

NEWFOUNDLAND AND LABRADOR
BOARD OF COMMISSIONERS OF PUBLIC UTILITIES
120 Torbay Road, P.O. Box 21040, St. John's, Newfoundland and Labrador, Canada, A1A 5B2

Hearing Transcript

2017 Automobile Insurance Review

September 12, 2018

PRESENT:

The Board:

Darlene Whalen, Chair and CEO
Dwanda Newman, Vice-Chair
James Oxford, Commissioner

Board Counsel/ Staff:

Jacqueline Glynn, Board Counsel
Ryan Oake, Regulatory Analyst
Peter O'Flaherty, Q.C., Hearing Counsel

Parties (Alphabetical Order)

Atlantic Provinces Trial Lawyers Association
Ernest Gittens

Campaign to Protect Accident Victims

Colin Feltham
Jerome Kennedy, Q.C.

Consumer Advocate

Dennis Browne, Q.C.
Andrew Wadden

Insurance Bureau of Canada (IBC)

Amanda Dean
Kevin Stamp, Q.C.
Trevor Foster

Spinal Cord Injury NL

Thomas Fraize, Q.C.
Lara Fraize-Burry
Michael Burry

Presenters:

Viivi Riis
Presenting on behalf of IBC

John Karapita
Allen Wynperle
Presenting on behalf of the Campaign

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<p>1 (9:00 a.m.)</p> <p>2 CHAIR:</p> <p>3 Q. Good morning, everybody. I think we're</p> <p>4 going right to IBC to introduce your first</p> <p>5 presenter.</p> <p>6 STAMP, Q.C.:</p> <p>7 Q. Yes, Madam Chair. Ms. Viivi Riis is here</p> <p>8 with us. I circulated her CV yesterday, so</p> <p>9 that should be on the system. I notice my</p> <p>10 friends next to me don't have a screen yet,</p> <p>11 so I don't know – the screen is not lit up.</p> <p>12 CHAIR:</p> <p>13 Q. We'll call our expert.</p> <p>14 KENNEDY, Q.C.:</p> <p>15 Q. That's fine.</p> <p>16 STAMP, Q.C.:</p> <p>17 Q. It's on.</p> <p>18 CHAIR:</p> <p>19 Q. Thank you.</p> <p>20 STAMP, Q.C.:</p> <p>21 Q. Good morning, Ms. Riis.</p> <p>22 A. Good morning.</p> <p>23 Q. Thank you for agreeing to come to St. John's</p> <p>24 to help us with this. First of all, I'd</p> <p>25 like, if you would, to introduce yourself</p>	<p>1 an interest in pain management as well. I</p> <p>2 have to apologize, I notice that there's</p> <p>3 1986 to 1991 is missing from my CV, and I</p> <p>4 think that was a formatting error on my</p> <p>5 part. So between 1986 and 1991, I worked</p> <p>6 for a company called Therapy Supplies, and I</p> <p>7 was an educational consultant, really part</p> <p>8 of the sales force, and I essentially went</p> <p>9 around to the hospitals and health</p> <p>10 organizations to train people on the use of</p> <p>11 transcutaneous electrical nerve stimulation,</p> <p>12 functional electrical stimulation, and those</p> <p>13 kinds of modalities. In 1991 through 1993,</p> <p>14 I worked as an ADP authorizer. This is a</p> <p>15 process in Ontario where we can prescribe</p> <p>16 equipment, wheelchairs, walkers, through a</p> <p>17 government program for people who needed</p> <p>18 such equipment, and the government would</p> <p>19 fund 75 percent of the equipment if</p> <p>20 prescribed by an ADP authorizer. So I had a</p> <p>21 lot of experience in dealing with the kinds</p> <p>22 of equipment that people with a variety of</p> <p>23 disabilities and impairment have. Then in</p> <p>24 1992, I started a business called Dynamic</p> <p>25 Rehabilitation with a partner who was also a</p>
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<p>1 and we're going to have you walk through</p> <p>2 your CV. It's been brought up on the screen</p> <p>3 in front of you. You may have a copy of it,</p> <p>4 in any event.</p> <p>5 MS. RIIS:</p> <p>6 A. Okay, thank you very much. My name is Viivi</p> <p>7 Riis. I'm a physical therapist by training,</p> <p>8 and I've been most recently working as a</p> <p>9 consultant to a variety of different</p> <p>10 parties, but to begin with my working career</p> <p>11 started in the physiotherapy field treating</p> <p>12 largely musculoskeletal injuries. I worked</p> <p>13 in private practice. I worked with the</p> <p>14 Workers Compensation Board in Ontario, now</p> <p>15 known as the Workplace Safety and Insurance</p> <p>16 Board. I also worked for several years at</p> <p>17 Sunnybrook Health Sciences Centre, and I</p> <p>18 became the supervisor of the outpatient</p> <p>19 physiotherapy department. Outpatient</p> <p>20 meaning people who were able to live at</p> <p>21 home, but could come in for treatment, and I</p> <p>22 focused primarily again on musculoskeletal</p> <p>23 injury, post-traumatic injury, and also I</p> <p>24 was the attending physiotherapist on the</p> <p>25 pain clinic there. So I've always had quite</p>	<p>1 physical therapist. Her particular area of</p> <p>2 interest was spinal cord injury, and, of</p> <p>3 course, my expertise was in musculoskeletal</p> <p>4 injury, and we started to offer health care</p> <p>5 services to people after motor vehicle</p> <p>6 collisions who were waiting to get publicly</p> <p>7 funded therapy. So even at that time,</p> <p>8 publicly funded treatment was available to</p> <p>9 people injured in traffic collisions, but</p> <p>10 often there was a waiting list, so we were</p> <p>11 delivering private therapy services in the</p> <p>12 home. That was an interesting time because</p> <p>13 we did a lot of work with insurance</p> <p>14 companies. We got referrals from insurers</p> <p>15 as well as from plaintiff lawyers. Insurers</p> <p>16 discovered that we were pretty comfortable</p> <p>17 with the health care system, we knew how to</p> <p>18 speak with physicians, we knew how to</p> <p>19 understand the test results, so a lot of</p> <p>20 insurers and lawyers started to use our</p> <p>21 company for case management services. That</p> <p>22 meant that we acted as navigators for</p> <p>23 injured people to work through the health</p> <p>24 care systems, and I say "systems" because in</p> <p>25 Ontario the public health system was first</p>

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1 payer, then private health benefits came
 2 next, and then the auto insurer was last
 3 payer. So it was quite complex and many
 4 people injured to this day find it difficult
 5 to navigate. So in the process of doing
 6 this case management work, and working with
 7 insurance companies, one insurer approached
 8 the University of Toronto, and I've had a
 9 faculty appointment in the Faculty of
 10 Medicine, Department of Physical Therapy at
 11 UT since about 1989, somebody approach U of
 12 T – it was actually All State Insurance and
 13 they were looking for somebody to train
 14 their insurance adjusters, their Section B
 15 adjusters on how the health care system
 16 works, because at that time the legislation
 17 and regulation changed in Ontario where the
 18 insurers became responsible for adjudicating
 19 about a million dollars in accident
 20 benefits. So I was picked or volunteered by
 21 the university to develop a training program
 22 for All State, and I ended up basically
 23 traveling across Canada training All State
 24 Section B adjusters, trying to give them
 25 information about how the health care system

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1 worked because the adjusters were
 2 responsible for this large sum of money, and
 3 they had to decide what was reasonable and
 4 necessary and what wasn't. The important
 5 piece that I always tried to reinforce was
 6 that it's not the adjuster's role to make
 7 medical decisions, but certainly they needed
 8 medical information to make good
 9 adjudication decisions. So we tried to give
 10 them information that would assist them in
 11 making good claims decisions, while not
 12 attempting to control the medical process.
 13 So I did a lot of training for insurance
 14 companies through that period.
 15 STAMP, Q.C.:
 16 Q. Ms. Riis, would you have any indication as
 17 to sort of what percentage of the Section B
 18 adjusters with All State, for example, it
 19 was a program involving All State, what
 20 percentage you saw or trained?
 21 MS. RIIS:
 22 A. My estimate would be 90 percent or more.
 23 They essentially rolled this out across the
 24 country, so we did training across the
 25 country ultimately, and through that process

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1 – I was trying to recall when I actually met
 2 IB, but I think it was during the process of
 3 insurance company training because I ended
 4 up being hired by other insurance companies
 5 to offer training to Section B adjusters
 6 around health care issues. We also did some
 7 training on Section A, looking particularly
 8 at brain injury and spinal cord injury
 9 issues, but I believe IBC heard about this
 10 program and then IBC actually contracted
 11 with me to develop an IBC claims manual and
 12 training program for AB adjusters, and again
 13 with IBC, I traveled across Canada; Alberta,
 14 the Atlantic Provinces, Ontario, to deliver
 15 this training to adjusters. So because
 16 Ontario had gone from a primarily tort
 17 system to a hybrid no fault in tort, there
 18 was a real adjustment for the insurance
 19 industry, and so they were trying to bring
 20 the adjusters up to speed on how to make
 21 good claims decisions around complex medical
 22 issues.
 23 STAMP, Q.C.:
 24 Q. When you say "AB adjusters", do you mean
 25 accident benefit adjusters?

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1 MS. RIIS:
 2 A. Accident benefits adjusters, yes.
 3 STAMP, Q.C.:
 4 Q. And do you have any recollection of the time
 5 frame that this – I guess, this first
 6 arrangement with IBC unfolded?
 7 MS. RIIS:
 8 A. I think it was around 2000 when I first
 9 started to do bits and pieces of work with
 10 IBC. I know there was – I think my initial
 11 engagement was around a project they were
 12 doing with McMaster University around
 13 fibromyalgia, to try to get their heads
 14 around what is fibromyalgia, how does it
 15 result after an auto collision and so on.
 16 So I did small pieces, and then that grew to
 17 the claims manual, but I'd say it was around
 18 2000.
 19 STAMP, Q.C.:
 20 Q. Okay. I'm sorry, carry on.
 21 MS. RIIS:
 22 A. So in the process of doing all of this
 23 education for the insurance industry, I also
 24 was able to – and it took me, I'd say, a
 25 decade. I was able to understand better how

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1 the insurance system works, to understand
 2 the interplay between accident benefits and
 3 bodily injury benefits, and this was a real
 4 eye opener for me because as a health care
 5 provider who had been working in the system
 6 for some time, I really didn't understand
 7 it. It's a complicated system, it's hard to
 8 understand, and then I also started to get
 9 hired by health professional organizations,
 10 so clinics, private clinics, the health
 11 professional associations, and they asked me
 12 to do training for them to help them
 13 understand how the insurance system works
 14 because it was really complicated, and I
 15 still say that to this day, most health care
 16 professionals still struggle with
 17 understanding the complexities between the
 18 insurance system. They know they're dealing
 19 with an insurance company, but I can't tell
 20 you how many times colleagues of mine have
 21 gotten into trouble because they have no
 22 consent to speak to the third party insurer,
 23 and yet they do because they don't know the
 24 difference between the first party and the
 25 third party insurer. So those kinds of sort

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1 of lack of information still is out there.
 2 So I think that's one of the real challenges
 3 of the system is that the health care
 4 industry has difficulty understanding the
 5 complexities of the auto insurance system,
 6 and the auto insurance system still
 7 struggles with understanding how health care
 8 works. I think a lot of us would like to
 9 think health care is scientific and it's
 10 black and white, but it's not, there are
 11 shades of gray. No two people react the
 12 same to a similar diagnosis or a similar
 13 injury, so it's tough on both sides. It's
 14 been very interesting for me because I sort
 15 of have my foot in both camps. Certainly,
 16 I'm a registered physiotherapist myself, so
 17 I do tend to align with the health
 18 professionals, but in my mind the accident
 19 benefits insurer and the health care
 20 professionals should be working in
 21 partnership to help the recovery of the
 22 injured person. So that's always been sort
 23 of what I've been trying to promote. Now as
 24 I say, I'd been contracted with IBC for a
 25 number of activities, but in 2006, I moved

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1 from Toronto to Collingwood, two hours north
 2 of Toronto, so I wasn't able to continue the
 3 policy work that I was doing. So between
 4 2006 and 2010, I also did work for an IBC
 5 arm called Health Claims for Auto Insurance.
 6 This is an online platform where health
 7 providers submit injury claim forms
 8 electronically directly to the insurance
 9 company. The insurance company adjudicates
 10 online, and the adjudication decision is
 11 transferred back to the health provider
 12 electronically. So it sort of streamlined
 13 some of the paperwork, and so I was engaged
 14 to liaise with the health industry to help
 15 them adopt and get accustomed to using this
 16 electronic platform, and this was of great
 17 interest to me because one of my passions is
 18 the need for more data in the private health
 19 system.
 20 (9:15 a.m.)
 21 In the public health system since 1984, the
 22 Canadian Institute of Health Information has
 23 required publicly funded institutions to
 24 submit standard data. So that's why CIHI
 25 can print all of these reports about waiting

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1 times for hip replacement surgeries, or
 2 success rates after cardiac events and so
 3 on. In the private health system, we have
 4 no idea. So I know in various provinces the
 5 insurance sector funded by premiums from
 6 drivers pay a lot of money for health care,
 7 and yet in most provinces they have no idea
 8 whether that health care is working or not;
 9 is it making people better, to what extent
 10 is it making people better and so on. So
 11 part of my interest in this is the data
 12 piece, and I think that's a really important
 13 one and something I did mention in my
 14 submission. I finished that engagement with
 15 Health Claims for Auto Insurance, and in
 16 2013, I started to work as a homecare
 17 physiotherapist in the South Georgian Bay
 18 area, and I do that to this day. I see a
 19 patient caseload that's very mixed. I see
 20 everybody from people injured in traffic
 21 collisions to people with Myasthenia Gravis,
 22 to people with spinal cord injury, to people
 23 with stroke, cardiac problems. So I have a
 24 very mixed caseload which has been really
 25 interesting and has forced me to do a lot of

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1 reading. Now I'd say about a third of my
 2 work is clinical practice, homecare,
 3 physiotherapy. I'd say about a third of my
 4 work is policy consultation with IBC. The
 5 work I do with IBC has covered the provinces
 6 where private insurance is in place;
 7 Alberta, Ontario, and the Atlantic
 8 Provinces, as well as Newfoundland, and then
 9 a third of my work is also working with
 10 health professional organizations, again
 11 continuing to work with them largely in the
 12 area of auto insurance and how can you find
 13 that work easier to do, because it's still –
 14 after years of being at it, it's still
 15 challenging for the health providers, as
 16 well as the insurers to manage that system.
 17 I'm not sure if I've missed anything.
 18 STAMP, Q.C.:
 19 Q. No, I don't think you did. That's fine.
 20 MS. RIIS:
 21 A. A mixed bag of tricks really.
 22 STAMP, Q.C.:
 23 Q. So you're still a physiotherapist today?
 24 MS. RIIS:
 25 A. Yes.

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1 STAMP, Q.C.:
 2 Q. You still do actual physiotherapy work
 3 yourself personally?
 4 MS. RIIS:
 5 A. Yes, and I've had no complaints sustained
 6 against me.
 7 STAMP, Q.C.:
 8 Q. And you say about a third of your work
 9 currently involves IBC – is it just IBC or
 10 insurers generally?
 11 MS. RIIS:
 12 A. Yeah, insurers because I have been hired by
 13 individual insurance companies to develop
 14 training programs for that company alone, so
 15 IBC and insurers would be about a third of
 16 my work. Another third would be other
 17 health professional organizations, clinics
 18 and so on, and then a third would be
 19 clinical practice in homecare.
 20 STAMP, Q.C.:
 21 Q. Right, okay. Now then I want to come back
 22 to your engagement. The reason you're here
 23 in the first instance, of course, I think
 24 you would have been contacted by IBC in this
 25 circumstance. Can you just outline for us

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1 how that evolved?
 2 MS. RIIS:
 3 A. So again I consult with IBC on a variety of
 4 policy issues, but certainly the topic of
 5 minor injury, and I don't like that term,
 6 and I'll speak to that, but I'm going to use
 7 it because it's the term that's in use in
 8 various provinces, but whenever the issue of
 9 minor injury cap or diagnostic and treatment
 10 protocols arise, IBC tends to consult with
 11 me. So I did understand in the spring of
 12 this year that something was going on in
 13 Newfoundland. I had understood there was a
 14 closed claims study happening, but I wasn't
 15 quite clear on what was happening, and I
 16 think it was around May that IBC shared a
 17 submission that was made to the Board, so I
 18 was able to read that submission, and they
 19 asked me my thoughts on it. Then it was in,
 20 I believe, early July that they asked me to
 21 get more involved and comment on three
 22 aspects of their submission, and these are
 23 the three areas I feel quite comfortable
 24 speaking to.
 25 Q. So tell me about that request and how did it

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1 come to you to do a report that you've done
 2 and so on, and on the three –
 3 MS. RIIS:
 4 A. So Ryan Steyn basically approached me in
 5 July. We discussed the submission that IBC
 6 was putting forward, and whether or not I
 7 would be willing to comment on the three
 8 points that they asked me to speak on, and
 9 that's the issue of how do you define minor
 10 injuries, evidence-based treatment
 11 protocols, as well as the impact of
 12 litigation on injuries.
 13 STAMP, Q.C.:
 14 Q. Those are the three topics that you were
 15 asked to think about?
 16 MS. RIIS:
 17 A. Right.
 18 STAMP, Q.C.:
 19 Q. Were you given any direction, Ms. Riis, as
 20 to how your report should be prepared?
 21 MS. RIIS:
 22 A. No. Quite honestly, I think that my work
 23 over the – since 2004 around the topic of
 24 minor injury definitions, diagnostic and
 25 treatment protocols, I think my work has

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1 informed IBC submission. So in some
 2 respect, I'm sort of speaking to
 3 recommendations I have made to IBC.
 4 STAMP, Q.C.:
 5 Q. You may come to this in your report
 6 generally, but was there involvement that
 7 you had had also, for example, in other
 8 Atlantic region areas on the definition
 9 issue of minor injury and so on?
 10 MS. RIIS:
 11 A. Did I have input on that?
 12 STAMP, Q.C.:
 13 Q. Well, I'm just wondering if it's going to
 14 come up in your next—in your report
 15 discussion or in something we –
 16 MS. RIIS:
 17 A. Yes.
 18 STAMP, Q.C.:
 19 Q. Okay.
 20 MS. RIIS:
 21 A. I'll be talking about the definition of
 22 minor injury. I didn't—I wasn't actively
 23 involved in developing IBC's submission to
 24 the Board. They did that on their own and
 25 gave it to me to read after it was done, and

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1 I had really no major suggestions to them at
 2 that time.
 3 STAMP, Q.C.:
 4 Q. Mr. Stein, as you say, contacted you with a
 5 request that on three specific points –
 6 MS. RIIS:
 7 A. Right.
 8 STAMP, Q.C.:
 9 Q. - could you provide some sort of a report to
 10 IBC that they would present to this Board?
 11 MS. RIIS:
 12 A. Right, yes.
 13 STAMP, Q.C.:
 14 Q. Is that correct?
 15 MS. RIIS:
 16 A. That's right, and then I wrote the report
 17 and submitted it to Mr. Stein.
 18 STAMP, Q.C.:
 19 Q. And did Mr. Stein have any input in the
 20 content of the report?
 21 MS. RIIS:
 22 A. No, I –
 23 STAMP, Q.C.:
 24 Q. Other than to name the topics?
 25 MS. RIIS:

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1 A. No, I submitted the final report to him. He
 2 did not have any input on it.
 3 STAMP, Q.C.:
 4 Q. Okay. So, the report that we have presented
 5 here is your report?
 6 MS. RIIS:
 7 A. Yes.
 8 STAMP, Q.C.:
 9 Q. Prepared solely by you?
 10 MS. RIIS:
 11 A. Yes.
 12 STAMP, Q.C.:
 13 Q. No input from anybody else except to
 14 identify the three topics that you've been
 15 asked to speak about?
 16 MS. RIIS:
 17 A. Yes, yes.
 18 STAMP, Q.C.:
 19 Q. Okay. After you presented the report to Mr.
 20 Stein, did you have any communication with
 21 him? Was there any criticism on his part
 22 that, you know, you've gone too far or
 23 didn't go far enough? Anything of that
 24 nature that occurred?
 25 MS. RIIS:

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1 A. No, you know, I did mention to him that I
 2 may have said a couple of things that were
 3 not complementary to the insurance industry
 4 in the report, so I wanted to give him a
 5 head's up.
 6 STAMP, Q.C.:
 7 Q. Okay. All right, well then, perhaps if we
 8 can bring up that report. You probably have
 9 a copy anyway, Ms. Riis, but we'll bring it
 10 up on the screen.
 11 MS. RIIS:
 12 A. Do you want to the report or the
 13 presentation?
 14 STAMP, Q.C.:
 15 Q. The presentation.
 16 MS. RIIS:
 17 A. The presentation.
 18 STAMP, Q.C.:
 19 Q. Yes, or the—you need both of those. How are
 20 you going to approach this?
 21 MS. RIIS:
 22 A. I was just going to speak to the
 23 presentation slides.
 24 STAMP, Q.C.:
 25 Q. Yes, okay.

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1 MS. RIIS:
 2 A. Which really speaks to the report, and then
 3 I'm happy to entertain questions about
 4 either.
 5 STAMP, Q.C.:
 6 Q. Sure.
 7 MS. RIIS:
 8 A. Okay.
 9 KENNEDY, Q.C.:
 10 Q. I'm just wondering, Madam Chair, has that
 11 been provided? I -
 12 STAMP, Q.C.:
 13 Q. Well, they were sent in here to IBC—to the
 14 PUB. I don't know where—if they've been
 15 circulated.
 16 CHAIR:
 17 Q. The presentation -
 18 STAMP, Q.C.:
 19 Q. It's just that these are charts that -
 20 KENNEDY, Q.C.:
 21 Q. They might just be charts, but we haven't—my
 22 understanding is we were to be provided with
 23 copies of any documents to be referred to
 24 the day before the hearing.
 25 CHAIR:

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1 Q. I guess this is her presentation slides. I
 2 don't recall getting presentation slides
 3 from the presenters in advance. I think
 4 we've been getting the reports.
 5 KENNEDY, Q.C.:
 6 Q. Certainly the Campaign's slides the other
 7 day were provided on Friday for the lawyer's
 8 panel on Monday.
 9 MS. RIIS:
 10 A. My slides are largely pictures. So, I don't
 11 think there's much in terms of text that
 12 you'll miss.
 13 KENNEDY, Q.C.:
 14 Q. Perhaps the witness can—we can discuss this.
 15 We should be, it's my understanding,
 16 provided with a copy of any documents that
 17 are to be referred to the day before a
 18 witness testifies. So, whatever the slides
 19 may be, that's not the point. The question
 20 is whether or not we have been provided with
 21 them. And my understanding again, Madam
 22 Chair, is that you indicated to counsel that
 23 they were to be provided to all other
 24 counsel, not left to the Board to send to
 25 us, but we had to provide to all other

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1 counsel because we made that mistake earlier
 2 ourselves in here.
 3 CHAIR:
 4 Q. Yes, I understand that. I haven't seen the
 5 slides, so I'm not sure if -
 6 STAMP, Q.C.:
 7 Q. I don't know when they were—I think they
 8 were passed to the PUB a couple of days ago.
 9 MS. KEAN:
 10 Q. It was filed with the Board on September 6th.
 11 STAMP, Q.C.:
 12 Q. Okay. That would be Monday, you said,
 13 right? The 6th.
 14 CHAIR:
 15 Q. But not copied to other counsel?
 16 STAMP, Q.C.:
 17 Q. Apparently not.
 18 MS. KEAN:
 19 Q. That was Thursday and apparently not copied,
 20 no.
 21 STAMP, Q.C.:
 22 Q. No.
 23 O'FLAHERTY, Q.C.:
 24 Q. Yes, Madam Chair, I think it's simply an
 25 oversight on—in terms of the filing of the

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1 document. I haven't seen the documents. As
 2 you say, they haven't been distributed among
 3 counsel. Maybe what we can do is simply
 4 they can be put on the—and we can have a
 5 look at them and see what the document is.
 6 And if it's something that Mr. Kennedy is—
 7 his client feels we need to take five
 8 minutes to look at and—or ten minutes to
 9 look at, maybe we can deal with on that
 10 basis, but as the witness has commented,
 11 they appear to be descriptive rather than
 12 text in any event. So, maybe we can just
 13 see what this is we're dealing with.
 14 KENNEDY, Q.C.:
 15 Q. That's fine.
 16 CHAIR:
 17 Q. We'll proceed.
 18 KENNEDY, Q.C.:
 19 Q. That's fine, yes.
 20 CHAIR:
 21 Q. We'll proceed and see where it goes.
 22 MS. RIIS:
 23 A. Thank you.
 24 STAMP, Q.C.:
 25 Q. So, if we can have the slides. Ms. Riis, is

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1 that what you prefer to see first of all?
 2 We all have a copy of the report, but we can
 3 bring the slides up. You'd like the slides
 4 brought up first?
 5 MS. RIIS:
 6 A. Sure.
 7 STAMP, Q.C.:
 8 Q. Okay.
 9 MS. RIIS:
 10 A. Yeah.
 11 STAMP, Q.C.:
 12 Q. We'll do it that way.
 13 MS. RIIS:
 14 A. All right, so again, thank you for allowing
 15 me to present here. I'm here because I do
 16 want to speak in support of the
 17 recommendations made by IBC related to the
 18 auto insurance system in Newfoundland and
 19 Labrador, and I'm going to speak to defining
 20 minor injuries. I'm going to say at this
 21 point that I also in my report did make a
 22 recommendation that that term not be used.
 23 It's been show in research that injured
 24 people find that it trivializes the impact
 25 of the injury on them. So, I will use the

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1 word "minor" for this hearing, but there is
 2 a recommendation in my report not to use
 3 that term if you can avoid it. And I have
 4 offered an alternative. So, I'll also be
 5 speaking to the rationale behind supporting-
 6 evidence based treatment and treatment
 7 protocols. And also, I'm going to make some
 8 comments on the impact of litigation on
 9 people who have suffered injury in traffic
 10 collisions. And I'm also--while not I'm not
 11 asked to do this, I did offer some
 12 suggestions on implementation. I was
 13 involved in implementation of a minor injury
 14 cap and diagnostic and treatment protocols
 15 in Alberta, and we had a really good
 16 implementation process because of a lot of
 17 education and engagement with all
 18 stakeholders. So, I will comment on those
 19 as well. Next slide, please. So, the term
 20 "minor injury" I've used it. I'm not happy
 21 about it. I think it downplays the effect
 22 of injuries on the lives of people who
 23 suffer them. Minor injuries in other
 24 Canadian jurisdictions generally refer to
 25 what health professionals historically call

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1 soft-tissue injuries, whiplash associated
 2 disorders or strains and sprains. And the
 3 term "minor injury" is a—it started out as a
 4 term used in regulation or legislation and
 5 it has absolutely no medical basis. The
 6 term "minor" is an adjective. It's not a
 7 diagnosis. It doesn't describe any kind of
 8 an injury, but unfortunately the medical
 9 professionals seem start to use it and they
 10 often talk about, "Oh, he has a minor
 11 injury," as if I'm supposed to know what
 12 that means. So, it's unfortunate that a
 13 term with no basis in medicine has become
 14 used by healthcare professionals. IBC has
 15 proposed a definition that captures
 16 specifically strains, sprains and whiplash
 17 injuries including any clinically associated
 18 sequela, whether physical or psychological
 19 in nature, that does not result in serious
 20 impairment. This definition is consistent
 21 with what international researchers have
 22 called type 1 injuries, and these are
 23 defined as those traffic injuries which have
 24 been shown in epidemiological studies to
 25 have a favourable nature history with

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1 recovery times ranging from days to a few
 2 months. The injuries include
 3 musculoskeletal injuries such as neck pain
 4 and associated disorders or what we now call
 5 NAD, grades 1 to 3; grade 1 and 2 sprains
 6 and strains of spine and limbs; traumatic
 7 radiculopathies, that's nerve compression
 8 that can be in the neck; mild traumatic
 9 brain injuries and post-traumatic
 10 psychological symptoms such as anxiety and
 11 stress. Most often, type 1 injuries improve
 12 within days to a few months of a collision,
 13 leaving no permanent serious impairment.
 14 Typically, the impact of the even the most
 15 effective treatment for type 1 injuries is
 16 modest and usually limited to a reduction in
 17 symptom intensity. What I just read was a
 18 quote from the research paper that I
 19 referred to the "OPTIMa Collaboration." So,
 20 this is what the researchers are saying
 21 about type 1 injuries, and that's
 22 essentially what IBC's definition captures.
 23 But some of you may have noticed that I
 24 said, "Most often these injuries go on to
 25 recover within a few days to a few months,"

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1 but researchers also point out that a small
 2 percentage may go on to develop prolonged
 3 disability associated with chronic
 4 conditions such as chronic pain syndromes or
 5 debilitating psychological impairments which
 6 may lead to serious impairment in the
 7 person’s ability to function in their daily
 8 life, and it’s for this reason, and there’s
 9 no way of predicting who will or won’t
 10 recover, we have to address compensation for
 11 those individuals who aren’t at fault and in
 12 spite of having sought evidence-based
 13 treatment, don’t recover fully. So, to
 14 address this, IBC has excluded from the
 15 definition, “Those who go on to suffer
 16 serious impairment.” So, the now the
 17 question is what do we mean by “serious
 18 impairment”? So, that does need to be
 19 defined and I don’t believe IBC’s submission
 20 has defined it, but certainly in other
 21 provinces it’s been defined using the
 22 person’s ability to function at their pre-
 23 accident level.
 24 (9:30 a.m.)
 25 MS. RIIS:

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1 A. This is important because it’s impossible to
 2 define disability or one’s ability to
 3 function without taking into account a
 4 variety of factors. And could I have the
 5 next slide? For example, amputation of
 6 someone’s non-dominant baby toe may have no
 7 effect on the ability of say a lawyer to
 8 return to their occupation, but amputation
 9 of a baby toe can derail the career of a
 10 ballerina. The injury or diagnosis does not
 11 define the disability, and for this reason I
 12 put up the World Health Organization
 13 International Classification of Functioning.
 14 And this is essentially how they identify
 15 function and ability or disability. So, the
 16 World Health Organization International
 17 Classification of Functioning conceptualizes
 18 a person’s level of functioning as a dynamic
 19 interaction between his or her health
 20 conditions, environmental factors and
 21 personal factors. It is a biopsychosocial
 22 model of disability based on an integration
 23 of the social and medical models of
 24 disability. And this is a really important
 25 piece and needs to be considered when

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1 defining serious impairment because again I
 2 have had had many patients who have the
 3 exact same diagnosis, but who respond
 4 completely differently to that injury and
 5 how it impacts their ability to function.
 6 So, as I said in my earlier example, the
 7 identical injury can affect one person
 8 minimally and another person very
 9 significantly. So that’s why this kind of
 10 biopsychosocial approach is very important.
 11 So, the identification of serious impairment
 12 must be based not solely on the diagnosis or
 13 the health condition, but also on an
 14 assessment of various factors that influence
 15 how an individual functions in his or her
 16 environment. So, it’s a combination of all
 17 these factors that determine the true effect
 18 of an injury on an individual’s
 19 participation in the ordinary activities and
 20 enjoyment of life. So, IBC has—their
 21 definition does allow to exclude people from
 22 a minor injury cap if they do go on to
 23 suffer impairment, and some will. The next
 24 slide, please. So, I’m going to move on to
 25 the discussion on evidence-based treatment.

