Lipson, Frank - Physical Medicine and Rehabilitation

A Conversation with
A PHYSIATRIST

Riverfront Medical Services (RMS): Doctor, some people are a little unclear as to what the Physiatrist discipline encompasses. Could you explain to us what special training and qualifications a Physiatrist needs and what the practice of Physiatry entails on a day-to-day basis?
Physiatrist: The Physiatrist's practice is basically a combined discipline. The physician treats a patient who has had chronic disease or chronic injury and rehabilitates the patient after a diagnosis by the Physiatrist or other physician has been made to rehabilitate the patient to a normal functioning level, or as close to a normal functioning level as the disease or injury process will allow. To train for Physiatrist, one combines a series of different disciplines and special techniques related to Physiatry itself. The disciplines that a Physiatrist must know in depth are neurology, neurosurgery, orthopaedics and rheumatology. This basic knowledge is combined with the anatomy, physiology and psychological needs of a patient. In the recovery phase of the illness, the physician combines physical modalities of treatment to achieve maximum independence for the person who has received the injury either through accident or through a disease process. The Physiatrist must know how muscles, bones and joints behave after injury. The Physiatrist knows how the physical modalities, heat, massage or exercise can impact on the disability and the disease and thus the usual course of events related to a specific injury is understood. The Physiatrist combines the physical with the psychological problems that the patient has received from the injury and tries to make the patient function maximally with the specific limitations that he or she has.
RMS: Doctor, you mentioned a combination of physical examination and exploration together with psychiatric components and psychological components. Could you expand a little bit on the interaction of the psychological with your physiatric expertise?
Physiatrist: Our training was on a rehab unit and we would do a total assessment of the patient. There would be Physiatrists and Psychologists involved with the care as well. We would have sessions with the Psychologist and the Physiatrist as to our reaction with the patient and what the patient was going through. We would analyze the various reports by the Psychologist and the Physiatrist and would integrate these into the treatment plan of the patient. The psychological and psychiatric reports were essential for the proper course and treatment that the patient with a chronic problem would have and, as one proceeded over the years of training, one accumulated an increasing knowledge of the responses that people have to injury. The injury would be incorporated with the psychological and psychiatric assessments that were done. One would develop a side expertise with psychiatry and psychology in relationship to chronic illness and chronic disability.
RMS: As a Physiatrist, do you often find your opinion at odds with those specialists of another discipline, for example, Orthopaedics?
Physiatrist: Not usually. I think that the opinions are complementary to one another. I deal a lot with Orthopaedic Surgeons at my hospital and they do the surgical correction of the problem and then it is a matter of trying to get the patient to his or her maximum function and there is very little disagreement between the Orthopod and myself. We have different functions with overlapping expertise and, yet, our opinions usually supplement each other. It is unusual for me to have differing opinions with the physicians that I am working with.
RMS: Do you often find an interaction or correlation between physical injury and psychological trauma? That is to ask specifically, do the two aspects often present together?
Physiatrist: There is always a psychological component to any accident. One can have very, very severe psychological reactions and that is a post-traumatic stress syndrome where life is threatened or where one is exposed to extreme physical or psychological injuries. That is at the one extreme and then there is another at the other extreme where persons feel that they have been unjustly victimized and feel, either overtly or covertly, that they deserve some type of reward for the accident and their reaction may not be overt, but they are reacting to feeling deprived and victimized and hence need compensation of some kind.
RMS: Have you seen any significant changes in the pattern of complaints you are asked to review? If so, could you explain what changes have taken place and why you feel that they have come about?
Physiatrist: I have been doing IME's for a number of years now and I have been treating patients for approximately thirty years and have seen a great number of accident victims in my office, all the way from whiplash to major trauma. People are much more aware of the compensation that is available to them at this time and the other aspect is that we are having major changes in society where people are not being hired for standard physical type work. As we move more towards an information society, some people, in reality, prefer to save themselves embarrassment and not have to expose themselves to a work force where they will not be employed. This group will accept disability more often and, in fact, are almost relieved by having some excuse for not getting back into the regular flow or life and work.
RMS: You are a former Chief of Medicine at one of Canada's leading hospitals. In addition to that, you are also a Rheumatologist and Associate Professor of Rheumatology at the University of Toronto and you are a qualified Internist and all this in addition to being a Physiatrist. Given your degrees of expertise, how do you manage to differentiate between treating and impartially assessing individuals? How do you maintain your impartiality whatever the discipline?
Physiatrist: I try to define the nature of the injury, the potential problems that people have and I listen very closely to what they tell me. I observe carefully whether the physical findings that are present reinforce the problems that the patients have delineated and I try to make sure there is a consistency in history and physical findings from the beginning of the examination to the very end of the examination. Initially, when I was a practicing physician and not doing IME's, it was very simple to listen to what the

patient said and try to do the best thing for the patient. As I became more involved with IME's I had to find peace with myself in terms of a consistency both for the patients that I saw that weren't IME's and those that were IME's. I think it took me some time to be truly consistent across the board in terms of treating both my own patients and the patients that I assess for IME's, equally. I know I'm doing a good job when I get an equal amount of comments both from the patients and also from the Adjusters. (Laughs).

RMS: Doctor, do you feel that the claims handler or the law firm assigning the IME to you always provide you with sufficient documentation to enable you to form a clear picture of the examinee's relevant medical history? If not and if I can ask you to generalize, what is the most missed documentation of relevance that you come across, or in this case do not come across?

Physiatrist: The ones that are perhaps the most difficult to decide, are the very, very complicated multiple trauma type of problems where the course of events, the specific injury, the pre-existing condition, the ambulance report and the emergency room report all help to clarify the relationship of the accident to the disability. The first week or two after the initial injury, one can more or less define what the course of events should be.

