Cameron, Hugh Urquhart - Orthopedic Surgeon

College of Physicians and Surgeons of Ontario (CPSO)

Practice Restrictions https://doctors.cpso.on.ca/DoctorDetails/Hugh-Urquhart-Cameron/0021440-26228

As from March 9, 2022, the following are imposed as terms, conditions and limitations on the certificate of registration held by Dr. Hugh Urquhart Cameron in accordance with an undertaking and consent given by Dr. Cameron to the College of Physicians and Surgeons of Ontario:

UNDERTAKING, ACKNOWLEDGEMENT AND CONSENT
("Undertaking")

of

DR. HUGH URQUHART CAMERON
("Dr. Cameron")

to

COLLEGE OF PHYSICIANS AND SURGEONS OF ONTARIO
(the "College")

A. PREAMBLE

(1) In this Undertaking:

"Code" means the Health Professions Procedural Code, which is Schedule 2 to the Regulated Health Professions Act, 1991, S.O. 1991, c. 18, as amended;

"Discipline Tribunal" means the Ontario Physicians and Surgeons Discipline Tribunal of the College;

"Ontario Physicians and Surgeons Discipline Tribunal" means the Discipline Committee established under the Code;

"Public Register" means the College's register that is available to the public.

(2) I, Dr. Cameron, certificate of registration number 26228, am a member of the College.

(3) I, Dr. Cameron, acknowledge that following a public complaint that raised concerns about my completion of an expert report in my orthopedic surgery practice, the College conducted an investigation bearing File Number CAS-125327-V8L2L0 (the "Investigation").

(4) I, Dr. Cameron, acknowledge that, in addition to accepting this Undertaking, the College will also deliver a caution in person.

B. UNDERTAKING

(5) I, Dr. Cameron, undertake to abide by the provisions of this Undertaking, effective immediately.

(6) Professional Education

(a) I, Dr. Cameron, undertake to participate in and successfully complete all aspects of the detailed IEP, attached hereto as Appendix "A", including all of the following professional education (the "Professional Education"):

(i) Review, reflection, and discussion of the following policies and other self-study with the instructor referenced in section (6)(a)(iii) below:

1. The College's Practice Guide: Medical Professionalism and College Policies;

2. Third Party Reports, CPSO policy;

3. Writing with Care, CMPA resource;

4. Treating physician reports, IME reports and expert opinions: The way forward, CMPA resource;

(ii) Medical letters, forms and reports, CMPA eLearning activity;

(iii) individualized instruction in communications and professionalism satisfactory to the College, with an instructor selected by the College.

(b) I, Dr. Cameron, undertake to provide proof to the College of my successful completion of the Professional Education, including proof of registration and attendance and participant assessment reports, within one (1) month of completing it. I acknowledge that the College will determine, in its sole discretion, whether I have successfully completed the Professional Education.

(c) I, Dr. Cameron, undertake to complete the Professional Education by June 1, 2022, or, if no satisfactory program is available by that time, by the first possible opportunity thereafter.

(d) I, Dr. Cameron, acknowledge that a report or reports may be provided to the College regarding my progress and compliance with the Professional Education.

(e) I, Dr. Cameron, acknowledge that if any of the programs/resources listed above become unavailable, substitution requests will be reviewed by the College and the College will determine in its sole discretion whether substitution is appropriate.

(7) Monitoring

(a) I, Dr. Cameron, undertake to inform the College of each and every location at which I practise or have privileges, including, but not limited to, any hospitals, clinics, offices, and any Independent Health Facilities with which I am affiliated, in any jurisdiction (collectively my "Practice Location" or "Practice Locations"), within five (5) days of executing this Undertaking. Going forward, I further undertake to inform the College of any and all new Practice Locations within five (5) days of commencing practice at that location.

C. ACKNOWLEDGEMENT

(8) I, Dr. Cameron, acknowledge that all appendices attached to or referred to in this Undertaking form part of this Undertaking.

(9) I, Dr. Cameron, acknowledge and undertake that I shall be solely responsible for payment of all fees, costs, charges, expenses, etc. arising from the implementation of any of the provisions of this Undertaking.

(10) I, Dr. Cameron, acknowledge that I have read and understand the provisions of this Undertaking and that I have obtained independent legal counsel in reviewing and executing this Undertaking, or have waived my right to do so.

(11) I, Dr. Cameron, acknowledge that the College will provide this Undertaking to any Chief of Staff, or a colleague with similar responsibilities, at any Practice Location ("Chief of Staff" or "Chiefs of Staff").

(12) I, Dr. Cameron, acknowledge that a breach by me of any provision of this Undertaking may constitute an act of professional misconduct and/or incompetence, and may result in a referral of specified allegations to the Discipline Tribunal of the College.

(13) I, Dr. Cameron, acknowledge that this Undertaking constitutes terms, conditions, and limitations on my certificate of registration for the purposes of section 23 of the Code.

(14) Public Register

(a) I, Dr. Cameron, acknowledge that, during the time period that this Undertaking remains in effect, this Undertaking shall be posted on the Public Register.

(b) I, Dr. Cameron, acknowledge that, in addition to this Undertaking being posted in accordance with section (14)(a) above, the following summary shall be posted on the Public Register during the time period that this Undertaking remains in effect:
The College conducted an investigation following a public complaint that raised concerns about Dr. Cameron's completion of an expert report in his orthopedic surgery practice. As a result of the investigation:

Dr. Cameron will engage in professional education in communications, professionalism and completing third party reports.

(c) I, Dr. Cameron, acknowledge that this Undertaking remains in effect until the College determines its terms are satisfied.

D. CONSENT

(15) I, Dr. Cameron, give my irrevocable consent to the College to provide the following information to any person who requires this information for the purposes of facilitating my completion of the Professional Education:

(a) any information the College has that led to the circumstances of my entering into this Undertaking;

(b) any information arising from any investigation into, or assessment of, my practice; and

(c) any information arising from the monitoring of my compliance with this Undertaking.

(16) I, Dr. Cameron, give my irrevocable consent to the College to provide all Chiefs of Staff with any information the College has that led to the circumstances of my entering into this Undertaking and/or any information arising from the monitoring of my compliance with this Undertaking.

(17) I, Dr. Cameron, give my irrevocable consent to any persons who facilitate my completion of the Professional Education, and to all Chiefs of Staff, to disclose to the College, and to one another, any of the following:

(a) any information relevant to this Undertaking;

(b) any information relevant for the purposes of monitoring my compliance with this Undertaking;

(c) any information which comes to their attention in the course of providing the Professional Education and which they reasonably believe indicates a potential risk of harm to my patients.

Concerns
Source: Member
Active Date: March 9, 2022
Expiry Date:
Summary:
Summary of the Undertaking given by Dr. Cameron to the College of Physicians and Surgeons of Ontario, effective March 9, 2022:

The College conducted an investigation following a public complaint that raised concerns about Dr. Cameron's completion of an expert report in his orthopedic surgery practice. As a result of the investigation:

Dr. Cameron will engage in professional education in communications, professionalism and completing third party reports.

Source: Inquiries, Complaints and Reports Committee
Active Date: November 17, 2021
Expiry Date:
Summary:
Please note that this matter has been appealed to HPARB by the complainant.

Caution-in-Person:

A summary of a decision of the Inquiries, Complaints and Reports Committee in which the disposition includes a "caution-in-person" is required by the College by-laws to be posted on the register, along with a note if the decision has been appealed. A "caution-in-person" disposition requires the physician to attend at the College and be verbally cautioned by a panel of the Committee. The summary will be removed from the register if the decision is overturned on appeal or review. Note that this requirement only applies to decisions arising out of a complaint dated on or after January 1, 2015 or if there was no complaint, the first appointment of investigators dated on or after January 1, 2015.

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N.C. and L.F. v H.U.C., 2021 CanLII 12967 (ON HPARB), <https://canlii.ca/t/jddg3

File # 19-CRV-0829

HEALTH PROFESSIONS APPEAL AND REVIEW BOARD

The Complaint.

6. The Applicants complained that the Respondent failed to provide an adequate report with respect to an injury sustained by the patient, in that he:

- included inaccurate and hurtful statements;
- slandered another physician;
- made comments outside of his scope of practice;
- breached the patient's mother's personal health information by including it in the report;

7. In addition, the Respondent "hid this report so [the patient] couldn't defend [him]self…Why was this a secret. Everybody hid the report to this day have not received it litigation guardian gave us a copy."

8. The patient made these additional comments in relation to the concerns:

- "Report should never have been held from a client. Also, the law states 30 days. To this day I have only seen it because the litigation guardian had it in the court binder, in which gave it to my parents";
- "Insurance company never informed me that a paper review was being conducted. No consent. This was never informed that paper review was being conducted? No consent not aware." and
- "Why does [the Respondent] not prove to you what he used?"

The Response

9. The Respondent provided a response which included that:

- he was retained by a law firm to perform a documentary review of the patient's orthopedic care;
- he neither saw nor examined the patient for the purposes of preparing the report;
- the report is accurate based on the documentation he was provided;
- he did not make comments outside of his scope of practice and pointed out that it was not within his field of expertise to comment on psychological issues;
- he did not hide the report and had no control over it once it was sent to the law firm;
- he had an obligation to review and consider all information which was placed before him including the patient's mother's personal health information; and
- having returned all records to the law firm, he maintains no records regarding this matter.

The Committee's Decision

10. The Committee investigated the complaint and accepted a remedial agreement signed by the Respondent. In signing this agreement, the Respondent acknowledged the need for education in the areas of communication and professionalism, particularly with respect to use of language relating to other health care providers, in regard to third party reports. The Respondent also expressed the intention to take the necessary steps to improve his practice. The remedial agreement provides that the Respondent will engage in self-study.

11. The Remedial Agreement stated:

I, [the Respondent], …, understand that the Inquiries, Complaints and Reports Committee of the College (the "ICR Committee") has considered the matter bearing file number 1106011 regarding a third-party report.

Further to this matter, I understand the Committee's concerns and agree that I would benefit from remedial work with respect to my:

• communication and professionalism, particularly with respect to use of language relating to other health care providers, in regard to third party reports.

I commit to participating in self-directed educational efforts to address these concerns.

Self-Study Report

I will follow up by submitting a typed self-study report (approximately 2,000 words), complete with references of any material reviewed, to the College within 4 months of the date I sign this Remedial Agreement. The report will include a description of the educational activities that I undertook to address the learning need, a summary of what I have learned, and an indication of how I have changed or plan to change my practice based upon this activity.

I understand that my self-study report will be reviewed by a staff member of the College, and if there are ongoing concerns as a result of that review, this matter will be taken back to the ICR Committee for consideration.

I understand that the payment of any and all costs arising from this Remedial Agreement is my sole responsibility.

24. At the Review, counsel for the Respondent took the position that the Committee made reasonable efforts to obtain the essential information to make an informed decision on the matters raised in the complaint. Counsel indicated that the Committee exercised its discretion not to obtain further records and that there was nothing to indicate that further information would have resulted in a change in the Committee's decision.

25. The Board notes that the Respondent's response indicates that the report he prepared for the insurer is based solely on records provided by counsel for the insurer. The Respondent confirmed that in preparing the report he neither saw nor examined the patient.

26. The Respondent's response indicated that he maintained no records relating to this matter. He indicated that the information which he had was sent to him by a law firm and the records would either have been returned to the law firm or destroyed. All that he retained was a copy of the report dated March 24, 2016 which he provided with his response to the complaint.

27. The Board observes that CPSO Policy Statement # 2-12: *Third Party Reports* states where there are no applicable legal obligations which govern the type of information physicians should retain, the College advises physicians to retain information including:

- the contract with the third party, outlining scope, purpose, timelines and fee arrangements;
- the documents, or information not created by the physician, which the physician relied upon when preparing the report.

28. Regarding destruction of ancillary material the above College policy states:

The College advises physicians to take these steps only if they are satisfied that this information will be retained by others and will be available for their own review should they be required to discuss the third-party report in the future.

29. The Board observes from reviewing the Record that following the Respondent completing the report and destroying or returning all records to counsel for the insurer, the information that the College advises physicians to retain, as set out in the College policy above, was solely in the possession of the insurer (or its legal counsel). Counsel for the insurer was requested to produce this information and documentation to the Committee but declined to do so.

30. The Board observes from a review of the Record that the Committee did not request the Respondent to produce the records which would have included his contract with the insurer along with the documents, information and reports regarding the patient upon which the Respondent relied in producing his third-party report. The Board also notes that the Committee did not compel production of the records from the insurer or its counsel.

31. The Board therefore finds that the Committee did not obtain the records the Respondent relied on and referred to in his report.

