury will not develop chronic pain or any significant long term functional impairment is accepted as having been established as credible evidence in these applications. In both his affidavit and evidence he commented on Dr. Lynch's evidence with respect to negative social stigma and his evidence included:

> **Q.** Thank you. Dr. Lacerte, at paragraph 6 of your affidavit, you respond to a statement made by Dr. Lynch in her affidavit to the effect that – and I quote here:
>
> "A negative social stigma has historically attached to persons suffering from chronic pain and soft tissue injury."
>
> Would you care to elaborate on your response?
>
> **A.** Well, that is not my – first and foremost, I think we need to separate soft tissue injury from chronic pain.
>
> I mean, they don't equate each other, as I mentioned. I mean, the vast majority of people will not develop chronic pain they're going to result.
>
> And secondly in that group, when you come with your ankle sprain or you come with your back flare up or you're coming with your bursitis or you're coming with your knee osteoarthritis, we're there to basically help people. I mean, there's no stigma attached, and we certainly can help.
>
> And often time, when you look at knee, osteoarthritis sometime it will go for years, you know, before they get a total hip – a total knee replacement.
>
> **Q.** Right.
>
> **A.** After which, the pain you know, resolves in the vast majority of cases.
>
> So, one thing is that certainly it's not my experience dealing with the – you know, with the patient immediately or in the – certainly the first year after the injury, you know, that there is any stigma.
>
> I think the stigma come – may occur when a person present with a lot of co-morbidity, pain, or that has really baffled the person treating. And, you know,

there's a lot of other issues that are compounding the problem like depression and so on.

That's really where, you know, there may be some stigma in some cases.

[59] I do note that his strongest expression of disagreement relates to what Dr. Lynch said in paragraph three of her September 25th, 2008 affidavit. Dr. Lynch recites patients who inform her that they "have been judged" and she extends that adverse judgment to "persons in the medical profession in a negative way". In paragraph six of his affidavit he expresses the opinion which I think is accurate "in my opinion, most practitioners treating pain have a strong preference for assuming an advocacy role on behalf of their patients rather than stigmatizing them." Dr. Lacerte's evidence about the multi-causal aspect of pain and the extensive medical personnel qualified in the diagnosis and management of pain disorders is as said, extensive with each discipline having their own area and their approach might well be different. He specifically singled out family doctors, those working in palliative care, emergency rooms, sports medicine, etc. Under cross-examination Dr. Lacerte indicated that you could have chronic pain without having any significant impact on your day-to-day activities. He made the valid point that medical knowledge moves on with time. Dr. Lacerte has some rather unkind views with respect to lawyers. He recites patients saying things such as "well, my lawyer says, you know, I should wait a bit because it might be too early and I may harm myself". He says that when lawyers take that position it undermines everything he is trying to do from a clinical behavioural perspective.

[60] Dr. Lacerte went on to reciting experiences where people will talk about their soft tissue injury (i.e., on a plane trip, an individual talking about his chronic low back pain) where as a person who is schizophrenic would not engage in conversation about her/his condition and in Dr. Lacerte's view if a person feels social stigma, they don't talk about it.

[61] In short, in his view there is no basis to conclude that there is pre-existing stereotype or disadvantage relating to motor vehicle accident claimants who suffer minor injuries.

The Evidence of Dr. J. David Cassidy:

[62] Dr. Cassidy has extensive experience and qualifications. All parties agreed that Dr. Cassidy was qualified as an expert Epidemiologist, specializing in Injury and Musculoskeletal Epidemiology.

[63] Dr. Cassidy filed a report dated August 18th, 2008. After listening to and reviewing the evidence that Dr. Cassidy gave before me and his report, I accept as very significant his following comment:

> Of particular relevance to this action, I was the scientific secretary of the Decade of the "Bone and Joint Task Force 2000-2010 that published an exhaustive review of the topic of neck pain and its associated disorders (e.g., headache, thoracic backache, radicular arm pain and temporomandibular disorders associated with neck pain). My role as scientific secretary was to maintain scientific rigor during this six-year international task force. The task force reviewed the world scientific literature on neck pain and summarized these findings with respect to epidemiology (incidence, prevalence and risk), diagnosis, prognosis and treatment. This Task Force consisted of a 5-member Advisory Committee of the Task Force consisted of world experts from various clinical and scientific disciplines, and they reviewed our work on a yearly basis. As part of the Decade of the Bone and Joint initiative, the task force was sanctioned by the World Health Organisation (WHO) and the United Nations (UN). The task force included experts from all relevant disciplines, including surgery, medicine, epidemiology, biostatistics, physical therapy, chiropractic, psychology, neurology, physiatry, occupational therapy, rheumatology, and economics. Our patient care guidelines and best evidence synthesis was published last February in the international journal Spine and the following month in the European Spine Journal. This document is state of the art with respect to evidence-based health care and neck pain.

[64] Dr. Cassidy's review and description of chronic neck pain is similar and comparable to that of the other expert witnesses. There is no specific pathological cause identified for most neck pain but rather that there are multiple risk factors encompassing a multi-causal model that includes biopsychosocial factors.

[65] Dr. Cassidy expresses the view the whiplashes are the most common traffic injury representing about 80% of all traffic injuries. His extensive research included the population based study of whiplash incident and recovery published in the New England Journal of Medicine. This was a study that took place between July 1994 and November 1997 in Saskatchewan when he was a professor at the College of Medicine at the University of Saskatchewan. The study was funded by a grant in aid of research from Saskatchewan Government Insurance (SGI) to the College of

Medicine, and received ethics approval from the University of Saskatchewan's Advisory Committee on Ethics in Human Experimentation.

[66] This is an appropriate point to comment on the extensive, vigorous cross-examination of Dr. Cassidy with respect to professionalism, credibility and weight to be given to the opinions he expressed based on his various research involvements. Mr. Mason, quite properly, extensively cross-examined Dr. Cassidy on the ethical requirements of research standards and of the need to be ever-vigilant with respect to bias and possible influence in research, particularly in regard to the funding of research and also academic advancement.

[67] The extensive cross-examination outlined very substantial funds being provided. In the case of the Saskatchewan study, Saskatchewan Government Insurance. Mr. Mason referred to his cross-examination as a number of propositions that in his view were like motherhood and apple pie. It is clear from the cross-examination that Dr. Cassidy was very familiar with the guidelines requirement of independent research, free of bias and free of outside interference. Dr. Cassidy indicated his familiarity with the World Medical Association Declaration of Helsinki Ethical Principles for Medical Research Involving Human Subjects. He confirmed that the study was reviewed by the Research Ethic Boards of the University of Saskatchewan and also by the University of Alberta. Dr. Cassidy agreed with the proposition "the right of research subjects to safeguard their integrity must always be respected."

[68] I see no reason to elaborate further and make reference to substantial portions of cross-examination as what is essential from the court's point of view is that any expert evidence to be accepted by the court must have the highest degree of independence and objectivity. Such is absolutely necessary for the court to attach significant weight to the experts' opinions. I have no hesitation in concluding that Dr. Cassidy was aware of all the prerequisites necessary and that he conducted himself at all times in an entirely ethical and professional manner.

[69] There is considerable cross-examination with respect to his conflict with a co-worker, Dr. Yong-Hing. I found his response to cross-examination with respect to that conflict thorough and credible.

[70] My remarks with respect to Dr. Youg-Hing equally apply to the cross-examination in relation to Dr. Bartsay.

[71] Mr. Mason, as was his entitlement, chose to attack the credibility and professionalism of Dr. Cassidy and did so for most of his cross-examination and spent very little effort in attacking the actual expert opinions expressed by Dr. Cassidy.

[72] Dr. Cassidy confirmed what was peer review in the New England Journal of Medicine is peer review and he stated specifically:

> **Q.** Isn't that a peer review?
>
> **A.** No, that's not peer review. The New England Journal of Medicine is peer review, sir.
>
> **Q.** Sure.
>
> **A.** And we did many, many analyses at the request of the New England Journal, and their statistician asked us a lot of the questions that you have asked, and we showed those analyses to that statistician.
>
> **Q.** Gotcha. But there'd be no way —
>
> **A.** That's peer review. That's scientific peer review.

[73] Dr. Cassidy noted that one of his constant and severe critics was an expert witness to plaintiffs in law suits and that was how that individual makes his living. This prompted Mr. Mason to suggest Dr. Cassidy made his living off of the insurance industry and his response was as follows:

> **Q.** And you make your money off Saskatchewan Government Insurance, doctor? Isn't that right? You made over three million dollars from SGI between 1995 and 2001.
>
> **A.** No. That money was granted to the University of Saskatchewan. I was paid a salary from the University of Saskatchewan, just like any other professor.

[74] In re-examination Dr. Cassidy said the following:

> **Q.** Okay. So fair to say then that after these kerfuffle's that my friend has presented you with today, your article was still peer reviewed and published by New England Journal of Medicine subsequent to those issues if you will?

A. It was.

...

Q. Okay. And about what was the time frame of those critiques and your response?

A. Well, it would have been shortly after the publication of the paper.

Q. So late 2000, into 2001?

A. October 2000.

Q. Okay, thank you. And oh, yes. It says on the document. Then subsequent to that when we had spoken direct this morning about the treatment of your article, the New England Journal of Medicine article and of course it's not your article, you're the lead author. But the treatment of that article by the Decade of the Bone and Joint Task Force, when was that study completed?

A. That was published in February of 2008, this year.

Q. Okay. So subsequent to the various critiques that my friend has put to you today?

A. Yes.

Q. Okay. And in the development of your study, I think you referred my friend, but I want to be clear. You referred him to the fact that a number of, you called them REB's approved of the study and REB is what?

A. Research Ethics Board.

Q. And could you describe which Research Ethics Boards approved of your New England Journal of Medicine Research study?

A. The one that was published, or subsequent analyses on that?

Q. All of them.

A. The University of Saskatchewan, the University of Alberta, the University of Toronto and Karolinska Institute in Stockholm.

Q. So all of these institutions have research ethics boards and all of them at different times condoned the approach of your study?

A. Yes.

...

Q. So how does that square with my friend's suggestion that these definitional terms were dictated to you?

A. Well, they weren't dictated to us. We took into account opinions from various people about claim closure but again, the main thing is that we actually studied its association with self-reported health recovery.

Q. Okay. An you've mentioned that point many times?

A. It's an important point and it's one that's often used to discredit the study.

[75] Dr. Cassidy in his report talked of the Saskatchewan study as follows:

> The study included all Saskatchewan adults, 18 years of age and older, who either made an insurance claim or where treated for a traffic injury between July 1, 1994 and December 31, 1996. On January 1, 1995, the insurance system changed from a tort-based system to a no-fault system. This eliminated most court actions for whiplash and greatly increased medical and income replacement benefits for injured claimants, regardless of fault. Of the 9,006 injured subjects eligible for our study, 7,462 reported whiplash injury to the neck (83% of all injuries). We found that the incidence of whiplash injury decreased from 417/100,000 Saskatchewan adults during the last 6 months of the tort period, to 302/100,000 in the first 6 months of the no-fault period and to 296/100,000 in the second 6 month period of the no-fault change. The greatest change was for younger persons and males, although the incidence for females was greater than males throughout the study period (see Table 2 in Cassidy at al., 2000). Overall, there was a 43% decrease in claims for men and a 15% decrease for women. With respect to claim duration, the median time to claim closure decreased from 433 days to 194 days, indicating that claims closed about twice as fast under the no-fault legislation. During both the tort and no-fault periods, we found that improvements in neck pain intensity, physical functioning and depressive symptoms resulted in faster claim closure. During both the tort and no-fault periods, claim closure was also independently influenced by age (older individuals took longer to close their claims), gender (females took longer to close their claims), pain intensity and spread (those with greater pain intensity and greater percentage of body in pain took longer to close their claims), lawyer involvement (claimants that retained legal advice early in the claim process took longer to close

> their claims), and early provision of health care (those that consulted both a medical practitioner and chiropractor took longer to close their claims than those that did not seek care, or had care from medical doctors alone, or with physical therapy).

[76] Dr. Cassidy went on to indicate the Saskatchewan study had limitations. He referenced them in his report in detail. Dr. Cassidy was asked to explain why the elimination of compensation for pain and suffering is associated with a decreased incidents and an improved prognosis of whiplash injury and said that they observed these findings in Saskatchewan but cannot state with certainty why this happened. He said that they suspect the elimination of payments for pain and suffering might have affected the decision to claim for an injury in some cases. With respect to improved prognosis, he commented that they believe the tort system is more adversarial and that legal conflict can delay recovery. **An adversarial system focussed the patient on pain and disability which is counter to the best methods of treatment which focusses patients on their abilities** [emphasis added]. He stated "in essence, tort insurance is counter-productive to proper health care after injury".

[77] Dr. Cassidy comments on the affidavit of Dr. Mary Lynch with respect to the types of losses due to soft tissue injury listed by Dr. Lynch. He responds "most of the symptoms that she lists are associated with depression ... loss of energy, appetite, sleep, sex drive, fun, self-esteem, confidence and ability to process information." He expanded further and of significance he went on to say that the neck pain task force found no evidence to support Dr. Lynch's view that chronic whiplash affects the ability of women to initiate or maintain a pregnancy, or to breast feed. He is not aware of any scientific evidence to support this view for any chronic pain patients.

[78] Finally, he notes that Dr. Lynch is in disagreement with the findings of the Decade of the Bone and Joint 2000-2010 Task Force on Neck Pain and Its Associate Disorders. In Dr. Cassidy's final statement in his report:

> In my opinion, it would be contrary to the best scientific evidence and not in the public interest to increase access to insurance benefits for pain and suffering after traffic injury. This would likely increase the number of claims and delay recovery from injury.

[79] It is to be noted that it is not an issue before me as to whether or not there should be increased access to insurance benefits. The constitutional issues before me do not encompass that question and while I have accepted the thoroughness of Dr. Cassidy's research and have a preference for his opinions where they are in conflict

with Dr. Lynch's, I would want to have a far more extensive hearing focussed on the final opinion expressed by Dr. Cassidy before adopting it as having been established.

