Quest #45 December 2000

UPDATE: PEER-REVIEW OF DRAFT OF THE CANADIAN ME/FM CLINICAL DEFINITIONS

AND TREATMENT PROTOCOLS TO TAKE PLACE MARCH 30TH TO APRIL 1, 2001

We are delighted to announce that the **Peer-review** of the **Canadian ME/FM Clinical Definitions and Treatment Protocols**, drafted by **Dr. Bruce Carruthers** of British Columbia and **Dr. Anil Jain** of Ontario will take place this **March 30th to April 1st, 2001** in **Toronto**, Ontario. Canadian and International doctors, experienced in diagnosing and/or treating ME/FM or doing ME/FM research, were selected to do the peer-review by a committee of doctors using guidelines developed by **Health Canada**. **Crystaal Corporation** of Mississauga is the proud sponsor of this historical event and they have hired **Science & Medicine Canada Inc**., a management company, to help the **National ME/FM Action Network** run this event.

MELATONIN TREATMENT OF SLEEP-WAKE CYCLE DISORDERS IN CHILDREN & ADOLESCENTS

By: Kate Andersen, M.Ed., Youth Consultant, National ME/FM Action Network

Researchers at **British Columbia's Children's Hospital** in Canada have published the results of a randomized, **double-blind, cross-over design study** of **effective doses of melatonin in children with multiple disabilities**. Their work, published in the **Journal of Pineal Research (2000, 29, 34-39)** included children with epilepsy, attention-deficit disorder, bipolar disorder, depression, brain tumor and other conditions. The young people in this study ranged in age from 4 to 21 years. Most children had more than two chronic disabilities in addition to a variety of health problems. These children were considered potential candidates for melatonin therapy because their disabilities involve a disruption of sleep-wake cycles and/or prevent them from fully utilizing environmental cues to set and reset their cycles. Previous research, clinical experience and parent reports suggested that a hormone known as melatonin could be a valuable form of therapy. Melatonin is a small, fat-soluble molecule that is produced mainly by the pineal gland but is secreted elsewhere in the body. It crosses most membrane barriers easily. Melatonin is synthesized by chemicals in the pineal gland. The neurotransmitter norepinephrine is primarily responsible for initiating the production of melatonin.

Circadian rhythms are the way that organisms adapt to changes of light and dark of the solar system, explain the researchers. A tiny section of the brain called the **suprachiasmatic nucleus (SCN) of the anterior hypothalamus is responsible for setting the circadian rhythm in humans and other animals.** The SCN responds to melatonin which can inhibit neurons and cause shifting of sleep-wake phases. Lesions of the SCN can disturb the ability of animals and humans to establish circadian rhythms. The pineal gland relies on cues from light transmitted through the retina to set sleep-wake rhythms in accordance with light signals suggesting it is day or night, time to be

awake or time to sleep. There are other cues from the environment that reinforce these biologically-based responses, cues such as quietness versus noise, changes in temperature, eating patterns and behavioral habits. Even mental functions, such as knowing how to read a clock and being aware of time, can help entrain sleep-wake cycles. Therefore, multiply disabled individuals are especially vulnerable to having sleep disorders, particularly if their disability involves disturbed brain function and/or blindness. **People with ME and FM have been found in several studies to have disturbed sleep-wake cycles.**

The impact of disturbed sleep on children's development and well-being is very significant. Sleep disturbance affects mood, cognition, sociability, activity level and even immune function. It also has a tremendous impact on caregivers whose own rest is often disturbed and who must frequently deal with a cranky, disorganized individual during the daytime. **Children's Hospital researchers**, **Drs. James Jan, Roger Freeman and Diane Fast** were well aware of the cost of sleep-phase disturbance in children with multiple disabilities and sought to find a way to improve the developmental gains as well as the quality of life for these children and their caregivers. A newly-available controlled-release (CR) form of the hormone offered an opportunity to adjust the timing and amount of melatonin in a manner that might be more effective. How to best use the new CR melatonin was unknown. Therefore, they assessed an initial group of **16 children** in a dose-finding study. The effective dose was established through adjustments by caregivers. The response to treatment was assessed by review of sleep charts and parent reports. **Improvements to sleep, as reported by parents and caregivers, were observed in 11 of these 16 children**. Then **42 multiple disabled children** were selected from a larger group of **144 children** who had been previously treated with fast-release melatonin.