The other area that is not always complete in terms of documentation is pre-existing illness. Sometimes very small details are very relevant. For example, if a person has had a back problem and was being medically investigated, the question is whether he or she had a disc problem before, whether he or she had a CT scan or an MRI, what it showed and how much it has changed from that time to the present. Then I think that if a pre-existing problem could effect the present symptom the information becomes very critical and this information is not available at all times. I can understand that because the claims handlers often do not have the information themselves or are not aware of the relevance of all the information and sometimes very key information is overlooked. At times, one has a problem getting release of information.

RMS: It's not unusual for somebody to suggest, from time to time, that IME's are "simply slanted insurer's examinations". How would you answer this from your own perspective?

Physiatrist: It is very unusual to find an actual difference in terms of physical abnormalities. In other words, measuring a joint's range of motion, measuring shortening of a limb, measuring range of motion is usually the same. The difference is the interpretation by the various physicians of the measuring of the physical findings and I do not think that there is anyone who is without their own way of viewing a situation. One automatically has some slant depending on what role one takes, whether one is treating an IME or both. I think it becomes very critical for one to look for inconsistencies that are presented. The more one can decide as to why there are differences. As a practicing Physician, an inconsistency doesn't always take on the same relevance that an inconsistency in an IME would have. That also applies to historical data as well as physical. Also, having a good knowledge from the time of the accident through to the final presentation, allows one to determine the timing which sometimes is very critical in terms of relationships of symptoms to the accident.

RMS: Doctor, one hears more each day of the preponderance of chronic illnesses or complaints such as for example, fibromyalgia, chronic fatigue syndrome or sympathetic dystrophy. As a physician qualified as you are in the Specialties of Physiatry, Rheumatology and Internal Medicine, you would possess an extensive professional insight into such complaints. Why then does there appear to be so much growth in these diagnoses and what is your experience with these illnesses?

Physiatrist: People like to have a diagnosis. People like to have a label and not infrequently doctors feel that they have not fulfilled the patient's need unless they label the patient with some specific disease process. A lot of the previously mentioned symptoms and syndromes may be more than one disease but because of our lack of knowledge we may be bundling these together. Not infrequently, a person can have a few symptoms, hear about a disease process and very quickly take on a lot of the symptoms of the disease and fall into that disease category. Not infrequently, people will discuss their condition with other people, or may read about it and it helps them delineate what is an acceptable disease process and they can fall into that symptom complex and, if the disease is accepted by society as a whole, it makes it a lot easier to have that disease. Accidents with symptoms need a diagnosis. Hence what was a symptom becomes a disease.

RMS: It is not unusual for insurers to receive detailed expert medical reports outlining chronic illnesses that were allegedly triggered by an accident or injury. Faced with such a report, how would you reconcile your own findings if they differed with those of your fellow specialist or specialists?

Physiatrist: Once again, the physical findings rarely ever differ. If there is a chronic condition that is triggered by an acute illness one would have to look through the literature to see if that relationship exists on a scientific basis. It is not unusual to find that people will have underlying disease processes that are dormant and the accident may have initially triggered off these dormant disease symptoms, but the injury was of such a nature that the symptoms should have been restricted to maybe a four or five week period, but the disease process would have occurred at some future time if the accident did not occur. Previous disease can also delay recovery.

RMS: How might a claim's handler best avoid getting caught in the middle of a "battle of the experts" where opinions differ?

Physiatrist: It is unusual for any two people to have the same opinion about anything. I think that if you have two quotes from two unbiased people that give you the same opinion, you could probably accept that. If you have two potentially biased people giving you an opinion, I would probably put the two together and divide by two and get something in between and accept a compromise between the two descriptions, providing both are of equal integrity.

RMS: In your experience Doctor, is it usual to encounter resistance from the examinee who may view you solely as an "insurance doctor" or are you able to assure them of your impartiality?

Physiatrist: As soon as they walk into the office, they assume that I am working for the insurance company and I think that with some people no matter what you say, no matter how fair you are, that perception is there. One has to work through that and one has to not only be fair but try as hard as possible to give them the perception that you are fair. You have to be fair to both parties. Fairness is the largest goal, regardless of whom the parties may be.

RMS: Just touching briefly on video surveillance, sometimes Counsel will point out that a doctor has formulated his opinion based partially on a video tape of his claimant performing activities that the claimant claims not to be able to perform. Counsel will then go further and typically suggest that this was simply a "good day" when the video was shot, but that on the whole, his or her client still remains unable to perform those functions on an ongoing basis.
Physiatrist: The one thing that one can conclude is that if one can see a normal function and there is no evidence of permanent injury then one can then conclude that the person has the ability to do that function. A seasoned clinician has a very good sense of the fluctuation of disability that is possible with a disease process or symptom complex. It is very unusual for someone to be totally disabled one day and functioning extremely well the next. This discrepancy may be relevant in people who have very delicate jobs such as flying of aeroplanes, officers of the law and employment of that sort or people who are doing exceptionally heavy work. The differences are usually weather and work related. There is some natural fluctuation of all symptoms. Marked inconsistency is unusual. Most people can work through the pain if at other times they are normal.

Frank Lipson: ZoomInfo Business People Information

Doctor's Name:	Lipson, Frank
Summary Information	
Registration Number:	21157
Surname:	Lipson
Given Name:	Frank
Gender:	Male
Accepting New Patients:	Yes
Current Registration:	Independent Practice
Certificate Issued on:	28 Dec 1967
Registration Status:	Active Member
Effective From:	28 Dec 1967
Graduated From:	University of Toronto
Year Graduated:	1964

Primary Practice Address:	2021 Cliff Road Suite 306 Mississauga ON L5A 3N7 Canada
Phone Number(s):	(905) 897-7777
Fax Number:	(905) 897-5913
Specialties	
Specialty:	Internal Medicine
Issued On:	17 Nov 1970
Type:	Permanent
Specialties	
Specialty:	Physical Medicine and Rehabilitation
Issued On:	16 Nov 1971
Type:	Permanent
Hospital Privileges:	NONE
Language(s) Fluent:	ENGLISH

Macdonald v. Sun Life Assurance Company of Canada, 2006 CanLII 41669 (ON S.C.) — 2006-12-13