32. In the Board's view, those records are relevant and necessary for the Committee to assess the complaint. The Committee indicated that because it had not obtained the collateral file from the law firm it "was difficult for the Committee to comment" on the concern that the Respondent included inaccurate or hurtful statements in his report. The Committee stated that it was "not in a position to speak to whether his comments or conclusions were inaccurate or hurtful." The Board finds that the Committee failed to make the required reasonable efforts to obtain the relevant documents in connection with the preparation of the report by the Respondent. The Board concludes that the Committee was therefore unable to assure itself that the Respondent met the standard of the profession expected of him in the circumstances.

33. Accordingly, the Board finds that the Committee's investigation was inadequate.

Reasonableness of the Decision

34. As the Board finds the Committee's investigation to be inadequate, it would be premature for the Board to comment on the reasonableness of the Committee's decision until the Committee conducts an adequate investigation and renders a further decision.

35. However, the Board notes that the Respondent has a history of findings from the Committee about the language used in his reports that have resulted in him being cautioned and counselled.

VI. DECISION

36. Pursuant to section 35(1) of the *Code*, the Board returns this matter to the Committee and requires it to conduct a further and adequate investigation and thereafter to reconsider this matter and issue a further decision with reasons.

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Taylor v. Durkee, 2018 ONSC 7203 (CanLII), <https://canlii.ca/t/hwc8b

[22] Dr. Hugh Cameron is an Orthopedic Surgeon who was called as a witness by the defence. Dr. Cameron examined the plaintiff on June 23, 2015.

[23] Dr. Cameron described how he performed a number of "validity" tests on the plaintiff during the course of his examination. These tests indicated inconsistent results. For example, when tests were repeated the plaintiff demonstrated a different level of functional ability. In addition, the plaintiff reported pain in her neck or back when there was in fact no rotation or movement of her back on testing.

[24] Dr. Cameron was of the view that there was no positive clinical finding on his examination and that the plaintiff displayed symptom exaggeration. He concluded that there was no orthopedic impairment or limitation in Ms. Taylor's case.

[25] In cross-examination Dr. Cameron agreed that even after surgery, some patients continue to experience pain. He described this as perceived pain and agreed that this pain often has no organic cause. He further agreed that this perceived pain is often very difficult to treat.

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Saleh v. Nebel, 2018 ONSC 452 (CanLII), <https://canlii.ca/t/hpxxw

There is no basis for interfering with the trial judge's qualification of Dr. Hugh Cameron as an expert witness concerning chronic pain generally

[77] Counsel for the appellant at trial and on this appeal objected to the trial judge's ruling that Dr. Hugh Cameron, an orthopedic surgeon, was qualified to express an opinion on chronic pain generally.

[78] I reject this submission.

[79] Dr. Cameron was called as an expert witness by the respondent. Counsel for the respondent at trial elicited evidence in his direct examination of Dr. Cameron which could prove that Dr. Cameron:

- had been qualified numerous times in court as an expert on the question of chronic pain;
- dealt constantly with soft tissue injuries;
- was an orthopedic surgeon practising for over 40 years;
- lectured on the issue of chronic pain in relation to joint replacements;
- had been asked to write an article about chronic pain for an American medical publication;
- taught and wrote about orthopedics.
- lectured all over Europe concerning orthopedics.

[80] Counsel for the appellant challenged Dr. Cameron's qualifications concerning chronic pain. He suggested his only experience concerned chronic pain after an orthopedic procedure and that he had never given a lecture on chronic pain following soft tissue injuries. Dr. Cameron agreed on cross-examination that he did not manage patients who were suffering chronic pain resulting from soft tissue injuries.

[81] The trial judge then ruled that Dr. Cameron was qualified among other things to speak about chronic pain generally.

[82] In his testimony Dr. Cameron indicated that some persons with soft tissue injuries develop a chronic pain disorder. Dr. Cameron testified that there are standardized tests intended to test complaints of chronic pain. Dr. Cameron testified that he administered these tests to the appellant, who failed them, and as a result Dr. Cameron believed the appellant was exaggerating his complaints of chronic pain.

[83] There is no basis upon which this court can interfere with the trial judge's qualification of Dr. Cameron.

[84] There was evidence which supported the trial judge's conclusion that Dr. Cameron was qualified to express opinions about soft tissue injuries and chronic pain.

[85] The appellant at paragraph 30 of his factum states that "Dr. Cameron was qualified as an expert in chronic pain generally despite not treating any patients with chronic pain caused by soft tissue injuries." Respectfully this does not disclose a legal error in the trial judge's reasoning. Absent such an error, even if I disagreed with the trial judge's conclusion concerning Dr. Cameron's expertise, which I do not, I could not substitute my conclusion for the trial judge's conclusion on this appeal.

[86] Whether the appellant's claim is barred by s. 267.5(5)(b) and the applicable Regulation is a question of mixed fact and law. The appellant has not demonstrated that the trial judge applied incorrect legal principles to the facts as he found them or that he made an error in law when he qualified Dr. Cameron as an expert.

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Taylor v. Durkee, 2017 ONSC 7357 (CanLII), <https://canlii.ca/t/hphx7

RULING RE: ADMISSIBILITY OF EXPERT EVIDENCE BY DR. HUGH CAMERON

MCKELVEY J.:

Background

[1] This case involves a claim for personal injury by the plaintiff, Donna Taylor, arising out of a motor vehicle accident. The plaintiff has introduced evidence that she suffers from a chronic pain syndrome or central sensitization. The evidence called by the plaintiff suggests that chronic pain syndrome is related to changes in brain chemistry, which in turn cause continuing and chronic suffering by individuals who suffer from this condition.

[2] In response, the defence proposes to call Dr. Hugh Cameron. Dr. Cameron is an Orthopedic Surgeon who has prepared two reports arising out of an examination which took place on June 23, 2015. The first report is dated June 23, 2015 and the second report is dated September 8, 2016, which comments in large part on reports delivered from other experts in which he provides his views on a number of issues including the central sensitization theory.

[3] This case is being tried before a jury. The plaintiff has brought an application to exclude portions of Dr. Cameron's evidence. The plaintiff agrees that Dr. Cameron should be entitled to testify about the soft tissue injuries sustained by the plaintiff in the motor vehicle accident and when they should have healed. The plaintiff also acknowledges that Dr. Cameron should be able to testify about certain validity tests that he conducted during the course of his examination, but argues that Dr. Cameron should not be allowed to relate those findings to the conclusion he draws of symptom exaggeration. The plaintiff also objects to Dr. Cameron equating positive Waddell signs which were identified by another medical expert on his physical examination to symptom exaggeration. Finally, the plaintiff takes issue with Dr. Cameron's right to comment on the theory of chronic pain syndrome or central sensitization. In this regard, the plaintiff objects to Dr. Cameron's linking of central sensitization to secondary gain and his comment that chronic sensitization only occurs when there is compensation at issue.

[4] In summary, the plaintiff takes the position that Dr. Cameron should be limited to giving evidence as to whether there is an organic cause for the plaintiff's continuing complaints of pain. According to the plaintiff, Dr. Cameron should not be entitled to go further, to comment on the plaintiff's credibility or the plaintiff's chronic pain theory.

[5] I advised counsel of the limits which would be placed on Dr. Cameron's evidence orally on December 4, 2017 and advised that written reasons would follow. These are those written reasons.

The Applicable Legal Principles

[6] In *R. v. Mohan*, 1994 CanLII 80 (SCC), [1994] 2 S.C.R. 9, the Supreme Court set out the basic requirements for the admission of expert evidence. These requirements are relevance, necessity, the absence of an exclusionary rule and a properly qualified expert. These requirements were reviewed and refined by the Ontario Court of Appeal in *R. v. Abbey*, 2009 ONCA 624 (CanLII). In that decision Justice Doherty outlined a two stage process which a court should follow. In the first phase, Justice Doherty stated that four preconditions to admissibility must be established as follows:

1. The proposed opinion must relate to a subject matter that is properly the subject of expert opinion evidence;
2. The witness must be qualified to give the opinion;
3. The proposed opinion must not run afoul of any exclusionary rule apart entirely from the expert opinion rule; and
4. The proposed opinion must be logically relevant to a material issue.

[7] At the second stage the court is required to act as a "gatekeeper" by balancing the benefit and cost of the proposed expert opinion. In the *Abbey* case, the Court of Appeal treated "necessity" not as a precondition to admissibility but as part of the "cost benefit" analysis to be evaluated at the gate keeping stage.

[8] The *Abbey* analysis was largely endorsed by the Supreme Court of Canada in its decision in *White Burgess Langille Inman v. Abbott and Haliburton Co.*, 2015 SCC 23 (CanLII). However, in that decision the court emphasized that the four *Mohan* factors which include necessity are threshold requirements. Evidence that does not meet those threshold requirements should be excluded. Thus, necessity is a threshold requirement which must be met before considering the gatekeeper analysis.

[9] In the *R v. Abbey* decision, the Court of Appeal outlines some basic legal principles which apply. At para. 71 it notes that expert evidence is presumptively inadmissible. The party tendering the evidence must establish its admissibility on a balance of probabilities. Thus, the onus is on the defendant to satisfy this court that Dr. Cameron's opinions are admissible on a balance of probabilities.

[10] The Ontario Court of Appeal has recently considered the Mohan factors in the context of a personal injury claim in their decision of *Bruff-Murphy v. Gunawardena*, 2017 ONCA 502 (CanLII), [2017] O.J. No. 3161. In that decision the court emphasized the court's important role as a gatekeeper in considering the cost benefit analysis. In that case, the court noted that there was a high probability that the expert would prove to be a troublesome expert witness, one who was intent on advocating for the defence and unwilling to properly fulfill his duties to the court. Similar issues have been raised by the plaintiff in this case about the proposed evidence of Dr. Cameron.

[11] The plaintiff argues that Dr. Cameron's proposed evidence that the plaintiff exhibits symptom magnification usurps the jury's function in determining the plaintiff's credibility and therefore has a high degree of potential prejudice in swaying the jury against the plaintiff.

[12] Initially during the argument the plaintiff took the position that Dr. Cameron showed evidence of bias. However, during the course of submissions the plaintiff's counsel acknowledged that there is no evidentiary foundation for such an allegation and this was withdrawn during the course of argument.

[13] There was no suggestion that Dr. Cameron's proposed evidence does not comply with the relevance and necessity criteria under *Mohan*, nor is there any exclusionary rule which would apply in the circumstances. Instead, the issues which were argued in this case related to the qualifications of Dr. Cameron to give evidence beyond his physical findings and the gatekeeping role which a court must consider before allowing expert evidence to be introduced at trial.

Analysis

[14] There is no issue about Dr. Cameron's general qualifications as an orthopedic surgeon. He was certified as an Orthopedic Surgeon in 1975 and is currently an Associate Professor at the University of Toronto Medical

School. He has published over 200 papers. His major focus in practice has been on joint replacement and he has performed over 5000 knee replacement surgeries and over 4000 hip replacement surgeries. He has been accepted as an expert in orthopedic surgery on numerous occasions. I accept his evidence that diagnosing the cause of a patient's pain and whether it is organic is an important consideration for his surgical practice. Dr. Cameron testified on the voir dire that chronic pain includes any pain which continues for a period of greater than six months. This includes almost all of his orthopedic patients. In order to predict whether a proposed surgery will be successful, an orthopedic surgeon needs to be able to assess the patient and determine whether the clinical evidence is bad enough to justify surgery. Perceived pain by a patient which is not supported by sufficient clinical evidence is likely to result in a poor result from surgery. Thus, differentiating the types of pain experienced by patients is an important part of Dr. Cameron's practice.

[15] I have therefore no difficulty in concluding that Dr. Cameron has sufficient qualifications to give evidence based on the history and physical examination taken of the plaintiff. This includes the results and significance of certain validity tests which were conducted by Dr. Cameron in order to determine the consistency or inconsistency of the plaintiff's reports of pain. Whether Dr. Cameron should also be entitled to provide the jury with his opinion that symptom exaggeration was present based on his examination of the plaintiff is a more difficult issue. I have concluded, however, that he should be entitled to provide this opinion in his evidence.

[16] Dr. Cameron's opinion that the plaintiff demonstrated symptom exaggeration is contained in his report of June 23, 2015 when he states,

In summary, clinical examination in this case was normal. I was unable to detect any abnormalities at all. Symptom exaggeration was obviously present with no consistency whatsoever on tests and re-tests. There was ample evidence of magnification with complaints of back pain on pseudorotation and complaints of neck pain on pseudoaxial loading. There was dissociated straight leg raising. There were complaints of skin tenderness in a diffuse area around the neck. She complained of back pain on bent leg raising, hip rotation, side leg lifting and carrying out the piriformis manoeuvre.

[17] I accept that Dr. Cameron's opinion reflects negatively on the evidence given by the plaintiff about the pain symptoms she has suffered since the accident. It is, of course, the responsibility of the trier of fact to decide the truthfulness of the plaintiff's evidence and not the responsibility of an expert like Dr. Cameron. Dr. Cameron does not directly attack the plaintiff's credibility. However, his evidence may reflect negatively on the plaintiff. In this regard I view Dr. Cameron's evidence as being permissible even though it may have some bearing on the jury's ultimate determination on the question of credibility. In my view this is a common feature of expert evidence. Expert evidence often has either a positive or negative impact on the evidence of other parties or witnesses who are called to give evidence. An example based on facts totally unrelated to this case would be a situation where a witness claimed to have a clear view of an accident and yet a medical physician testified about limitations with respect to that person's eyesight which call into question the credibility of that witness or party's evidence.

