

Dr. William Gnam, Psychiatrist

[P.B. and State Farm](#) [+] Appeal, 2014-07-30, FSCO 4240

5. Dr. Gnam's method

Arbitrator Feldman stated that one of the experts testifying before him, Dr. W. Gnam, a psychiatrist, in the absence of any method being specified in the 4th Edition of the *Guides*, devised his own scale to convert GAF scores to WPI ratings, as follows:

GAF Score	Description of Impairment	WPI Rating
71 - 80	Minimal	0 - 5%
61 - 70	Mild	10 - 20%
51 - 60	Moderate	21 - 37%
41 - 50	Serious	38 - 54%
≤ 40	Extreme (Profound)	>55%

The obvious criticism of this approach is that paragraph 2(1.2)(f) of the 1996 *Schedule* requires that the impairments or combination, *in accordance with the 4th Edition*, result in 55% or more WPI.

Decision No. 2157/09, 2014 ONWSIAT 938 (CanLII), <<http://canlii.ca/t/g87v8>> 2014-04-29

(a) Dr. Gnam's evidence

[48] In his affidavit, Dr. Gnam referred to his book chapter, in which he concluded that credible scientific evidence suggests that disabling mental conditions may arise from workplace factors, but **the practical uncertainties involved in clinical adjudication of individual claims, including the risk of erroneously concluding that work-related factors have contributed to the condition, imply that restrictions on the compensability of stress claims are necessary.** Dr. Gnam provided background to clinical evaluation, and noted that the categorization of mental stress claims used by workers' compensation boards only loosely corresponds to terminology used by most psychologists and psychiatrists. The most commonly used classification system for diagnosis is

the Diagnostic and Statistical Manual of Mental Disorders, fourth edition (DSM-IV), published by the American Psychiatric Association (1994).[19]

[49] In his affidavit, Dr. Gnam reviewed the scientific literature released since the publication of his book chapter in 2001. Dr. Gnam reported that the robust scientific evidence published during that period “suggests that the contribution of workplace factors to the genesis of major depression is minor.” Dr. Gnam relied primarily upon two long-term studies of twins in support of this conclusion: “Kendler 2002”[20] and “Kendler 2006”[21] (referred to together as the “Kendler twin studies”). Dr. Gnam reported that these studies have demonstrated that the maximum causal proportion of major depression attributable to adverse work exposures is low, and that the majority of causal weight is attributable to numerous other factors, such as genetic risk, past history of depression, lifetime trauma, marital problems in the preceding year, or exposure to numerous other stressful life events (apart from adverse work exposures) in the preceding year. Dr. Gnam notes that these scientific results are representative of the population of adult males and females, but they do not facilitate or allow the identification of relevant causal factors for any individual.

[50] In Dr. Gnam’s opinion, the risk of over-valuing work-related causal factors is heightened by the fact that work factors may be more readily reported by the patient to the clinician, whereas more important genetic and other factors, which often are unknown or not reported, may not be directly discerned by the evaluating clinician. In Dr. Gnam’s view, there are two limitations when clinicians are asked to opine upon causation for chronic stress. The first is that there is a lack of standardization of terms, such as “burnout” or mental stress. The second limitation is that there are no “reproducible and valid clinical methods to adjudicate the relative causal importance of multiple factors that might be relevant for any specific individual who has developed a disabling mental disorder.”[22] Dr. Gnam states that treating mental stress claims in the same manner as physical claims “would place upon the employer-funded insurance plan the costs of some impairments that they could not act in good faith to prevent.”[23]

[51] Dr. Gnam distinguishes chronic mental stress claims from mental disability arising from acute mental stress, reporting that there is robust scientific evidence that exposure to traumatic events can precipitate mental disorders such as Post-Traumatic Stress Disorder.

[52] Dr. Gnam testified that there is no dispute on the existence of a relationship between workplace stress and mental disorder, but with regard to the strength of the relationship. There is a weak association and the studies are flawed in ways that cannot be prevented, particularly with regard to selection

bias. Selection bias is the process whereby workers who are more susceptible to mental disorders either chose or were assigned to jobs with higher strain.[24] In Dr. Gnam's view, selection bias undermines the strength of the results of the studies which show an association between job strain and mental disorders.