[2] **I have deliberated for a very long time before delivering these reasons. Although the action out of which the problem arose has long been concluded, this case raises vexing issues as to what role may be properly played by organizations such as Riverfront in the formulation of an expert witness' opinion.**

[85] My understanding of Linda's evidence is that her telephone conversation with Dr. Lipson was directed to the differences in Dr. Lipson's responses to the query concerning goods and services. She did not recall discussing the deletion of the highlighted portion. However when asked by Mr. Pepper whether she would have removed it if she understood that Dr. Lipson wanted it to stay, she not surprisingly, replied in the negative. I agree with Mr. Faith's
submission that this is not the same as saying that she would not have deleted it without Dr. Lipson's express authorization. I further agree with Mr. Faith's submission that **there is no evidence to suggest that Dr. Lipson ever gave his express consent or authorization to the deletion of the paragraph.**

[86] It was also submitted by Mr. Pepper that **the fax Dr. Lipson sent to Linda on March 15, 2005 at 13:43 (Exhibit 19) might reasonably have caused Miss Geladeris to assume that Dr. Lipson had consented to the deletion**. Again I agree with Mr. Faith's submission that this fax was in response to a question from Miss Geladeris about whether the 18 pages of additional documentation that had been sent to Dr. Lipson on March 15th at 13:02 had changed his opinion. His negative response to that question could not reasonably have been taken to be an authorization to delete the highlighted portion.

[87] Dr. Lipson's written statement does not change my view of the matter. Indeed there is very little in Dr. Lipson's statement that is material to the question before me. Taken at its highest for Riverfront, the statement merely repeats what is undisputed in the evidence, namely, that Dr. Lipson did not authorize the deletion, but that he did not recall objecting to it either. His belief that Riverfront would not have made the deletion without believing that they had his consent to do so, is of no assistance to me whatsoever. In the first place it is not evidence but is merely an expression of Dr. Lipson's belief. In any event, the crucial issue is not whether Linda affixed Dr. Lipson's signature to the report knowing that she knew was not authorized do so but rather whether Riverfront took reasonable steps to ensure that the report that was sent out under Dr. Lipson's signature was in fact authorized by him. I must regretfully conclude that they did not.

[88] It is stating the obvious that an expert's report delivered for the purpose of compliance with the *Rules of Civil Procedure* and the *Evidence Act* is an extremely important document. Anyone involved in the preparation of such reports must know that courts place a very strong reliance on the contents of these reports and that the proper administration of justice demands that these reports accurately reflect the opinion of the expert who has written them. The requirement in the *Rules of Civil Procedure* and the *Evidence Act* that the expert sign the report is intended to provide assurance that the statements in the report are those of the expert.

[89] While I am not prepared to categorically reject the use of a signature stamp or other electronic means to replicate a signature on a report, it is a practice that should be restricted to circumstances where

(a) There are good and sufficient reasons why the expert is not able to manually sign the report.

(b) In such a case the report should clearly disclose the means by which the signature was replicated and the name and position of the person affixing the signature and that it was done with the express authority of the expert.

(c) The expert has agreed in writing in advance that he /she will be bound by a replicated signature affixed to a report by the person he/ she has authorized to do so, and he/ she bears a personal responsibility to the Court for any mis-statement or omission in the report.

(d) The expert should be promptly provided with a copy of the report.

[90] Frankly, I was surprised to hear that before this problem arose, it was not the Riverfront's practice to do so although as noted, Riverfront has taken steps to correct this practice.

[91] In this case there was no valid reason why Riverfront could not have sent the final version of the report to Dr. Lipson by courier or other means for his signature. Had this been done the problem that developed in this case would probably never have arisen. Upon reading the report Dr. Lipson would have likely noticed the deletion. He could then have notified Linda that he insisted that the highlighted

portion remain, in which case no problem would likely have arisen. The other possibility is that he might have signed the report without objecting to the deletion. In that event the discrepancies between the various versions of his report might have gone undiscovered unless counsel for the plaintiff in cross examination had asked him, as often done, whether he had written any draft reports. I will assume that Dr. Lipson under those circumstances would have acknowledged that he had done so or if he had not remembered whether he did or not, Riverfront's file could have been produced which would have revealed the various versions of the report. This would have lead to the next question that arises.

Was it was proper for Riverfront to have suggested to Dr. Lipson that highlighted portion be deleted?

[92] Dr. Levy testified that the quality control function of Riverfront addresses solely the issue of grammar, typing and ensuring that the reports are clear and concise and that the questions posed by the client have been answered. To Dr. Levy's knowledge Riverfront would never suggest substantive changes. Dr. Levy's concern about the highlighted portion was that it was essentially a repetition of what Dr. Lipson had said in his 2003 report and that it didn't add or take anything away from the opinion expressed by Dr. Lipson in his previous reports. Mr. Pepper submits that the deletion of the highlighted portion did not alter Dr. Lipson's conclusion in the March 2005 addendum nor did it alter or contradict his previously expressed opinions in the 2003 and 2004 reports, and that the proposed deletion did not favour Mr. Greenside's client.

Did the highlighted portion add or detract anything from the previous reports and was its deletion favourable to the defendant's position?

[93] In the his report of April 4, 2003 Dr. Lipson makes the following comment about Dr. Georgeovich:

> Dr. Georgeovich, the neurologist whom she was referred to suggested that trauma was the cause of the protruding disc at the L4-5 level, causing cauda equina compression.
>
> Dr. Georgeovich stated in his report of May 4, 1998 that Ms MacDonald reported being free of any significant back pain prior to the slip and fall although she had reported mild intermittent back pain infrequently over the years but said that she had never experienced back pain of this magnitude and severity previously.

[94] Later in the report, Dr. Lipson summarizes his impression as follows:

> In summary, Ms MacDonald had degenerative disc disease, probably with a preexisting central prolapse. The fall increased the amount of bulging and cauda equina syndrome occurred that was decompressed. She sustained nerve damage and was given myelogram dye that she had an allergic reaction to. I think the combination of the two have caused residual pain.