[18] The plaintiff also argues that Dr. Cameron's opinion about symptom exaggeration should not be allowed because it is addressed to the ultimate issue before the jury. In this case, the ultimate issue before the jury is an assessment of the plaintiff's general damages. Thus, Dr. Cameron's opinion does not directly address the ultimate issue but it is apparent that his opinion has the potential to influence the jury with respect to the amount of general damages which should be awarded in this case.

[19] It is clear, however, that there is no absolute rule barring opinion evidence on the ultimate issue before the jury. See *R. v. Mohan*, [1994] 2 S.C.R. at p. 24. It is also apparent, however, that where an expert opinion is close to the ultimate issue, the criteria of necessity and cost benefit analysis are more strictly applied to exclude expert evidence. Having said that, it is routine in personal injury actions for medical experts to testify on their diagnosis and prognosis of a plaintiff's condition. Medical diagnoses are normally beyond the experience or knowledge of a jury and are important pieces of evidence for a jury to consider for a proper assessment of damages. In the present case the plaintiff has called its own expert who has given evidence that the plaintiff suffers from chronic pain syndrome or central sensitization, a condition which the expert says is likely permanent. Fairness would suggest that the defence expert ought to be able to express his opinion with respect to the medical diagnosis and prognosis for the plaintiff's condition which is at variance with that of the plaintiff's expert. Dr. Cameron in this case has set out his opinion and the reasons which led him to this conclusion. In my view his evidence does not go to the ultimate issue in this case. Dr. Cameron's opinion will be compared to that of the plaintiff's expert and the jury will be able to consider both opinions and the weight which should be given to them in reaching their conclusion on what amount is reasonable to compensate the plaintiff for her general damages. Thus, Dr. Cameron's opinion is evidence that the jury may take into account when assessing the nature of the injuries suffered by the plaintiff, just as they would with any other expert witness.

[20] I have therefore concluded that Dr. Cameron's opinion falls within his area of experience as an orthopedic surgeon and his routine assessment of different types of chronic pain. He will be entitled to give his opinion that the plaintiff has symptom magnification.

[21] Dr. Cameron will not, however, be permitted to give opinion evidence on the issue of chronic pain syndrome or central sensitization. I find that he does not have the necessary qualifications in this area and his evidence does not pass the necessary cost benefit analysis.

[22] Dr. Cameron's opinions about central sensitization are contained in his report of September 8, 2016, which comments on a report delivered from the plaintiff's expert. He states as follows in his report,

This is a theory. The concept is that, if someone has pain somewhere or other for three months or six months or whatever, they will develop changes in the brain and spinal cord. It then does not matter what happens to the original pain, i.e. whether or not it goes away, the pain will remain because of the changes in the brain, hence, the well-known title of the pain in the brain syndrome.

When this theory first came out several years ago, I was quite intrigued with it. However, after thinking about it for a few minutes, I realized that there were some discrepancies.

After all, I have been an Orthopedic Surgeon for a long time. What I principally do for a living is replace joints. I have replaced in excess of 4000 hips and about 5000 knees.

If this theory of central sensitization or pain in the brain syndrome was right, then I have (sic) wasting my time for the last 30 years because no patient would get better. Furthermore, all my joint replacement colleagues around the world would have been wasting their time and collectively between us we wasted the time of several million people because they would not get better.

As in fact all orthopedic surgeon (sic) and most patients know, joint replacement is a highly successful procedure. The patient's pain goes away and they get back to work.

It seems to me that this pain in the brain theory is only produced when there is compensation at issue. I thought that the American's were developing several firm rulings on the diagnosis of pain syndrome when compensation is at issue. In fact, I thought that they actually had published these rules but I have not seen them.

[23] In his cross-examination on the voir dire, Dr. Cameron acknowledged that he has done no independent study of central sensitization. In addition, the defence stated at this point in his cross-examination that they were not attempting to qualify Dr. Cameron as an expert in central sensitization (or chronic pain syndrome), but only on chronic pain. In my view it is clear that Dr. Cameron, based on his own evidence, is simply expressing his own personal views about chronic pain syndrome or central sensitization without having the necessary expertise to give an informed opinion about it. In terms of a cost benefit analysis, his opinion has little probative value and there is a significant risk that the jury could be unduly influenced by his opinions. This conclusion is supported by a significant inconsistency in Dr. Cameron's analysis. Dr. Cameron's comment that if the theory of central sensitization is correct, joint replacement surgery would be a waste of time is inconsistent with his other evidence that the purpose of assessing the true nature of a patient's pain is to identify those patients which will benefit from surgery from those who will not. His own evidence supports the importance of distinguishing between different types of pain to ensure that surgery is only performed on patients who are reasonably expected to benefit from surgery. In exercising this court's discretionary gatekeeping role, I therefore have concluded that Dr. Cameron should not be permitted to give any evidence with respect to the central sensitization theory. For the same reasons Dr. Cameron will not be permitted to give any evidence with respect to the relationship between the central sensitization theory and the role of compensation in connection with this theory.

[24] In his report of September 8, 2016, Dr. Cameron comments that a self-assessment tool where the patient reports the degree of pain and functional limitation is not likely to be very accurate. I have concluded that those comments as contained in his report are properly admissible. The reliability of a patient's pain complaints are within his qualifications as an Orthopedic Surgeon and his participation in a research study on this point supports his expertise in this area. However, I have concluded that Dr. Cameron should be limited to the comments he makes in his report. His report does not include any commentary on his research project. In the voir dire, Dr. Cameron commented fairly extensively on his research. However, none of this information was contained in his report as required by Rule 53.03(2.1)(6)(ii). This provision requires an expert to include in his or her report a description of any research conducted by the expert that lead him or her to form the opinion.

[25] While Rule 53.08 authorizes leave to be granted to allow an expert to testify even where his report does not comply with Rule 53.03, it is subject to considering whether granting the leave "will cause prejudice to the opposite party or will cause undue delay in the conduct of the trial". In this case the plaintiff has closed its case having already introduced the expert evidence it intends to rely on. I have concluded that the failure of the defence to advise the plaintiff of its intention to have Dr. Cameron comment on his research does cause prejudice to the plaintiff's position. The plaintiff has already called its own expert evidence and has closed its case. I therefore conclude that having failed to disclose the substance of his research in his report, Dr. Cameron should be strictly limited to the comments he made in the report on the value of the patient's self assessment tool.

[26] The final issue to be addressed in terms of Dr. Cameron's evidence is the need for him to present his evidence in a professional and respectful manner. I am concerned that some of Dr. Cameron's comments in his report as well as the voir dire are sarcastic and disparaging of other experts. I am concerned that such comments could unfairly prejudice the jury against other experts who have testified. For example, in his report as well as in his evidence on the voir dire, Dr. Cameron referred to the Waddell signs as the "Waddell signs of symptom exaggeration" despite the fact that the evidence at this trial has made it clear that Dr. Waddell never

adopted this characterization and in fact disputed the inference that the Waddell signs were reflective of symptom exaggeration.

[27] Dr. Cameron also referred to the central sensitization theory as the “pain in the brain” syndrome which appears to be a term designed to disparage unfairly the plaintiff’s theory. Another example is Dr. Cameron’s refusal to acknowledge in his evidence that a chiropractor who has previously given evidence should be properly referred to as “Dr.” despite the fact that in this jurisdiction that is the appropriate title for a chiropractor.

[28] I have therefore concluded that Dr. Cameron has a tendency to make unprofessional comments about the opinions of others that do not fall in line with his own. I have advised counsel that Dr. Cameron will be expected to give his evidence before the jury in a professional manner. If he fails to do so I may intervene in his evidence before the jury and or direct some comments in my charge which will address his behaviour while giving evidence.

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Shaw v Mkheyan, 2017 ONSC 851 (CanLII), <https://canlii.ca/t/gxct0

[21] The defendants led expert evidence from Dr. Hugh Cameron, also a leading orthopaedic surgeon with expertise in arthritis.

[22] The issue of causation was the subject of expert evidence at trial. Dr. Backstein’s opinion was that the force of the accident converted Shaw’s asymptomatic arthritis in his left knee into symptomatic arthritis, causing Shaw’s left knee pain and two left knee surgeries.

[23] Dr. Cameron’s opinion was that Shaw’s left knee injury arose as a result of Shaw’s preexisting osteoarthritis and was not caused by the accident.

[24] For the reasons that follow, I prefer the evidence of Dr. Backstein to that of Dr. Cameron.

[25] Both experts considered Shaw’s preexisting osteoarthritis.

[29] Dr. Cameron gave evidence that based on the July 26, 2008 x-ray which showed that Shaw had tricompartmental osteoarthritis in his left knee, it was his opinion that Shaw’s left knee injury was not caused by the accident since osteoarthritis is “relentlessly progressive”.

[30] Dr. Backstein disagreed with Dr. Cameron’s opinion that osteoarthritis is relentlessly progressive. Dr. Backstein’s opinion is that many people with osteoarthritis have no pain (“asymptomatic”), let alone necessarily require total knee replacement surgery as did Shaw.

[31] This was a critical causation issue in this matter.

[32] Dr. Cameron provided no basis to support his conclusion that once a patient is diagnosed with arthritis, the condition would necessarily get worse, let alone be “relentless” as he described it.

[33] On the other hand, Dr. Backstein gave detailed evidence about his experience as an orthopaedic surgeon. His evidence was that people can have osteoarthritis and not be aware of it since it does not necessarily become symptomatic.

[34] Dr. Backstein's evidence was that osteoarthritis was common for someone of Shaw's age (58 years old) at the time of the accident. In Dr. Backstein's experience, this did not mean that arthritis in this age group would necessarily be symptomatic.

[35] Dr. Backstein gave the example of a patient who had arthritis in both knees but only saw him because of a complaint in one knee. In Dr. Backstein's example, the other knee had no symptoms but the osteoarthritis had progressed to the same extent in both knees.

[36] Dr. Cameron's opinion that any person with osteoarthritis would inevitably suffer the type of pain which Shaw endured, without any triggering event, is not consistent with Dr. Backstein's unchallenged direct experience in this area or with Dr. Backstein's uncontested opinion that most people at age 58 have some degeneration caused by osteoarthritis but that such arthritis is not necessarily symptomatic.

[37] Dr. Backstein's opinion is that osteoarthritis is not "relentlessly progressive" and can be asymptomatic until an event happens that converts the arthritis to symptomatic. Dr. Backstein's opinion conforms to his experience as a leading orthopaedic surgeon. Dr. Backstein was not cross-examined on his experience. I prefer Dr. Backstein's evidence to the unsupported comments of Dr. Cameron.

[38] The second area of dispute between Dr. Backstein and Dr. Cameron was as to the degree of force required to cause arthritic pain.

[39] Dr. Cameron's evidence was that in order for the accident to have caused Shaw's osteoarthritis, Shaw would have needed to "smash" his knee so severely in the accident that he would have been in severe pain and thought that his knee was broken. Dr. Cameron's opinion was that a bump of the knee would not even be sufficient.

[40] Since there was no evidence that Shaw's pain reached such a level after the accident, Dr. Cameron concluded that the injuries to Shaw's left knee were not caused by the accident.

[41] Dr. Backstein disagreed with Dr. Cameron's opinion. Dr. Backstein's opinion was that only a "very minor force" would be required to convert asymptomatic arthritis into symptomatic arthritis. Dr. Backstein's opinion was that the force from a car accident, even if a minor accident, could be sufficient.

[42] Consequently, it was Dr. Backstein's opinion that the force of the car accident converted Shaw's asymptomatic arthritis to symptomatic arthritis.

[43] Again, for the reasons I discuss below, I prefer the opinion of Dr. Backstein.

[44] Dr. Cameron did not address in his evidence whether the same force (*i.e.* smashing the knee) would be required to cause osteoarthritis from a car accident if the person had preexisting osteoarthritis.

[61] Dr. Cameron provided no evidence on the issue of the force required to convert asymptomatic arthritis to symptomatic arthritis. Even if Dr. Cameron could be taken as concluding that "smashing" the knee would be required for someone with preexisting arthritis, *i.e.* that such a person could only obtain post-traumatic arthritis if he or she felt as if the knee was broken, Dr. Cameron gave no basis for that opinion.

[62] I accept Dr. Backstein's opinion that Dr. Cameron's conclusion that osteoarthritis from a car accident can only occur if a person (i) smashes his or her knee and (ii) suffers such pain that the person could not even move the knee, is not consistent with Dr. Backstein's experience (again unchallenged) that such a degree of force

and agony is not required. That was shown by the examples from Dr. Backstein's treatment of patients as I discuss above.