The effectiveness of the therapy was inferred from treatment decisions made by the children's caregivers after the study. After using it in the clinical trial, 23 subjects switched to that form of the medication whereas 13 others continued melatonin therapy by using a combination of FR and CR doses. In these subjects, the researchers report that the most **effective average dose of controlled-release melatonin (5.7 mg.) is slightly lower than the FR dose (7.1 mg.)** One treatment had to be discontinued because of excessive sedation. Four children may have developed a tolerance to melatonin but this was difficult to prove as children with multiple disabilities often have unrecognized causes of sleep disturbances. The most common reason for discontinuing the CR melatonin was difficulty swallowing the tablets. **Jan, Freeman and Fast** comment that **children appear to require higher amounts of melatonin** than adults, according to the literature reviewed. They suggest that this may be because endogenous **melatonin levels are higher in children** and that children **metabolize this hormone faster before puberty**. The researchers state that studies confirm **that fast-release melatonin is most effective when there is only delayed sleep onset** and that **controlled-release form is more useful for sleep maintenance**. The researchers did not find any serious side-effects nor have they been reported in the literature. It appears that taking melatonin does not lower the threshold for seizures and may even have a beneficial effect on seizure disorders. The researchers state that

physicians who use melatonin treatment should be aware that there are many medications which interfere with its metabolism. **Special caution is required when children are taking other medications**; melatonin-drug sleep interactions are very important. Although melatonin treatment is not recommended for every type of sleep disturbance, and many children require a combination of approaches to sleep, the establishment of normal sleep patterns in children with disrupted sleep-wake cycles "dramatically changes the children as they soon become less irritable, calmer, happier, more playful, and more affectionate. Cognitive functioning, speed of learning, memory and problem-solving abilities tend to improve. They are able to socialize better and may have less self-injurious behavior" (p. 496).

According to **Dr. Jan**, **melatonin will be available as a prescription drug in Canada in a couple of years**. Health Canada has approved a trial and a study has been initiated. In the meanwhile, **families can ask their physician if he or she is willing to make a special request to obtain melatonin from countries where it is approved (such as the United States) by making a special application to the Health Protection Branch**. As **Drs. Jan, Freeman and Fast** state: "While this therapy is remarkably safe, this **treatment should still be in the hands of skilled physicians** who are also familiar with the problems of the disabled."

COMMENTARY **by Kate Andersen, M.Ed., Youth Consultant, National ME/FM Action Network**

This is an important piece of research for people with **ME and FM** for several reasons. First of all, it shows that researchers can study complex clinical problems in a scientifically rigorous fashion, while seeking clinically meaningful results that improve the quality of life of their patients and their patients' caregivers. The protocols of this study were difficult to establish and to follow, as each child's treatment was essentially individualized. Parents' and caregivers' reports and treatment decisions were accepted as reliable and clinically meaningful. Although theoretically people with ME and FM might be good candidates for melatonin therapy, the findings of this study cannot be assumed to be generalizable to children and adolescents with ME and FM. In fact, a recent research report of a study on night-time melatonin levels in a very small sample of adolescents with CFS reported no differences in timing of melatonin increase in saliva between patients and controls, nor did the time of sleep onset and duration of sleep differ significantly between patients and controls **(Knook et al., 2000).** The researchers suggest that there is no indication for melatonin supplementation in adolescents with CFS. However, they found a highly significant DIFFERENCE in melatonin levels between these adolescents with CFS and controls which suggests the relationship of this hormone to sleep problems in this population needs further study. The bottom-line is that, as with most research on ME/CFS, we need larger sample sizes, and replication.

Clinical experience suggests that melatonin can be effective with some youngsters with CFS. In writing about CFS in youth, CFS expert **Dr. Charles Lapp** comments that when other methods fail he will "suggest melatonin, the natural brain hormone that induces

restfulness in sleep in normal individuals". He emphasizes that treatment of sleep disruption begins with good sleep habits. Dr. Lapp recommends the following: a) a regular bedtime; b) avoid caffeine, exertion and other stimulation for an hour or more before bedtime; c) use the bed for sleeping only - not reading, TV or homework!; d) if you have trouble falling asleep or find yourself wide awake during the middle of the night, get up. Go to an easy chair or couch and do something quiet like reading, listening to the radio or watching television. Once you feel sleepy again, return to bed. If you awaken briefly but frequently during the night, consider using a red night light, as regular white light has a tendency to awaken us. Dr. Lapp does not hesitate to use medication if necessary.

Over-the-counter treatments:a) the herb valerian (500-750 mg nightly); b) a mild antihistamine like Benedryl (25-50mg), Tylenol PM or Excedrin PM.

Prescription medication: a) Doxepin in low doses (1 mg to 20 mg, typically 10 mg) plus the Valium-like drug, Klonopin at 0.5 to 1 mg nightly. Klonopin is rapid-acting and helps you to fall asleep, while doxepin keeps you asleep. b) Trazadone (50 mg nightly), an antidepressant that increases the depth and quality of sleep; c)Ambien (5-10 mg nightly), which is a uniquely structured sleep drug that is only mildly habituating and does not seem to loose effectiveness over time.

Other options: include Ativan, Xanax, Valium, Halcion, Doral, Prosom, Restoril and others, but these tend to habituate and adapt (wear off) after time. Please note that not all of these medications are available in Canada, but where there are no Canadian substitutes, they may be obtained by your doctor through special application to the **Health Protection Branch** in Ottawa.