[95] In his Addendum of June 30, 2004 he acknowledges receipt of a number of reports of the plaintiff's doctors and then writes,

After review of this further documentation, the fact is there were two levels of disc problems when the myelogram was done and the relative lack of severe pain at the time of the fall suggests to me a preexisting disease process that was aggravated by the fall.

He makes no reference to Dr. Georgeovich's report or opinion.

[96] He also points out that in his experience one does not have an acute herniated disc causing significant neurological deficits without having major pain. He again repeats the opinion that the severity of the reaction to the dye contrast material in the myelogram is relevant to the possibility of her having developed an arachnoiditis and for that to be of the cause of some of the discomfort that she is still experiencing.

[97] The portion of the draft report of March 2005 which was deleted at the suggestion of Linda and which Dr. Levy says that he reviewed, reads as follows:

Dr. Georgeovich makes the diagnosis of cauda equina compression because of Ms MacDonald's fall associated with the onset of back pain and relationship she presents to him between the fall and back pain. I am not sure if Dr. Georgeovich was aware of her May 1996 disc problem. The myelogram showed a large disc that was surgically removed. Dr. Georgeovich's diagnosis was correct. The question that remains unanswered is what role did the fall of February 11, 1997 play in aggravating her preexisting degenerative disc disease with disc herniation. It may be the "straw that broke the camel's back" or it may not be related at all. The course of events from December 1, 1996 to February 20, 1997 including

any work report of the accident, medical notes, work history, medication history are key if that question is to be answered.

[98] I cannot accept Dr. Levy's contention that this portion of Dr. Lipson's report did not add anything to his previous reports. In his first report Dr. Lipson states that Dr. Georgeovich "suggested that the trauma was the cause of the protruding disc at L4-5 level causing cauda equina compression". In the draft report of March 2005 Dr. Lipson suggests that Dr. Georgeovich made this diagnosis because of Ms MacDonald's fall associated with the onset of back pain and the relationship presented to him between the fall and back pain. He then questions if Dr. Georgeovich was aware of the plaintiff's May 1996 disc problem. It is important to remember that the additional information sent to Dr. Lipson in March 2005 included handwritten notes of Dr. Shawna Forbes which he quotes at the outset of his report as referencing "low back pain with 2 days of shooting pains down the legs after being kicked by her husband". Dr. Lipson quite properly questions whether, if Dr. Georgeovich had been aware of that problem that she would have drawn the same conclusion regarding the causal connection between the fall and the cauda equina compression.

[99] Dr. Lipson then goes on to say that Dr. Georgeovich's diagnosis was correct. In the same paragraph Dr. Lipson had described Dr. Georgeovich's diagnosis as "cauda equina compression because of Ms. McDonald's fall associated with the onset of back pain". This is the essence of the plaintiff's case on damages. Arguably that statement was helpful to the plaintiff's position. The defendant on the other hand would argue that the sentence that follows suggests that Dr. Lipson was merely agreeing with the diagnosis of disc herniation causing cauda equina compression but not with Dr. Georgeovich's opinion as the cause of the condition. Dr. Lipson goes on to say that the latter question remains unanswered. Or as he put it "it might be the straw that broke the camel's back or it might not be related at all". The answer to the question according to Dr. Lipson depended upon the course of events from December 1, 1996 to February 20, 1997 including any report of the accident, medical notes, work history, medication history. IfDr. Lipson at some time felt or even gave serious consideration to an opinion that the fall might have been the straw that broke the camel's back this was something that the plaintiff's counsel was entitled to know because it was certainly consistent with the theory of the plaintiff's case on causation. At the very least, the highlighted paragraph represented an expression of the Dr. Lipson reasoning processes with respect to the crucial question of causation.

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Chan v. Erin Mills Town Centre Corporation, 2005 CanLII 43678 (ON S.C.) — 2005-11-25

Dr. Lipson

[47] **Dr. Lipson described himself as a "non-expert expert"** on PPS and was candid to acknowledge the limitations of his expertise in this area. He has treated many polio survivors, but only three patients with PPS and none who had developed PPS following trauma. He acknowledged that Dr. Cashman and Dr. Bruno were more expert in this area. Otherwise, I found Dr. Lipson to be a fair and credible witness in all respects.

[60] In July 1995, Dr. Chan's treating orthopaedic surgeon, Dr. Brian Day, wrote that Dr. Chan had shown only "minimal improvement" and that he has "persistent symptoms that have plateaued". Dr. Lipson testified that he relied on Dr. Day's opinion to conclude that Dr. Chan was able to slowly recover some of his strength and had some increase in function. He thought that the severe loss in strength after this was not diagnostic of atrophy of disuse, but of loss of function gradually over time and was best explained by PPS.

[61] Dr. Lipson based his diagnosis of PPS on Dr. Chan's complaints of extreme fatigue, his clinical observations of severe atrophy of the muscles of the left leg and, importantly to Dr. Lipson, the absence of left ankle dorsiflexion. Dr. Lipson noted that left ankle dorsiflexion was present on Dr. van Rijn's examination in September 1996, but when Dr. Lipson examined Dr. Chan in August 2002, this was completely absent. The major dorsiflexor of the foot is the tibialis anterior muscle, which originates in and around the knee from the lateral condyle of the tibia. The absence of dorsiflexion (the ability to lift the foot up) indicated to Dr. Lipson that some new neurological weakness had occurred, which is one of the

