Quest #51 January 2002

NATIONAL ME/FM ACTION NETWORK is proud to announce that we will be hosting the **First International Symposium on the Parallels between Post-Polio Sequelae (PPS), Myalgic Encephalomyelitis / Chronic Fatigue Syndrome (ME/CFS) and Fibromyalgia Syndrome** (FMS) on **June 15th, 2002, 1:00 – 4:00 P.M. at the Holiday Inn Hotel & Suites Toronto-Markham, Ontario** (approximately 20 mins. drive from Toronto's Lester B. Pearson International Airport) We are delighted to feature two internationally-renowned researchers, **Dr. Elizabeth Dowsett**, leading British ME researcher and **Dr. Richard L. Bruno**, the world's leading expert on Post-Polio Sequelae. Tickets are **$8.00** in advance and **$10.00** at the door. To reserve a seat, please contact **Mary Ellen** – Manager – Special Projects for the **National ME/FM Action Network**, P.O. Box 66172, Town Center Postal Outlet, 1355 Kingston Rd., Pickering, ON L1V 6P7 – - **Tel/Fax: (905) 831-4744** - E-Mail: **marye@pathcom.com** Out-of towners wishing to stay at the Hotel should ask for a reduced symposium room rate by phoning the **hotel** toll- free at **1-800-387-3303 or (905) 474-0444.** Please book as soon as possible.

BRITISH GOVERNMENT TAKES STAND ON ME/CFS - By: Liana Brittain, Research Consultant & Reporter

In **January 2002**, the **British Department of Health** gave the government response to the **ME/CFS Independent Working Group's Report**. This report had been nearly four years in the making. The Department of Health endorsed the view of the ME/CFS Independent Working Group Report that "this is a chronic illness and the Health and social care professionals should recognize it as such". Under the new guidelines, any doctor who ignores or refuses to follow them, could be liable for disciplinary action, according to Chris Clark, chief executive of Action for ME. The Department of Health has tasked both the Medical Research Council and the National Institute of Clinical Excellence to address a variety of related issues. They have indicated that a timetable and appropriate terms of reference will be agreed upon by the end of February.

The Department of Health report goes on to indicate that it will ask the Medical Research Council "... to develop a broad strategy for advancing biomedical and health services research on chronic fatigue syndrome ME/CFS" and to also "...appoint an independent scientific advisory group", who's responsibility it will be to investigate "... research-relevant surveys of the concerns of patients and carers ". According to Dr. Michael Fitzpatrick, author of The Tyranny of Health, from the biomedical model perspective, "ME/CFS is a condition like many other medical conditions where illness results from a specific pathological defect in physiological functioning, mediated at organ, tissue, cellular and/or molecular level, by as yet undefined mechanisms". It is this perspective that the Department of Health is endorsing.

Comprehensive clinical guidelines will be the responsibility of the National Institute of Clinical Excellence. In addition, two National Service Frameworks will be developed by the External Reference Groups. One will address the needs of children and adolescents, while the other will examine adults with long term medical conditions. The Department of Health is aware of the importance of creating a partnership with the patient and family. It also acknowledges that, especially for young people, education, social life, and family life can be disrupted.

For greater detail and depth on this topic, the references for this article can be found at the following internet sites:

1. *A Report of the ME/CFS Working Group* **http://www.doh.gov.uk/cmo/cfsmereport/index.htm**

2. *The Government Response to the CFS/ME Independent Working Group's Report* - **http://www.doh.gov.uk/cmo/cfsmereport/response.htm**

3. *The ME Association Welcomes 'Wake-Up Call' in CMO Report Published 11th January 2002* - **http://www.meassociation.org.uk/flatest.htm**

FIBROMYALGIA: Integrative Care with BOTOX for Headache/ Muscle pain relief -

By: Dr. Gordon Ko MD CCFP(EM) FRCPC FAAPM&R

Muscle pain can range from simple conditions like localized myofascial trigger points to complex chronic pain syndromes like Fibromyalgia (FM). The latter by definition is a **syndrome** i.e. "a collection of symptoms" and not a true disease (since all regular lab tests are normal). It is therefore made by a **diagnosis of exclusion** (tests for cancer, multiple sclerosis, lupus, thyroid disease etc. are all normal, so it must be FM). Symptoms include widespread muscle pain and stiffness with 11 or more characteristic tender points on palpation. It affects 2% of the population, mostly females around 40 to 50 years of age. Symptoms in FM include 1. musculoskeletal complaints: "hurt all over", stiffness, swollen feeling in tissues; 2. non-musculoskeletal: fatigue, poor sleep, "pins & needles" sensation and 3. associated syndromes such as irritable bowel syndrome (41.8%) , dysmenorrhea , female urethral syndrome , noncardiac chest pain , plantar heel pain , migraine headache, temporomandibular joint pain, Sjogren's syndrome , carpal tunnel syndrome (14.1%) and raynaud's syndrome (38%). Higher anxiety and depression have also been reported. **70% of chronic fatigue syndrome (CFS) patients also have the criteria for FM.**

FM is a difficult-to-treat, potentially disabling problem. It is estimated that the total cost of musculo-skeletal pain is about $80 billion. In Canada, back in 1989, it was estimated that private insurance carriers paid out over 200 million dollars a year in long term disability payments for FM. In our recent survey of 116 physiatrists (rehabilitation MD specialists) in Ontario, 55% of respondents agreed that FM is a "real disabling condition". When asked what type of alternative therapy is helpful, 14 different types were mentioned with the top three being acupuncture, biofeedback and chiropractic.