[156] Ironically, Dr. Cameron's speculation that a patient may have pain and not report it would assist Shaw's position if he did not attend at his family doctor as frequently as the defendants submit would have been appropriate. I do not rely on such unfounded speculation of Dr. Cameron for the reasons I discuss above.

[179] For the reasons I discuss below, I find that Shaw did not meet the requirement of s. 4.3(2)(b) of the Regulation. Dr. Cameron's evidence does not constitute evidence from a physician that the lower back injuries caused by the accident were permanent.

[180] Dr. Backstein led no evidence as to whether the lower back injury was permanent. His only evidence was that there was a possibility surgery might be required for the lower back, without any opinion as to whether the injury would continue for an indefinite time period.

[181] On cross-examination, Dr. Cameron agreed that he had said in his report that if a person has a long-standing history of back pain, "it is obviously not going to go away and he will therefore continue to have intermittent back symptoms".

[182] However, Dr. Cameron's reference was in relation to his review of the past instances of recorded back pain for Shaw, which arose from a car accident in 1986 that had resolved five months later, as well as an OHIP record from August 2004 and an October 2005 complaint of low back pain.

[183] At no point did Dr. Cameron agree that the lower back injuries caused by the accident were permanent. While Dr. Cameron's general statement referred to back pain recurring, he was clear on re-examination that while back pain might be expected to come back from time to time, he did not expect lower back pain from the accident to be permanent.

[184] In re-examination, Dr. Cameron was asked about his evidence summarized above. Dr. Cameron was then taken to the other point he had made in his report and agreed that after his comment in his report about recurring back pain, he had also stated "However, simple uncomplicated soft tissue strains do resolve".

[185] Dr. Cameron's evidence in re-examination was that the accident only generated "simple soft tissue" damage which he compared to a sprained ankle. Dr. Cameron's opinion was that he would expect any lower back pain from the accident to resolve within six weeks from the accident.

[186] Consequently, I do not find that Dr. Cameron's evidence was that the injuries suffered by Shaw to his lower back from the accident were permanent.

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Jugmohan v. Royle, 2016 ONCA 827 (CanLII), <https://canlii.ca/t/gvg30

[9] With respect to the second ground of appeal, the appellant submits that the trial judge erred by disregarding relevant medical evidence that supported her position on the threshold motion and arrived at an unsupported conclusion. The appellant argues that the only expert evidence tendered in response to her evidence was that of Dr. Cameron, who was demonstrably partisan and who based his opinion on a superficial review of the medical evidence.

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Mork v Sanghera, 2016 ONSC 5108 (CanLII), <https://canlii.ca/t/gswln

[1] The defendants seek an order that the plaintiff, Saokeng Mork, "attend at a defence medical assessment with Dr. Hugh Cameron, Orthopaedic Surgeon and Chronic Pain Specialist". There are available appointment dates on August 17, 19 and 26, 2016.

[11] The real issue in this motion engages all of the remaining factors set out in *Bonello*. Does the plaintiff's injury fall outside the expertise of the present defence medical examinations by a psychiatrist and a physiatrist? Is there sufficient evidence before me to persuade me that an examination by Dr. Cameron is necessary to enable the defendant to fairly investigate and call reasonable responding evidence at trial? Is there evidence that fairness requires the examination requested here?

[12] In my view, on the record before me, there is insufficient evidence for me to grant the order requested.

[13] The defence proposes that Dr. Cameron can give evidence in his area of expertise as both an orthopaedic surgeon and a chronic pain specialist.

[14] In reviewing Dr. Cameron's 79-page resume, there is much to show that he is in an expert in orthopaedics, particularly knees and shoulders. However, the plaintiff's counsel has not put forward an orthopaedic expert report. Indeed, the only examination undertaken by an orthopaedic specialist was at the request of Mr. Mork's accident benefit insurer more than five years ago. On this basis, I see no need for such an examination.

[15] With respect to Dr. Cameron's expertise in chronic pain, there are only three entries in his resume. Under "Non-peer Reviewed - Journal Publications," there is a 1978 article in the Canadian Orthopaedic Nurses Association Journal entitled, "The Physiology and Psychology of Pain." Later, in 1985 and 1986, there are again non-peer reviewed articles referred to in "Mod Med Cand" entitled, "The Patellofemoral Pain Syndrome." The word "pain" does not otherwise show up in his resume. The phrase "chronic pain" does not show up at all.

[16] The defendant also relies upon a 2016 judgment in *Dimopoulos v. Mustafa*, 2016 ONSC 429, [2016] O.J. No. 287. There, Tzimas J. said, "The court also heard from Dr. Cameron who was qualified as an expert in orthopaedic surgery, soft tissue injury, chronic pain and the treatment of orthopaedic and soft tissue injury, and causation in these areas as it pertains to the plaintiff." The defence suggests that this shows that Dr. Cameron is qualified to provide the proposed expert evidence. There is, however, no description of any attack on Dr. Cameron's qualifications. There is no evidence of what was put forward at that trial to support his expertise. It is to be noted that Justice Tzimas did not rely upon Dr. Cameron's evidence. I can only rely on the materials filed with this motion to determine whether it would be just to have the plaintiff undergo a defence medical. What was before Tzimas J. is unknown to me on this motion.

[17] I agree with the defendant that I need not determine Dr. Cameron's expertise at this point; that would be for the trial judge. On the other hand, the moving party must put forward sufficient evidence to persuade the court of the need for the proposed examination.

[18] Focussing on the *Bonello* factors in issue, there is no doubt that Mr. Mork's injuries fall outside the expertise of defendant's psychiatrist and physiatrist. There is still the issue of chronic pain and neuropsychology along with experts dealing with the damages issues. That may be for another motion. However, the plaintiff is not

relying on an orthopedic report; I see no need for the defence to have one. While it may be that the defendant will need a report from a chronic pain specialist, I do not have sufficient evidence that Dr. Cameron can provide helpful evidence for the defendant and the court. Given that, it seems unfair to have the plaintiff examined by an unnecessary orthopedic expert and a medical practitioner who is not properly qualified with respect to chronic pain.

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Leo v Hadzalic, 2016 ONSC 1924 (CanLII), <https://canlii.ca/t/gnzd1

[5] The Defendants have attempted to set up an independent medical exam (IME) with Dr. Hugh Cameron, an orthopedic surgeon in Toronto. The Plaintiff's solicitor sought various conditions with respect to the examination, most of which were agreed to. The only condition in contention is whether there can be an audio recording of the examination.

Allegation that Dr. Cameron is Biased

Plaintiff's Position

[33] The Plaintiff argues that Dr. Cameron is biased or has an alleged bias and therefore the examination should be recorded.

[34] The Plaintiff argues that past adverse findings against an expert who has been found by other Courts to be a partisan advocate on behalf of the defence seriously weakens the credibility and weight of the of expert's evidence. He relies on the case of *Bakalenikov v. Semkiw*, 2010 ONSC 4928.

[35] The Plaintiff argues that adverse findings have been made against Dr. Cameron in several cases, including *Thukral*, *Esterreicher* and *Bacchus*.

Defendants' Position

[36] The Defendants rely on the *Bellamy* case and argue that the alleged bias of Dr. Cameron's orientation is immaterial, because there has been no report to the College of Physicians and Surgeons.

[45] The Court finds that the fact that a doctor does examinations for the most part for either the Plaintiff or the Defendant does not indicate a bias on the part of that doctor.

[46] The Court finds that while the Plaintiff has raised concerns about Dr. Cameron, these concerns do not satisfy the assertions of bias or lack of competence by Dr. Cameron. Furthermore, no misconduct is alleged and there is no misconduct that is subject to a report to the College of Physicians and Surgeons.

[47] The fact that several decisions have not accepted the evidence of Dr. Cameron is not a substantial and compelling reason to allow the recording of the examination.

[48] The fact that the recording device may be the size of a pencil, as opposed to a small tape recorder or other recording device, is no reason to change the previous rulings on whether recordings are acceptable.

[49] While Dr. Cameron may provide more defence medical examinations than plaintiff medical examinations; he has the obligation to be objective. Furthermore, he is required to act in a professional manner and with integrity when providing evidence to courts. Based on Dr. Cameron having an obligation to be objective

and being subject to the same requirements of professional integrity before the courts as other experts, the Court does not find that there is a bias or apprehension of bias by Dr. Cameron.

[50] Furthermore, the Plaintiff has the right to cross-examine Dr. Cameron at trial.

[51] In conclusion, the Court does not find that the Plaintiff has presented substantial and compelling reasons why the medical examination should be recorded.

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Thi Le-Thu Mac v. Thi Le and Loi Van Ly, 2011 ONSC 645 (CanLII), <https://canlii.ca/t/2fkmj

[4] On consent, without court order, the plaintiff was assessed by Dr. Hugh Cameron, an orthopedic surgeon, on September 9, 2009. Dr. Cameron delivered a report dated September 11, 2009 dealing with the physical injuries suffered by the plaintiff. In that report he opined that the injuries sustained by the plaintiff have not resulted in a permanent and serious impairment of an important physical function.

[5] The Master was influenced by the fact that Dr. Cameron did not indicate in his report the need for another expert to deal with the chronic pain claim. He also said he was not satisfied that Dr. Cameron lacked an appropriate level of experience or knowledge to deal with it and that while Dr. Cameron's 40 page curriculum vitae did not highlight claimed expertise in the area, he would have expected that Dr. Cameron would have filed an affidavit acknowledging any such limitations on his ability to comment.

[6] The appropriate standard of review from an order of a Master is set out in the decision of *Zeitoun v. Economical Insurance Group* (2008), 2008 CanLII 20996 (ON SCDC), 91 O.R. (3d) 131 (Div.Ct.); aff'd 2009 ONCA 415 (CanLII), 96 O.R. (3d) 639 (C.A.). The standard of review on appeal from a Master is the same as the standard of review on an appeal from a judge, as set out in *Housen v. Nikolaisen*, 2002 SCC 33 (CanLII), [2002] 2 S.C.R. 235. The decision will be interfered with only if the Master made an error of law or exercised his or her discretion on the wrong principles or misapprehended the evidence such that there is a palpable and overriding error.

[7] In my view, the Master effectively erred in law and exercised his discretion on wrong disciples. I say this for the following reasons.

[8] It is not, in my view, the purview of an expert retained on behalf of a party to decide whether some other expert should be retained to support the party on whose behalf he or she was retained. That is the traditional role of a party and the solicitors for that party. Indeed, an expert is not to be an advocate for the party retaining that expert. There is nothing, of course, wrong for an expert asked to provide an opinion to say that the opinion is outside of his or her expertise, and that for that reason someone else should be retained. That is not the case here. Dr. Cameron felt qualified to deal with the physical injuries sustained by the plaintiff and to provide his opinion regarding that. The fact that Dr. Cameron did not indicate the need for a physiatrist to examine the plaintiff to deal with the claim for chronic pain syndrome is no reason, in my view to deny a request that a physiatrist examine the plaintiff. To hold that there had to be an opinion from Dr. Cameron that a physiatrist was required was acting on a wrong principle and an error in law.

[9] It is common ground that Dr. Cameron did not deal with the issue of whether the plaintiff suffers from chronic pain syndrome. Dr. Ogilvie-Harris in his report of October 26, 2009 referred to Dr. Cameron's report of September 11, 2009 and stated that Dr. Cameron had considered the mechanical aspects of the plaintiff's injury but had not dealt with the issue of a chronic pain syndrome. This is not a case in which Dr. Cameron opined on

the chronic pain syndrome and the defendant is now seeking to have another examination by someone else on that issue.

[10] Whether Dr. Cameron was qualified to provide an opinion on chronic pain syndrome is thus, in my view, of little importance, as he did not do so. In any event, I have considerable difficulty with the Master's statement that he was not satisfied that Dr. Cameron lacked the appropriate experience or knowledge to opine on the claim based on a chronic pain syndrome. He had no basis to conclude that Dr. Cameron had such expertise, particularly when such expertise could not be gleaned from Dr. Cameron's 40 page curriculum vitae. While it would have been possible for Dr. Cameron to state in an affidavit that he lacked the expertise to deal with that chronic pain syndrome claim, I do not see a lack of such an affidavit permitting a conclusion that Dr. Cameron had the appropriate expertise. It was an error in principle and in law to so conclude.

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O'Brien v. Charbonneau, 2009 CanLII 10664 (ON SC), <https://canlii.ca/t/22r1v

[14] Dr. Hugh Cameron was called by the Defendant as an expert in orthopaedic medicine. He saw Mrs. O'Brien at the request of counsel for the Defendant to provide a medicolegal opinion. He saw the Plaintiff on May 4, 2007 for a period of about twenty minutes. His physical examination took up ten minutes of that time. He testified that if you take any longer to complete the physical examination you don't know what you're doing. He acknowledged her complaints of occasional neck pain, pain in the right side of her low back and pain in the right ankle. His examination failed to reveal any decrease in her range of movement. His opinion was that she had suffered a simple, uncomplicated strain of the neck and back from which recovery would be expected. He stated that there were essentially no physical findings and no objective corroborating evidence of any significant ongoing orthopaedic pathology. In his view, she was able to do anything which she wished without fear of harm, required no treatment as a result of the injuries sustained in the accident and would not require treatment in the future.

