Tucker, Joan M., Psychiatrist

D.F. and Wawanesa **https://www5.fsco.gov.on.ca/AD/5136**

Decision Date: 2017-02-03, Adjudicator: Deborah Pressman, Regulation: 403/96, Decision: Arbitration, Preliminary Issue, FSCO 5136

Submitting to the Examination:

I find that Ms. F.'s conduct and behaviour was not 'unreasonable' and it cannot be said that she did not submit to the examination conducted by the psychiatrist, Dr. Tucker

Wawanesa relied on Dr. Tucker's opinion and testimony to support its argument that Ms. F. did not "attend and submit" to the examination. But her evidence did not convince me that Ms. F. failed to "attend and submit" as required by section 44(9)iii of the *Schedule*. Dr. Tuckerlacked insight into Ms. F.'s history with previous medical assessors and significantly, it was Dr. Tucker who terminated the examination after a fairly brief interaction with Ms. F.

Much of her testimony and opinions were not relevant to a determination of non-compliance under the *Schedule*. For example, she testified that there is no reason for claimants (including Ms. F.) to feel angry, upset, or hostile during the start of the assessment. She also opined that because the assessment experience, including the signing of the consent form, was not a new experience for Ms. F., having undergone multiple assessments, Ms. F. should have behaved better.

Notably, the test under the relevant section speaks to "attend" and "submit." It does not oblige a claimant being assessed under section 44(9)iii to exhibit good behaviour and suppress her anger or frustration during an examination.

I do not find that Ms. F.'s failure to sign the consent form at the start of the examination or her emotional agitation with Dr. Tucker at the preliminary stages of the examination amounted to a failure to "attend and submit." Given the strained relations and mistrust between Wawanesa and Ms. F., it was not unreasonable for Ms. F to question consent forms and ask about the medical disclosure of her information. Wawanesa did not provide me with any authority that demands an applicant sign a consent form prior to an examination under section 44(9)iii of the *Schedule*.

Mr. Tim Vatskos, Wawanesa's adjuster, has handled Ms. F.'s claim for the last 12 years. He testified to the many challenges in his dealings with Ms. F. and I agree that it has been difficult for Wawanesa to contend with the applicant.

The evidence presented confirmed that Ms. F. has had a long history of requiring accommodation at IEs and often demanded much patience from her medical assessors.[5] But Dr. Tucker admitted that she was not familiar with Ms. F.'s history and reviewed the medical brief after the assessment and not before.

Dr. Tucker testified that Ms. F.'s unusual behaviour was an intentional attempt to frustrate the examination and was not related to a psychological condition. However, Dr. Tucker admitted that she did not have enough time to form an opinion with respect to Ms. F.'s psychological or mental state and the existence of any psychological conditions. Therefore, I cannot accept her opinion as a basis for

determining that Ms. F. failed to 'attend and submit' to the examination. In fact, Dr. Rennie, Ms. F.'s treating doctor, testified that Ms. F. has been exhibiting symptoms of paranoia, depression and other difficult behaviour for many years.[6]

When asked why Dr. Tucker did not allow Ms. F. a break before terminating the assessment, she testified that a break was not necessary and would not change the prospects of continuing the assessment. She explained that a break is reserved for situations of true psychotic episodes in order to allow patients to receive treatment and calm down before resuming an assessment.

Surely a claimant like Ms. F., with a history of difficulties participating in assessments could have been afforded an opportunity for a break so she could calm down and then attempt to continue with the assessment.[7] The examination had been scheduled for three hours and Ms. F. was, in fact, willing to continue her examination within an hour after she had an opportunity to calm down.

I find that Ms. F. consented to participate in the assessment and submitted to the best of her ability. She showed up at Centric and stayed for about an hour. She had discussions, albeit emotional and loud, regarding the consent form and the disclosure of her medical information. Eventually, she was ready to proceed, but by that point the examination had already been terminated by Dr. Tucker and Ms. F. was not afforded another opportunity to re-attend.[8]

I find that Centric did not make reasonable efforts to allow Ms. F. more time to complete the examination and that Dr. Tucker's abrupt exit from Centric, prior to the scheduled end time of the examination, prevented the examination from taking place.