important diagnostic criteria for PPS. This is the principal basis of his diagnosis and of his opinion that PPS emerged after the accident, but independently of it.
[71] Dr. Lipson rejected the link between trauma and PPS in Dr. Chan's case because he thought that if there had been a disease process going on between 1993 and 1995, this would have interfered with the healing that did take place. But what healing did take place? By July 1995, two years post-accident, he had shown only minimal improvement and had persistent symptoms that had plateaued. This means he was neither getting better, nor worse. By September 1996, Dr. van Rijn noted that his function had decreased. According to Dr. Cashman, whose opinion I accept, any improvement in function between 1993 and 1995 was due to the rehabilitation for his patellar injury and not due to any delay in the onset of PPS symptoms. The clinical records of Dr. House, Dr. van Rijn, Dr. Day and Mr. Oldham are consistent with this. None of the improvement was lasting. After Dr. Chan discontinued physiotherapy in the summer of 1995, his decline is even more evident.
[72] **Post Polio Syndrome cannot be explained on the basis of new neurological weakness in the left ankle as Dr. Lipson thought**. It cannot be explained on the basis that Dr. Chan would have developed PPS regardless due to a lifetime of overuse. He had no indicators of PPS before the accident. Not all polio survivors develop PPS and apart from having had polio as a young child, Dr. Chan had none of the known risk factors.
[77] **Although Dr. Lipson thought that PPS developed independently of the fracture for reasons I have already explained, he agreed that the fracture was a contributing factor and aggravated the disease.** Thus, even if the injury and its consequences did not cause PPS, this evidence establishes that the fracture and its resulting impact on Dr. Chan's ability to function as before is a material contributing factor to his overall impairment.
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Compierchio Jones v. Guido Mazolla, 2004 CanLII 29151 (ON S.C.) — 2004-01-08
[29] **Dr. Lipson, a rheumatologist**, saw Ms. Jones more recently, in September 2003 at the request of the defendant's lawyers. He indicated that Ms. Jones' major complaints were chest pain, back pain with radiation to the shoulders, chest pain, headaches that were severe and long lasting, and an inability to focus and concentrate. **The physical examination of Ms. Jones showed nothing unusual.** Dr. Lipson observed Ms. Jones and did not feel that she looked encumbered. He was unable to see any visible evidence of discomfort and did not see her protecting her neck or back when she moved. **In his opinion, she did not have a specific physical impairment and was able to function and lead a normal life.**
[36] On reviewing the evidence, I am satisfied that Ms. Jones continues to suffer neck and back pain, headaches and sleeplessness arising from her accident. **Although Dr. Paitich and Dr. Lipson were of the view that she does not suffer a disability, Ms. Jones' evidence and that of the other witnesses, both medical and non-medical, point to significant problems that have been ongoing since the accident. The absence of objective physical indicia of her pain is not unusual in injuries of this type.** Dr. Paitich saw Ms. Jones just six months after the accident. Although he was of the opinion that Ms. Jones did not have a disability, he also expressed the view that Ms. Jones was a genuine person, with no inconsistencies in what she said.
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Decision No. 2236/06, 2006 ONWSIAT
Decision No. 2682/07, 2007 ONWSIAT
Decision No. 2626/07, 2007 ONWSIAT
Decision No. 406/06, 2006 ONWSIAT
Decision No. 576/07, 2007 ONWSIAT
Decision no. 462/06, 2006 ONWSIAT
Decision No. 1299/06, 2007 ONWSIAT
Decision No. 1076/05, 2006 ONWSIAT
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Cortez and Wawanesa
Dr. F. **Lipson** is a specialist in Internal Medicine and Physical Medicine and Rehabilitation who **conducted a paper medical review in 2007**. His June 18, 2007 report states that the first MRI was

interpreted as showing a disc herniation as the cause of the C7 nerve root compression. The second MRI, however, had a very different finding, showing degenerative, not traumatic, major narrowing of the C6-7 neuroforamina without a disc herniation. **Dr.Lipson states that if the latter interpretation was correct, then there was no relationship between the accidents of March 14 and September 11, 2002 and the symptoms developed by Mr. Cortez in March 2003.**

Dr. **Lipson** further opined that even if there were a disc herniation, one would have anticipated neurological symptoms at a much earlier stage than six months after the second accident.

Dr. Lipson critiques the report of Dr. S.W.J. Wong, arguing that invalid assumptions were made without directly comparing both MRIs, namely that there was evidence of C7 nerve root injury in the first MRI, that the disc herniation was small which is why it was missed in the second MRI and that the severe narrowing of the neuroformen bilaterally at C6/C7 revealed in the July 23, 2004 MRI made the C7 nerve root more vulnerable to damage and more difficult to heal.

...Dr. **Lipson**, an expert in internal medicine and physical medicine and rehabilitation, commented in his 2007 IME paper review that Mr. Cortez showed no evidence of neurological deficit at this time, and that there was no contraindication, either by the MRI or by physical findings, for him returning to work doing a medium level job.

...(j) **I find that Dr. Lipson was at a distinct disadvantage in not having personally seen the Applicant and in commenting more than two years after the disability period in dispute.**

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B.P. and Primmum Insurance Company

Should certain medical reports be allowed into evidence?

The parties made submissions as to whether five medical reports should be entered into evidence.

Dr. F. **Lipson**, a physiatrist, prepared a report dated January 5, 2005 for Primmum. This report was served on B.P. on November 13, 2006. Primmum submitted that it believed this report had been served earlier [See note 2 below.], and was only served on B.P. the day before the hearing due to inadvertence. Primmum asked that I waive the thirty day service required by Rule 38 of the *Dispute Resolution Practice Code(Fourth Edition, Updated C October 2003)* (the "*Code* ") and exercise my discretion to allow the report into evidence. The Applicant objected to this request.