[53] Dr. Gnam testified that he did not agree with Dr. Stansfeld's conclusion, based upon Stansfeld and Candy 2006, *supra*, that there was evidence of "robust" relationships for job strain and common mental disorder based upon two studies. In Dr. Gnam's view, one study did not conclude that there was any association and the null hypothesis was not disproved; in the other, the increased risk found was derived from combined data of two studies, a pooled meta-analysis. Dr. Gnam also discussed the literature cited by Dr. Stansfeld and his view that the magnitude of the association was not strong; the strength of the association found was further undermined by wide confidence intervals in the results. In his opinion, the evidence of an association between job strain and mental disorder was not robust.

[54] With regard to the studies that found a strong relationship between workplace bullying and mental disorders,[25] Dr. Gnam testified that the way the exposure was defined could not rule out an acute traumatic event.

[55] Referring to the Kendler twin studies, Dr. Gnam noted they showed that 9% of overall adverse events were work-related. There was a high risk of depression after traumatic events, on the scale of five to ten orders of magnitude; therefore, the association with workplace events was relatively low by comparison.

[56] Dr. Gnam testified that clinicians are not trained to answer questions of causation and this is not how treatment decisions are made. Treatment decisions have nothing to do with causation; causation is rarely important to treatment decisions. Clinicians do not have a sound basis to reach conclusions about causation.

[57] Dr. Gnam discussed the strength of the association between acute traumatic events and the onset of mental disorder at some length. For example, there is a 30-fold risk of mental disorder after an assault. In Dr. Gnam's words, the science is "airtight."

[58] Dr. Gnam's Addendum Report (p. 5) notes that "epidemiological estimates of population attributable risk cannot be used in the adjudication of an individual case." During his testimony, he agreed that this statement would apply to all epidemiology, not just as it relates to mental disorders.

[59] Dr. Gnam's affidavit (paragraph 20) addresses what he identifies as the second limitation in the adjudication of chronic stress claims: "no reproducible and valid clinical methods have been developed to adjudicate the relative causal importance of the multiple causal factors that might be relevant for any specific individual who has developed a disabling mental disorder." In his view, "once the list of candidate factors is identified, there is no accepted or validated method for assigning attribution among the factors, and the typical approach is to assume that all identified factors are significant." Dr. Gnam was asked whether this statement also held true for other, non-mental conditions. In response, Dr. Gnam acknowledged that this was outside his expertise. He did not want to do injustice to other fields by speculating as it was so variable.

[60] Dr. Gnam was questioned about the following passages from his book chapter, *supra*, (at pp. 316-317):

Job strain has also been studied as a risk factor for the development of mental disorders (and the disability induced by mental disorders). Using nationally representative samples of the male workforce in Sweden and the United States (Karasek 1979), and large samples of male and female workers in Germany and Finland (Braun and Hollander 1988; Kauppinen-Toropainen and Hanninen 1981), mental disorders such as depression were reported to occur much more frequently in jobs with high strain. These three studies share some results and design features that suggest a causal relationship between job strain and mental disorder. They all reported a strong association (relative risk [RR] of 1.5 or greater) between job strain and mental disorder and some evidence of gradient (higher reported job strain was associated with higher rates of mental disorder). Moreover, the psychiatric diagnostic instruments used were adequate to define mental disorders using non-professional interviewers. However, these studies also share one critical limitation in establishing causation. None of them adequately controlled for selection bias – the process whereby workers more susceptible to mental disorders either chose or were assigned to jobs with higher strain. Multivariate regression analyses are inadequate controls for bias when selection occurs on the basis of respondent characteristics that were unobserved by the study. In studies involving psychiatric disorders, selection on the basis of unobserved characteristics appears very plausible.

Job strain predicted short-term absence due to mental disorder in the Whitehall II study of English civil servants (Stansfeld et al. 1997; Fletcher 1988). This study also found that lower decision authority, lower work skill discretion, higher work demands and lower levels of social support were all associated with higher levels of mental disorder. Conflicting work demands, and the threats of job loss or position change were also associated with higher levels of mental disorder. The Whitehall II study shares the favourable design features noted in the three studies above. A further desirable feature is longitudinal follow-up, which allows the temporal sequence of job strain and mental disorder to be determined. A plausible temporal sequence is supportive of causal relation (and in the Whitehall II study "exposure" to various job characteristics clearly preceded the occurrence of mental disorder), but the Whitehall II study did not address the problem of selection bias described above.

These studies are mutually consistent and add some scientific credibility to the hypothesis that chronic non-traumatic workplace stress causes mental disorders.

The strength of the evidence is not completely conclusive, mainly because these studies fail to account for selection bias in their analyses.