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1 Why is this important? Aren’t treatment
 2 providers doing the best they can? I do
 3 believe health professionals are trying to
 4 do their best, but the fact of the matter is
 5 that there is no single approach that is
 6 known to be effective for type 1 injuries.
 7 In addition, there’s a lot of treatments out
 8 there that are very popular, but that have
 9 not shown—being shown to be effective or in
 10 fact have been shown to be ineffective. I
 11 don’t know if any of you are following the—
 12 Dr. Caulfield and the Goop website. Gwyneth
 13 Paltrow has this website. She’s making all
 14 kinds of medical recommendations on her
 15 website that have absolutely no basis in
 16 fact and there’s a Canadian
 17 doctor/researcher out of Alberta who is
 18 basically contradicting all of the claims
 19 she’s making, and it’s a lot of fun to read.
 20 But people are interested in healthcare,
 21 people are on the internet, they want to try
 22 a variety of different kinds of
 23 intervention. So, there’s a lot out there.
 24 We also have to recognize that intuitively
 25 the public tends to believe that if some

<p style="text-align: right;">Page 33</p> <p>1 treatment is good, more treatment must be 2 better. And we see this approach in 3 conversations about Canada’s public health 4 system. Many people are simply asking for 5 more money to be put in and more money to be 6 put in, but when you go deeper into the 7 discussion about Canada’s health system, 8 there is recognition that we need to 9 structure it differently, not just put more 10 money into it. So, I’ve seen many injured 11 people because of this perception that more 12 must be better. I’ve seen many injured 13 people subjected to months and years of a 14 variety of different treatment types 15 including physiotherapy, chiropractic, 16 massage therapy, naturopathy, injections and 17 so on. Often, I see that the only reason 18 more treatment is recommended by a health 19 professional is because the patient is not 20 getting better. And so, it seems like 21 trying something different might work. And 22 I also think that as a health professional 23 we feel compelled to do something. So, even 24 though I know my patient is not getting 25 better, I feel I need to keep trying. And</p>	<p style="text-align: right;">Page 35</p> <p>1 are following the “Exercise is Medicine” 2 piece, but the Canadian health care system 3 has a program called Exercise is Medicine, 4 and they’ve basically said if you could put 5 exercise into a pill, 100 percent of us 6 would be taking this pill. So, movement, 7 activity, resuming your normal activities is 8 the most important thing for people who have 9 type 1 injuries, but if the injured person 10 has pain and nobody explains to them that 11 it’s okay for them to gradually increase 12 their activities, they tend to avoid 13 activities which makes them weaker, which 14 makes them less tolerant to healing and 15 recovering from the injury. The next slide, 16 please. So, another reason to promote 17 evidence-based care in the form of 18 guidelines or protocols is that it’s hard 19 for health professionals to stay current 20 with all of the literature that’s published 21 on the variety of health conditions they 22 treat. As a physiotherapist I treat people 23 after traffic collisions, but I also have 24 patients with stroke, myasthenia gravis, 25 ALS, spinal cord injury and so on. If I</p>
<p style="text-align: right;">Page 34</p> <p>1 so, sometimes we sort of fall a victim to 2 this instinct to want to be helpful even 3 though we know it’s not working, but in 4 fact, the research on type 1 injuries shows 5 that high levels of initial health care 6 utilization are actually associated with 7 poorer recovery, worse recovery from neck 8 injuries after traffic collisions. Too many 9 health visits, too many different care 10 providers seem to result in poorer outcomes. 11 So, I can’t say that that’s an absolute 12 fact, but the research is pointing in that 13 direction. So, much of the research we’re 14 reading now is recommending less treatment, 15 not more treatment. And in fact, the sort 16 of common intervention that’s recommended 17 for all injuries is to offer reassurance and 18 education. So, it’s important to explain to 19 injured people who have type 1 injuries that 20 this will not disable for life, this will 21 heal, and you need to resume your usual 22 activities as soon as possible. If people 23 receive this kind of guidance, they tend not 24 to become fearful, they tend not to withdraw 25 from activities. I don’t know if any of you</p>	<p style="text-align: right;">Page 36</p> <p>1 were to stay current on all of those topics 2 and what the best treatment is for all of 3 those conditions, I wouldn’t have any time 4 to see patients. Evidence-based guidelines 5 help me by summarizing what we know works 6 and what we know doesn’t work. And often 7 they’re sort of a middle ground. The 8 guidelines often will say, “We know that 9 this works. We’re not sure about this. 10 We’re 50/50 on this intervention. So, you 11 can try it if you think it’ll work,” or it 12 will say, “This intervention is not 13 recommended because we know it doesn’t work 14 or it impedes recovery.” The guidelines 15 also offer me protection against malpractice 16 suits, because it lays out in general terms 17 what good treatment looks like. So, most 18 health professionals like working with 19 guidelines. Guidelines are not intended to 20 be prescriptive. They are not written to 21 say, “You must do this. You must do that.” 22 Guidelines are written to offer a summary of 23 the research, what research supports, what 24 it doesn’t support, where treatment is 25 considered to be equivocal, and it also</p>

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1 allows the treatment provider to exercise
 2 clinical judgment. So, if a patient comes
 3 in to me and I think they're going to
 4 benefit from doing yoga three times a week,
 5 I'm perfectly free to prescribe that. So,
 6 it does allow clinical judgment. It cannot
 7 be prescriptive, otherwise, health
 8 professionals would not adopt it. So, I'll
 9 give you a couple of examples. Acute low
 10 back pain is the leading cause of disability
 11 worldwide. I would hazard to guess that
 12 most of us in the room has had an episode of
 13 low back pain, and you may have seen your
 14 family doctor to get treatment for low back
 15 pain, and you have likely been told to take
 16 some Tylenol. Tylenol is the most common
 17 medication prescribed for treatment of acute
 18 low back pain, but the truth is there was an
 19 article published in "The Lancet" in 2014
 20 that there's actually no scientific evidence
 21 to support Tylenol as being any better than
 22 placebo in reducing recovery time. So,
 23 there's a lot of habitual practice that has
 24 evolved over time and because health
 25 providers often find it difficult to stay

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1 abreast of all of the current literature, we
 2 continue to practice through habit. So, for
 3 example, you know, as a physiotherapist I
 4 often will put a hot pack on somebody and if
 5 I were to read up about it, I would probably
 6 find that hot packs are not shown to be
 7 particularly effective in management of neck
 8 pain. But it's something, you know, we
 9 learn to do as an undergraduate. You've
 10 done it. It feels good to the patient, so
 11 sometimes we keep doing those treatments.
 12 I also looked up images for whiplash
 13 treatment and I got many pictures like the
 14 one you're looking at showing somebody
 15 wearing a soft collar. But in fact, it's
 16 long been demonstrated that a soft collar in
 17 fact is detrimental to recovery from mild to
 18 moderate neck pain injuries. So, again, if
 19 you were to ask the general population
 20 what's the treatment for whiplash, I'll bet
 21 you many of them would to this day say "oh
 22 yeah, a collar is what you need after a
 23 whiplash injury". But in fact, the research
 24 shows us that we should not be prescribing
 25 collars. So, that's an example of an

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1 evidence-based guideline would say do not
 2 offer a collar. So that would protect me
 3 from getting a malpractice complaint. It
 4 would help me to know I shouldn't be
 5 prescribing a collar. But it would also say
 6 that yoga has been shown to be effective in
 7 some studies, not effective in other
 8 studies. So, even though it's not proven to
 9 be effective, if I think it might be
 10 suitable for an individual patient, I'd be
 11 free to prescribe that.
 12 So, in my view, treatment should not be
 13 denied a patient if it is helping the person
 14 to recover their ability to function. But
 15 injured people shouldn't be subject to
 16 prolonged treatment that's ineffective or
 17 perhaps even harmful and Newfoundland
 18 drivers should not have to pay for
 19 ineffective or harmful treatment. So, I
 20 think that's another important piece. If
 21 ineffective treatment is being offered, it's
 22 costing everybody some money and it's not
 23 helping the patient.
 24 And again, many of my patients are so
 25 frustrated by the system because they are

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1 told to continue attending treatment, even
 2 though they know it's not helping. And
 3 often I'll ask them, "well, why do you keep
 4 going to treatment if it's not helping?
 5 Well, my lawyer told me I should keep
 6 going." And I said "well, does your
 7 physiotherapist or chiropractor want you to
 8 keep going? No, they discharged me but the
 9 lawyer told me to keep going, so the
 10 physiotherapist said that's fine". And of
 11 course, as a physiotherapist, if I have a
 12 private practice, I'm happy to have patients
 13 come to me.
 14 So, I think this prolonged and ongoing
 15 treatment is a burden primarily to the
 16 injured person. So, I think if somebody is
 17 being subjected to prolonged and repetitive
 18 treatment, it's really important that it be
 19 helping them and that it be helping them to
 20 return their ability to participate in their
 21 families, their social lives and to become a
 22 contributing member of society as well. I
 23 think those larger goals are important to
 24 consider.
 25 STAMP, Q.C.:

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1 Q. Ms. Riis, when we were here a couple of days
 2 ago, I guess it was, I guess it was maybe
 3 Monday, we had two people who came in who
 4 had been in accidents and the sense I had in
 5 part from what they were telling us is that
 6 how badly they were off was partly
 7 demonstrated by how many times they went to
 8 physio and chiropractic and massage and so
 9 on. The more they went, the worse they
 10 were. And that was explaining why they
 11 were, I guess, uncomfortable.

12 MS. RIIS:

13 A. Yes. So, it is my experience – and you
 14 know, I’ll talk about this a little bit more
 15 later too, but in speaking to some of the
 16 Section B adjusters in Newfoundland, it’s my
 17 understanding that treatment continues until
 18 the claim is settled. So, it appears to me
 19 that, like in other provinces, that the
 20 treatment is used as a mechanism to prove
 21 how disabled somebody is, and this, of
 22 course, supports the claim for pain and
 23 suffering. It’s a frustrating conflict
 24 between the Section – in Section B and I
 25 will talk about that a little bit more.

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1 (9:45 a.m.)
 2 Next slide please. So, not only is it
 3 unfair to injured persons to receive
 4 ineffective treatment, it’s also unfair to
 5 policyholders across the province to have to
 6 pay for ineffective treatment. So, that’s
 7 in part the goal of evidence-based care.
 8 Injured persons shouldn’t have to waste
 9 their time on treatment that’s unlikely to
 10 help and drivers in Newfoundland should not
 11 pay increasing premiums in order to pay for
 12 treatment that doesn’t work.

13 Currently, there seems to be little to
 14 support delivery of the best care possible
 15 for injured persons. I believe that the
 16 health care providers simply prescribe
 17 whatever treatment they feel is appropriate
 18 and insurance adjusters are sort of left to
 19 their own devices to figure out if they need
 20 to approve that or not. And I suspect that
 21 unreasonable denials of treatment are
 22 happening and I’m certain that unreasonable
 23 approvals of treatment are happening as
 24 well. Because again, there’s no common
 25 understanding of what constitutes good

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1 treatment for Type 1 injuries.
 2 And I don’t have a great deal of data
 3 to share with you, but IBC did provide me
 4 this information and I understand that
 5 treatment costs have increased by 108
 6 percent between 2001 and 2017 as compared to
 7 a 38 percent increase in inflation. But I
 8 also gather that general damages awards have
 9 continued to increase. So, this suggests to
 10 me that in spite of more and more expensive
 11 treatment, injured persons still aren’t
 12 getting better because they’re still able to
 13 settle for large pain and suffering amounts.

14 Next slide please. So, the third topic
 15 that I wanted to speak on was litigation and
 16 the conflicting incentives around
 17 litigation. In my mind, Section B is
 18 intended to promote recovery of injured
 19 people. It’s meant to provide access to
 20 health care that’s reasonable and necessary
 21 that will promote recovery without forcing
 22 the injured person to reach into their
 23 pocket for large sums of money for ongoing
 24 treatment. And this treatment should be
 25 paid for by the person’s own insurer and I

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1 believe the cap right now is \$25,000. And
 2 in addition, there’s compensation for loss
 3 of income and other damages.

4 So, I think when on the one hand you’re
 5 being provided funds to seek good health
 6 care, but on the other hand your bodily
 7 injury claim is based on how sick you are,
 8 the injured person is in a conflicted
 9 situation. On the one hand, they want to
 10 get better. On the other hand, if they get
 11 better and go back to work and are perfectly
 12 fine, then there’s no bodily injury claim.
 13 So, I think it puts people in an awkward
 14 situation and I think that’s difficult.

15 I also think if somebody who collides
 16 with a moose – and I don’t believe moose
 17 have insurance liability coverage – they’re
 18 essentially left with no bodily injury claim
 19 at all. And I think one of the
 20 recommendations IBC put forward, I’m not
 21 speaking to this, was to increase the cap to
 22 \$50,000 and I think this is going to be
 23 beneficial for those people who don’t have
 24 the opportunity to submit a bodily injury
 25 claim where it’s a single vehicle accident,

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1 so to speak.

2 I think also that the conflict between

3 Section B intended for recovery and Section

4 A to compensate for pecuniary and non-

5 pecuniary losses is confusing to many

6 injured people. I think many injured people

7 don't understand the difference between

8 Section B and Section A. They often don't

9 understand that there are two insurance

10 companies involved. Or if the third party

11 was insured by the same insurance company

12 that covers Section B, they think it's all

13 one person or one claim against the at-fault

14 party. I think it generates a lot of

15 difficulty for the injured person.

16 Also, one of the biggest problems with

17 this hybrid systems is that if an insurance

18 adjuster denies a claim for treatment, the

19 patient often feels angry and they feel

20 "this isn't fair. I should have this

21 treatment" and that creates a sense of

22 injustice and the sense of injustice has

23 been shown in health care research to

24 contribute to prolonged disability. So,

25 this system which is somewhat adversarial I

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1 think actually can inhibit recovery because

2 it creates friction between the insurance

3 company and the injured person. So, I think

4 that's also one of the downsides. So, one

5 of the other recommendations I've made is to

6 provide some more education for the general

7 consumer, the public, as well as for the

8 other stakeholders in the system.

9 Next slide. So, these are the

10 additional points that I wanted to mention.

11 I wasn't asked to comment on this, but I

12 offered the information anyway to the Board.

13 I would hope that you could be the first

14 province in Canada not to use the term

15 "minor injury". Type 1 injury is one

16 suggestion. You may find something better.

17 But I do think the term "minor injury"

18 trivializes the impact of this injury on

19 some people and it creates friction again.

20 Patients have told us that, you know, "when

21 you tell me my injury is minor, I think you

22 don't believe me" and it forces the injured

23 person to sort of prove that they're

24 hurting, to prove that they're disabled and

25 it becomes a real struggle.

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1 The second piece is consumer education.

2 I think consumers need access to easy-to-

3 understand information about navigating the

4 system and knowing their rights. This is

5 hard because when we buy insurance we

6 typically don't think we're going to need

7 it. So, we don't read up about the system

8 until after we've been in an accident. And

9 so, at that point, you're dealing with your

10 injury. You're dealing with the paperwork

11 involved in making a claim. You're dealing

12 with getting your car fixed. And it's not a

13 great time to be reading about the

14 complexities of the auto insurance system.

15 So, there needs to be education not only to

16 consumers, but also to health care

17 professionals, so in general there's a

18 heightened sense of how the system works and

19 that with Section B, you're working with

20 your own insurance company.

21 And I also think stakeholder education

22 is critical. So, everybody involved in the

23 system, if you're going to introduce a new

24 system, particularly the evidence-based

25 treatment protocols and the minor injury

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1 cap, education and ongoing guidance during

2 implementation can reduce a lot of conflict

3 and delays due to this misunderstanding of

4 the intent of the new system.

5 In Alberta, when we implemented in

6 2004, we set up a stakeholder dialogue prior

7 to implementation and following

8 implementation, we had a monthly

9 teleconference with all stakeholders,

10 including government representatives, the

11 health professional associations. I was

12 there for IBC. Insurers were on the call.

13 And we talked about what's working, what's

14 not working. When something was not working

15 because of lack of clarity, the government

16 had the power to issue explanatory

17 bulletins. So, the government would issue a

18 bulletin underscoring the intent of certain

19 parts of the process.

20 That was really helpful and the system

21 implemented quite well and insurers and

22 health professionals had a much stronger

23 working relationship. Prior to that, health

24 professionals perceived insurers as the

25 enemy of the injured person and I think that

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1 really improved after we had these
 2 stakeholder dialogues ongoing for several
 3 months. And that lasted for well over a
 4 year and it really helped put the system
 5 into play.
 6 So, those are my comments and I will be
 7 happy to entertain questions.
 8 STAMP, Q.C.:
 9 Q. Ms. Riis, before you turn over to questions
 10 from others, I did speak to you initially at
 11 one point about the Nova Scotia, New
 12 Brunswick experience and so on. But I
 13 guess, maybe can you answer this way: how
 14 does this protocol arrangement work? I
 15 mean, a patient is injured. How does it
 16 actually work in practice? What happens?
 17 MS. RIIS:
 18 A. So, the scenario would be this: The
 19 collision happens. Very often people with
 20 Type 1 injuries do not feel the need to go
 21 to emergency. They don't generally call the
 22 paramedics. They might go see their family
 23 doctor. But the first thing they'd
 24 typically do, if they've been in a
 25 collision, is call their insurance company

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1 and let them know they've been in a
 2 collision.
 3 And so, in say Nova Scotia or Alberta,
 4 what would happen, the insurance company is
 5 expected – I think I even – I'm not sure,
 6 but I think they're required to give the
 7 injured person guidance to seek medical
 8 attention. So, whether that's go to Emerg,
 9 go to your family doctor, go to your – you
 10 know, if you have a physiotherapist, your
 11 physiotherapist or chiropractor. And they
 12 would also tell the injured person to tell
 13 your health care professional to call us and
 14 we'll set up an arrangement so payment can
 15 happen directly to the clinic. So, when
 16 these have been implemented, one of the
 17 benefits of it is that the patient does not
 18 have to pay for the treatment and then get
 19 reimbursed by the insurer. The insurer sets
 20 up a direct pay mechanism with the health
 21 care clinic. And I think that's a huge
 22 advantage. Takes away a great deal of
 23 bureaucracy out of the process.
 24 Because the insurance company and the
 25 treatment provider understand what the

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1 treatment protocol is, everybody knows what
 2 the treatment is going to look like. So,
 3 the insurer doesn't need to get a detailed
 4 explanation of what treatment are you going
 5 to do, how many times and so on. The
 6 treatment is pre-approved. So, the
 7 clinician knows they're going to get paid
 8 for the protocol treatment and the insurer
 9 knows that they're going to pay it. And so
 10 basically treatment starts.
 11 STAMP, Q.C.:
 12 Q. And how is it followed?
 13 MS. RIIS:
 14 A. So, in the guideline, there's usually the
 15 requirement for an initial assessment. That
 16 would be included as part of the guideline.
 17 And you can include reporting periods, so
 18 progress report might be required at 12
 19 weeks. So, at the 12-week mark -- so most of
 20 the guidelines cover a 12-week period, three
 21 months post injury because three months is
 22 generally a timeline during which most of
 23 these injuries should be resolving. And at
 24 three months, the provider either discharges
 25 the patient, if the patient has done well,

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1 or if the patient needs additional
 2 treatment, a progress report would be
 3 submitted with a request for additional
 4 treatment to continue. And at that point,
 5 the insurance company would adjudicate based
 6 on what they understand is going on.
 7 The health care providers, they're not
 8 very good at times in explaining to the
 9 insurance company why more treatment would
 10 help. They simply put in a request for more
 11 treatment. So, what the insurance company
 12 sees is "okay, this person has had 12 weeks
 13 of treatment. They don't seem to be any
 14 better" and sometimes health providers don't
 15 give a progress report on function to the
 16 insurer. So, the insurer thinks "well,
 17 they're no better". So, the insurance
 18 company is stuck with the situation where
 19 the patient's not getting better and now
 20 we're being asked to pay for more treatment.
 21 How do we know this more treatment is going
 22 to help? So, there's a lot of work, I
 23 think, that could be done to help the health
 24 professionals communicate more clearly with
 25 insurers and for insurers to know what

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1 questions to ask to understand why will this
 2 additional treatment help.
 3 But in any case, if somebody hasn't
 4 recovered during the protocol, then they go
 5 into the traditional system where they
 6 submit a claim for further treatment,
 7 explain to the insurance adjuster why. The
 8 insurance adjuster approves or denies that
 9 treatment.
 10 STAMP, Q.C.:
 11 Q. So, have you had any direct involvement with
 12 say the Nova Scotia situation or New
 13 Brunswick, for example, and to see how it's
 14 worked over there?
 15 (10:00 a.m.)
 16 MS. RIIS:
 17 A. I haven't been involved recently with Nova
 18 Scotia. I was involved in the initial
 19 introduction of the diagnosis treatment
 20 protocols. I was involved in the training.
 21 To be honest, I haven't heard anything good
 22 or bad in terms of what's happening in Nova
 23 Scotia. So, I'm assuming it's coasting. I
 24 don't know.
 25 STAMP, Q.C.:

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1 Q. And what about Alberta, for example?
 2 MS. RIIS:
 3 A. Yeah. In Alberta, I continue to be involved
 4 and I think their diagnostic treatment
 5 protocols continue to work quite well. I
 6 believe the relationships between the health
 7 industry and the insurance industry are
 8 generally very good, much better than in
 9 Ontario and other provinces.
 10 STAMP, Q.C.:
 11 Q. Ms. Riis, thanks very much. Others will
 12 have questions for you, of course.
 13 MS. RIIS:
 14 A. Sure.
 15 KENNEDY, Q.C.:
 16 Q. Thank you, Madam Chair. I will be asking
 17 some questions on behalf of the Campaign.
 18 O'FLAHERTY, Q.C.:
 19 Q. Excuse me, Mr. Kennedy. Just one moment.
 20 Madam Chair, just for the sake of order for
 21 the assistance of counsel, we do have copies
 22 of the slides. I don't – I think they track
 23 the presentation. I don't know if counsel
 24 want those now or would you like to have the
 25 slides for the purposes of your questioning?

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1 Because we have them printed right now.
 2 KENNEDY, Q.C.:
 3 Q. I think what I'd prefer to do, because I
 4 want to make sure that we use our time
 5 wisely, I'll just continue with the
 6 questioning, Mr. O'Flaherty, and there's a
 7 break. There's one particular slide I want
 8 to look at. So, we could either do it now
 9 or do it then, Madam Chair, whatever you
 10 want.
 11 CHAIR:
 12 Q. If you – when you request it, we can do it
 13 then.
 14 KENNEDY, Q.C.:
 15 Q. Thank you. Ms. Riis, my name is Jerome
 16 Kennedy. I'm appearing on behalf of the
 17 Campaign to Protect Innocent Victims –
 18 Accident Victims. Ms. Riis, I'm going to
 19 refer you to report, if we could call the
 20 report up, please, at page 13. In the
 21 second paragraph there, Ms. Riis, you say
 22 that you recommend – support the
 23 recommendations made by IBC. Do you see
 24 that?
 25 MS. RIIS:

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1 A. Yes.
 2 KENNEDY, Q.C.:
 3 Q. Okay, now one of the recommendations made by
 4 IBC is that there be a minor injury cap of
 5 \$5,000 for general damages for pain and
 6 suffering, are you aware of that?
 7 MS. RIIS:
 8 A. I am aware of that.
 9 KENNEDY, Q.C.:
 10 Q. And do you support that recommendation?
 11 MS. RIIS:
 12 A. I am not going to comment on the amount
 13 that's being recommended, but I do support
 14 the concept of a cap. I have no objection
 15 to that.
 16 KENNEDY, Q.C.:
 17 Q. And why would you support the recommendation
 18 of a cap if we're dealing with
 19 implementation of protocols for evidence
 20 based treatment, what is the relationship
 21 between the two?
 22 MS. RIIS:
 23 A. Having worked with people with catastrophic
 24 injury, I really feel that somebody with a
 25 spinal cord—a young man with a spinal cord

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1 injury for the rest of his life is going to
 2 need a lot of money, shouldn't be capped,
 3 and I think the money needs to be directed
 4 towards those severe injuries. The
 5 pecuniary losses of an individual with a
 6 Type 1 injury is not going to be capped, as
 7 I understand it. This is a cap on general
 8 damages, is that correct?
 9 KENNEDY, Q.C.:
 10 Q. That's correct, yes, that's the IBC
 11 proposal, yes.
 12 MS. RIIS:
 13 A. Yeah, so it's my understanding that if
 14 somebody with a Type 1 injury requires
 15 treatment for a prolonged period of time,
 16 that that can be covered through the
 17 settlement.
 18 KENNEDY, Q.C.:
 19 Q. But I don't understand, I guess what I'm
 20 missing here as a healthcare provider, and
 21 you're here talking about basically accident
 22 benefits, improving the delivery of
 23 benefits, why you would have any position on
 24 the imposition of a minor injury cap?
 25 MS. RIIS:

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1 A. I said I have no objection to the imposition
 2 of a cap and that's partly because of the
 3 comments I made about the effects of
 4 litigation. I think that the pain and
 5 suffering award essentially compensations
 6 for disability and so I think people who are
 7 in the position of trying to recover, but at
 8 the same time wanting to maximize the pain
 9 and suffering award, I think that puts them
 10 in an awkward situation. So I think if the
 11 pain and suffering award is capped in cases
 12 of minor injury, or Type 1 injuries, I don't
 13 think they're going to miss out on necessary
 14 treatment, on lost income. I think it's a
 15 cap on the general damages, which is
 16 different from capping future treatment.
 17 KENNEDY, Q.C.:
 18 Q. So this is, you're using the words "I
 19 think", "my opinion", so it's basically your
 20 subjective opinion, is that correct?
 21 MS. RIIS:
 22 A. Yes.
 23 KENNEDY, Q.C.:
 24 Q. Okay. Now, on Monday I think it was, this
 25 is Wednesday now, on Monday we heard from

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1 two victims, innocent victims of motor
 2 vehicle accidents and we heard from a panel
 3 of lawyers, have you reviewed the testimony
 4 provided by these individuals?
 5 MS. RIIS:
 6 A. I have copies of the testimony, but I
 7 haven't reviewed all of it, I reviewed parts
 8 of it. It was quite extensive.
 9 KENNEDY, Q.C.:
 10 Q. So when you say you reviewed parts of it,
 11 what have you reviewed?
 12 MS. RIIS:
 13 A. I reviewed, I believe it was two cases of
 14 people who had Type 1 injuries who went on
 15 to suffer prolonged disability and prolonged
 16 impact on their lives.
 17 KENNEDY, Q.C.:
 18 Q. So if there was a cap in place, since you've
 19 given your opinion, would they be caught by
 20 the cap, in your opinion as a healthcare -
 21 MS. RIIS:
 22 A. According to the definition as I read it,
 23 no.
 24 KENNEDY, Q.C.:
 25 Q. They wouldn't.