[80] Dr. Cassidy's report and evidence does not bear on the allegation of stigmatization and stereotyping except in a very marginal manner in that any program that eliminates or reduces litigation thereby reduces exposure to the adversarial system and its pressures.

Evidence of Dr. E. M. Rosenberg:

[81] Dr. Rosenberg filed a report dated May 16, 2008 and gave evidence in the applications. Dr. Rosenberg's report focussed on issues relating to post-traumatic stress disorder and chronic pain from the perspective of a psychiatrist. In the application all parties agreed that he was qualified as an expert in adult psychiatry including the definition, diagnosis, symptoms, treatment and neurological and physiological implications of post-traumatic stress disorder and including psychiatric evaluation of individuals suffering from pain disorders.

[82] Dr. Rosenberg's report and direct evidence deals with post-traumatic stress disorder, chronic pain, restoration of functionability, multi-factor consideration of pain. He did not touch upon the matter of stigmatization or stereotyping until cross-examined by Mr. Mason. Dr. Rosenberg acknowledged that if someone in a position of authority held a view and expressed a view publically that promoted negative social stigmas or stereotypes against a particular individual within a group that that could affect the stress and anxiety or even depression of that individual and he simply said it could.

[83] A significant part of his evidence in response to Mr. Mason's cross-examination is as follows:

> **Q.** Let me ask you this, from your experience if you have an accident victim that comes in and you've had discussions with accident victims in a number of cases, of course, and treated people in a number of cases, correct?
>
> **A.** Yes.
>
> **Q.** Yeah. If you had an accident victim come in and they read this and said look, I feel like I'm being blamed for an increase in premiums, would you take that seriously?

A. Would I take it seriously?

Q. Yeah.

A. I would try and explore it in the best psychiatric fashion with the individual.

Q. Sure. Would you feel that that was demeaning an accident victim?

A. No.

Q. You wouldn't? Okay. Let's carry on. Let's go to Tab 2. This is a news report – again it appears to be a release by the Insurance Bureau of Canada. I'm looking at Select Committee Ignores Consumers, an Auto Insurance Report.

Do you see that, doctor?

A. Yes.

Q. And you'll see in the 4th paragraph:

> "The Committee results are extremely disappointing, Forgeron says."

Mr. Forgeron will be testifying later in his hearing. He's with the Insurance Bureau of Canada.

A. Okay.

Q. "The reasons for high rates, high rates are crystal clear. But the committee has chosen to focus on the symptoms of the problem instead of solving the larger issues behind increases, namely soft tissue injury awards."

My question to you, doctor, is this – when you're reading this, does this give you the impression or you – do you form the conclusion that soft tissue injury victims are being blamed for high rates and premiums?

A. I don't assign any blame to it at all.

Q. You don't? If you were an accident – you had an accident victim come into your office and tell you that this is causing them stress and anxiety would you suggest or would you feel that that does in fact cause stress and anxiety?

Or could cause stress and anxiety.

A. To the particular individual?

Q. Yes.

A. I think it might cause stress for to the particular individual.

Q. Sure.

A. But again I wouldn't assign blame.

Q. All right. All right. Let's go to the next tab. Okay?

A. Okay. Tab 3.

Q. Tab 3. This is a newspaper article, it was referred to earlier, Newfoundland and Labrador still dealing with higher auto insurance rates. I just want to look at the first sentence in here, doctor:

> "Automobile insurance rates in Newfoundland and Labrador have more than doubled since 1990 primarily due to claim payments for pain and suffering awards involving minor injuries."

Is you answer the same to this as well, that this would not demean or cause stress for an accident victim, minor injury accident victim?

A. I can't find anything demeaning in this statement.

Q. You can't, eh? Okay. All right. If minor injury victims, significant portion of minor injury victims, doctor, are being referred to as fraudsters in the community – of communities and public, is that something that would cause you concern that it would be demeaning to accident victims?

A. If someone, an individual is referred to as a fraudster, specifically referring to that individual, that could be viewed as demeaning.

...

Q. All right. Let's turn to Tab 6 in our documents. This is from Canadian Insurance E-news, another press release dated February 6th, 2002.

Again I'm not asking whether this is true or not. But the fact that the statement is made is what's important to me and what I'm putting to you. It says:

"Sprains and strains the culprit in Nova Scotia."

Then it goes on to speak about the problems with escalating insurance premiums and the driver of that bodily injury claims. Does the comments, doctor, "Sprains and strains the culprit", does that suggest to you that accident victims are demeaned or have been demeaned in today's society?

A. No.

Q. It does not?

A. No.

Q. You think that's perfectly fine, do you?

A. Oh, I don't think it's perfectly fine. I think it's an example perhaps of hyperbole in the press.

[84] Mr. Mason went on to refer to a study done at St. Francis Xavier University where the term opportunistic fraud is defined and Mr. Mason suggested to Dr. Rosenberg that this would be demeaning to accident victims and Dr. Rosenberg's answer was:

A. If you pointed it out to the accident victim. I don't know how many accident victims would have access to this study.

[85] Dr. Rosenberg was shown the video and his evidence is as follows:

Q. So, doctor, I see you have a smile on your face and you had a little bit of a chuckle I thought when you saw the injured victim in this being portrayed in this video running back into the home.

Is this something that you find would be demeaning to accident victims in this province, that that type of video would be on a website with a national organization.

A. If it was pointed out to them, yes.

Q. Okay. So we have studies that have been prepared, dealing with opportunistic fraud that are out in the academic literature, correct? We looked at that.

A. Yes.

Q. Okay. We looked at a video, sir, that I would suggest to you was for a period of time on a national website of the Insurance Bureau of Canada.

A. Yes.

Q. Okay. And you would agree with me with that type of information out there in the public that that would have – that would entrench the negative stereotypes against accident victims, wouldn't it?

A. I don't think I would go that far. I would go back to what I said if it was pointed out to the claimants that this was a possibility.

Q. Sure. What if their neighbour saw it and spoke to the accident victim about it? That's something that you would fee [sic] would have a negative impact on the accident victim, correct?

A. Again the same thing would apply. It would have to be pointed out to the accident victim.

[86] Upon re-examination he responded:

Q. In the context of all this sort of discussion that surrounds us, how does that bear on particular individuals that you treat as patients?

A. Quite honestly, very little. Most people are concerned about themselves, and themselves within the context of society, not with what somebody else is saying about them.

There are certain instances where an individual will complain about a particular individual, an employer, or a particular stress of the workplace, but as a part of a group I've not encountered that.

[87] I repeat what I said earlier that there is no evidence as to the number of people who may have seen the video *et cetera* and that the video was not established before me to be a best seller.

Evidence of Viivi Riis:

[88] Ms. Riis is the type of expert witness that has credibility built upon a strong base of practical experience, i.e., 1979 to 1986. Physiotherapy private practice then Worker's Compensation Rehabilitation Centre and at Sonnybrook Health Sciences Centre. She moved on from this hands-on practical experience to management services assisting injured persons to navigate the public/private health care system. She has done work with individual insurance companies and was hired on a consulting basis in 2000 by IBC to develop and deliver educational materials for auto insurance claims adjusters. Active also in a teaching capacity at the University of Toronto. Her qualifications as an expert in physical therapy with particular expertise in treating patients who have suffered traumatic musculoskeletal injuries, including strains, sprains and traumatic injuries was accepted by all parties.

[89] Ms. Riis' affidavit with attachments is extensive.

[90] In her affidavit, Ms. Riis responds directly to that portion of Dr. Lynch's affidavit where Dr. Lynch references "a negative social stigma... attached to persons suffering from chronic pain and soft injury". Her response is:

> ... I do not agree that there is a general disapproval attached to victims of soft tissue injuries and chronic pain. Indeed, since I began practicing as a physiotherapist more than twenty years ago, I have seen significant growth in the amount of publicity around the prevalence of these conditions. There has been a commensurate increase in the research effort in this area and in the academic journal articles making the results of this research available to health professionals.
>
> It is my experience that when patients become involved in legal proceedings arising from an injury, they may feel quite uncomfortable with the processes involved. By their very nature, such suits can involve various medical examinations and questioning by representatives of all the parties involved in the case. These processes can be arduous, even exhausting and, as a treating practitioner, I have seen the emotional impact they can have on people. I have also with some frequency encountered surprise and resistance from injury victims when their health care providers advise and advocate active approaches to treating conditions such as chronic pain. These approaches include an emphasis on movement, exercise and return to function in spite of ongoing pain.

[91] She also disputes Dr. Lynch's evidence where Dr. Lynch expresses a view there are not enough medical specialists appropriately trained in the diagnosis and the management of pain disorders to handle the volume of patients in Nova Scotia. Her response was:

> ...Indeed, multidisciplinary rehabilitation is considered desirable for the management of chronic pain and is available in more than two centres in Nova Scotia. The majority of outpatient treatment of injuries resulting from automobile collisions, including chronic pain conditions, takes place outside the publicly funded health system, where it is directly funded by auto insurers. In Nova Scotia, there are many private health facilities where multi-disciplinary care, appropriate for treatment of soft tissue and chronic pain conditions, is funded by private sources, including WCB, auto insurance and supplementary health insurers. By way of illustration, I have attached, as Exhibit J to this affidavit, a list of treatment facilities that are recognized by the Nova Scotia WCB for multi-disciplinary and inter-disciplinary management of injuries including musculoskeletal injuries and chronic pain.

[92] In her evidence she stated:

> **Q.** Paragraph 17 of your affidavit, you respond to the statement made by Dr. Lynch at paragraph 9 of her affidavit, in which she states:
>
> > "A negative social stigma has historically attached to persons suffering from chronic pain and soft tissue injury."
>
> And do you agree with that statement? Or you've responded to it. Maybe you could elaborate.
>
> **A.** Yeah. I don't – I don't agree that there's a negative social stigma.
>
> In fact, in my experience, in the last 10 to 15 years, and in my involvement in the chronic pain academic world, as well as with those patients, I think there is more and more acceptance of chronic pain or invisible conditions as legitimate and real.
>
> I think the academic literature has shown an exponential growth in research on pain. The World Health Organization has recognized pain internationally. Pain is – pain relief is considered a human right.

> So I think from a social standpoint, there's no longer that attitude. I think at some point in time there may have been this concept that if you can't see an injury, you know, something fishy's happening. I don't think that exists anymore.
>
> **Q.** Do you draw any distinction between people who suffer a soft tissue injury, acute pain over weeks and months, eventually return to their pre-injury function, versus someone who has developed chronic pain on this particular point of potential stigma, or being judged negatively?
>
> **A.** I do – I do see a distinction. I think all of us in the court room have probably had a week-end sports injury and – or a fall or sprained our ankle, and we go on to uneventful recovery. And I don't believe that there's a social stigma attached to that kind of injury.
>
> However, I think if complications arise, and somebody doesn't recover from their injuries as expected, then often this engine starts to turn where they might be seeing several doctors.
>
> If they have a claim they're seeing doctors who will produce very different opinions of what's causing their symptoms and pain. And I think that process really changes the individuals' sort of health environment.

[93] She elaborated further in her evidence about the impact of an injured party seeing a physician who would express a certain opinion and then another physician selected by their representative who would have a completely opposing opinion and that often the insurer would then get a third opinion. She has seen patients who have seen four, five and six doctors. She indicated that this forces the patient to focus on and repeat their symptoms. She expressed the view for continuing education and that although the normal response to pain is to avoid it, when somebody moves into chronic pain the opposite advice becomes true and that person needs to move and stay active as much as possible.

[94] She repeated the contents of her affidavit as relates to Dr. Lynch's view that there were not enough medical specialists available by stating the following:

> **A.** In my experience, chronic pain management is recommended in the literature to occur in a multi-disciplinary setting. So most of the pain protocols that I've encountered in my work involve private practices that are manned by physical therapists, occupational therapists, chiropractors, massage therapists, psychologists.
>
> These practices may exist in a single physical facility, but often they are virtual interdisciplinary practices where a physical therapist, occupational

therapist and psychologist may have separate physical locations, or in fact the treatment may be delivered in the community in the patient's home, and they communicate with each other throughout the process of treatment to deliver care. Now, these kinds of practices are typically funded privately, but certainly in the auto insurance sector, auto insurance companies are aware of these kinds of facilities and use them.

In Nova Scotia, I spoke with the – a colleague in Nova Scotia who indicated that there are a number of such practices through the province. And I also then consulted with the WCB of Nova Scotia and they identified a number of clinics that deliver that kind of multi-disciplinary care.

Q. And just turning to paragraph 20, you summarize your evidence. Can you briefly just comment on your summary at paragraph 20?

A. Again, in my experience, the majority of the people I've worked with who have traumatic musculoskeletal injury go on to an uneventful recovery, but when I use the word, "recovery," it's not necessarily pain free. Often there is residual pain, and it's really a matter of enabling the person to function at as high a level as possible while coping with their pain.

And again, there's much work in the literature on cognitive behavioural therapy and helping the person cope with the pain, live with the pain and function as opposed to not function.

[95] Ms. Riis was subjected to vigorous cross-examination. She was pressed as to the remunerations received from insurance companies and it appears that between 1992 and 1997 and for the period to 2003 the ratio of her income was 60/40 and subsequently 50/50. She had more engagement with plaintiffs' lawyers. Her evidence at trial:

Q. More engagement. I'm thinking about income, because —

A. Yeah. More income.

Q. And so the plaintiff lawyers actually paid you for your services.

A. Yes.

[96] Since 2004 most of her work is consulting with insurance companies, health professions such as the Ontario Physiotherapy Association, Ontario Chiropractic Association and some co-ordination of health services in a public/private sector.

When questioned about stigma she indicated that that means we are talking about society as a whole and therefore talking about a societal question. She has heard that some insurance adjusters talk of soft tissue injury victims as people who have "won the auto lotto".

> **Q.** Yes. But have you heard from insurance adjusters or members of society at large that, "look, these soft tissue injury victims are causing our premiums to go up or auto insurance premiums to go up"?
>
> **A.** I have heard that, and I think that's a fact.