[61] Specifically, Dr. Gnam was asked about the statement that the studies observed a “strong association” between job strain and mental disorders. Dr. Gnam testified that the studies recorded it as a strong association using relative risk, which is different from an odds ratio.

[62] During his testimony, Dr. Gnam’s attention was drawn to the following statement in his book chapter (p. 318):

In summary, scientific research from several sources strongly supports the view that certain mental aspects of the workplace may lead to medical illness, mental disorder, and other disabling mental conditions. Collectively, the studies cited above provide as strong or stronger evidence of workplace causation than exists for several industrial diseases.

[63] Dr. Gnam testified that there is a consistent relationship and a sufficient number of studies establish causation. The magnitude of the association is how much of the disorder is related to the exposure. Dr. Gnam testified that he still stands by this statement.

[64] Dr. Gnam’s chapter states that the evidence does not necessarily assist in the evaluation of work-related causation for any individual mental disability claim. Dr. Gnam was asked whether it was still possible to make such a determination. Dr. Gnam testified that an increase in risk does not translate to an individual case; it does not prove causation for any individual, which is the complicated part. It also does not rule out a workplace events as a causal factor. The difficulty is that there is no way to rule out genetic and other factors, which are relevant in the development of depression, and cannot be measured. It makes it harder to make definitive statements about causation.

[65] Dr. Gnam estimated that the odds ratio for the association between job strain and mental disorder was in the range of 1.0 to 1.5 or 1.8. In his view, the numbers are too high due to selection bias. Selection bias did not invalidate the association, but weakens the relationship. Dr. Gnam’s attention was drawn to Dr. Stansfeld’s report stating that there was robust evidence of an association between job strain and mental disorder. In Dr. Gnam’s view, “robust” means a lot of evidence. He felt that Dr. Stansfeld’s conclusion (Stansfeld and Candy 2006, *supra*) was optimistic because it was only based upon two studies. In one of the studies, the null hypothesis was not disproved. The odds ratio of 1.82 was based upon the pooled results in the meta-analysis. Lamontagne *et al.* 2008 also used that figure in the Australian study.[\[26\]](#)

[66] During his testimony, Dr. Gnam’s attention was drawn to the studies of the association between workplace bullying and mental disorder,

such as Kivimäki 2003, *supra*. That study described the measures used to identify bullying (p. 779):

Bullying was measured by the following question:

“Workplace bullying refers to a situation where someone is subjected to social isolation or exclusion, his or her work and efforts are devalued, he or she is threatened, derogatory comments are made about him or her in his or her absence, or other negative behavior that is aimed to torment, wear down, or frustrate the victim occur. Have you been subjected to such bullying?”

[67] The Kivimäki 2003 study found an odds ratio of 4.2 (95% CI 2.0 to 8.6) for the association between prolonged bullying and incident depression, after adjustment for sex, age, and income. Dr. Gnam felt that the way the exposure was measured could not rule out acute traumatic exposure; he felt that some of the association was related to acute traumatic exposure. Dr. Gnam characterized bullying as a single or recurrent episode of intimidating behaviour. Dr. Gnam testified that the bullying literature talks about physical bullying as one kind of bullying. Dr. Gnam also felt that selection bias applied to the bullying studies because the individuals who are prone to mental disorders may also be perceived as weak and vulnerable, implying that they are more likely to be bullied.

[68] Dr. Gnam acknowledged that there is a risk of underinclusion in limiting mental stress entitlement to acute traumatic events based upon the epidemiology. There could be individual cases that do not meet the statutory requirement where the workplace is an important cause of a mental disorder. Usually the cases are complicated and there are multiple causative factors. Clinicians may employ psychometric tests or pencil and paper tests for the diagnosis of mental disorders, but there is no objective test relevant to causation.

Ms. M.G. and Economical [+] Arbitration, 2012-11-23 FSCO 3907

Overall, I preferred the evidence of Drs. Levitt and Kaplan over that of Dr. Gnam, despite the latter’s criticism of their methodology and findings, for two main reasons. The first was that I found their evidence was more consistent with the first-hand accounts of family members and treating practitioners who have interacted with Ms. M.G. regularly over time. The second was that I found Drs. Levitt’s and Kaplan’s analyses of the criteria for each level of impairment in the *Guides*, and the application of the criteria to the facts, to be more thorough and accurate than that of Dr. Gnam, and to be more in keeping with the intent of the *Guides*, particularly with regard to the interpretation of “useful” function...