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1 MS. RIIS:
 2 A. No.
 3 KENNEDY, Q.C.:
 4 Q. So the woman with the whiplash, there was
 5 three, I think, one woman had been involved
 6 in three accidents, you're saying that there
 7 would be a cumulative effect of all three
 8 accidents?
 9 MS. RIIS:
 10 A. I don't know the case in sufficient detail,
 11 so I don't want to comment on that.
 12 KENNEDY, Q.C.:
 13 Q. You just commented, Ms. Riis, you said it
 14 wouldn't be caught by the cap.
 15 MS. RIIS:
 16 A. I don't want to comment on it because I
 17 haven't read it in detail and I'm afraid
 18 that you are going to interpret my responses
 19 as if I've read it in detail and I just
 20 haven't.
 21 KENNEDY, Q.C.:
 22 Q. Well you just said that -
 23 MS. RIIS:
 24 A. My initial impression was that I didn't
 25 think they would be caught by the cap

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1 because it was my impression, having not
2 read the entire document, that they went on
3 to suffer significant impairment.
4 KENNEDY, Q.C.:
5 Q. So wouldn't a better answer have been "I
6 have no comment"?"
7 MS. RIIS:
8 A. Thank you.
9 KENNEDY, Q.C.:
10 Q. Would that have been your better answer?
11 MS. RIIS:
12 A. Yes, thank you.
13 KENNEDY, Q.C.:
14 Q. Yeah, it would, sure. Now, in terms of the
15 Closed Claim Study prepared by Oliver Wyman,
16 have you reviewed that?
17 MS. RIIS:
18 A. No.
19 KENNEDY, Q.C.:
20 Q. So do you know how many cases were looked at
21 in the Closed Claims Study?
22 MS. RIIS:
23 A. No.
24 KENNEDY, Q.C.:
25 Q. No. So when we're talking here about

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1 definitions and you don't like the term
2 "minor injury", did you review the evidence
3 of Dr. Karl Misik who testified five or six
4 days ago, on a Friday?
5 MS. RIIS:
6 A. Again, only in part.
7 KENNEDY, Q.C.:
8 Q. Okay, and what part did you review?
9 MS. RIIS:
10 A. The first two pages.
11 KENNEDY, Q.C.:
12 Q. The first two pages of his testimony?
13 MS. RIIS:
14 A. Yes.
15 KENNEDY, Q.C.:
16 Q. Dr. Misik also didn't like the term "minor
17 injury", but for different reasons because
18 he basically, if I can summarize, testified
19 that the effect upon individuals can be very
20 different and what you describe minor for
21 one person would not be minor for a second
22 person, do you agree with that assessment by
23 Dr. Misik?
24 MS. RIIS:
25 A. I wouldn't use that language, but I

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1 understand what he was saying, so yes, I
2 would agree with him that the impact of one
3 injury may be different on two different
4 people.
5 KENNEDY, Q.C.:
6 Q. Mr. Stamp asked you—and I'm going to come
7 back to that, Mr. Stamp asked you how you
8 got here. It's been a common question for
9 everyone. You were asked by the IBC to
10 review their submission and file a report.
11 MS. RIIS:
12 A. Yes.
13 KENNEDY, Q.C.:
14 Q. Okay, so nothing unusual about that. If we
15 could look at page 2 of your report, please?
16 So you indicate here, as you have indicated
17 in your CV, that you're a registered
18 physiotherapist in good standing since '79
19 and you have a Master's degree in
20 Rehabilitation & Science, correct?
21 MS. RIIS:
22 A. Correct.
23 KENNEDY, Q.C.:
24 Q. So you're not a medical doctor, physician?
25 MS. RIIS:

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1 A. No.
2 KENNEDY, Q.C.:
3 Q. No. You also state, "I have been engaged in
4 the introduction of minor injury definitions
5 and/or evidence based protocols in Alberta,
6 Nova Scotia, New Brunswick and Ontario."
7 That's correct, is it?
8 MS. RIIS:
9 A. Correct.
10 KENNEDY, Q.C.:
11 Q. And at each of these occasions you've been
12 hired by IBC, is that correct?
13 MS. RIIS:
14 A. Yes.
15 KENNEDY, Q.C.:
16 Q. Okay, so we know that the Nova Scotia and
17 New Brunswick definitions came in around—or
18 the caps came in around 2003, 2004, so your
19 relationship –
20 MS. RIIS:
21 A. Alberta was 2004.
22 KENNEDY, Q.C.:
23 Q. Nova Scotia and New Brunswick were on 2003,
24 2004, weren't they? I thought Alberta was
25 2007?

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1 MS. RIIS:
 2 A. I don't think so, I think Nova Scotia was
 3 later than that. Amanda, do you know?
 4 KENNEDY, Q.C.:
 5 Q. We can deal with that, I don't think—I think
 6 it's around—in 2007 there's a constitutional
 7 challenge in Nova Scotia, is that what
 8 you're talking about?
 9 MS. RIIS:
 10 A. Well I was involved in Nova Scotia in 2012.
 11 KENNEDY, Q.C.:
 12 Q. Okay, so in any event, you've been involved
 13 in four different provinces in terms of the
 14 introduction of minor injury definitions and
 15 protocols?
 16 MS. RIIS:
 17 A. Yes.
 18 KENNEDY, Q.C.:
 19 Q. In each one of those provinces, IBC was the
 20 proponent or a proponent for the cap, a
 21 minor injury cap on general damages for pain
 22 and suffering?
 23 MS. RIIS:
 24 A. Yes.
 25 KENNEDY, Q.C.:

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1 Q. So your relationship with the IBC in terms
 2 of this kind of hearing goes back 15 years,
 3 maybe?
 4 MS. RIIS:
 5 A. Yes.
 6 KENNEDY, Q.C.:
 7 Q. Okay, have you ever testified at one of
 8 these hearings for the other side, for the
 9 people who are challenging the cap?
 10 MS. RIIS:
 11 A. I haven't testified in a government hearing
 12 for the other side, no.
 13 KENNEDY, Q.C.:
 14 Q. Okay, so your relationship with the IBC,
 15 though, I understand goes back further than
 16 15 years ago, it goes back to the '90s?
 17 MS. RIIS:
 18 A. I'm going to say early 2000s, I can't recall
 19 exactly when, but I'd say the turn of the
 20 century.
 21 KENNEDY, Q.C.:
 22 Q. And if we could perhaps have your CV brought
 23 up for a second. And if we could go, Ms.
 24 Riis, to page 3 under "Articles, Education
 25 Materials and Publications". 1994 to 2008

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1 you indicate that you have authored several
 2 injury reference manuals on the topic of
 3 rehabilitation for auto insurance companies,
 4 so that would have started with Allstate,
 5 would it, and then with IBC and other
 6 individual insurance companies?
 7 MS. RIIS:
 8 A. Yes.
 9 KENNEDY, Q.C.:
 10 Q. Okay. Then in 2004 to 2010, you were a
 11 consultant for the Insurance Bureau of
 12 Canada participating as a researcher in a
 13 survey among automobile insurers to gather
 14 data pertaining to the utilization of the
 15 minor injury guideline.
 16 MS. RIIS:
 17 A. Yes.
 18 KENNEDY, Q.C.:
 19 Q. Okay, so we know at least until 1994 you're
 20 working in some aspect with the insurance
 21 industry, is that the first time that you
 22 had worked with the insurance industry or
 23 for the insurance industry?
 24 MS. RIIS:
 25 A. Apart from treating patients that were

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1 injured in traffic collisions, yes.
 2 KENNEDY, Q.C.:
 3 Q. So then in 2008, you consulted with the IBC
 4 in reparation and presentation of paper and
 5 poster at World Congress on Neck Pain, a
 6 survey—is this all the one thing, a survey
 7 examining the effect of reforms on the
 8 Alberta benefit system?
 9 MS. RIIS:
 10 A. Yes.
 11 KENNEDY, Q.C.:
 12 Q. Okay, so in 2008 you consulted, I'm assuming
 13 you were hired as a consultant to work with
 14 IBC?
 15 MS. RIIS:
 16 A. Yes, yes.
 17 KENNEDY, Q.C.:
 18 Q. Okay, if we then go to page 2, you see
 19 expert witness at the Nova Scotia
 20 Constitutional Challenge. Now that's why I
 21 think—I thought Nova Scotia and we had a
 22 lawyer from Nova Scotia here earlier, I
 23 thought it was 2003, 2004, around then that
 24 the cap came in, in Nova Scotia, and then
 25 there was a constitutional challenge. So

<p style="text-align: right;">Page 69</p> <p>1 your CV indicates that you were an expert 2 witness at the Nova Scotia Constitutional 3 Challenge? 4 MS. RIIS: 5 A. Yes. 6 KENNEDY, Q.C.: 7 Q. And that's 2009. 8 MS. RIIS: 9 A. Yes. 10 KENNEDY, Q.C.: 11 Q. Did you testify there? 12 MS. RIIS: 13 A. Yes. 14 KENNEDY, Q.C.: 15 Q. Who did you testify for as a witness? Who 16 called you as a witness? 17 MS. RIIS: 18 A. IBC. 19 KENNEDY, Q.C.: 20 Q. IBC. When we look at the next one, 21 Taskforce Member, May to October, 2011, you 22 were appointed as the IBC representative to 23 New Brunswick Minor Personal Cap Working 24 Group by the Minister of Justice to assist 25 in development of recommendations regarding</p>	<p style="text-align: right;">Page 71</p> <p>1 members and non-voting members? 2 MS. RIIS: 3 A. Yes, and I was a non-voting member. 4 KENNEDY, Q.C.: 5 Q. Okay, how many voting members on that panel 6 were there? 7 MS. RIIS: 8 A. I'm going to say at least 15. 9 KENNEDY, Q.C.: 10 Q. And were there other non-voting members 11 besides yourself? 12 MS. RIIS: 13 A. Yes. 14 KENNEDY, Q.C.: 15 Q. How many of those were there? 16 MS. RIIS: 17 A. Again, I don't know what the accurate number 18 is? 19 KENNEDY, Q.C.: 20 Q. What was the difference between a voting 21 member and a non-voting member to the best 22 of your understanding? 23 MS. RIIS: 24 A. A voting member was a scientist that 25 participated in the actual scientific</p>
<p style="text-align: right;">Page 70</p> <p>1 definition of minor personal injury and cap. 2 So you were the IBC representative? 3 MS. RIIS: 4 A. Correct. 5 KENNEDY, Q.C.: 6 Q. In 2013, I think this one may be referred to 7 in your report, I think it is referred to, 8 actually, you call it the Optima Project 9 Expert Panel. 10 MS. RIIS: 11 A. Yes. 12 KENNEDY, Q.C.: 13 Q. You represent IBC on an expert panel which 14 resulted in publication enabling recovery 15 from common traffic injuries that focus on 16 the injured person? 17 MS. RIIS: 18 A. Correct. 19 KENNEDY, Q.C.: 20 Q. How many people were on that panel? 21 MS. RIIS: 22 A. Oh, I'd have to count, but I'd say 20 at 23 least. 24 KENNEDY, Q.C.: 25 Q. Okay, and were there such things as voting</p>	<p style="text-align: right;">Page 72</p> <p>1 research review process that lead to the 2 publication. The non-voting members were 3 there to offer guidance and to establish a 4 framework for some of the discussions. So 5 we had a lot of researchers from around the 6 world who didn't understand how the auto 7 insurance system worked and the non-voting 8 members were there to offer sort of a 9 framework in which to consider the research. 10 KENNEDY, Q.C.: 11 Q. If you go up a little bit further then, the 12 National Pain Strategy, December 2017 to 13 present, as stakeholder representing the 14 Insurance Bureau of Canada at the McMaster 15 Health Forum. So again, you were appointed 16 or hired by the IBC. 17 MS. RIIS: 18 A. Yes. 19 KENNEDY, Q.C.: 20 Q. Is that health forum, is that an ongoing 21 thing, Ms. Riis? 22 MS. RIIS: 23 A. Yes. 24 KENNEDY, Q.C.: 25 Q. And if we could go to page 1 of your CV,</p>

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1 please? And we talked about 1992 to 2008,
 2 2008 to the present, so Health Service
 3 Management, that's simply your company, I'm
 4 assuming?
 5 MS. RIIS:
 6 A. Yes.
 7 KENNEDY, Q.C.:
 8 Q. Okay. The second bullet from the bottom of
 9 that one, I guess, develop training programs
 10 for insurance companies on catastrophic
 11 claims, we've talked about that, you talked
 12 about that earlier, did you?
 13 MS. RIIS:
 14 A. Yes.
 15 (10:15 a.m.)
 16 KENNEDY, Q.C.:
 17 Q. Consulting on auto insurance issues and
 18 reform in Alberta, Nova Scotia and New
 19 Brunswick?
 20 MS. RIIS:
 21 A. Yes.
 22 KENNEDY, Q.C.:
 23 Q. Okay, and you talked about that. And then
 24 consulting with Ontario, Alberta and Nova
 25 Scotia health professional associates and

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1 academic groups. Who would—give me an
 2 example, please, of a health professional
 3 association?
 4 MS. RIIS:
 5 A. So the Ontario Physiotherapy Association;
 6 the Registered Massage Therapist
 7 Association; I spoke with the Nova Scotia
 8 Physiotherapy Association, I did
 9 presentations for them; University of
 10 Toronto; Dalhousie, so various health
 11 professional groups would invite me in to
 12 speak on the reforms and the impact on the
 13 delivery of healthcare.
 14 KENNEDY, Q.C.:
 15 Q. Okay. If I could now ask you to look at
 16 page 2 again, we're still on page 2, and
 17 this is where you talk about—it's the
 18 sentence after you talk about also been
 19 engaged in the introduction of minor injury
 20 definitions and/or evidence based protocols,
 21 Alberta, Nova Scotia, New Brunswick and
 22 Ontario. And you go on to say, "This has
 23 allowed me to work closely with multiple
 24 stakeholders, the general public,
 25 governments, health professional

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1 associations" et cetera, but then in all of
 2 these circumstances you were hired by the
 3 IBC, is that correct?
 4 MS. RIIS:
 5 A. Yes, I was engaged with IBC, but I was also
 6 engaged separately by some health
 7 professional associations around the same
 8 issue, but when I was engaged by, say the
 9 Ontario Physiotherapy Association or the
 10 Alberta Physiotherapy Association, they
 11 wanted me to speak to them as a
 12 physiotherapist trainer.
 13 KENNEDY, Q.C.:
 14 Q. When you were involved in Alberta, Nova
 15 Scotia, New Brunswick and Ontario in terms
 16 of the introduction of minor injury
 17 definitions and/or evidence based protocols,
 18 your submissions would have supported IBC's
 19 submission, is that correct?
 20 MS. RIIS:
 21 A. I'd like to think that IBC supports my
 22 recommendations.
 23 KENNEDY, Q.C.:
 24 Q. IBC are paying you, correct? You're not
 25 paying them?

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1 MS. RIIS:
 2 A. That's correct.
 3 KENNEDY, Q.C.:
 4 Q. Yes. Have you ever been retained, for
 5 example, to question the validity of a cap
 6 or whether or not a minor injury cap should
 7 be brought in?
 8 MS. RIIS:
 9 A. I've been asked to consider the pros and
 10 cons of a cap, but certainly I have not
 11 written this type of a submission opposing a
 12 cap.
 13 KENNEDY, Q.C.:
 14 Q. Okay. We've talked about minor injuries, so
 15 I'm not going to deal with that because you
 16 are pretty clear on that, except I'm going
 17 to come back to that report that you refer
 18 to—or maybe, let's do it now. There has
 19 been a report prepared by the Newfoundland
 20 and Labrador Chiropractic Association which
 21 has been filed with the Board, have you seen
 22 that?
 23 MS. RIIS:
 24 A. No, I haven't.
 25 KENNEDY, Q.C.:

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1 Q. Could we bring that up, please? And first I
 2 guess I should ask, since you determined
 3 that certain treatments are ineffective, do
 4 you accept that chiropractic is an effective
 5 treatment for some injuries sustained in
 6 motor vehicle accidents?
 7 MS. RIIS:
 8 A. Yes.
 9 KENNEDY, Q.C.:
 10 Q. Do you accept that massage therapy is an
 11 effective treatment for injuries sustained
 12 in motor vehicle accidents?
 13 MS. RIIS:
 14 A. Yes.
 15 KENNEDY, Q.C.:
 16 Q. Do you accept that physiotherapy is an
 17 appropriate treatment?
 18 MS. RIIS:
 19 A. Yes.
 20 KENNEDY, Q.C.:
 21 Q. Would kinesiology or a kinesiologist be
 22 individuals or a practice which could help
 23 in the treatment of motor vehicle injuries?
 24 MS. RIIS:
 25 A. Yes.

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1 KENNEDY, Q.C.:
 2 Q. So when you say that there are certain
 3 treatments that have been shown to be
 4 ineffective, which ones are you referring
 5 to?
 6 MS. RIIS:
 7 A. Soft collar, rest, avoiding usual
 8 activities.
 9 KENNEDY, Q.C.:
 10 Q. So you would consider those to be
 11 treatments?
 12 MS. RIIS:
 13 A. Yes. A treatment, a term we often use
 14 instead of treatment is "intervention", so
 15 if I sit down with my patient and speak to
 16 them about what happened to you, what's the
 17 anatomy of your injury, what is the impact
 18 of your injury, I consider that an
 19 intervention that's geared towards
 20 supporting their health.
 21 KENNEDY, Q.C.:
 22 Q. Okay.
 23 MS. RIIS:
 24 A. We can spend a lot of time talking about the
 25 literature and what works and what doesn't

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1 work. In general, passive treatments are
 2 shown to offer symptomatic relief only and
 3 tend generally not to contribute to
 4 functional recovery.
 5 KENNEDY, Q.C.:
 6 Q. Okay, so let's deal with the ones that don't
 7 work. We talked about the ones you accept
 8 work, so the neck collar is one?
 9 MS. RIIS:
 10 A. Right.
 11 KENNEDY, Q.C.:
 12 Q. Rest; in other words, to rest.
 13 MS. RIIS:
 14 A. Basically immobility is detrimental in most
 15 cases.
 16 KENNEDY, Q.C.:
 17 Q. Avoiding your daily activities?
 18 MS. RIIS:
 19 A. Right.
 20 KENNEDY, Q.C.:
 21 Q. What else? Is there anything else there?
 22 Like Tylenol, you said, doesn't work for
 23 lower back pain.
 24 MS. RIIS:
 25 A. For low back pain.

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1 KENNEDY, Q.C.:
 2 Q. Okay, anything else?
 3 MS. RIIS:
 4 A. I would not be able to comment right now
 5 because I would have to have it in front of
 6 me, there are so many studies that list so
 7 many different interventions that work,
 8 don't work, are equivocal, so I'm not
 9 prepared to try to make a list of them right
 10 now.
 11 KENNEDY, Q.C.:
 12 Q. Okay, now I'm assuming that in your work you
 13 have done for IBC and as a physiotherapist
 14 you've seen reports that have been prepared
 15 by medical doctors, by physicians?
 16 MS. RIIS:
 17 A. Yes.
 18 KENNEDY, Q.C.:
 19 Q. And oftentimes we'll see in these medical
 20 reports, "I saw the patient within days of
 21 the accident, I prescribed rest, I told the
 22 patient to rest, to avoid doing their daily
 23 activities and to take Tylenol." Common in
 24 a medical report we will see in personal
 25 injuries cases, isn't it?

<p style="text-align: right;">Page 81</p> <p>1 MS. RIIS: 2 A. That's right. 3 KENNEDY, Q.C.: 4 Q. So do you disagree with the medical 5 profession in that respect, that they're not 6 doing things properly? 7 MS. RIIS: 8 A. I can't comment on an individual report. 9 KENNEDY, Q.C.: 10 Q. I'm talking in general, Ms. Riis, and this 11 is something that we can provide probably 12 hundreds of reports where those kinds of 13 comments are made by physicians. Do you 14 disagree with what physicians are 15 prescribing? 16 MS. RIIS: 17 A. I can't comment without knowing the 18 specifics of the case. 19 KENNEDY, Q.C.: 20 Q. The neck collar which you say is an 21 ineffective treatment, can physiotherapists 22 prescribe a neck collar? Can they give a 23 neck collar? 24 MS. RIIS: 25 A. Yes.</p>	<p style="text-align: right;">Page 83</p> <p>1 KENNEDY, Q.C.: 2 Q. So do you disagree with the medical 3 profession in terms of the prescribing of 4 the neck collar? 5 MS. RIIS: 6 A. I can't comment on an individual case. 7 KENNEDY, Q.C.: 8 Q. But you had made general statements here 9 that there are ineffective treatments—and 10 I've just given you examples, you've given 11 us examples, all of which appear to me to be 12 areas in which the physician prescribes the 13 kinds of things that you deem to be 14 ineffective. 15 MS. RIIS: 16 A. I also said that evidence based guidelines 17 are not prescriptive, they don't prohibit a 18 health professional from prescribing a 19 treatment that may not have support in the 20 literature. That's why I can't comment on a 21 specific case. I can't in general disagree. 22 KENNEDY, Q.C.: 23 Q. Okay, so now if we can go to the 24 Chiropractic Association Report and if I 25 could ask you to look at, the pages are not</p>
<p style="text-align: right;">Page 82</p> <p>1 KENNEDY, Q.C.: 2 Q. Okay, most often it would be the physician 3 at first instance, is that correct? Or the 4 emergency, the doctor in the emergency ward? 5 MS. RIIS: 6 A. I would say that most Type 1 injuries tend 7 not to go to emergency, but if they do, then 8 they would see a doctor. In some hospitals 9 they have implemented physiotherapists to do 10 the triage, so it could be a doctor or 11 physiotherapist, depending on what programs 12 that hospital had in place. 13 KENNEDY, Q.C.: 14 Q. So do you know what happens in Newfoundland 15 and Labrador? 16 MS. RIIS: 17 A. No. 18 KENNEDY, Q.C.: 19 Q. No. So in this province if a neck collar is 20 prescribed, it's usually done at the 21 emergency, I would suggest to you at the 22 emergency ward, the emergency department or 23 in the doctor's office. 24 MS. RIIS: 25 A. Yes.</p>	<p style="text-align: right;">Page 84</p> <p>1 numbered, Ms. Riis, one, two, three, four, 2 five—the sixth page in defining minor 3 injury. Now, if we look at the minor injury 4 here, you'll see that that's the term that's 5 used in the provinces of Nova Scotia, New 6 Brunswick, Alberta, Ontario, with some 7 differences in terms of, I'm not sure they 8 all have the clinically associated sequelae. 9 MS. RIIS: 10 A. Right. 11 KENNEDY, Q.C.: 12 Q. Okay. So the Chiropractic Association then 13 goes on to talk about, they refer to this 14 report and this is the report on which you 15 sat on a panel as a non-voting member. 16 MS. RIIS: 17 A. Uh-hm. 18 KENNEDY, Q.C.: 19 Q. Was this a qualified panel and report, do 20 you think? 21 MS. RIIS: 22 A. Was this a? 23 KENNEDY, Q.C.: 24 Q. The panel that looked at, that was put 25 together to look at this, to prepare this</p>

<p style="text-align: right;">Page 85</p> <p>1 report, were they qualified?</p> <p>2 MS. RIIS:</p> <p>3 A. Yes.</p> <p>4 KENNEDY, Q.C.:</p> <p>5 Q. Was it a--is the report a good report in</p> <p>6 your opinion?</p> <p>7 MS. RIIS:</p> <p>8 A. Yes.</p> <p>9 KENNEDY, Q.C.:</p> <p>10 Q. Okay, do you agree with the statement that's</p> <p>11 outlined there in the Chiropractic Report,</p> <p>12 "Having considered the narrative of persons</p> <p>13 who have experienced injuries and received</p> <p>14 care under the MIG, Minor Injury Guidelines,</p> <p>15 we have concluded that it is not appropriate</p> <p>16 to categorize either the injuries or their</p> <p>17 associated symptoms as minor injuries. In</p> <p>18 as much as they can be associated with a</p> <p>19 broad range of symptomatology and with some</p> <p>20 degree of disability for activities of daily</p> <p>21 life and work. It is our view there is no</p> <p>22 scientific rationale or merit in continuing</p> <p>23 to employ the term minor injury." Do you</p> <p>24 agree with that statement?</p> <p>25 MS. RIIS:</p>	<p style="text-align: right;">Page 87</p> <p>1 KENNEDY, Q.C.:</p> <p>2 Q. Do you agree with that?</p> <p>3 MS. RIIS:</p> <p>4 A. Yes.</p> <p>5 KENNEDY, Q.C.:</p> <p>6 Q. Okay, there's a report here a little bit</p> <p>7 further down and I'll ask if you're familiar</p> <p>8 with this, it's quoted in this, "The Bone</p> <p>9 and Joint Decade Taskforce on Neck Pain and</p> <p>10 Associated Disorders suggest that most</p> <p>11 people with neck pain do not"—well, first,</p> <p>12 are you familiar with this report?</p> <p>13 MS. RIIS:</p> <p>14 A. Yes.</p> <p>15 KENNEDY, Q.C.:</p> <p>16 Q. Okay. "Most people with neck pain do not</p> <p>17 experience a complete resolution of</p> <p>18 symptoms. Between 50 percent and 85 percent</p> <p>19 of those who experience neck pain at some</p> <p>20 initial point will report neck pain again</p> <p>21 one to five years later. These numbers</p> <p>22 appear to be similar in the general</p> <p>23 populations in workers and after motor</p> <p>24 vehicle crashes." Do you agree with that</p> <p>25 statement?</p>
<p style="text-align: right;">Page 86</p> <p>1 A. I do.</p> <p>2 KENNEDY, Q.C.:</p> <p>3 Q. Okay. Now if we go to the next page, excuse</p> <p>4 me, it starts at the bottom of the page,</p> <p>5 "Cote also acknowledges"—sorry, we have to</p> <p>6 go back to the page we were on, yeah, next</p> <p>7 page, right there, okay, up a little bit</p> <p>8 further, thank you. "Cote also acknowledges</p> <p>9 for the purpose of the development of this</p> <p>10 guideline the population of interest</p> <p>11 included injured persons with injuries</p> <p>12 commonly caused or exacerbated by a traffic</p> <p>13 collision. These are injuries that lead to</p> <p>14 a physical, mental or psychological</p> <p>15 impairment for which the scientific evidence</p> <p>16 suggests that at least 50 percent of the</p> <p>17 patients recover within six months." Do you</p> <p>18 agree with that statement?</p> <p>19 MS. RIIS:</p> <p>20 A. Yes.</p> <p>21 KENNEDY, Q.C.:</p> <p>22 Q. So that would mean that 50 percent of the</p> <p>23 patients don't recover within six months?</p> <p>24 MS. RIIS:</p> <p>25 A. That's what it implies, yes.</p>	<p style="text-align: right;">Page 88</p> <p>1 MS. RIIS:</p> <p>2 A. Yes.</p> <p>3 KENNEDY, Q.C.:</p> <p>4 Q. Okay, so now I want to discuss very briefly</p> <p>5 the issue of the clinically associated</p> <p>6 sequelae that's part of the definition in a</p> <p>7 couple of provinces, does that relate to</p> <p>8 psychological or emotional pain or distress?</p> <p>9 MS. RIIS:</p> <p>10 A. Yes.</p> <p>11 KENNEDY, Q.C.:</p> <p>12 Q. Now, would you agree with me, Ms. Riis, that</p> <p>13 the effect of motor vehicle injuries can not</p> <p>14 only be significant physical pain, but</p> <p>15 significant psychological and emotional</p> <p>16 stress?</p> <p>17 MS. RIIS:</p> <p>18 A. May I read an excerpt from that paper, from</p> <p>19 the Optima paper?</p> <p>20 KENNEDY, Q.C.:</p> <p>21 Q. Sure, if you—where are you referring to this</p> <p>22 —</p> <p>23 MS. RIIS:</p> <p>24 A. It's on page 4 of my report.</p> <p>25 KENNEDY, Q.C.:</p>

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1 Q. Okay.

2 MS. RIIS:

3 A. So it's the fourth paragraph in italics,

4 starts with "Injuries resulting from traffic

5 collisions often present as clusters of

6 physical, mental and psychological

7 impairments." So yes.

8 KENNEDY, Q.C.:

9 Q. Okay, because we heard from two ladies who

10 were injured in motor vehicle accidents here

11 on Monday and although they were very

12 physically, the physical injuries were real,

13 the psychological pain, the emotional stress

14 was palpable. So is that a factor that

15 should be considered in terms of any

16 definition of Type 1 or minor injuries?