[97] With respect to malingering, the suggestion that soft tissue injury victims are malingerers she stated:

> **A.** You know, I know there are individuals that feel that way. Again, I think there are individuals in any field, whether it being the insurance industry, the health profession, the legal profession – I think there are people in all walks of life who have that perception, but I think it's the exception and not the rule.

[98] With respect to fraud it is her view and based on her experience that some health professions are enabling fraudulent activities and she has had personal experience where she has received an invoice from a health professional, show it to an injured person and the injured person would say "I didn't go for treatment on those days". Her conclusion is that fraud happens but based on her experience it is driven in large part by the health professional community and whether the claimants are engaged in fraud, that has not been her experience. She quite readily acknowledges that she does not have any empirical evidence but, based on her experience, she does not accept that insurance adjusters and society at large contain a large percentage of people who view accident victims as persons who are committing fraud.

> **Q.** Yeah, okay. Thank you. And as I understand it, your position that you don't feel that there's a general disapproval attached to victims of soft tissue injuries with chronic pain is based on the academic literature out there. There's been a lot more studies done on these types of conditions. Correct?
>
> **A.** That and also organizations such as the Canadian Pain Society, the Canadian Pain Coalition. They're far more visible now. They're far more engaged with the general public. They're far more engaged with support groups. So people who suffer from chronic pain can talk to other people who have chronic pain. And I just think there's more in the general public or in the public realm, as well as in the academic literature.

[99] She gave evidence of one of the questions in the health care community is the problem of over-treatment and she gives the example to give massage therapy five days per week, two hours per day where there is no evidence that that kind of treatment will help anybody with pain recover any faster. And yet she says that this happens all the time.

> **Q.** In terms of – Dr. Lynch – her affidavit stated that there are not enough medical specialists appropriately trained in the diagnosis and management.
>
> So, would you agree with her that while there may be a whole group of people out there that are treating, they're not appropriately trained to provide a diagnosis?
>
> **A.** No, I wouldn't agree with that.
>
> **Q.** You wouldn't. So is it your view that a physiotherapist can diagnose soft tissue injury, chronic pain?
>
> **A.** No.
>
> **Q.** No.
>
> **A.** But a physical therapist is trained at the undergraduate level to recognize that somebody's condition may be moving into chronic pain.
>
> **Q.** Yeah.
>
> **A.** Typically a physical therapist would treat somebody in the acute phase and generally recovery occurs in six to 12 weeks, but if one is approaching 12 weeks and the patient continues to have pain that affects their ability to function then the therapist should be starting to think, "Okay, what's going on here? Have I missed something? Okay, let's send the patient back to the GP who may send the patient to a specialist for assessment."
>
> And as that moves forward eventually a diagnosis of chronic pain may be made by somebody, such as the family physician or the orthopaedic surgeon or the physiatrist or the psychiatrist or – there are a number of professions that I understand can diagnose chronic pain.

[100] Wherever the evidence of Viivi Riis is in conflict with the evidence of Dr. Mary Lynch, I prefer the evidence of Ms. Riis.

[101] The Supreme Court of Canada has consistently said that a proper factual foundation must exist before measuring legislation against the provisions of the *Charter*. In **MacKay** v. **Manitoba**, [1989] 2 S.C.R. 357:

> The Essential Need to Establish the Factual Basis in *Charter* Cases
>
> *Charter* cases will frequently be concerned with concepts and principles that are of fundamental importance to Canadian society. For example, issues pertaining to freedom of religion, freedom of expression and the right to life, liberty and the security of the individual will have to be considered by the courts. Decisions on these issues must be carefully considered as they will profoundly affect the lives of Canadians and all residents of Canada. In light of the importance and the impact that these decisions may have in the future, the courts have every right to expect and indeed to insist upon the careful preparation and presentation of a factual basis in most *Charter* cases. The relevant facts put forward may cover a wide spectrum dealing with scientific, social, economic and political aspects. Often expert opinion as to the future impact of the impugned legislation and the result of the possible decisions pertaining to it may be of great assistance to the courts.
>
> *Charter* decisions should not and must not be made in a factual vacuum. To attempt to do so would trivialize the *Charter* and inevitably result in ill-considered opinions. The presentation of facts is not, as stated by the respondent, a mere technicality; rather, it is essential to a proper consideration of *Charter* issues.

[102] The Supreme Court of Canada reiterated the requirement of a proper factual foundation in **Danson** v. **Ontario (Attorney General)**, [1990] 2 S.C.R. 1086:

> The Need for Facts
>
> This Court has been vigilant to ensure that a proper factual foundation exists before measuring legislation against the provisions of the *Charter*, particularly where the effects of impugned legislation are the subject of the attack. For example, in *R. v. Edwards Books and Art Ltd.,* [1986] 2 S.C.R. 713, at pp. 767-68, this Court declined to hold that the *Retail Business Holidays Act*, R.S.O. 1980, c. 453, infringed the s. 2(a) *Charter* rights of Hindus or Moslems in the absence of evidence about the details of their respective religious observance. Similarly, in *Rio Hotel Ltd. v. New Brunswick (Liquor licensing Board)*, [1987] 2 S.C.R. 59, at p. 83, this Court declined to consider a s. 2(b) *Charter* challenge to certain provisions of the *Liquor Control Act*, R.S.N.B. 1973, c. L-10, in the absence of evidence on the nature of the conduct that was claimed to constitute "expression" within the meaning of s. 2(b).

[103] I am, however, particularly mindful of the remarks of Iacobucci, J. in **Law**, *supra*, at p. 535:

> One consideration which the Court has frequently referred to with respect to the issue of pre-existing disadvantage is the role of stereotypes. A stereotype may be described as a misconception whereby a person or, more often, a group is unfairly portrayed as possessing undesirable traits, or traits which the group, or at least some of its members, do not possess. In my view, probably the most prevalent reason that a given legislative provision may be found to infringe s. 15(1) is that it reflects and reinforces existing inaccurate understandings of the merits, capabilities and worth of a particular person or group within Canadian society, resulting in further stigmatization of that person or the members of the group or otherwise in their unfair treatment. This view accords with the emphasis placed by this Court ever since *Andrews, supra,* upon the role of s. 15(1) in overcoming prejudicial stereotypes in society. However, proof of the existence of a stereotype in society regarding a particular person or group is not an indispensable element of a successful claim under s. 15(1). Such a restriction would unduly constrain discrimination analysis, when there is more than one way to demonstrate a violation of human dignity. I emphasize, then, that any demonstration by a claimant that a legislative provision or other state action has the effect of perpetuating or promoting the view that the individual is less capable, or less worthy of recognition or value as a human being or as a member of Canadian society (whether or not it involves a demonstration that the provision or other state action corroborates or exacerbates an existing prejudicial stereotype), will suffice to establish an infringement of s. 15(1).

[104] I am mindful, also, of Mr. Siebrits quoting from **Law** in his final argument referencing portions of paragraph 77 as follows:

> "A court may often, where appropriate, determine on the basis of judicial notice and logical reasoning alone whether the impugned legislation infringes Section 15(1). It is well established that a court may take judicial notice of notorious and undisputed facts or of facts which are capable of immediate and accurate demonstration by resorting to readily accessible sources of undisputed accuracy."

A little further down:

> "There will frequently be instances in which a court may appropriately take judicial notice of some or all of the facts necessary to underpin a discrimination claim and in which the Court should engage in a process of logically reasoning from those facts to arrive at a finding that Section 15(1) has been infringed as a matter of law."

Factor Two: The correspondence, or lack thereof, between the ground or grounds on which the claim is based and the actual need, capacity, or circumstances of the claimant or others.

[105] The legislative scheme being attacked specifically s. 113B(1)(a) of the *Insurance Act* is, as noted, broader than the Alberta provision held by Whitman, A.C.J. to be unconstitutional. The cap applies to **all** minor injuries and not restricted solely to"soft tissue injuries". The legislative scheme does not deny those accident victims who suffer minor injuries the right to pursue their pecuniary losses such as loss of income, health care costs, loss of domestic services, *et cetera, et cetera*. This provides an interesting contrast with the legislative scheme considered by the Supreme Court of Canada in **Nova Scotia (Workers' Compensation Board) v. Martin** [2003] 2 S.C.R. 504. The Supreme Court of Canada found a lack of correspondence between the *Nova Scotia Workers' Compensation Act* and the needs of injured workers who lost, **entirely**, the right to sue their employer in tort, but receive none of the other benefits (with one limited exception) accorded to other injured workers under the Workers Compensation regime. The *Insurance Act* does not extinguish the right of recovery in tort for minor injuries, and does provide a response to those in this broad category, albeit with a financial limitation. Additionally, the fact that the legislative scheme does not cap the amount of non-pecuniary damages that can be claimed by more seriously injured claimants does not support an argument that those less seriously injured have been stereotyped or discriminated. The remarks of Justice Binnie in **Granovsky**, *supra*, with respect to the distinction between temporary and permanent disabilities is relevant.

> ¶77 ... there is no stigma in being treated as 'better off' where in fact that is the reality of the applicant's medical history"...
>
> ...
>
> ¶81 While I have every sympathy for the appellant's injured back and the problematic employment history to which it may have contributed, I do not believe that a reasonably objective person, standing in his shoes and taking into account the context of the CPP and its method of financing through contributions, would consider that the greater allowance made for persons with greater disabilities in terms of CPP contribution "marginalized" or "stigmatized" him or demeaned his sense of worth and dignity as a human being.

[106] It is worth, again, to note that in **Granovsky**, people with temporary disabilities were completely excluded from receiving benefits.

> Moreover, the correspondence factor of the *Law* test must be applied in a contextual manner that takes into account the fact that perfect correspondence between loss and damage awards is not possible in respect of pain and suffering and loss of expectation of life. This point was made in a trilogy of cases decided by the Supreme Court of Canada in 1978 (the "Trilogy") where the Supreme Court established a cap of $100,000 for non-pecuniary damages for those who have suffered the most catastrophic of injuries.

[107] In **Andrews** v. **Grand & Toy Alberta Ltd.**, [1978] 2 S.C.R. 229, (Andrews – 21 year-old quadriplegic), Dickson, J. (as he then was) at para 261 stated:

> However, if the principle of the paramountcy of care is accepted, then it follows that there is more room for the consideration of other policy factors in the assessment of damages for non-pecuniary losses. In particular, this is the area where the social burden of large awards deserves considerable weight. The sheer fact is that there is no objective yardstick for translating non-pecuniary losses, such as pain and suffering and loss of amenities, into monetary terms. This area is open to widely extravagant claims. It is in this area that awards in the United States have soared to dramatically high levels in recent years. Statistically, it is the area where the danger of excessive burden of expense is greatest.
>
> It is also the area where there is the clearest justification for moderation.

[108] In **Arnold** v. **Teno**, [1978] 2 S.C.R. 287, Arnold was a 4 ½ year-old little girl who suffered brain injuries with severe physical and mental impairment. The Supreme Court of Canada identified the affordability of auto insurance as a social cost that could properly be taken into account in capping non-pecuniary damages.

[109] In **Thornton** v. **School Dist. No. 57 (Prince George)**, [1978] 2 S.C.R. 267, Thornton was 18 years of age at the date of trial. He was rendered a quadriplegic during his school's physical education class. His injuries left him wholly dependent upon male orderly assistance for his day-to-day needs. The British Columbia Court of Appeal approved of the trial judge assessing $200,000.00 (1978 dollars) as compensation for physical and mental pain and suffering, loss of amenities and enjoyment of life and loss of expectation of life. The Supreme Court of Canada reduced the award under this heading to $100,000.00 for the reasons expressed by the Supreme Court of Canada in **Andrews**, *supra*.

[110] In **Lee** v. **Dawson** (2006), 267 D.L.R. (4th) 138 the British Columbia Court of Appeal dealt with an appeal where the jury awarded $2,000,000.00 for non-pecuniary

damages, *et cetera*, and the trial judge reduced this award to $294,600.00 holding that the plaintiff could not be awarded more than the rough upper limit established at common law by the Supreme Court of Canada. This limitation was attacked, arguing that the placing of a common law cap on non-pecuniary damages for a plaintiff with catastrophic injuries constitute a violation of the values consistent with s. 15(1) of the *Charter* in that it was alleged it discriminated against classes of persons injured in negligence actions. The British Columbia Court of Appeal dismissed the appeal based on argument advanced under s. 15(1) of the *Charter*.

[111] It is, at best, debatable whether this factor applies in the applications before me and I conclude the legislation does not exclude the right of recovery in tort from minor injuries. It applies to a somewhat broader category than a more restricted area of soft tissue injuries (although 70 - 80 percent of accident victims suffer alone or in conjunction with some other injury, a "soft tissue injury"). Applying this factor in a contextual manner, I conclude the limitation on recovery which applies to all citizens (albeit impacting only those who have suffered minor injury) falls within the Supreme Court of Canada determination that it is in the area for clearest justification for moderation.

Factor Three: The Ameliorative Purpose or Affects of the Impugned Law Upon a More Disadvantaged Person or Group in Society.

[112] An ameliorative purpose or effect of the impugned law upon a more disadvantaged person or group in society will likely not constitute discrimination under s. 15(1) of the *Charter* where the exclusion of the more advantaged individuals largely corresponds to the greater need or the different circumstances experienced by the disadvantaged group targeted by the legislation. This type of contextual factor is not directly applicable here although it must be remembered that the challenged threshold does yield lower insurance premiums for all drivers, including those who are old, young or poor. Persons who suffer "minor injuries" are not a disadvantaged group in society such as the deaf.

Factor Four: The Nature and Scope of the Interest Affected by the Impugned Law.

[113] The fourth contextual factor identified in **Law** in determining whether the legislation is discriminatory is the nature and scope of the interest affected. The more severe and localized the consequences of the legislation on the affected group, the

more likely that the differential treatment responsible for these consequences constitutes discrimination within the meaning of s. 15(1).

[114] As noted by L'Heureux-Dubé in **Eagan** (cited by Iacobucci, J. at para. 74 in **Law**), the discriminatory calibre of differential treatment cannot be fully appreciated without evaluating the economic, constitutional and societal significance attributed to the interest or interests adversely affected by the legislation in question. It should be considered whether the distinction restricts access to a fundamental social institution or affects "a basic aspect of full membership in Canadian society" or "constitute[s] a complete non-recognition of a particular group".