...Secondly, Dr. Gnam failed to consider, compare and differentiate the criteria for moderate, marked and severe impairment before arriving at his conclusion. His statement, that mental impairment that appears to “preclude *some* but not *all* useful functioning” [emphasis added] is consistent with Moderate impairment, is not accurate. If one looks at the three descriptions of Class 3, 4, and 5 (Moderate, Marked and Extreme Impairment), they clearly describe a continuum. In between 3 (“impairment levels are compatible with *some*, but not all, useful functioning,”) and 5 (“impairment levels *preclude* useful functioning”), there is category 4: “impairment levels *significantly* impede useful functioning.” I find there is no evidence that the changes to Ms. M.G.’s ADL’s have been anything less than significant. ...

...Dr. Gnam considered Ms. M.G.’s function in this area to be mildly to moderately impaired, on the basis that: “. . . [she] continues to have meaningful relationships, was observed (during the OT and Psychiatry assessments) to have adaptive and appropriate social interactions with others, but nonetheless has reduced social motivation related to sleep and mood impairment, as well as self-reported embarrassment due to her persistent disabilities.”

I find this assessment underrates Ms. M.G.’s situation and does not begin to encompass the complete shut-down in her social and family life and intimate relationships since her failed attempts to return to work.

T.S. and Allstate - 3 [+] Arbitration, 2011-11-15 FSCO 3369

The unexplained failure of the DAC assessors to consistently assign impairment numbers to all causally related impairments has, at the very least, made determination of this issue much more difficult, as did the absence of a psychologist from the DAC assessors as mandated by the FSCO *CAT Guidelines*.

However, given the fundamental problems with the DAC, and the failure to have a psychologist participate in the DAC's deliberations, merely referring this matter back to the original assessors, would have been unproductive.

Dr. Gnam, the other DAC assessor called to testify, was an attractive witness. It is clear that he has read and considered the *AMA Guides* in depth and that he has clear opinions as to their application.

Even the cleverest expert, however, may have his Achilles heel. In Dr. Gnam's case, it was his willingness to provide a psychiatric assessment without the opportunity to review the testing that would form part of the mandatory psychological assessment. Indeed, in his testimony Dr. Gnam minimized the role of psychologists. It is also troubling that Dr. Gnam failed to contact Ms. Nguyen to discuss her analysis of T.S.'s capabilities when it was obvious from his testimony that Dr. Gnam had some reservations about her conclusions.

In light of his signing the final DAC report (with no psychological component) despite his own comments that further psychological testing was indicated and that he would defer in that domain to a neuro-psychological assessor, Dr. Gnam's conclusions must be carefully considered.

Even so, Dr. Gnam diagnosed a Major Depressive Disorder, single episode, chronic as well as a pain disorder. He also accepted the causation of such disorders as being due to the MVA.

Dr. Gnam, however, did not consider that his diagnosis translated directly into serious impairment. Rather, he found most impairments in the various domains to be moderate, and hence not qualifying for catastrophic status.

Of course, in so doing Dr. Gnam had neither the benefit of a full psychological report or an O.T. assessment that fairly addressed T.S.'s activities of daily living challenges, including those related to employment.

It is again important to emphasize that a psychological Med/Rehab DAC, undertaken by Dr. Gadon about a month prior to the CAT DAC, noted that T.S.'s "psychological impairments are considered to be of moderate-severe intensity."

Dr. Gnam has elaborated that diagnosis does not translate directly into impairment, and that the *AMA Guides* deals with impairment. That may well be the case in many situations. One can be grateful for instance that a diagnosis of AIDS no longer necessarily translates directly into serious impairment, provided that appropriate treatment is received on a timely basis.

Dr. Gnam deprecated the usefulness of Dr. Hoff's and Dr. Manohar's opinions since, in his opinion, they spoke to diagnosis rather than directly to impairment.

In the absence of any method being specified in the 4th edition of the *Guides*, Dr. Gnam devised his own scale to convert GAF scores to whole-person impairment ratings. The conversion scale developed by Dr. Gnam is as follows:

Using this method, he determined that the appropriate whole-person impairment rating for Mr. Jaggernaut based on mental or behavioural impairments was in the range of 24% to 34% (based on a GAF score of 55 and allowing some room for uncertainty), but Dr. Gnam subsequently agreed that the impairment rating could be higher if Mr. Jaggernaut's condition had deteriorated since the time that Dr. Gnam had assessed him.