...***Dr. Lipson***

As noted above, Dr. **Lipson**, a physiatrist, prepared a January 5, 2005 paper review for the Insurer. **Without having seen B.P., Dr. Lipsonopined that the Applicant did not meet the definition of catastrophic impairment** as it was his view that the 32% Dr. Ameis' had recorded for a through the knee amputation would incorporate all standard requisite care, as well as all cosmetic, adaption, personal concerns and all other aspects of an amputation. **Dr. Lipson provides no support for this opinion; in fact, he never refers directly to the *Guides* in his report.**

Dr. Lipson appears to have, at best, only a very superficial understanding of the *Guides* . He advises that since B.P. has only lost one leg, he cannot be considered to have a catastrophic impairment. **Dr. Lipson's failure to properly analyse and rate every potential impairment, his superficial review of B.P.'s injuries, combined with his failure to examine the Applicant, causes me to give no weight to his report.**

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Valancius and Aviva Canada Inc.
Ms. Valancius underwent a physiatry assessment by Dr. F. **Lipson** on March 25, 2004, where Ms. Valancius was reported as saying that she was "doing all her pre-accident functions and activities at this time" and that "her only complaint [was] that she experiences tightness in her neck and her lower back." **Ms. Valancius testified that she did not know and could not remember if this was true.** Dr. **Lipson** reported and testified that Ms. Valancius had no evidence of carpal tunnel syndrome at the time of the examination. Dr. **Lipson** reported that Ms. Valancius took "the occasional Tylenol" and testified that she controlled any pain with "a minor analgesic." **Dr. Lipson concluded that Ms. Valancius was not substantially disabled from her pre-accident caregiving and housekeeping duties**. **At the hearing, Dr. Lipson acknowledged that he did not specifically know what Ms. Valancius' pre-accident caregiving and housekeeping tasks were and that he had not observed Ms. Valancius performing any of her actual household duties during the examination.**
....
....
Hailu and Aviva Canada
Aviva's and Mrs. Hailu's psychological evaluations during the fall of 2003 support her continued partial disability. Both Dr. Peter Waxer, her psychologist, and Dr. Kilian Walsh, Aviva's psychiatric examiner, generally agreed with the diagnosis of depression, anxiety and driving phobia. Dr. Walsh reported in December 2003 that Mrs. Hailu said her spouse performed the heavier household chores. **His report is followed by that of Dr. Frank Lipson, a physiatrist retained by Aviva, who stated in January 2004 that Mrs. Hailu said she was back doing most of the housework.**
....These general comments or opinions have little weight in comparison with Mrs. Hailu's **admissions to Drs. Walsh and Lipson** that she was**performing all but the heavier tasks beginning in December 2003.** I find that her contemporaneous admissions about her abilities that are recorded from meetings with health care practitioners are more reliable because they show steady improvement of her function that is fairly consistent with her own experts' findings. **Mrs. Hailu did not present any reliable evidence to contradict these statements, and I rely on them.**
....
....
Antony and RBC General - Prelim. 2
By letter dated April 25, 2003, RBC wrote Ms. Antony advising her that pursuant to section 42 of the *Schedule* they had arranged for her to attend the following insurer medical examinations ("IMEs") for the purpose of determining her IRB eligibility:
S a Functional Abilities Evaluation for April 28, 2003;
S Dr. Pendergast, a psychologist, for April 29, 2003; and,
S Dr. F. **Lipson**, a physiatrist, for April 30, 2003.

Result:

1. RBC's adjournment request is denied. The arbitration hearing shall proceed, as scheduled, on May 26, 27, 28 and 29, 2003.
....
Pinhasov, D. and Guarantee

On November 29, 1996, Mr. Pinhasov was **examined by Dr. F. Lipson, a physiatrist, at Guarantee's request**. Dr. **Lipson** diagnosed soft-tissue injury to his cervical and lumbar spine as a result of the accident; however, **he did not see any reason, from the physical standpoint, why Mr. Pinhasov could not return to his work as a travel agent.**
...**Conclusion about Disability:**

I have found Mr. Pinhasov's pre-accident occupation as a travel agent involves sitting, working at a desk using a computer, and speaking on the telephone for prolonged periods. Before the accident, he worked up to 60 hours per week. After the accident, the evidence is that he is only able to work approximately 25 hours per week.

Many health care practitioners have commented on Mr. Pinhasov's functional ability; however, I find their opinions depended largely on whether they were prepared to believe Mr. Pinhasov's complaints of pain and disability, in the light of the physiological findings that are essentially soft tissue in nature, and their view about the nature of such injuries.

While the consensus of medical opinion is that most soft-tissue injuries heal within six months of the onset of trauma causing them, it is conceded that at least 10 percent of such patients will go on to develop symptoms of chronic pain syndrome that last a long time. The reasons for this are not known....
....

Rocca and AXA - Appeal
The arbitrator concluded on a balance of probabilities that the accident played a significant role in the development of the pathology. She thought it likely that the disc was not herniated in the accident itself, but that the impact weakened the disc making it more vulnerable to eventual herniation. In drawing this conclusion, she **preferred the evidence** of two orthopaedic surgeons, Dr. Roscoe and Dr. Ogilvie-Harris **over that of Dr. Lipson, the specialist retained by AXA.**
...Dr. Roscoe's opinion as to the contribution of the accident to the herniation was shared by Dr. Ogilvie-Harris who did not testify but whose reports were filed in evidence. Dr. Ogilvie-Harris was aware that Mr. Rocca's job involved a mix of labour and lighter duties and of his prior history of back pain. Report dated May 11, 1998, marked Arbitration Exhibit 1, Tab 13. He confirmed Dr. Roscoe's opinion that Mr. Rocca remained disabled from his job. **Although Dr. Lipson, AXA's orthopaedic expert, did not think the herniation was related to the accident, he testified that, given the condition of Mr. Rocca's back, he could "sit, stand and do minimal twisting and bending, but not work a full day as a labourer."** Transcript of testimony of Dr. Frank **Lipson** taken on November 30, 1998, p. 12, Q. 40. **While Dr.Lipson was under a misapprehension as to the physical component of Mr. Rocca's job, his evidence does not suggest that Mr. Rocca was able to do a job that involved a significant proportion of physical work.**
....

Maksimovic and AXA
Dr. Lipson, a physician retained by AXA, came to a similar conclusion in his letter of September 9, 1994. Further, Dr. Moddel, a neurologist, acknowledging her psychological problems, concluded in his August 25, 1994 report that the accident "plays very little part in this

patient's continuing disabilities and her problems are clearly on a psychological basis." **These doctors also came to their conclusions after one interview with Mrs. Maksimovic.**

....

