Ms. M.G. and Economical **[+]** Arbitration, 2012-11-23, Reg 403/96.
Final Decision, appeal pending

As can be seen from the chart above, the only assessment of physical impairments that falls short in this case is that of the Custom Rehab team. I did not find their assessment and rating to be as reasonable or as persuasive as those of Dr. Garner or the Drs. Becker for a number of reasons. The first reason is that I do not find the Custom Rehab team had a realistic or accurate grasp of Ms. M.G.'s actual functional abilities for her activities of daily living. As discussed above, I did not find Ms. Krushed's extrapolations from her observations of Ms. M.G.'s abilities to complete daily living tasks and engage in social activities to be realistic or reasonable. Consequently, to the extent Dr. Mathoo and Dr. Dost relied on Ms. Krushed's faulty statements and conclusions, their reports are similarly inadequate.

The second reason I prefer the evidence of Kaplan and Kaplan and Omega over that of Custom Rehab, is that I find the Custom Rehab team's approach resulted in their under-rating of Ms. M.G.'s physical impairments. There appear to be a number of reasons for this. One is that the team members did not consult with each other, or even exchange their reports; each simply conducted his or her own assessment and prepared a report, and the team leader, Dr. Mathoo, included their findings in his Executive Summary. I find this lack of communication impeded the exercise of clinical judgment or interpretive analysis by team members - essential components of assessing the impact of impairments on daily functioning.

The effect of this compartmentalized approach can be seen in how the Custom Rehab team members accounted, or rather, failed to account, for the effects of pain on daily functioning...

Similar difficulties arose regarding Custom Rehab's view that Ms. M.G.'s complaints of incontinence were not rateable. As noted, I find the evidence indicates she complained consistently after the accident of this condition, which did not exist before, and, on a balance of probabilities, these symptoms were caused by the accident. Dr. Mathoo and Dr. Dost acknowledged Ms. M.G.'s complaints but dismissed them....

Mallatt and Personoal **[+]** Arbitration, 2011-12-16, Reg 403/96.
Preliminary Issue

On December 3, 2007, Ms. Mallat applied to Personal for a determination of catastrophic impairment. Personal denied her application for a catastrophic designation on the basis of the reports of their expert, Dr. Dost, on April 22, 2008 and June 10, 2008, wherein he opined that the Glasgow Coma Scale ("GCS") scores were recorded after sedation and intubation and therefore were invalid. Ms. Mallat disagreed with this finding and applied for mediation.

5. Personal declined the request for catastrophic impairment status and arranged for a paper review to take place with MDAC. The prime reviewer was Dr. Rehan Dost, neurologist.

For these reasons, I give little, if any, weight to the opinion of Personal's expert, Dr. Dost that intubation and medications administered for the purposes of surgery invalidated Ms. Mallat's GCS score of 8. I find that Dr. Dost ignored very relevant medical information that he should have taken into consideration when giving his opinion.

I find that based on the hospital records, which Dr. Dost should have reviewed, his assumption that Ms. Mallat was intubated at the time the GCS was administered was clearly wrong.

Dr. Dost missed the very relevant fact that when the surgery was finished at 12:33 a.m., the hospital records show that Ms. Mallat, who was only intubated for the surgery, was no longer intubated post-surgery. Nevertheless, in his very brief report he states that the "sub score" of 8 (taken 3½ hours post-surgery) was invalid because Ms. Mallat was intubated at the time the GCS was administered.

Dr. Dost in his report stated: "The GSC [sic] scores of 8 were recorded post-surgery ***after*** the client had been given large doses of medications, which would significantly alter the GCS score, and indeed induce anaesthesia for the necessary surgical procedures. Consequently, the depression in the GCS score is not due to traumatic brain impairment, rather due to the effects of medication. [Emphasis added]

Again, I find that this is an inaccurate reflection of the medical evidence.

The hospital records show that from the time of her accident until her surgery, Ms. Mallat had been administered the powerful drugs, Fentanyl nine times and Propofol three times. Prior to surgery, for emergency procedures, the last time she was administered Propofol was at 5:20 p.m., and the last time she was given Fentanyl was at 8:30 p.m. At 8:50 p.m. she was taken to the operating room, intubated and administered a general anaesthetic.