[115] The unfettered ability to bring an action for non-pecuniary damages is not a fundamental constitutional and/or societal interest. This can be seen from the rulings of the Supreme Court of Canada imposing a cap of $100,000 (in 1978 dollars) on all non-pecuniary damages claims, as explained in the various passages from the Trilogy cited above. Moreover, it has already been established in other areas that a restriction on a person's ability to sue for non-pecuniary damages is acceptable. For example, the fact that there is a significant restriction in terms of what an injured worker can obtain for non-economic loss under provincial Workers' Compensation legislation as compared to that recoverable under the tort system has been held not to engage s. 15(1) of the *Charter.*

CONCLUSION – ISSUE ONE:

[116] The applicants, Gionet and MacDonald, challenge s. 113B (1) of the *Insurance Act*, alleging it discriminates against individuals with certain types of pain and discomfort and therefore constitutes discrimination based on physical disability as defined in s. 15(1) of the *Charter.* As noted in the references to the law as stated by the Supreme Court of Canada, the onus is upon the applicants to establish an infringement of *Charter* rights. The applicants have advanced this position almost entirely by focussing on the factor advanced that they are part of a group that is subject to stigmatization and stereotyping as a consequence of the legislation. I have recited in some detail evidence before me.

[117] In **Morrow** v. **Zhang** (2008), 86 Alta L.R. (4th) 137, Whitman, J.A. at para 205 stated:

> The evidence before me suggests that minor injury victims, particularly those suffering from a whiplash associated disorder are subjected to stereotyping and prejudice. In sum, they are often viewed as malingerers who exaggerate their injuries

> or their effects in an effort to gain financially. The fact that these injuries are often not objectively verifiable may contribute to this perception.

[118] He went on to say that this characterizes this group of injury victims as less worthy and less deserving of damages resulting in the *Act* perpetuating the unfortunate stereotyping that he concluded arose.

[119] The evidence before me not only fails to meet the onus on the applicants to establish an infringement of their rights on a balance of probabilities, but rather the evidence before me establishes overwhelmingly that there is no stigmatization or marginalization **resulting** from the legislation. What limited stigmatization and marginalization exists is a by-product of the adversarial system which pre-dates the legislation and which, through the process of education, etc., is ever-diminishing.

[120] Unfortunately, the nature of the tort recovery system which is adversarial requires patients to focus on their pain and disability which is counter to the best methods of treatment which focusses patients on their abilities. I conclude that the evidence advanced by the applicants falls markedly short of meeting the onus that persons suffering soft tissue injuries, even those that result in chronic pain, are stereotyped, stigmatized or disadvantaged by society.

[121] I note that after having reached my conclusion the following interesting comment by Whitman, A.C.J., in **Morrow**, *supra*, at para. 269 as follows:

> ¶269 I am also in agreement with the Crown that the reasonable person standing in the shoes of the claimant group would be aware that other Canadian jurisdictions had enacted caps in response to what they similarly perceived to be a problem with rising premiums resulting from the increasing claim costs from automobile accidents. However, the reasonable person in the position of the claimant would also know that other jurisdictions that have adopted definitions of "minor injury", such as Nova Scotia, New Brunswick and Prince Edward Island, have not imposed caps that apply exclusively to soft tissue injuries (see Injury Regulation - Insurance Act, N.B. Reg. 2003-20; *Insurance Act*, R.S.N.S. 1989, c. 231 s. 113B(1); *Insurance Act*, R.S.P.E.I. 1988, c. I-4). All three of the definitions of "minor injury" are very similar.

[122] It appears, therefore, that Whitman, A.C.J. concluded the exclusive club whose membership was limited to "soft tissue injuries" bore the entire impact of the Alberta legislation.

[123] As a trial judge I have some difficulty following the directions given by the Supreme Court of Canada. I am compelled to, as I am now doing, consider the four

factors which are neither exhaustive nor is any one factor paramount or is a majority of them required to find discrimination has been proven on a balance of probabilities. I make note of the fact that none of the parties in any of the applications before me suggested consideration of any other factors than those dealt with in **Law**. The applicants Gionet and MacDonald focussed almost entirely on their allegation that the legislation perpetuated disadvantage, stereotyping and stigmatization. In **Kapp**, *supra*, the majority reasons of McLachlin, C.J. and Abella, C.J. revisited the test under s. 15(1) as elaborated in **Law**, *supra*, and direct the second step of the cap test is in essence the perpetuating disadvantage advancing stereotyping and stigmatization. The applicants advance that the definition of minor injury is a discrimination based upon physical disability, however, the definition of minor injury is governed by the duration of the injury, that is minor injuries being less than permanent and less severe than any physical disability is temporary. It seems to me untenable to suggest that those who suffer a temporary minor injury suffer discriminatory treatment under the impugned legislation by comparison to those who suffer enduring serious injuries. An instructive case is **Granovsky** v. **Canada**, *supra,* where Mr. Granovsky suffered a temporary disability that prevented him from qualifying for CPP pension entitlements which were available only to persons with severe and prolonged disability. His claim for discrimination was unanimously rejected.

[124] In any event, as I have already indicated, not only have the applicants failed to establish on a balance of probabilities that the *Insurance Act* s. 113B(1) creates stigmatization and stereotyping, I have indicated that the evidence is overwhelming to the contrary. What stigmatization and stereotyping might be said to exist is on a reducing basis (education) and its existence pre-dates the insurance cap legislation arising on a limited basis out of the adversarial system. I conclude on the totality of the evidence which I reviewed carefully and after reflection on the arguments advanced by counsel that s. 113(B)(1)(a) of the *Insurance Act* does not infringe s. 15(1) of the *Charter*.

ISSUE TWO: Does Section 113(B)(1)(a) of the *Insurance Act* Infringe Section 15(1) of the *Charter* on the Basis of Sex?

[125] The applicants Gionet and MacDonald maintain that s. 113(B)(1)(a) of the *Insurance Act* discriminates on the basis of sex by disproportionately affecting women with minor injuries as a result of an automobile accident. The evidence advanced by the applicants is primarily the evidence of Professor Lucinda Finley who provided an affidavit, supplementary affidavit and gave evidence in court. Her

evidence is, to a limited degree, supported by the personal opinion of Dr. Mary Lynch. In support of her opinion, Professor Finley makes reference in paragraph eight of her affidavit to her examining how juries allocated their awards between economic loss damages and non-economic loss damages in cases where the gender and age of the plaintiff could be ascertained. This particular research referenced in paragraph eight took place in California and her conclusion was:

> .. that a cap on non-economic loss damages has "a discriminatory disparate impact on women and elderly people injured by medical malpractice. The reason a cap on non-economic loss damages has a discriminatory adverse impact on women is that juries award women victims of malpractice a greater proportion of their overall compensatory damages in the form of non-economic damages than male victims of malpractice. A cap on these damages therefore operates to deprive women of a greater amount of their overall award. A cap on non-economic loss also exacerbates existing gender-based disparities in the tort system.

[126] By capping non-pecuniary damages, she maintains that the legislation disproportionately affects the rights of women. She states, specifically with respect to the elderly:

> The reason that the elderly are discriminatorily disadvantaged by caps is that juries also award elderly plaintiffs, both male and female, a much greater proportion of their overall damage awards as non-economic loss compared to non-elderly plaintiffs. This is due to the fact that elderly plaintiffs, whose working days are behind them, do not incur the same extent of past or future wage loss as non-elderly plaintiffs. Moreover, given their shorter life expectancy, elderly plaintiffs will not incur as many years of projected future medical expenses. But despite these reduced areas of economic loss, elderly victims of malpractice still suffer immensely and experience debilitating pain and reduced life activities. Non-economic loss damages become the principal way for the jury to assess the severity and life-altering effects of the injury.

[127] Professor Finley applies her methodology to a study of Nova Scotia motor vehicle injury cases which I will comment on shortly. The first point that should be made is that she is advancing the argument of discrimination based on the proportionality of damages received by women for non-pecuniary damages. The appropriate comparator group being advanced is men who suffer injuries arising out of an automobile accident that exceed the cap. With respect to selecting the proper comparator group I make reference to the test for identifying the proper comparator group as set out by the Supreme Court of Canada in **Hodge** at para. 23 as follows:

> The appropriate comparator group is the one which mirrors the characteristics of the claimant (or claimant group) relevant to the benefit or advantage sought except that

> the statutory definition includes a personal characteristic that is offensive to the *Charter*.

[128] The Nova Scotia Court of Appeal in **Downey** v. **Nova Scotia (Workers' Compensation Appeal Tribunal)**, *supra*, dealt with an appeal where it was argued by the applicant that a cap on his benefits for his chronic pain discriminates against him on the basis of disability and breaches s. 15 of the *Charter*. The Workers' Compensation Appeals Tribunal found that the appropriate comparative group is "injured workers subject to the *Act* who do not have chronic pain and who are eligible for permanent benefits as a result of a permanent medical impairment." The WCAT went on to conclude that the cap was not discriminatory as it found that as compared to workers without chronic pain, no burden was imposed on or benefit withheld from the appellant because he had chronic pain. This finding was after reviewing the four contextual factors identified in **Law**.

[129] The appellant in **Downey** advanced that the appropriate comparator group is the one he outlined as an alternative, workers with permanent disabilities or permanent, partial impairment of greater than six percent who do not experience chronic pain but who are eligible for compensation proportionate to the disability or impairment. The WCAT conclusion was based upon **Hodge** v. **Canada (Minister of Human Resources Development)**, *supra,* Cromwell, J.A., in **Downey**, *supra*, page 12, para 63 commented:

> It was careful to compare the benefits available to workers like the appellant with chronic pain to benefits available to workers without chronic pain. In doing so, it properly took into account the nature of permanent partial disability benefits to all workers, like the appellant, who were injured before 1990.

[130] In the case before me the allegation of discrimination is based on gender.

[131] The appropriate comparator group should mirror the characteristics of the claimant group except for the personal characteristic that is alleged to offend the *Charter* which, in this case, is gender and applying the **Hodge** test, the appropriate comparator group would be males with similar injuries to women. That is, males with injuries arising from an automobile accident that do not pass the threshold. At one time the applicants appeared to have acknowledged this in their brief.

[132] Proceeding on the basis that the appropriate comparator group is males with similar injuries to women, (i.e., minor injuries) it is clear that there is no discrimination against women. There was no allegation that the intent of the

legislation was to discriminate against women and as to the effect of the legislation, s. 113(B)(1)(a) treats men and women in an identical fashion in terms of their ability to recover pecuniary and non-pecuniary damages. The impugned provision does not create a distinction based on enumerated or analogist ground. As both men and women recover full pecuniary damages and both men and women who suffer minor injuries receive non-pecuniary damages up to the cap of $2,500.00.

[133] Although I have concluded that there has not been established any discrimination by s. 113(B)(1)(a) on the basis of sex, the applicants went to a great deal of time, effort and expense to advance the evidence of Professor Finley and I want to give them the benefit of my assessment of her evidence.

[134] It is clear from Professor Finley's affidavits that she bases her ultimate opinion with respect to Nova Scotia substantially on her analysis of jury awards, for example, in paragraph five of her main affidavit:

> .... Any cap on non-economic loss damages will deprive women of a much greater proportion of what a jury awards than men. Such caps lead to an inequality in compensation for women and unequal access to justice for women.

[135] Earlier in paragraph five of her affidavit, Professor Finley also does not hesitate to make several pronouncements, including that where there is a cap on non-economic damages it impairs the ability of accident victims to find legal representation and, further, in her expert opinion there is no evidence that caps on non-economic damages have any significant affect on insurance rates. In her expert opinion where there are caps, insurance companies' profitability increases and insurance premiums are not reduced, *et cetera*.

[136] Jury awards in the United States of America are not a particularly strong foundation for expressing opinions on the damage recoveries made in Nova Scotia primarily by reviewing a limited number of judge alone reported cases (or in this case an unreliable chart).

[137] Professor Finley's background and research upon which she places great reliance, relates further in paragraph eight to her examining how juries allocated their awards between economic loss damages and non-economic damages in cases where the gender and age of the plaintiff could be ascertained. One of her supporting arguments is that the reasons a cap on non-economic loss damages has a discriminatory, adverse affect on women is that juries award women, victims of medical malpractice, a greater proportion of their overall compensatory damages in

the form of non-economic damages than male victims of medical malpractice. Therefore, the cap operates to deprive women of a greater amount of their overall award.

[138] All of Professor Finley's "research" is really unnecessary for the court to recognize the simply obvious situation that when you are dealing with economic damage awards, they are related to the employment and remuneration from employment. It is an acknowledged fact that initially, predominantly males were in the workplace and were paid more than those women who ventured forth. That is still the case today although, very clearly, women have made advancements since then, particularly in professions such as medicine, law, real estate, the military, teaching, governments of all levels, bus drivers, *et cetera*, *et cetera*. The conclusion advanced by Dr. Finley is a generalization women in the workforce in our society overall tend to have less employment advancement opportunities and income than their male counterparts. I take judicial notice of that still being the situation in Canadian society (Nova Scotia) but what **you cannot take judicial notice of is the degree and extent to which it continues to exist**.

[139] Acknowledging there continues to exist a degree of disparity between the employment and remuneration of females in Canadian society does not permit the court to speculate. To determine the degree and extent of any disparity would require evidence as to the impact of societal changes, wage parity and other legislation, examination of how damage awards relate to a personal decision by a house husband or house wife, to remain entirely or partially out of the work force, *et cetera*, *et cetera*. The degree to which judicial notice takes into account the continued existence does not automatically permit the conclusion discrimination exists in tort recovery between males and females. Professor Finley, wherever she notes a distinction or difference between the tort recovery, automatically labels it discrimination.

[140] In paragraph nine of her affidavit, Professor Finley makes it clear that she utilizes her findings for California medical malpractice suits for determining her expert "testimony" relative to the cap on non-economic damages imposed in Nova Scotia. In fact, in paragraph nine she specifically states "I recently performed a similar study of Nova Scotia motor vehicle injury cases."