Dr. Lapp states: "More important than medications, PWCs should strive to go with the flow or accommodate their own body rhythm. Studies of cortisol production in PWCs suggest that the natural body rhythm (or diurnal cycle) is shifted several hours to the right. That is, if you were used to falling asleep at 10:00 pm, your body might now feel more comfortable nodding off at 1:00 or 2:00 am. Similarly, if you toss and turn all night, or if you are up for an hour or two, it is best to sleep in the next day until you feel somewhat rested."

Dr. Lapp also states that when this shifted body rhythm interferes with work, school or social activities, however, he highly recommends "using melatonin to trigger your nighttime body rhythm cycle, then upon awakening opening all the blinds and curtains so that you get plenty of light exposure for 2-3 hours each morning. In darker Northern climates it may be necessary to invest in a light box to accomplish this" (my emphasis).

Finally, he comments: "Occasionally there will be periods when the PWC just can't sleep at all. In such cases it is best to nap and catch up whenever possible, but I will occasionally prescribe powerful soporifics such as chloral hydrate or short-acting barbiturates. When used for short periods of time, these generally induce a reasonable sleep and re-establish a more normal sleep cycle. "

[Ed. Note: Ms **Kate Andersen** can be reached at Tel. **(604) 732-6030** or E-mail: **kate_andersen_uvic@yahoo.com**

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SYNAPTIC TECHNOLOGY STUDY ON PAIN CONTROL & ASSOCIATED CONDITIONS & FM/CFS STUDY

By: Rowland Warwick, New S.E.A. Technology & Links to ME/FM

Synaptic technology has come a long way since its conception. It started with a double-blind study to evaluate the clinical Analgesia/Anesthesia efficacy on acute pain of the High Frequency Neuromodulator in various dental settings. (Published in Oral

Surgery, Medicine, and Pathology Vol. 63 No 4 pp 501-505 April-1987). Results: Placebo rating - 8.5% favorable**, Synaptic Electronic Activation** (S.E.A.) Tech. - 92.8% favorable.

Invasive dental procedures were chosen as a medium to show just how effective at controlling pain this technology is. Prior to S.E.A. Technology, no electrotherapy devices have been able to create 'profound long-term' Analgesia/Anesthesia. (Mann and Silverstone, 1989 Silverstone, 1992).

This breakthrough in technology has shown **neurotransmitter modulation in humans 24 hrs after treatment**, relative to pre-treatment levels. (Silverstone, 1996) This is unique to S.E.A. Tech. **Neurotransmitters** such as Serotonin, Beta - Endorphins, Enkephalins, A.C.T.H., Somatostatin , Gamma Aminobutyric Acid (G.A.B.A)., Epinephrine and Norepinephrines were shown to be **modulated.** The use of S.E.A. Tech. has wide parameters including controlling the pain associated with F.M. / C.F.S. Three years ago, we happened to be treating F.M. patients for their pain and they

noticed changes were occurring above and beyond the gradual pain reduction. So, we put together a small group of F.M./C.F.S. sufferers to study and found that their **overall sleep pattern seemed to be the first thing to change, in a manner which allowed them to have more energy** through the day and recover from flare-ups and bouts of fatigue more easily.

Over the next two years we collected subjective information from a number of study groups and from personal case studies which indicated that the improvement was consistent. We needed a way to prove clinically and independently that what was happening was effecting the pathogenous and changing that condition long term. This is the reason why we have mounted the present study, using the E.E.G. of sleep patterns to see what changes have been affected, if any, by the Synaptic treatment. The **study** has been running **since Oct. 1999** and we intend to keep it going until **April 2001** so there is still time for many more participants to join the study. We can only accommodate people from the **Toronto area** at this time, where we have **4 clinics participating** in this study. If you would like to participate in this free study, call **(416) 225 -4654** and speak with the study's Coordinator, **Rowland Warwick**.

This new therapy has a hand- held remote control, which is operated by the patient, who is in total control of his/her own treatment. There are no contraindications other than Cardiac Pacemaker and Pregnancy. The device is very safe. It has been approved by the **F.D.A**. and **Health Canada.** Its notification under the Health Act is the ability to control acute and chronic pain and speed up the healing process.

