



Accident Benefit REPORTER

“Directly Causes”



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ACCIDENT BENEFITS

The test for entitlement to accident benefits is contained in the Section 2(1) of the Ontario Automobile Insurance Ontario Regulation 403/96, Statutory Accident Benefits Schedule – Accidents on or After November 1, 1996, as follows:

2(1) In this Regulation, “**accident**” means an incident in which the use or operation of an automobile **directly causes an impairment** or directly causes damage to any prescription eyewear, denture, hearing aid, prosthesis or other medical or dental devise; (“accident”)

The importance of this section is the use of the words “directly causes”. This would appear to be an attempt to create a limitation on what had previously been the entitlement of an injured claimant to benefits arising as a result of the motor vehicle accident. In the case of *Desbiens v. Mordini* [2004] O.J. No. 4735, Ontario Superior Court, the Court said that to require an insured person to trace “the chain of causation” with precision is inconsistent with the policy. The extent of coverage for the consequences of an accident is governed by the “as a result of” test, which requires proof that an accident **materially or significantly contributed** to the disability or impairment that gives rise to the claim for benefits.

A major case involving the interpretation of “directly causes” is the case of *Greenhalgh v ING Halifax Insurance Co.* (2004). In that case, the Court of Appeal applied the test as set out in “*Chisholm*” as follows: “if the use or operation of a vehicle was a cause of the injuries, was there an intervening act or intervening acts that resulted in the injuries, that cannot be said to be part of the ordinary course of things? In that

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sense, can it be said that the use or operation of a vehicle was a ‘direct cause’ of the injuries?” In the particular case, the plaintiff had left her motor vehicle in winter when it became disabled and she subsequently froze. The Appeal Court found that her injuries were not the “direct result of an accident” within the meaning of the legislation. In a later case called *Sohi v ING Insurance Company of Canada*, the Director Delegate confirmed that the definition of “accident” requires a “direct causal connection between the use or operation of an automobile and every impairment that gives rise to a claim for benefits”.

I would suggest the Court in the final analysis will probably stretch most circumstances to include indirectly caused consequences, although this issue is yet to be firmly dealt with by the Court.

At the very least, the words “directly causes” are likely to effect cases in which there is intervening medical malpractice, as opposed to unintended consequence of the medical treatment - which do not amount to medical malpractice. In the former case, the plaintiff will not be compensated for the consequences of the malpractice. In the latter case, the plaintiff will probably recover from his or her own automobile insurer, the unfortunate results of treatment for the “directly caused” injury.

TORT CLAIMS

An interesting case where the issue of “directly causes” came before the Court was one of my own cases, *David v Frost and TTC*, wherein a 19 year old man was involved in a car accident with a TTC vehicle. He suffered a relatively bad neck injury. His treating surgeon, consequently operated on the young man and fused his neck at the C2-C3 level. Following the surgery, the doctor called the father of the 19 year old and advised him that he was unhappy with the first surgery and that he would like to proceed with another surgery to clean up the original surgery. The father and son agreed to proceed with the second surgery and the neck was fused at level C1-C2. In fact, what had happened was that prior to the first surgery, the doctor had misread the x-ray and fused the wrong level. I planned to bring action against both the TTC and the doctor. The father and the son both absolutely refused to permit me to pursue an action against the doctor. However, the TTC insisted on adding the doctor as a third party. They wanted to bring the action before the Court in order to

insulate themselves from the financial consequences of the damages that would flow from what they argued was unnecessary surgery.

The matter came up for trial before Mr. Justice Parker. He concluded that the only issue was whether or not there was medical negligence, i.e. malpractice. If in fact there was malpractice then it was a *novus actus interveniens*. The Defendant, TTC, was not responsible for the consequences of that malpractice. Suffice it to say the TTC won on that issue and it did not have to pay for the damages that arose from the doctor's mistake.

What follows from *David v Frost and TTC* is that there is no special entitlement or loss of entitlement related to intervening medical malpractice. If there is in fact medical malpractice in the treatment of a patient, then the defendant (in this instance, a motor vehicle insurer) is insulated from any responsibility to pay for the results of that malpractice. If the treatment accorded to the Plaintiff results in increased damages, the defendant (again the motor vehicle insurer) is only liable to pay for it if in fact the treatment does not result from medical malpractice.

