NATIONAL ME / FM ACTION NETWORK

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ANNOUNCEMENT

A meeting was held on August 17, 2005 between directors of FM-CFS Canada and the National ME/FM Action Network, two national organizations focused on helping Canadians with ME/CFS and/or FM.

The two boards of directors have agreed on the desirability of a solid coalition of associations and support groups across the country. They have also agreed on the benefits of a common front to solicit funds and support from governments, health professionals, donors, and business contributors, while respecting the initiatives taken by each regional and provincial group.

Therefore, FM-CFS Canada and the National ME/FM Action Network have decided to work together towards

- provision of better information to the public on Fibromyalgia and Myalgic Encephalomyelitis/Chronic Fatique Syndrome;
- improvement of services and support to the patients;
- education of health care providers;
- recognition and funding

We hope this joining of our forces will mark a new era and offer hope for all those people afflicted by FM and ME/CFS, and that you will support our two organizations in our efforts to get things moving in Canada so that our rights to adequate health care become fully respected.

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Groundbreaking Genetic Research Studies on ME/CFS

By: Philipa Corning, Ph.D., B.Sc., Vice-President

During the past few months exciting news has been circulating in the ME/CFS community. Two UK researchers have separately been conducting preliminary research at the genetic and molecular level. Their scientific findings support each other's research results. Both have discovered that ME/CFS sufferers exhibited particular patterns of different genetic activity from those associated with normal individuals, and therefore, subsequent differences in unusual "gene expression" – the process by which a gene's coded information is converted into structures operating in a cell. These unusual gene expressions are both measurable and show clear physical changes. Dr. Russell Lane, a neurologist at Charing Cross Hospital in London, said: " This new work shows that some aspects of this complex illness may be understandable in molecular terms and that chronic fatigue syndrome is not a "made up" illness." In addition, Dr. Charles Shepherd, a medical adviser to the ME Association of the UK said: "This work is very significant. It gives us clues about genetic abnormalities that can guide new research into the causal mechanism of the condition, which hopefully can lead us to novel treatments."

These two researchers are Dr. John Gow and Dr. Jonathan Kerr. Dr. Gow is a senior lecturer in Clinical Neuroscience at Glasgow University, works at Glasgow's Southern General Hospital, and is a researcher who has contributed to at least 25 research papers. He presented his research paper in Japan in Feb 2005. Dr. Kerr carries out his research at the Imperial College in London, and his paper was due to be published in the Journal of Clinical Pathology in August. Both scientists along with their teams have finished phase one of the most encouraging research studies in the history of ME/CFS. Furthermore, both researchers plan to embark on a second larger research study to verify the initial findings of a unique "gene signature" for patients with ME/CFS. Dr. Gow said: "We have identified genes which were up-regulated compared with genes in normal healthy individuals, suggesting we could possibly have a diagnostic test for this syndrome which doesn't exist at the moment." Furthermore: "Our work has given us clues as to which pathways are up- or down-regulated, and we know which drugs activate different pathways so we think we can find drug treatments that will be beneficial to patients". Therefore, hopefully in the near future, this could lead to a diagnostic test and new treatments.

Although we humans are born with the same genetic blue print, the makeup of each individual's genes and the expression of those genes are different. Each gene is found on one of 46 chromosomes in each cell of the human body, and each gene produces an expression, for example, blue eyes, brown hair, diabetes, etc. Because each person's gene makeup is different, the result is different genetic expression. This genetic expression is independent of environmental influences. However, certain genes can be influenced by outside environmental conditions, and therefore everyone's genetic makeup will make them vulnerable to different problems.

Dr. Gow's research discovered a malfunction in sufferers' genes, which appears to prompt their immune system to "work overtime", making patients extremely tired. It seems to indicate that certain people have a genetic predisposition to developing ME/CFS and others do not. Something in the external environment causes the "switching on/off" genes in a person to switch the immune system on and not turn it off. Certain triggers (such as viruses, physical/emotional stressors, etc.) can initiate ME/CFS in those genetically disposed. This research indicates that this research group can test for ME/CFS at the genetic level. This does not mean testing for predisposition, but testing for particular genetic activity that someone is experiencing when he is afflicted with the illness. Once that genetic activity has been detected, the study claims that drugs already available can be used to treat ME/CFS at the genetic level. Dr. Gow said that a cocktail of drugs could be used to "turn off" the genes (that are acting in an abnormal manner thus causing the disease) thereby allowing the afflicted person to have "a fairly normal" life. On 1 Feb 2005, the university has already patented the novel biomarkers or genes involved as a means of diagnosing ME/CFS. Apparently the test is quick and cheap. Thus a prototype diagnostic testing kit has already been developed, that would allow doctors to obtain a "yes or no" answer in disease diagnosis for ME/CFS. Furthermore, the university has also patented a triple drug treatment in Feb 2005.

In his research, Dr. Kerr has compared levels of gene expression in the white blood cells of healthy individuals to those who were diagnosed as having ME/CFS. His team found differences in 35 of the 9,522 genes that they analyzed using DNA micro-analysis technology. They confirmed that 15 genes were up to four times as active in people with ME/CFS, while one gene was less active. In addition, they have discovered differences in blood

proteins related to the changes in gene expression. This could possibly lead to a diagnostic blood test for the illness. Furthermore, Dr. Kerr said: "We have shown that a significant part of the pathogenesis resides in the white blood cells and in their activity." Several genes that have been identified play important roles in the mitochondria (energy producing structures inside each cell), and in nerve cells. Dr. Kerr stated: "The involvement of such genes does seem to fit with the fact that these patients lack energy and suffer fatigue. This research will open the door to development of pharmacological interventions."

The future research of Dr. Kerr appears to be fully funded, however, Dr. Gow's research was about to grind to a halt due to lack of further funding, however, the ME Association in the UK came to the rescue. This group has announced that it was going to continue to fund his vital genetic research so that he and his team can continue with phase two of the study. This phase was expected to commence in August 2005. The research group will be using a technique called DNA chip microassay analysis to map out what is happening to a vast amount of individual genetic information – over 33,000 gene sequences in each individual. They will be carrying out this genetic analysis on a large group of people with ME/CFS, another large group of healthy matched controls, and a further large group of people with a range of other illnesses, such as multiple sclerosis and depression, in which fatigue is a major clinical symptom. Using this method, the scientists will be trying to identify whether there is a unique profile of genetic abnormalities in persons afflicted with ME/CFS by looking for data which indicates that certain specific genes are either up-regulated or down-regulated, meaning that they are being over-active, under-active or "switched-off".

The activity of these genes (or gene expression) can have very important consequences on the types of cellular activity, including crucial biochemical pathways that they control in the nervous system, immune system, and all other parts of the body. Functional changes affected by altered gene regulation offer an explanation of the fatigue experienced by patients afflicted with ME/CFS. Thus the aim of this study is to identify specific gene abnormalities as diagnostic biomarkers. This would confirm the results of phase one (the smaller study). Information gained in this larger study will hopefully lead to clinical trials of drug treatment aimed at managing the underlying cause of ME/CFS.