[141] Professor Finley went on to outline her methodology. It is clear that she did not do the research herself and that the research was faulty and unreliable. What Professor Finley did hardly qualifies as her having performed a study. What she did

was far too superficial to be labelled anywhere near research or a "study". It is probably correct that some of the errors pointed out to Professor Finley (but not all) are supportive of her basic thesis; nevertheless, the reliability of her so-called research foundation in Nova Scotia is far from the thorough type of research the court would want to rely upon in accepting all or a portion of an expert's opinion.

[142] I want to make it clear that I am not suggesting an expert cannot rely upon research done by others, indeed, that is a very common practice. In the applications before me the experts rely upon publication of articles that have passed strict ethical and peer review. In addition, experts utilize statistics from what are considered reliable sources such as Statistics Canada. Clearly, here, the "research" foundation to which Professor Finley applies her methodology is sloppy, amateurish, far from thorough and unreliable.

[143] I will recite, shortly, some of the evidence of Professor Finley which helped to lead me to the clear conclusion that her so-called research as it relates to Nova Scotia motor vehicle injury cases was shallow and unreliable.

[144] Professor Finley has gone through an exercise with one goal in mind, not objectivity but to advance the premise concluded by her in her previous research and, in particular, the California jury cases. In order for any expert to have credibility, the expert should have some measure of objectivity in questioning of her thesis without its blind acceptance.

[145] Professor Finley says the Nova Scotia cap on non-economic damages will have the effect of rendering women's soft tissue injury claims virtually worthless and that has really not been established by any evidentiary basis and, even if it were, it would apply equally to males.

[146] Professor Finley also advances herself as an expert in relation to the elderly and minors. The foundation for her expert and professional opinion is very narrow, perhaps as little as three cases reviewed. And yet she has no hesitation in suggesting the disproportionate impact of the cap on non-economic damages on the elderly is as she found in her study of California medical malpractice cases.

[147] Professor Finley's opinion with respect to Nova Scotia is based on a chart, the author of which has not been identified. Very clearly she never took the time and effort to look at the cases that are supposedly the foundation for the chart. It is quite probable that Professor Finley never even read the headnotes of the cases she relied

upon. It is quite appropriate for an expert to author research which the expert may or may not personally participate in, but one would normally expect the expert to have provided direction, guidelines, possibly some degree of supervision and at least some measure of checking the results of the research.

[148] Some of her evidence that has led me to the foregoing is as follows:

Q. Okay. And am I right in you've never written about Canadian law?

A. That is correct.

...

Q. So this is the only case in which you've actually testified in Canada?

A. Yes.

...

Q. And is the jury trial more the rule than the exception in these sorts of cases in the United States?

A. Yes, I think it is more the rule.

Q. Okay.

A. I know that's a big difference from Canada.

...

Q. For those sorts of injuries are you able to give us an idea of what would be typical non-economic jury awards in American courts?

A. No. I haven't studied that. I couldn't tell you.

Q. Would you anticipate those awards to be higher?

A. I really think I have no basis to answer your question. I haven't studied soft tissue auto injury cases in the US.

...

Q. In American courts when a plaintiff wins a case do the courts typically award costs, in other words a separate head of —

A. Not – no, in the – no, there are no cost and attorney fee shifting statutes for tort cases. Each party would bear their own costs.

Q. That's the typical system in the United States?

A. So, it would come out of – you know, the – in the contingent fee system in the US the plaintiff's lawyer would expect to get – you know, in effect, the costs to be paid or reimbursed out of any recovery.

Q. Are you aware that the Nova Scotia system may be somewhat different from that?

A. Yes, it is.

...

Q. Were you aware that in Canadian law non-economic damages are not considered compensatory?

A. I'm aware that the high court said that in the Andrews trilogy, and I actually think they're wrong. I highly disagree with them.

....

So, I think when the Canadian Supreme Court said that non-economic damages don't compensate, they weren't thinking, they were wrong.

...

Q. And that is that the assumption that you make throughout this piece is that women are typically marginally employed – more poorly employed than men and so their damages are less, right?

A. I'm surmising that as a reason why that their economic damages tend to be less and they tend to get a great proportion of their damages in non-economic, yes.

...

Q. I take it you carefully then reviewed the cases and came up with your summary chart?

A. I didn't do the summary chart, no. I did the numerical analysis.

...

A. It's not – it's – I thought I'd been clear. It's not my case summary. I didn't prepare it.

Q. No, but let's be clear.

A. Okay.

Q. It's a case summary of which you rely upon —

A. Right. Right.

Q. — to do you analysis?

A. I use it. Right. Right.

Q. So, it forms part of your report, does it not?

A. Right.

...

Q. How can we tell that you haven't used it from your affidavit or from your methodology? Where do you indicate which cases you haven't used from the cases at Exhibit "C" to your affidavit?

A. In my own notes that I used, not in – I didn't go through the whole chart in my affidavit and say which cases I used or didn't use.

Q. So anybody reading your analysis, taking your chart, we really can't determine which cases that found its way into your affidavit, can we?

A. No. And nowhere in the affidavit do I say that I used every case in the chart. I say that I went through ever [sic] case in the chart and selected according to the following criteria.

[149] It is impossible to determine which of the cases in the "chart" were utilized by Professor Finley and which of the cases were discarded and the reasons for either acceptance or discarding of the various cases. Reliance on the chart is clear:

> **Q.** And you incorporated them into your analysis.
>
> **A.** I used whatever they put down on the chart that was provided to me and to you.
>
> ...
>
> **Q.** So those were economic losses that should have been attributable in this case to the women.
>
> **A.** Yes.
>
> **Q.** They're not in your chart, are they?
>
> **A.** No.
>
> **Q.** And they should have been.
>
> **A.** Yes.

[150] There follows in her evidence a number of cases which she admits were erroneously treated. She does state that most of the errors substantiate her thesis, but clearly not all of them do and the errors on top of the other concerns previously noted bring clearly into question the reliability of the foundation for her "expert" opinion:

> **Q.** But nobody in this courtroom can check your numbers, can they? I mean, basically you're telling us, "Trust me. I excluded it. I've got it."
>
> **A.** I'll be glad to produce a list. I'll be glad to redo my study. I'll be glad to check every case report myself and redo the study. I'd be quite glad to do that.
>
> **Q.** We're right here right now. I'm cross-examining you.
>
> **A.** Yeah.

Q. And I'm asking you about how careful you were in proofing this material and putting your summary together. So we're right here right now.

A. It's not – you keep calling it my summary.

[151] A further example of the type of error is in her evidence as follows:

Q. And my question is, is it possible that you may have used both summaries for purposes of your analysis?

A. Yes, I believe I did.

Q. And sorry, if you use both would that then be an error on your part? You would only use it once, correct? You'd use the Court of Appeal?

A. I think it – the chart should have used *Dennis v. Kavanaugh* once and in reporting on the trial Decision should have reported that the damages were reduced to a hundred and fifty on appeal.

Q. Right. And what did you use? Did you actually do that? Or did it – what, inadvertently did you include?

A. I think I would have counted it twice.

Q. I see, okay.

A. Because I've said I didn't look at – I already told you I didn't go into Lexus and pull up the actual case Decision so –

Q. Go it. So there'd be some double counting here?

A. In that instance, yes.

...

Q. Turn to Tab – reference number 25. And that's the MacDougall Decision again and again we're dealing with the Court of Appeal Decision. Do you want to pass up that Decision. Thank you.

So Professor Lynch (sic) is it fair to say that this case may have been counted twice as well?

A. It appears that way, yes.

[152] In paragraph ten of her initial affidavit she makes reference to "**I obtained case reports** of adjudicated Nova Scotia motor vehicle cases decided during the 21-year period 1986 - 2006 that resulted in recoveries for injury plaintiffs. From this data I selected the cases in which.... (*et cetera*)." **It turns out that she did not obtain case reports**, notes or anything other than a poorly constructed error-filled chart prepared by some unknown person or persons in the office of the solicitors for the applicants:

> **Q.** And I must confess having read your words "I obtained case reports, " I took that to mean that you obtained a complete copy of the case reports for all the cases referred to in the chart, so I was mistaken.
>
> Now, further with respect to methodology do I understand that not only did you not get a copy of the actual cases but somebody else reviewed the cases and prepared a chart that you relied on?
>
> **A.** That is correct.
>
> **Q.** And I take it, professor, you don't – I take it you probably would have indicated already, but you don't know who prepared that chart or what qualifications they have or what they read or how closely they read it, you just took the chart and arrived at your conclusions reading the chart, correct?
>
> **A.** I was told it was attorneys.
>
> **Q.** All right. Did you make any check of their work? Did you read the chart and then randomly go through some of the case reports to check to see how they reconciled?
>
> **A.** No.
>
> **Q.** All right. Now, the – so, the – all of your opinions, statistical or otherwise, in your report are based on a chart and your interpretation of that chart that somebody else prepared?
>
> **A.** Yes, it's based on the chart of the damages awarded in those cases.
>
> **Q.** Right. Prepared by somebody else and you didn't check it?
>
> **A.** That's correct.

...

> **Q.** Thank you. And then you prepared your report and the chart was attached – thank you for that – but you do not indicated anywhere in the report which cases you concluded were minor injury cases. Do you agree?
>
> **A.** That's right.

[153] Rather than add several pages to this already lengthy decision I simply want to comment that I am impressed with the evidence and affidavit of Michael Trebilcock. He certainly appears to have an excellent grasp of the insurance industry, both in Canada and the United States of America; however, more to the point, I find the opinions he expresses in paragraphs 37 to 39 inclusive commenting on the opinion that Professor Finley used and I accept Professor Trebilcock's views and conclude that he knows that of which he speaks based on extremely extensive and broad experience and I therefore prefer his expert opinions over those of Professor Finley.

CONCLUSION – ISSUE TWO:

[154] I have had no difficulty in reaching the conclusion that the applicants have failed to establish on a balance of probabilities that s. 113B(1)(a) of the *Insurance Act* infringes s. 15(1) of the *Charter* on the basis of sex. I would only add that the applicants fall markedly short of the threshold "balance of probabilities" that the evidence they advanced, primarily that of Professor Finley, I find totally unreliable.

ISSUE THREE: Does Section 2(1)(d)(ii) of the Automobile Insurance Tort Recovery Limitation Regulations Infringe Section 15(1) of the *Charter* on the Basis of Physical Disability?

[155] The applicants, Gionet and MacDonald advance this argument stating in their view...:

> Regulation section 2 (1)(d)(ii) violates s. 15(1) of the Charter because it discriminates based on physical disability, against individuals suffering from certain forms of chronic pain, as compared to individuals with a physical disability who meet or exceed the threshold test for injuries to avoid the cap.

[156] The evidence advanced by the applicants in relation to this Regulation is the same evidence advanced by them in their allegation that discrimination exists by virtue of s. 113B(1)(a) of the *Insurance Act*. Greater reliance is placed upon the

evidence of Dr. Lynch rather than the evidence of Dr. Finley which is almost entirely related to the gender argument. I see no reason to repeat substantial portions of the evidence. The law recited applies equally to this issue. The comparator group advanced by the applicants is "crucial" to the s. 15(1) analysis.

[157] This chronic pain Regulation, it should be noted, does not limit or confine what chronic pain amounts to a minor injury. Quite the contrary, what Regulation 2(1)(d)(ii) does is to provide expressly that a certain category of chronic pain are **not** considered a minor injury. It excludes certain things such as serious comas, burns and amputations, as well as a certain category of chronic pain from being considered minor injuries. This does not mean that all other such injuries **are** minor injuries. The result is that a person who meets the definition of chronic pain in the Regulation is deemed not to be a minor injury and they can sue for damages for pain and suffering without legislative limit. This is not different than the comparator group advanced by the applicants, namely, "individuals who meet or exceed the threshold". They are treated equally. Their ability to sue for pain and suffering damages is not affected and no possible case exists for discrimination. Sufferers of chronic pain outside Regulation 2(1)(d)(ii) are not labelled minor injuries. Their position will depend upon the application of the test in s. 113B(1) of the *Insurance Act*. I conclude that those who suffer minor injuries cannot be characterized, as a group, as physically disabled, see **Granovsky**, above. I have already commented that there is no reason to repeat substantial portions of the evidence. The evidence established that chronic pain affects different people in different ways. Under Regulation 2(1)(d)(ii)(A) a diagnosis of chronic pain is required by a medical specialist appropriately trained in the diagnosis and management of pain disorders. The end result, what permitted is the individualized evaluation of chronic pain sufferers as mandated by **Martin**, above.

CONCLUSION – ISSUE THREE:

[158] The applicants have failed to establish on a balance of probabilities that Regulation 2(1)(d)(i) infringes s. 15(1) of the *Charter* on the basis of physical disability and, once again, on the totality of the evidence and after careful reflection of the arguments advanced by counsel I reach the same conclusion as I did on issue one, namely, the main focus of the applicants maintaining that this Regulation results in stigmatization and stereotyping of chronic pain suffers is not a conclusion supported by the evidence and what limited stigmatization and stereotyping takes place is a result of the adversarial system.

ISSUE FOUR: Are Sections 2(1)(f), (g) and (h) of the Auto Insurance Tort Recovery Limitation Regulations *Ultra Vires* the *Insurance Act*?