17 MS. RIIS:

18 A. Yes, I think that those kinds of symptoms is

19 what needs to be considered when evaluating

20 whether someone has suffered a serious

21 impairment.

22 KENNEDY, Q.C.:

23 Q. Because we can see broken bones, I think one

24 of the ladies actually used this term, you

25 see a broken bone, you know it's going to

Page 90

1 get better, but the depression, and anxiety,

2 the stress can be very real. Do you agree

3 with that?

4 MS. RIIS:

5 A. Yes.

6 KENNEDY, Q.C.:

7 Q. And I'll just use the example of, we had two

8 single mothers, one single mother who was

9 very active, she ran marathons, she was in

10 body building competitions, she went to the

11 gym every day, she walked 10 kilometers and

12 all of a sudden she gets rear-ended. She

13 says, "I don't feel I can look after my

14 children, I am depending on everyone for

15 everything." She talked about the effect on

16 her psychologically and emotionally. Do you

17 feel that that psychological and emotional

18 effect is considered enough in terms of

19 these definitions that you are putting

20 forward and treatment protocols?

21 MS. RIIS:

22 A. I think that would be the whole point of the

23 treatment protocols is to ensure that the

24 psychological sequelae that come with most

25 traffic collisions, strain and sprain

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1 injuries, they need to be addressed early

2 on. They shouldn't be allowed to blossom

3 into full blown severe depression. If

4 addressed early on and the guideline can

5 include management of those symptoms early

6 on, I think that can only help.

7 (10:30 a.m.)

8 KENNEDY, Q.C.:

9 Q. Okay, so are you suggesting that this

10 psychological injury, emotion distress, call

11 it what you like, is a minor injury?

12 MS. RIIS:

13 A. A psychological injury is a psychological

14 injury, whether it goes on to become a

15 serious impairment or not is a different

16 question.

17 KENNEDY, Q.C.:

18 Q. So are you, I guess my question for you, you

19 can, are you minimizing in any way the

20 significance of psychological injury,

21 emotional stress on individuals who are

22 involved in motor vehicle accidents?

23 MS. RIIS:

24 A. No, and in fact my position is that these

25 injuries have been undertreated

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1 historically. Physical treatment provides,

2 such as physiotherapists, chiropractors,

3 kinesiologists, massage therapists, we have

4 tended to focus on the body part and we need

5 to do a better job of addressing the

6 psychological after effects of traffic

7 injuries.

8 KENNEDY, Q.C.:

9 Q. If I can now ask you to go to, just excuse

10 me please, at pages 6, let's start at page 6

11 of your report and it's the paragraph, go

12 down a little bit, please, and this is the

13 paragraph, "Regardless of how a person is

14 injured or who is at fault, treatment should

15 be consistent and based on the scientific

16 evidence of effectiveness so the public can

17 have confidence that treatment is likely to

18 promote good health outcomes. To deprive

19 quality healthcare from persons who are in

20 some way responsible for a collision is

21 unethical and will result in higher costs to

22 his or her family, insurers, the healthcare

23 system and society at large." You say

24 you've spoken to some Section B adjusters in

25 this province?

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1 MS. RIIS:
 2 A. Yes.
 3 KENNEDY, Q.C.:
 4 Q. How many have you spoken to?
 5 MS. RIIS:
 6 A. Two.
 7 KENNEDY, Q.C.:
 8 Q. Do they give you the impression that Section
 9 B works wonderfully, that people are
 10 provided with the treatments that they are
 11 prescribed by their physicians and other
 12 health care providers?
 13 MS. RIIS:
 14 A. I would say that their comments suggested
 15 that in some cases, treatment tends to be
 16 prolonged and seemingly of no effect. Not
 17 all cases, but some.
 18 KENNEDY, Q.C.:
 19 Q. Okay, I guess my question is, lawyers don't
 20 prescribe treatment, correct?
 21 MS. RIIS:
 22 A. I hope not.
 23 KENNEDY, Q.C.:
 24 Q. No, that's correct. So, when you say that
 25 the lawyers tell the clients to continue to

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1 go to treatments, that's not an accurate
 2 statement in being prescribe treatments, is
 3 it?
 4 MS. RIIS:
 5 A. Lawyers are not qualified to prescribe
 6 treatment, but in my experience, they have
 7 given instruction to my patients to continue
 8 treatment.
 9 KENNEDY, Q.C.:
 10 Q. Do you know how anything happens in
 11 Newfoundland and Labrador?
 12 MS. RIIS:
 13 A. Colleagues of mine in Newfoundland and
 14 Labrador have indicated that that happens
 15 here as well.
 16 KENNEDY, Q.C.:
 17 Q. Now, let's just look at what happened with
 18 one of our accident victims who testified
 19 the other day. She testified that on
 20 numerous occasions or a number of occasions,
 21 if not numerous occasions, her lawyer had to
 22 get involved because the adjuster, her
 23 adjuster would not provide further treatment
 24 that were prescribed by the physician. Did
 25 you read that part in her testimony?

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1 MS. RIIS:
 2 A. No, I didn't. So, the adjuster would not
 3 approve a claim for additional treatment
 4 prescribed by the doctor.
 5 STAMP, Q.C.:
 6 Q. That's not actually what was said, Madam
 7 Chair. What was said was there was a delay
 8 in getting the approval. That's a different
 9 thing.
 10 KENNEDY, Q.C.:
 11 Q. If you can go back to—we got the transcript
 12 and what Ms. Elliott said was that without
 13 her lawyer getting involved, she would not
 14 have received the treatments. She said
 15 there was a delay in the response from the
 16 Section B adjuster, but that she felt that
 17 without the lawyer, the treatments wouldn't
 18 have been approved.
 19 STAMP, Q.C.:
 20 Q. It wasn't refused, there was a delay.
 21 CHAIR:
 22 Q. I think the qualification as to the way she
 23 felt is fine. We can check the transcript
 24 for the accuracy.
 25 KENNEDY, Q.C.:

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1 Q. So, the Section B adjusters in this
 2 province, we've heard from the lawyers on
 3 the Panel that it's very difficult—that
 4 they've got to fight for their clients to
 5 get Section B coverage. Are you aware of
 6 that?
 7 MS. RIIS:
 8 A. Yes.
 9 KENNEDY, Q.C.:
 10 Q. Okay. So, you're saying that Section B, and
 11 I'll go to the next page of your report, "I
 12 acknowledge that there may be a few
 13 misinformed adjusters who may not understand
 14 that costs decrease as health outcomes
 15 improve". What do you mean by that?
 16 MS. RIIS:
 17 A. When people get better after injury, there
 18 are lower costs to the insurance company, to
 19 the individual, him or herself and to
 20 society.
 21 KENNEDY, Q.C.:
 22 Q. Okay, let's go to—if we could bring up the
 23 Oliver Wyman report, April 25, 2018,
 24 Subject, Other Coverages Reviewed, Private
 25 Passenger Automobiles. And you understand

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1 that Section B coverage in this province,
 2 there's a maximum of \$25,000.00.
 3 MS. RIIS:
 4 A. Yes.
 5 KENNEDY, Q.C.:
 6 Q. That you refer to the disability income, I
 7 think is \$140.00 per week. So, the maximum
 8 is \$25,000.00, but according to what you're
 9 saying, we should never get close to the
 10 maximum, should we?
 11 MS. RIIS:
 12 A. I can't comment on an individual case. I
 13 think it's entirely conceivable that you
 14 might get close to a maximum.
 15 KENNEDY, Q.C.:
 16 Q. Okay. So, let's just look at what—if we
 17 could go to page 11 of this report prepared
 18 by Oliver Wyman, under the heading "Accident
 19 Benefits", next page, or next heading
 20 please. So, we see here under Accident
 21 Benefits, "as part of the 2018 Closed Claim
 22 Study, the survey asked for information
 23 pertaining to amounts collected under
 24 Accident Benefits from the Third Party's own
 25 insurer", so that's Section B, correct?

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1 MS. RIIS:
 2 A. Correct.
 3 KENNEDY, Q.C.:
 4 Q. - "that reduced the amounts payable by the
 5 first party insurer under bodily injury
 6 coverage. The majority of claimant files
 7 did not include this information and was
 8 coded as unknown. Specifically, as we
 9 stated in our Closed Claim Summary Report
 10 dated April 19, 2018 'insurers were asked to
 11 report Medical Rehabilitation costs and
 12 Disability Income Costs pertaining to Auto
 13 No-Fault (Section B). For the majority of
 14 claimants these items were reported as
 15 unknown. For the 235 claimants that had
 16 reported Medical and Rehabilitation costs,
 17 the average Medical and Rehabilitation costs
 18 were \$3,058.00. For the 234 (sic.)
 19 claimants who had reported Disability Income
 20 costs, the average paid disability income
 21 costs were \$462.00". So you see those
 22 numbers there.
 23 MS. RIIS:
 24 A. I see those numbers.
 25 KENNEDY, Q.C.:

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1 Q. Do you know what it costs for either massage
 2 or physiotherapy or chiropractic in this
 3 Province per hour and per treatment?
 4 MS. RIIS:
 5 A. I was told that typically treatments are
 6 billed per visit and it's approximately
 7 \$90.00 an hour.
 8 KENNEDY, Q.C.:
 9 Q. Okay. So, if the average of those 235
 10 people was \$3,058.00, does that should to
 11 you like the right amount? Do you have any
 12 way to know what the right amount is?
 13 MS. RIIS:
 14 A. I have no way of knowing that.
 15 KENNEDY, Q.C.:
 16 Q. So, if we were simply to divide 90 into
 17 \$3,058.00, can you help me there?
 18 MS. RIIS:
 19 A. I can't help you there.
 20 KENNEDY, Q.C.:
 21 Q. Okay. So, 30 treatments? Does that sound
 22 like that should be a good amount of
 23 treatments to you?
 24 MS. RIIS:
 25 A. I have no idea what went into that three

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1 thousand dollars. It could have been a
 2 report for \$2,000.00; I have no idea what's
 3 in there, so I can't comment. I can't take
 4 this as a proxy for the number of treatments
 5 somebody had.
 6 KENNEDY, Q.C.:
 7 Q. Okay. Well, let's go down here now,
 8 further. "IBC who validated the data
 9 collected for the Newfoundland and Labrador
 10 2018 Closed Claim Study is unable to verify
 11 the reported data for the Section B
 12 questions in the survey". So, it's coming
 13 from, this data is coming from IBC, but they
 14 can't validate it or whatever, but in any
 15 event, you're saying that improved treatment
 16 will—not improved treatment, let me put it
 17 this way—that there would be more money
 18 available for costs—we could go up to
 19 \$50,000.00, correct?
 20 MS. RIIS:
 21 A. Right.
 22 KENNEDY, Q.C.:
 23 Q. So, what difference does it make to the
 24 injured person if they can only access three
 25 or five thousand if there's a maximum

Page 101

1 increased?

2 MS. RIIS:

3 A. I'm afraid I don't understand the question.

4 KENNEDY, Q.C.:

5 Q. So, we have a maximum right now of

6 \$25,000.00.

7 MS. RIIS:

8 A. Right.

9 KENNEDY, Q.C.:

10 Q. We have an average of 235 claimants with

11 \$3,000.00.

12 MS. RIIS:

13 A. Right.

14 KENNEDY, Q.C.:

15 Q. So, one of the proposals is to increase

16 accident benefits to \$50,000.00.

17 MS. RIIS:

18 A. Right.

19 KENNEDY, Q.C.:

20 Q. What difference will it make if there were

21 not—if it's only \$3,000.00 being utilized?

22 Why would the situation improve?

23 MS. RIIS:

24 A. I can't comment on the financial analysis,

25 I'm sorry.

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1 KENNEDY, Q.C.:

2 Q. Okay.

3 MS. RIIS:

4 A. I can say that if somebody had a spinal cord

5 injury that \$50,000.00 would be a great use.

6 KENNEDY, Q.C.:

7 Q. Now, let's go to page 9 of your report.

8 You're talking about the impact of

9 litigation. So, we've talked about or we've

10 heard from the lawyers and the victims in

11 terms of accessing, the difficulty in

12 accessing Section B benefits. "Litigation

13 and the prospects for large financial awards

14 tend to reward poor health outcomes more

15 generously the good ones". Are you saying

16 that people are engaging in fraudulent

17 activity?

18 MS. RIIS:

19 A. No.

20 KENNEDY, Q.C.:

21 Q. You go on to state that, and I think your

22 term here today, if I can just find it,

23 yeah, let's go to your report first and then

24 I'll come to your statement today. Page 10

25 of the report please. You're talking about

Page 103

1 an Australian inquiry in terms of linking

2 benefits to delayed rehabilitation related

3 treatment. "While this is not necessarily

4 true in all cases, I can attest to it being

5 true in patients with whom I have worked.

6 Some of whom received instruction from

7 counsel not to go back to work or normal

8 activities until they felt 100 percent

9 better". So, that's something in your

10 personal experience have encountered.

11 MS. RIIS:

12 A. Yes.

13 KENNEDY, Q.C.:

14 Q. Now, we heard from two accident victims

15 here on Monday who said they had to go back

16 to work, they had no choice. They were

17 single mothers with children; they needed to

18 work. So, are you suggesting that the

19 \$140.00 per week that would come from the

20 disability income is enough to keep people

21 going while they are off work?

22 MS. RIIS:

23 A. I'm not qualified to comment on that.

24 KENNEDY, Q.C.:

25 Q. Okay. And then you say in receiving

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1 instructions from counsel. Now, treatment—

2 there's a prescription from a doctor as to,

3 for physiotherapy or massage, for example,

4 and/or, usually physio then massage. Is

5 that the practice that you're aware of?

6 MS. RIIS:

7 A. Yes.

8 KENNEDY, Q.C.:

9 Q. The person goes to the physiotherapist or

10 the massage therapist or the chiropractor,

11 are you aware, in this province, that the

12 Section B adjuster will then require a

13 report from the physiotherapist or the

14 massage therapist as to whether or not more

15 treatments are required and if so, how many?

16 MS. RIIS:

17 A. Yes.

18 KENNEDY, Q.C.:

19 Q. So, how is the lawyer impacting that if they

20 physiotherapist or the massage therapist who

21 are presumably doing their job

22 professionally and ethically are referring

23 or are advising there should be further

24 treatment? How is that the lawyers fault?

25 MS. RIIS:

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1 A. I didn't say that that was the lawyer's
 2 fault.
 3 KENNEDY, Q.C.:
 4 Q. You said that the lawyer told me to keep
 5 going, but it's not helping me. The
 6 individual said to you that the lawyer—I'm
 7 going to treatments –
 8 MS. RIIS:
 9 A. Yes, so in my –
 10 KENNEDY, Q.C.:
 11 Q. - the lawyer told me to keep going.
 12 MS. RIIS:
 13 A. In my experience I have discharged a patient
 14 to a home program with follow-up in a month
 15 or two months and the patient called me back
 16 and said, my lawyer wants me to keep coming
 17 on a weekly basis.
 18 KENNEDY, Q.C.:
 19 Q. So, how many instances of that has occurred?
 20 MS. RIIS:
 21 A. I would say at least 20 to 30.
 22 KENNEDY, Q.C.:
 23 Q. Twenty to thirty, do you know if that
 24 happens in this province?
 25 MS. RIIS:

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1 A. Yes, because colleagues of mine told me that
 2 it happens.
 3 KENNEDY, Q.C.:
 4 Q. So, colleagues of yours being which
 5 colleagues?
 6 MS. RIIS:
 7 A. Physiotherapists.
 8 KENNEDY, Q.C.:
 9 Q. Physiotherapists, okay. So, the
 10 physiotherapists you're saying, is simply
 11 agreeing with the lawyer that treatment
 12 should continue?
 13 MS. RIIS:
 14 A. A lot of physiotherapists and chiropractors
 15 are intimidated when a lawyer gets involved
 16 in this kind of a case. There have been
 17 incidents where—I'll give you another
 18 example of mine. I had worked with a
 19 patient's physiatrist. We had designed a
 20 gradual return-to-work program. The
 21 physiatrist supported that program. And
 22 when I tried to implement the program, a
 23 complaint was filed against me to my
 24 college. So, there's some anxiety among
 25 health professionals getting involved with

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1 what they perceive to be an adversarial
 2 system. So, I think when a patient comes
 3 back or the lawyer calls my office and says
 4 I want this patient to continue, I might be
 5 tended to just go along with it because I
 6 don't want to get into any trouble.
 7 KENNEDY, Q.C.:
 8 Q. Well, would that be –
 9 MS. RIIS:
 10 A. I would say this is the exception and not
 11 the rule. I don't want to imply that this
 12 happens constantly, but it has happened and
 13 I'm sure it's happened in this province too.
 14 KENNEDY, Q.C.:
 15 Q. So, when you said no complaints were
 16 sustained against you earlier in your
 17 testimony, that's what you're talking about.
 18 MS. RIIS:
 19 A. Right.
 20 KENNEDY, Q.C.:
 21 Q. Okay. So, the physiotherapist--the Section
 22 B adjuster will require a report or an
 23 update from the physiotherapist or massage
 24 therapist as to the number of treatments,
 25 whether or not further treatments are

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1 required.
 2 MS. RIIS:
 3 A. Right.
 4 KENNEDY, Q.C.:
 5 Q. You're aware that that happens, that's a
 6 standard thing?
 7 MS. RIIS:
 8 A. Yes.
 9 KENNEDY, Q.C.:
 10 Q. Are you also aware that Section B adjusters
 11 will have or require their own insured to
 12 engage in an independent medical
 13 examinations?
 14 MS. RIIS:
 15 A. Yes.
 16 KENNEDY, Q.C.:
 17 Q. And are you aware that that is something
 18 that regularly occurs?
 19 MS. RIIS:
 20 A. Yes.
 21 KENNEDY, Q.C.:
 22 Q. And are you aware of recent problems, at
 23 least in Ontario, with independent medical
 24 examiners?
 25 MS. RIIS:

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1 A. There has always been problems with
 2 independent medical examiners.
 3 KENNEDY, Q.C.:
 4 Q. Are you aware of a study or anything in
 5 Ontario which found significant problems
 6 with the independent medical examiners being
 7 utilized?
 8 MS. RIIS:
 9 A. No.
 10 KENNEDY, Q.C.:
 11 Q. Okay, so now let's continue here. So, if
 12 the person—if the lawyer says don't go back
 13 to work or the lawyer says keep going to
 14 treatments, you're suggesting that the
 15 lawyer controls the situation, are you,
 16 through intimidation or otherwise?
 17 (10:45 a.m.)
 18 MS. RIIS:
 19 A. I'm not sure what the lawyer's motivation
 20 is, but I know that there are times when
 21 lawyers are giving the injured person advice
 22 to continue with treatment or do a certain
 23 kind of treatment. In the same way, I
 24 objected when insurance adjusters try to
 25 make medical decisions. I don't think

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1 lawyers or insurance adjusters are qualified
 2 to decide what treatment is appropriate
 3 treatment. I think that should be left in
 4 the realm of the medical professionals.
 5 KENNEDY, Q.C.:
 6 Q. The lawyers who testified here the other day
 7 said their motivation was to get the best
 8 job done they could for their clients.
 9 MS. RIIS:
 10 A. I'm sure that's true.
 11 KENNEDY, Q.C.:
 12 Q. Now, let's go back to the return to work.
 13 So, the lawyers says, "don't return to
 14 work". We've had two people here who have
 15 to go to work. If a person doesn't return
 16 to work and doesn't have the appropriate
 17 medical documentation or support, then any
 18 loss of wage income will not be sustained
 19 will it?
 20 MS. RIIS:
 21 A. I imagine not.
 22 KENNEDY, Q.C.:
 23 Q. A doctor has to be the one who indicates to
 24 an individual whether or not he or she
 25 should go back to work. Do you agree with

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1 me there?
 2 MS. RIIS:
 3 A. No.
 4 KENNEDY, Q.C.:
 5 Q. Have you seen letters from doctors in the
 6 province saying I advise so and so to be off
 7 work until two weeks, three weeks, come back
 8 and gives another letter?
 9 MS. RIIS:
 10 A. Not from this province, but from other
 11 provinces.
 12 KENNEDY, Q.C.:
 13 Q. Okay. And are you aware of one of the
 14 victims who testified here the other day who
 15 said, even though her doctor told her to
 16 stay off work, she had to go back. Are you
 17 aware of situations –
 18 MS. RIIS:
 19 A. No, -
 20 KENNEDY, Q.C.:
 21 Q. - like that?
 22 MS. RIIS:
 23 A. - oh yes, I understand there are people who
 24 will go back to work under any
 25 circumstances.

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1 KENNEDY, Q.C.:
 2 Q. If I could ask you to look at page 10 of
 3 your report, we're still here and another
 4 common and often costly problem in
 5 adversarial systems is when two
 6 medical/legal reports come to conflicting
 7 opinions. We had an individual, an actuary
 8 who gave evidence here—I think it came
 9 through Mr. Allen, I'm not sure at times,
 10 but—who talked about, I think it was the
 11 Osborne or Coulter Osborne report in Ontario
 12 around 2007 which identified this as one of
 13 the problems.
 14 MS. RIIS:
 15 A. Yes.
 16 KENNEDY, Q.C.:
 17 Q. So, if we go two conflicting opinions, then
 18 a court is certainly qualified to determine
 19 which of two conflicting opinions to accept,
 20 is that correct?
 21 MS. RIIS:
 22 A. I don't know if they're qualified, but I
 23 understand they have the authority to do so.
 24 KENNEDY, Q.C.:
 25 Q. Okay, so wait now, so doctors—let's play

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1 this out now. So doctors prescribe
 2 treatments that don't work, lawyers
 3 involvement in the system simply obstructs
 4 the system and judges are not qualified to
 5 make decisions. Are those accurate
 6 summaries of your comments?
 7 MS. RIIS:
 8 A. That's not what I said, no, that's not what
 9 I said.
 10 KENNEDY, Q.C.:
 11 Q. I thought you said judges are not qualified
 12 or they're –
 13 MS. RIIS:
 14 A. I don't think judges are qualified to make
 15 medical decisions.
 16 KENNEDY, Q.C.:
 17 Q. Wait now, so judges are not qualified to
 18 make medical decisions. So, experts testify
 19 in front of judges. A judge has to make a
 20 determination, that's the way our system
 21 works.
 22 MS. RIIS:
 23 A. I think the judge is qualified to make the
 24 determination based on medical information
 25 provided by medical experts, yes.

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1 KENNEDY, Q.C.:
 2 Q. Okay. So, my question to you was, when
 3 there are two—you talk about two
 4 medical/legal reports with conflicting
 5 opinions and my question to you was whether
 6 or not the judge is in a good position or
 7 qualified to make that decision. I thought
 8 you said you didn't know if they were
 9 qualified, but they had the authority to do
 10 it.
 11 MS. RIIS:
 12 A. That's right.
 13 KENNEDY, Q.C.:
 14 Q. So, are they qualified or not to make the
 15 decision?
 16 MS. RIIS:
 17 A. If somebody without medical training reads
 18 to medical reports and doesn't assess the
 19 patient, it is unclear to me how they can
 20 made the medical decision. Perhaps I'm
 21 perplexed, perhaps that's my answer.
 22 KENNEDY, Q.C.:
 23 Q. So, if we look at these evidence based
 24 protocols you're talking about and again, I
 25 want to make sure that I understand this

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1 correct, your testimony was you would hope
 2 that we would be the first province in
 3 Canada to avoid the use of minor. So, that
 4 pre-supposes the introduction of a minor
 5 injury cap, is that correct? Because it
 6 doesn't matter if they're general damages
 7 for—if the system stays the same, the
 8 definition of minor injury doesn't matter,
 9 does it?
 10 MS. RIIS:
 11 A. I don't think I understand your question.
 12 KENNEDY, Q.C.:
 13 Q. Okay. Your testimony was that you would
 14 hope that we would be the first province in
 15 Canada to avoid the use of minor, the term
 16 minor or minor injury.
 17 MS. RIIS:
 18 A. Yes.
 19 KENNEDY, Q.C.:
 20 Q. So, that pre-supposes that there will be a
 21 cap brought in.
 22 MS. RIIS:
 23 A. So, if these changes are implemented, I
 24 would hope that Newfoundland would avoid the
 25 use of the term "minor". I do not pre-

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1 suppose that these changes are happening.
 2 It's my understanding that's why we're at
 3 the hearing so the Board can consider
 4 whether or not to proceed. Am I correct?
 5 KENNEDY, Q.C.:
 6 Q. Yes, but that's not the way you phrase your
 7 answer. You said you would hope, you didn't
 8 say if this Board or if the Province brings
 9 in –
 10 MS. RIIS:
 11 A. I apologize for my mis-statement.
 12 KENNEDY, Q.C.:
 13 Q. Now, the insurance industry doesn't need a
 14 cap to argue for evidence based treatment
 15 protocol, do they? They're two separate
 16 issues.
 17 MS. RIIS:
 18 A. I believe you're right, yes.
 19 KENNEDY, Q.C.:
 20 Q. That's not in your report, is it?
 21 MS. RIIS:
 22 A. No.
 23 KENNEDY, Q.C.:
 24 Q. In terms then of the IBC proposal to make
 25 Section B mandatory and I don't think anyone

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1 disagrees with that and to increase benefit
 2 levels to \$50,000.00 for medical
 3 rehabilitation. Are you aware of what
 4 percentage of claimants in this province get
 5 cut off after \$5,000.00 of benefits?
 6 MS. RIIS:
 7 A. No.
 8 KENNEDY, Q.C.:
 9 Q. Are you aware of what percentage of
 10 claimants get cut off after \$1,000.00,
 11 \$3,000.00 or \$4,000.00 of benefits?
 12 MS. RIIS:
 13 A. No.
 14 KENNEDY, Q.C.:
 15 Q. Do you know what percentage of claimants in
 16 Newfoundland and Labrador actually exhaust
 17 the limit of \$25,000.00?
 18 MS. RIIS:
 19 A. No.
 20 KENNEDY, Q.C.:
 21 Q. So, do you know whether the move to
 22 \$50,000.00 from \$25,000.00 would even make a
 23 practical difference to any claimants if you
 24 had not looked at these statistics?
 25 MS. RIIS:

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1 A. I know that if someone has a spinal cord
 2 injury or severe brain injury, \$50,000.00
 3 will be well appreciated over \$25,000.00.
 4 KENNEDY, Q.C.:
 5 Q. Perhaps Madam Chair, at this point, I know
 6 it's five minutes early, but it might be a
 7 good time to break. I'll just get the
 8 presentation and have a look at it. I don't
 9 think I have any questions on it, but I want
 10 to make sure.
 11 CHAIR:
 12 Q. Sure.
 13 KENNEDY, Q.C.:
 14 Q. Thank you very much.
 15 (BREAK – 10:53 A.M.)
 16 (RESUME – 11:24 .AM.)
 17 KENNEDY, Q.C.:
 18 Q. I don't have any further questions, Madam
 19 Chair, thank you.
 20 CHAIR:
 21 Q. Thank you, Mr. Kennedy. Mr. Gittens?
 22 Sorry, I was waiting for you to get seated.
 23 MR. GITTENS:
 24 Q. Thank you, Madam Chair. There's no secret
 25 what I do. I'm going to tell you the five

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1 things I'm going to address and then we can
 2 walk through them, alright?
 3 MS. RIIS:
 4 A. Fine.
 5 MR. GITTENS:
 6 Q. The first one I'm going to address is your
 7 background and go over your CV again, but in
 8 very short form. The second item I'm going
 9 to address with you is you're here
 10 ostensibly as an independent consultant, is
 11 what I understand you. And then I'll with
 12 the definition you have of "minor"; your
 13 evidence in relation to—your testimony in
 14 relation to the evidence based treatment
 15 protocols, which by the time, I find very
 16 helpful; and then, I think your third item
 17 was the effective litigation. I have some
 18 disagreements with you on that one. So, no
 19 secret.
 20 If we can go back to your resume, your
 21 CV, if we can go back to your earlier years,
 22 please. We can go around the year 2000, go
 23 down to there. It's no secret from what
 24 you've identified here that you have an
 25 extensive involvement, not just with, as a

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1 physiotherapist, but also in relation to the
 2 insurance industry. I mean, that's obvious
 3 on the face of it. But it's also that over
 4 the years you have done an extensive amount
 5 of work for independent insurance companies
 6 and then for an extensive period of time,
 7 you've been—we'll use whatever expression
 8 you want to use—carrying the water for the
 9 IBC is the one I would use, but you've been
 10 acting on their behalf. Is that a fair
 11 statement?
 12 MS. RIIS:
 13 A. Yes, I've consulted to them.
 14 MR. GITTENS:
 15 Q. Okay, you're a consultant to them, but in
 16 many of these situation that you find
 17 yourself, your –
 18 MS. RIIS:
 19 A. Yes.
 20 MR. GITTENS:
 21 Q. - assessment of what the policies you will
 22 support are pretty much congruent with
 23 theirs.
 24 MS. RIIS:
 25 A. Yes.