REVIEW OF PUBLISHED RANDOMIZED CONTROLLED TREATMENT TRIALS TO DATE:

MEDICATIONS published to be effective for pain in FM: Amitriptyline (10-50 mg effective for first 2 months) ; augmented with Fluoxetine (Prozac) ; Cyclobenzaprine (10 mg at night) ; improves evening fatigue augmented with ibuprofen (Advil) Dothiepin ;

Human growth hormone (9 month study of 50 women with low IGF-1 levels); Paroxetine (Paxil) ; SER282 (antidiencephalon immune serum) ; Somadril (carisoprodol, paracetamol, caffeine) ; Tramadol (iv single dose) ;

Tryptophan (5 hydroxytryptophan 100 mg tid)

The following medications were found to be not effective for pain: Acetaminophen (paracetamol) , Anti-inflammatories: Ibuprofen alone Naproxen Tenoxicam + Bromazepan , Calcitonin , Chlormezanone muscle relaxant , Chlorpromazine ; Imipramine ; Lidocaine sphenopalatine nerve block ; iv Lidocaine, Morphine ; Moclobemide (Monoamine oxidase inhibitor) ; Prednisone 15 mg/ day (aggravates FM) ; SSRIs: Citalopram , Fluoxetine alone ; Zolpidem ; Zopiclone

PHYSICAL THERAPIES found to be helpful in FM: Aerobic exercise when combined with flexibility and strength training, is superior to relaxation. ; Hydrotherapy. ; Pool exercise ; TENS (uncontrolled study) .

Physical therapies not statistically helpful: Laser , Shape of sleep pillow , Visible electromagnetic fields

PSYCHOLOGICAL THERAPIES found to be helpful: Group therapy including relaxation and cognitive behavioral training ; Hypnotherapy ; Meditation-based stress reduction program

It has been documented that FM patients are high consumers of nonphysician and alternative medical interventions. One study comparing those using such services found no differences in level of pain and functional impairment. Another study of 111 fibromyalgia subjects found that 98% had used at least one complementary medical strategy in the preceding 6 months and that such use was correlated with lower age, higher pain and higher disability. Use of complementary therapies was seen in patients of a higher socioeconomic status and a longer duration of fibromyalgia. The most popular therapy was oral supplementation and the most popular source of advice was from a magazine (40%).

COMPLEMENTARY / ALTERNATIVE MEDICINE TREATMENTS with positive clinical trials in FM include: Acupuncture ; Biofeedback relaxation and EMG muscle biofeedback ; Chiropractic therapy (4 weeks of spinal manipulation, soft tissue therapy, passive stretching) ; Copper wire bedsheet ; Cranial electrotherapy stimulation ; DHEA supplementation ; Dietary indole supplementation (ascorbigen and broccoli powder) ; Homeopathy ; Magnetic sleep pads (pain intensity level reduced over 6 months) ; Multimodality approach including nutrition and hormone replacement ; Prolotherapy (75% pain improvement; unblinded study) ; Super Malic (malic acid 200 mg and magnesium 50 mg: 6 tablets bid)

It has also been documented that 72% of fibromyalgia patients have myofascial trigger points. Trigger points (in muscle with taut bands) differ from tender points. Tender points do not usually respond to injections of local anesthetic, but trigger points in fibromyalgia do. Current theories as to the pathophysiology of myofascial trigger points include the nerve's dysfunctional motor end-plate where excessive acetylcholine is released. It is based on such current thinking as well as clinical evidence, that Botulinum toxin A (BOTOX) has been found to be effective in treating trigger points through its prolonged blockade of acetylcholine release. This allows the injected muscle the opportunity to relax for the approximate duration of 3 months. A further advantage in its use for FM patients is the absence of any systemic side-effects (unlike the usual oral medications like amitriptyline, anti-inflammatories, opioids). It is metabolized in muscle and does not affect liver/ renal/ stomach function or worsen "brain fog".

Case reports of some of our FM/ CFS patients who responded well to an integrative approach are described below. This involves the use of BOTOX to palliate chronic muscle pain /headaches and DETOX (detoxification of unhealthy toxins, negative emotions) to resolve perpetuation of their FM.

Patient profile #1: Ms. S was a 33 yr old married mother of one, disabled customer service worker with FM and right sciatica for 5 years. Chronic pain risk factors included childhood sexual abuse; major depressive disorder, panic attacks agoraphobia; abnormal sleep EEG (restless legs, alpha-delta intrusion), slip and fall injury 10/98 and car accident 01/99 with 2 week hospitalization, subsequent home care and wheelchair use.

Previous treatments: Physiotherapy, chiropractic, massage, laser and Chan-Gunn acupuncture, hydrotherapy, podiatry orthotics, psychotherapy. Medications: oxycontin, flexeril, relafen, neurontin, rivotril, stadol, imovane. No response to epidural cortisone injections, facet joint injections/ nerve blocks.

Pretreatment findings: (15-03/00) 5'10" 320 lbs. obese.

18/18 tender points (TPs) (3+ severe pain noted with Fischer algometer).

Visual analogue scale (VAS) for pain: 10/10. Fibromyalgia impact questionnaire (FIQ): 69.4/ 90 Revised Oswestry (OSW): 23/ 50. Short-form McGill pain questionnaire (SFMcGill): 37 /45.

[higher scores indicate more severe pain]

Initial procaine injections: Trigger point injections: trapezii, scalene anticus, rt. erector spinae, right piriformis. Post-injection pain diary recorded short-term improvement with these injections.

BOTOX injections: (03-04/00) 200 units: R piriformis, R erector spinae (T11), both upper trapezii muscles. All injections were done with EMG guidance.