While this vital research is funded for the next year by ME Association of the UK, this organization believes that continued government funding will be lacking, and that it will have to be the researcher's main source of funds. It can only do this through donations to its two research funds. If any one wishes to donate to support either this study or future studies, he/she is asked to make contributions at the MEA website at: <http://www.meassociation.org.uk>.

Diagnosing Lyme Disease in People with ME/CFS and/or FMS Symptoms

By: Margaret Parlor, Advisor - Youth Issues & Director

This article is intended to provide information only, and is NOT medical advice.

I would like to thank Jim Wilson and Joan McComas of the Canadian Lyme Disease Foundation (www.canlyme.com) for their input into this article.

If a person meets the diagnostic criteria for Myalgic Encephalomyelitis /Chronic Fatigue Syndrome (ME/CFS) or Fibromyalgia Syndrome (FMS), the diagnosing doctor is supposed to consider the possibility that the symptoms are caused by Lyme Disease (1, 2). Diagnosing Lyme Disease opens up new treatment possibilities and alerts patients to the hazards of immunosuppression, notably steroid use (3, 4).

Diagnosing Lyme Disease, I assumed, was quite straightforward. Then I started hearing reports from the U.S. of a number of people who had been diagnosed with ME/CFS and/or FMS by experienced doctors and who were now being found to have Lyme Disease. When I looked into the subject of Lyme Disease, I found that diagnosing it is not as easy as it sounds.

Diagnosis is based on symptoms, evidence of exposure or possibility of exposure, test results, and response to treatment. It turns out that people are often not aware of having been exposed, that the possibility of exposure has been underestimated in Canada, that Lyme is very difficult to test for, and that Lyme can be difficult to treat.

Definition

In simple terms, Lyme disease is thought of as a bacterial infection caused by a corkscrew shaped bacterium Borrelia burgdorferi (Bb), called a spirochete. A treatment guide for Lyme Disease gives a more thorough definition. Lyme disease, it states, "is not simply an infection with Borrelia burgdorferi, but a complex illness potentially complicated by multiple tick-borne co-infections. In later stages, it also includes a very significant degree of immune suppression. This not only serves to perpetuate the infections, but it is probably responsible for the

reactivation of latent infections, such as herpes-type viruses. Many collateral conditions result in those who have been chronically ill so it is not surprising that damage to virtually all bodily systems can result." (3)

Lyme Disease was first noted in Europe in the 1880's and in the United States in 1970. It was rediscovered in Lyme, Connecticut, in an outbreak that began in 1975 (5), though an investigation of museum samples of mice and ticks shows Bb was in the U.S. animal population before then.(6) The first reported Ontario case of Lyme Disease was in 1977. (7)

Since the 1970's, hundreds of thousands of cases have been reported in the United States, but only several hundred in Canada. "I don't think that doctors realize that we have considerable Lyme Disease in Canada" states Jim Wilson, president of the Lyme Disease Foundation of Canada. "They aren't looking for it. I think they have missed thousands, probably tens of thousands of cases. People with Lyme are getting diagnoses such as MS, Alzheimer's, ME/CFS and Fibromyalgia. "

Exposure

The primary vectors of Lyme disease are ticks. While it was thought that deer ticks were responsible for spreading Lyme disease, other species have been found to transmit it as well (5). Most bites occur from ticks in the nymph stage when they are only the size of a poppy seed (8). While doctors will ask if the patient remembers being bitten, fewer than 50% of Lyme disease patients recall a tick bite (4).

Alternate transmission may be through the placenta during pregnancy, through breast milk, through drinking unpasteurized infected milk, and through blood transfusions. Sexual transmission has not been documented in humans; however, Bb has been noted in canine semen. (7)

It is not safe to assume that one can catch Lyme Disease only in areas known to have endemic populations of ticks. Firstly, there has not been adequate field research in Canada to identify endemic areas. Lyme Disease carrying ticks have been found in every province.(8) Secondly, because birds have been found to carry infected ticks, Lyme Disease could be contracted in unexpected locations. (7)

It is a myth that you have to be in the woods to get a tick bite. The ticks that cause Lyme disease are found in your lawn, garden, on low bush, wild grasses and weeds, especially along pathways. If you own outdoor pets it is very easy for them to transport ticks into the home. (8)

There is a specific symptom that shows exposure to a Bb infection -- Erythema migrans, a bull's eye rash that appears several days to several weeks after a tick bite. It is present in fewer than half the cases of Lyme Disease and may not be noticed even if present. (3)

Symptoms

The symptoms of Lyme Disease are varied. Let me simply quote four passages, the first two to give a brief overview of the symptoms, and the latter two to show that the symptoms are often confused with conditions like ME/CFS and FMS.

"People with Lyme disease may have various symptoms which include skin, arthritic/ rheumatic, gastrointestinal, cardiac and neurological abnormalities. Psychiatric and cognitive symptoms may develop." (7)

"Lyme Disease rarely affects only one system in the body. For example, you may have bowel problems with poor memory, poor concentration and migrating joint pain while having tremors, heart palpitations, fatigue and weird tingling sensations in various areas of your body with spots in your vision. This is only one of many scenarios.(8)"

"Some of the more common incorrect diagnoses for Lyme Disease include: Fibromyalgia, Arthritis of various types, ME/CFS, Heart disorders, Lupus, MS, Bipolar disorder, other Psychiatric disorders, early ALS, early Alzheimer's Disease, Irritable Bowel Syndrome, Crohn's Disease and many other more nondescript illnesses. (8)"

"The clinical features of chronic Lyme disease can be indistinguishable from fibromyalgia and chronic fatigue syndrome. These illnesses must be closely scrutinized for the possibility of etiological Borrelia burgdorferi infection (4).

Testing

The Center for Disease Control recommends that testing be done in a two step process: "Initial testing should use an enzyme immunoassay (EIA) or immunofluorescent assay (IFA); Specimens yielding positive or equivocal results should be tested further by using a standardized Western immunoblot assay. Specimens negative by a sensitive EIA or IFA do not need further testing." (9)

Other doctors disagree with having a two-step testing method using an EIA or IFA as a screening test and a western blot test only if the screening test is positive. An ELISA test is often substitituted for the EIA or IFA screening tests. These doctors, you will see, argue that the screening tests miss too many cases. The

PCR (polymerase chain reaction) test mentioned below relies on a different technology. It is used to identify particular bacteria, but again it may not find the bacteria in the first place.

After noting that "Lyme is diagnosed clinically, as no currently available test, no matter the source or type, is definitive in ruling in or ruling out infection with these pathogens or whether these infections are responsible for the patient's symptoms", Dr. Burrascano writes: "The suggestion that two-tiered testing, utilizing an ELISA as a screening tool, followed, if positive, by a confirmatory western blot, is illogical in this illness. The ELISA is not sensitive enough to serve as an adequate screen, and there are many patients with Lyme who test negative by ELISA yet have fully diagnostic western blots. I therefore recommend against using the ELISA." He recommends ordering both the IgM and the IgG western blots. (3)

The evidence based guidelines for the management of Lyme disease state: "Treatment decisions should not be based routinely or exclusively on laboratory findings. The two-tier diagnostic criteria, requiring both a positive enzyme-linked immunosorbent assay (ELISA) and western blot, lacks sensitivity and leaves a significant number of individuals with Lyme disease undiagnosed and untreated...Diagnosis of Lyme disease by two-tier confirmation fails to detect up to 90% of cases and does not distinguish between acute, chronic or resolved infection." (4)

Dr. Charles Crist, a noted Lyme doctor, writes: "It's important to know that screening tests like the EIA, ELISA, IFA and PCR can be negative even when the Western blot (confirmatory test) is positive. I presented research that supported this at the 1994 International Lyme Borreliosis Conference held in Bologna, Italy. For this reason I believe the screening tests are practically worthless, and is why I use the Western blot to "screen" for borreliosis, even though it is a "confirmatory" test. " (10)

Even when it comes to interpreting the results of the Western Blot test, there is disagreement around the CDC standard.