Pinhasov, S, and Guarantee

Orthopaedic specialists who have examined Ms. Pinhasov's left knee have expressed different opinions. **In November 1996, Dr. Lipson, conducting an insurer's examination, found nothing physiologically wrong with her left knee. He felt the pain was delayed in its onset and therefore probably not due to the accident.**

....

Zeppieri and Liberty Mutual

Dr. **Lipson**'s opinion was that the Applicant's neck injury related to the accident was essentially resolved, and that the Applicant was now functioning at his pre-accident level with respect to his neck and low back. He agreed with Drs. Ameis and Langer that the Applicant's main functional problem was his tremor, and that the tremor, carpal tunnel syndrome (which Dr. **Lipson** described as "slight") and dizziness did not result from the accident.

....

Rocca and AXA

Cause of Back Injury

An MRI performed in January 1997 revealed that Mr. Rocca has a small disc herniation at L5-S1, with no impingement on the nerve root and a large herniated disc at L4-L5 on the left side, with impingement on the L5 nerve root. The parties disagree whether these significant physical findings are related to the accident.

In addition, the Applicant argued that the Insurer should be estopped from challenging the cause of Mr. Rocca's back injury on the basis that it paid benefits until November 1997 without raising the issue of causation. However, the existence of the disc herniation did not become apparent until January 1997. In addition, **Dr. Frank Lipson clearly questioned the connection between the accident and the disc herniation in his report of March 3, 1997**. The Insurer is not estopped from questioning the relationship between Mr. Rocca's disc herniation and the accident. ...**The Insurer's expert, Dr. Frank Lipson, testified that disc herniations may occur spontaneously**, **if there is significant pre-existing degenerative disc disease, as there was in this case.** Even relatively minor actions such as **coughing can trigger the herniation**. Mr. Rocca gave a history of onset of pain after coughing, which is similar to the histories given by other patients. Although trauma to the back may cause disc herniation, the symptoms of the herniation would occur relatively soon after the accident (within weeks), unless the patient was bedridden, in which case symptoms would first appear when the patient became more mobile. **Dr. Lipson concluded, based on Mr. Rocca's significant pre-accident degenerative disc disease and the chronology of symptoms, that the herniation occurred in the fall of 1996 and was not related to the accident.**

...Dr. Roscoe, Mr. Rocca's treating orthopaedic surgeon, testified that the MRI results alone would contraindicate heavy physical labour, because the nerve root lying over the disc herniation would likely cause inflammation. Also, **Dr. Lipson, the Insurer's medical expert, testified that Mr. Rocca could not return to paving duties because of the disc herniation, although,**

as discussed above, Dr. Lipsondid not believe the herniation was related to the accident. I am satisfied that Mr. Rocca could not perform the physical aspects of the paving duties described above, in light of the documented disc herniation, without significant, disabling pain. Therefore, I conclude he was physically incapable of returning to the essential duties of his pre-accident employment from August 1997 and ongoing.

....

Gogos and General Accident

Other specialists found that Ms. Gogos was capable of returning to work. **For example, in April 1996, Dr. Frank Lipson, a physiatrist, performed an independent examination of Ms. Gogos for the Insurer and concluded that Ms. Gogos suffered a soft tissue injury to her cervical and lumbar spine in the accident and that despite some continuing discomfort, she was capable of returning to her pre-accident job on a gradual basis over the next four to six weeks.**

...Disability: July 16 to December 25, 1996

Regarding the first period (between the termination of benefits and the beginning of her panic attacks), the bulk of medical and rehabilitation evidence establishes that Ms. Gogos was not substantially disabled from her work as a hairstyling instructor. **Drs. Lipson** and Gitelman, as well as the kinesiologist, Ms. Bowker, all **found that Ms. Gogos was capable of returning to work**. Only Dr. Brown reported that Ms. Gogos was unable to work, and this was only for the seven weeks in which he actually treated her. While Dr. Brown stated that the prognosis for Ms. Gogos' **full** recovery was poor, he also indicated that a further assessment would be required in order to determine her status following the period of treatment.

Ms. Gogos rejected suggestions in the reports of Drs. Lipson and Gitelman and Ms. Bowker **that her physical condition had improved since the accident. However, Dr. Lipson had had the advantage of seeing Ms. Gogos twice between January and April 1996 and clearly documented an improvement in her condition. Dr. Lipson, in particular, began with the clear opinion that she was incapable of returning to work in January 1996, but then determined that she was no longer disabled in April 1996**. Further, two functional capacities evaluations were performed in 1996 and the only area in which Ms. Gogos' condition significantly worsened was in overhead reaching, something not identified by Ms. Gogos as a frequent or essential requirement of her job as a hairstyling instructor. Other than this, her overall capacity remained the same or improved.

....

Worthman and AXA Insurance (Canada)

*Dr. Frank **Lipson***

Dr. **Lipson**, **specialist in internal medicine, physiatry and rheumatology**, conducted an Insurer's Medical Examination of Mrs. Worthman on March 14, 1997. **Dr. Lipson wrote that Mrs. Worthman walked to the examining room with a minor limp while barely using her cane as an assistive device and that she was able to sit 35 to 40 minutes without apparent discomfort**. He found no evidence of rheumatoid arthritis or osteoarthritis other than psoriatic changes in her nails. He saw little evidence of muscle spasm in her lower back when she walked and none when he examined it. Mrs. Worthman had unusual feelings and non-specific sensory

motor changes that had no organicity. The range of motion of her cervical spine and arms was normal. **Elevation of her left leg caused discomfort: Dr. Lipson testified that when he moved her leg she started to cry and the examination ended.**

Dr. Lipson testified that he would have expected Mrs. Worthman's symptoms to have peaked within the first 8 to 10 days of the accident and to have resolved within three months. He also testified that he had no doubt in his mind that any deterioration after February 10, 1995, was **completely coincidental.** Thereafter, she would have returned to her pre-existing pattern of periodic exacerbations of her underlying symptomatology with little or no organic basis for her complaints. **Dr. Lipson felt that nothing related Mrs. Worthman's continuing problems to the accident**. If she was able to work for one or two months after the accident then there was no accident-related reason for her to stop. **Patients do not continue to deteriorate from minor injuries, as such injuries are** not progressive.