DETOX: weaned off oxycontin and anti-inflammatory drugs; referred to naturopath/ homeopath for nutritional and spiritual counselling (Hamer paradigm).

Post-injection findings: (30-05/00). 5/18 tender points (1+ < 4kg.) VAS 4/10, FIQ: 11.3/90, OSW: 1/ 50, SFMcGill 2 /45. She reported for the first time in years that she was able to walk several blocks, make beds without help, do laundry, dishes, most yard work.

(11/00): After 3rd series BOTOX (400 units): she had lost 34 lbs. and began vocational retraining for registered practical nurse. [she returned in Nov 2001 for further BOTOX]

Patient profile #2: Ms. J was a 47 yr-old female, store owner diagnosed with migraines, FM, CFS after fumigation gas exposure (1989). Past history: hypothyroidism, childhood growing pains and tailbone fracture. Seen numerous medical specialists and had normal MRI / SPECT head scans. Treated with amitriptyline, anti-inflammatories, SSRIs (prozac-like drugs), tryptophan. No headache relief with imitrex, sandomigran, opioids.

Pre-treatment findings (01/00): 5'8"; 145lbs. BP 100/70 mmHg. Wore dark sunglasses. Severe (3x/month) left-sided classical migraines and constant daily tension headaches.

VAS for headache: 7.5/10. FIQ:70.7/90. 18/18 TPs using Fischer algometer.

DETOX: Hydrotherapy, psychotherapy and dental amalgam removal, intravenous heavy metals chelation and "neuraltherapy injections" including traumeel (continues this regularly).

BOTOX injections (09/00): Headache protocol (25 units) + upper trapezii (37.5 units each)

Post-injection (11/00): Reported for the first time in 11 years being completely headache free for 3 weeks. VAS:7/10. FIQ:63.5/90. 18/18 TPs

After 2nd BOTOX (200 units), there were further improvements in her pain/ FM scores: (02/01) VAS:0/10. FIQ:53/90. Continues to improve with HEEL homotoxicological detoxification.

Patient profile #3: Ms. S was a 46 yr-old married mother of 2, church worker with FM, irritable bowel, migraines. Taking bellergal, codeine, dicetel and ginger, echinacea, milk thistle, garlic, vitaminE, coEnzymeQ10. Risk factors: childhood abuse with alcoholic parents; iv drug abuse (hepatitis C 1995). Car accident (1989) with whiplash, right frozen shoulder.

Pre-treatment findings (06/00): No anemia or jaundice. 5'4",114 lbs, BP134/99mmHg. VAS: 5/10. SFMcGill: 25/45. Pain Disability index (PDI):30/70. FIQ:57/100. 18/18 TPs (1-1.5kg). Marked skin sensitivity. Treated with hydrotherapy, Neurontin (slowly up to 2400mg/day).

DETOX: Weaned off codeine, bellergal. Naturopathic treatment: METAGENICS protocol with elimination diet, ultrainflammx, fibroplex. Follow-up (09/00): better appetite and weight up to 119 lbs.

VAS: 4/10. SFMcGill: 13/45. PDI: 18/70.

BOTOX injections (12/00): 25 units for headache with supraorbital nerve blocks. 75 units: upper trapezii + cervical paraspinal muscles.

Post-injection (01/01): Described "an excellent response". Headaches resolved (with fewer wrinkles!).

VAS:3/10. SFMcGill:7/45. PDI:11/70. FIQ:14/100. 8/18 TPs. Returned in March 2001 for 300 units and continues to do well. [Returned for more BOTOX in December 2001]

DISCUSSION - One previous published study on botox for fibromyalgia found it not to be effective. This was a small study of 10 patients who underwent alternate injections of lidocaine or Botox into the upper trapezius muscles solely. Only one patient reported relief of pain for 2 weeks and that was with lidocaine. On the other hand, several earlier studies have demonstrated clinical effectiveness for myofascial pain including recent randomized controlled trials. BOTOX helps in mechanical low back pain, headache (migraine, tension and cervicogenic types) treatment including FM patients who also suffer from headache.

Our experience with the treatment of muscle pain can be summarized in the following recommendations:

1. Remember FM is made by a diagnosis of "exclusion". One should first get a thorough medical work-up to rule out similar diseases that may be more easily managed (e.g. menopause, hypothyroidism) or that may be lethal (e.g. cancer, ALS, lupus).
2. When symptoms are mild and early in onset, use traditional therapies recommended by the medical doctor and nutritional approaches by the naturopath. Complete a full trial of more conservative physiotherapy (myofascial therapy, aerobic exercise, aquatherapy), psychotherapy, group education. Intermittent use of medications such as amitriptyline or procaine / traumeel / sarapin trigger point injections are necessary if symptoms are more severe. Botox has the advantage of providing much longer lasting muscle spasm/ pain relief.
3. At the Canadian Centre for Integrative Medicine, we aim to use the "four component paradigm" based on the model developed by Dietrich Klinghardt MD PhD. By identifying the root sources of symptoms in each component, we may then be able to resolve FM and other chronic conditions by addressing and treating each problem with effective modalities. The four modalities are:
    a. **ELECTROMAGNETIC-NEUROLOGICAL:** (e.g. radiation exposure, autonomic nervous system disturbances) complementary treatment options include: acupuncture, neural therapy;
    b. **BIOCHEMICAL:** (e.g. hormones, nutritional deficiencies parasite, heavy metal toxins) treat with diet modification, chelation detoxification, naturopathy
    c. **STRUCTURAL:** (e.g. joint-misalignments, ligament deficiency) treat with exercise therapies, manipulation, osteopathy, prolotherapy
    d. **PSYCHOSOCIAL-SPIRITUAL:** (e.g. negative emotions, "talk-sick" people) treat with biofeedback, emotional freedom technique, prayer

    For more information, check out website: www.MusclePainRelief.ca (Several articles such as Botox, Naturopathy as well as a similar article with most of the references will be posted under "calendar") And/ or make your own direct appointment with our naturopath, physiotherapist, acupuncturist or psychology consultants at **(905) 471-9355**. Dr. Ko presently sees patients (OHIP) only through a referral from your family physician.