According to the Evidence based guidelines: "The Centers for Disease Control and Prevention (CDC) considers a western blot positive if at least 5 of 10 immunoglobulin G (IgG) bands or 2 of 3 immunoglobulin M (IgM) bands are positive. However, other definitions for western blot confirmation have been proposed to improve the test sensitivity. In fact, several studies showed that sensitivity and specificity for both the IgM and IgG western blot range from 92 to 96% when only two specific bands are positive." (4)

Dr. Crist writes: "Antibodies are very specific as to what they bind; consequently, in over 700 borreliosis patients false positive blot results occurred in only three percent of them, based upon research I presented at the 2000 International Lyme Borreliosis conference. Data from those same 700 patients showed that if their Western blots had even one antibody significantly associated with the Lyme bacteria, then there was a 97 percent chance they would feel better with antibiotics. Consequently, I tell my patients not to worry if the laboratory interpretation is 'negative' or 'equivocal' if they have antibodies that are significantly associated with Borrelia burgdorferi." (10)

There are reasons that the Western Blot test may be negative even if Bb is present in the body. These include testing too early before the antibodies are established, and testing too late when the Bb has hidden itself from the immune system. A negative test may become positive after a course of antibiotics as the antibiotics may force Bb out of hiding. (3).

Jim Wilson reports that the two step testing method is used all across Canada. "Your chances of having Lyme Disease identified are less than 10% using Canada procedures" he states. His recommendation is to go through the Canadian screening in case it is positive because then you are guaranteed treatment. "If you can afford it", he suggests, "have a certified Western Blot test done at an accredited laboratory familiar with Lyme Disease at the same time. You don't want to waste time waiting for the Canadian results to come in because the sooner treatment starts the better. And if you get a positive result on a certified test from an accredited lab and you are symptomatic, our position is that the doctor would risk a malpractice case if he or she ignored these facts and relied on the very flawed standards of the CDC."

Response to treatment

The use of antibiotics is a key part of treatment. Jim Wilson reports that many people with health conditions such as ME/CFS or FMS first start to suspect an infectious cause for their condition when they are on antibiotics for something like a sore throat. They notice that the throat gets better but that their other symptoms improve as well. "If you notice that happening, talk to your doctor about it" he advises. "It could very well be Lyme Disease."

In diagnosing Lyme disease, Dr Burrascano notes that "consideration should be given to tick exposure, rashes (even atypical ones), evolution of typical symptoms in a previously asymptomatic individual, and results of tests for tick-borne pathogens." Then he adds that "Another very important factor is response to treatment -- presence or absence of Jarisch Herxheimer-like reactions, the classic four-

week cycle of waxing and waning of symptoms, and improvement with therapy." (3)
A Jarish Herxheimer-like reaction is a flare that occurs several days after the onset of appropriate antibiotic therapy. Symptoms often flare due to lysis of the spirochetes with release of increased amount of antigenic material and possibly bacterial toxins. (3)

It is thought that the four-week cycle of waxing and waning symptoms reflects the organism's cell cycle. With treatment, these monthly symptom flares are exaggerated and presumably represent recurrent herxheimer-like reactions. (3)

Treatment includes "not only antibiotics, but rehab programs, nutritional supplements, enforced rest, low carbohydrate high fiber diets, attention to food sensitivities, avoidance of stress, abstinence from caffeine and alcohol, and absolutely no immunosuppressants, even local doses of steroids (intra articular injections, for example)." Repeated treatment failures should cause the clinician to evaluate for co-infection, concurrent diagnoses, or alternate diagnoses. (3)

The medical community is divided on how long Lyme disease should be treated. Some physicians treat patients for 30 days only and assume that remaining symptoms reflect a self-perpetuating autoimmune response. Other physicians assume that the persistent symptoms reflect ongoing infection and gauge the duration of treatment by the patient's individual clinical response. This conflict is addressed in an article entitled "Lyme Disease: Two Standards of Care". The author points out that there is support for both models and suggests that it is the responsibility of health care providers to present both models to patients so they can make a meaningfully informed choice on whether to continue or curtail treatment. (11)

Conclusion

It is safe to assume that there are a number of Canadians who have been diagnosed with ME/CFS and/or FMS who have Lyme Disease, but whether the number is large or small is far from clear.

The clinical guidelines for both ME/CFS and for FMS recommend that Lyme Disease be considered if the criteria for ME/CFS or FMS are met. If you meet the clinical criteria and haven't been assessed for Lyme Disease, you should discuss this possibility with your medical advisor. If you have been assessed in the past, you may wish to review your discussions in light of the current information available about Lyme Disease.

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Post Script

I wrote this material in June 2005. During the summer, Lyme Disease had a high profile. Feature articles appeared in the Globe and Mail (August 20) and the Ottawa Citizen (September 10). The Chief Public Health Officer for Canada, Dr. Butler-Jones, was asked about Lyme Disease when he appeared on the Peter Warren Show of CKNW radio in Vancouver on September 4.

Both the National ME/FM Action Network and the Canadian Lyme Disease Foundation contacted Dr. Butler-Jones with concerns about the information he put forward. In mid-September, Dr. Butler-Jones announced:

"I am pleased that my Agency has been planning a conference bringing together national and international experts to address key issues related to the diagnosis, treatment and surveillance of Lyme disease, as well as ongoing education for health professionals and the public. A key outcome of the conference, which we hope will take place before next April, would be the publication of revised national guidelines based on the current science. As well, the Canadian Institutes of Health Research is currently funding a five-year, $820,000 health research project on Lyme Disease to study the properties of the tick."

This is very good news for people who may have Lyme Disease. This work should result in improved diagnosis and treatment of Lyme, though it must be recognized that the Disease is extremely complex and it is not reasonable to expect all the uncertainty around Lyme Disease to disappear.

Please let the National ME/FM Action Network know about your experiences investigating Lyme Disease. This will help us monitor this situation as it unfolds.

Legal News & Views

Intervenor status by National ME/FM Action Network in *Lowe v. Guarantee Insurance* - Update

By: Hugh R. Scher, Barrister & Solicitor for the National ME/FM Action Network

[**Ed. Note** *If you were sent to a third party to have your health condition assessed and the assessor came to a conclusion that you didn't like, could you sue the assessor? Someone involved in a car accident in Ontario decided to try. Before the trial started, the assessors asked the judge to dismiss the case against them arguing that they could not be sued. The trial judge agreed with the assessors, and the accident victim appealed the decision. The National ME/FM Action Network was very concerned about the unfairness that could result if assessors were immune from law suits, so asked to participate at the appeal. Mr. Hugh Scher, a noted disability lawyer in Toronto and a friend of the Action Network, represented our organization.*

As the following report shows, the Court of Appeal ruled that the assessors were not automatically off the hook. The case was sent back to the trial judge to hear the evidence against the assessors.