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1 MR. GITTENS:
 2 Q. Okay. So, we know then and we can go
 3 through the rest of it for the more recent
 4 times from 2014 coming up now, you can give
 5 us that there. Yeah, you went back into
 6 physiotherapy in one third of your
 7 professional life.
 8 MS. RIIS:
 9 A. Um-hm.
 10 MR. GITTENS:
 11 Q. You've maintained one third of your
 12 professional life with the IBC or within the
 13 industry and I didn't get—the other third
 14 was what?
 15 MS. RIIS:
 16 A. The other third was working with health care
 17 companies, health professional associations,
 18 working with the health care industry.
 19 MR. GITTENS:
 20 Q. Okay, got ya. So, you have a cross-section
 21 of involvement, but it's not unfair to you
 22 to say that, as I've used the expression,
 23 you've carried the water for the IBC before.
 24 MS. RIIS:
 25 A. Yes.

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1 MR. GITTENS:
 2 Q. Okay. Feel free to disagree with me, most
 3 people do.
 4 MS. RIIS:
 5 A. I'm not sure about the language.
 6 MR. GITTENS:
 7 Q. I tend to use colloquialisms a lot. I
 8 believe it's my way of being down with the
 9 earthy guys, right. So, anyhow we've
 10 established number 1 that you've got a
 11 meaningful involvement with the IBC.
 12 They've asked you to come here to speak on
 13 this matter. And when people come before a
 14 Board like this, many of them, several of
 15 them, like actuaries who are consultants
 16 will say, well, you know, I've done some
 17 work for the insurance companies, but I've
 18 also done work for plaintiffs in this
 19 regard. I am essentially an independent
 20 consultant. The views I give are my own.
 21 That's a fair statement?
 22 MS. RIIS:
 23 A. Yes.
 24 MR. GITTENS:
 25 Q. Okay. But in this particular case, and I

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1 don't see anything wrong with your being
 2 here on behalf of the IBC, maybe I should be
 3 clear on that, but I think it's—the word
 4 I'll use is disingenuous for an independent
 5 consultant to come forward and say I'm here
 6 because I'm an independent consultant and my
 7 views are entirely my own, when in fact,
 8 they are—I'm going to try for another
 9 expression, not carrying the water this
 10 time—I'm here to support the proposals being
 11 put forward by the IBC, shall we say in this
 12 particular case, okay?
 13 MS. RIIS:
 14 A. Yes.
 15 MR. GITTENS:
 16 Q. So, once we get past that, we can say that's
 17 what you're here for, am I –
 18 MS. RIIS:
 19 A. I would like to say that many of the
 20 positions that IBC takes have been informed
 21 by my engagement with them.
 22 MR. GITTENS:
 23 Q. Um-hm.
 24 MS. RIIS:
 25 A. So, I genuinely do believe that they reflect

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1 my own views also, but I'm here, being paid
 2 by IBC to support my views and their views.
 3 MR. GITTENS:
 4 Q. Understood. This is one of those cases
 5 where you can't throw out the bathwater
 6 without throwing out the baby.
 7 MS. RIIS:
 8 A. That's right.
 9 (11:30 a.m.)
 10 MR. GITTENS:
 11 Q. Alright. So, now, we've established your
 12 background. We've established your degree
 13 of independence and you're not challenging
 14 the fact when I suggest to you that you're
 15 here to support the IBC view?
 16 MS. RIIS:
 17 A. Yes.
 18 MR. GITTENS:
 19 Q. Okay. Let's move onto the definition of
 20 "minor" that you took some issue with. And
 21 I actually thank you for that because we had
 22 Dr. Misik give us testimony a couple, well
 23 sometime last week I think it was, and one
 24 of the things he said was that, you know, I
 25 don't buy into this minor definition because

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1 every single one of my patients is an
 2 individual needing individual treatment.
 3 But then you came today and what did you
 4 say? Well, you said, well no two people
 5 react the same to the same injury.
 6 MS. RIIS:
 7 A. Correct.
 8 MR. GITTENS:
 9 Q. Which is just another way of saying what
 10 he's saying.
 11 MS. RIIS:
 12 A. Yes.
 13 MR. GITTENS:
 14 Q. He was basing a lot of his comments that you
 15 saw on his research into what he says was
 16 genetics. And he was saying like, you know,
 17 each person, even the person who is very
 18 stoic gets hurts, says, no big deal, keeps
 19 on going. You can trace some of that, he's
 20 suggesting, back to the genetic makeup of
 21 that person. Whereas somebody else got the
 22 same injury, same degree of pain and they're
 23 out of it for god knows how long; they're a
 24 basket case. So, I take it when you use the
 25 word—you say you're not supporting the use

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1 of the word "minor", you're essentially
 2 saying much of what he is saying, is you
 3 can't take this definition and put a line
 4 through and mark off a whole bunch of
 5 people.
 6 MS. RIIS:
 7 A. Correct.
 8 MR. GITTENS:
 9 Q. Okay, but when you said minor, you then went
 10 on to say, well you know, it's probably more
 11 like a Type One—you'll accept the definition
 12 of say Type 1 type of injuries and run with
 13 that, instead of using the word minor. Am I
 14 getting that correct?
 15 MS. RIIS:
 16 A. I borrowed the term from the OPTIMA
 17 Collaboration Publication, Enabling Recovery
 18 from Traffic Injuries. That's what they
 19 called it. So, I don't have a better word,
 20 so I used Type 1 injuries, but I wouldn't be
 21 opposed to other terms either.
 22 MR. GITTENS:
 23 Q. Well, you know, as a lawyer representing
 24 plaintiffs, let's just call it, the people
 25 we're going to shaft. You see how you can

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1 put any words you want in it, right, the
 2 people –
 3 MS. RIIS:
 4 A. Exactly.
 5 MR. GITTENS:
 6 Q. - who we say you don't qualify for any type
 7 of settlement except what we are going to
 8 say is 5 or 7 or \$10,000.00, words are
 9 words. You can define it as minor; we can
 10 define it as Type One; or we can define it
 11 as those people we are going to screw out of
 12 the current system, so that we can do better
 13 for the other people. Understand what I'm
 14 saying?
 15 MS. RIIS:
 16 A. I do understand.
 17 MR. GITTENS:
 18 Q. Okay. Now, when we use the definition of
 19 what was minor and I'll take you to page 3
 20 of your report, the top of page 3, the
 21 "minor" definition was sprains, strains and
 22 whiplash injuries including any clinically
 23 associated sequelae whether physical or
 24 psychological in nature that does not result
 25 in serious impairment. We're all familiar

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1 with that definition. It takes in most of
 2 what is going on in Ontario, Nova Scotia,
 3 New Brunswick and PEI, at least. I haven't
 4 checked with the other provinces. If you go
 5 down to the second paragraph on that page,
 6 define minor injuries realistically you say,
 7 that's where you introduce the concept of
 8 Type 1. And the Type 1 injury as you define
 9 at the very bottom there, you say, Type 1
 10 injuries are those traffic injuries which
 11 have been shown in epidem –
 12 MS. RIIS:
 13 A. Epidemiological.
 14 MR. GITTENS:
 15 Q. Thank you—studies to have a favourable
 16 natural history, recovery times ranging from
 17 days to a few months. And then you go on to
 18 say, you're not saying but you're adopting
 19 this.
 20 MS. RIIS:
 21 A. I'm citing from a paper.
 22 MR. GITTENS:
 23 Q. Right. "These injuries include
 24 musculoskeletal injuries such as neck pain
 25 and associated disorders, any of these,

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1 grades one through three. Grades one and
 2 two sprains and strains of the spine and
 3 limbs, traumatic radio—can you say that word
 4 for me too?
 5 MS. RIIS:
 6 A. Radiculopathies.
 7 MR. GITTENS:
 8 Q. Thank you very much—mildly traumatic brain
 9 injuries and post traumatic psychological
 10 symptoms such as anxiety and stress”. So
 11 you take your Type 1 and you really stuff a
 12 bunch of stuff in there and add on a fair
 13 number of other injury types to the minor
 14 definition. Is that what is happening?
 15 MS. RIIS:
 16 A. That’s’ what this group of researchers did.
 17 MR. GITTENS:
 18 Q. Alright. And then you say, more often—so,
 19 we’ve listed all those things and if you go
 20 down to the next quote, it says “injuries
 21 resulting from traffic collisions often
 22 present as clusters of physical, mental and
 23 psychological impairments. Although the
 24 primary symptoms of NAD is neck pain. It
 25 also includes physical and psychological

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1 symptoms such as back pain, headaches, arm
 2 pain, temporomandibular disorders and
 3 depressive symptomology”. So, to be honest,
 4 what’s going on here while we’ve taken the
 5 very specific minor definition which only
 6 referred to the sequelae, back to that,
 7 associated sequelae and physical and
 8 psychological in nature that does not result
 9 in serious impairment, when you transform
 10 that into the Type 1 you add on all these
 11 additional injury types including disorders
 12 and depressive symptomology. So, that minor
 13 definition has, in fact, been expanded. Is
 14 that a fair statement?
 15 MS. RIIS:
 16 A. No. I think the term sequelae captures what
 17 was outlined in that paper.
 18 MR. GITTENS:
 19 Q. Okay. So, therefore, instead of using a
 20 generic term, you’ve simply put all these
 21 additional things into that minor injury
 22 definition.
 23 MS. RIIS:
 24 A. I just cited from the paper what the
 25 researchers indicated about Type 1 injuries.

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1 MR. GITTENS:
 2 Q. Right.
 3 MS. RIIS:
 4 A. So, Type 1 injuries, it’s not a simple,
 5 physical injury. There are various other
 6 things that happen simultaneously. And it’s
 7 difficult to tease out to say that the sore
 8 neck is one piece and the anxiety is a
 9 separate injury. They are part and parcel
 10 of the same syndrome or pattern.
 11 MR. GITTENS:
 12 Q. Okay, so is it fair for me to say to this
 13 Board that when we use the expression that
 14 has been used so far, “minor injury” or
 15 whether we translate it into the new and
 16 improved Type One, there are a lot of
 17 details—the devil is in the detail, as they
 18 say –
 19 MS. RIIS:
 20 A. Yes.
 21 MR. GITTENS:
 22 Q. - all these additional things that make up
 23 what is intended to be covered by whatever
 24 cap is going to be imposed.
 25 MS. RIIS:

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1 A. Yes.
 2 MR. GITTENS:
 3 Q. Alright. So, first we know you got an
 4 impressive background; second we know you’re
 5 here for the IBC; third we know that the
 6 definition of minor includes a lot of other
 7 stuff that is being proposed that there be a
 8 cap on. Am I getting it all correct so far?
 9 MS. RIIS:
 10 A. I wouldn’t say it’s including a lot of other
 11 stuff. I think it’s being clear about what
 12 we mean when we talk about neck associated
 13 disorders. Neck associated disorders is not
 14 a simple neck injury. Neck associated
 15 disorder may be neck pain as well as
 16 anxiety, as well as some pain down the arm,
 17 as well as some dizziness. So, we’re trying
 18 to describe the actual injury more
 19 precisely. And I know in Alberta they have
 20 a health practitioner’s guide where they
 21 specifically define what do we mean by
 22 Grades 1 and 2 sprain. So, I think that
 23 kind of detail can be very helpful
 24 implementation should the Board decide to go
 25 in this direction.

1 MR. GITTENS:
 2 Q. So, it's fair to say then that, you know, we
 3 all deal in the real world, the general
 4 public, whether at the end of the day this
 5 process results in a minor injury cap or a
 6 Type 1 cap or whatever expression is being
 7 used, the general public will not, at first
 8 glance, see all those associated disorders
 9 as being caught up in that definition.
 10 MS. RIIS:
 11 A. That's why I've recommended public education
 12 should this be implemented.
 13 MR. GITTENS:
 14 Q. Okay, some public education is a wonderful
 15 thing. Even myself, even with insurance,
 16 you know, you learn a thing or two. Let's
 17 move on then from – that's the third item I
 18 wanted to deal with. You then went on to
 19 talk about the evidence-based treatment
 20 protocols, and I must say, as a layperson I
 21 can see the merit, and I see what I
 22 understand you to be defining as being not
 23 mandatory treatments, but a set of
 24 guidelines, if you wish, that the treatment
 25 physicians can utilize, don't have to

1 MR. GITTENS:
 2 Q. "Type 1 injury is that at least 50 percent
 3 of patients should be expected to recover
 4 within six months".
 5 MS. RIIS:
 6 A. Yes.
 7 MR. GITTENS:
 8 Q. Okay. Being an ornery type, I read that to
 9 say 50 percent of the patients will not be
 10 expected to recover within six months?
 11 MS. RIIS:
 12 Q. Yes.
 13 MR. GITTENS:
 14 Q. Fair statement?
 15 MS. RIIS:
 16 A. Yes.
 17 MR. GITTENS:
 18 Q. Now the cap, whatever definition is used, is
 19 intended to draw a line for all the people,
 20 and I don't know whether the line is six
 21 months, if they aren't resolved in six
 22 months or not, but at some point we know
 23 that even within six months if we were to
 24 have the cap cut off all those people who
 25 normally would be resolved within six

1 utilize, but may utilize as they go along
 2 with their jobs, and I must say that seems
 3 to be completely on all fours with what Dr.
 4 Misik was saying in terms of what he would
 5 apply to treat his patients, and apparently
 6 he has about 48 years, or some foolish
 7 number like that, of treatment of injuries
 8 in this province. So we then went on to
 9 reference, if I recall correctly, the
 10 Chiropractic Association's submission, and
 11 if we can get to that and look at – let's
 12 see what page that would be. The 7th page of
 13 the chiropractic submission, and that one is
 14 the – yes, the very first paragraph, and
 15 that's where the reference to the Type 1 is
 16 made, and it says, "Type 1 injury", the
 17 second line, "Type 1 injury is that at least
 18 50 percent of patients should be expected to
 19 recover within six months".
 20 MS. RIIS:
 21 A. Sorry, are you on the Chiropractic Report?
 22 MR. GITTENS:
 23 Q. I certainly hope so. Yeah, second line.
 24 MS. RIIS:
 25 A. Sorry, okay, thank you.

1 months, so we don't have to have them go
 2 through the litigation stream and cause all
 3 the problems they are apparently causing
 4 everybody, we know that at least one out of
 5 every two people that will be caught by the
 6 cap will not fit the definition of being
 7 resolved within six months?
 8 MS. RIIS:
 9 A. I think if you apply the cap
 10 chronologically, that would be true.
 11 MR. GITTENS:
 12 Q. Okay.
 13 MS. RIIS:
 14 A. And remember there's an exception allowed
 15 for people who go on to sustain serious
 16 impairment. They would not be capped. It's
 17 also of interest that currently in Boston
 18 the International Association for the Study
 19 of Pain is underway right now, and they just
 20 published a report that at any time in the
 21 world, 30 percent of the population reports
 22 neck pain that has been present for three
 23 months or more. So in the general
 24 population, there's 30 percent of us in this
 25 room that can have some kind of neck pain.

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1 So there's already a pretty high prevalence
 2 of next pain. So to think that recovery is
 3 equivalent to being pain free is a concept
 4 that the health care professionals are
 5 starting to recognize is possibly not
 6 achievable.
 7 MR. GITTENS:
 8 Q. Okay, so I gather what you're saying is
 9 everybody is hurting somewhat, so to bring
 10 everybody back to a point where they're not
 11 hurting is unrealistic?
 12 MS. RIIS:
 13 A. Right.
 14 MR. GITTENS:
 15 Q. All right, but a cap and a definition of
 16 what it applies to is going to have some
 17 component of when it is – where you cut it
 18 off, where you realistically expect these
 19 people to be no longer suffering from the
 20 injury caused by the accident. Isn't that
 21 implicit in this process?
 22 MS. RIIS:
 23 A. One of my comments was that should the Board
 24 implement this cap, I think that there needs
 25 to be great consideration given to the

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1 exception. So those people that have a
 2 level of suffering that goes beyond and
 3 affects their ability to function in life,
 4 and I think that needs to be based on their
 5 ability to function in their pre-accident
 6 activity. We use the word "recovery", but
 7 we often don't talk about what do we mean by
 8 that; does recovery mean they're back at
 9 work, they're playing golf, they're able to
 10 take their dog for a walk, or does recovery
 11 mean that they don't have any pain at all.
 12 So there's so much nuance in this language,
 13 and that's why should some kind of a cap be
 14 assigned, it needs to be clearly defined.
 15 Any of the uncertainties, like, when we
 16 rolled this out in Alberta, most of the
 17 questions were from health professionals and
 18 insurers on, does this person fit into the
 19 minor injury cap or not, are they eligible
 20 for treatment in the diagnostic and
 21 treatment protocols. So the art of defining
 22 the language in the definition is very
 23 important, and at this stage we haven't – I
 24 haven't seen a definition that's
 25 comprehensive enough to be able to do that.

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1 (11:45 a.m.)
 2 MR. GITTENS:
 3 Q. Okay. So you're telling me there are caps
 4 in several provinces across Canada. You're
 5 here as an expert in this field, and correct
 6 me if I'm wrong, but I'm hearing you telling
 7 this Board that at this point in time you
 8 are not satisfied with a definition that's
 9 really applicable?
 10 MS. RIIS:
 11 A. I have only seen the definition that's being
 12 put forward. It offers an exception based
 13 on serious impairment, and it would be my
 14 recommendation that should it be adopted,
 15 that serious impairment be carefully
 16 defined. It has been defined in other
 17 provinces, and I think that it has been
 18 effective in other provinces.
 19 MR. GITTENS:
 20 Q. Okay. So when you talk about serious
 21 impairment then, are we talking – is there a
 22 time limit, is there a six month – I'm
 23 looking at the documentation that was
 24 produced.
 25 MS. RIIS:

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1 A. I would say that it not be based on a time
 2 limit because there's so much variation. I
 3 think – it's my sense that basing the
 4 definition of serious impairment on a
 5 person's ability to do activities that they
 6 did prior to the accident would be the
 7 fairest way of proceeding. So if somebody
 8 is impeded from being able to work, if they
 9 are unable to carry on with their child care
 10 activities, et cetera, then they should be
 11 able to escape the cap. I don't think it
 12 should be based on chronological symptoms or
 13 stiffness or anything like that.
 14 MR. GITTENS:
 15 Q. Okay. It's curious because when you made
 16 that comment, it reminds me of some of the
 17 testimony of Dr. Misik, when he kept
 18 referring to the fact that, you know, I've
 19 got clients – patients that he's dealt with
 20 seven or eight years ago, and they come back
 21 and he knows that what they're suffering
 22 from six, seven, eight years later has its
 23 genesis in the incident that he treated them
 24 for five to seven years earlier. So when
 25 you are talking about not having a time

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1 frame of – I was using six months because of
 2 what they had here. You are saying that
 3 there should be some mechanism that allows a
 4 person who experiences some impact or
 5 deficiency in their functioning, regardless
 6 of when that occurs, to escape the cap?
 7 MS. RIIS:
 8 A. Assuming that sufficient time has passed to
 9 allow for healing, and after the person has
 10 sustained whatever treatment is necessary to
 11 promote the healing. So I wouldn't want to
 12 assign that definition two days after the
 13 accident, but I think after a sufficient
 14 amount of time has passed for healing to
 15 happen, for appropriate treatment to have
 16 been received, to have ruled out the
 17 possibility of further improvement, I think
 18 at that point it is probable reasonable to
 19 assess their ability to function.
 20 MR. GITTENS:
 21 Q. Okay. Forgive me for not letting you get
 22 off this one easy by saying I think it
 23 should be some time frame. You're here as
 24 the expert in the physiotherapy and in the
 25 insurance industry, and you're carrying—good

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1 God, and I (unintelligible) a lot again—
 2 you're carrying the –
 3 MS. RIIS:
 4 A. Water.
 5 MR. GITTENS:
 6 Q. - argument for the IBC. No, no, the
 7 argument. What time frame do you have in
 8 mind should be applied to say to these
 9 people, you know, if you go beyond that,
 10 you're probably not capped?
 11 MS. RIIS:
 12 A. I'm not prepared to answer that question.
 13 It wasn't part of my submission. I would be
 14 able to come up with an answer if I was
 15 given a chance to do some more review about
 16 healing times and recovery times, and
 17 rehabilitation times, but I can't give you
 18 an answer right now.
 19 MR. GITTENS:
 20 Q. So you're telling this Board that despite
 21 your many years of involvement on all these
 22 policy groups and so on, and being
 23 intricately involved in this analysis, up to
 24 this point in time you don't have a sense of
 25 whether or not a cap, if it's going to be

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1 imposed, should have a time frame for people
 2 who should not be underneath it?
 3 MS. RIIS:
 4 A. I have a sense, but I'm not prepared to put
 5 an answer forward.
 6 MR. GITTENS:
 7 Q. Maybe we can meet after and you can tell it
 8 to me in sign language or something.
 9 MS. RIIS:
 10 A. I would be happy to do that.
 11 MR. GITTENS:
 12 Q. Fine. The circumstances that jump at me
 13 when I hear the definition of any of that,
 14 however, is the clients that I have who come
 15 forward later and say, you know, Ernest,
 16 everything is fine, I'm doing great, but I
 17 have the occasional flare up, you know. They
 18 seem to be able to function completely, do
 19 all their jobs they used to do before,
 20 they've plateaued or whatever the expression
 21 the doctors want to use for them, but they
 22 continue to experience the occasional – the
 23 best words I can use is the words they use,
 24 "flare ups". How does a cap deal with, or
 25 how will a cap that you're contemplating

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1 deal with those individuals?
 2 MS. RIIS:
 3 A. It's my understanding that the cap is not
 4 intended to deal with health care needs
 5 going forward. I would think that the
 6 settlement would deal with that as a
 7 pecuniary loss. For example, if I had a
 8 patient who had had ongoing symptoms related
 9 to a Type 1 type injury, and they came to
 10 me, I'd been seeing them for six months,
 11 they come back every two or three weeks and
 12 say, oh, I had a flare up last week, and I
 13 see this as a pattern, I would make a
 14 recommendation that they have access to
 15 treatment on a monthly basis for, you know,
 16 for treatments on an ongoing basis, and I
 17 would think that would be covered by the
 18 pecuniary settlement.
 19 MR. GITTENS:
 20 Q. Okay. That actually brings up another issue
 21 I have with what you've said, and it takes
 22 us into the third category of your evidence,
 23 your presentation, and that is when you were
 24 dealing with the role of litigation and the
 25 process. Correct me if I'm wrong, but I

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1 gather from what you've said, and this is my
 2 summation of it, my interpretation, that you
 3 saw the litigation process as being the
 4 mechanism by which there would be
 5 compensation primarily for pecuniary
 6 damages; loss of wages, cost of future care,
 7 things of that sort. I didn't gather from
 8 you that you appreciated that part of the
 9 litigation process is designed to compensate
 10 someone for, as best as it can,
 11 inconvenience, pain, discomfort, you know,
 12 loss of the lifestyle?
 13 MS. RIIS:
 14 A. I do understand that, and I apologize if I
 15 didn't make that clear. I'm not opposed to
 16 the non-pecuniary loss settlement or damages
 17 being paid out. There's something called
 18 perceived injustice. Research shows us that
 19 if injured people feel that they've been
 20 treated unfairly, that that actually
 21 contributes to prolonged symptoms, more
 22 severe symptoms, prolonged disability. So
 23 trying to achieve a sense that some justice
 24 has happened is actually good for your
 25 health. So I'm not opposed to the concept

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1 of pain and suffering awards, but at the
 2 same time, I know that whenever my patients
 3 have received that compensation, it doesn't
 4 make them better, and they've said to me,
 5 well, they could have given me \$100,000.00
 6 and I still would have been no better.
 7 MR. GITTENS:
 8 Q. Right.
 9 MS. RIIS:
 10 A. So it's my understanding that the non-
 11 pecuniary losses are to try to even the
 12 scales of justice a little bit, so the
 13 victim feels that some punishment or some
 14 justice has been achieved because they were
 15 injured through no fault of their own. So I
 16 don't think it's a bad thing, but again I
 17 know from my experience that it doesn't cure
 18 patients, and whether you give them
 19 \$5,000.00 or \$5,000,000.00, they're not
 20 going to feel any better.
 21 MR. GITTENS:
 22 Q. I couldn't agree with you more, but when I
 23 just asked you about what is your
 24 recommendation in relation to flare ups, for
 25 instance, you went directly to the issue of,

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1 well, we could offer them another three
 2 weeks or four weeks, five weeks of treatment
 3 to deal with the immediate issue that
 4 they're dealing with, and I didn't see a
 5 sense - I didn't get a sense from you of a
 6 component that has to deal with the fact
 7 that it's been 15 damn years and I'm still
 8 having this irritation every few weeks or
 9 every couple of months, you know,
 10 frustrating.
 11 MS. RIIS:
 12 A. Uh-hm. If somebody is having flare ups that
 13 are significantly impacting their lives,
 14 they need to go and see a doctor and have
 15 that checked out. Most flare ups, in my
 16 experience, can be dealt with through short
 17 periods of treatment, and I'm hoping that
 18 that treatment will work, it will reduce the
 19 flare up, it will get them back up on their
 20 feet and going. So to me, I see the flare
 21 up as a temporary problem. It doesn't flare
 22 and stay there. It's an up and down, and
 23 the whole point of treatment, which is a
 24 health care expense, is to reduce the
 25 symptoms during that flare up and help the

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1 person cope with it.
 2 MR. GITTENS:
 3 Q. Okay, but there's no component for the
 4 aggravation.
 5 MS. RIIS:
 6 A. I would think that would be in the pain and
 7 suffering award.
 8 MR. GITTENS:
 9 Q. Okay, and the pain and suffering award is
 10 the one that you're trying to put the cap
 11 on?
 12 MS. RIIS:
 13 A. Talking about cap on, yes.
 14 MR. GITTENS:
 15 Q. Got ya. Now the biggest issue I had with
 16 what you were saying throughout your
 17 testimony, and Mr. Kennedy picked up on it
 18 earlier, so I feel confident that I'm not
 19 the only one, is that your background in
 20 treatment of people who have been injured,
 21 and your promotion of the concept of
 22 evidence-based treatment protocols, which I
 23 said earlier on, and I stay with, just seems
 24 quite sensible and quite practical and
 25 should be helpful, I didn't know where you

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1 got from that spot where you're saying, you
 2 know, I think we should have these treatment
 3 protocols, it should help because as a
 4 practitioner, I'm all about getting my
 5 patients back to good health as best as I
 6 can, I didn't see the link between your
 7 professional background, what appears to be
 8 your personal interest, and the concept of a
 9 cap. It just seems to me what's the
 10 connection is what I was asking myself
 11 between the two. You are here saying, you
 12 know, I'd like to find mechanisms by which
 13 we can help individuals who have been hurt
 14 get back to utility, get back to the best
 15 place as they can in, I take it, the
 16 shortest time with the least amount of pain
 17 and at the least cost – I mean, that makes
 18 sense, but I didn't see the link between
 19 that and what's that got to do with imposing
 20 a cap on their pain and suffering, their
 21 non-pecuniary awards or their settlement.
 22 Please make that link for us, because I'm
 23 sure you've got it in there someplace, it's
 24 just I didn't see it when you were giving
 25 your presentation?

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1 MS. RIIS:
 2 A. Wherever a minor injury cap and diagnostic
 3 and treatment protocols have introduced,
 4 there's a link between the two. So people
 5 who are injured with the type of injury
 6 that's defined as a minor injury are
 7 eligible for treatment in the treatment
 8 protocols. So they're fast tracked to
 9 receive pre-approved treatment, and that's
 10 part of the condition of – if they want to
 11 escape the cap, if they turn out not to have
 12 a good recovery that's anticipated, we know
 13 that they have done everything they can to
 14 mitigate their injuries, and, therefore, if
 15 they do have a serious impairment, in my
 16 view that would be inability to function at
 17 their pre-accident activities, then they
 18 would be eligible to escape the cap. So I've
 19 always seen there to be a link between the
 20 diagnostic treatment protocols, eligibility
 21 for the treatment protocols, and then moving
 22 forward to the cap, and IBC asked me to
 23 comment on the definition from a health care
 24 perspective.
 25 MR. GITTENS:

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1 Q. I've always been concerned about the
 2 psychologist or the scientist who put the
 3 fly in the bottle, and then congratulate
 4 themselves because they teach the fly how to
 5 get out of the bottle. You're creating a
 6 cap, okay, you're creating a cap, and then
 7 you're telling us it's going to be helpful
 8 for people if they're able to find a way not
 9 to be covered by the cap, because that's
 10 going to assist them in their recovery,
 11 unless I'm misinterpreting what you're
 12 saying, that appears to be what you're
 13 saying?
 14 MS. RIIS:
 15 A. Yeah, quite honestly, I'm sort of confused
 16 at what you just said also. Can you repeat?
 17 MR. GITTENS:
 18 Q. Sure.
 19 MS. RIIS:
 20 A. Yeah, quite honestly, I'm sort of confused
 21 at what you just said also. Can you repeat?
 22 MR. GITTENS:
 23 Q. Sure. It just means that we're both on the
 24 same page. Right now, there is no cap in
 25 this province.