The additional studies that have been done, and the ones that are on-going, are showing much wider use and application of S.E.A.Tech. in the control and treatment of other conditions that were not evident to us in the beginning. Some of these benefits are now backed up with studies in essential tremor, cancer pain, depression, sleep patterns, relief of muscle spasm, incontinence, irritable bowel and bladder syndromes helped or eradicated, re-educated old pain pathways, re-calibrated neural pathways, which exploit a phenomenon called "neuronal plasticity". With this help to the Central Nervous System, patients are able to become less dependent on their medication, and, in many cases, can be weaned off completely.Did you know that scientists at **McGil University** recently announced that, according to their research, serotonin production is 53% higher in men's brains than in women's. This fact is one of the biggest gender divergences ever in human brains. People with sleep disorders are usually deprived of non-REM sleep. Serotonin, G.A.B.A. Dopamine, Norpinephrine and hormone, Melatonin, are required to make the transition from REM to non- REM sleep. However, there is an imbalance of neurochemicals / neurotransmitters in those individuals suffering from insomnia, anxiety disorders, depression, chronic pain. (F.M. & C.F.S. fall into this category.) In 4 different study groups in the U.S. it's been found that , in the spinal fluid of fibromyalgia patients, substance P is on average 2 to 3 times higher than in ordinary patients and that there are low levels of serum serotonin, platelet serotonin and serotonin in the central nervous system, compared with normal controls. All patients with chronic pain have reduced levels of blood serotonin compared with healthy subjects (approx. 20-25% less).Did you know that naturally-occurring Endorphins were found to be 48 times more potent than morphine when injected into the brain and 3 times more powerful when injected into the bloodstream? (S.H.Snyder,1977) & (R. Bolles & Fanselow 1982). Finally, a study started in England and completed by the University of California at Irvine found that 'long term potentiation' of high frequency stimulation to the hippocampus, not only strengthens existing synapses, but it also creates new ones. (Lynch et al .1988).

ACCURATELY COMPLETING QUESTIONNAIRE INCLUDED WITH DISABILITY APPLICATION IS IMPORTANT FOR FAVORABLE DECISION - By: Kurt Arndt, Canada

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Canada Pension Plan - (CPP)

Accurately completing the Questionnaire included with the disability application is important for a favorable decision. When making application for CPP disability benefits, it is important to keep in mind that YOU have the responsibility to demonstrate that you meet the conditions of entitlement. The onus for providing proof of the severity of your condition is yours. Remember that the CPP defines disability as a physical and/or mental condition that is severe and prolonged where the severity of the medical condition must be to such a significant extent that the individual is incapable of regularly working at any job, including modified work or light sedentary work. Keeping this in mind will assist you in completing your questionnaire. Attention to detail is important.and reviews regarding your health. They will base an opinion regarding your medical condition on this questionnaire. It is extremely important to clearly indicate your condition and how it affects your functioning. It is not good enough to simply say "that I ache all over", without clearly indicating how your pain limits your ability to function in a working environment. For example; when describing back pain do not simply state that you have significant pain in your back area; instead indicate that you suffer from significant back pain which affects you in the following fashion: pain dramatically restricts back movement; unable to sit for more than 10 to 15 minutes; unable to stand for more than 10 minutes; unable to bend forward to pick up objects from the floor; must lie flat on my back on a hard surface for approximately 2 to 3 hours a day at intermittent intervals (etc.). Furthermore, you should indicate how the pain is in fact limiting your function. This can be stated in many ways. For example, "I feel pain to such a significant extent that it effects my concentration, memory, mood, etc. (don’t ever use etc. in your questionnaire) that I am incapable of concentrating on any specific task during this time period." You should further describe your pain as to its intensity, its predictability or unpredictability, how long it lasts, and its after-affects, such as profound fatigue, exhaustion, etc.. Do this for all of the locations where you have pain to demonstrate the various areas of your body that are affected.

Do not be afraid of providing too much detail. If you can accurately indicate the limitations of your condition, this will give the adjudicator an overall picture of how significantly your condition impacts on your ability to work. Remember, just because you have fibromyalgia does not mean that your condition will preclude all kinds of work. Each medical condition affects individuals differently; it is important for you to demonstrate how your condition specifically affects your ability to work at any job. Do not be afraid to use extra sheets of paper in order to accurately describe your condition. You are not bound by the space that is made available in the application questionnaire. Remember, your questionnaire is your opportunity to clearly describe your medical difficulties to the adjudicator and how these difficulties preclude employment.

Prior to completing the actual medical questionnaire it would be appropriate to review each question without actually filling in any of the spaces. Think about each question

and jot down your answers on a separate piece of paper until you are satisfied with your response. If your condition does not allow you to complete the questionnaire in your own handwriting make certain that this fact is indicated at the conclusion of the questionnaire. For example; indicate that the questionnaire "was filled in by hand by my daughter as I am unable to write for more than a few minutes due to increasing hand and wrist pain." This will at least explain to the adjudicator that the handwriting which is neat and clear has not been completed in the applicants hand due to your medical limitations. Otherwise, the adjudicator may think "How can this individual write so well when they indicate that they are unable to write for any period of time?"

After you have completed your questionnaire, try this approach; give your spouse or close friend (friend is preferred) your disability questionnaire and ask them to review it. Let this third party tell you whether or not they believe the information is sufficient to demonstrate that you suffer from a severe condition. If the severity of your condition is not made clear to your friend, then you definitely need to provide more information to clarify and explain. Often your medical questionnaire and the doctor's initial medical report are all the information that the CPP will receive prior to making its decision. If your questionnaire cannot convince your spouse or friend, then it certainly won't convince a third party adjudicator.