Dr. Dost, in giving his expert opinion on the effects of medication on the GCS tests, should have been aware that the drug Fentanyl when administered intravenously leaves the system within a half hour to one hour; and when administered inter-muscular between one and two hours. The drug Propofol leaves the system at a faster rate. The evidence shows that "recovery from anaesthesia or sedation is rapid. …the majority of patients are generally awake, responsive to verbal commands and oriented in approximately 7 to 8 min. [sic] [See note 7 below]"

Based on these facts, the medications opined by Dr. Dost, to "induce anaesthesia for the necessary surgical procedures" would clearly have left Ms. Mallat's system by the time she was given the GCS test three and a half hours post-surgery. Moreover, there is no medical evidence, whatsoever, that post-surgery Ms. Mallat was "administered large doses of medications" that would "induce anaesthesia."

Accordingly, for these reasons, I give little weight to Dr. Dost's opinion that a lower GCS score of 8 was a result of the effect of intubation and medications administered for the purposes of surgery.

Dost, Rehan, Neurologist

Decision No. 824/09I, 2011 ONWSIAT 2174 (CanLII) – 2011-09-16

Ontario Workplace Safety and Insurance Appeals Tribunal — Ontario

[25] The employer retained the services of Riverfront Medical Services to prepare a multi-disciplinary report on causation. The multi-discliplinary panel was composed of the following medical professionals:

Dr. Rehan Dost, Neurologist

Dr. Dost notes that no physical examination findings have been identified by every neurologist, neuro-ophthalmologist, ENT evaluation and physiatrist with the exception of Dr. David J. Spence who found neurological findings which did not fit a known pattern of neurological injury. MRI both prior to and subsequent to the date of loss demonstrated small white matter lesions, which do not correspond to the vertebrobasilar system and are a normal finding in individuals of the employee's age group. An MRA did demonstrate a slightly narrowed vertebral artery which is an entirely nonspecific finding and cannot be used to make the diagnosis of dissection. Dr. Dost notes that the temporal lag between the onset of vertiginous symptoms and the head impact is incompatible with traumatic injury to the central nervous system or peripheral vestibular system.

Dr. Dost puts forth that the employee sustained a "mild" closed head injury and that her current cognitive complaints are not attributable to the effects of closed head injury for the reasons detailed in his report.

Dr. Dost concludes that from a neurological perspective there is no cognitive or physical neurological impairment and hence no disability.

[45] Having so noted, the Panel also observes that neither Dr. Levy nor Dr. Dost provide an explanation as to why the worker's symptoms are much greater since the accident compared with the period prior to the accident. Dr. Steinberg addresses this point, ascribing the worsening of symptoms to coincidence.

[46] The Panel notes that even if the view of the members of the Riverfront Medical Services multidisciplinary panel is correct, that is to say that the worker had an undiagnosed VBI condition pre-accident, that fact would not disentitle the worker. In the Panel's view, if it were to accept that opinion, it would still be more likely than not that the worker's pre-existing VBI condition was significantly aggravated by the workplace accident either directly on the date of the accident, or indirectly by way of the chiropractic treatment.

[47] Based on the above, it is the Panel's conclusion that it is more likely than not that the workplace accident of February 14, 2002 caused the worker's VBI condition. The worker is entitled to benefits for her VBI condition. This entitlement replaces the

entitlement granted for the condition which had been misdiagnosed as a vestibular disorder.

M.R. and Gore Mutual [+] Arbitration, 2010-12-23, Reg 403/96.
Final Decision

After the "CAT" rebuttal assessment of Kaplan and Kaplan was prepared, a copy was provided to Riverfront for comment. There is no evidence before me that Riverfront ever requested or received any additional documentation concerning the Applicant. Dr. Dost and Dr. Shapiro each prepared a response in support of their original conclusions.