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1 MS. RIIS:
 2 A. Um-hm.
 3 MR. GITTENS:
 4 Q. A person gets injured, you are suggesting
 5 that we should be basing their treatment on
 6 evidence-based treatment protocols. Full
 7 marks. I'm with you on that. We can be in
 8 lockstep on that one. And when the person—
 9 because we've implemented that, we expect
 10 that their treatments will be shorter, their
 11 recovery time will be shorter, they'll get
 12 better faster. That's the basis on which
 13 you're saying that?
 14 MS. RIIS:
 15 A. Right, right.
 16 (12:00 p.m.)
 17 MR. GITTENS:
 18 Q. Okay. And that's what we have right now.
 19 Well, apart from a better, oh no, you're
 20 right, a better evidence-based treatment
 21 protocol. I'm with you. Then you stop
 22 there, and you say, "Oh by way, while we're
 23 talking about this, you should implement a
 24 cap." And I'm saying—I'm asking you to
 25 please show the Board why one is connected

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1 to the other. And then, I understand you to
 2 say, “Well, you know, it’s connected because
 3 a person is able to not be covered by the
 4 cap, they will get this evidence-based
 5 treatment which will get them back to good
 6 health sooner.”
 7 MS. RIIS:
 8 A. So, it’s my understanding that ultimately
 9 the issue is to try to reduce the cost of
 10 auto insurance premiums for drivers. And I
 11 think that imposition of a cap is intent to
 12 try to do that. I’m not an expert on the
 13 actuarial analysis around that and I’m not
 14 going to comment on any figures, but
 15 theoretically if--the literature suggests
 16 that about 80 percent of the injuries
 17 sustained in traffic collisions worldwide
 18 tend to be soft-tissue injuries. And many
 19 of these go on to heal without any need for
 20 treatment, any claim for benefits. Some of
 21 them go onto need some treatment, and the
 22 person recovers fully, and gets back to
 23 their life and doesn’t have any events. And
 24 then, there are a few people that will go on
 25 to suffer prolonged disability. I think

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1 that if--the treatment protocols are
 2 intended to get the best possible treatment
 3 to these people as soon as possible. In
 4 Newfoundland I’ve seen that your treatment
 5 costs have gone up and I understand from IBC
 6 that the cost of settlement for non-
 7 pecuniary damages have gone up. So, that
 8 tells me that you’re paying more and more
 9 for treatment, but people aren’t getting
 10 better which is why you’re paying more and
 11 more for pain and suffering, because more
 12 people are having more pain and more
 13 suffering in spite of the industry paying
 14 for more treatment. So, something is not
 15 working. And I think if we can put in a
 16 situation where we have some assurance that
 17 more people will recover better and faster,
 18 there is going to be less need for the pain
 19 and suffering. And as I said, in my
 20 experience, whether you give somebody X or Y
 21 dollars, it’s not going to cure them.
 22 They’re going to continue to have some
 23 issues if they have that kind of a
 24 settlement.
 25 MR. GITTENS:

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1 Q. Okay. I hear what you’re saying, and I
 2 understand you come before the Board as an
 3 expert in the treatment and that you have
 4 said that in—when it comes to the treatment,
 5 you’re a proponent of this evidence-based
 6 treatment protocols. And then, I hear you
 7 to say in your last answer, at some point
 8 that’s the way it stops. And then you’ve
 9 been told that there is this cost situation
 10 that has to be dealt with, and you’ve been
 11 told by the IBC that this cost situation can
 12 be dealt with by a cap, and you’re all in
 13 for that? Am I getting this correct, or am
 14 misrepresenting you?
 15 MS. RIIS:
 16 A. I’d say that’s accurate.
 17 MR. GITTENS:
 18 Q. Okay. So, let’s nail down—I think I’m
 19 almost done. Number one, you have an
 20 extensive background assisting the IBC.
 21 Number two, you’re here not really as an
 22 independent person giving independent
 23 analysis, you’re here as part of the IBC’s
 24 proposal that they want this Board to
 25 understand. Number three, when it comes to

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1 minor—the definition of a minor injury,
 2 you’re more inclined to go with the type 1,
 3 but when you go with the type 1, you’re
 4 recognizing that that includes a fair number
 5 of other things that need to be made—people
 6 need to be made aware of?
 7 MS. RIIS:
 8 A. Yes.
 9 MR. GITTENS:
 10 Q. Because it covers all of those things?
 11 MS. RIIS:
 12 A. Yes.
 13 MR. GITTENS:
 14 Q. Not just whatever one might think the word
 15 “minor” says?
 16 MS. RIIS:
 17 A. And treatment needs to be focused on that.
 18 MR. GITTENS:
 19 Q. And treatment. And then, you get to the
 20 treatment protocols. You’re accepting that
 21 some people who will normally go through
 22 that process, 50 percent of them within six
 23 months or thereabouts, but you don’t have
 24 any—no, I’m sorry, I don’t say you don’t
 25 have any idea. You’re not willing to share

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1 with the Board what you think the timeframes
 2 should be as a cut-off point for those
 3 individuals. So, we're not able to that,
 4 but that's fair enough. I'm not going to
 5 force you on that. And finally, when it
 6 comes to the link between the cap and what
 7 you're knowable about, which is treatment
 8 protocols and your patients, you're
 9 acknowledging that that's just the stuff
 10 that the IBC passed onto you and you're
 11 passing onto the Board? Am I getting –
 12 MS. RIIS:
 13 A. I think you're characterizing my
 14 understanding of the cap as a cost-saving
 15 measure in a limited way. I have been
 16 engaged in conversations about that and I do
 17 believe that IBC generally believes it will
 18 be a cost-saving measure, but I can't give
 19 testimony in that regard. I also want to
 20 comment about my independence. I am first
 21 and foremost a licensed physical therapist.
 22 MR. GITTENS:
 23 Q. Got you.
 24 MS. RIIS:
 25 A. I am on the Board of the Canadian

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1 Physiotherapy Association. I've just been
 2 invited to the Board of Spinal Cord Injury
 3 Ontario which is an advocacy group promoting
 4 health care and integration issues for
 5 people with spinal cord injury. I am in
 6 great part motivated by what's best for
 7 injured people. And I think at some level
 8 all of the stakeholders are, but I think as
 9 a health care professional like Dr.—was it
 10 Misik?
 11 MR. GITTENS:
 12 Q. Misik.
 13 MS. RIIS:
 14 A. Misik. I think I'm on that team as well.
 15 MR. GITTENS:
 16 Q. Got you.
 17 MS. RIIS:
 18 A. I appreciate they're not paying me to be
 19 here, but I want to assure you that I very
 20 much am sitting on that bench as well.
 21 MR. GITTENS:
 22 Q. I don't challenge you in that regard at all.
 23 MS. RIIS:
 24 A. Okay.
 25 MR. GITTENS:

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1 Q. Thank you very much. No further questions,
 2 Madam Chair.
 3 CHAIR:
 4 Q. Thank you, Mr. Gittens. Mr. Fraize?
 5 FRAIZE, Q.C.:
 6 Q. We have some questions. My colleague is
 7 going first, I'm going second.
 8 CHAIR:
 9 Q. Okay.
 10 MS. FRAIZE-BURRY:
 11 Q. I just have a few questions and then we'll
 12 move onto him. In your practice or your
 13 experience dealing with other medical
 14 professionals, have you seen patients that
 15 were capped, say either in any of the other
 16 provinces that do have a cap right now, that
 17 you would consider to have a serious
 18 impairment? So, have you experienced people
 19 falling through the cracks?
 20 MS. RIIS:
 21 A. Oh, so people capped when they serious
 22 impairment?
 23 MS. FRAIZE-BURRY:
 24 Q. Yes.
 25 MS. RIIS:

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1 A. I have seen many disputes like that. I
 2 personally have not had a case like that,
 3 but I definitely have seen disputes around
 4 where an insurance company said, "We think
 5 that they fall under the cap," whereas the
 6 injured person says, "No, I don't." And
 7 I've seen these disputes go both ways, and
 8 often it's dueling medical examinations and
 9 you know, there's—in provinces there are
 10 different dispute resolution mechanisms or
 11 trial. So, I have seen situations where
 12 there are grey areas. And again, these
 13 disputes often will highlight where there's
 14 a problem with the definition. And that's
 15 why, thinking now, so if Newfoundland
 16 decides to put in place some sort of a cap,
 17 thinking carefully about the language around
 18 that is important.
 19 MS. FRAIZE-BURRY:
 20 Q. Just as a –
 21 MS. RIIS:
 22 A. People can fall through the cracks, yes.
 23 MS. FRAIZE-BURRY:
 24 Q. And so, it has happened?
 25 MS. RIIS:

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1 A. I'm sure it's happened. I'm sure that
 2 people with serious impairment have been
 3 capped, and I'm sure people without serious
 4 impairment have escaped the cap. I've seen
 5 it go both ways.
 6 MS. FRAIZE-BURRY:
 7 Q. But in that situation, wouldn't it be better
 8 for everybody that you err on the side of
 9 caution in terms of maybe they're not quite
 10 as injured as they say, than someone who is
 11 dealing with an injury every day being
 12 denied compensation for that?
 13 MS. RIIS:
 14 A. Yeah. In my experience, this tends to be a
 15 legal question, and legal questions are not
 16 well answered in the realm of human
 17 experience. So, it really ultimately boils
 18 down to how convincing one expert is versus
 19 another. I mean, if I could invent a
 20 system, I would just give everybody all the
 21 treatment they wanted and all the money they
 22 felt they needed for justice, but it's not
 23 feasible. The drivers of Newfoundland would
 24 not put up with that. So, there has to be
 25 sort of a balance of being as fair as

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1 possible around health care needs, but also
 2 being fair to the people who are paying for
 3 the system.
 4 MS. FRAIZE-BURRY:
 5 Q. Okay. And I heard you just mention that you
 6 have joined the Board of Spinal Cord Injury
 7 Ontario?
 8 MS. RIIS:
 9 A. Yes.
 10 MS. FRAIZE-BURRY:
 11 Q. Obviously we're Spinal Cord Injury
 12 Newfoundland and Labrador.
 13 MS. RIIS:
 14 A. Yes.
 15 MS. FRAIZE-BURRY:
 16 Q. So, I will ask if a person with a spinal
 17 cord injury was to say receive a secondary
 18 injury in an automobile accident, and that
 19 would be say a minor injury or a type one,
 20 what kind of impact would you expect that
 21 injury to have on their quality of life?
 22 MS. RIIS:
 23 A. Again, I can't comment on an individual
 24 situation. So, you're talking about
 25 somebody who already has a spinal cord

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1 injury?
 2 MS. FRAIZE-BURRY:
 3 Q. Um-hm.
 4 MS. RIIS:
 5 A. And is rear-ended and has then a whiplash
 6 injury?
 7 MS. FRAIZE-BURRY:
 8 Q. Um-hm.
 9 MS. RIIS:
 10 A. So, it's feasible that it could be a
 11 Type 1 injury; it could be treated as Type 1
 12 injury, or because of pre-existing
 13 complications related to the spinal cord
 14 injury that this person may go on to suffer
 15 serious impairment in which their ability to
 16 function, quality of life, does not return
 17 to their pre-accident level of functioning.
 18 So, I can see that going either way.
 19 MS. FRAIZE-BURRY:
 20 Q. Okay. And so when a person in their
 21 physiotherapist's opinion has been
 22 determined to get all the benefit they can
 23 from treatment but is still dealing with
 24 pain on say a daily basis, where are they
 25 supposed to go from there?

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1 MS. RIIS:
 2 A. Again, every province has its own sort of
 3 network of pain resources and I know right
 4 now there's a great deal of movement in all
 5 the provinces on managing pain and
 6 particularly chronic pain more effectively.
 7 So, I can't speak to exactly where somebody
 8 would go in Newfoundland and Labrador, but
 9 certainly in Ontario there are a variety of
 10 pain societies, the Canadian Pain Society.
 11 There's support groups and networks. So,
 12 that's one option. Again, perhaps this
 13 person needs their settlement to include
 14 health care expenses to manage chronic pain
 15 going forward. So, they would continue with
 16 whether it's physiotherapy, with physician,
 17 with medication, et cetera.
 18 So, it's hard to comment in a general
 19 way, but I think there's a lot more
 20 attention being put on pain management right
 21 now and I hope that in future that will
 22 become much more accessible to all.
 23 MS. FRAIZE-BURRY:
 24 Q. Okay. And I might be incorrect in this, but
 25

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1 in some of your previous evidence, you
 2 discuss certain treatments that primarily
 3 deal with the management of symptoms rather
 4 than dealing with -
 5 MS. RIIS:
 6 A. Right.
 7 MS. FRAIZE-BURRY:
 8 Q. - what's causing the issue. But, those
 9 treatments, if they're allowing that person
 10 to be able to live their daily life as best
 11 they can, isn't there some inherent value in
 12 that in and of itself?
 13 MS. RIIS:
 14 A. Yeah, and so this is - we're talking about
 15 maintenance and this has been sort of a
 16 controversial thing and various health
 17 professional associations have taken varying
 18 positions on it feeling that maintenance is
 19 something separate from treatment. I think
 20 if it's clear that say a massage therapy
 21 treatment, you know, every couple of weeks
 22 keeps that person able to work or able to
 23 play a golf game every week, I think that's
 24 fair game. But to me, that would not be
 25 affected by the cap. That would be covered

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1 by the pecuniary side of the settlement.
 2 MS. FRAIZE-BURRY:
 3 Q. All right. Do you want to -
 4 FRAIZE, Q.C.:
 5 Q. I have some questions. Can you hear me?
 6 MS. RIIS:
 7 A. Yes.
 8 FRAIZE, Q.C.:
 9 Q. Just a couple of things. I think you agree
 10 that insurance companies, for the most part,
 11 want to maximize their profits. Do you
 12 agree with that?
 13 MS. RIIS:
 14 A. No.
 15 FRAIZE, Q.C.:
 16 Q. They're private enterprise.
 17 MS. RIIS:
 18 A. I can only give you my experience, based on
 19 working with the insurance industry.
 20 Certainly they're private companies. Just
 21 as all of us with private businesses want to
 22 maximize our profits, I think insurance
 23 companies don't want to be in the red. I
 24 think that the behaviour of some insurance
 25 adjusters certainly gives that impression

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1 and I think that's unfortunate.
 2 FRAIZE, Q.C.:
 3 Q. Oh, I'm going to get to that in a couple of
 4 minutes.
 5 MS. RIIS:
 6 A. But I think that the industry at large
 7 recognizes that they're going to maximize
 8 their profits by getting people well.
 9 FRAIZE, Q.C.:
 10 Q. Do you also agree that one of the - the cap
 11 is supposed to reduce the premiums for the
 12 insured, a person that caused the accident,
 13 correct?
 14 MS. RIIS:
 15 A. No. The cap is supposed to reduce the
 16 premium for all drivers who buy an insurance
 17 policy.
 18 FRAIZE, Q.C.:
 19 Q. But, it's the insured is the person that
 20 causes the accident and they're the ones
 21 that paid the premium. So, indirectly,
 22 we're trying to reduce the premiums maybe
 23 across the board, but it's the party that's
 24 caused the injury that we're trying to
 25 reduce the premium for, correct?

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1 MS. RIIS:
 2 A. Well, if you could predict who's going to
 3 cause the injury then you're going to be -
 4 you can select who you apply the reduction
 5 to or not. But, I don't know how you could
 6 do that.
 7 FRAIZE, Q.C.:
 8 Q. Okay. Now, and of course, the victim wants
 9 to be compensated, put back to where they
 10 were, because of the accident and so forth.
 11 MS. RIIS:
 12 A. Right.
 13 FRAIZE, Q.C.:
 14 Q. One of the problems that is going to be
 15 created with a cap is that we're going to
 16 have a definition and for lawyers that
 17 represent injured parties, the innocent
 18 parties, the first thing we're going to have
 19 to argue that this injury is not within this
 20 definition. So, not only do we have to
 21 argue the injury, the quantum of damages,
 22 now we got to get us outside of a definition
 23 suggested by the insurance company.
 24 Now, in litigation there's a little
 25 catch 22. It's called when you go to court,

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1 they can put in an offer in a sealed
 2 envelope. At the end of the day, if you
 3 don't win all the costs go against you. You
 4 can bet that the amount offered by the
 5 insurance company will be the cap amount.
 6 So, one of the dangers of this cap and
 7 the definition, depends on how it make – how
 8 big you make the definition, is you've made
 9 the situation uneven for the injured party
 10 versus the insurance company. So, going to
 11 what you were saying about the definition,
 12 the definition is critical because the wider
 13 that definition, the harder it is to get
 14 compensation for the victim. Are you with
 15 me?
 16 MS. RIIS:
 17 A. I'm with you, but I have a question about
 18 your first statement. You said the first
 19 thing you have to do is figure out how to
 20 get somebody out of the cap. But -
 21 FRAIZE, Q.C.:
 22 Q. What I mean by that is outside the
 23 definition.
 24 MS. RIIS:
 25 A. Right.

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1 FRAIZE, Q.C.:
 2 Q. Because if you fall within the definition, a
 3 cap applies.
 4 MS. RIIS:
 5 A. To the general damage, the non-pecuniary
 6 losses.
 7 FRAIZE, Q.C.:
 8 Q. So, litigation in other provinces have shown
 9 the battle is trying to get outside of the
 10 definition. Now, with that said, I want to
 11 go back to a point my learned colleagues
 12 have raised. Part of your report talks
 13 about changing the treatment process. I'm
 14 going to use the word treatment process. Is
 15 that a fair statement, how injured parties
 16 are treated, the treatment given? Isn't
 17 that what you're saying inside your report?
 18 MS. RIIS:
 19 A. I'm going to say that it may not result in
 20 much change in treatment, but hopefully it
 21 will improve treatment in some
 22 circumstances. I mean, I'm assuming that
 23 most health care professionals are doing the
 24 best they can.
 25 FRAIZE, Q.C.:

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1 Q. But you've indicated in your report like the
 2 protocol as you call it for Section B and
 3 Section A.
 4 MS. RIIS:
 5 A. Um-hm.
 6 FRAIZE, Q.C.:
 7 Q. Now, in this province, our accidents are
 8 going down, okay. For some reason, they're
 9 going down. We got safer drivers maybe, I
 10 don't know.
 11 MS. RIIS:
 12 A. Fewer moose.
 13 FRAIZE, Q.C.:
 14 Q. Less potholes. I'm not quite sure what the
 15 problem is. But, if we are correct that –
 16 you seem to be emphasizing in your report
 17 that if we can somehow get these – I think
 18 you used the words "treatment protocols" put
 19 in place that will get people better quicker
 20 and reduce the quantum of damage. So,
 21 theoretically, if we listen to what you've
 22 said and that works and our accidents are
 23 going down, so therefore the damage awards
 24 that insurance companies would have to pay
 25 would go down without the cap.

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1 MS. RIIS:
 2 A. I can't comment on that because I haven't
 3 seen – I don't know what all of the numbers
 4 are. I know that treatment costs have been
 5 going up.
 6 FRAIZE, Q.C.:
 7 Q. But if accidents are going down -
 8 MS. RIIS:
 9 A. You would hope, but I don't know if that's
 10 true.
 11 FRAIZE, Q.C.:
 12 Q. Yeah, and your process is the treatment
 13 protocols are going to make people get
 14 better quicker. So, two of them together
 15 should somehow reduce the amounts that the
 16 insurance companies have to pay out
 17 theoretically.
 18 MS. RIIS:
 19 A. It sounds like a logical assumption, but I
 20 can't confirm it.
 21 (12:15 p.m.)
 22 FRAIZE, Q.C.:
 23 Q. Okay. Now, you're a physiotherapist. I
 24 don't know if you've encountered this, but
 25 as a practising lawyer, I've encountered

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1 problems dealing with insurance companies
 2 when we have to get medical reports, and I
 3 suggested we get a physiotherapist's report,
 4 a massage report, a chiropractor, then the
 5 insurance company comes back or the adjuster
 6 says "no, we're not going to pay for those,
 7 but we want the doctor to give us a report
 8 telling us all about the treatments". Now,
 9 that's sort of arse backwards. I find that.
 10 Have you encountered that in your practice?
 11 MS. RIIS:
 12 A. Yes, and I agree with you on this.
 13 FRAIZE, Q.C.:
 14 Q. Right, it's arse backwards.
 15 MS. RIIS:
 16 A. I'm not going to say that.
 17 FRAIZE, Q.C.:
 18 Q. Okay. I'm just picking up where Mr. Gittens
 19 left off.
 20 MR. GITTENS:
 21 Q. Bad example.
 22 FRAIZE, Q.C.:
 23 Q. Almost there, Ernie. Almost there. Now,
 24 question for you. We have an aging
 25 population and that means we got more people

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1 out there driving that are seniors. Do you
 2 agree that an accident would affect a senior
 3 more than a young person?
 4 MS. RIIS:
 5 A. So, I go back to my World Health
 6 Organization International Classification of
 7 Functioning. That's the whole point of
 8 using that kind of a framework is because
 9 you can't judge a person's injury or
 10 severity of injury based on the diagnosis
 11 alone. There are so many factors that have
 12 to be taken into consideration and in fact,
 13 one of the other things that I got from the
 14 International Association for the Study of
 15 Pain is that psychologically informed
 16 practice which balances the individuals and
 17 societal needs is something that we have to
 18 get better at doing in the health care
 19 system. So, I think the protocols will help
 20 that happen.
 21 FRAIZE, Q.C.:
 22 Q. Well, the reason why I – I end up dealing
 23 with a number of seniors, mostly dealing
 24 with estate planning and some other
 25 organizations I'm involved with. And from

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1 what I've observed is that when seniors get
 2 into an accident, especially say around 75,
 3 when they have an accident, what is called a
 4 soft tissue, what the insurance company
 5 calls minor and I have other words for it,
 6 but that person ends up getting treatment.
 7 So, they end up having to go back and forth
 8 and so forth and they get numerous
 9 treatments because as they're older, they
 10 take longer for them to get better.
 11 MS. RIIS:
 12 A. Yes.
 13 FRAIZE, Q.C.:
 14 Q. And as one of my clients did a math exercise
 15 for me and they looked at what their pension
 16 was and how much time they spent doing the
 17 physio and massage and the chiropractor over
 18 the three years and when we did the
 19 calculations, the settlement that that
 20 person got was sort of equal to that.
 21 Because it opened my eyes to a question.
 22 When we look at a senior, because they're in
 23 later years of life, an accident has a great
 24 effect on their quality of life. A. they
 25 don't move as fast, number one, plus they

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1 got to take time out of their limited time
 2 to get the necessary treatments. Now do you
 3 agree that because of a senior, their
 4 quality of life is far more affected than
 5 say a 22-year-old?
 6 MS. RIIS:
 7 A. I wouldn't say that as a blanket statement.
 8 I do agree that in many situations a senior
 9 can be more severely affected. I just had
 10 dinner with a woman yesterday who fell off a
 11 ladder and broke her humerus in four spots.
 12 She's 82. And she had surgery six months
 13 ago; had to totally reconstruct her arm and
 14 shoulder, and she basically said "I'm back
 15 to normal now". So, I think everybody's
 16 different and that's why sometimes I'm
 17 reluctant to comment on these general
 18 statements. So, I think what you're saying
 19 may be true in many cases with seniors, but
 20 I think – I don't think we can take it as a
 21 blanket rule.
 22 FRAIZE, Q.C.:
 23 Q. But if we get into the situation of a senior
 24 and that – like these definitions the
 25 insurance companies want to use for the cap

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1 or whatever would catch that senior. That
 2 could be soft tissue, but the effect on
 3 quality of life is dramatic. And that's
 4 what's – and I don't know if this is fair
 5 question. But many times when we end up
 6 having to go to court and prove our case,
 7 that's what courts look at. They look at
 8 the quality of life affected by the injury
 9 and that victim should be compensated
 10 fairly.

11 Now, in your report you talk on the
 12 treatment side. But, the danger of a cap is
 13 once we try to fit things into a little box
 14 not everything fits in that little box.

15 And with that, let me raise another
 16 question for you. I had another case
 17 involving – it was an automobile accident,
 18 but the bags went off and the young people
 19 aboard the vehicle, each time they boarded a
 20 vehicle were scared because when the bags
 21 went off, they thought the car was on fire.
 22 So, psychologically they weren't affected,
 23 but the problem with a definition like a cap
 24 would affect their ability to receive
 25 something. But for a young person, that is

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1 very dramatic. Never had been in that
 2 situation and bingo. It takes years.

3 MS. RIIS:
 4 A. So, you're talking about posttraumatic
 5 stress disorder?

6 FRAIZE, Q.C.:
 7 Q. Yes.

8 MS. RIIS:
 9 A. So, as I understand it, if somebody is
 10 affected by a psychological impairment that
 11 affects their ability to function in life,
 12 they could escape the cap.

13 FRAIZE, Q.C.:
 14 Q. But the definition, the way it's worded or
 15 how they're trying to treat it, makes it a
 16 situation we have a two-tier test. We have
 17 to go and try to get us outside the cap.

18 Now, bear with me for a second. I lost
 19 my train of thought.

20 Going back to this concept of serious
 21 impairment, that in itself becomes – can
 22 become a legal argument, can't it? What is
 23 a serious impairment?

24 MS. RIIS:
 25 A. Yes.

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1 FRAIZE, Q.C.:
 2 Q. And that's where the field is going to
 3 become uneven for the victims because first
 4 you got to argue either you're outside the
 5 cap or it's a serious impairment and you're
 6 going to have the medical evidence, so
 7 you're going to have that first line. So,
 8 these treatment protocols that you're
 9 talking about are completely independent of
 10 the concept of a cap, correct?

11 MS. RIIS:
 12 A. Yes.

13 FRAIZE, Q.C.:
 14 Q. Okay. Have no connection? The cap is
 15 simply -

16 MS. RIIS:
 17 A. No, that's not true. That's not true. I
 18 made a comment earlier that in some
 19 provinces in order to escape the cap, one
 20 has to do everything they can to mitigate
 21 their loss, their injury, and part of that
 22 is receiving evidence-based treatment. It
 23 doesn't mean the person has to subject
 24 themselves to protocol treatment, but as
 25 long as they can prove that they've had good

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1 treatment to try and recover from their
 2 injuries. And so, if they can show that
 3 they've done everything they can to recover
 4 from their injuries and they continue to
 5 have a serious impairment, then they can
 6 escape the cap.

7 FRAIZE, Q.C.:
 8 Q. But your report, for the most part, has
 9 nothing to do with a cap. You're talking
 10 about treatments. You're talking about the
 11 treatment protocols.