Unfortunately, if a plaintiff is faced with any issue suggesting he or she has increased medical problems created by the actions of the doctor or hospital, then the doctor or hospital should be added as a defendant in order to ensure that the plaintiff is not deprived of damages by the reason of a finding by the Court of medical malpractice. If the case is reasonably clear that there is no malpractice in spite of the bad consequences, the insurer or its solicitors are likely to be willing to make an agreement (because of the costs involved proceeding against the doctor and the hospital) to accept responsibility. In the absence of such an agreement, the plaintiff's solicitor should bring action against the doctor and the hospital.

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When Health Care Professionals Make Mistakes



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When an ill or injured person goes to a health care practitioner, (doctor, nurse, physiotherapist, pharmacists, chiropractor or whatever), the individual expects to be healed, not hurt. Sadly, sometimes the intervention of a health care practitioner aggravates the problem rather than helping it.

What does that mean to the unfortunate patient who trusted her health care practitioner to make her better only to discover that she was made worse?

There are no guarantees in life or specifically that every illness, injury or disease can be cured or helped. Health care practitioners cannot guarantee the outcome for any patient. However, the law insists that they act in a way that is consistent with what a similar, competent practitioner would do in the same circumstances. In fact, the test for judging the adequacy of the actions of a health care practitioner are no different than the one used to assess responsibility for a car accident. In the latter, the court asks what the average reasonable driver would have done in the circumstances leading up to an accident. In the former, the question becomes what the average reasonable health care practitioner would have done in the situation presented to him or her by the patient. In either case, if it is decided the person did not meet this standard, he or she will be found to have acted negligently.

In car accidents, judges and juries are able to apply common sense, personal experience and the “*Rules of the Road*” to determine whether fault is to be found with someone’s driving. Operating a car is something most of us are very familiar with. We do not need post-graduate degrees to distinguish acceptable from unacceptable operation of a motor vehicle. However, this is not the case with most inquiries into the adequacy of health care received by a particular patient. As members of the community, we are not nearly so informed and experienced in the technical and scientific world of health care as we are with driving cars.

In order to understand whether there is legitimate criticism to be levelled at the actions of a health care practitioner, it is absolutely necessary to enlist the help of appropriate and



independent health care professionals to critically examine what went on. Only such a practitioner is permitted to level the criticism in court against another practitioner. These consultants are known as “experts”. It is only when this kind of expert is prepared to say that the health care practitioner in question failed to display the standard of competence exhibited by his or her peers in a given situation that there can be any justification for pursuing a claim for damages. Even when negligence is demonstrated, expert opinion must also establish the negligence as the cause of the harm or outcome.

This sort of investigation is absolutely essential. Most health care negligence cases are defended vigorously and huge amounts of time and disbursements are incurred to prosecute them. It is foolhardy to proceed with this kind of litigation without having solid expert support for the case. The importance of this is underscored by the statistical data that is available. In Canada most of us believe that the United States is a hot bed of successful medical negligence litigation. That is a myth. According to one recent U.S. study, out of every one-hundred medical malpractice cases filed: one case actually proceeds to judgment in favour of the plaintiff; six cases result in verdicts for the defence; twenty-two cases are settled by the defendants and seventy-one cases are abandoned in one way or another. In other words, approximately 77% of patients in the United States who commence a lawsuit for negligent health care are unsuccessful. At a recent conference in Florida, it was said that 85% of medical negligence cases that go to trial in that state are lost by the plaintiffs.

Experience in Canada is not dissimilar. The Canadian Medical Protective Association is an umbrella organization that defends Canadian doctors accused of negligence by their patients. The Association’s recent statistics suggest that just over two-thirds of all lawsuits brought against physicians in Canada are unsuccessful.

Patients assume that a bad outcome must mean there was negligence involved in their care. That is simply not so. As was said earlier, health care practitioners cannot guarantee the hoped for result. They can only do their best to try and achieve that. It is a fact of life that some patients simply cannot be treated successfully and may be made worse. All of this can easily happen without medical negligence on anyone’s part.

This underscores the necessity of carefully investigating a potential medical negligence case before even contemplating litigation. Thomson, Rogers is recognized as a leader in the field of medical negligence. This reputation has been achieved by our devotion to ensuring that each and every potential case is thoroughly investigated to see that clients are not dragged through litigation that has little hope of success. Our track record defies all of the statistical data mentioned. The reason for that is simple. We do our homework.