[159] The applicants Gionet and MacDonald advance that these sections are inconsistent with the spirit, meaning, wording and purposes of the *Insurance Act*. It is in his argument relating to these Regulations that Mr. Mason stressed most forcefully the ability of the court to draw assistance in determining the intent, purpose and objective of legislation by reviewing legislative history and its evolution. Mr. Mason goes further and specifically made reference to the text Sullivan on the Construction of Statutes, 5th Edition where at p. 589 it is stated "combining legislative history with legislative evolution can make for a very persuasive argument." I agree with Mr. Mason's statement as to the law, however, I do not accept his conclusion that the intent, purpose and objective of the *Insurance Act* was to protect injured parties. The protection of injured parties at least to the extent that the legislative intent was attempted to be clarified and not overreaching as evidenced by the debates, *et cetera*. He does make it clear that this aspect was a consideration but I repeat the intention of the Legislature was to address what was perceived to be an insurance crisis. Mr. Mason specifically advanced in argument at p. 1722 of the trial transcript "the overall intent of the legislation looking at clause 3, was to protect accident victims, My Lord." In my view the overall intention of the legislation was the reduction of automobile insurance premiums by controlling claim costs with respect primarily to automobile accident and the desire to strengthen the consumer protection provisions of the *Insurance Act*. Automobile insurance is to most Canadians a necessity and, in the government's view, in Nova Scotia and elsewhere, the cost of automobile insurance in particular was coming beyond the capacity of elders and young people, limited income citizens, single parents, *et cetera, et cetera*. These sections are set out above at pages six and seven. Section 2(1)(f) deals with the definition of "resolves", 2(1)(g) with "substantial interference" and 2(1)(h) with "usual daily activities". On this issue, Mr. Mason argued at great length and with great conviction. Both counsel acknowledge that the intent of the legislation is significant. I have also reviewed carefully the references by counsel to Dreigers, Sullivan and Cote. Mr. Mason's view is that the intent of the *Act* was to protect accident victims. He advanced the view that at the end of the day the court should provide the provision under dispute to have the intent of protecting accident victims. In Mr. Mason's view this was brought about by a deal made in the Legislature to protect accident victims and that true to form the Conservative government of the day deceived the electorate. In his view, at times the IBC was running the province, not the government and at the very least IBC and the government had an incestuous relationship. And in his view the cap is being used by the insurance industry to take

away rights of Nova Scotians. I indicated in the course of argument that I was not conducting an inquiry as to the conduct of insurance agents or adjusters. Mr. Mason provided a chart tracing the legislative history of these sections and in his view it discloses on the part of government a policy of deception to the electorate, to the Legislature, to the Liberal Party and to Nova Scotians. I made it clear in argument that Mr. Mason could not expect me to make findings that the government and the Liberal Party which supported the legislation were deceived as that is well beyond the mandate of this law suit. However, Mr. Mason persisted in stating in argument his position is that there was deception and I made it clear to him that the only luxury that I have is to decide on the evidence before me. That before me is an *Act* that was democratically passed in the Legislature. It had to be a majority because there was in an existence a minority government and that I could not make any objective finding that somebody was duped or not.

[160] Mr. Mason did outline his argument on the definition of resolve but not before, in my view, somewhat misstating the position of the Liberal Party, in particular its Leader at the time (trial transcript pp. 1775 to 1779).

[161] Mr. Mason advances the view that the word "resolve" means pain free. He maintains that that definition must prevail because the Regulation defining resolved did not come into being until 20 days later. Mr. Mason in argument did acknowledge that the Legislature has authority under s. 5 to make some change in the common interpretation of a word (trial transcript p. 1799). In his view, the Legislature in this case went too far.

[162] Mr. Mason attached particular weight to a number of cases and I therefore wish to comment on them. In **Way** v. **Covert** (1997), 147 D.L.R. (4th) 505, this is a decision of the Nova Scotia Court of Appeal where the appellant, a mentally disabled adult, living with her brother received the Family Benefits Allowance. The *Act* was amended and the appellant was advised she was no longer entitled to shelter allowance due to her brother's income level. The Court of Appeal confirmed that the *Act* empowers the Governor in Council to enact Regulations to more particularly define what is taken into account to determine income, it was clear that the income of others with the exception of a spouse or co-habited has no bearing on whether the applicant is "a person in need". The Regulation could not stand because it was inconsistent with its parent Statute. The appellant was eligible for the benefits under the *Act* and the Regulations could not take away that eligibility because of the income level of her brother and therefore the Regulation was deemed invalid.

[163] In my view it cannot be said, in the case before me, that the introduction of the definition for resolves contained in the Regulation takes away a substantive right and it is what it purports to be, a definition of the term used in the Statute and nothing more.

[164] **Morine** v. **L. & J. Parker Equipment Inc.** (2001), 193 N.S.R. (2nd) 51. This is also a decision of the Nova Scotia Court of Appeal. Cromwell, J.A. in reference to **Way** v. **Covert**, *supra*, stated at para. 49:

> ¶49 A regulation is not valid if it is inconsistent with its parent statute...

[165] And further at para. 50 and 51:

> ¶50 ... In my opinion, a regulation which absolutely bars remedies specifically authorized by the Code cannot be said to be necessary for the effectual working of the Code within the meaning of s. 7. Nor, in my view, can the creation of a limitation period against which no relief can be granted and which effectively takes away a right conferred by the Code be said to be a matter of determining the procedure to be followed in any proceedings under the Act within the meaning of s. 7(i) of the Code.
>
> ¶51 ... the parent statute required the Immigration Appeal Board to give reasons for its disposition of an appeal at the request of either party. The Board was given the authority to make rules not inconsistent with the parent statute "governing the activities of the Board and the practice and procedure in relation to appeals to the Board under this Act.": see. s. 8(1) Immigration Appeal Board Act, R.S. 1970, c. I-3. Purporting to act pursuant to that authority, the Board made a rule requiring a request for reasons to be made in writing within thirty days of the date of disposition of the appeal. The Court held that the rule was ultra vires because it abridged a right conferred in unqualified terms by the parent statute.

[166] Both the **Way** and **Morine** cases dealt with benefit conferring remedial Statutes designed to protect the interests of the respective plaintiffs. In such a case any doubt arising from the difficulties of the language should be resolved in favour of the claimants. Clearly both of these cases deal with an entirely different statutory / regulation situation then that which is before the court in these applications. One of the cases relied upon by the applicants, is **Ogilvie, et. al.** v. **Nova Scotia (Minister of Community Services)** (2004), 224 N.S.R. (2d) 227. The Statute in question was the *Employment Support and Income Assistance Act* and the Regulation to that *Act* which deemed income to self-employed persons. Justice Hood of this court concluded the Statute in her case did not authorize the creation of the Regulation. Justice Hood found that the Regulation eliminated most self-employed persons from

eligibility for assistance or at best severely limited the level of assistance they could receive and that such a Regulation was in her view inconsistent with the purpose of the *Act*. I am unable on the evidence and the law before me to reach the conclusion advanced by Mr. Mason in that in his view the Regulation takes away all the concessions that were made in the deal by the legislators. Mr. Mason's argument on behalf of the applicants applies to all of the Regulations, he advances are *ultra vires.* The starting point to the *ultra vires* argument is the principle of parliamentary sovereignty and the *Charter* (s. 52) makes the Constitution supreme in relation to laws enacted by the House of Assembly.

[167] In assessing whether a Regulation is *ultra vires* its parent legislation, some of the guiding principles established by the jurisprudence are as follows:

(a) where a Regulation falls within the contemplation of a power confirmed by a Statute, a court should only consider interfering with the exercise by the Governor in Council of its Regulation making authority if there is a condition precedent to the exercise of that power that has not been observed, if it conflicts with the provisions of the empowering Act, or if the Regulation was enacted in bad faith deliberately directing what was prohibited **(Investment Property Owners' Association of Nova Scotia** v. **Nova Scotia**, (1984), 15 D.L.R. 4th 192 (N.S.C.A.) at pp. 196-197, **Ross Barrett & Sons** v. **A.S. (Guardian ad litem of)** (1995), 33 C.P.C. (3d) 250 (N.S.C.A.) at para. 18);

(b) it is not the function of the court to pass judgment upon the wisdom of the Governor in Council in making Regulations so long as it has acted within the bounds of the authority delegated to it by the Legislature (**Wentzell et al** v. **Attorney General of Nova Scotia**, [1985] N.S.J. No. 395 (C.A.) (QL) at para. 11, **Ross Barrett & Sons**, *supra* at para. 19);

(c) in determining if there is an inconsistency between the Regulation and the parent Statute, the court should not restrict its consideration simply to the authorizing section of the Act, but should look to the statue as a whole and its intent and its spirit (**Kubel** v. ***Alberta (Minister of Justice)***, [2006] 32 C.C.L.I. (4th) 243 (Alta. Q.B.). at para. 23, **Johnson** v. **Federated Mutual Insurance Co.** (1989), 60 D.L.R. (4th) 417 (Alta. C.A.));

(d) when considering the validity of subordinate legislation, a court must proceed on the assumption that such legislation is within the authority conferred by the parent statute and should not declare it invalid unless there is clear evidence to support such a finding (**Heppner** v. **Alberta (Minister of Environment)** (1977), 80 D.L.R. (3d) 112 (Alta. C.A.) at p. 118);

(e) enabling legislation may grant the statutory delegate the requisite authority to define terms in a manner that is at variance with the plain and ordinary meaning normally attributed to such terms (**Johnson**, *supra* at p. 424; **Kubel**, *supra* at para. 23; c/f **Szmuilowicz** v. **Ontario (Ministry of Health)** (1995) 24 O.R. (3d) 204, (Div. Ct.)); and

(f) a definition that amounts to a colourable attempt to amend the legislation or is adopted in an effort to satisfy some other collateral purpose is *ultra vires* (**Kubel**, *supra* at para. 23).

[168] I conclude that the definitions "resolves", "substantial interference" and "usual daily activities" are consistent with the objectives of controlling claim costs with automobile accidents, reduction of automobile insurance premiums and the desire to strengthen the consumer protection provisions of the *Insurance Act*. Automobile insurance is to most Canadians a necessity. The situation confronting the Nova Scotia House of Assembly was not dissimilar to what occurred elsewhere in Canada and, indeed, outside of Canada, namely that insurance premiums were rising to the point where many members of society and, in particular, elders, youths, single parents, low income citizens, *et cetera* were not only in danger of but had reached the stage where insurance costs were beyond their capacity.

[169] In my view the House of Assembly was aware of s. 5(3)(na) of the *Insurance Act* which provides the Governor in Council may make Regulations defining any word or expression used but not defined in the *Act* and, further, that it would be necessary to define various terms in the new legislation to ensure that the intent and objectives of the House of Assembly were met. The argument that the definition of "resolves" constitutes an attempt to amend the legislation has not been established. The phrase "resolves within 12 months" must be interpreted in light of the first two parts of the definition of minor injury and quotes in s. 113(B)(1)(a)(i)and (ii) interpreting words in a section of an *Act* in their entire context consistent with the purpose of the *Act* has been acknowledged by the Supreme Court of Canada to be the

preferred approach to statutory interpretation **Bell Express Vu Limited Partnership** v. **Rex**, [2002] 2 S.C.R. 559. Based on the evidence before me, the term "resolves" does not mean that in the definition of minor injury one has to be "pain free" within 12 months following the accident. "Resolves", based on the evidence, must be interpreted in the context of functional impairment as opposed to pain measurement. It is acknowledged that the Governor in Council does not have unfettered discretion in terms of defining terms used in the parent legislation however I conclude that the definitions here were anticipated and considered to be necessary and advisable to accomplish the objectives of the legislation.

[170] It should be also noted that the burden is upon the applicants to demonstrate otherwise and the nature of this burden was discussed by Chief Justice MacKeigan in **Investors Property Owners' Association of Nova Scotia** v. **Attorney General of Nova Scotia** (1984), 15 D.L.R. (4th) 192:

> I respectfully adopt and here apply what Dickson, J. (now C.J.C.), said when upholding the validity of a federal order-in-council in Irving Oil Limited, Canaport Limited, Kent Lines Limited, Kent Lines Limited and Thorne's Hardwar[d] [sic] Limited v. National Harbours Board (1983), 46 N.R. 91 (S.C.C.), at p. 95:
>
> > "The mere fact that a statutory power is vested in the Governor in Council does not mean that it is beyond judicial review: Attorney General of Canada v. Inuit Tapirisat of Canada, [1980] 2 S.C.R. 735 at p. 748; 33 N.R. 304. I have no doubt as to the right of the courts to act in the event that statutorily prescribed conditions have not been met and where there is therefore fatal jurisdictional defect. Law and jurisdiction are within the ambit of judicial control and the courts are entitled to see that statutory procedures have been properly complied with: R. v. National Fish Co., [1931] Ex. C.R. 75; Minister of Health v. The King (on the Prosecution of Jaffe), [1931] A.C. 494 at p. 533. Decisions made by the Governor in Council in matters of public convenience and general policy are final and not reviewable in legal proceedings. Although, as I have indicated, the possibility of striking down an order in council on jurisdictional or other compelling grounds remains open, it would take an egregious case to warrant such action. This is not such a case. [emphasis added]

[171] While I have made reference to the Late Chief Justice MacKeigan's decision I am inclined to the view that he may be overstating the test and that it is more appropriate to describe it as a test on the balance of probabilities threshold. This would mean that, all things being equal, the validity of the legislation/regulation by a democratically elected body should prevail.

[172] Mr. Mason makes much of the legislation outside of Nova Scotia and, in particular, the history of the Ontario legislation. I would agree with Mr. Mason that the Nova Scotia Legislature could have used clearer terminology and articulated the terms in the Statute and Regulation in a clearer fashion particularly by way of amendment; however, I also agree with the position advance by Mr. Machum on behalf of the defendant Roy that the intention of the Legislature in Ontario cannot be imputed to the Legislature in Nova Scotia.

CONCLUSION – ISSUE FOUR:

[173] I conclude that the applicants have failed to meet the burden of establishing these Regulations are *ultra vires* on a balance of probabilities and, further, they appear to me to be clearly consistent with the legislation and entirely within the power of the Legislature permitting the Governor in Council to make Regulations defining any word of expression used but not defined in the legislation.

SAQUOIA McKINNON

[174] **The issue as stated in the pre-trial brief of the Insurance Bureau of Canada, has Saquoia McKinnon been discriminated against on the basis of mental disability?** Before going directly to the issue, I want to directly address the argument advanced by the solicitors for Adam Thomas Roy, mainly that the application need not be heard due to an agreement between counsel.

[175] Before the trial commenced, I conducted a pre-trial conference on September 4, 2008 and arranged for a transcript. Ms. McKinnon's counsel indicated he was advancing a s. 15 *Charter* argument and that I was dealing with the Constitutional argument and not as to whether her injury was serious or not. Solicitors for Adam Roy, early on in the conference, indicated that there was a need for contextual background for the Constitutional challenge and stated it had to be determined whether Ms. McKinnon was impacted by the legislation. Specifically, whether she met the definition of being seriously injured. Saquoia McKinnon's solicitors advised that the Court could go on the assumption that Ms. McKinnon does have a serious long-standing, permanent injury and then address the Constitutionality issues arising out of that with Roy retaining the ability for a discrete subsequent hearing to decide whether or not she was affected or not by the cap.