    [Dr. Gordon Ko MD FRCPC is presently medical director for the Canadian Centre for Integrative Medicine, Markham and is Senior University associate professor, and lecturer,

Department of Medicine (Sunnybrook & Women's College Health Science Centre) University of Toronto. He has additional American board certifications in naturopathy, physiatry, electromyography and serves on the executive board for the Canadian Association of Orthopaedic Medicine.]

REFERENCES FOR ARTICLE: Please see insert enclosed with this newsletter.

HOW INSURANCE FIRMS TRY TO SCARE CLAIMANT

By Dr. Jeff Ennis, Community Editorial Board, The Hamilton Spectator – Friday, January 18, 2002

"Peek-a-boo is a game we usually play with babies. However, insurance investigators who perform videotape surveillance on insurance claimants following an accident have never outgrown this game. The only difference is this adult form of peek-a-boo is not fun for all participants.

The general public believes the insurance industry uses videotape surveillance to help catch people committing insurance fraud.

If this is true, then the use of videotape surveillance in personal injury cases makes sense. After all, the general public absorbs the cost of insurance fraud.

But videotape surveillance is not always used this way. It is performed routinely on anyone who makes an insurance claim that involves personal injury. It is no longer a tool to investigate insurance fraud. It is now a tool of intimidation.

Surveillance is now used to make the injured party believe the insurance company will be able to convince a court he is lying about his injuries and his inability to do things such as work. The insurance company's hope is the claimant will back off of any lawsuit and will settle the matter in favour of the insurer.

I have seen film after film showing injured people walking, driving or carrying things. Investigators write statements like: "Mr. X was observed getting out of his car, moving in a smooth and fluid fashion."

The intimation is that Mr. X cannot possibly be experiencing any pain because he moved so well. The only way Mr. X can prove he is feeling unwell is to show he has pain by limping or moaning. He might stop driving and doing any activities. In fact, Mr. X might choose to stay in his home in order to escape the intrusion of surveillance.

The result is that Mr. X's life becomes more restricted and his ability to manage his pain is severely compromised.

In fact, the use of surveillance as a tool of intimidation tends to undo much of the work done by chronic pain management programs. The negative effect of surveillance is likely to continue to plague people like Mr. X long after their cases are closed.

Fortunately, the courts recognize that surveillance in personal injury cases is of limited value. There are multiple scientific problems with it.

For example, no one has tested the likelihood that two people viewing the same surveillance tape will come to the same conclusion.

In a study called Who Can Catch a Liar?, researchers found judges, federal polygraphers, robbery investigators, psychiatrists and regular folks were unable to catch liars.

The only people who could catch them were U.S. Secret Service Agents. Since Secret Service Agents are not usually hired to analyze videotapes in personal injury cases in Canada, the usefulness of these tapes to detect fraud is questionable at best.

Mr. Justice J. Burchell of the Nova Scotia Supreme Court said in his decision in Smith v. Avis Transport of Canada Ltd. and Harvia: "My general reaction is that evidence of this kind (surveillance) must be received with definite reservations. It must be remembered that the tape was taken by persons who were paid to gather evidence intending to discredit the plaintiff…

"It should also be remembered that evidence of this kind is subject to a high degree of manipulation. The most obvious possibility is that a tape may be edited by the person who operates the camera."

Given that videotape surveillance can cause harm, it is important that its use as intimidation be reviewed by the courts. The courts should control its use just as they control wiretaps.

The insurance company should have to demonstrate that fraud is likely taking place before permission to use videotape surveillance is granted.

Until the courts reign in the investigative powers of insurance companies, it is up to injured individuals, their families, legal counsel and health care providers to encourage good coping and function regardless of surveillance and to trust in the ability of the courts to act justly.

After all, surveillance is not a game of peek-a-book. It is a serious game that requires proper rules.

[Ed. Note: Dr. Jeff Ennis of Dundas is an assistant professor of psychiatry with a subspecialty practice in the management of chronic pain.]

HAVE YOU BEEN UNDER SURVEILLANCE BY YOUR INSURANCE COMPANY? HAVE YOU BEEN ASKED TO ATTEND AN INDEPENDENT MEDICAL EXAMINATION OR FUNCTIONAL ABILITIES EVALUATION OR ANY OTHER TYPE OF ASSESSMENT BY YOUR INSURANCE COMPANY OR CANADA PENSION PLAN OR WORKMEN'S COMPENSATION BOARD?

The National ME/FM Action Network is compiling a **National Registry**, please help us fight for fair treatment of disabled people by spreading word of our important survey.