It is not at all clear at this stage how broad the impact of this decision will be. For one thing, this case dealt only with a particular kind of assessment under Ontario's motor vehicle accident scheme. For another, the court put restrictions on what can be argued in a lawsuit against assessors. For now, though, we know that assessors can be sued, which is a very important legal breakthrough. And we are hoping to participate in an upcoming case (Worthman v.AssessMed) which will push the issue another step forward.]

On July 15, 2005, the Ontario Court of Appeal released its reasons for decision in the above matter. The ruling of the Appeal Court reverses the order of Justice Lane which denied the individual plaintiffs the right to pursue a claim as against a DAC (Designated Assessment Centre) assessor for reason of bias, breach of neutrality, negligence and incompetence. The Appeal Court reversed the decision of Justice Lane finding that individuals could pursue claims of bias, breach of the duty of neutrality, and bad faith in the conduct of an assessment and in the preparation of the assessment report. The court found that mere negligence or incompetence was not sufficient to justify an action as against a DAC assessor.

The Court of Appeal found that DACs have a materially different mandate from the categories of individuals considered by the motion judge, which included expert witnesses and court-appointed assessors.

Assessing the nature of the duty owed by DAC assessors to individuals, the court noted that it is reasonably foreseeable that a biased or careless DAC assessment could cause harm to the person

being assessed in terms of delayed treatment and denied benefits. Although the relationship between DAC assessors and the persons they assess does not fall squarely within one of the previously recognized categories of proximate relationships, the court held that it is at least arguable that the SABS (Statutory Accident Benefit Schedule) legislative framework creates a relationship of sufficient proximity such that the relationship should be viewed as similar to claims which have been allowed to proceed based on being analogous to negligent misrepresentation. In finding a duty of care owed by DAC assessors to insurers and insureds, the court found that "the legislatively created decision-making function distinguishes DACs from expert witnesses, court-appointed assessors, and the types of assessors considered by the motions judge "and creates a close and direct relationship to the persons they assess". Viewed in this way, the court concludes that it is not plain and obvious that the potential role of DAC assessors as expert witnesses should be viewed as the primary defining element of that relationship. The court further notes that legislative directives relating to conflict of interest, professional experience, neutrality and competence serve to form the nature of the duty owed by DAC assessors.

While the court concludes that the legislatively created decision-making role performed by DACs creates a sufficiently proximate relationship to create both duties of competence and neutrality, the court goes on to determine that because the decision-making role is carried out in the context of a dispute resolution process, policy considerations justify not recognizing a duty of competence. As such, mere carelessness is not sufficient to expose a DAC to legal action given their role as a decision-maker in the dispute resolution context which is best enhanced by affording immunity for simple negligence. Further justifications for this decision include that it would unnecessarily complicate the process and that such errors and omissions, where they occur, are likely to be addressed in the context of the dispute resolution process itself where relief for any damages caused due to a careless assessment will likely be addressed.

With respect to the breach of the duty to be neutral and free of bias, the court found that the same policy considerations do not apply and that DAC assessors could be subject to legal action in these circumstances.

While the motions' judge concluded that the doctrine of witness immunity served to protect DACs from legal action, the Court of Appeal found that to the extent that DACs have a duty of care to the appellants arising from their statutory role as decision makers, that may be viewed as a free-standing basis for liability, separate and apart from their role as witnesses. In the circumstances, pending determination of the scope of their duty, the court found that it is not plain and obvious that DACs should be relieved of liability by virtue only of the fact that they may be called upon to testify in court.

In this case, the court was persuaded that bad faith on the part of DAC assessors by virtue of their bias and breach of neutrality could serve to cause damages to individual insureds in circumstances where the DAC produces a report which because of its bias serves to deprive an insured of income replacement or other such benefits under the statutory accident benefit schedule. The court was persuaded that because of their role as statutorily appointed experts that DACs owe a duty of care to insured which can be the subject of legal action in circumstances where the DAC acts in bad faith to deprive the insured of their just entitlement to benefits.

It remains to be seen how this duty of care will be interpreted by the courts with respect to this or any other future actions against DAC assessors. In particular it remains to be seen what limitations, if any, the courts will place upon this duty of care in future matters. Further, it remains to be seen how the courts will interpret this duty of care with respect to other assessors such as third party medical assessors conducting assessments on behalf of insurance companies, particularly where there is no legislative mandate for such assessments and where such assessments are typically viewed as part and parcel of the litigation process.

As you are aware, the case of Worthman v. AssessMed which is presently before the Divisional court seeks to address this very issue. In Worthman the court will examine whether a third party assessor in the context of an insurance dispute may be the subject of legal action in circumstances of a breach of a duty of competence, neutrality and bad faith. In Worthman, the motions' court judge found that sufficient evidence existed such that a breach of a duty could be found and from which the IME report could be found to be not protected by privilege. As such, the motions' court dismissed the motion for summary judgment and it is that decision which is now the subject of appeal.

The Worthman case provides a good opportunity for the court to address the nature of the duty owed by third party insurers and assessors in the conduct of medical assessments and if the duty is found to exist, the nature and scope of that duty owed to third party insureds in the context of a disputed claim where the insurer's assessment serves as the basis for denial of benefits to an insured because of alleged incompetence, bias and bad faith demonstrated by the assessor both in the conduct of the assessment

and in the preparation and production of the assessment report.

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St. John's Supreme Court Judge allows malpractice suit

A former St. John's woman can go ahead with her malpractice lawsuit against two psychiatrists and the Health Care Corp. of St. John's. The Supreme Court of Newfoundland and Labrador Justice Raymond Halley dismissed a non-suit application by the defendants – the Health Care Corp., James Karagianis and David Craig. Judith Day Alleges the defendants were negligent in their diagnosis and treatment of her during two hospital admissions in 1995. Day, a retired nurse, now lives in Fredericton, N.B. She was admitted to the Waterford Hospital and the Health Sciences Centre in 1995 and claims she was wrongfully diagnosed and treated as having bipolar disorder, similar to manic depression. The defendants sought a non-suit ruling, in which the proceeding can be dismissed on the grounds "that upon the facts and the law no case has been made out." They also asserted there is a time limitation and that has been exceeded. Halley disagreed and has allowed Day's case to go forward. Day filed her statement of claim in November 1998 alleging nine areas of negligence against Karagianis, eight against Craig and seven against the corporation. There are also claims of illegal confinement and failure to properly deal with her appeal for release. She has said she was diagnosed by other doctors as having fibromyalgia, a debilitating connective tissue disorder which causes widespread pain.

(Ed. Note: Judy Day can be reached at 280 Dunn's Crossing, Fredericton, NB, E3B 2A6 Tel. 1-506-454-5444; Email: Jmld@nb.sympatico.ca

A criminal record for taking vitamins? Yes it could happen here in Canada!!!

By: Philipa Corning, Ph.D., B.Sc.