12 MS. RIIS:
 13 A. Yes.

14 FRAIZE, Q.C.:
 15 Q. A person that's injured, what they should
 16 have.

17 MS. RIIS:
 18 A. To me, the treatment protocols are what I'm
 19 most familiar with as a health care
 20 provider. This is a process whereby if
 21 somebody has a certain kind of injury that's
 22 relatively well described in the definition,
 23 they can just go ahead and get that
 24 treatment right away without a lot of back
 25 and forth with the insurance company,

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1 without waiting for approvals. They can
 2 just start treatment. The treatment
 3 provider doesn't have to submit a report
 4 about how many visits or what kind of
 5 treatment. It speeds the process of
 6 starting treatment. The injured person, I
 7 hope, would feel like wow, this is happening
 8 fast and I'm not arguing with anybody.
 9 There's less paperwork. So, I think that's
 10 one of the real benefits of the protocol.
 11 Secondly, the injured person, the
 12 health care provider and the insurer all
 13 know what is involved in evidence-based
 14 treatment and they feel confident that this
 15 person's getting the best treatment possible
 16 for them.
 17 FRAIZE, Q.C.:
 18 Q. But you can have all of that without having
 19 a cap?
 20 MS. RIIS:
 21 A. Yes, you could.
 22 FRAIZE, Q.C.:
 23 Q. Because a cap is just for reducing premiums.
 24 You made a comment of making a connection
 25

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1 after a settlement of an accident that
 2 treatments stop? Okay. Because under our
 3 Section B, I think it goes to four years
 4 after the accident. So, you know, Section B
 5 has a timeline, not only a quantity.
 6 MS. RIIS:
 7 A. Yes.
 8 FRAIZE, Q.C.:
 9 Q. An amount, but also expires.
 10 MS. RIIS:
 11 A. Yes. Four years here.
 12 FRAIZE, Q.C.:
 13 Q. My point being that sometimes these
 14 accidents are settled two years or three
 15 years out and then the treatments, as
 16 supplied by Section B, are no longer
 17 available and in the settlement, they are
 18 provided funding for future treatment, okay.
 19 So, consequently, I don't even know how you
 20 would even gauge if the people still got
 21 their treatments or not because it wouldn't
 22 be done by the Section B. It would just be
 23 the person doing it themselves. Maybe
 24 they've exhausted their cover, right. And I
 25 think – all right. Those are all my

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1 questions. Thank you.
 2 CHAIR:
 3 Q. Thank you.
 4 STAMP, Q.C.:
 5 Q. Oh, I'm sorry, yes. I was just going to say
 6 a point, but I forgot -
 7 CHAIR:
 8 Q. Sure.
 9 STAMP, Q.C.:
 10 Q. My apologies.
 11 CHAIR:
 12 Q. Consumer Advocate.
 13 MR. WADDEN:
 14 Q. Afternoon, Ms. Riis. How are you? Thanks
 15 very much for coming. I'm Andrew Wadden.
 16 I'm counsel for the Consumer Advocate, Mr.
 17 Browne sitting to my right. We appreciate
 18 your evidence today and we were discussing
 19 over the break how it's thus far been quite
 20 helpful, so we thank you for that.
 21 MS. RIIS:
 22 A. Thank you.
 23 MR. WADDEN:
 24 Q. I just got a few sort of points of
 25 clarification and follow up. Mr. Browne may

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1 as well.
 2 MS. RIIS:
 3 A. Sure.
 4 MR. WADDEN:
 5 Q. One of the things you started off with today
 6 is talking about training that's needed for
 7 adjusters in terms of new accident benefits
 8 regimes and that's been done, and I think
 9 you said you've done some training in fact
 10 with All State in the US.
 11 MS. RIIS:
 12 A. Um-hm.
 13 MR. WADDEN:
 14 Q. Give me a better idea, if you would, of what
 15 that looks like. Let's just say the new – a
 16 new accident benefits regime comes in in
 17 Newfoundland. What happens? I mean, do you
 18 and others like you sort of descend on the
 19 province and sort of go to the insurance
 20 companies and -
 21 MS. RIIS:
 22 A. Like Batman.
 23 MR. WADDEN:
 24 Q. Does IBC facilitate? How does that work?
 25 MS. RIIS:

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1 A. What has happened in other provinces is that
 2 the government facilitates that.
 3 MR. WADDEN:
 4 Q. Okay.
 5 MS. RIIS:
 6 A. So, the government pulls together
 7 stakeholders prior to implementation,
 8 discusses with stakeholders what the plans
 9 are for implementation. So, for example,
 10 the medical association, the chiropractic
 11 association, the physiotherapy association,
 12 they could then convey this information back
 13 to their members prior to implementation.
 14 Most of these associations also have private
 15 practice groups which are the people that
 16 most typically treat auto collisions and so,
 17 these private practice groups would get more
 18 and more involved. The insurance industry
 19 would also be considered a stakeholder and
 20 would be given preliminary information and
 21 my experience has been government pulls
 22 these stakeholders together.
 23 I have worked with all stakeholder
 24 groups to produce training and we had
 25

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1 insurance adjusters, health care providers
 2 and actually lawyers, plaintiff lawyers, in
 3 the same room. So, we all heard the same
 4 information. A lot of questions, good
 5 questions were raised which gave guidance to
 6 the government in terms of where do we need
 7 to issue interpretive bulletins to clarify
 8 the intent of the new regulation.
 9 So, that's what we've done in the past.
 10 And as I also mentioned earlier, in Alberta,
 11 we followed up with monthly stakeholder
 12 conversations where we shared what's
 13 working, what's not working. So, insurance
 14 companies would call me and say "you know,
 15 we've got chiropractors and they're always
 16 trying to put in for 30 visits for
 17 temporomandibular joint". I'd contact the
 18 registrar of the College of Chiropractors in
 19 Alberta and say "is this reasonable
 20 practice?" The registrar would say "well,
 21 not really. I'll talk to them." Or the
 22 health – a physiotherapist would call the
 23 physiotherapy association and say "this
 24 adjuster refuses to approve any of my
 25 recommendations for this treatment" and the

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1 physiotherapy person would contact me and
 2 I'd talk to the insurance company and say –
 3 I try to give them information about why
 4 this is perhaps not a reasonable approach or
 5 a supportable approach.
 6 (12:30 p.m.)
 7 So, we did a lot of very casual back
 8 and forth without having to go through
 9 disputes and engaging lawyers in the early
 10 stage of a process. So, I personally
 11 thought that was really good and I know in
 12 conversations I've had with other
 13 stakeholder groups, they also felt that
 14 worked really well.
 15 MR. WADDEN:
 16 Q. Okay. Thank you. I guess sticking with the
 17 topic of accident benefits and reform, in
 18 that vein. We're trying to get a better
 19 idea of sort of consumer satisfaction where
 20 that's been done elsewhere, okay, consumer,
 21 injured person satisfaction. One of the
 22 things we heard from a panel of injured
 23 people that were here today, and we've all
 24 heard anecdotally I'm sure at times, is
 25 issues with response times. In other words,

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1 the injured person being able to avail of
 2 their accident benefits, okay. So, have you
 3 seen in other jurisdictions that that
 4 particular issue is rectified?
 5 MS. RIIS:
 6 A. I know the problem is universal. I think
 7 there's always room for the insurance
 8 industry to respond more rapidly and I've
 9 heard many complaints of injured persons and
 10 health care providers saying "the insurer
 11 won't call me. The insurer won't call me."
 12 I've heard just as many complaints from the
 13 insurance industry saying "the health
 14 provider won't call me", physicians refusing
 15 to hand over medical records until they
 16 receive huge payments for it. So, the
 17 problem comes from both sides.
 18 But from the perspective of the
 19 insurance industry, I know that's a problem.
 20 It's certainly one in the training sessions
 21 I've done, it's one of the things we
 22 emphasize is that in this system, we don't
 23 want to be adversarial. We don't want the
 24 patient to feel that they're not being
 25

<p style="text-align: right;">Page 189</p> <p>1 serviced by their own insurance company. 2 This is your policyholder. You need to be 3 responsive to them. So, it's certainly 4 something we've emphasized. Have we cured 5 it in all cases? I can't comment on that. 6 MR. WADDEN: 7 Q. Okay. 8 MS. RIIS: 9 A. I wish we could cure it. But I hope that 10 that kind of behaviour is reduced when the 11 system becomes more cooperative. 12 MR. WADDEN: 13 Q. Okay. Can we bring up the – it's the IBC 14 February 2018 report or submission, I should 15 say. And Ms. Riis, while we're waiting for 16 that, is that a report you – you wouldn't 17 have that physically in front of you, do 18 you? 19 MS. RIIS: 20 A. I don't have it in front of me. 21 MR. WADDEN: 22 Q. Okay. 23 MS. RIIS: 24 A. I was just thinking about one of the – may I 25 just go ahead?</p>	<p style="text-align: right;">Page 191</p> <p>1 treatment protocols in place did reduce 2 disputes. It's not – I can't prove that 3 it's 100 percent there and it's still 4 continuing, but at that time, it was looking 5 good. 6 MR. WADDEN: 7 Q. Right, okay. Thank you. We have that up 8 now. Can we go to page nine? And I should 9 ask you as well, Ms. Riis, did you – have 10 you reviewed – have you seen this report? 11 MS. RIIS: 12 A. No. I saw their May submission. I don't 13 think I've reviewed their February 14 submission. 15 MR. WADDEN: 16 Q. Okay. So, you wouldn't have had any input 17 into this particular report then? 18 MS. RIIS: 19 A. No. 20 MR. WADDEN: 21 Q. All right. Well, that's fine. Can we pan 22 down just under that graph that paragraph 23 there, starts with "Alberta"? Yeah. And 24 they're speaking of their proposal here in 25 terms of accident benefits and you can see</p>
<p style="text-align: right;">Page 190</p> <p>1 MR. WADDEN: 2 Q. Go ahead. Yeah, while we're waiting you 3 might as well go ahead. 4 MS. RIIS: 5 A. In Alberta, we studied injury claims data 6 prior to implementation of the reforms and 7 after implementation of the reforms and one 8 of the things we discovered is that 9 insurance companies were paying more per 10 claim in the first 12 weeks post-injury. 11 So, insurers were paying more to support 12 treatment of injured people, but at 26 13 weeks, at six months after, there was a 14 lower average cost per claim. So, this sort 15 of supports the concept that if you treat 16 people well and give them good treatment 17 early on, it can reduce the overall cost of 18 claims. 19 The other thing we looked at is 20 disputes. So, we used the IME as a proxy 21 for dispute and we had fewer episodes of 22 disputes requiring an independent medical 23 examination. So, this study suggests that 24 the process of having the diagnostic 25</p>	<p style="text-align: right;">Page 192</p> <p>1 "Alberta and Nova Scotia also have 2 diagnostic and treatment protocols. The 3 intent is to provide people with common 4 injuries with immediate access to evidence- 5 based treatment" and it goes on. And I can 6 tell you that the – without bringing it up, 7 that Intact, in their submission, has also 8 suggested a similar change to the accident 9 benefits program and have touted that it 10 will mean easier and faster access, okay. 11 So that sounds great, but this idea of 12 immediate access, and I suppose the word 13 "immediate" has various definitions, but 14 we're trying to get an idea of how quickly a 15 consumer is going to be able to get at their 16 Section B, okay. And you're telling me that 17 there's still, in other jurisdictions, 18 presumably Nova Scotia and Alberta where new 19 Section B ways have been implemented, that 20 there are still delays for the client, the 21 consumer? 22 MS. RIIS: 23 A. I meant that sometimes when a client tries 24 to reach an adjuster, does the adjuster 25 return the phone call immediately.</p>

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1 MR. WADDEN:
 2 Q. Right.
 3 MS. RIIS:
 4 A. So, I'm talking about that.
 5 MR. WADDEN:
 6 Q. Yeah.
 7 MS. RIIS:
 8 A. But in terms of access to treatment, I would
 9 say that that's happening quickly because
 10 all that has to happen, theoretically I
 11 could go from my damaged car, walk into a
 12 physiotherapy or chiropractic clinic and say
 13 "I was just hurt in a car accident. Can you
 14 treat me?" and it starts then. The patient
 15 would have to give his insurance information
 16 to the physiotherapist. I would call the
 17 insurer and say "your policyholder is here.
 18 He's just had an accident" and the insurer
 19 will tell me "great, get started".
 20 MR. WADDEN:
 21 Q. So that has sped up, okay.
 22 MS. RIIS:
 23 A. That has sped up.
 24 MR. WADDEN:
 25 Q. Okay. That's helpful. And I think Mr.

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1 Stamp was asking you earlier sort of what it
 2 looks like on the ground when someone gets
 3 hurt, right.
 4 MS. RIIS:
 5 A. Yes.
 6 MR. WADDEN:
 7 Q. So, let's – if you don't mind, can I just go
 8 into that in a little more detail?
 9 MS. RIIS:
 10 A. Sure.
 11 MR. WADDEN:
 12 Q. I'm in an accident on a Monday. On
 13 Wednesday, I'm having some effects in my
 14 neck. I haven't gone to see my GP yet. I
 15 feel I want some physiotherapy treatment.
 16 So, how am I getting there?
 17 MS. RIIS:
 18 A. Have you called your insurer?
 19 MR. WADDEN:
 20 Q. No, but I will if you want me to.
 21 MS. RIIS:
 22 A. Okay. So, all you'd have to do is contact
 23 your physiotherapist, chiropractor, doctor,
 24 to say "I was in an accident. I need to be
 25 seen".

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1 MR. WADDEN:
 2 Q. Right. That simple?
 3 MS. RIIS:
 4 A. It's that simple. And that's why the
 5 education is important. If this is
 6 implemented, the physiotherapist and
 7 chiropractor or massage therapist have to
 8 know they need to contact the insurer to
 9 tell the insurer.
 10 MR. WADDEN:
 11 Q. Yes, right.
 12 MS. RIIS:
 13 A. There's a claim coming forward, but they're
 14 here for treatment now.
 15 MR. WADDEN:
 16 Q. Okay. And in practice, in your view, that
 17 appears to be working in these other
 18 jurisdictions?
 19 MS. RIIS:
 20 A. Yes.
 21 MR. WADDEN:
 22 Q. Okay.
 23 MS. RIIS:
 24 A. I would say that works. The only time it
 25 gets complicated, sometimes patients want to

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1 see a physiotherapist, a chiropractor and a
 2 naturopath and they would go see all three
 3 and then instead of having one person
 4 coordinating treatment, you've got multiple
 5 treatment providers. So, the insurer has to
 6 get involved and the patient needs to
 7 realize that there needs to be one person to
 8 coordinate that treatment. That's been part
 9 of the – that's another reason the protocols
 10 are good is that the protocols typically
 11 require a single coordinating practitioner.
 12 MR. WADDEN:
 13 Q. Right.
 14 MS. RIIS:
 15 A. It's up to the injured person to decide who
 16 that is and so, for example, if the injured
 17 person says "you're my family doctor. I
 18 want you to coordinate my care," you're the
 19 one then decides, "okay, what kind of
 20 treatment do you want? You want to see
 21 physiotherapy and massage. That's fine."
 22 And the patient can see physiotherapy and
 23 massage. Or if they come to me and say
 24 "Viivi, I want you to coordinate my care",
 25 I'm going to say "great. I think you need

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1 some physiotherapy and I think you could
 2 benefit from massage” and I could coordinate
 3 all of that.
 4 But there needs to be some coordination
 5 because what has happened in the past is
 6 patients are seeing multiple treatment
 7 providers, none of whom talk with each
 8 other. In the private sector, there’s a lot
 9 of silos of health care. We don’t have team
 10 meetings. Nobody’s paying for it. So,
 11 there’s a lack of coordination. But the
 12 protocols permit a structure that encourages
 13 coordination of care, which I think is good.
 14 MR. WADDEN:
 15 Q. Okay, so you’ve taken me to my next point
 16 and I want to get a better understanding of
 17 the role of this coordinating position, and
 18 it’s actually referenced in the next
 19 paragraph in that report, and I guess that
 20 is in terms of the ongoing treatment for
 21 that person, right?
 22 MS. RIIS:
 23 A. Yes.
 24 MR. WADDEN:
 25 Q. So this can generally be that person’s

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1 existing family physician or if it could be-
 2 what if they don’t have a family physician?
 3 MS. RIIS:
 4 A. You know, ideally it’s perfect if it would
 5 be the person’s existing family physician or
 6 an existing chiropractor or existing physio,
 7 somebody who knows this person because
 8 that’s often the question, at what level
 9 were you functioning prior to the accident?
 10 But if the person has been perfectly healthy
 11 all their life, they’ve never seen a doctor
 12 in their life, then they can go to a walk-in
 13 clinic, they can go to the physiotherapist
 14 down the road, the chiropractor down the
 15 road. And again, hopefully if they don’t
 16 know what to do, they will contact their
 17 insurance company who can give them this
 18 kind of advice. The insurance company
 19 shouldn’t be able to force them to go to any
 20 particular clinic, that’s how it’s worked in
 21 the other jurisdictions, so again, if a
 22 patient has a history with a certain clinic,
 23 the patient is free to continue with the
 24 clinic that’s familiar to them.
 25 MR. WADDEN:

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1 Q. Yes. Any issues in the other jurisdictions
 2 where this sort of methodology has been
 3 implemented whereby there’s trouble
 4 accessing a coordinating physician, you
 5 know.
 6 MS. RIIS:
 7 A. Honestly physicians are not primarily the
 8 coordinators.
 9 MR. WADDEN:
 10 Q. Okay.
 11 MS. RIIS:
 12 A. It tends to be physiotherapists and
 13 chiropractors in the other jurisdictions.
 14 MR. WADDEN:
 15 Q. Oh, all right, okay.
 16 MS. RIIS:
 17 A. Most physicians aren’t interested in doing
 18 this piece of the work, so it tends to go to
 19 physiotherapists and chiropractors, so many
 20 patients who see a physician, the physician
 21 says that’s not a problem, you should see a
 22 physiotherapist or a chiropractor and that
 23 physio or chiropractor will coordinate and
 24 keep the family physician in the loop.
 25 MR. WADDEN:

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1 Q. Okay, so I want to backtrack there now, you
 2 just said oftentimes it seems to be the
 3 case, in your view, that physicians aren’t
 4 interested in that particular piece of work.
 5 Is it not the case that, and that paragraph
 6 in fact discussed it, where we just were,
 7 the one that starts with “The protocols”,
 8 that in those jurisdictions there’s a
 9 government approved fee schedule, so it is,
 10 they do get paid for it?
 11 MS. RIIS:
 12 A. Yes.
 13 MR. WADDEN:
 14 Q. But it’s the case that generally it ends up
 15 not being the coordinating—a physician being
 16 the coordinating individual?
 17 MS. RIIS:
 18 A. That’s my experience, yes.
 19 MR. WADDEN:
 20 Q. Okay. One of the things that was discussed
 21 is this idea that under a new accident
 22 benefits regime the auto insurer, at least
 23 in the other jurisdictions, as I understand
 24 it, becomes first payer?
 25 MS. RIIS:

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1 A. Yes, in Alberta and I think Nova Scotia the
 2 auto insurer becomes first payer, so that
 3 means that the injured individual does not
 4 have to exhaust their group health benefits
 5 or their work benefits and I think that's a
 6 good thing.
 7 MR. WADDEN:
 8 Q. Sure, yes, because as you know here in
 9 Newfoundland when people want to go to their
 10 Section B, they first, for example, have to
 11 go to perhaps their own Blue Cross that they
 12 pay for or health benefits under their
 13 employer.
 14 MS. RIIS:
 15 A. Right, right, and that again, they feel that
 16 that's unfair because I didn't cause the
 17 accident, why should I have to use up my
 18 benefits? So again, it contributes to that
 19 perceived injustice, so I think making the
 20 auto insurer first payer for these
 21 situations can be a benefit.
 22 MR. WADDEN:
 23 Q. Right, and this may be outside your purview
 24 but I'm hoping you might know this, in those
 25 jurisdictions where that's been implemented

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1 and we have people, for example who have
 2 their own, we'll say Blue Cross insurance
 3 that they pay for and a change has been
 4 made, so now Blue Cross is no longer the
 5 first payer, do you know if people in those
 6 jurisdictions have experienced a reduction
 7 in premiums for those insurers who normally
 8 they would have gone to to be the first
 9 payer?
 10 MS. RIIS:
 11 A. I have no idea.
 12 MR. WADDEN:
 13 Q. Okay.
 14 MS. RIIS:
 15 A. It's interesting, though, in Ontario where
 16 the auto insurer is still last payer, I have
 17 seen group health insurers exclude coverage
 18 for motor vehicle accidents.
 19 MR. WADDEN:
 20 Q. Optionally or –
 21 MS. RIIS:
 22 A. No, they basically say that, so, if it's a
 23 group health carrier, they'll say that, you
 24 know, we'll cover whatever musculoskeletal
 25 injuries you have, but we don't cover

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1 injuries from motor vehicle collisions.
 2 MR. WADDEN:
 3 Q. Okay.
 4 MS. RIIS:
 5 Q. The other area that I think requires a lot
 6 of sort of explanation is I believe in
 7 Newfoundland the insurance industry does pay
 8 a levy because it's given that people
 9 injured in automobile accidents are going to
 10 use some public health services, like
 11 emergency rooms, maybe x-rays, so there is a
 12 levy paid. So I think that's something a
 13 lot of healthcare providers don't understand
 14 and needs to be shared.
 15 MR. WADDEN:
 16 Q. Okay. Can we just flip to page 10, the next
 17 page of IBC submission? You can see there
 18 on page 10 there are some submissions there
 19 with respect to the development of the
 20 treatment protocols, none of which, I'm
 21 sure, are unfamiliar to you. There was some
 22 comment there, I think, about, let's see,
 23 timelines on treatments. Yes, under No. 1
 24 there, not the first point No. 1, the second
 25 point No. 1 under filing provisions, do you

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1 see that?
 2 MS. RIIS:
 3 A. Yes.
 4 MR. WADDEN:
 5 Q. "The treatment protocol should consist of up
 6 to 10 or 21 treatment visits, depending on
 7 the injury seriousness for up to 90 days as
 8 in Alberta and Nova Scotia." Now I know
 9 this is not your submission, you didn't
 10 write that, so this is not a fair question,
 11 that's fine, but I'm trying to get a better
 12 understanding what that means, this 90-day
 13 period, what's that all about?
 14 (12:45 p.m.)
 15 MS. RIIS:
 16 A. Well essentially it means that these
 17 protocol treatments should be delivered
 18 within a 90-day period and when the 90-day
 19 period is up, then it reverts to
 20 conventional Section B procedures.
 21 MR. WADDEN:
 22 Q. Okay, why is that?
 23 MS. RIIS:
 24 A. The expectation, the whole concept of
 25 treatment protocols is if you treat people

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1 effectively, they're going to get better,
 2 and it's accepted that 90 days or three
 3 months is typical tissue healing time. So
 4 if at 90 days this individual is not
 5 recovered or significantly improved, one
 6 needs to start asking some questions about
 7 is there something we missed? Is there an
 8 occult fracture that has been overlooked, is
 9 this person developing chronic pain
 10 syndrome? There needs to be a sober second
 11 look at what's happening here, so that's why
 12 it's sort of a chance to pause and reassess
 13 the whole situation at 90 days, which is
 14 from a medical point of view, a reasonable
 15 point for this type of an injury.
 16 MR. WADDEN:
 17 Q. Tell me what you've seen in other
 18 jurisdictions with respect to this 90-day
 19 time period? Are people getting, you know,
 20 practically are people getting cut off after
 21 90 days and it becomes much more difficult
 22 for them to avail, to continue to avail of
 23 the benefits or what's happening?
 24 MS. RIIS:
 25 A. In my experience they're not getting cut off

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1 at all, again if the healthcare professional
 2 can explain why further treatment is needed,
 3 what the goals of treatment are and if the
 4 health professional can report on their
 5 success in achieving the goals, I find the
 6 insurers are happy to approve ongoing
 7 treatment. So I haven't had the experience
 8 that they get cut off. That's not to say
 9 that there aren't some insurers that may
 10 just try to cut people off at the 90 days,
 11 but certainly that hasn't been my experience
 12 in Alberta, Ontario or Nova Scotia.
 13 MR. WADDEN:
 14 Q. Okay, and after that 90-day period, assuming
 15 that there is some sort of report required,
 16 who is dealing with that? Is it again that
 17 coordinating individual, is the onus upon
 18 the insured to get that report and get it to
 19 the insurer or what's going on there?
 20 MS. RIIS:
 21 A. No, the healthcare practitioner, the
 22 coordinating healthcare practitioner has to
 23 write a report on what's happening, what's
 24 needed going forward and again, I find
 25 there's fewer disputes at this point because

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1 the working relationship generally is very
 2 good during the course of the protocols.
 3 And as I said, there was less reliance on
 4 IMEs when we looked at the Alberta data
 5 after implementation.
 6 MR. WADDEN:
 7 Q. Okay. Can we just move down, it's already
 8 there on the screen, No. 4 there and I'll
 9 just read it into the record, it says, "Also
 10 as in Alberta and Nova Scotia, physicians,
 11 physiotherapists and chiropractors should be
 12 the only health providers eligible to
 13 coordinate treatment within the protocols;
 14 however, they should be able to use some of
 15 the injured person's treatment visits for
 16 massage therapy, acupuncture, dental
 17 services, psychological services and
 18 occupational therapy." So I read that and
 19 it kind of struck me that there almost seems
 20 to be some sort of imposed segregation
 21 between the professions. So, someone such
 22 as yourself, a physiotherapist, you can be a
 23 coordinator?
 24 MS. RIIS:
 25 A. Right.

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1 MR. WADDEN:
 2 Q. Or a physician obviously, right?
 3 MS. RIIS:
 4 A. Right.
 5 MR. WADDEN:
 6 Q. But if you're a massage therapist, you don't
 7 get to do that. What's the rationale there?
 8 MS. RIIS:
 9 A. I think that the original rationale is that
 10 massage therapists are not regulated health
 11 professionals in all provinces, I'm not sure
 12 if they are regulated here or not, but
 13 physicians, physiotherapists, chiropractors
 14 are regulated health professionals and
 15 again, they're sort of the obvious treatment
 16 providers for musculoskeletal injury, that's
 17 what these people do.
 18 MR. WADDEN:
 19 Q. Sure.
 20 MS. RIIS:
 21 A. The reason that they didn't include an
 22 acupuncturist, for example, again, there are
 23 a variety of people doing acupuncture and
 24 the regulation of that field is, varies from
 25 place to place. Dental services are

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1 probably rarely required, if somebody has a
 2 jaw strain or sprain, and likewise
 3 psychological services, most of these people
 4 start with a physical injury first and then
 5 it might progress and psychological symptoms
 6 become recognized in the first week or two
 7 of treatment. So as a starting point most
 8 of these injuries start as a physical
 9 injury, so the physical treatment provider
 10 is engaged. All of these treatment
 11 providers, physicians, physiotherapists, and
 12 chiropractors are able to assess for
 13 psychological symptoms, they cannot diagnose
 14 a psychological problem, but I am required
 15 to determine if somebody says "I can't
 16 sleep, I'm crying all the time", I need to
 17 recognize that this person needs help, so I
 18 might call their family physician and say I
 19 think there's some psychological issues that
 20 need to be addressed, or I can say to the
 21 patient are you interested in seeing a
 22 psychologist or a councillor and we can put
 23 that into play.
 24 MR. WADDEN:
 25 Q. Okay. Let me just ask you generally, rather

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1 than going through, you know, 50 different
 2 questions, in your experience in these other
 3 jurisdictions where this new accident
 4 benefits regime has been put in place, what
 5 are the main, if any, problems?
 6 MS. RIIS:
 7 A. I would say ambiguity around the definition
 8 and how people interpret the definition.
 9 That's where I have seen a lot of the
 10 dispute. I always say to health
 11 professionals it's not your business to
 12 decide if this falls in the cap or not, it's
 13 irrelevant. You just need to treat that
 14 patient, assess the patient, figure out
 15 what's wrong with them and treat them. But
 16 then if the insurance company starts to say
 17 they're in the cap, they're not in the cap,
 18 the ambiguity around the definition has
 19 always been a problem and that's why there
 20 have been efforts to refine and improve the
 21 definition in some areas.
 22 MR. WADDEN:
 23 Q. In terms of, and you're talking about the
 24 cap now, so let me just go to the cap for a
 25 second. In other jurisdictions, aside from

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1 the new accident benefits regime that may
 2 have been implemented, where a cap has been
 3 implemented, right, so we'll say Nova
 4 Scotia, obviously as you know there's
 5 oftentimes disputes as between the injured
 6 person or the injured person and their
 7 counsel and the insurer, right?
 8 MS. RIIS:
 9 A. Yes.
 10 MR. WADDEN:
 11 Q. Do you ever get called in on any of these
 12 disputes to give sort of any—or any of your
 13 colleagues to give a professional opinion on
 14 whether or not a person should be restricted
 15 to cap damages or if they fall outside the
 16 cap?
 17 MS. RIIS:
 18 A. No, to me that's a legal definition.
 19 MR. WADDEN:
 20 Q. Right.
 21 MS. RIIS:
 22 A. So as a physiotherapist I'm called to
 23 provide my opinion on what the injuries are,
 24 and so I would provide my opinion to say
 25 here's what I think the injuries are, here's

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1 what I think the physiotherapy prognosis is,
 2 and that's the end of my expertise. I think
 3 that's where we've had a lot of problems.
 4 When these systems are implemented,
 5 sometimes the healthcare professionals think
 6 it's their job to make that legal
 7 determination and they don't understand that
 8 it is a legal determination, not a medical
 9 one. So there's confusion about who should
 10 be making the determination, so again, I
 11 underscore the need to educate all the
 12 stakeholders about the definition being a
 13 legal definition and it's not one that
 14 health providers should be making or trying
 15 to make. Did I go off on a tangent?
 16 MR. WADDEN:
 17 Q. No, no, not at all, that's fine. Just one
 18 more point of clarification because when I
 19 asked you a moment ago about struggles and
 20 problems in terms of any new accident
 21 benefits regime that's been implemented, you
 22 started talking more about the cap and
 23 arguments over the definitions, that's why I
 24 followed up with a question.
 25 MS. RIIS:

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1 A. Yes.

2 MR. WADDEN:

3 Q. But let me go back to that for a second

4 because, you know, someone could avail of

5 their accident benefits, as long as they're

6 injured, you know, it's a no fault type of

7 regime, but I'm just trying to get an idea

8 with all these new protocols that are being

9 suggested for Newfoundland and which have

10 already been implemented elsewhere, and

11 under which we're being told the system

12 works better, people get more treatment,

13 this accident benefits regime is overall

14 better than what you have in Newfoundland

15 right now, I get the sense from you it is

16 better, in your view, but again, I want to

17 get—there's got to be challenges with it,

18 right, there's got to be the criticisms in

19 other jurisdictions.

20 MS. RIIS:

21 A. Of course.

22 MR. WADDEN:

23 Q. So if our government, this Board decides

24 that this new regime that's being suggested

25 is a good idea, what can we expect to be the

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1 main problems to come out of it?

2 (1:00 p.m.)