SUCCESSFUL APPEAL OF DECISION FROM MINISTER OF HUMAN RESOURCES DEVELOPMENT CANADA (CPP)

By: David Lackman, Barrister & Solicitor, Lackman, Firestone Law Offices, 357 Bay Street, Suite 401, Toronto ON M5H 2T7 – Tel. (416) 364-0020 – Fax (416) 364-0389 – Web: www.LTDClaims.com (Initial Consultation Free)

The decision in ***McCormick***, issued in Ottawa, Ontario on **December 11, 2000** by the Canada Pension Plan Review Tribunal involves

the Appellant, a 25 year-old woman, who was successful in appealing a decision of the Minister of Human Resources Development, Canada which had denied her claim for CPP disability benefits. Her claim was based principally on two medical conditions - Chronic Fatigue Syndrome and Neurogenic Orthostatic Hypotension, both of which her physician indicated in his evidence were of "significant medical concern".

As to the CFS claim, the evidence presented was that the appellant experienced severe and debilitating fatigue-related symptoms which incapacitated her from all types of work and from functioning in and around the home.

The tribunal expressed reservation as to whether the CFS was likely to be "long continued and of indefinite duration", which must be shown in order to support a finding of "prolonged" disability. Its reservations were based on a stated concern about "the somewhat mysterious nature of this syndrome's etiology and course". Nevertheless, importantly, the tribunal concluded that the appellant met the requirements of the CPP disability test on the balance of probabilities. It would appear that the *combination* of the

two conditions was found to have rendered the appellant's disabilities both "severe and prolonged", as required under the CPP legislation in order to qualify for the benefits.

[Ed. note: If you would like a copy of the actual decision of the Review Tribunal, please request **DECISION OF THE REVIEW TRIBUNAL - REFERENCE: 508-690-641 and** send a stamped ($0.47), self-addressed envelope to the National ME/FM Action Network, 3836 Carling Ave., Nepean, ON K2K 2Y6 Canada.

"ENSURING INSURERS PLAY FAIR", dated Thursday, Feb 8, 2001 -

By: Steve Buist, Science Reporter, The Hamilton Spectator

A CASE AFFECTING US ALL -- The law compels insurance companies to be fair with all claims for losses. But that legal obligation must be backed up with potentially large penalties to deter insurers from unfairly denying claims, a Hamilton lawyer argued at the Supreme Court. It's a case that affects every person with insurance.

The case before the **Supreme Court of Canada** is known simply as **Whiten v. Pilot Insurance Co**. When Canada's highest court releases that decision, perhaps in another month or so, it won't spark the same sort of passionate discussion as the recent case of Saskatchewan farmer Robert Latimer, who was convicted of killing his severely disabled daughter. But in its own quiet way, the consequences of **Whiten v. Pilot** will have far-reaching implications for any Canadian who holds an insurance policy. The case is causing the **Supreme Court to examine the question of good faith, and the special relationship that exists between an insurance company and a policy holder.** Specifically, the **court is looking at what should be the penalty when an insurance company grotesquely abuses its power.**

The nightmare began shortly after midnight on **Jan. 18, 1994**. As they were getting ready for bed, Daphne Whiten and her husband, Keith, discovered that their home in Haliburton was on fire. The couple and their daughter were forced to scramble out into the frigid -18 C night wearing only their pajamas, then watched as their two-storey home and all their possessions, including a number of antiques, burned to the ground. Their three cats perished in the fire, and Keith, barefoot and freezing, ended up in hospital with frostbite. For the Whitens, however, their troubles had only just begun. That's because Pilot Insurance, which insured their home, decided the fire was arson and then set about trying to prove its case. All the while, the insurance company refused to pay the Whitens' claim for their losses. But there was just one rather inconvenient problem: no one agreed with Pilot's notion that the fire was arson. The first firefighters on the scene said the fire was accidental. The company's own experienced adjuster said the fire was accidental and strongly recommended payment of the claim. **Pilot** replaced him and then kept his report secret. The company then asked the **Insurance Crime Prevention Bureau** to investigate. The bureau's role as a quasi-independent agency is to root out insurance fraud, but when the **ICPB** concluded that the fire wasn't arson, **Pilot** ignored that recommendation, too.

Pilot then hired an independent engineering expert, who wrote three separate reports stating that the fire was accidental. Those were ignored as well, and then the company refused to meet with the expert when he expressed his concerns. To rub salt in the Whitens' wounds, **Pilot** also terminated the couple's rent payments on their rented cottage without telling them. That was after the Whitens had lost everything in the fire, were unemployed and living on welfare. The Whitens sued Pilot for their losses and also asked the court to impose additional punitive damages against the company. Throughout the whole ordeal, the Whitens had fully co-operated with the insurance company. They voluntarily agreed to lengthy taped interviews the same day of the fire, they assisted in the investigation, and later, they even voluntarily agreed to take lie-detector tests with no conditions attached.