You might consider that choice of healthcare is your decision to make, and that no one has the right to curtail it. Therefore you would say: "No, that couldn't happen here."

But it did in the USA in the 1970s. Cancer patients that returned to the US after receiving vitamin B_{17} (laetrile) treatments in Mexico were arrested, charged, convicted, and given criminal records for being in possession of and for using this vitamin. It was against the law to choose this treatment instead of the conventional modalities.

Indeed, it can happen again, because globally the stage has already been set through an organization known as Codex (Codex Alimentarius Commission), in which the EU (European Union) is the most powerful member. Its guidelines consider vitamins and minerals as DRUGS. In fact, health-freedom advocate Chris Gupta and Dr. William Campbell Douglas II, MD. warn that Health Canada is pro-Codex. In fact if you input "Codex Alimentarius in Canada" and do a web search, a web page will appear with Health Canada and the Canadian flag up at the top. Furthermore, Health Canada has already classified vitamins and minerals as drugs in Jan 2004, and posted on its website, the Codex "upper safe limits" for supplements as desirable limits for Canadians to follow. So is the stage already set in Canada for acceptance and adoption of the Codex guidelines? It looks somewhat suspicious.

Why be Concerned?

According to Judith Hall (Red Flags Columnist) in her article "Codex, A Disaster Waiting to Happen": "It (Codex) was created in 1963 by two bodies of the United Nations, the Food and Agriculture Organization and the World Health Organization, to oversee food safety." Now, that sounds reasonable, however, "The threat has been quietly building, step by step, for several years." Now nutrient supplements are the focus of Codex's action. The last act of this drama took place in Rome from July 4 to 9, 2005 at a meeting of the Codex Alimentarius Commission, when new worldwide guidelines for dietary supplements were formally ratified and finalized. These new rules have already been voluntarily put in place in Australia, Denmark, Norway, and Germany, where supplements are regulated as DRUGS." Note that Australia is not a member of the EU.

Life in a Codex Country

Helke Ferrie describes her experience in Germany in her article "The Greatest Threat to Freedom of Choice in Health Care that this Century has Ever Produced" published in Vitality magazine in its Feb 2005 issue. In the mid 1990s, she traveled to Germany in order to attend to her mother who had suffered a stroke. She took a list of common nutrients supplements: vitamins C, E and B, as well as inositol and Co-enzyme Q10 to the local pharmacy, expecting to pick them up just as she did here in Canada. Instead, the pharmacist handed her a small package and a small metal container, which contained vitamins E and C respectively. The price tag was about $210.00 Canadian. The vitamins were

synthetic, their dosage levels were exceeding low, and they were expensive.

She enquired why she could not buy vitamins E and C at higher dosages, and the other supplements on her list. Furthermore, she asked why they were so expensive. The reply was that Germany is a Codex country. In fact, the pharmacist could not understand how she could obtain all the supplements in Canada without a prescription and at higher dosages than legally allowed in Germany.

Germany used to be one of the countries of Europe in which natural medicine was widely practiced. So what a backward step in medical treatment and patient healthcare choice!!

Codex Impact on the Future

Judith Hall in her article "Codex, A Disaster Waiting to Happen" assesses the impact of Codex. "What Codex ratifies will have worldwide impact due to globalization and interlocking treaties of the World Trade Organization, the NAFT, and GATT agreements." (Furthermore, this forced standardization will continue with the FTAA [Free Trade Area of the Americas]). "Ironically, all this is called "harmonization". Any nation including the United States and Canada which doesn't conform is liable to trade sanctions that could be crippling to its economy. So the final curtain of this dark drama will be nation after nation bowing to the new regulations rather than risk losing megabucks" in international trade.

Who is Behind this Movement?

The super powers with the most to gain, i.e., the big pharmaceutical companies. After all, they can afford to hire the most powerful lobbyists in any country, they buy off researchers, and they mind-condition doctors. It is to their advantage that we become ill, i.e., sickness is a marketing opportunity. In fact since its initiation in 1963, 90 % of all attendees at Codex conferences were favourable toward pharmaceutical companies. Very few attendees (all with no voting powers) represented nutrient supplements and natural health modalities. Therefore, in a Codex country:

…all supplements will be synthetic and thus of low quality;
…the "upper safe limits" for supplements will be much lower than the RDAs (minimum levels of nutrients needed to prevent disease);
…supplement price will be very expensive;
…a physician's prescription will be required;
…there will only be a narrow "positive list" of supplements available (literature indicates only 28 so far);
…it will be illegal to practice natural medicine;
…it will be illegal to distribute, sell or possess nutrients supplements; and
...dissemination of health-related information about nutrient products for prevention and treatment of illness will be prohibited.

Is it too late?

On 12 July 2005, the European Court in Luxembourg supported and gave its blessing to the restrictive Food Supplements Directive (formerly referred to as guidelines) compiled by Codex Alimentarius Commission even though the court's Advocate General, Leendert Geelhoed advised that the Directive was in contradiction to the constitution of the EU and all international trade agreements. The court judges disagreed with its Advocate General and ruled that the Directive was "properly founded" in EU law, and rationalized its restriction were justified by the need to "protect the public" through the compilation of a "positive list" of supplements approved for consumer use. The judges continued to say that the Directive would get rid of differing national rules liable to impede the free trade of supplements and the functioning of the internal European market. This legislation will outlaw the sale of thousands of vitamin and mineral supplements across the EU.

At first this ruling was a great blow for the Alliance for Natural Health that had mounted this legal challenge against the Directive in the European court. The spokesman for the Alliance for Natural Health said the following about the ruling; "We had expected a better verdict. On the surface it looks like bad news, because they are upholding the Food Supplements Directive and that is disappointing… However, there may be a positive side to this." Why? Because the judgment may have left a "way out" for substances naturally occurring in our foods. In its preliminary analysis of the European Court's judgment, the Alliance for Natural Health legal and scientific team indicated that the ban on vitamins and minerals not found on the Directive's "positive list" does not apply at all to vitamins and minerals normally found in or consumed as part of the diet.

With the above information in mind, it makes sense to support Bill C-420 here in Canada. This Bill would place vitamins and minerals back into the category of foods (Health Canada had removed all supplements from the category of food and placed them under the category of drugs in Jan 2004) which would mean that the Codex Food Supplement Directives would not apply. This would go a long way to preventing Codex from taking over our right to choose or not to choose to use natural nutrient supplements.

On 9 March 2005, Bill C-420 originally introduced by Dr. James Lunney, MP for Nanaimo-Alberni, has unanimously and successfully passed its second reading in Parliament. It proposes to amend the Food and Drugs Act, i.e., it suggests that the Office of Natural Health Products be moved under a food style directorate rather than under a drug style directorate. In this manner, the safety, quality, and manufacture of nutrients could be monitored as they should, i.e., as foods. This would also allow Canadians a greater freedom of choice in their personal health care, i.e., conventional medications, natural supplements, or a combination of the two.