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Jennifer Esterreicher v. Non-Marine Underwriters, Mbrs. of Lloyd's, 2008 ONFSCDRS 197 (CanLII), <https://canlii.ca/t/jq7np

Expert Evidence

(a) Dr. Hugh Cameron

Dr. Hugh Cameron, a vastly experienced orthopaedic surgeon, examined and assessed Ms. Esterreicher on Lloyd's behalf on December 3, 2004, about 5 months before the first disputed treatment plan was submitted. He concluded that she might have some back symptoms, but he would not relate them to the accident.[15] On February 4, 2005, apparently in response to a request for his opinion on whether further chiropractic treatment was appropriate, he wrote as follows:

It is well known in the rehabilitation field, or should be well known, that any form of prolonged therapy, especially passive, is not only of no value but is actively detrimental in further emphasizing the illness role. Once a full range of movement has been regained there is no indication for further passive therapies.[16]

Repeating the finding of his earlier examination, he concluded that further treatment was neither reasonable nor necessary.

In March 2005, Dr. Cameron was asked to review the x-rays of Ms. Esterreicher's spine, knee and elbow. He agreed that she had possibly sustained a compression fracture at T11 (identified as T12 in his report, but clarified in his testimony). He noted that her post-accident complaints of mid-back pain and a notation in the records of pain in the thoracolumbar joint were consistent with her having sustained this fracture. He concluded however that, based on the severity of the fracture, "one would have expected this lady to have some complaints of pain at the thoracolumbar junction for about 3 months. One would not expect that this, however, would produce long-term symptoms.[17]" In his testimony, he agreed that the fracture would have hurt when it was sustained. However, there are no long term effects in the "vast majority" of patients. He agreed that the records show that Ms. Esterreicher has consistently complained of back pain, since the accident and conceded that symptoms do not resolve within the expected time for all patients.

Dr. Cameron authored several further reports, upon receiving more material from Lloyd's, his most recent being dated March 9, 2007.[18] His opinion did not change. In his latest report, he indicated that it was impossible to determine at this time whether the wedging at T11 was caused by a compression fracture, or an adolescent condition known as Scheurmann's disease.

Dr. Cameron elaborated on his reports in his testimony. He testified that, when he saw Ms. Esterreicher, he probably spent a total of 25 minutes with her, of which his examination of her was the shortest part. He doubted Ms. Esterreicher's assertion that he spent a total of 17 minutes with her, but there was no record in his notes of how long he spent. He indicated that he did not ask about how her body was thrown about in the accident, because he would not trust her memory in that regard. He testified that everyone will get neck and back pain at some time. Therefore, unless there is a complaint within a week of the accident, he would not link such pain to the accident. He drew the analogy to spraining one's ankle. You either sprain it and you know it, or you did not sprain it. He testified that he has never seen a patient who needed ongoing passive therapy, more than several months after an accident. The aim of passive therapy was to get the patient to a full range of motion. That is usually achieved in a few weeks. Once that has been achieved, strengthening and exercise was all that was reasonable and necessary. He described this approach as "not rocket science". He suggested that what Ms. Esterreicher should do is go to a gym two or three times a week and "do some sit-ups".

Dr. Cameron chided the service providers who recommended the disputed treatment, saying that they should know better. He indicated that the Chiropractic College warns in its Guidelines against the risk of patients becoming addicted to treatment, but admitted that he could not identify a specific Guideline, not having read them in detail. He was nevertheless confident that the College has issued a warning against the risk dependency. He elaborated on his view of a patient playing the "illness role", saying that this behaviour was a ploy to avoid doing things, like a child complaining of a stomach ache to avoid going to school. Referring to passive therapy as a "laying on of hands", he testified that patients can become as addicted to passive therapy as they can to crack cocaine.

Dr. Cameron agreed that pain can persist, even with a full range of motion and he agreed that chronic pain can be debilitating but testified that there is no sure way of telling whether a patient is in pain, absent objective evidence. Any other approach requires reliance on credibility and, when compensation is in issue, he is not prepared to rely on a patient's credibility.

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(a) Causation

Lloyd's attacked the question of causation on two fronts. It questioned whether the injuries for which Ms. Esterreicher was treated were caused by the accident and it questioned whether she continued to experience pain from any injuries she suffered. I find that the disputed treatment plans address injuries resulting from the accident. There is no evidence that Ms. Esterreicher suffered any of the symptoms prior to the accident. I do not accept Dr. Cameron's opinion that symptoms cannot be linked to the accident, unless reported immediately. That opinion does not consider that an injured person is likely to first seek treatment for only the most significant injury, it does not consider the possibility of progressive dysfunction caused by reported injury and it does not consider the psychological sequelae of physical injury, as diagnosed by Dr. Panjwani. In addition, although Ms. Esterreicher did not report all of the symptoms when she attended at the emergency department in Thunder Bay, her symptoms are consistent with the statement she gave in March 2001, when she reported back pain, injuries to her knee and elbow and a bump on her head. That report is sufficiently close to the accident to establish a temporal link. There is no evidence that Ms. Esterreicher suffered any further injuries in the intervening three months.

In any event, the major debilitating factor for Ms. Esterreicher is her back pain which she reported immediately and of which she has persistently complained. I do not accept Dr. Cameron's opinion that the fracture that Ms. Esterreicher suffered at T11 was not caused by the accident. There is no evidence of pre-accident symptoms consistent with that fracture and the reported post-accident symptoms are consistent with the fracture. Even if I were to accept that the fracture pre-dated the accident, I would not conclude that the accident did not cause the back pain at issue because there is no evidence of pre-accident back pain. Given the same history that Dr. Cameron reviewed, none of the other health care professionals, including the DAC assessors, doubted the connection of her symptoms to the accident. I prefer their opinion.

I further find that Ms. Esterreicher continues to experience pain from the injuries caused by the accident. I do not accept Dr. Cameron's opinion that the Ms. Esterreicher was "playing the illness role". Her conduct was not consistent with his own description of that role as one of a patient who uses injury as an excuse to avoid doing things. Ms. Esterreicher has not used the accident as an excuse for inaction. Since the accident, despite significant challenges to obtaining recommended treatment and engaging in recommended exercises, she has completed her education as scheduled, missed hardly a day of work, started her career and accepted and held a challenging position in that career. She had also engaged in an extensive exercise program. Dr. Cameron's opinion does not take that into account.

Dr. Cameron does not give a single example of what Ms. Esterreicher has avoided. His opinion is further compromised by the fact that it appears to be beyond his orthopaedic expertise. Determining Ms. Esterreicher's motive appears to be a venture into the realm of psychology or psychiatry, with no basis established for Dr. Cameron's expertise in those areas. Dr. Cameron's approach was to seek an orthopaedic explanation for Ms. Cameron's complaints and doubt their veracity if he did not find one. But Ms. Esterreicher was not seeking orthopaedic intervention. Given his pre-conceived opinion that no treatment is required once full range of motion has been achieved, one wonders why he examined Ms. Esterreicher except to find confirmation for his opinion.

I reject Dr. Cameron's opinion and I accept Ms. Esterreicher's evidence regarding her continued pain, bolstered by the opinions of Lorne Gleeson, Dr. Advent, Ms. Mueller and Ms. Hansen, all of whom found objective evidence to support the reports of pain, upon palpation of Ms. Esterreicher's tissue and muscles, long after Dr. Cameron had formed his opinion.

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I do not accept Dr. Cameron's opinion that the kind of treatment in issue is never warranted once a full range of motion has been achieved. Dr. Cameron admitted that pain might persist, even with a full range of motion. It therefore appears that Markham is using his medical opinion to attack the judicially established principle that pain relief can be a legitimate goal of treatment. Attacking jurisprudence is not a function of expert evidence. Dr. Cameron's opinion can be rejected for that reason alone.

In addition, Dr. Cameron suggests that Ms. Esterreicher's solution is exercise, without taking into account the fact that she was already engaged in an extensive exercise program. His opinion focuses on the pain relief goal of the treatment, without taking into account the goal of improving function through pain relief. Further, it is again not immediately apparent that Dr. Cameron, whose expertise is in orthopaedics, is properly qualified to render an opinion on appropriate rehabilitation practice. I find that he is at least not as qualified to render that opinion as the practitioners of rehabilitative medicine with whom he disagreed. I again prefer the opinions of Lorne Gleeson, Dr. Advent, Ms. Mueller and Ms. Hansen, all of whom found it reasonable to continue treatment, long after Dr. Cameron concluded none was needed. The opinions of Dr. Advent, Ms. Mueller and Ms. Hansen, are particularly persuasive because they assessed the treatment as part of an overall treatment and rehabilitation strategy that included exercise, and they considered the risk of dependency in Ms. Esterreicher's particular circumstances. They did not, as Dr. Cameron did, base their opinions on general expectations and presumptions about the rate of recovery.

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Gaukel v. Thukral, 2008 CanLII 45544 (ON SC), <https://canlii.ca/t/20p19

[24] Significantly, Dr. Cameron, for the defence, felt her problems were not permanent but he could give no prediction as to when they might resolve but that they would "spontaneously". He also agreed with the treating physicians that any further treatment would not cause any improvements, except perhaps for some stretching exercises.

[34] The overwhelming evidence in this case is that the problems this plaintiff is currently experiencing are permanent. This is the evidence of the four treating physicians who testified. They came to that conclusion because of the length of time the problems have been ongoing, the lack of any improvement despite significant treatment, and the fact that all testing has been basically negative, which means there is no identifiable cause of the pain which could then be treated.

[35] Dr. Cameron, for the defence, felt that the injury was not permanent and would sometime in the future spontaneously disappear. He could give no plausable explanation as to why that might occur, nor could he give any time frame as to when it might occur. He also testified that he felt his opinion was superior to the other 4 treating physicians, even though only having met the plaintiff on one occasion for less than one-half hour, because the treating physicians "could well be emotionally involved and, therefore, their evidence may be slanted." There is no such evidence before this court to that effect. I reject Dr. Cameron's opinion on the permanency test, and prefer the opinions of the treating physicians as having much more substance and reasoning.

[54] The theory of the defence,on this issue, as illicited from Dr. Cameron, was that the injury of the plaintiff caused by the accident, lasted only 2 to 3 months and any problems she has had thereafter has nothing to do with the car accident. Dr. Cameron conceded 5-10 per cent of patients with injuries similar to the palintiff do not heal. He gave no explanation as to why she did not fall into that category, other than he felt the surviellance depicted

no disability. His theory, based on some short periods of raking and sweeping and once carrying a jug of water 6 years ago, lacked any credible basis on which it might be accepted.

[55] Three of four doctors for the plaintiff, especially the family doctor, were of the view that the accident caused the plaintiff's on-going problems. One of her doctors did not know the cause.

[56] The evidence that this court accepts is that the plaintiff was pain free, symptom free and participating in all her normal activities at the time of the accident. This court has found that clearly changed after the accident, and no plausible explanation was presented by the defence to rebut the opinions of the treating physicians of the plaintiff. I accept them as more probable than the unsubstantiated theory of Dr. Cameron. It is clear that the jury came to the same conclusion on causation.

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Macdonald v. Sun Life Assurance Company of Canada, 2006 CanLII 41669 (ON SC), <https://canlii.ca/t/1q596

[32] I refused to grant leave pursuant to section 53.08 because I was of the view that to do so would cause undue delay in the conduct of the trial. It should be noted that the jury had already been excluded for a considerable period while the *voir dire* was taking place. If Dr. Lipson was permitted to continue with his testimony it is obvious that he would have been cross-examined at great length with respect to the discrepancies between his draft report and the served report. The jury would likely have had to devote a great deal of time in determining to what extent Dr. Lipson's opinion was influenced by the "quality control" activities of Riverfront. This would have caused an undue delay in the conduct of a trial that had already been considerably delayed.

[33] Moreover in view of the unsatisfactory nature of Dr. Lipson's evidence with respect to the origin of the reports in question, in addition to the undue delay which would be caused by the presentation of his evidence, his evidence would be more likely to confuse and confound the jurors rather than to assist them in their fact finding task. In such circumstances, there is a residual discretion in the court on a cost benefit analysis to refuse to admit the expert evidence[1].

[34] I was also of the opinion that quite apart from the problems relating to the reports, that the defendant would not suffer any significant prejudice by not having Dr. Lipson's evidence before the jury since the defendant intended to call Dr. Hugh Cameron an orthopedic surgeon whose evidence would be similar to that of Dr. Lipson. Having heard Dr. Cameron's evidence I am satisfied that my opinion was correct.