At the trial, **Pilot** admitted that the jury could reasonably conclude that the company either withheld information or provided misleading information to its experts, and that the company's lawyers had even tried to influence the experts' opinions to support the arson theory. Even when the deputy fire chief was given misleading information by **Pilot**, he still concluded that it wasn't arson. Incredibly, after a four-week trial, the insurance company eventually conceded that the evidence showed without a doubt that the fire was accidental.

The six jurors went ballistic. Not only did they award the Whitens **$287,300** for their losses, they determined that **Pilot'**s conduct was so reprehensible that they tacked on a staggering $1 million in punitive damages against the company, the largest award ever in Canada against an insurer for acting in bad faith. **Pilot** appealed the judgment, arguing that there was no need for punitive damages, or conversely, even if they were warranted, $1 million was utterly excessive.

The **Ontario Court of Appeal** ruled that **Pilot** should pay punitive damages, and there was no disagreement about the behavior of the company.

"The evidence overwhelmingly showed that (Pilot) handled the plaintiff's claim unfairly and in bad faith," said the decision, "that it deliberately ignored any opinion that would oblige it to comply ... and that it abused its financial position. "Pilot's conduct was so reprehensible that a punitive award was justified."

But in a split 2-1 ruling, the appeal court agreed that $1 million was too much and knocked it back to $100,000. The Whitens then sought to appeal and the Supreme Court agreed to hear the case just before Christmas. But the case took an interesting twist before it reached the highest court in the land. The Insurance Council of Canada asked for permission to intervene and present the argument that any punitive damage awards in insurance cases should be capped at $25,000. In response, the Ontario Trial Lawyers Association was allowed to present the countering position that there should be no limit and that judges should have the discretion to impose a suitable penalty of any size. To argue its case before the Supreme Court, the association chose Hamilton lawyer **Bob Munroe**, a civil litigation specialist.

Now, the Supreme Court will look not only at the specifics of the Whitens' case but at whether there should also be limits on the amount of punishment a judge can hand out when an insurance company has flagrantly abused its power.

A closer look at the underlying principles of this case helps show why it is important to you, the consumer. We enter into many different types of contracts in the course of everyday life. In a normal commercial contract, the two sides are allowed to protect their own interests. As long as you live up to the terms of the agreement, you're not obliged to put the other side's interest on the same level with your own. But an insurance contract carries different obligations because the two sides aren't on an equal footing.

You pay your insurance premium for peace of mind, knowing that you will be protected in the event of an unforeseen disaster -- whether it's the loss of your health or employment or property. When you have to call on insurance, you're already in a vulnerable position.

"Both parties know that if that disaster strikes, the insured will be dependent upon the insurance company living up to its obligations under the contract in a fair and reasonable way," said Munroe.

"Many people have nowhere else to turn in those circumstances.

"It's difficult to get into a long drawn-out battle with the person who has agreed to protect you and help you in those circumstances," Munroe added.

That battle might end up being one-sided. On one hand would be a large, well-funded company with plenty of resources at its disposal while on the other hand would be a person who's been hurt or who has suffered a loss. So to level the playing field, an insurance contract carries with it an obligation of good faith on both sides. The legal principle of good faith requires the insurer to put your interests on par with its own interests. Neither side is supposed to seek an unfair advantage in living up to the contract.

"It means an insured person has an obligation to be honest and truthful and fair with the insurance company," said Munroe, "but similarly, the insurance company has an obligation to not put its own interests above the interests of the insured person."

Because of this special need for good faith between the insurer and a policy holder, it's all the more serious when there are problems of bad faith. That's where punitive damages enter the picture. In addition to replacing your loss, the law allows for the court to impose a punishment on the insurer in the rare cases where the behavior is considered shockingly malicious or vindictive. The idea is that punitive damages would act to deter not only the wrongdoing of that company but any other company that might want to behave in a similar fashion. The Insurance Council of Canada disagrees with that notion for two reasons.

First, large punitive damage awards in a few isolated cases means that all of that company's policy holders will pay the price through higher premiums.

"Insurance is an animal where the many pay into the pot and the pot is then used to satisfy the claims of the few," said Neil Finkelstein, a Toronto lawyer who represented the Insurance Council of Canada before the Supreme Court.

"Not everybody who buys insurance collects. If you have very large punitive damages awards, what you're really doing is punishing the whole insurance pool."

The council also points out that there's already a government regulatory agency in Ontario with the power to lay charges and collect fines if an insurance company steps out of line. The **Financial Services Commission of Ontario** is responsible for watching over the insurance industry. Under the Insurance Act, the Superintendent of Insurance has the power to prosecute charges, which can lead to fines of up to $100,000 for a first offense, rising to a maximum of $200,000 for repeated offenses.

What rankles the Insurance Council of Canada is that punitive damages go directly to the person who has been wronged -- in essence, it's like winning the lottery.