Dr. Lipson did not include in his report certain items that were in Mrs. Worthman's favour. He testified that although he did not mention it in the report he was aware that both Dr. Ein and Dr. Chaiton found significantly increased muscle spasm. **Similarly, Dr. Lipson did not write in his report that Mrs. Worthman did not want to bend and that she was restricted in forward and lateral flexion and in rotation; he testified that this omission was a significant oversight in his report**. (He testified that he was not aware when he wrote the report that Dr. Ein and Dr. Chaiton had also observed increased restriction of motion.) **He did not mention that Mrs. Worthman's pre-existing conditions rendered her more vulnerable.**

In his conclusion, Dr. **Lipson** wrote that Mrs. Worthman is in the same state that she was before the accident. However, he testified that his impression of her pre-accident work was as set out at the bottom of page 3 of his report, where he wrote that Mrs. Worthman "is capable of doing the financial collections at this stage and some of the minor work."

In considering Dr. Lipson's report, I find that the omissions are significant. Furthermore, his conclusion is based on a limited view of Mrs. Worthman's pre-accident work that is closer to what Mrs. Worthman currently does. I find that the essential tasks she continued to perform before the accident constituted more than the minor work Dr. **Lipson** refers to. Finally, Dr. Chaiton is an equally qualified rheumatologist who has followed Mrs. Worthman for years, and he did not present himself as her advocate at the hearing. Accordingly, I prefer his findings over those of Dr. **Lipson**.

....

Da Silva and Kingsway

I do, however, allow the expenses incurred in the preparation of Dr. **Lipson** and Dr. Rosenbluth for testimony at the aborted arbitration hearing in July, being $428 and $450, respectively, for a total of $878. These expenses are not related to Kingsway's adjustment of the file but to its preparation for arbitration.

....

Martin and Liberty Mutual

On March 21, 1996, at the insurer's request, **Ms. Martin was also examined by Dr. Frank Lipson, a specialist in internal medicine and rehabilitation medicine, who taught for**

thirteen years in the field of rheumatology at the University of Toronto. Dr. Lipson thought Ms. Martin had "pains compatible with fibromyalgia, but there is no organic evidence to prove a disability being present." He concluded that "Organically, and from a physical standpoint, there is nothing that would prevent Mrs. Martin from returning to her job as a transcriber at this time." **He also wrote that "She appears to be extremely emotional..." and "It appears that most of the disabilities at this time are psychological in nature." There is no indication in Dr. Lipson's report that he read any reports with respect to Ms. Martin or had any history other than that what she told him at the examination.**
...**I find these three medical and psychological reports, the FAE, and the rehabilitation consultants' reports from the same time period, provide insufficient support for Liberty Mutual's decision to terminate Ms. Martin's income replacement benefits**. In order to properly terminate benefits, the insurer would have to conclude on the basis of all the information before it, that Ms. Martin was substantially able to perform the essential tasks of her employment as a medical transcriptionist at May 21, 1996. That is the test to which all the expert assessors and claims examiners should have been directing their minds.

Arbitrators often find the expert reports presented in a hearing do not directly address the issues that are in dispute. When a party commissions a report from a health care expert, it must realize that these professionals frequently have no understanding of the eligibility test under consideration. The party has two choices— (1) it can either "educate" the expert in advance of the examination by providing information about the precise eligibility test, and subsidiary issues, such as "causation," or (2) it can let the expert perform an evaluation and hope to glean enough evidence from the subsequent report to peg the insured person correctly on the proper eligibility scale.

In Ms. Martin's case, Dr. Garber's and **Dr. Lipson's reports demonstrate no understanding on their part about the eligibility tests for weekly income benefits**. Also, Dr. Garber did not know that he had to provide a copy of his report to Ms. Martin, under the terms of the*Schedule*. see sections 64(7) and 65(3) of the *1994 Schedule.* Further, and most critically, once the reports were received, Liberty Mutual failed to distil from them reasonable conclusions about Ms. Martin's level of disability, according to the *Schedule*'s provisions.
....Similarly, **Dr. Lipson's report stresses no "organic pathology," although he admits that Ms. Martin complains of pains "compatible with fibromyalgia" and says that she appears to be "extremely emotional," to the point of hyperventilating during his interview**. He concludes Ms. Martin has "no specific physical disability related to her musculoskeletal system." Dr. **Lipson** emphasizes that "organically, and from a physical standpoint, there is nothing that would prevent Mrs. Martin from returning to her job as a transcriber at this time." However, he concludes: "It appears that most of the disabilities at this time are psychological in nature." In addition, Dr. **Lipson** makes no reference to any testing performed by others that he has reviewed and **his report is replete with vague, yet qualified, statements about Ms. Martin's range of motion, such as "neck mobility was fairly free," "essentially normal," and "essentially negative."** In my opinion, an insurer receiving such a report could be sure of only one thing— that in his examination, Dr. Lipson had detected no clear, organic basis for Ms. Martin's subjective complaints, while at the same time recognizing that she reported pain compatible with a diagnosis of fibromyalgia and appeared to him to be suffering from a psychological disability.

....
....
Dugas and Wellington
Dr. Nicol referred the Applicant to two different specialists, Dr. J.M. Clark, a pain control consultant, and **Dr. Frank Lipson, a rheumatologist**, in connection with his diagnosis of fibromyalgia.
...In June 1993, the Applicant saw Dr. **Lipson**, who reported:

Physical examination reveals an almost normal range of motion of the cervical spine. Right shoulder movement is normal and there is very little evidence of neurological damage involving the upper extremity. Her hip mobility is fairly good and the knees and ankles are essentially normal.

...

She does have a problem with her neck but the limiting factor is a fibromyalgia...