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Francis v. Hassania, 2004 CanLII 45965 (ON SC), <https://canlii.ca/t/1jdl7

[17] Dr. Hugh Cameron disagrees. He examined Ms. Francis in February 2002 and testified on behalf of the defence. He is of the opinion that Ms. Francis' symptoms and their etiology are attributed to a pre-existing, degenerative condition unrelated to the trauma of the accident. He accepts the fact that Ms. Francis had no symptoms before the accident, but rejects the opinion of the other doctors that a direct, separate and distinct trauma to the patellofemoral joint is the cause of the disabling pain and the ultimate deterioration of both the patellofemoral joint, and the weight-bearing femorotibial joint. In Dr. Cameron's opinion the pain from the accident arose as a result of already weakened quadriceps muscles, which in turn sped up the acceleration of the deterioration. He expresses his conclusion as follows:

So this girl, who was getting degenerative changes, got some quadriceps weakness and in a sense lost control of her knee and hasn't ever been able to regain it. So that's why her knee became painful.

In his opinion, the pathology, the deterioration and the consequent disabling pain were not trauma-induced. He says Ms. Francis would have suffered these in any event, whether or not the accident happened, three to five years after the date of the accident when Ms. Francis was between 28 to 30 years of age. Dr. Cameron believes Dr. Gittens' early notation in November 1993 of "crepitations with discomfort under the right patella, down bilaterally, degenerative changes in the knees with mild osteophytes and spurring of the tibial spines and some irregularity under the patella" indicates a pre-existing degenerative condition in the right knee. He also supports his opinion on the assumption "that two or three years after the accident Ms. Francis just developed symptoms [to her left knee with] no particular injury to the knee; she just got sore."

[18] On the evidence, however, Ms. Francis suffered several serious falls caused by the right knee giving way after the accident, which in turn caused injury to her left knee. Dr. Nixon reports a "twisting" of the left knee during one of these falls in 1998. The evidence does not support Dr. Cameron's belief that the left knee "just got sore", with "no particular injury to the knee." Dr. Cameron relied substantially on this false assumption which seriously undermines the validity of his ultimate opinion regarding the inevitability of Ms. Francis' pain and suffering within three to five years from the date of the accident.

[19] Dr. Cameron's opinion that Ms. Francis would have suffered disabling pain in her knees three to five years after the date of the accident is not supported on the evidence. His conclusion that Ms. Francis had a long-standing arthritic change in her knees before the accident is not supported by the medical history. It is based solely on his interpretation of Dr. Gittens' November 1993 consultation note. It is not based on his examination of Ms. Francis, nor does it take into account the nine-year history of Ms. Francis' condition before his consultation. Dr. Cameron, without reason or explanation, cavalierly dismisses the other medical reports and opinions as "just sort of fluff".

[20] Dr. Gittens' note of November 1993 states Ms. Francis was showing spur formation from the upper and lower pole of the patella. Dr. Cameron says this indicates long-standing arthritic change, because spur formation obviously takes years to occur. However, both Dr. Prior and Dr. McGoey, who conducted post-injury arthroscopic examinations of the knee, found no clinical support for Dr. Cameron's conclusion that Dr. Gittens' radiological findings in November 1993 were indicative of any pre-existing arthritic condition in the right knee. Nor did Dr. Prior find any significant features of osteroarthritis present in the right knee when he took x-rays. Dr. Prior disagreed with Dr. Cameron's opinion that spurring of the tibial spines is indicative of arthritic degeneration. He also disagreed with Dr. Cameron's conclusion that Ms. Francis' quadriceps muscles were already weakened. Quadricep wastage, he said, can occur as early as 48 hours after trauma. Before the accident Ms. Francis was physically active, having regularly enjoyed activities such as walking, jogging and dancing. On the evidence as a whole, Dr. Gittens' note "quads are down bilaterally", made four months after the accident, is entirely consistent with Ms. Francis' condition being trauma-induced, and not as a result of a pre-existing arthritic degeneration, as opined by Dr. Cameron.

[21] There is no support in the evidence for Dr. Cameron's conclusion that Ms. Francis would have suffered chronic and disabling knee pain three to five years after July 1993, even if the accident had not occurred. Both the clinical and anecdotal evidence support the conclusion that the accident caused severe trauma to Ms. Francis' knees, as a result of which she has not only suffered long-term pain, but has also been severely curtailed in her day-to-day activities, including her ability to establish herself in the workplace. Dr. Cameron ignores the weight of clinical evidence and medical opinion that Ms. Francis' ongoing problems relate to the patellofemoral joint, that is

the vertical plane, and not to the tibialfemoral joint, being the horizontal plane of the pre-accident osteotomies. Though Dr. Cameron casually mentioned that these osteotomies are now performed above the level of the knee, he does not critique the relative success of the 1981 and 1983 osteotomies which corrected Ms. Francis' childhood knock-knees. Indeed, all of the evidence supports the conclusion that the previous mal-alignment was properly corrected and remains so to date. As stated by Dr. Erin Boynton in her medical/legal report dated February 3, 2004,

. . . This woman has been adequately corrected and remains in good alignment to date, so we would not anticipate significant deterioration of her patellofemoral joint over the years.

[44] For reasons above I have rejected the opinion of Dr. Cameron as to the imminent effect of the pre-existing condition of her knees. Ms. Francis' childhood mal-alignment was successfully corrected by surgery many years before the accident. Other than Dr. Cameron's unsupported opinion, there is no evidence that Ms. Francis would have suffered disabling pain in her knees at an early age. I have accepted the evidence of Dr. McGoey that the probable onset of symptoms related to the pre-existing condition would have occurred some twenty-five years after 1993, that is, in 2018. Based on the evidence of diligence and efforts the plaintiff was making towards the establishment of a career when the accident occurred, it is probable Ms. Francis would have established herself in a social work career soon after 1993. She would have had sufficient time and opportunity to achieve seniority by 2018, had the accident not occurred. She would have been experienced enough to qualify for administrative or management positions which are relatively sedentary as compared to entry-level positions. The effect of her pre-existing condition would not have been as limiting on her earning capacity as was the injury from the accident, which occurred before she could establish herself in her chosen career.

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Rondeau v. Allstate Insurance Company of Canada, 2004 CanLII 7612 (ON SC), <https://canlii.ca/t/1h99v

[24] In respect of the plaintiff's injuries, there were three medical opinions provided; by Dr. Yadav, her attending orthopedic specialist, by Dr. Hugh Cameron, an orthopedic specialist retained by the defendant, and by Dr. Schatzker who performed the initial surgery. The decision to terminate the plaintiff's benefits on November 27, 1996 according to correspondence sent to the plaintiff, dated October 28, 1996, was based on the opinions of Dr. Yadav and of Dr. Cameron, which were available to the defendant at that time.

[29] Dr. Cameron who also testified in these proceedings examined the plaintiff on August 14, 1996 and provided a medical report of the same date. That report, which was at the time relied upon by the defendant to deny benefits, states that she "is capable of performing all her activities of daily living and is capable of performing her duties as a caregiver". In view of numerous symptoms that appear to suggest otherwise, which he described in his report, I have difficulty accepting that conclusion. For example, in making reference to the contents of a physiotherapy report, he seems to accept that she was having difficulties with her right ankle and right knee, pain in stair climbing, ladder climbing, kneeling and crawling. He concluded that her ability to kneel and squat was limited; but that this limitation was probably due to the hardware and that once the hardware was removed he predicted that she would be "perfectly functional". However accurate his prognosis may have been, I am not satisfied that his observations at that point in time justified the conclusion referred to above, since the hardware was yet to be removed. His opinion was merely speculation and premature until that surgery was performed later. As a result, I find his report of little assistance as it relates to her condition at 104 weeks, and I certainly do not believe that it provides the justification, as the defendant's representative apparently felt that it did, to terminate the plaintiff's benefits at that stage. His evidence at trial did not alter my view in that respect. He

failed to compare her function at that time with her capabilities before the accident, nor did he appear to have considered the requirements of the regulation before concluding that she was ineligible.

[38] On the occasion of his second examination, which was six years after his first examination, Dr. Cameron' s opinion was that the original surgery had been so successful that the necessity for an ankle fusion would be delayed for a significant period of time. He concluded that her ankle injury was not disabling, and that a fusion would not prevent her from being able to carry out her normal activities. In fact, when testifying in this Court, he indicated that he viewed her knee injury as more significant than her ankle injury, because of the highly successful treatment of her ankle. Although all three doctors concur that eventually she will require an ankle fusion, they disagree as to the extent that it will reduce the mobility in the joint.

[39] As he had failed to do in his earlier report, when giving his evidence in this Court, Dr. Cameron neither addressed the specific caregiving activities with which the plaintiff had been involved nor the definition of caregiving activities or the extent of the disability required to qualify her for benefits under the legislation. However, it is apparent that his diagnosis as well as his prognosis of her injuries when he examined the plaintiff on the second occasion, despite the likelihood of an ankle fusion, would eliminate her from qualifying as "suffering a substantial inability to engage in the caregiving activities that she was engaged in at the time of the accident". Essentially, as I understood his evidence, Dr. Cameron felt that after accepting some degree of pain and some restriction of mobility, and having to perform her activities more deliberately, she could function as she had previously. In that respect his opinion falls within the scope of the criteria established in other cases.

[40] At the stage that Dr. Yadav completed the further removal of hardware on April 18th, 2001, he testified that in his opinion her pain and problems were ongoing and continuous. He saw her on a follow-up to the surgery in September of 2001 and not again for a year and a half. It appears evident from his notes and consultations that until the hardware was removed in June of 1999 she continued to be disabled from performing her caregiving activities. Coincidently that is in keeping with Dr. Cameron's earlier opinion that she would be in pain until the hardware causing her discomfort was removed. Although she had returned to school in September of 1998, her evidence was that she continued to be too tired and sore to perform her caregiving activities during that period.

[41] Dr. Schatzker saw her on December 19th 2003 and provided a report of the same date. Perhaps his most significant comment was "The most disabling feature, on examination today, was the very severe back pain. As I have already stated, in my view this is unrelated to the accident." He also did not deal in that report with a comparison of her ability to perform her pre-accident caregiving activities with her present capabilities. He stated that her injuries are limiting factors in her ability to perform activities and stated that he disagreed with Dr. Cameron's view that there is "nothing" that prevents her from performing her caregiving activities. He felt that the injuries to her right ankle and knee are "major limitations". Despite his obvious view that Dr. Cameron had exaggerated a lack of symptoms, I would expect that statement to mean, given his own description of her symptoms, that permitted to take longer to perform activities than she had, and accepting some pain and some loss of mobility, she is still capable of performing the caregiving activities that she performed at the time of the accident.

[42] Accepting that all three doctors recognize that she continues to suffer from pain and limitation of movement to some degree, I certainly cannot conclude that either Dr. Yadav or Dr. Schatzker actually disagree with Dr. Cameron's view that in spite of those limitations she can still perform the same activities that she performed before the accident.

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Laura B. Uwase v. Royal & Sunalliance Insurance Company of Canada, 2003 ONFSCDRS 170 (CanLII), <https://canlii.ca/t/jq6f2

Ms. Uwase was injured in a motor vehicle accident on August 18, 2001. At the time of the accident, Ms. Uwase was employed as a passenger information representative at Toronto's Pearson International Airport. Ms. Uwase received income replacement benefits from August 25, 2001 to July 26, 2002. On May 2, 2002, Royal issued a stoppage of benefits based on insurer's examination reports issued by The Independent Group of Medical Specialists Inc. ("IGMS"). Ms. Uwase requested an assessment at a designated assessment centre ("Disability DAC") under section 37 of the *Schedule.* The assessment took place on July 10, 2002. Dr. Hugh Cameron of the Disability DAC reported that Ms. Uwase was no longer disabled and, on this basis, Royal terminated benefits as of July 26, 2002.

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Ms. Uwase's position is that the assessment she attended on July 10, 2002 was so flawed that she was effectively denied her right to be assessed by a Disability DAC. Accordingly, Royal's termination of her benefits was not done in accordance with section 37 of the *Schedule.* She submits that her income replacement benefits should be reinstated until they are properly terminated under section 37 of the *Schedule.*

Ms. Uwase outlined several ways in which the DAC did not comply with the Disability Designated Assessment Centre Assessment Guide (April 2000), published by the Minister's Committee on the Designated Assessment Centre System (the "Guide"). Primarily, her concerns lie in the absence of an assessment team, the fact that no independent assessment of her work activities was done, and the vagueness of Dr. Cameron's report.

More specifically, Ms. Uwase submitted that the Disability DAC was improper for the following reasons: the DAC did not have the resources to assess her actual work activities; no independent assessment of work activities was conducted; there was no core assessment team present in this case; there was no case coordinator; no standard appointment confirmation letter was sent; no assessment plan or executive summary were completed; and, the final report was not in the proper format and did not clearly articulate Dr. Cameron's conclusion.