"The plaintiff takes the money and goes to Florida or buys a house or buys a car," said Finkelstein. "It's not the same thing as a fine, where the fine goes into the public purse and is used for public purposes.

"I'm saying the punishment should be administered by the regulator. If you want to impose a fine, call it a fine and the money should go to the public purse." But there are problems with those arguments.

The first is simple: whether it's a fine or a punitive damages award, the cost is still going to be passed on to the people who pay premiums. That alone is disturbing, according to Munroe's presentation to the Supreme Court. The claim that "premiums will rise because of punitive damages awards implicitly suggests that insurers believe that it is reasonable to pass along the cost of their misconduct to the very people they are abusing," Munroe wrote.

"Policy holders will then be in the ironic position of being required to insure themselves not only against their own personal misfortunes but also against potential malicious mistreatment at the hands of their insurers."

But there's a second obstacle that's more troublesome -- the apparent reluctance of the **Financial Services Commission** to get involved in these cases. Over the past three years, there hasn't been one fine collected by **FSCO** related to the improper conduct of an insurance company against a policy holder. Surprisingly, **FSCO** actually investigated the **Whiten v. Pilot** case and decided not to lay a charge against the insurance company. Had they gone ahead, it might have even been one of the easiest cases ever to prosecute, since more than one court had already lambasted Pilot for its actions and

the company itself admitted it was wrong. But FSCO decided that this was an isolated case and not indicative of the way **Pilot** does business. That's a little like saying because you stopped properly for 4,999 red lights, you shouldn't get a ticket if you zoom through the 5,000th one.

FSCO also said one of the reasons for not laying a charge was that there had been a punitive damages award in the civil case, even though there's nothing that prevents both a fine in provincial court and punitive damages in civil court.

Follow the logic through and you're left with a Catch-22 situation: the insurance council arguing that FSCO should be the ones handing out punishment in cases like Whiten v. Pilot, and FSCO saying that it looks to civil courts to award punitive damages in individual cases.

Munroe's argument was that judges should continue to have the ability to punish wrongdoers with no cap on the size of the award. If the Supreme Court accepts the insurance industry's proposal of a $25,000 limit, he said, it would allow companies to go through a cost-benefit analysis. In fact, it might even encourage more Draconian behavior, because companies would already know what the maximum penalty would be.

"You'd essentially be allowing them to calculate whether it was worthwhile to engage in that kind of behaviour," said Munroe. "A cap would amount to a licence fee." It may seem ironic, **Munroe** added, but giving judges the discretion over the size of awards is actually a benefit for the consumer. "Insurers who have been punished often enough, to the point of affecting premiums, will become less profitable," **Munroe** wrote. "Those companies which do not engage in malicious, reprehensible and contemptuous behavior will not be subject to awards and therefore will have lower costs and offer lower premiums to consumers."

Good Faith

An insurance company "holds a position of power over an insured; conversely, the insured is in a vulnerable position, entirely dependent on the insurer when a loss occurs. For those reasons, in every insurance contract an insurer has an implied obligation to deal with the claims of its insureds in good faith. That obligation to act in good faith is separate from the insurer's obligation to compensate its insured for a loss covered by the policy."

UPDATE: NATIONAL ME/FM ACTION NETWORK URGES CANADIAN COLLEGES OF

PHYSICIANS & SURGEONS TO DEVELOP GUIDELINES FOR I.M.E. DOCTORS -

By: Mary Ellen - Manager - Special Projects

In **QUEST 43**, the **Alberta College of Physicians & Surgeons'** new, 15-page document, **guidelines for medical doctors who perform Independent Medical Examinations** (IME's) on behalf of third parties, such as private insurance companies, was highlighted.

In **QUEST 44**, a copy of the Form letter urging every president of each of the Colleges of Physicians & Surgeons across the country to adopt the Alberta guidelines or establish similar guidelines was included and our members urged to send letters as well. To date, we have preliminary responses from the provinces of **Nova Scotia, Manitoba and British Columbia.**

We urge you to continue the pressure on your province by sending in our Form letter or, if you have undergone an IME which you consider to be unfair, please write a short, calm, one-page letter describing your personal experience and the reasons that you feel ethical guidelines are needed to protect the patient. Please place a **cc. National ME/FM Action Network** at the bottom of your letter and send us a copy so that the Colleges know that we are keeping track of these letters.

Were you treated in a respectful manner? Were you examined by a doctor experienced in treating disabled people with your illness? Were you examined by a doctor who obviously was current on the scientific research about your illness?

Our member in British Columbia, **Doug Quance**, is putting together a package regarding the importance of protecting patients through ethical guidelines for IME doctors. This package will be delivered to three speakers who will be giving presentations at the **Tenth Annual Ethics Conference "Ethics 2001" of the British Columbia Medical Association & The College of Physicians and Surgeons of British Columbia on March 29-31, 2001.** It is hoped that the speakers will raise this important topic at their conference.