[176] Mr. Cameron, on behalf of the Attorney General of Nova Scotia, made it clear that he is calling psychiatric evidence, not to discuss Ms. McKinnon's situation, that is whether her PTSD was serious or not but, rather, to discuss PTSD itself. And in his view it was immaterial whether it was serious or not.

[177] Mr. Siebrits, solicitor for Ms. McKinnon, went on to indicate that there were two issues, that of age as a minor and that of the psychological aspect. He indicated that Ms. McKinnon did not have an issue with the evidence being adduced by the Attorney General of Nova Scotia about PTSD and simply disputed inclusion of that evidence.

[178] The applicants Gionet and MacDonald had before these applications withdrawn their s. 7 *Charter* challenge and in the extensive 29-page brief filed on behalf of the applicant Saquoia McKinnon, Mr. Siebrits did not mention any *Charter* argument based upon the age of Ms. McKinnon. Mr. Mason, on behalf of Ms. Gionet, had initially raised a *Charter* challenge on the basis of age, however, he confirmed with the court (trial transcript page 1710) that their was no *Charter* challenge based on age. Mr. Siebrits proceeding to argue the age *Charter* challenge and there was some limited comment in the evidence. The solicitors for the defendant Roy did comment on the age *Charter* challenge in their brief and what I am really left with is an argument based on the wording in Regulation 2(1)(g) of the *Automobile Insurance Tort Recovery Act*. The use of the terms "regular employment" itself is one of two measures of the severity of an injury; the other being as contained in the definition of serious impairment, substantial interference with a person's ability to perform their usual daily activities. Generally speaking a youth, take for an example a two year old child, would obviously be unable to avail the provision with respect to "regular employment" in proving the child's injury is more than a minor injury; however, regular employment is merely one type of activity that a person may perform during that person's activities of daily living.

[179] The activities of daily living of a person may or may not include, depending on that person's age and circumstances, getting up, going to work, going to school, enjoying the playground, personal chores, *et cetera, et cetera*. The use of the word "or" is disjunctive. I noted that the *Charter* age argument was not set out in the brief filed on behalf of Ms. McKinnon but it was referenced in correspondence dated September 29, 2008 to the court in response to the brief filed on behalf of the defendant Roy. The position of Ms. McKinnon seems to me to ignore the definition of "usual daily activities". Page 41 of the brief filed on behalf of the defendant Roy:

> "usual daily activities" means the essential elements of the activities that are necessary for the person's provision of their own care and are important to people who are similarly situated considering, among other things, the injured person's age. [Emphasis Added]

> Such specific consideration of an individual's age is, in the words of McLachlin C.J.C., the "antithesis of the logic of the stereotype" or discrimination. *(Winko v. British Columbia (Forensic Psychiatric Institute)*, [1999] 2 S.C.R. 625 at para. 89)

> As a result, a full appreciation of the entire definition of "resolves" does not make any age-related distinction. All other factors assumed, so long as an individual continues to suffer a substantial interference with the ability to perform either her/his usual daily activities OR regular employment, s/he will have the ability to potentially receive general damages in excess of $2,500.00 [emphasis added]

[180] My final comment is that the evidence of Professor Finley was once again unsatisfactory. On the age question, Professor Finley's foundation is so small (a total of seven cases) that it cannot be given any measure of weight. In addition, Professor Finley's suggestion seems to me to disregard the ability to claim damages for loss of earning capacity or as sometimes cited as diminution of the employment/earning horizon.

[181] The solicitors for Mr. Roy wanted an indication of what evidence was being called on behalf of Ms. McKinnon and her solicitor advised that he had no intention to call any doctors. At this point the court adjourned to give counsel an opportunity to discuss various matters outstanding between them. After the break, Mr. Roy's counsel advised as follows:

> **MR. MACHUM:** ...First of all, I believe My Friend made some comments before we broke about, you know, not having notice and that sort of thing but I also think he agrees that there was never, it was never, we never gave up that argument of resolution or not resolution and he, and, in fact, it was in our expert report but the question was how do we proceed forward in this case... My Lord, from my client to set aside the issue of whether, in fact, her condition had resolved or not resolved until another day but proceed for the purpose of Your Lordship's deliberations on the basis that she had an unresolved condition, that is, post traumatic stress disorder, that is impacted by the Legislation. ... in return for that My Friend has indicated to me that, you know, we won't be seeing, eh, Saquoia McKinnon on the stand talking about her condition. We won't see medical experts on the stand talking about the gravity of her condition, eh, that the operative assumption would be that she has serious post traumatic stress disorder for the purpose of Your Lordship's consideration of whether the Legislation in question is constitutional or not and I should add, My Lord, that the question of whether, following your decision on the

constitutionality issue, we may well find ourselves in another court setting arguing whether, in fact, her condition had resolved or not. We're keeping our powder dry on that issue. We're just not putting it before Your Lordship and that's in effect may be in the form of a damages kind of argument or a trial on damages. I don't know if that addresses what we talked about.

MR. SIEBRITS: That is my understanding as well, My Lord, and I would agree with My Learned Friend's comments and that was, in fact, my understanding coming in today as well is that we were ... be proceeding on that basis so I would agree with that My Lord.

...

MR. CAMERON: My Lord, since the Attorney General never took a position on whether Saquoia had a serious, or not serious injury, this agreement between counsel is certainly fine with Attorney General.

...

MR. GALWAY: I am not a party to that case although I will make submissions at the end asking for standing to intervene and make submissions in the McKinnon litigation. That's not opposed as I understand it.

COURT: I'll just deal with that right now. Any opposition to Mr. Galway's client being an intervener in the McKinnon?

MR. SIEBRITS: No, My Lord.

COURT: Okay, perhaps we should.

MR. CAMERON: None, My Lord.

COURT: None Mr. Presse (sic, Mason)?

MR. MASON: No, My Lord.

...

MR. MACHUM: Well, I think, My Lord, I guess what we're saying is we really mostly want Your Lordship's view on whether, assuming it is serious, does this Legislation as drafted ...

COURT: Yes. Okay.

MR. MACHUM: .. improperly impact or is it constitutional or not.

...

MR. CAMERON: I'm sorry, My Lord, and I just want to be clear that from the Attorney General's point of view there are really 2 major legal issues. One is the interpretation of the statute and then the second is the constitutional issue.

...

MR. SIEBRITS: We .. from our perspective, My Lord, we're happy with the agreement that's been reached.

[182] Mr. Machum, one of the solicitors for Roy in argument October 30, 2008 reiterated their view of the agreement citing some of the transcript of the September 4th pre-trial conference and went further to express the view that they were not quite certain why they were here in the first place, indicting that there had been no case referred to where the government or Roy say "look, you're free to go beyond the cap" which is the position maintained by the Attorney General of Nova Scotia and Roy. Roy's position is that Saquoia McKinnon meets the criteria and is not barred by the words that they are complaining about and, yet, they still insist upon going to court. Mr. Machum specifically says that their position is the government says you are free to do what you say you cannot do and that it is baffling as to why Ms. McKinnon spent all the time and resources on these applications rather than going to trial. Roy takes the position that McKinnon's solicitor has been aware for some time that their position is that the words "physical in nature" did not bar her beyond the cap if they established that her condition was unresolved. The only evidence called is that of the Attorney General of Nova Scotia and it is overwhelmingly the affect that the admitted serious condition of Post Traumatic Stress Disorder was, at least in part, physical in nature.

[183] Mr. Siebrits spent most of his time in argument as to the meaning of "physical in nature" and how that term caused discrimination against Ms. McKinnon. It appears very clear from the agreement between counsel that the solicitors for Roy at the trial transcript p. 2409 restated that their position for some time was that the words "physical in nature" did not bar Mr. Siebrits' client beyond the cap if she established that her condition was unresolved. The government's position was confirmed at p. 2408 of the trial transcript:

THE COURT: Are you accurately expressing the government's position Mr. —

MR. CAMERON: I say that very thing in my Brief, My Lord. I say this is a passing strange case.

[184] Mr. Cameron's remarks were just after Mr. Machum reiterated Mr. Siebrits' client was not barred by the words he is complaining about. Mr. Machum at p. 2409 of the trial transcript confirmed that he had instructions from his client to set aside for the purpose of this constitutional hearing whether her condition is resolved or not resolved and to proceed for the purpose of deliberations on the grounds that she has an unresolved condition of Post Traumatic Stress Disorder. Mr. Machum went on to say the question now raised by Mr. Siebrits is "is she discriminated against when those words 'physical in nature' are used in the section we are looking at?". Mr. Machum's response "[W]e say not. And we've never said she was. From the beginning, from sending our experts' reports to My Friend, from filing our Brief we've been consistent in saying that that is not a barrier to this claimant." In the evidence advanced by the Attorney General and the defendant Roy is that Ms. McKinnon has suffered an injury "physical in nature." It is therefore difficult to comprehend why Mr. Siebrits continued at great time, expense and effort that his client was discriminated upon because her injury was not "physical in nature".

[185] Despite Mr. Siebrits' strenuous efforts, I am unable to read and interpret the term "physical in nature" as meaning exclusively physical. The position taken by the defendant Roy and the Attorney General of Nova Scotia seems to me to almost amount to a form of estoppel where the court accepts their evidence and argument and concludes that PSTD is physical in nature. They claim it is physical in nature, and provided it goes beyond "resolved within twelve months" it gives rise to entitlement as a claim to exceed the cap and not discrimination. I would also add that Mr. Siebrits accepts that PSTD has a physical component (see trial transcript p. 2327) and Mr. Siebrits specifically accepts the expert evidence before the court at transcript p. 2337:

THE COURT That the medical expertise now says that it is physical in nature?

MR. SIEBRITS: I'm absolutely agreeing with all the experts, My Lord. There's – I can't think of anything that the experts have said that I don't agree with.

[186] Mr. Machum at p. 2439 of the trial transcript conceded on record that if I make a finding Ms. McKinnon fits within the definition, his client would be bound by such at trial. Mr. Siebrits response at p. 2440 of the trial transcript was to continue to argue "physical in nature."

[187] I think it is important to set out in some detail Mr. Siebrits' response:

> **BY MR. SIEBRITS:** My Lord, I've got about five minutes of rebuttal and perhaps we can just get it over with. My Lord, I'm going to limit my rebuttal to the issue of physical. I think the fundamental question for me that is not getting answered by My Friends is why is it there? If it can be so widely interpreted and it can mean mental and psychological and all these other things, why do they put it in? It is, it has got meaning. By looking at the part, "in nature" you can't suddenly make the jump from black to white or sort of you know, go from one extreme to another. You can't suddenly include those things. The "in nature" part, yes, it is a broader term but it allows one to look at what is the primary or fundamental aspects of the defining the word, "physical". Physical is in there.
>
> You can't suddenly say okay physical in nature so it must mean all kinds of other things. You're still stuck with the words. And it's words that the Legislature put in. I'm not suggesting that there should be all these artificial differences between what goes on in the brain to the body. I think that's been the evidence all along and I'm certainly not disputing at all what the experts are saying that they say there may be physical symptoms. Some people don't have it but there may be. I don't have a problem with that. They say that there can be neurological changes in the brain when one has a certain type of mental disorders. I'm not disputing that.
>
> What I am saying is that there is still the distinction being made between mental and physical despite what they've said. The distinction remains. The distinction remains in their own field of medicine. They make the distinction themselves when they write articles and when they apply for grants, they make the distinction between physical injuries and mental injuries.

[188] It is very difficult for me to make a definitive conclusion to what counsel have agreed upon, at least to the point that Mr. Siebrits appears to have in his own mind at least retained the right to argue what is meant by "physical in nature". With respect it certainly does not change physical to the distinction suggested from something that is white to something that is black. The fundamental of white is it is white. The fundamental of physical is that it is physical. If you attach the words "in nature" to either they are there for some reason and purpose, but they do not when attached to the word "white" change the meaning to black. Mr. Siebrits repeats his analogies at page 2471 of the trial transcript.

[189] Given the time, resources and effort put into these applications by all parties I conclude fairness dictates that I proceed to deal with the issue. Although there appears to be a measure of agreement, if strictly applied would render it probably unnecessary. I repeat that the proper course for the court is to proceed to address and hopefully answer the issue.

[190] The only evidence advanced by Saquoia McKinnon is an information affidavit of Kathryn Jean McKinnon. The expert evidence before me is that of doctors Gnam, Bagnell and Rosenberg. Their evidence is educational, enlightening and very persuasive.

[191] Dr. Gnam's evidence starts with his affidavit. His qualifications were acknowledged as an expert in psychiatry including the definition, diagnosis, symptoms, treatment and neurological and physiological implications of PTSD.

[192] The affidavit of May 2, 2008 references his report of April 28, 2008. He also provides copies of all the public research which he references in his independent psychiatric report. His report deals with three issues. The first one is not before me, namely, specific medical condition of Saquoia McKinnon. He begins his comments on Post Traumatic Stress Disorder and discernable physical symptoms as follows:

> POST-TRAUMATIC STRESS DISORDER AND DISCERNABLE PHYSICAL SYMPTOMS
>
> While psychiatric disorders are defined primarily by psychological, emotional, and cognitive symptoms, many disorders also have, as core features of the disorder, observable physical manifestations that may be noted and reported by the patient themselves (symptoms), or observed by an evaluating clinician (signs). In the case of PTSD, I now consider whether persons suffering from PTSD that persists for more than one year typically have such discernable physical manifestations. I define PTSD using the prevailing and dominant diagnostic criteria used in North America, found in the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV). I begin this discussion by defining PTSD according to the prevailing diagnostic criteria, and by describing the most common physical manifestation of PTSD. I then consider whether such a physical manifestation of PTSD is common in persons with PTSD that persists for more than one year.
>
> ...
>
> The most common discernable physical manifestation of PTSD is exaggerated startle response, listed in the DSM-IV as criterion D(5), one of the symptoms of

hyperarousal. Exaggerated startle response is defined as an abnormal and amplified startle response to stimuli, often (but no exclusively) unexpected auditory stimuli such as sudden loud sounds.