Currently in the US, there is a comparable bill before Congress that is pro-health care choice and anti-Codex. It is Bill H.R. 4004 or as it is more commonly known the Health Freedom Bill. Just as our Bill C-420, it proposes to retain the classification of nutrient supplements as foods. This bill is supported by the Association of American Physicians and Surgeons, and the Dietary Supplement Education Alliance. However, each time this bill returns to Congress, it has had less and less Congressional support. If in the end, it should be defeated, Codex will then become the law of the land.

In Canada, Bill C-420 still has one more reading in Parliament. If it is defeated at that time, then Codex will also become the law of the land in our country.

Logical Rationale?

In a time when health costs are spiraling, one would expect that Health Canada would be interested in lowering those costs. There is plenty of scientific evidence supporting the fact that nutrients supplements lower morbidity of a serious disease and improve clinical outcomes. For example, it is well known that vitamin C prevents scurvy, and that folic acid taken during pregnancy prevents certain deformities in the fetus. How odd, that Health Canada instead of performing its job as our protector, now has to be forced into doing that very job. One would think that this department would be in the forefront of advancing all opportunities to improve the health care of its citizens. In this instance, that is not happening. It seems to be paving the way for Codex in Canada.

What Can I Do?

Since Bill C-420 has presently been sent out to the Health committee prior to its return to Parliament for the third and final reading, you have time to contact members of the Parliamentary Standing Committee on Health and Members of Parliament in order to try to impress on them the importance of supporting Bill C-420 in its unamended form. The most efficient way of doing this is by visiting our website: www.mefmaction.net, click on Canadian News at the left of the screen, and then click on the "Support Bill C-420". At the end of the text, you will find choices: Sample Letter, List of Members of the Parliamentary Standing Committee, and List of Members of Parliament. You can copy this sample letter, select the email addresses of members of the Committee and Parliament, and send it to as many members as you wish.

Please remember that it is essential to the health of Canadians, and to their freedom of choice in healthcare that we broadcast our support for Bill C-420, and stop Codex from dictating that we must only depend on conventional medicine.

Insurance Bad Faith: the case of *Fidler v. Sun Life*

By: Faith E. Hayman, Trial & Appellate lawyer.

Introduction

Mrs. Fidler really did not like the way she had been treated by her disability insurer. So when Sun Life agreed to reinstate her benefits, with interest, a week before trial, she decided to take the company to trial anyway.

You might ask, what was left to fight about? The only remaining claims were for damages for mental distress and bad faith.

You might also ask, who was her lawyer? The answer: for the first several days of trial, she had none.

From these inauspicious beginnings unfolds the legal case of *Fidler v. Sun Life* 2004 BCCA 273, which is currently scheduled to be argued in the Supreme Court of Canada on December 6, 2005.

Factual background

In 1990, while working at the Royal Bank, Connie Fidler became ill with an acute urinary infection leading to acute pyelonephritis for which she was hospitalized July 2-5, 1990 and given IV antibiotics. After the infection cleared, Ms. Fidler suffered from debilitating fatigue, which was diagnosed as post-infectious chronic fatigue syndrome. Her application for long-term disability insurance was initially denied.

Ms. Fidler pursued an appeal. By then, she had been assessed by five doctors including 4 specialists. There was general medical agreement that Ms. Fidler had chronic fatigue syndrome, a diagnosis of exclusion and one for which there is no proven

effective therapy. On March 21, 1991, Sun Life approved Ms. Fidler's claim and arranged to enforce CPP offset provisions.

On April 4, 1991, CPP approved Ms. Fidler's application for benefits retroactive to October, 1990. As time passed, Ms. Fidler was also diagnosed with fibromyalgia and it became increasingly clear that her disabilities were long term. Ms. Fidler continued to receive CPP disability benefits through to the date of trial.

On June 5, 1991, Sun Life referred Ms. Fidler's claim to its rehabilitation department. Over the next several months, Ms. Fidler explored whether she could work from her home to prepare for a potential return to work. She purchased a computer and attempted to take a computer course, but was too ill to continue. Sun Life made no referral to its rehabilitation department in 1994. It initiated a referral September, 1995, but did not follow through on the referral. Sun Life made no referrals to its rehabilitation department after 1996.

Over the period March, 1991 to May 12, 1997, Sun Life availed itself of several methods to assess Ms. Fidler's disability claims. Sun Life initiated requests for, and adjudicated Ms. Fidler's claim on the basis of, supplementary medical reports from Ms. Fidler's treating doctors, disability questionnaires to the doctors, supplementary statements, claimant interview reports, questionnaires and consults of treating doctors, telephone interviews, background investigation checks, disability assessments, and internal medical opinions.

At certain stages, Sun Life unilaterally ceased paying benefits. For example, on September 29, 1992, Sun Life terminated Ms. Fidler's benefits effective January, 1993, (the change of definition date from "own occupation" to "any occupation"). The medical evidence at the time was that Ms. Fidler was not able to work at any occupation. Ms. Fidler then obtained updated reports from her treating specialist. Sun Life still withheld benefits. The termination of benefits was causing Ms. Fidler severe financial stress. A further report dated January 20, 1993 was sent, and Sun Life changed its mind and reinstated benefits. A similar episode recurred in 1994.

In December, 1995, Sun Life requested Ms. Fidler to complete a Lifestyle Questionnaire. She did so on January 3, 1996, and the questionnaire was forwarded to Sun Life together with a notation that Ms. Fidler's husband was recently killed in an accident while working in Japan. In July, Sun Life requested Ms. Fidler to complete a Supplementary Statement, which she did on August 5, 1996. In that statement, Ms. Fidler described the following problems: "chronic pain, unable to sleep, weak physically, irritable bowel & stomach, eyes sensitive to light, headaches, no concentration, short term memory very poor, chronically tired". Ms. Fidler wrote "I feel I am doing well to take care of myself and my daily business – i.e. paying bills, shopping, etc. and as this seems like a full time effort for me I cannot imagine trying to hold a job." At the same time, Sun Life commissioned surveillance, which was done in August and September, 1996, with a report released to Sun Life dated September 28, 1996.

According to the trial judge, the tapes showed Ms. Fidler "carrying out a number of what can be described as errands or personal business activities."

Sun Life reported in an internal memorandum dated December 16, 1996 that the claimant was active for "5 FULL DAYS!" In fact, Ms. Fidler was observed shopping for only two consecutive days. At trial, the representative of Sun Life, Mr. Craig, admitted that this description of the surveillance was an exaggeration.

By letter dated May 12, 1997, Sun Life wrote to Ms. Fidler advising that it had terminated benefits effective April 30th, 1997 on the basis of a non-medical investigation.

In response, Ms. Fidler wrote a series of letters and made several phone calls trying to clarify the basis for Sun Life's decision. She requested production of the surveillance videotapes. However, the 1996 and 1998 tapes were not released until February, 2002, and the 2001 tape was not released until a week before trial.

Internal memos disclose that Sun Life was aware that its decision to terminate benefits was mishandled and that it lacked medical evidence to support its position. An internal memo dated June 17, 1997 stated:

"The long delays between the time of the surveillance and advice of termination would not be in our favor if this case went to court. The best way to have handled this case would have been to arrange for an IME before declining or at leaving (sic) have an MC (medical consultant) review file and provide his comments.