Included in the package will be a document, **"INDEPENDENT MEDICAL EXAMINATIONS IN CANADA: THE NEED FOR REFORM",** written by our member in **Quebec, Lise Noel**, who puts forward the case for the Colorado Model (see QUEST # 32, October/November 1998) as offering the best guarantee so far for a truly independent medical examination. A Ph.D. in History, **Lise Noel** has lectured extensively and written dozens of articles on the problem of human rights. Her book on the subject has won the **Governor General's Award** (in French) in 1989 and the updated translation in English, **INTOLERANCE. THE PARAMETERS OF OPPRESSION**, published in 1994 by McGill-Queens University Press has received the **American Gustavus Myers Center Award** For **The Study of Human Rights in North America**. **Lise Noel** believes that as individuals, citizens, tax-payers and consumers of health services, not only do people with an illness have the same rights as those who are in good health, but also that the ten percent of those who are chronically ill, the so-called "heavy cases", among the sick population, have the same rights as the ninety percent who eventually will get their health back.

After the conference, **Doug Quance** plans to continue placing pressure on the **College of Physicians and Surgeons of British Columbia** about the urgent need for ethical guidelines for doctors performing independent medical examinations. Anyone in British Columbia, who would like to participate, is asked to contact **Doug** by email at **dougq@home.com**

As well as communicating with the College in your province, also, please continue to urge people who have attended an IME at the request of an insurance company or Canada Pension Plan to fill out our **Registry Submission Form**. Armed with up-to-date statistics we are in a better position to argue the desperate need for these guidelines To get a copy or copies of our confidential, 7 question, simple **Registry Submission Form**, please contact: **Mary Ellen**, Manager, Special Projects - Phone: **(905) 831-4744** - Mail: **P.O. Box 66172, Town Center Postal Outlet, 1355 Kingston Rd., Pickering, ON., L1V 6P7 -** E-mail: **marye@pathcom.com** or download the Form from our website at: **www3.sympatico.ca/me-fm.action/medexam.html**

BOOKS/NEWSLETTERS/REPORTS/VIDEOS ETC.: 1) STRICKEN - by Peggy Munson. $24.95 U.S. Haworth Press - To Order call: 1-800-429-6784 - 2) FIBROMYALGIE (French) By: Marcel Guite and Agathe Drouin Begin Available in book stores; 3) ADOLESCENCE AND MYALGIC ENCEPHALOMYELITIS / CHRONIC FATIGUE SYNDROME - JOURNEYS WITH THE DRAGON - By: Naida Edgar Brotherston, MSW, RSW - Price: **$49.95 U.S. Hard. $24.95 U.S. Soft -**

Available through The Haworth Medical Press Tel. 1-800-429-6784 - Fax: 1-800-895-0582; 4) LIVING WITH FIBROMYALGIA & CHRONIC PAIN - 96 pages - By: Gwyneth Graham and Camilla Lawson $9.95 - Cheque or Money Order to: Gralaw Enterprises, P.O. Box 66608, Stoney Creek Postal Outlet, Stoney Creek, ON L8G 5E5 Canada

ONTARIO GOVERNMENT LAUNCHES 24-HOUR HOTLINE FOR HEALTHCARE IN TORONTO AREA -

Round-the-clock health advice will be given through a toll-free number, seven days a week at all hours. **144 Registered Nurses** with at least five years experience will determine if the individual who telephoned needs immediate help, requires a visit to the doctor or can take care of the ailment at home.

The nurses will be able to link calls to 911 for emergency and can fax information to hospital emergency rooms. The project is expected to expand to the rest of Ontario. Similar services are offered in New Brunswick and Quebec. The number **1-866-797-0000** - applies to people living in the **416** and **905 area code.**

OUR WORLD:

ME: MANAGING ENERGY

NAUSEA: A QUICK STAY ON THE ‘LOVE BOAT’ -

By: Lorraine Legendre, Ottawa.

QUEST COLLECTION BOOK - FIVE YEARS: By popular request, **the National ME/FM Action Network** has published an easy to read book consisting of a **collection** of important articles which have appeared in our **'QUEST'** newsletters over the years. For easy reference, these articles have been grouped into sections, according to their focus i.e. medical, legal etc. We have kept the **cost** of the book to a minimum at **$20.00** each which includes shipping and printing. Please make **your cheque payable to the National ME/FM Action Network** and let us know how many copies you would like.

LEGAL/RESEARCH PACKAGE - Medical and Legal Information. Please make **cheque payable to Marj van de Sande** in the amount of **$25.00** (our Director of Education) to cover photocopying, postage charges etc., **151 Arbour Ridge Circle NW, Calgary, AB T3G 3V9 - Tel/Fax: (403) 547-8799 - E-mail: vandesam@cadvision.com**

MEMBERSHIP: $25.00 per year includes bi-monthly newsletters - Please make cheque payable to:

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WEB: http://www3.sympatico.ca/me-fm.action/

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