The message in all of this is that the cost of a preliminary investigation is worth its weight in gold. It may seem risky to spend several thousand dollars to determine whether there is a case, but that is a pittance compared to the hundreds of thousands of dollars that could be thrown away pursuing a lawsuit that is destined to fail. Malpractice cases can be won but it requires the kind of knowledge, experience and hard work that Thomson, Rogers brings to every case.

Denny H. Dixon, Partner



Damage Assessment Software

*T*hroughout the *Insurance Act* of Ontario, there is a general theme that claimants should not be allowed to recover the same financial loss from two different sources.

This principle against double recovery goes hand in hand with the Ontario accident benefit system and how it interacts with the right to sue at-fault drivers (known as your tort rights).

In short, the legislation provides that damages in your tort claim will be reduced by your accident benefit entitlement and, as a result, the value of your tort claim varies with the extent of your accident benefit entitlement.

Even without this interplay between the tort system and the accident benefit system, calculating the value of your accident benefit entitlement and the value of a tort claim are complicated tasks. Experts are customarily retained to conduct this complicated analysis which involves calculating the present value of a number of anticipated losses and needs on the part of the accident victim. In relatively large, complicated, catastrophic claims the process of properly assessing the claims can be very daunting.

To resolve this problem, a new product is now available to help lawyers, insurance adjusters and rehabilitation consultants calculate the value of a tort claim and the present value of future care costs.

The software has knowledge of both the current Bill 198 Ontario motor vehicle scheme as well as the former Bill 59 Ontario motor vehicle scheme.

The software was developed by Darcy Merkur, one of our Partners who practises personal injury law with us. The software is an easy to use Excel program that is designed for even the most novice Excel users. The Personal Injury Damages Calculator is now available through Carswell.

Joseph Pileggi



Assessing Attendant Care Using The Form 1

There are different forms and rates based on the date of accident, as opposed to the date of the assessment.

Rates are those used in Part 4 of the Form 1 to calculate monthly benefit:

Date of Accident	Part 1	Part 2	Part 3
Accidents After October 1, 2003	\$10.53	\$7.00	\$16.86
Accidents After March 1, 2006	\$11.23	\$7.74	\$17.98
Accidents After February 1, 2007	\$11.23	\$8.00	\$17.98

Bill 164: Accidents between January 1, 1994 to October 31, 1996 – there is a different form and rates are indexed yearly.

(Indexed Rates)

Year	Level 1	Level 2	Level 3	\$3,000	\$6,000	\$10,000
1994	\$8.75	\$6.85	\$14.00	\$3,000.00	\$6,000.00	\$10,000.00
1995	\$8.77	\$6.85	\$14.03			\$10,200.00
1996	\$8.97	\$6.85	\$14.35	\$3,075.14	\$6,150.28	\$10,250.46
1997	\$9.10	\$6.85	\$14.57	\$3,121.27	\$6,242.53	\$10,404.22
1998	\$9.25	\$6.85	\$14.80	\$3,171.21	\$6,342.41	\$10,570.69
1999	\$9.31	\$6.85	\$14.80	\$3,192.41	\$6,386.81	\$10,644.68
2000	\$9.55	\$6.85	\$15.29	\$3,276.44	\$6,552.87	\$10,921.44
2001	\$9.81	\$6.85	\$15.70	\$3,364.90	\$6,729.80	\$11,216.32
2002	\$10.07	\$6.85	\$16.11	\$3,452.39	\$6,904.77	\$11,507.94
2003	\$10.30	\$6.85	\$16.48	\$3,531.79	\$7,063.58	\$11,772.62
2004	\$10.53	\$7.15	\$16.84	\$3,609.49	\$7,218.98	\$12,031.62
2005	\$10.72	\$7.45	\$17.14	\$3,674.46	\$7,348.92	\$12,248.19
2006	\$11.08	\$7.75	\$17.72	\$3,799.39	\$7,598.78	\$12,664.63
2007	\$11.16	\$8.00	\$17.84	\$3,825.99	\$7,651.97	\$12,753.28

Minimum wage increases begin in February of each year.

Courtesy of Martha Binstock, Rehabilitation Planning Inc.



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