The deviation from the Guide in this case is not so significant that I can find Ms. Uwase was effectively denied her right to be assessed by a Disability DAC. Accordingly, I do not find that the termination of Ms. Uwase's benefits was in breach of section 37 of the *Schedule.*

Dr. Cameron is the only medical professional to have examined Ms. Uwase for the purpose of the Disability DAC. Although the Guide requires a core team to be available to assess a claimant, the language of the Guide makes it clear that not every member of the core team must examine a claimant: "The term 'core team' is not meant to imply that these 4 assessors will see every claimant, but rather it is from this group of assessors that the 'case-specific assessment team' will most often be drawn."[2] I do not find that Dr. Cameron's being the sole assessor in this case is a significant deviation from the Guide. I have no evidence as to whether there was a core team identified in this case.

Although the DAC did not conduct an independent assessment of Ms. Uwase's work activities, it is apparent from the report that Dr. Cameron discussed Ms. Uwase's work with her during the examination. He wrote: "She said at the time of the accident she had a summer job at the airport. This was office work and walking around giving information."

Dr. Cameron was in possession of a Functional Abilities Evaluation ("FAE") conducted by IGMS on March 3, 2002. The FAE report identifies Ms. Uwase's pre-accident job as a Customer Service Agent at the airport. It indicates that the typical work day is 480 minutes with 30 minutes for a lunch break and other breaks, with a net time worked of 450 minutes. The assessors at IGMS tested Ms. Uwase's ability to stand, sit and walk and her dexterity, vision and hearing. IGMS concluded that Ms. Uwase was not disabled from returning to her pre-accident employment. IGMS did not conduct an on-site work assessment.

Dr. Cameron was also in possession of a report prepared by Dr. Paul Robert, orthopaedic surgeon, also with IGMS. Dr. Robert refers to Ms. Uwase's pre-accident job as a Passenger Information Representative and he concludes that she is not prevented from returning to that employment.

Dr. Cameron had the IGMS descriptions of Ms. Uwase's pre-accident employment and he obtained employment-related information directly from Ms. Uwase. A job-site assessment is not a prerequisite to an adequate Disability DAC. In this regard, the Guide states as follows: "The DAC can gather further information from the claimant and rely on their professional and clinical expertise and experience when identifying the essential tasks or caregiving/normal life activities which it will base the assessment upon. ... In the unique case, the DAC may elect to conduct its own *in situ* task/activity analysis."[3]

It is not contemplated that a Disability DAC conduct an independent assessment of a claimant's work activities on every occasion. Rather, a Disability DAC would undertake a job site assessment only in a unique case.

In this case, I find it was reasonable for the DAC to not conduct a job site assessment. Dr. Cameron had the reports of IGMS and the opportunity to interview Ms. Uwase, and therefore had sufficient information to draw a conclusion.

Finally, Ms. Uwase objects to Dr. Cameron's report, indicating that it does not clearly articulate his conclusions as the Guide requires. In his report, Dr. Cameron concludes in the following terms: "In my opinion therefore this lady has to all intents and purposes recovered from the effects of this accident. One would not anticipate any prolonged effects or any effects in the future. She is no longer disabled and is fit to carry out all her routine normal activities including those of employment."

Although Dr. Cameron did not phrase his conclusions in the precise language of the *Schedule,* I do not find his conclusions to be so indeterminate or vague that his report does not comply with the Guide.

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Frankfurter v. Gibbons, 2003 CanLII 15731 (ON SC), <https://canlii.ca/t/1bw6w

[19] The defendant's medical expert was Dr. Hugh Cameron, an orthopaedic surgeon, who examined the plaintiff on August 3, 2001. Dr. Cameron was of the opinion that it was unlikely that there was any significant injury from an orthopaedic point of view as a result of the accident and that she was neurologically normal. He noted that, when tested passively, the plaintiff had full range of motion through her neck, shoulders and back. He stated that he would have expected her injuries to have resolved to her pre-accident status within a few weeks or months at best. He was critical of the passive form of therapy she had received, which he believed was actively detrimental in further emphasizing the illness role, and recommended a more active self-directed home exercise program to strengthen her neck and shoulder muscles.

[20] Dr. Cameron testified that, in his view, the complaints post-accident were almost the same as the complaints pre-accident. He also believed that psychoemotional factors, by which he meant her general experience of anxiety, might explain the symptom magnification and widespread tenderness to pain reported by others. He testified that, based on his review of Dr. Shapira's records, these factors appear to have pre-dated the accident. He speculated that she might have had the same tenderness in her neck before the accident as result of the operation of these factors in her life. His prognosis was uncertain. On the one hand he said that he thought she would get better and become more active, particularly as stresses in her life are reduced or eliminated. On the other hand he said she might continue to have some symptoms in her neck and shoulder because she had, he thought, experienced this pain for some time before the accident. In his words, "the accident did her no good, but equally it does not appear to have done her any particular harm".

[25] The defendant's expert, Dr. Cameron, disagreed with this conclusion in several respects although there is also considerable agreement between Dr. Cameron and Dr. Tepperman, the plaintiff's principal expert. Dr. Cameron says that the plaintiff is neurologically normal and that it is unlikely there was any significant injury from an orthopaedic point of view. Dr. Tepperman does not disagree with either of these statements. Both experts also agreed that most patients suffering from the plaintiff's injuries would have resolved such injuries within a few weeks or months at best. Where they part company is with respect to the explanation for the plaintiff's continuing experience of pain. Dr. Tepperman concluded that the plaintiff had suffered a soft tissue injury to her neck and attributed the chronicity of the stiffness and pain to the plaintiff's low pain threshold which inhibited her rehabilitation after this injury by limiting the active therapy she could tolerate. He acknowledges that other stressful events in the plaintiff's life since the accident could have further exacerbated her condition but are not the primary cause of her disability. Dr. Cameron, however, attributed the plaintiff's stiffness and associated pain to psychoemotional factors which pre-dated the accident. As the defendant's counsel put the point in his closing statement, the plaintiff would have had back pain as a physical response to the general anxiety in her life even if the accident had not occurred. It was also his view that there was no certainty that this disability was permanent. If the plaintiff could reduce or eliminate the stress in her life, in his view it was possible that the plaintiff's condition would improve.

[26] In my view, the evidence supports the finding that the disability results from the accident. The plaintiff was a very credible witness when she spoke of the stiffness and pain she suffered. Her physical condition was supported by the evidence of her non-medical witnesses. More significantly, I believe all of the medical experts confirmed the plaintiff's physical condition in their examinations of the plaintiff. I do not believe that Dr. Cameron's explanation for her condition was supported by the evidence. Neither Dr. Shapira nor Dr. Stillo indicated that the plaintiff suffered from a similar condition prior to the accident. Dr. Shapira was even more emphatic that the plaintiff was able to deal with stressful events in her life before the accident and had not experienced insomnia. On the other hand, the evidence does support Dr. Tepperman's view that the plaintiff experienced a low pain threshold which has inhibited her recovery by limiting the active therapy she found tolerable. The evidence of symptom magnification reported by each of Dr. Tepperman, Dr. Potashner and Dr. Cameron is consistent with this finding of a low pain threshold. While the plaintiff did follow the rehabilitation programme prescribed for her, I also find that, because of this low tolerance for neck pain, she has exhibited a marked preference for passive forms of therapy which has prolonged her condition and ultimately rendered it chronic.

[27] In short, I accept the position of the plaintiff that the plaintiff, as in *Altomonte v. Matthews* [2001] O.J. No. 5756 which is similar in this regard, is one of those persons who does not recover from a soft tissue injury but

develops chronic pain after continuation of this injury for a period of time. I also accept the evidence of Dr. Tepperman and Dr. Shapira that the emotional factors in her life exacerbated the plaintiff's stiffness and pain but did not cause it. I should note that there was no suggestion by any of the medical experts, including Dr. Cameron, that the plaintiff did not genuinely suffer the pain and stiffness of which she complains. The description of the plaintiff in *Lemire (Litigation Guardian of) v. Roztek Ltd.* [1997] O.J. No. 2307 — "she has a genuine low pain threshold and a low emotional threshold that gets in the way of her being able to make a sufficiently adequate recovery to reach a point where she is no longer able disabled by her injuries"— also captures the plaintiff's circumstances in this case.

[28] For the foregoing reasons, I find that the plaintiff has a suffered a chronic disability which takes the form of stiffness and pain in her neck with pain radiating from time to time into her right shoulder blade or into her arm and central fingers. I also find that this impairment resulted from the automobile accident of March 6, 1999. The plaintiff also suffers from insomnia arising from the need to exercise her neck or shoulder periodically during the night. I also find that this condition is permanent and that she will have to make adjustments to her life style to accommodate the intermittent discomfort this will entail and continue with active and passive treatments as well as medication as required.

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Susan P. Driver v. Traders General Insurance Co., 2003 ONFSCDRS 2 (CanLII), <https://canlii.ca/t/jq6g0

In a second letter dated the same day, Traders notified Ms. Driver that it intended to terminate her IRBs on the basis of a May 28, 1999 Disability DAC assessment report by Dr. Hugh Cameron, an orthopaedic surgeon. Although not asked to do so, Dr. Cameron commented that the passive treatment Ms. Driver had received "to date" was ineffectual and that no further treatment was reasonable or necessary. On the basis of that comment, Traders' letter advised that it would accept no further treatments at HealthWinds or any other treatment facility, although it agreed to honour the May 26, 1999 Treatment Plan.[21]

Traders' letter concludes:

I have also enclosed a copy of the IE report prepared by Dr. Keith Nicholson [a neuropsychologist] on June 1, 1999. Dr. Nicholson states that "She might benefit from brief intervention to facilitate effective use of compensatory strategies for cognitive problems." It is recommended that you provide your family doctor with this report and discuss the availability of psychological intervention.

The letter encloses an Application for Mediation should Ms. Driver dispute the decision to discontinue benefits.

I find that it would not be reasonable for Traders to deny treatment based on the opinion of Dr. Cameron alone, as he was not specifically asked to comment on treatment at all, and his comments about previous ineffective, passive treatment clearly did not refer to Vistasp therapy. Furthermore, I find that Dr. Cameron based his opinion that treatment up to that time was inappropriate largely on the April 1999 IE report of Dr. Reuven Lexier, another orthopaedic surgeon, as well as his own belief (shared by Dr. Lexier), that passive forms of treatment were "worthless." I find this to be a somewhat rigid view, not supported in Dr. Cameron's case. Dr. Lexier's report pre-dated Ms. Driver's first Vistasp treatment and it is clear his opinion applied to the passive physiotherapy and massage she received prior to Vistasp, which even Ms. Driver agreed did her no good at the time.

However, Traders did not rely exclusively on Dr. Cameron's opinion, but also on that of Dr. Nicholson. Although Dr. Nicholson accepted Ms. Driver's pain as legitimate, and identified it as the primary cause of her cognitive

difficulties, he felt her reaction to the accident was partly dependent on pre-existing personality and psychosocial issues. He recommended psychological intervention to address these issues and to provide relaxation training and compensatory strategies for cognitive problems, and a gradual return to all pre-accident activities. Dr. Nicholson stated that active physiotherapy or other "such modality may be very helpful in facilitating recovery," but advised that "there should perhaps be some consideration given to the degree of exacerbation of physical problems with more active treatment." I find that Traders interpreted "some consideration" to justify denying *any* further therapy except for psychological intervention at that point. I find this to be a somewhat hard line, and not reasonable in the circumstances.

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Finlayson v. Roberts, 2000 CanLII 16890 (ON CA), <https://canlii.ca/t/1fbd3

[11] The defendant's expert, Dr. Cameron, examined the plaintiff in 1990. In his view, while the likelihood of Ms. Finlayson developing osteoarthritis was relatively high, the likelihood of her needing surgery was relatively low. He testified that consistent with his original diagnosis, each year that went by would decrease the likelihood that Ms. Finlayson would need surgery. He testified that surgery is a matter of individual choice, based on considerations such as pain and ability to walk. He testified that Ms. Finlayson's analgesic intake was low, and that she walked well. Thus, Dr. Cameron felt that the likelihood of Ms. Finlayson needing surgery at this point was very remote. Furthermore, he saw no reason why she could not continue work as an ICU nurse.

[12] In his assessment of the plaintiff's future, it was open to the trial judge to choose between these conflicting medical opinions. However, in so doing, the trial judge misapprehended the medical evidence before him.

[13] On cross-examination, Dr. Cameron was asked whether having seen Ms. Finlayson more recently and having heard her complaints of pain, Dr. English had a better opportunity to form a judgment. Dr. Cameron responded:

A. No, I don't think so, because you see this is fairly straight forward. There's no big mystery here, I mean, as to what happened to her and what the eventual outcome is liable to be. I don't think anything has changed since my initial report. I think events have come out exactly as I suggested they would. As to Ted English having seen her three times and my seeing her once, I don't think that matters a great deal, because the decision based on whether or not she needs surgery, there are a couple criteria which I discussed earlier, and that is pain and inability to walk.