In addition, and contrary to what it told Ms. Fidler, Sun Life had not conducted a "thorough review" of Ms. Fidler's claim prior to terminating her benefits. This is evident from a Sun Life memo by the Principle Claims Administrator in Montreal dated March 18, 1998, which noted:

"The claimant's condition has not changed according to the medical reports on file and our decision was based solely on the results on the investigation.

In January, 1998 Ms. Fidler forwarded a letter from her family doctor, Dr. Wilkinson, which confirmed that she was unable to work, suggested that Sun Life schedule an Independent Medical Assessment ("IME") and assist with a graduated exercise program and cognitive therapy. In response, Sun Life prepared a memo which stated: "An IME is essential if we wish to maintain our denial successfully in the event of litigation." Sun Life did not reinstate benefits, nor did it refer Ms. Fidler's claim to its rehabilitation department, nor did it take any steps to schedule an IME until September, 1998.

Once Sun Life finally scheduled an IME, Ms. Fidler immediately attended in the hope that this would resolve any outstanding questions. At the same time, Sun Life conducted further surveillance of Ms. Fidler. The doctor chosen by Sun Life, Dr. Wade, a rheumatologist, forwarded a lengthy report to Sun Life advising that Ms. Fidler's "number one complaint is that of pain" and that she also complained of poor sleep, fatigue, irritable bowel, and headaches. Sun Life had provided Dr. Wade with Ms. Fidler's Lifestyle Questionnaire and the 1996 surveillance which he did not consider significant. In his conclusions, Dr. Wade recommended a graduated rehabilitation program, medication and counseling. He wrote: "It would be my opinion that Connie Fidler is increasingly able to consider returning to work on a graduated basis. Prior to this being successful, she should embark upon a graduated training program to improve her level of physical fitness."

Instead of making a referral to its rehabilitation department and reinstating benefits pending Ms. Fidler's hoped for recovery, Sun Life forwarded Dr. Wade's report to its Medical Consultant ("MC"). The MC did not conduct a physical examination of Ms. Fidler. In a 2 page handwritten note, the MC concluded that Ms. Fidler was not disabled from working. Sun Life then considered how to justify ignoring Dr. Wade's report in the following internal memo generated by someone in its Disability Management Unit:

"When an examining doctor makes recommendations, we look bad if we do not follow through with recommendations as we are asking for his opinion. I would recommend that you stress that result of IME & medical do not support T.D.A.O. (total disability any occupation), however, as a good will gesture we would pay 3 months of benefits to assist with her back to work efforts and also stress that file will be closed with this handling..."

Upon hearing that her file would be closed, Ms. Fidler retained a lawyer and a letter was sent returning Sun Life's cheque. In January, 2000, Ms. Fidler underwent a functional capacity evaluation requested by Sun Life, traveling from Oliver to Coquitlam, to be assessed by an OT chosen by Sun Life. By the end of the FCE, Ms. Fidler was in tears. The evaluator, Ms. Fast, concluded:

"Ms. Fidler would be considered currently to have limitations with respect to receptionist duties due to her slow speed of movement, particularly with regard to her keyboarding ability. Below average short term memory function might also limit her ability to successfully perform such job duties. Her overall tolerance to activity is limited such that I would consider her incapable of more than half-time employment at a sedentary level currently, although I would expect this could be increased on a gradual basis.

After October, 2000, and well into the trial, Ms. Fidler was without legal representation. Ms. Fidler explained that in order to retain counsel, she would have to withdraw a portion of her RRSP's, something she was reluctant to do.

In September, 2001, Ms. Fidler underwent a second IME with Dr. Wade, who noted she had experienced "further significant stress related to the status of her disability" and again made suggestions concerning her rehabilitation. Again, Sun Life took no steps to reinstate benefits or assist in rehabilitation.

Sun Life examined Ms. Fidler for discovery in March and October, 2001. Sun Life made no offer to reinstate benefits following these examinations for discovery. Also in October, 2001, Sun Life conducted a further 9 days' of surveillance.

One week before trial, following a brief examination for discovery, Sun Life offered to pay all of Ms. Fidler's outstanding benefits and to reinstate benefits.

The trial proceeded on the assessment of damages for mental distress and punitive damages only.

The trial judge found that Ms. Fidler's own doctors consistently confirmed Ms. Fidler's total disability and that Ms. Fidler would likely have been successful at trial on the issue of whether she was totally disabled.

Damages at trial

At trial, the judge found that Ms. Fidler had experienced significant mental distress as a result of Sun Life's wrongful denial of benefits over a five year period, and awarded her $20,000 damages in mental distress.

The trial judge dismissed Ms. Fidler's claim for punitive damages on the basis that Ms. Fidler's illness was hard to assess and Sun Life's conduct was not so bad that it deserved punishment.

Appeal

Sun Life did not like the idea of paying Ms Fidler $20,000.00, when it believed that she had not faced any particular financial hardship as a result of their failure to pay benefits, so it appealed.

Ms. Fidler cross-appealed the trial judge's decision to dismiss the award of punitive damages.

At the hearing before the B.C. Court of Appeal, the first issue to be considered was the trial judge's award of damages for mental distress.

Historically, judges in England and Canada have taken the position that it would not be a good idea for the law to compensate people for emotional suffering when there was a breach of a contract because they feared that claims for all types of emotional suffering would flood the courts.

The law developed an exception to this general rule in cases where an important aspect of the contract is to provide "peace of mind".

Some ten years ago, in *Warrington v. Great-West* (1996), 139 D.L.R. (4th) 18, the B.C. Court of Appeal had held that disability insurance policies were one of those special types of contracts which are designed to provide "peace of mind". In *Fidler,* the Court of Appeal reiterated its reasoning in *Warrington.* The Court of Appeal affirmed that Ms. Fidler had suffered mental distress as a result of the non-payment of benefits, and upheld the trial judge's award of $20,000.

In its appeal to the Supreme Court of Canada, Sun Life is arguing that an award should only be made where an insurance company commits a further wrong, in addition to refusing to pay benefits. Counsel for Ms. Fidler will argue that when a disability insurer breaches the contract, the decision to not pay benefits alone can adversely impact disability insureds in the following ways:

a) when benefits are improperly denied or terminated, the insured's financial security, both short-term and long-term, is lost;

b) persons who need disability insurance are exceptionally vulnerable. Unlike most other insurance contracts, the insured's vulnerability is not only economic but also involves a seriously compromised state of health which can be significantly worsened by the additional stress of not receiving disability benefits;

c) because benefits are payable on a monthly basis, issues of entitlement and the consequences of non-payment can arise during any given month, and can recur repeatedly;

d) the relationship between the insured and the insurer in a disability claim cannot be ended once it has soured. It is comparable to a marriage with no provision for a divorce: for as long as the insured remains disabled from working, he/she is compelled to live in a state of financial dependency on the insurer; and

e) disability benefits are often tied to other incidents of employment such as continued contributions to the employee's pension plan and continuation of extended health benefit coverage. Therefore the implications to the insured of being denied disability benefits can significantly exceed the loss of benefits themselves.

Although damages for mental distress are not substantial (they generally range from $5,000 to $20,000), they are a meaningful acknowledgement of the emotional suffering many insureds experience when benefits which they are legally entitled to be paid are wrongfully denied.