To receive a copy or copies of the simple, confidential, 7 question Registry Submission Form, please Contact: **Mary Ellen**, Manager of Special Projects, Phone or fax: **(905) 831-4744** - Mail: **P.O. Box 66172, Town Center Postal Outlet, 1355 Kingston Rd**., **Pickering, ON., L1V 6P7** - Email: **marye@pathcom.com** - Or download the Form from our website at **www3.sympatico.ca/me-fm.action/medexam.html**

THE RIGHT TO OBTAIN DEFENCE - PSYCHIATRIC MEDICALS - IS IT ABSOLUTE? -BY: Robert H. Littlejohn, Barrister (Ontario)

[Ed Note: People who find themselves in the position of being asked to attend a psychiatric independent medical examination by their insurance company or Canada Pension Plan, where there has been no medical evidence to suggest that such an examination is appropriate, consider bringing this article to the attention of your lawyer]

In any personal injury lawsuit, most counsel assume that Defence counsel is absolutely entitled to obtain any Defence medical of its choosing. This assumption is based upon the understanding that both counsel are entitled to debate the case as they see fit and, further, the parties have a constitutional right to a fair trial.

In my view, Defence counsel has recently tried to "push the envelope" and requested Defence medicals, which have little or no evidential basis, particularly those cases involving chronic pain syndrome and/or fibromyalgia.

The question arises what should be done if Defence counsel asks your client to attend a Defence Psychiatric medical when this medical is patently unreasonable and unnecessary.

I have recently attended court on two occasions to determine what, if anything, the courts will do when entitlement to a defence psychiatric medical is challenged. A favorable judicial response was obtained on each occasion.

Entitlement to a Defence Psychiatric Medical

To challenge this entitlement, one might consider the following elements, which Defence counsel must satisfy to get a court order for a Defence Psychiatric Medical.

1. The absence or existence of foundation evidence such as:
2. A pre-existing psychological/psychiatric condition.
3. Psychological/psychiatric complaints made by the injured Plaintiff at the time of and/or after the collision.
4. Observations made by treating doctors before, during; and/or after the collision which might be interpreted as having a psychiatric/psychological underpinning,
5. Prescription and non-prescription medications and/or treatments such as counseling and/or psychotherapy received by the Plaintiff before, during, and/or after the collision, which would indicate a psychiatric/psychological condition.

At all times, the onus is on the Defendant to prove entitlement.

In most cases, this Defence medical is sought after Examinations for Discovery have concluded and most, if not all, of the Plaintiff’s medical documentation from treating doctors has been produced. To satisfy the onus, Defence Counsel relies upon the answers given by the Plaintiff under oath at the Discovery and the medical documents.

To get a Court Order, Defence Counsel must satisfy the following statutory requirements:

1. Rule 33.02 of the Rules of Civil Procedure.
2. Section 105 of the Courts of Justice Act (hereinafter "CJA")

These statutory sections are cited below:

Order For Examination

Contents of Order:

33.02 (1) An order under section 105 of the Courts of Justice Act **may** specify the time, place and purpose of the examination and shall name the health practitioner or practitioners by whom it is to be conducted.

Further Examinations:

a. The court may order a second examination or further examinations on such terms respecting costs and other matters as are just.

Section 105

105. (1) In this section,

"Health practitioner: means a person licensed to practice medicine or dentistry in Ontario or any other jurisdiction, a psychologist registered under the Psychologists Registration Act or a person certified or registered as a psychologist by another jurisdiction.

Order for physical or mental examination

(2) Where the physical or mental condition of a party to a proceeding is in question, the court, or motion, may order the party to undergo a physical or mental examination by one or more health practitioners.

Idem

b. Where the question of a party's physical or mental condition is first raised by another party, an order under this section shall not be made unless the allegation is relevant to a material issue in the proceeding and there is good reason to believe that there is substance to the allegation.

Further examinations

c. The court may, on motion, order further physical or mental examinations.

How are these statutory provisions interpreted:

Pursuant to the Supreme Court of Canada decision, Caisse populaire de Maniwaki v. Giroux (1993), it was confirmed at pg. 14 that:

> "If the insured does not fulfill his or her contractual obligation to provide the evidence requested, the insurer may interrupt performance of its obligation…

These two obligations are" interdependent and not simply juxtaposed" (at pg 14)

However, this conclusion is qualified by an earlier statement in its reasoning at pg. 10:

"…The extent and frequency of the insurer's requests for information must certainly be reasonable…." And further, at pg.13:

"…. If the insurance company wishes to terminate the payments it is making… Let that party prove it"

Accordingly, the Supreme Court of Canada will not sanction an abuse of process if the insurer has been on claim for a significant period of time.

> At its core, defence counsel can request entitlement where the Plaintiff's "mental" condition "is in question": 105 (2) CJA. A Court Order should not be made, however, "unless the (alleged mental condition) is relevant to a material issue in the proceeding and there is good reason to believe that there is substance to the allegation: s.105 (3) CJA. Further, the defence expert must satisfy the eligibility requirements in s. 105 (1), normally by way of curriculum vitae. These experts' qualifications should always be double-checked by Internet, your client, if the client is knowledgeable, or your retained expert in the same field.
>
> Often, Defence Counsel has not fully appreciated the full extent of his/her responsibility to satisfy the Court before making the request for a Defence psychiatric Medical.
>
> A Divisional Court case, Robinson v Kilby (1996) requires Affidavit evidence from Defence Counsel's proposed psychiatric expert before this type of Defence medical is ordered.
>
> The Affidavit should establish that a psychiatric assessment would be likely to produce relevant information for use at Trial. In essence it was the ruling of the Divisional Court at pg. 5 that:
>
> "An order requiring a respondent who has not placed his psychological make up in issue in an action to submit to a psychological or psychiatric examination is a particularly intrusive step and should not be routinely ordered:
>
> In other words, a psychiatric assessment cannot be arbitrary, unfairly used to degrade and/or humiliate the injured Plaintiff. This type of Assessment cannot be employed to represent an abuse of the litigation process. The Assessment must have the likelihood of providing evidence of probative value.
>
> On September 25, 2001, I appeared before the Honorable Madam Justice Klowali and was successful in preventing a Court Order for a defence Psychiatric Medical despite the fact a Defence physiatrist suggested it was necessary.
>
> In her Endorsement, she commented that:
>
> "I see little if anything to persuade me, a Defence Medical by way of a psychiatric evaluation would produce relevant information. Rather it seems a fishing expedition to try to disprove the plaintiff's claims:"

Her Endorsement was converted into an Order, and duly served on opposing counsel.