Q. Yes. Now, Doctor, you did say that the pain can be subjective?

A. Yes.

Q. All right. He had the advantage of seeing her more recently than you did, and to determine the pain based on certain complaints, fair?

A. Well, yes, but you see there's always a – trial contaminates things, if I can put it that way. No one in their right mind is going to come up to a doctor and say my foot has suddenly, magically gotten better two weeks before a trial. Then, so, you cannot rely on this sort of a situation, and you have to really rely on her analgesic intake.

[14] The trial judge's response to this evidence was, at paras. 102 and 103:

On being asked whether it would have helped him to see the final report of Dr. English, Dr. Cameron made some disturbing and in my view quite inappropriate statements. In effect, he said that it would not have helped him to see the opinion in question, because it was, or would be, "contaminated" because it was issued too close to the commencement of the trial. The clear implication is that the timing of the opinion relative to the commencement of the trial would have caused Dr. English to tailor his opinion in a way more favourable to a larger recovery by the plaintiff. No particulars were given. The opinion was expressed as a generalization that included Dr. English. Having heard the careful manner in which the latter explained the changed complaints of pain (by a patient that he had come to trust in such matters) had caused him to change his opinion as to the desirability of a fusion operation. I felt that Dr. English was being recklessly and irresponsibly maligned and insulted. I remember thinking that if this had been a jury trial I would have had to point out to the jury, in no uncertain terms, that Dr. Cameron's status as an eminent orthopaedic surgeon did not include qualification to express opinions of this sort – and that the opinion should be ignored. I believe that a privilege has been abused and that the court has a duty to protect its process from such abuse. There is also a self-damaging aspect to such a generalized assertion of "contamination". The question that arises naturally is whether any opinion of Dr. Cameron himself that is issued close to the time of trial is seen by him as similarly "contaminated". If so, an expert witness is inviting disbelief of his opinions – or is asserting a right to, or acknowledging practice of, tailoring of opinion evidence.

At the time I was beginning to become angry about this matter I was diverted and instructed by the superior response of Mr. Manes, who proceeded to conduct a virtual clinic on advocacy in cross-examination, by consistently addressing his questions to Dr. Cameron's best professional self, treating the doctor almost as if he were Mane's own expert witness. As a result of astute questioning a large number of acknowledgements favourable to the plaintiff's case were obtained.

[15] This reasoning shows a clear misunderstanding by the trial judge of the concern being expressed by Dr. Cameron. Dr. Cameron was expressing the legitimate opinion that assertions of pain may be suspect when made on the brink of a trial. This concern was not directed at Dr. English. That the trial judge's judgment was distorted is confirmed by a reading of the cross-examination to which he paid such high tribute. Contrary to his expressed recollection, the evidence given by Dr. Cameron in cross-examination generally confirms Dr. Cameron's earlier testimony and includes no retractions. Answers favourable to the plaintiff included acknowledgements of the pain she was suffering and of her stoic nature, and the expectation that she is likely to suffer from ongoing osteoarthritis.

[16] On one point the trial judge simply misconceived answers of Dr. Cameron on cross-examination. He made two observations at separate points in his reasons, at paras. 105 and 51:

Dr. Cameron also acknowledged that he agreed with Dr. Czitrom that there would not be any significant improvement, and that pain could reach such severity that further surgical intervention would be necessary. Dr. Czitrom had estimated that there would be 10% chance that such further surgery would become necessary over the ten years following June, 1990, whereas Dr. Cameron was of the opinion that there was a 25% chance of that. On the whole then, the result of the cross-examination was a position much less sanguine than that expressed by Dr. Cameron in his direct testimony.

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Faraj Saliba v. Allstate Insurance Company of Canada, 1999 ONFSCDRS 171 (CanLII), <https://canlii.ca/t/jq5fs

At the time of Dr. Howell's examination, approximately a year had elapsed since Mr. Saliba went off work on August 3, 1993. During that time, the clinical notes of Dr. Phills show no significant improvement in Mr. Saliba's condition. To the extent that Dr. A. Ameis, physiatrist, Dr. E. Urovitz and Dr. H. Cameron, orthopaedic surgeons, have adopted Dr. Howell's opinion on disability, I also reject their opinions.

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Dr. Hugh Cameron, an orthopaedic surgeon, assessed Mr. Saliba on behalf of Progressive following the surgery. He opined that the surgery should not have been performed because Mr. Saliba had a normal neurological examination, and because Mr. Saliba had a psychological problem; not a physical one. He opined that even if Mr. Saliba had not developed quadriplegia, the surgery would not have been successful, since a psychological problem cannot be fixed by surgery. Since I have concluded that Mr. Saliba is physically disabled and there is an additional psychological component to that disability, I reject Dr. Cameron's opinion.

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Drs. Cameron, Urovitz, Ameis and Gray opined that the second accident produced little or no ill effects, at most caused a very minor neck and back strain, which should have resolved somewhere between June 1992 and December 1992. All relied on Dr. Wismer's examination, and/or on the physiotherapist's statements in reaching their conclusion. However, those health practitioners felt it impossible to apportion responsibility to one accident or another. I reject the opinions that the effects of the second motor vehicle accident were trivial. Of the remaining opinions, two suggest the first accident is 75% responsible and the second 25% responsible. Even a 25% amount is more than minimal or trivial and is therefore material or significant.[13] I find it probable that both accidents significantly contributed to Mr. Saliba's disability.

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Oussama Oueidat v. Progressive Casualty Insurance Company, 1998 ONICDRG 78 (CanLII), <https://canlii.ca/t/jq589

Dr. Hugh Cameron, an orthopaedic specialist, examined Mr. Oueidat at Progressive's request on June 28, 1996, three and a half months after the accident. He found "no abnormalities" of Mr. Oueidat's left knee. He found "evidence of symptom exaggeration, with complaints of tenderness extending well above and well below the knee." He thought Mr. Oueidat should go for one month of active exercise, then return to work. Dr. Cameron was of the opinion that "lifting of a heavy nature is ... fairly seldom required" of hospital cleaners. He found no evidence that Mr. Oueidat had sustained "any injury of a permanent irreversible organic nature."

Dr. Cameron later reviewed Dr. Young's operative report, the MRI report, and other reports and records before preparing a second report for Progressive, dated February 20, 1997. He did not change his opinions and thought Mr. Oueidat should return to work immediately. He testified at the hearing that he thought Mr. Oueidat's left knee injury pre-dated the 1996 car accident, although he believed it could have been asymptomatic until then. On examination-in-chief, Dr. Cameron testified that he thought the amount of chondral damage reported was "pretty minimal" and that it was "no significant disability," although he thought that after standing on his feet all day Mr. Oueidat might have aching.

On cross-examination, Dr. Cameron testified that he when he examined Mr. Oueidat, he recorded Mr. Oueidat's "inappropriate" responses on certain testing, for example on pseudo-rotation, but where he responded appropriately, for example, on a test of pseudo-axial loading, he did not report the response. Dr. Cameron testified that he believed that job descriptions, such as Mr. Oueidat's as a hospital cleaner, "have to be over written," meaning that the tasks and weights involved are exaggerated. He believed assistance was always available in a hospital setting where heavy lifting was required. Dr. Cameron agreed that in a case of chondral contusion, the damage to the joint surface was permanent and susceptible to osteoarthritis and that if it was the size of a two dollar coin, it was "maybe significant" although "we're not talking bone exposure or a serious injury."

Conclusion on Disability

The case law as it has developed at the Commission does not require that the accident be the sole cause of the disability, rather it must be a "significant" or "material" contributing factor to the condition. Thus, it is not necessary for me to determine whether Mr. Oueidat sustained the initial damage to his femoral condyle in the motor vehicle accident of March 13, 1996—rather, I must determine whether the accident significantly contributed to the disability that is claimed, for example, by aggravating or exacerbating a previously asymptomatic condition.

I accept Dr. Cameron's opinion that the combination of the normal MRI scan in September 1996, coupled with the injury in 1993, and the degenerative findings in x-rays taken only a few weeks after the 1996 accident that also showed evidence of Pellegrini-Stida disease, might indicate Mr. Oueidat had early degenerative osteoarthritis developing before the accident. However, I also accept the applicant's evidence about his pre-accident health and find that Mr. Oueidat's left knee was asymptomatic prior to the 1996 accident, except for one incident in 1993 that cleared within a few days.

I find that Mr. Oueidat did suffer trauma to his knees and legs in the 1996 accident. I accept Mr. Oueidat's evidence as to the debilitating pain he experiences in his left knee and that he suffers from recurrent, unpredictable instability in that joint. I prefer Dr. Young's evidence, as the surgeon who has examined the joint, that the lesion to the femoral condyle is extensive enough to be disabling from work such as Mr. Oueidat was required to perform. I accept the job descriptions, as filed, together with the oral descriptions by Mr. Oueidat of the nature of the work he had to perform in preference to the speculation of Dr. Cameron as to his view of the real nature of the hospital job. I find on the basis of the physical injuries to his knees and legs that Mr. Oueidat suffered on March 13, 1996, that he cannot perform the essential tasks of both his employment as a hospital cleaner and his job as a food runner, at present, or at any time since the accident. As a result, Progressive must pay him weekly income replacement benefits, from September 17, 1996, ongoing.

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In this case, Progressive terminated weekly income benefits based on the opinions contained in the neurological report of Dr. G. Moddel and Dr. H. Cameron's report of June 28, 1996. Dr. Cameron, an orthopaedic specialist with a particular expertise in knees, who has casually observed the work of hospital cleaners over his career, was of the opinion that Mr. Oueidat would be fit to return to his cleaning job after a short period of active exercise. When Dr. Cameron received further documents from Progressive, in February 1997, he wrote a second report in which he gave the opinion that the injury to Mr. Oueidat's knee could well have pre-dated the motor vehicle accident. He still thought Mr. Oueidat should return to work.

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On March 24, 1998 Progressive asked Mr. Oueidat to attend another examination by Dr. Cameron, in accordance with section 65 of the *Schedule,* relating to his claim for weekly benefits. Mr. Oueidat replied that not only was he unavailable on the date selected for the examination (April 8th), but that he would not attend an examination by Dr. Cameron, since he had already been examined by him and a re-examination was "neither reasonable nor necessary."

Under the provisions of section 65 of the *Schedule,* an insurer may "as often as reasonably necessary" schedule an examination by a health professional or a person with expertise in vocational rehabilitation. The policy reasons compelling such a broad right of intrusion into the insured person's health or vocational situation have been set out in several arbitration and appeal decisions relating to this *Schedule* and its predecessor. Mr. Oueidat did agree to attend a psychological assessment with a psychologist of the insurer's choice (Dr. Peter Bernstein, C.Psych.) in April, 1998, shortly before the arbitration.

In support of its motion, Progressive presented a brief of fourteen decisions at arbitration and on appeal concerned with adjournments and insurer's examinations.[2] I find these cases are helpful to set out the competing interests that should be balanced in rendering a decision that is fair to both parties and respectful of the authority of the Commission to control its processes. However, I find that the facts of this case are distinguishable. Mr. Oueidat submitted that no reassessment was "reasonably necessary" by Dr. Cameron because of Dr. Cameron's negative findings on the first examination and the unaltered conclusions of his supplementary report. For example, Dr. Cameron did not find that Mr. Oueidat's knee was injured and healing, a finding that would invite reassessment. Mr. Oueidat submitted that when a specialist on an insurer's examination offers the opinion that nothing is wrong, and confirms this opinion after receipt of further information, then it is not reasonable to require the insured person to reattend on that same specialist.

In establishing when an insurer examination is reasonably necessary, in addition to reviewing the case law mentioned above, it is useful to consider the Commissioner's Guideline No.2/95. I have no evidence of Progressive's reasons for requesting another examination by Dr. Cameron— reasons were requested by Mr. Oueidat and never provided. An examination should be requested only for the purpose of obtaining necessary information, as suggested in the Commissioner's Guideline. In this case, besides Dr. Cameron's reports and the reports already provided by Mr. Oueidat, Progressive had several other orthopaedic reports on Mr. Oueidat, including independent reports from orthopaedic specialists at medical/rehabilitation DAC assessments. Mr. Oueidat did cooperate to attend for a lengthy psychological assessment by Dr. Bernstein requested by Progressive shortly before the hearing, so clearly he was willing to submit to some examinations under section 65. However, it is not at all clear to me, that Mr. Oueidat's purported willingness to be examined by *any other* orthopaedic specialist was conveyed to Progressive.

In these unique circumstances, I accept Mr. Oueidat's submission that an orthopaedic examination by Dr. Cameron in April 1998 was not "reasonably necessary." In so finding, then, it is clear that the provisions of section 71.1(c) have not been breached.

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