Decision No. 968/09, 2010 ONWSIAT 323 (CanLII), <http://canlii.ca/t/2bks2

> [25] Mr. Russell reviewed Dr. Tucker's report, and noted that it suggested that the worker was a malingerer, and was exaggerating her symptoms. He submitted that this was remarkable, considering the number of specialists who had seen her. He then reviewed the extensive reporting from psychiatrists in the file, and submitted that there was evidence of a significant deterioration in the worker's condition, and that the NEL quantum should be increased. He submitted that an appropriate rating would be somewhere in the middle of the moderate impairment scale, in the range of 30 to 35%. He felt that she was well past the threshold of the moderate level, and clearly was moving toward the middle zone, while the expectations of the higher range of that zone were not met.
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> [39] In the second NEL assessment report, dated September 4, 2007, psychiatrist Dr. Tucker reported as follows:

Activities of Daily Living

[The worker] reports that she gets up "whenever" and has difficulty sleeping at night because she is aggravated and tired. She states that she does not do anything during the day and she simply sits on the couch. Her daughter takes care of the shopping. Her fingers, wrists and elbows hurt and consequently she does not get involved in any cleaning activities. She states that she rarely watches television and just sits on the couch.

Socialization

[The worker] reports that she does not see any friends. She has not been out with any men. She stays home alone most of the time.

Adaptation to Stress

[The worker] reports that she does not adapt well to stress. She breaks down crying for no reason.

Concentration, Persistence and Pace

When I examined her concentration I noted that [the worker] put forth a very poor effort. Specifically when I asked her what the date was she stated she could not recall. She was able to repeat three objects but then stated that she was unable to remember them after three minutes. When I asked her to calculate serial 7's she struggled stating that math was not her forte and came up with the wrong answer. Similarly when I asked her to repeat three digits after me she got one digit wrong. Given that there is likely no organic basis to her presentation this suggests to me that there is an exaggeration of symptoms and a lack of authenticity as none of these tasks should be at all difficult.

Mental Status Exam

[The worker] presents as a casually dressed woman who is angry in interview and not particularly cooperative. She feels that she has been hard done by. She does maintain good eye contact. Her affect is flat and she appears frustrated about the whole process. Subjectively she describes herself as completely immobilized by her pain and by her mood symptoms. As mentioned above in the cognitive assessment she puts forth a very poor effort suggesting that she is exaggerating her symptoms.

Impression

[The worker] is a 48 year-old woman who worked as a case worker for [the employer]. She has gone off work on two occasions for Carpel Tunnel and associated physical pain. In the process she has developed symptoms of a mild depression fuelled by her anger at the system for not taking her case more seriously. There are upcoming legal aspects to her case as well as vocational rehabilitation intervention which she feels she is not ready to face. I believe that she is an unreliable historian based on the assessment of cognitive function and as such it is difficult to determine if there is indeed much impairment. Based on my review my opinion is that the impairment is in the mild range.

> [40] In reviewing the above reports, it appears that all of the later reports are consistent, with the exception of psychiatrist Dr. Tucker's report dated September 4, 2007. I do not find her report persuasive, for a number of reasons, not the least of which is that Dr. Tucker's opinion is out of keeping with the contents of the other reports. The actual content of the report – that the worker does not go out much, that her daughter does the cleaning, and so on – is very similar to that in the other reports, although the comments are framed in a manner which portrays the worker in a negative light. Clearly something happened between the doctor and the worker which made the worker respond in the manner in which she did, and which provoked the doctor to write a somewhat negative report with respect to the worker. The

comments therein, and the worker's behaviour as described in the report, are consistent with the worker's description of what had occurred at the consultation, when she berated Dr. Tucker for her "lack of professionalism", as she put it, in not advising her that the appointment needed to be rescheduled because the doctor was on vacation.

Decision No. 409/09, 2009 ONWSIAT 2210 (CanLII), <http://canlii.ca/t/2b33w

[5] By letter dated May 31, 2005, Mr. Green objected, on behalf of the worker. Mr. Green felt that Dr. Tucker's report needed to be read with Dr. Gotkind's psychiatric reports and the psychovocational assessment of September 29, 2004 by psychologist Dr. Kingstone. He submitted that those reports suggested that the psychiatric effects of the worker's injuries were far from mild. He noted that Dr. Tucker had not administered the more elaborate testing that was done on the psychovocational assessment, and that the worker was not provided with the results of this assessment. In the circumstances, the results of the psychovocational assessment were more persuasive, and the worker's chronic pain should be found to be at the highest end of the moderate range (45%).

[40] The psychological evidence, therefore, other than Dr. Tucker's report, indicates that the worker's impairment is predominantly within the higher end of Class 3, with some features of a lower Class 3 impairment, and some falling within Class 4. While Dr. Tucker mentions many of the same characteristics (disturbed sleep, depression, anxiety, memory and concentration difficulties), she consistently rates the worker in the mild to low moderate range. She did not administer any tests with respect to the level of the worker's depression or anxiety. A number of the categories on the Activities of Daily Living form were not assessed, and of those which are, some are in conflict with what is in the body of the report. I therefore do not find Dr. Tucker's evaluation to be persuasive in its conclusions regarding the level of the worker's impairment.