Dr. Dost disagrees with the conclusions of Kaplan and Kaplan concerning the extent of the Applicant's functional limitations due to mental and behavioural impairments. Dr. Dost, in his response dated June 4, 2009, focuses on the Applicant's ability to drive. Dr. Dost suggests that the ability to safely operate a motor vehicle, the "most demanding of the ADL":

> … implies a level of attention, processing speed, memory, forethought, judgement, visuospatial organization, eye hand coordination and perceptual integration which would preclude a rating of Marked under ADL and Concentration Persistence and Pace.

Dr. Dost states that a Marked (Class 4) rating implies that the impairment significantly impedes function, meaning all function. Thus, if a complex function (like driving) is spared, the implication is that the level of impairment cannot exceed Mild (Class 2), at least for: (1) activities of daily living; and (2) concentration, persistence and pace.

Dr. Dost also states that if any assessor or treating practitioner honestly believed that the Applicant's mental and behavioural impairments could affect his ability to safely operate a vehicle, this must be reported to the Registrar of Motor Vehicles. Subsequently, the Applicant's licence was, in fact, suspended pending the Ministry being provided with further information concerning the Applicant's psychological and cognitive condition and concerning his medications.

With respect to Social Functioning, Dr. Dost indicates that since the Applicant was able to establish some rapport with members of Riverfront's assessment team, the degree of impairment could not be Marked.

With respect to Adaptation, again Dr. Dost concludes that the ability to drive together with the ability to tolerate several medicolegal evaluations indicates a level of function which would preclude a Marked (Class 4) impairment. Dr. Dost does not explain in his report what he means when he says that the Applicant "tolerated" the evaluations and, of course, since he never bothered to seek further medical information, he would have no idea as to what effect (if any) the "CAT" assessments might have had on the Applicant once the assessments were completed.

Dr. Dost did not testify at this hearing. There is no indication that the other members of the assessment team at Riverfront concur in his opinion. I find Dr. Dost's reliance upon the Applicant's continued ability to drive in placing him in the "mild" category for three of the four areas of function to be an unreasonable method of assessing the degree of functional limitation

experienced by the Applicant. According to Dr. Levitt, whose testimony I accept, driving is an "overlearned" activity — an experienced driver does not typically need to devote much conscious thought to this activity — and this is probably even more accurate for a professional driver like the Applicant. The idea that being able to drive would automatically mean that a person would be placed in the mild impairment category for three of four functional areas seems far too simplistic an approach and not one that is mandated by the *Guides*. According to the *Guides*, a person with *moderate* impairment levels can still have some useful functioning in all four areas of function. A person with *marked* impairment levels will find useful functioning significantly impeded (but not precluded). Therefore, even at the*marked* level of impairment, one can expect some useful function in multiple areas of functioning.

.....While it is not entirely the fault of Dr. Shapiro (since the Insurer failed to provide him with relevant documents that were clearly in its possession and since the Applicant in his interview tended to downplay his functional limitations), given all of the foregoing (including the admissions of Dr. Shapiro on cross-examination), I find that I cannot give the opinion of Dr. Shapiro (as expressed in his written reports) much weight. Since Dr. Shapiro was the only expert in the original report to deal with clause 2(1.2)(g) of the *Schedule*, this means that I am giving that report little weight in this case. I have also rejected the attempts by Dr.Dost to bolster Dr. Shapiro's original opinion (for reasons previously given).

Augello and Economical Mutual **[+]** Arbitration, 2008-12-18, Reg 403/96.
Final Decision, appeal rendered

One of Dr. Brigham's claims to fame is that he participated in the development of the original guidelines, and claims to have a special insight into what was intended by the committee which draughted the original guidelines. Dr. Ameis and Dr. Brigham have posited that the intention or original meaning of the provision was that no numeric rating could be given to psychological disorders, with the result that such disorders could not directly be added to the numerical physical rating to push the whole person impairment over the necessary threshold for catastrophic impairment.

It is clear from the Catastrophic report of the Custom Rehab team, headed by Dr. Rehan Dost, neurologist, that the Insurer's experts were firmly in the Brigham/Ameis camp, finding a 20% whole person impairment, when, as they acknowledged in their own report, the amount under a *Desbiens* approach would have been 55%.

Indeed, Economical has acknowledged that should the *Desbiens* approach be found to be appropriate, Ms. Augello would meet the criteria for catastrophic impairment.