After addressing Ms. Fidler's claim for damages for mental distress, Chief Justice Finch and Prowse J.A. next examined Sun Life's actions and the trial judge's reasons for dismissing Ms. Fidler's claim for punitive damages.

They noted that there was a vast power imbalance between the insurer and the insured, which meant that an insurer is held to a standard of "utmost good faith" in adjudicating the insurance claim.

A key issue at trial and on appeal was whether Sun Life's refusal to pay benefits should be excused because Ms. Fidler's illness could not be verified by objective tests. It was submitted that elements of ambiguity or uncertainty or conflict concerning the nature and extent of an insured's disability will exist in most cases and that the logical extension of this argument was that an insurer would never be exposed to a punitive damages award where an insured suffers a "subjective" illness.

The Chief Justice recognize that insureds who become disabled because of illnesses which are difficult to assess stand in need of disability benefits as much as those with obvious physical disabilities. How the insurer investigates a given claim may depend on the circumstances of the case, but an insurer's accountability for paying benefits should not be lowered because of the nature of the disability. Finch C.J.B.C. held that where disabilities are difficult to assess, it becomes that much more important for insurers to proceed "openly, fairly and cautiously."

The Chief Justice noted that Sun Life had not accurately described the surveillance video and had not provided Ms. Fidler with a fair and reasonable opportunity to challenge its decision to terminate her benefits and observed that after breach, Sun Life's focus was on defending the claim, rather than on fairly adjudicating it. Finch C.J.B.C. concluded that the most probable motive for Sun Life's decision to

reinstate benefits one week prior to trial was an awareness just before trial that Ms. Fidler had decided not to back down.

The plaintiff argued that there was a need for deterrence, and that if punitive damages were not awarded as a deterrent for Sun Life's conduct, the lesson would be that insurers can terminate benefits in cases such as this with impunity, knowing that if insureds persist in their claim, they can make amends without penalty at the doorstep of trial. The corollary would be that insureds who are disabled from working and entitled to benefits will be forced to press their claims through a difficult and oppressive litigation process because nothing short of that (and possibly not even trial) will create sufficient financial risk to an insurer to pressure it to pay benefits that are due and owing.

The Court of Appeal accepted that without an award of punitive damages, Sun Life would experience no meaningful adverse consequence for its actions. Finch C.J.B.C. and Prowse J.A. held that Ms. Fidler should be awarded damages of $100,000, which was roughly equivalent to double the total amount of benefits which Sun Life withheld over the five year period leading up to trial. Ryan J.A. held that Ms. Fidler's cross-appeal should be dismissed.

Supreme Court of Canada

Sun Life has since appealed the Court of Appeal decision to the Supreme Court of Canada.

Conclusion

The final word on the standard of insurer conduct in disability insurance cases remains to be determined by the Supreme Court of Canada. In the meantime, however, the B.C. Court of Appeal has recognized the great power imbalance between insurers and insureds in disability insurance cases and the vulnerability of the insureds, and it has emphasized the need for insurers to proceed openly and cautiously in order to ensure that insureds are treated fairly and reasonably throughout the adjudication process.

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NETWORK NOTES

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The focus of our new website is to make it as user-friendly as possible. If you have already saved our website in your "**Favourites**", delete it and then save it again. Instead of the **'e'** that usually precedes a website, you will find our logo, which will make it easy to locate. **http://www.mefmaction.net**

IME/FAE Registry Submission

The **National ME/FM Action Network** continues to urge those who have attended an **Independent Medical Examination (IME)**, **Functional Abilities Evaluation (FAE)** or any other form of assessment at the request of an insurance company, Canada Pension Plan (CPP) or Workplace Safety & Insurance Board (WSIB) to fill out our 7-question, confidential, **Independent Medical Examination Registry Submission Form** so that the names of the doctors and healthcare professionals who evaluated you can be put on record. Patients, doctors, lawyers, advocates, support groups wishing to receive a copy or copies of the Form, or to inquire about specific IME doctors, please contact: **National ME/FM Action Network** – Or download the Form from our website at **www.mefmaction.net**

MEMBERSHIP: **$25.00 per year, which includes quarterly newsletters**
Payment can be made by **CHEQUE, VISA or MASTERCARD.**
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Resources

Consensus Documents

FMS Consensus Document US$24.95
Quote Code No. FMS40 for a 40% discount.
"The Fibromyalgia Syndrome: A Clinical Case Definition for Practitioners". *Haworth Press*, 2004. (soft cover book) **ISBN:** 0-7890-2574-4
Phone: **800-429-6784** Fax: **607-771-0012**
Email: **orders@haworthpressinc.com**
Online: **http://www.haworthpress.com/store/product.asp?sku=5342 FMS 40**

ME/CFS Consensus Document US$14.95
Quote Code CFS 46 to buy it at US$8.00.
Myalgic Encephalomyelitis/Chronic Fatigue Syndrome: Clinical Working Case Definition, Diagnostic and Treatment Protocols. *Journal of Chronic Fatigue Syndrome,* Vol. 11, No. 1, 2003. Haworth Press 2003/2004 **ISBN:** 0-7890-2207-9
Phone: **800-429-6784** Fax: **607-771-0012**
Email: **orders@haworthpressinc.com**
Online: **http://www.haworthpress.com/store/product.asp?sku=4958 CFS46**

Network Resources

The following resources can be ordered from the National ME/FM Action Network. Prices include shipping and handling. Cheques should be made payable to the National ME/FM Action Network or you may pay by VISA or MasterCard.

Quest Collections
By popular request, the **National ME/FM Action Network** has published two collections of important articles which have appeared in **'QUEST'** newsletters. The articles in each five-year collection have been grouped into sections according to their focus.
Quest Collection I (1993 - 1998): $20.00
Quest Collection II (1999 – 2003): $38.00

New Resources

TEACH-ME: A Sourcebook for Teachers (Second Edition): $22.00
Discount on bulk orders
With Dr. D. S. Bell, Dr. B. M. Carruthers and the TEACH-ME Task Force (teachers with ME/CFS and/or FMS)
This educational resource book will enhance teachers' and parents' understanding of ME/CFS and FMS in young people, and assist educators in developing educational modifications and programs.

The Canada Pension Plan Disability Benefits Guidelines: $7.00.
New up-dated guidelines have been designed to assist those disabled by ME/CFS and/or FMS applying for Canada Pension Plan Disability Benefits. It will help you understand the criteria, important items to include and walks you through the various steps of the process.

Legal Disability Manual: **$60.00**
Approx. 400 pages *Editor: M. van de Sande*
The Legal Disability Manual includes section on: FMS and ME/CFS Overview; The Medical Report and Expert Witnesses; Independent Medical Examinations; CPP Disability Benefits, Disability Insurance and Other Legal Articles; Case Law; Psychological Factors, Tests, and Treatments; and Research Abstracts. Many of the articles have been written specifically for the **National ME/FM Action Network** by lawyers and doctors. Our new Canada Pension Plan Disability Benefits Guidelines are also included in the Legal Disability Manual. This manual is a must for those in litigation.
[In order to keep our members abreast with the most up-to-date information, Case Law, etc. pursuant to the 2004 publication of this manual, will be placed on our website in the "Members Only- Legal Library".]