Entitlement to SAB and/or Disability pending the Hearing of a Motion for entitlement to a Defence Psychiatric Medical:

Often an insurer will cut off an insured's weekly benefits if the insured refuses to attend a psychiatric/psychological assessment.

A disability contract often has this contractual requirement. In a motor vehicle case, the Statutory Accident Benefit carrier has an apparent absolute obligation under the Regulations: s.42

In disability cases, a recent Divisional Court decision; Dempster et al. v Mutual Life of Canada (August 15, 2001) has considered entitlement to weekly payments before the Motion is heard.

Despite the reasoning in Giroux; the Divisional Court determined that entitlement to weekly payments was discretionary. It opined at pg. 415 that terms could be considered by the parties to redress the situation where the injured Plaintiff's weekly payments would be delayed. Rule 37.13 of the Rules of Civil Procedure entitled any Judge to make such an order where circumstances warranted it.

On December 20, 2001, I argued a similar Motion under the Statutory Accident Benefits (SAB) Regulations. In my case, SAB counsel refused to schedule a Motion for entitlement to a psychiatric assessment and cut off my client's weekly payments when my client refused to attend psychiatric assessment. The weekly payments were cut off on October 20, 2001.

My client had been on claim for four years and eight months and was into the "any occupation" clause of the SAB policy. He had received Canada Pension Plan Benefits from the outset but required the additional weekly payments to support his wife and family.

On December 20, 2001, the Honorable Madame Justice Boyko ordered that my client's weekly payments be reinstated from the cut-off date of October 20, 2001 to the date the Motion is to be heard January 17, 2002. She relied on the Dempster decision Endorsement.

Her ruling is the first known favorable decision in a SAB setting. Of note, however, is that:

i. The Divisional Court, Dempster decision, failed to consider the ruling in the Supreme Court of Canada decision, Giroux, particularly the finding at p. 14 earlier quoted.

ii. No consideration was given to Defence Counsel's argument that this issue had not been previously mediated.

I argued that there were no requirements to mediate entitlement to a Defence Psychiatric Medical since this entitlement is not strictly adjudicated by the Financial Services Commission (FSCO)

Conclusion/Summary: Defence Counsel does not have an absolute entitlement to a psychiatric assessment. Further, Defence Counsel has an obligation to prove entitlement to this type of Defence medical and must speedily attend a Court Hearing to have the issue adjudicated. At all times, the burden of proof is on the Insurer to prove entitlement and not the other way around.

Insurance companies routinely seek Defence psychiatric medicals in any case for which they are required to make ongoing payments.

It is my suggestion that any insured injured Plaintiff ought to carefully address whether he/she will attend a Defence Psychiatric medical before a decision is made to refuse attendance.

This Article canvasses those issues, which might be taken into consideration before making such an important, drastic contractual decision. Each case should be individually reviewed on its own facts and the arguments posted in the Article should not be generally employed on the assumption that the results obtained by the writer will be accepted by other Courts in this province or this country.

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WHITEN v. PILOT INSURANCE COMPANY: How an Insurer Got Burned in a Home Fire - By David Lackman

Introduction - In almost every insurance contract there exists an implied covenant of good faith and fair dealing between insurer and insured, regardless of whether the contact exists to provide long-term disability, life, home, automobile or other types of insurance coverage. An insurer's flagrant breach of that covenant by, for example, refusing to pay a claim despite convincing evidence supporting the claim, or by engaging in a course of oppressive conduct calculated to pressure a vulnerable insured into submission, may now put the "victim" on an new, or at least greatly improved, footing in her fight with the insurer, in light of the recent decision of the Supreme Court of Canada in *Whiten v. Pilot Insurance Company* (2002 SCC 18) awarding record punitive damages against a major insurer. While the *Whiten* decision arose out of a home fire loss, the principles that emerge are equally applicable to most insurance settings, including private disability insurance contracts.

Background - The Whitens discovered a fire in their Haliburton home shortly following midnight in January 1994 and were forced to flee to the outside wearing only their night clothes. The fire completely destroyed their home and all of their possessions, including their three cats. While standing barefoot in the bone-chilling, minus 18 Celsius temperature, helplessly watching their world crumble around them, Keith Whiten, who gave his slippers to his daughter, suffered such frostbite to his feet that he was subsequently confined to a wheelchair.

While one would hope that such an ordeal represented the end of a horror-story for the Whitens, it would in fact turn out to be only the beginning of a tale even more haunting and sinister than the likes of Stephen King might pen – an odyssey that would take the Whitens through the Ontario court system right up to the Supreme Court of Canada, fighting every step of the uncharted way for what little of their dignity remained to be salvaged.