Based upon my clinical experience with patients with PTSD, it is my opinion that exaggerated startle response occurs very frequently among persons who have PTSD that persists for more than one year. this could cause serious and significant impairment, depending upon the circumstances of the patient's particular case.

[193] Dr. Gnam goes on to refer to the published research and comments:

The implication of these studies is that the frequency of exaggerated startle response and other symptoms of hyperarousal arises among groups with chronic PTSD. This occurs because those with less severe PTSD without hyperarousal symptoms preferentially recover within the first year, leaving those persons with more severe PTSD that includes exaggerated startle response and other hyperarousal symptoms. While to my knowledge no published study has estimated the rates of exaggerated startle response among persons with persistent PTSD that causes serious impairment, based upon my own clinical experience the frequency of such symptoms is 80 - 90% of cases.

THE FUNCTIONAL NEUROANATOMY OF POST-TRAUMATIC STRESS DISORDER

Finally, I herein provide a brief opinion about whether PTSD of a moderate to severe nature is known to result in structural brain changes that are related to the expression and perpetuation of the troubling symptoms of the disorder – the symptoms that cause suffering and impairment.

Functional neuroimaging technologies, including single-photon emission tomography (SPECT), positron emission tomography (PET), and functional magnetic resonance imaging (MRI) have substantially enhanced psychiatry's understanding of the structural brain changes that occur with numerous psychiatric disorders. Functional neuroimaging allows changes in brain functioning to be captured and defined visually. At the outset it should be understood that while the new neuroimaging technologies depict functional brain changes (related to the release and uptake of neurotransmitters), such changes always indicate underlying modifications in brain structure. These modifications include the formation of new receptors and sites of release of neurotransmitters, new or altered dendritic connections, and, in some disorders, the growth or atrophy of neurons themselves in certain brain regions.

With respect to PTSD, a decade of functional neuroimaging research has in my opinion produced substantial and convincing evidence that persons with moderate to severe PTSD also sustain functional (and underlying structural) brain changes.

And, further

> Such evidence can be understood and interpreted on at least two levels. The first level relates to the basic understanding that PTSD is associated with structural brain changes that are related to symptom formation and perpetuation. The second level pertains to a deeper understanding of the specific structural brain changes that lead to particular symptoms, and the overall causal pathological process that leads to symptom formation. This latter level of understanding is inherently complex and unresolved scientifically, and will be the subject of decades of further research. However, the absence of fully articulated and proven causal model relating PTSD to brain changes does not weaken the overall finding that persistent PTSD of a moderate to severe nature is associated with structural brain changes.

[194] It is noted in his evidence before me, Dr. Gnam is not only a doctor of medicine but a doctor of philosophy and he is one who has a background of hands-on assessment and treatment of people with PTSD.

> DR. GNAM, DIRECT EXAMINATION BY MS. HELLSTROM
>
> **Q.** Thank you. Turning to employment. You're currently a consulting psychiatrist for the Psychological Trauma Program with the Centre for Addiction and Mental Health?
>
> **A.** That is correct.
>
> **Q.** And how long have you been there?
>
> **A.** I've been in that particular role for five years.
>
> **Q.** And in that role, would you ever have the opportunity to see or treat persons with PTSD?
>
> **A.** Frequently. The clinic is involved in the assessment and treatment of persons that have sustained psychological problems that have developed as a result of workplace injury.
>
> The workplace injury may involve a physical injury, but it could be a worker that's been held up at gunpoint and has developed psychological symptoms.
>
> So in the course of assessing and treating people through the clinic, I've seen hundreds of clients, patients, with PTSD and related health problems.

[195] I will not be repetitive and simply note that Dr. Gnam was asked:

Q. Thank you, doctor. What, if any, physical manifestations can accompany a diagnosis of post-traumatic stress disorder?

A. In my report, I talk about two particular physical manifestations.

...

Q. Thank you.

A. So in this report, I talk about two discernable or measurable physical manifestations – exaggerated startle response and structural brain changes.

[196] Dr. Gnam made very effective use of a replica of a diagram that was used to opine his existing opinion and in using the diagram explained to the court the structural changes that happen to the brain in moderate to severe PTSD and how that happens and why it happens. His final direct evidence was particularly clear and helpful:

> ... So, it's shifted the debate now. There's no longer a debate in psychiatry about whether or not these changes are specific to PTSD and they exist, it's just how do they fit in an overall causal explanation and are they the end result, are they somehow in the middle, are they a result of other processes? That we don't know, but there is now no debate about that structural brain changes exist in moderate to severe PTSD.
>
> Q. Thank you. So, doctor, in what percentage of patients with moderate to severe post-traumatic stress disorder would we see these functional or structural changes of the brain?
>
> A. In my – obviously not every person with PTSD has been subjected to these kind of analyses. These are very expensive tests, often academic centres spend millions and millions of dollars to have these tests, but the powerful thing about biological research of this nature is that if enough studies with enough people from different backgrounds and different kinds of trauma show the same results, one can say with confidence that these changes are present in all persons with severe PTSD.

[197] Dr. Gnam's expert opinion was consistent and unshaken or diminished in any way by cross-examination as can be seen from the following portion of his cross-examination:

...

A. Well, no, I agreed that there would be a physical reaction. I mean that is really the point in which we're at in neuro-science and its relationship to psychiatry. We don't see the brain as divorced from the body.

We see the brain as being intimately connected to the body, both influenced by the body and influencing the body. So a fear – neuro response is a good example of how perception – how a stimulus that causes one to feel fearful results in physical manifestations.

Q. Okay. Okay. Thank you. And I think that's a good point that you're making.

There's no clear distinction between mental and physical. The brain controls the body and it's intimately involved in all aspects of the body.

But traditionally or in layman's terms, common terms, their distinction has been made between people who study mental disorders and people who study broken toes.

A. Medicine wouldn't accept the distinction anymore. It has to be emphasized how important this new evidence from neuro – functional neuro imaging, which has really evolved over the last ten years is.

When the Diagnostic and statistical Manual criteria were last revised by scientific panels – so that takes us back to about the mid-1990s, 1994. This neuro imaging technology was only just beginning, and was not being used scientifically.

At that time, psychiatry purposely was agnostic about whether most mental disorders have an underlying brain structure relationship. Many people believed that, but there wasn't yet the technology to be able to demonstrate that clearly.

That's why the DSM-IV focuses on signs and symptoms observable or reportable phenomena, and never one step deeper to talk about brain changes. They didn't want to say, because they felt the scientific evidence wasn't conclusive one way or the other.

> It's a different ball game now. The – really, the pendulum has swung. So now the question is, are there any psychiatric disorders that don't have – that are severe and persistent that don't have underlying structural brain changes?
>
> That has become the question. It no longer is, "Are most?" It's, "Are there any that don't?"

Evidence of Dr. Alexa Bagnell:

[198] By agreement Dr. Bagnell was qualified as an expert in child psychiatry including the definition, diagnosis, symptoms, treatment and neurological and physiological implications of Post Traumatic Stress Disorder.

[199] Dr. Bagnell provided a report dated June 30, 2008. In her report, Dr. Bagnell makes the point that PTSD is a relatively new area over the past two decades in child and adolescent psychiatry, as prior to this children were believed to have only transient stress as a result of a traumatic event. Dr. Bagnell notes in her report:

> Although any child exposed to a traumatic event may develop PTSD, many do not. Children and adolescents with a family history or individual past history of anxiety disorders are at higher risk of developing PTSD (Asarnow et al., 1999), as are those with more family dysfunction and less emotional support (Lyons-Ruth et al, 1999), and females (Kessler et al., 1995). youth who experience repetitive trauma are also higher risk of developing PTSD. The degree of exposure (emotional and physical proximity) to the traumatic event and closeness to victims are both positively correlated with PTSD (Hubbard et al. 1995; Pynoos et al., 1993).

[200] And, further

> ... In children there is evidence of changes in portions of the prefrontal cortex with increased gray matter and volume, but not changes in hippocampus volume (Richert et al, 2006; Carrion et al, 2001; Teicher et al, 2003). There is also evidence of functional brain differences in the processing of traumatic images in youth with and without PTSD symptoms who experienced the same traumatic event (Yang et al, 2004). These studies are consistent with adult research in PTSD that there are structural and functional changes in the brain in those with PTSD compared to those who do not have PTSD. These results also lend support to the importance of neurodevelopmental stage and timing of the traumatic event, as well as individual vulnerability and risk factors.

[201] In her evidence, she repeats the three categories of symptoms of child PTSD then went on to explain how the body responds to PTSD. Dr. Bagnell effectively

used an exhibit, the pictures in which showed a cutout of the brain cut in half. Dr. Bagnell described the symptoms in terms of functional brain changes and structural and functional changes of the brain in children with PTSD and then was asked:

> **A.** So, how authoritative is this information --
>
> **Q.** Yes.
>
> **A.** — that I've given? I mean, it's not controversial, in terms of psychiatry, research and expertise that there are brain changes, in terms of how the brain functions with Post Traumatic Stress Disorder.

[202] Dr. Bagnell was subject to a vigorous cross-examination:

> **Q.** My understanding of some of what you've said in your reports is that a person suffering from PTSD may experience physical symptoms. Is that correct?
>
> **A.** That is correct.
>
> **Q.** Isn't it true that when I just asked you about these symptoms that are physical in nature, you understood the words – the common meaning of the word physical to be something related to the body as opposed to the mind, or something that's tangible, concrete?
>
> **A.** I guess I'm a big believer that the brain and the body are kind of one. The brain runs the body —
>
> **Q.** Yeah.
>
> **A.** So, a lot of my work is breaking down how the brain controls the body and causes us to —
>
> **Q.** Absolutely, And I – I think there's a – there might be some question about; Is there a formal distinction, or is this something as a pure mental disorder? Have you ever heard of something as a pure mental disorder? Have you ever heard of that sort of categorization, or that term?
>
> **A.** Well, I mean, mental disorder, I have definitely heard that term before.
>
> **Q.** Yeah.

A. Mental disorder. But —

Q. And you would agree that there's a common distinction between, say, mental disorders as opposed to physical problems with the body? In the common language?

A. I – I think there are people that don't see how mental disorders are in the brain. I think there are people that still think that mental disorders are – you can will yourself out of —

Q. Yeah.

A. — out of things. So —

Q. But that's not your belief?

A. No, and it's not the belief of my field.

Q. Yeah.

A. Psychiatry. I mean, there's great evidence that mental disorders are brain based.

[203] Dr. Bagnell acknowledged that it is much more difficult to do studies in children and adolescents because of ethics approval but slowly but surely they are starting to get more in the child and adolescent fields.

[204] Dr. Bagnell gave her evidence in an impressive manner and it is not at all difficult to accept the sincerity, depth and correctness of her expert opinion.

[205] Of passing interest is the House of Lords 1982 decision in **McLoughlin** v. **O'Brian**, [1983] 1 A.C. 410. Mrs. McLoughlin's husband and three children were involved in a car accident while she was at home some two miles away. She was told of the accident and, on attending at the hospital, learned that her youngest daughter had been killed and she saw the injured state of her husband and other children. It was advanced that she suffered severe shock resulting in psychiatric illness. Lord Russel of Killowen comments at p 429:

> The facts in this case, and the physical illness suffered by the plaintiff as a result of mental trauma caused to her by what she learned, heard and saw at the hospital, have been set out in the speech of my noble and learned friend, Lord Wilberforce, and I do not repeat them.

[206] Lord Wilberforce at p. 418:

> Although we continue to use the hallowed expression "nervous shock," English law, and common understanding, have moved some distance since recognition was given to this symptom as a basis for liability. Whatever is unknown about the mind-body relationship (and the area of ignorance seems to expand with that of knowledge), it is now accepted by medical science that recognisable and severe physical damage to the human body and system may be caused by the impact, through the senses, of external events on the mind. There may thus be produced what is as identifiable an illness as any that may be caused by direct physical impact. It is safe to say that this, in general terms, is understood by the ordinary man or woman who is hypothesised by the courts in situations where claims for negligence are made. [emphasis added]

CONCLUSION:

[207] Ms. McKinnon has led absolutely no evidence to rebut the expert medical testimony provided by Dr. Gnam, Dr. Bagnell and Dr. Rosenberg which evidence I find impressive and most convincing. I accept the conclusion that the brain is part of the body and that PTSD has been established to be an injury "physical in nature". Ms. McKinnon has led no evidence to the contrary. The accepted evidence of the three experts is definitive. I do not accept the argument advanced by Ms. McKinnon's solicitor that the terminology used by the Legislature "physical in nature" was meant to reinforce and strengthen the word "physical" from what it would have meant if it stood alone. If the intention were to strengthen the word "physical" then it could easily have been done by adding such terminology as "purely physical", "solely physical", *et cetera*. The addition of the words "in nature" obviously, rather than reinforce and strengthen the word "physical", were intended to extend what the word "physical" would mean if it stood alone. I conclude that Ms. McKinnon, if she has a permanent, serious impairment of an important body function which is caused by a continuing injury or an injury which is not "resolved" within 12 months, then she will not be restricted in terms of her claim and her non-pecuniary damages given the fact that her injuries are "physical in nature". The trial judge can only make a determination based on the case that is the evidence before it and I find as a fact that in the terms of Ms. McKinnon's s. 15(1) challenge no distinction has been made with respect to her injury on the basis of mental disability and, therefore, there is no need to proceed with the consideration of the four contextual factors from **Law** and, again, no other factors have been advanced. The specific factual situation before me means that Ms. McKinnon's challenge to 113(B)(1) of the *Insurance Act* and s. 2(1)(f) of the Regulations has not been established. Ms. McKinnon's application is dismissed.

RESULT:

[208] The applications are dismissed. What remains outstanding is a determination of the issue as it relates to s. 1 of the *Charter*. After a short break from this file I will address this issue and it will constitute Part II of this decision.

Walter R.E. Goodfellow, J.