Though the Whitens had for years, like most people, thought they had purchased "piece of mind" when they paid their hard-earned premium dollars over to Pilot Insurance Company for home insurance – the very piece of mind that Pilot profitably promoted through it's advertising material – they received instead the mind-numbing indignation of not only having their claim denied during their time of greatest need, but of being maliciously accused by Pilot and its lawyer of torching their own residence for the insurance money. As would later be found by Supreme Court:

"The allegation that the family had torched it's own home was contradicted by the local fire chief, the (insurer's) own expert investigator, and its initial expert, all of whom said there was no evidence whatsoever of arson. (Pilot's) position, based on wishful thinking, was wholly discredited at trial. Pilot's appellate counsel conceded here and in the Ontario Court of Appeal that there was no air of reality to the allegation of arson."

To aggravate matters, during the time the Whitens were renting a cottage as temporary residence after the fire, and were in desperate financial straits while Pilot was still investigating the claim, Pilot's Head Office instructed a local adjuster to tell the landlord of the cottage that Pilot was no longer going to pay rent. The following Spring, the Whitens even offered to submit to a lie detector test administered by an expert chosen by Pilot, yet Pilot refused. All of the indignity was compounded by the fact that the Whitens lived in a small community where locals were aware that their home wasn't being rebuilt because the insurer was claiming arson. And, the irony – indeed the insidiousness – of the whole affair was that the Whitens would have stood to gain nothing by burning down their home. The insurance proceeds would only have paidthe fair market value, which could just as well have been obtained by the Whitens on a sale of the house without risking their lives, their daughter's safety, their reputations, their entire possessions and their cats. As the Supreme Court stated: *"It defies common sense to think they would have risked so much for so little"*.

The Verdict - After a costly eight-week trial, and before the jury retired to deliberate and reach a verdict, the trial judge gave basic instructions to the jury regarding the awarding of punitive damages. He stated, in part:

"…if you determine that Pilot's defence of arson failed and that Pilot breached the provision of the policy of insurance by denying the plaintiff's claim, you must then go on to determine whether the plaintiff is entitled, as well, to recover punitive damages. Punitive damages can be awarded in certain circumstances to serve as a punishment. In this case, depending on your finding of fact, punitive damages can be awarded to deter Pilot and other insurers from engaging in improper conduct in dealing with the claims of their insureds ***".***

The jury, in addition to awarding the Whitens their actual losses (known as compensatory damages), went on to award punitive damages against Pilot of $1 million, the largest verdict of its kind ever made in Canada. Needless to say, the verdict reflected the jury's revulsion and outrage toward the high-handed and callous disregard shown by Pilot in the manner in which it breached its fundamental duty of good faith owed to its insureds.

Court of Appeal - Unrepentant – perhaps downright indignant – over the verdict, Pilot sought immediate refuge from the fallout by challenging the verdict in the Ontario Court of Appeal. Pilot knew that, historically, the Court of Appeal rarely embraced lofty punitive damage awards, especially in insurance contact settings such as this. Unfortunately, Pilot was correct. The majority of the Appeal Court held that, while an award of punitive damages was indeed justified by Pilot's conduct, the $1 million amount *"is simply too high"*. The Court looked to other insurance cases, observing that awards against similar insurers who had acted unacceptably had never exceeded $50,000.00, and characterizing the present case as an isolated incident with no evidence that Pilot's unacceptable conduct was part and parcel of a corporate strategy. In the opinion of the majority of that Court, an award of $100,000.00 – one-tenth of the jury's verdict – would act as a sufficient deterrent to this and other insurers. What was not explained was how

$100,000.00, for a company that admitted to a net worth of approximately $231 million, could represent anything more than a "license fee" to continue its open season on vulnerable insureds.

The sole dissenter on the panel, Mr. Justice Laskin, who would have allowed the $1 million award to stand, put it bluntly, referring to Pilot's conduct as *"exceptionally reprehensible"*, and cautioning that to be meaningful, an award of punitive damages *"must sting"* rather than be perceived merely as a cost of doing business. In his view:

"Pilot acted maliciously and vindictively by maintaining a serious accusation of arson for two years in the face of the opinions of an adjuster and several experts it had retained that the fire was accidental. It abused the obvious power imbalance in its relationship with its insured by refusing to pay a claim that it knew or surely should have known was valid, and even by cutting off rental payments on the Whitens' rented cottage. It took advantage of its dominant financial position to try to force the Whitens to compromise or even abandon their claim. Indeed, throughout the nearly two years that the claim was outstanding, Pilot entirely disregarded the Whitens' rights."

Supreme Court of Canada

The Whitens took exception to the Court of Appeal's reduction of the jury's punitive damage award, and were granted leave (permission) to appeal by the Supreme Court of Canada. It should be noted that, in civil cases, leave is usually only granted where the Court views a matter to be of such importance – not to the litigants *per se* but as a matter of national legal significance – that consideration by the High Court is desirable.

The Supreme Court, in a 6 – 1 majority decision, opened its discussion noting how the jury was *"clearly outraged by the high-handed tactics employed by the respondent, Pilot Insurance Company, following its unjustified refusal to pay the appellant's claim…"***.** The Court went on to review the history and evolution of the law of punitive damages in other common law jurisdictions, including England, Australia, New Zealand, Ireland, and the United States, and remarked that there is a substantial consensus as follows**:** ***"****the general objectives of punitive damages are punishment (in the sense of retribution), deterrence of the wrongdoer and others, and denunciation (that is, the means by which the jury or judge expresses its outrage at the egregious conduct)"*. The Court, however, cautioned that, where punitive damages are warranted, the amount must be *"proportional" and "rationally related to the objectives for which the punitive damages are awarded (retribution, deterrence and denunciation)"***.** In other words, the amount must not be higher than is necessary to fulfil its purpose; otherwise, it may be considered irrational or disproportional. As stated by the Court, *"a disproportionate award overshoots its purpose and becomes irrational. A less than proportionate award fails to achieve its purpose"***.** It was therefore important for the Court to look closely at the conduct of the insurer and the vulnerability of the claimant, in order to assess "rationality" and "proportionality".

Factors Considered - The Supreme Court canvassed a variety of factors that courts had previously considered in similar cases, including:

- whether the misconduct was planned and deliberate

- whether the defendant persisted in the outrageous conduct over a lengthy period of time
- whether the defendant conceded or attempted to cover up its misconduct
- whether the defendant profited from its misconduct
- the financial or other vulnerability of the plaintiff

In the end result, the Court's opinion was that the jury's award, while high, was nevertheless ***"within the rational limits within which a jury must be allowed to operate…was not so disproportionate as to exceed the bounds of rationality…(and) did not overshoot its purpose"***. Mr. Justice Binnie, writing for the majority (and adopting Mr. Justice Laskin's dissenting rationale in the Court of Appeal) was particularly struck by the disparity in power (the "power imbalance") between Pilot and the Whitens, and the Whitens' vulnerability:

"Pilot holds itself out to the public as a sure guide to a "safe harbour". In its advertising material it refers to itself as 'Your Pilot' and makes such statements as: 'At Pilot Insurance Company, guiding people like you into safe harbours has been our mission for nearly 75 years.'

Insurance contracts, as Pilot's self-description shows, are sold by the insurance industry and purchased by members of the public for peace of mind. The more devastating the loss, the more the insured may be at the financial mercy of the insurer, and the more difficult it may be to challenge a wrongful refusal to pay the claim. Deterrence is required. The obligation of good faith dealing means that the appellant's peace of mind should have been Pilot's objective, and her vulnerability ought not to have been aggravated as a negotiating tactic. It is this relationship of reliance and vulnerability that was outrageously exploited by Pilot in this case. The jury, it appears, decided a powerful message of retribution, deterrence and denunciation had to be sent to the respondent and they sent it".

Lessons Learned - There is little doubt that, following *Whiten*, the executive boardrooms of many insurers were buzzing over its implications for their day-to-day claims handling practices. Insurers who, as a matter of policy, strive to adjust claims in a fair-minded way, having regard for their fundamental obligations toward their insureds, probably have little to fear in *Whiten*. Indeed, the conduct in *Whiten* was so egregious that, in a perverse way, the case may provide some comfort to insurers who are satisfied that they could hardly abuse their insureds to that extent even if they tried. On the other hand, for all the other Pilots out there, *Whiten* will hopefully strike a nerve that, like a major spasm, jerks them into abandoning their arrogance and living up to their catchy advertising slogans, not to mention their legal obligations under the contract.

In the context of long-term disability (LTD) claims, bad faith on the part of an insurer is frequently perceived, easy to allege, and a challenge to prove. To confuse an insurer's "denial" of a claim, or "termination" of payments, with "bad faith", is overly simplistic and wrong. Indeed, many policy breaches based on non-payment, while actionable, would not support a bad faith award. One must therefore examine closely the particular "conduct" (including "motivations") of the insurer, the protocols and procedures followed by the insurer, and the information relied upon (or ignored) by the insurer, in assessing whether a claim for punitive damages might be appropriate.

Disability criteria that we see in LTD policies often contain "qualifying" language. Medical opinions may vary, for example, as to whether the insured is or continues to be "totally disabled", as those words are typically defined in the policy. Once confronted with the claimant's treating physician's certification of disability, insurers will typically call upon their medical advisors to assess disability "independently". Is it then bad faith if the claim is denied? Possibly, if the insurer's medical advisor never examined the claimant, or never spoke to the claimant or her employer, or never read the file, before proceeding to render an opinion on disability that will affect the financial security of the claimant. At times an insurer will rely on the opinion of a "medical committee" before denying a claim. Is there bad faith at play? There may be if the insurer's "medical committee" consists of a non-medically-trained claims adjudicator and a GP who visits the insurance company weekly to review claims that are outside his area of medical expertise. Frequent or harassing requests by an insurer for medical assessments, or inappropriate requests for mental health assessments, may signify that the insurer is spending more time and resources on a fishing expedition than on dealing in good faith with the insured's claim.

Another sensitive area in LTD claims involves what is commonly referred to as the "change in definition". Most disability policies make benefits available for the first year of disability as long as the claimant, during that period, is totally disabled from performing the essential tasks of her "own occupation". After the first year, the definition of total disability usually changes so that, to maintain her entitlement, the claimant must now establish that she is disabled from performing not only her "own occupation" but "any occupation" for which she is, or may reasonably become, suited by reason of her education, training or experience. Once again, bad faith should not be assumed just because the claimant is taken off benefits. However, close scrutiny of the actual wording of the relevant provisions of the policy, of the available medical evidence, and of the insurer's explanation and conduct with respect to the termination, might then be warranted.

Conclusion - In truth, *Whiten* will not make a weak claim strong, or turn a good faith denial into a bad faith award. One must be mindful of what prompted the jury and Courts in *Whiten* to lash out at Pilot in the first place: overwhelming evidence of connivance, some of it reflected in rather startling correspondence between the insurer, its experts and its counsel, designed to derail an otherwise honest and straightforward claim made by decent people who at the time couldn't have been more vulnerable. The circumstances supporting substantial punitive damages couldn't have been more compelling.

Fortunately, however, since punitive damage claims can be successfully based on conduct less abusive than that exposed in the Pilot case, *Whiten* stands as a stark reminder to the industry that insurers who play with fire are eventually going to get burned.

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