3 MS. RIIS:

4 A. I think there's always criticisms no matter

5 what you do, you're going to have criticisms

6 if you stay where you are, you're going to

7 have criticisms if you implement a new

8 system. I would think that initially when

9 implemented effectively so everyone

10 understands their role in the process, I

11 think you're going to see some benefits. I

12 think over the long term there will be some

13 effort to find ways of escaping the cap,

14 because I think people who have been injured

15 through no fault of their own feel that they

16 want as much justice as possible, so

17 escaping the cap makes them feel like

18 they're going to get a larger settlement and

19 that's going to be more fair for them. So

20 over time sometimes we see erosion of the

21 premium savings that come from

22 implementation. So I'd say that's one

23 problem and again, it often revolves around

24 ambiguities in interpretation of the

25 definition, and part of that problem is

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1 because health providers think that they're

2 supposed to be making the determination

3 which, in my view, they should not be. They

4 should simply be assessing the patient,

5 treating them. So I'd say again, I think

6 I'm repeating myself, I guess the other

7 problems I've seen, I mean, I'm thinking of

8 an example in Ontario but we're not talking

9 about the Ontario system here. If I think

10 of anything else, I'll –

11 MR. WADDEN:

12 Q. All right, that's fine. I think Mr. Browne

13 may have a couple of questions for you as

14 well. Thank you very much.

15 BROWNE, Q.C.:

16 Q. Yes, I wanted to go to the Ontario system

17 because in the Ontario system –

18 MS. RIIS:

19 A. Don't.

20 BROWNE, Q.C.:

21 Q. - you have a large deductible as one of the

22 possibilities there and here we're all

23 talking cap, a deductible is one of terms of

24 reference that has to be looked at as well.

25 Can you comment on the Ontario system

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1 deductible and how that works in terms of

2 your profession?

3 MS. RIIS:

4 A. No. I'll be honest with you, I have not had

5 much to do in any discussions around the

6 deductible, exactly how that is applied and

7 how it works, so I would be uncomfortable

8 commenting on that.

9 BROWNE, Q.C.:

10 Q. In terms of your own report, you stated on

11 page 10, if we can go to page 10 and we see

12 on the top of the page there, "The purpose

13 of auto insurance is to facilitate recovery

14 of any financial loss and most importantly

15 enable injured persons to recover and return

16 to their pre-accident lives. It is my

17 experience that the litigation process

18 cannot undermine achievement of this latter

19 goal. This has been documented in the

20 medical literature." Can you expand upon

21 that?

22 MS. RIIS:

23 A. So again, I've provided two examples where

24 this Australian inquiry found that in this

25 situation the third party insurer is

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1 unwilling to accept any liability, so this
 2 forces the injured person into a posture
 3 where they have to prove their disability,
 4 emphasize their disability, focus on their
 5 disability and that's from a rehabilitation
 6 perspective, that's the last thing you want
 7 somebody to do is focus on how horrible
 8 their life is, but the system sort of forces
 9 one to think about how disabled I am, you
 10 have to answer a lot of questions about what
 11 I can't do, what I wish I could do, how much
 12 pain I have and you're repeating this over
 13 and over. And, of course, there's the
 14 perception that the size of the award, the
 15 non-pecuniary damages is tied to absence of
 16 recovery, so there's a perception that
 17 there's a disincentive to recovery in some
 18 situations.
 19 BROWNE, Q.C.:
 20 Q. In terms of the, you're talking about a
 21 return to their pre-accident lives, a return
 22 to work, and in terms of a return to work,
 23 you go to the first, a person who is injured
 24 in an accident, goes to see their physician.
 25 The physician's first diagnosis really is

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1 you need a few days off work and therefore,
 2 three or four days off to see how you are
 3 doing. And there's now some concern that
 4 that immediate prescription of taking the
 5 first few days off is not perhaps the
 6 correct one. Some employers get notes that
 7 say "So and so has been in an accident",
 8 they can't work because they have a doctor's
 9 note saying they're off for three or four
 10 days. There's some jurisdictions that are
 11 considering an implementation at that
 12 particular point of the doctor's note, for
 13 the doctor to also give the employer a
 14 functional abilities, can you comment on
 15 that?
 16 MS. RIIS:
 17 A. Abilities, uh-hm. I think in most cases
 18 when a doctor is asked to comment on
 19 disability, it's a very difficult thing to
 20 do. Essentially when you go to see your
 21 doctor, the doctor is going to say, you
 22 think you can work? And if you say no, I
 23 can't work, the doctor is going to sign you
 24 off. A functional abilities evaluation is
 25 something that's carried out by, typically

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1 physiotherapists, kinesiologists,
 2 chiropractors where you get the job
 3 description of the patient, look at what the
 4 physical demands of the job are and you
 5 actually put them through their paces to see
 6 if they can or cannot do those activities.
 7 Often I have found patients may have
 8 difficulty with a certain activity, so we
 9 might say, "He can't be lifting anything
 10 over 25 pounds, but other than that, he can
 11 do his work." So the general recommendation
 12 right now in both the auto insurance sphere
 13 and the Workers' Compensation sphere, is
 14 that with soft-tissue injuries, I'm not
 15 talking about somebody who is fractured or
 16 dislocated a joint, but with soft-tissue
 17 injuries generally speaking are returned to
 18 usual activities as soon as possible is the
 19 best recommendation. And again, if I am a
 20 GP and I have known you for 40 years and I
 21 have a sense of who you are and how you
 22 function, it still may be appropriate for me
 23 to say take a couple of days off work, so
 24 I'm not saying it's wrong, I'm just saying
 25 that in general we should be seeing more

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1 recommendations to resume normal activities
 2 as soon as possible. That seems to result
 3 in better health outcomes in the long term.
 4 BROWNE, Q.C.:
 5 Q. You also mention in your evidence about the
 6 Tylenol study, you know, they go to the
 7 doctor and the doctor says, well take
 8 Tylenol for a few days, but some doctors are
 9 prescribing other than Tylenol and we have a
 10 bit of a crisis in this country now because
 11 of what is out there in the system. Can you
 12 tell us your experience in reference to
 13 that? Is there an over prescription of
 14 painkillers that have addiction in their
 15 result, have you had that experience?
 16 MS. RIIS:
 17 A. I'm a drugless practitioner so I don't have
 18 expertise in prescription medications, et
 19 cetera. I think I would just refer you to
 20 what you can read in the media, there are a
 21 lot of initiatives by the Canadian Pain
 22 Society, there's a number of national groups
 23 that are publishing information and
 24 recommendations on prescribing patters of
 25 physicians and alternative treatments for

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1 pain, instead of medication. So I think
 2 there's some movement happening in that
 3 regard and I suspect that is going to
 4 continue for a number of years now.
 5 BROWNE, Q.C.:
 6 Q. You must have worked within your own
 7 profession with clients who are under some
 8 kind of pain prescription as well, have you
 9 come across it, anecdotally?
 10 MS. RIIS:
 11 A. Yes, so certainly as a physiotherapist, or
 12 chiropractors, we're supposed to ask what
 13 medication are you taking, because often a
 14 patient may be experience headaches or
 15 dizziness and that may be a side effect of
 16 medication. So, you know, if we are
 17 concerned that medication is causing side
 18 effects, we have to contact the physician,
 19 express our concern and the physician would
 20 then review the medication. So certainly
 21 I've seen those cases, I've seen cases in
 22 particular where patients had prescription
 23 medication from their physician and then
 24 they're buying over-the-counter stuff as
 25 well, and so that's of great concern, so we

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1 always have to refer back to the physician,
 2 let them know that there's over-the-counter,
 3 so I think the medication issue is being
 4 looked at far more closely by all healthcare
 5 professionals.
 6 BROWNE, Q.C.:
 7 Q. In terms of your resumé, some things caught
 8 my attention there under your professional
 9 activities it states there, the third last
 10 from, the bottom there, it says, "Expert
 11 witness at FSCO arbitration, file number
 12 between Shiva Ahmadi and Allstate.
 13 MS. RIIS:
 14 A. That was a financial services commission of
 15 Ontario which would be the counterpart to
 16 the Board, and it was a case, that case I
 17 had mentioned earlier where I had developed
 18 a return to work plan with the woman's
 19 physiatrist and the claimant disputed that I
 20 was appropriate in recommending that return
 21 to work problem, so it was a dispute
 22 resolution mechanism.
 23 BROWNE, Q.C.:
 24 Q. Okay, do you see dispute resolution
 25 mechanisms as more appropriate than perhaps

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1 the litigation, the court litigation, do you
 2 have any comments on that from your own
 3 experience?
 4 MS. RIIS:
 5 A. Again, not my area of expertise. I don't
 6 think I want to comment on that without
 7 being able to give it much more thought.
 8 BROWNE, Q.C.:
 9 Q. Thank you very much.
 10 MS. RIIS:
 11 A. Thank you.
 12 CHAIR:
 13 Q. Thank you. Any questions, Mr. O'Flaherty?
 14 O'FLAHERTY, Q.C.:
 15 Q. I don't have any questions for the
 16 presenter, thank you.
 17 STAMP, Q.C.:
 18 Q. Madam chair, I just have one question. Ms.
 19 Riis, a couple of questions have focussed on
 20 the issue of serious impairment because
 21 that's obviously an exclusion from the
 22 definition, whatever you want to call that
 23 definition or how do you define it or what
 24 you call it, how you label it, and it talks
 25 about, these definitions appear to talk

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1 about impairment of a physical or cognitive
 2 function, is that the standard type of
 3 exclusion?
 4 MS. RIIS:
 5 A. I know that's one definition, but it really—
 6 so physical or cognitive function, physical
 7 means the functioning of your body, your
 8 anatomy; and cognitive means the functioning
 9 of your mind and your ability to think. But
 10 then the question is what constitutes a
 11 serious impairment of that and that again,
 12 my feeling is referring to the World Health
 13 Organization classification and framing that
 14 in terms of functioning would be the most
 15 reasonable way to go because I think what I
 16 heard is that many presenters have commented
 17 that the same injury in two different people
 18 manifests itself or can manifest itself in
 19 very different ways, so that's why we have
 20 to look at the end result of how are they
 21 functioning.
 22 STAMP, Q.C.:
 23 Q. And so the serious impairment definition is
 24 also important because that picks up on both
 25 the psychological, as well as the physical?

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1 MS. RIIS:
 2 A. Yes, of course.
 3 STAMP, Q.C.:
 4 Q. Thank you.
 5 CHAIR:
 6 Q. Thank you. Thank you, Ms. Riis, that's very
 7 helpful, very interesting.
 8 MS. RIIS:
 9 A. Thank you.
 10 CHAIR:
 11 Q. I guess you can step down whenever you're
 12 ready. You don't have to sit there and
 13 listen to us.
 14 MS. RIIS:
 15 A. Okay.
 16 KENNEDY, Q.C.:
 17 Q. Members of the Board, we've got a bit of a
 18 scheduling problem here. We have two
 19 individuals from Ontario who are here and
 20 ready to give evidence, but based on what
 21 I'm seeing, even if we can present their
 22 evidence in an hour, we're going to need who
 23 knows for cross-examination, so I'd think at
 24 a minimum it would be an hour and a half. I
 25 don't know would the Board, we'd obviously

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1 ask you to consider hearing this evidence,
 2 whether or not you want to take a break and
 3 come back after lunch. We can't bring them
 4 back for tomorrow and Dr. Lazar is here
 5 tomorrow and he's going to be, I would
 6 assume the full morning.
 7 CHAIR:
 8 Q. Are your presenters available in the morning
 9 to finish if they get part of it done today?
 10 KENNEDY, Q.C.:
 11 Q. I don't think so. They are scheduled to
 12 head back to Ontario tonight.
 13 CHAIR:
 14 Q. So your proposal is that they present
 15 everything today?
 16 KENNEDY, Q.C.:
 17 Q. Yes.
 18 CHAIR:
 19 Q. And how long is their presentation?
 20 KENNEDY, Q.C.:
 21 Q. Well I can, again, lawyers are horrible at
 22 predicting timeframes, but I would think
 23 that their presentation, from our
 24 perspective, would be an hour. Now, as for
 25 cross-examination, I'm sure that Mr. Stamp

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1 will have a few questions for sure, and
 2 other counsel, I don't know.
 3 CHAIR:
 4 Q. So we need at least an hour.
 5 KENNEDY, Q.C.:
 6 Q. We need an hour and a half, I think to be
 7 fair.
 8 CHAIR:
 9 Q. Let's suggest we take a nature break because
 10 we're going to be here for an hour and a
 11 half in any event, if we come back.
 12 MR. WADDEN:
 13 Q. Madam Chair, we really want to hear from the
 14 Ontario Trial Lawyers Association, quite
 15 frankly, but we have other commitments this
 16 afternoon.
 17 CHAIR:
 18 Q. That's what I was going to say, you're going
 19 to have to canvass amongst each other to see
 20 if there's either party who can't stay for
 21 the afternoon, then I guess we can't -
 22 MR. WADDEN:
 23 Q. Maybe there's another solution, maybe we can
 24 even start earlier tomorrow, I don't know,
 25 but this afternoon is going to be a problem.

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1 CHAIR:
 2 Q. Okay.
 3 KENNEDY, Q.C.:
 4 Q. Well maybe can we just start now and we need
 5 to present these witnesses, they're going to
 6 be also referring to some of the things that
 7 Ms. Riis talked about.
 8 CHAIR:
 9 Q. Well if we're going to start now and you're
 10 going to be an hour, I need a break.
 11 KENNEDY, Q.C.:
 12 Q. Sure, and I know staff and everyone is going
 13 to need a break, that's what I'm saying,
 14 yeah.
 15 CHAIR:
 16 Q. I can sit here until 5:00 but I do need a
 17 few minutes break.
 18 STAMP, Q.C.:
 19 Q. Madam Chair, have we determined what time
 20 the consumer advocate has to leave, is that
 21 something we can identify?
 22 CHAIR:
 23 Q. Yes, that would be helpful, so can I just
 24 suggest, maybe you can canvass amongst each
 25 other, that will be helpful too. I'll go do

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1 what I business and you can take care of it.
 2 (RECESS – 1:10 p.m.)
 3 (RESUME – 1:17 p.m.)
 4 CHAIR:
 5 Q. Welcome gentlemen.
 6 KENNEDY, Q.C.:
 7 Q. Thank you.
 8 CHAIR:
 9 Q. Don't feel rushed, but I understand we are
 10 here until 2:30.
 11 KENNEDY, Q.C.:
 12 Q. No, we are going to shorten up our
 13 presentation a little to make sure other
 14 parties have time for cross-examination.
 15 CHAIR:
 16 Q. Excellent, so we're good until you tell us
 17 we're done.
 18 KENNEDY, Q.C.:
 19 Q. Okay. Thank you very much, Madam Chair
 20 members of the Board. The next presentation
 21 we have will be from the Ontario Trial
 22 Lawyers Association. We have with us Allen
 23 Wynperle who is the present elect of the
 24 association and John Karapita, the director
 25 of Public Affairs. I'm going to have both

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1 of these gentlemen introduce themselves with
 2 a couple of minutes of their background and
 3 some introductory statements that will
 4 probably take around five minutes each.
 5 Gentlemen, whoever wishes to start.
 6 MR. KARAPITA:
 7 A. I'll jump in. My name is John Karapita, I'm
 8 the director of Public Affairs with the
 9 Ontario Trial Lawyers Association. I am not
 10 a lawyer, I'll just be clear about that
 11 upfront. I'm a staff member within the
 12 Association and I've been with OTLA now for
 13 the last eight years or so.
 14 MR. WYNPERLE:
 15 A. I am Allen Wynperle, I am a lawyer from
 16 Hamilton, Ontario, being called to the bar
 17 in 1996. I'm a certified specialist in
 18 civil litigation in Ontario in 2002, past
 19 president of the Hamilton Law Association,
 20 past president of the Hamilton Medical Legal
 21 Society, present elect of the Ontario Trial
 22 Lawyers Association, as my friend already
 23 said today, and I did sit on the board of
 24 Spinal Cord Injury Ontario for about 8 years
 25 previously as well.

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1 KENNEDY, Q.C.:
 2 Q. So, if we could now have some introductory
 3 comments, Mr. Wynperle, perhaps you could
 4 give some background of what OTLA does and
 5 Mr. Karapita can talk about how you fellows
 6 got here today?
 7 MR. KARAPITA:
 8 A. You go ahead, yes.
 9 MR. WYNPERLE:
 10 A. Okay, what I wanted to talk about was a
 11 little bit about the Ontario experience
 12 because I think it's important that when you
 13 start going down the road of amending auto
 14 insurance legislation you consider that
 15 experience and what has happened to us. We
 16 have had, since 1990, a no-fault or a hybrid
 17 legislation where there's accident benefits
 18 and there is a limited right to lawsuit and
 19 every government has had their hand in
 20 changing that balance, but over the last 10
 21 years mostly, there have been significant
 22 complaint by the insurance industry of lack
 23 of profitability, there have been
 24 significant complaints from insureds that
 25 they're paying too much for premiums, and so

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1 the government has gone on a probably once
 2 every year or two cycle of cutting benefits
 3 for insureds, and this is, like I said,
 4 generally brought up by the insurance
 5 industry who feel that they cannot support
 6 the present product at the premiums that are
 7 presently existing in Ontario. And I will
 8 say that the premiums in Ontario seems to
 9 be, from everything we understand, to be the
 10 most expensive in the country. So, for
 11 example, in Ontario pain and suffering
 12 damages are not given at all to an injured
 13 person unless their injuries are serious and
 14 permanent. There is a deductible of
 15 \$38,000, unlike your \$2,500 deductible and
 16 we have mostly juries who decide these cases
 17 in Ontario and they don't know about the
 18 deductible. So if they think they're giving
 19 somebody \$50,000, they believe they're
 20 giving somebody \$50,000. They don't know
 21 that \$38,000 of that is going back to the
 22 at-fault driver's insurance company. That's
 23 done afterwards by a judge. There's no
 24 prejudgment interest on pain and suffering
 25 damages and past loss of income is only at

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1 70 percent, so past loss to date of trial is
 2 only at 70 percent. And with respect to the
 3 accident benefits, we heard a lot today
 4 about, you know, injury protocol, treatment
 5 protocols and so on and so forth. We have
 6 what's called a minor injury guideline for
 7 accident benefits in Ontario. It provides
 8 \$3,500 for treatment early on. There's no
 9 doubt that people can get that \$3,500 of
 10 treatment early on without much dispute from
 11 their insurance company. The problem
 12 happens with what after that if anything is
 13 necessary because the vast majority of
 14 disputes that we have on accident benefits
 15 are with respect to whether someone stays
 16 within the minor injury guideline cap of
 17 \$3,500 for treatment, or they can get out of
 18 that cap. So there's a process for that,
 19 but the fact is I suspect that there is a
 20 significant inefficiency in that dispute
 21 process. The insurance company will assess
 22 them with medicals, oftentimes the insured
 23 person will have to get medicals, there's a
 24 dispute resolution process and we're told
 25 that 50 percent of the matters within the

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1 dispute resolution process are does the
 2 person suffice to get out of the minor
 3 injury guideline? And it's a huge, huge
 4 issue. You know, we've heard a lot today
 5 about defining regulations and defining
 6 legislation. Every time these things are
 7 redefined and they have been redefined on
 8 almost a continuous basis, there is
 9 significant cost to the system. Every
 10 lawyer will tell you that uncertainty is
 11 costing their clients money and the more you
 12 amend the legislation, the more uncertainty
 13 you create. That is absolutely the case, in
 14 Ontario we have found that it is a very
 15 costly process because every time they amend
 16 the legislation, ultimately the courts will
 17 need to define that, those regulations and
 18 qualify what's right, what's wrong. The
 19 fact of the matter is it's a very expensive
 20 process, both for injured people and for
 21 insurance companies when you start amending
 22 legislation. We have experienced a lot of
 23 that in our system. Despite 17 cuts to
 24 benefit rights for accident victims in the
 25 last eight years, we don't appear to be much

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1 better off. Injured people are getting less
 2 damages and they're getting less treatment
 3 because there's just not as much funding on
 4 the accident benefit side, and policy
 5 holders are not receiving the benefit of
 6 reduced premiums. Sadly, you know, when
 7 some of these benefit cuts were implemented,
 8 there was temporary reduction in premiums
 9 but as of last year, several large insurers
 10 have received premium increases in the
 11 province of Ontario by our regulator. And
 12 so what we see is a system where we're on a
 13 carousel, we're on a ferris wheel, we're
 14 going round and round and round, we end up
 15 in the same spot every two to three years
 16 and that's causing the government to take
 17 away rights from injured victims which is,
 18 in my submission, highly unfair. We have a
 19 situation in Ontario where we have 9 million
 20 policy holders, insurance companies are
 21 taking in 13 billion dollars in auto
 22 insurance revenue for policies, and we do
 23 not seem to be able to get the system under
 24 control because those 9 million policy
 25 holders continue to pay increasing premiums

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1 all the time, despite all of these cuts.
 2 O'FLAHERTY, Q.C.:
 3 Q. Madam Chair, just one moment, I'm sorry to
 4 interrupt the presentation. We have a
 5 technical issue. We need a moment just to
 6 change the card in the machine.
 7 (OFF RECORD)
 8 REPORTER:
 9 Q. We are back on the record, thank you.
 10 CHAIR:
 11 Q. Thank you very much.
 12 MR. WYNPERLE:
 13 A. A few things that were raised today which I
 14 found very interesting, in Ontario one of
 15 the significant issues has been whether the
 16 auto insurance system is paying its fair
 17 share of the rehabilitation costs in the
 18 province, and what we have actually seen is
 19 our auditor general in Ontario describing a
 20 downloading from the auto insurance system
 21 onto the public system, which is, in my
 22 submission very dangerous. As a taxpayer it
 23 is very upsetting that the auto insurance
 24 system is short changing the provincial
 25 healthcare system by hundreds of millions of

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1 dollars over almost thirty years now. The
 2 auditor general said in 2014 that over a
 3 billion dollars was essentially missing from
 4 the Ontario healthcare coffers over the
 5 course of time as a result of the shifting
 6 of the burden, if you will, by not having
 7 people properly funded for their healthcare
 8 by their auto insurer. And it is a
 9 significant issue.
 10 The other thing I just want to raise
 11 that I heard today in the discussions was
 12 about seniors. I think they are the most
 13 affected by the changes in legislation.
 14 They don't have claims for loss of income
 15 because they're retired, generally speaking,
 16 and pain and suffering damages mean a lot to
 17 them, and taking that away has seriously
 18 affected the rights of senior citizens; in
 19 fact, I've had that conversation with
 20 politicians who are responsible for senior
 21 citizens in Ontario. It is a very hard
 22 thing to tell someone whose life has been
 23 dramatically affected, their quality of life
 24 has been dramatically affected there is very
 25 little or nothing I can do for you because

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1 the cost of taking a case to trial is worth
 2 far more than your pain and suffering
 3 damages once we take off the deductible, or
 4 in a situation like there where you are
 5 taking a huge risk with a senior in a
 6 situation where the case might be capped at
 7 \$7,500 or something like that. It is very
 8 hard to tell them that. It is not something
 9 they deserve after a lifetime's worth of
 10 work, so those are my comments.
 11 KENNEDY, Q.C.:
 12 Q. Mr. Karapita, could you please have some
 13 preliminary comments?
 14 MR. KARAPITA:
 15 A. Thank you. I was just going to add to the
 16 dialogue here today to give you some context
 17 for why we got involved, and I think it
 18 started when we saw the letter that the IBC
 19 had sent to MHAs last week about the review
 20 before this Board and I read it, and as I
 21 read it, it brought to mind many of the
 22 experiences that we faced in Ontario is
 23 eerily reminiscent over the last several
 24 years of what we've seen in our dealings
 25 with the Insurance Bureau of Canada, the

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1 property casualty insurance industry in
 2 general. And in the letter a number of
 3 points stood out to me because, as I say,
 4 they were similar to what we've seen, that
 5 auto insurance premiums are too high, our
 6 claims are too high relative to premiums,
 7 that real change is needed, that there is a
 8 well-meaning dialogue that is being sought
 9 with elective officials, but on that point
 10 there is a complaint about sources from
 11 outside the industry and a suggestion that –
 12 STAMP, Q.C.:
 13 Q. Excuse me, Madam Chair, if I just might
 14 inquire, do we have a copy of this letter
 15 that is being referred to?
 16 CHAIR:
 17 Q. The Board?
 18 STAMP, Q.C.:
 19 Q. Is it in the materials we have?
 20 MR. FELTHAM:
 21 Q. No, it's not in the Board record, I just
 22 made that inquiry myself.
 23 STAMP, Q.C.:
 24 Q. Okay, that's fine, go ahead, thank you.
 25 MR. KARAPITA:

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1 A. And I'll just clarify, it is a letter that
 2 the IBC sent. And as I say, it brought to
 3 mind some of the experiences that we had in
 4 Ontario and I just want to hark back to a
 5 time in 2013 when we saw something from the
 6 Ontario vice-president of the Insurance
 7 Bureau who said many of the same things. We
 8 know that the price of auto insurance is too
 9 high, consumers deserve a competitive auto
 10 insurance system. And what's significant
 11 about that quote and I truncated it
 12 somewhat, is that if the context of those
 13 remarks that came in the aftermath of some
 14 of the biggest changes to the policies, as
 15 my colleague referred to in 2010, we had the
 16 imposition of a minor injury guideline that
 17 saw benefits slashed from \$100,000 to a
 18 maximum of \$3,500. We saw those changes
 19 take effect almost immediately and
 20 typically, I know having some experience
 21 with the industry that these things, you
 22 know, a change to the policy does not
 23 necessarily always show up in data right
 24 away. Sometimes it can take a number of
 25 years, but in the case of the minor injury

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1 guideline with claims under accident
 2 benefits, those changes showed up right
 3 away, so much so that one insurance CEO from
 4 the Economical Mutual Insurance Company, at
 5 the time one of the largest companies, said,
 6 and this was barely six months into the
 7 implementation of that new product, they
 8 said, "We are starting to see the benefits
 9 of the 2010 auto insurance reforms that was
 10 combined with underwriting discipline to
 11 generate stronger results." And some of
 12 that underwriting discipline was a push for
 13 higher premiums from 2009 to 2012, we saw
 14 premiums increase in Ontario by some 15
 15 percent. The reductions that they saw,
 16 those benefits to the industry combined to
 17 create more than 27 percent, a 27 percent
 18 reduction in overall claims costs, not just
 19 accident benefits, first party no-fault
 20 benefits, but it was an overall benefit to
 21 the industry. Through that same time period
 22 when the IBC VP had issued that statement,
 23 we were putting out information to our own
 24 elected representatives voicing some concern
 25 about that situation, that we were seeing

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1 claims costs drop. We saw the trends
 2 towards higher premiums and yet the IBC went
 3 so far as to suggest that we were
 4 provoking myths and that they were the
 5 purveyors of fact and they alone.
 6 (1:30 p.m.)
 7 MR. KARAPITA:
 8 Q. What they did at the time too, they were
 9 warning of what they called a tsunami
 10 rolling through Ontario's auto insurance
 11 system because of unresolved legal disputes,
 12 which never came to pass. They wrote to our
 13 finance minister at the time urging concern
 14 about the term the "fragile savings" that
 15 were brought about through the 2010 reform.
 16 And it's pretty clear that the data since
 17 that time, the data initially, but the data
 18 since that time has confirmed and the data
 19 I'm talking about is the GISA data which is
 20 generated by the industry itself, but it
 21 proved that those savings were permanent and
 22 well entrenched. So it was in the context
 23 of that history that we faced in Ontario
 24 that we brought forward some concerns to our
 25 colleagues here in St. John's to talk about

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1 our own experience. It's what we saw as a
 2 pattern of the industry focussing on
 3 selected mounting claims costs, using the
 4 Ontario context, if you will, and the
 5 pattern of downplaying the insurance
 6 industry's profitability and dismissing the
 7 need, frankly, for accountability and
 8 transparency in some of that data.
 9 KENNEDY, Q.C.:
 10 Q. Okay, so if I could just ask you a couple of
 11 points of clarification, Mr. Karapita.
 12 First, I see from your background, which is
 13 attached to the letter that's been filed
 14 with the Board, that at one point did you
 15 work with the Insurance Bureau of Canada?
 16 MR. KARAPITA:
 17 A. That's correct, sir, I did.
 18 KENNEDY, Q.C.:
 19 Q. Where did you work with them and for how
 20 long?
 21 MR. KARAPITA:
 22 A. I worked for the IBC in Toronto from March
 23 1999 until January 2008.
 24 KENNEDY, Q.C.:
 25 Q. And what was your role with the Insurance

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1 Bureau of Canada?
 2 MR. KARAPITA:
 3 A. Initially I was the manager of government
 4 relations in the Ontario regional office of
 5 IBC which is part of the headquarters in
 6 Toronto, and then I moved on to the public
 7 affairs and marketing department of IBC
 8 first as an external relation or media
 9 relations manager and manager of regional
 10 issues.
 11 KENNEDY, Q.C.:
 12 Q. How long have you been with the Ontario
 13 Trial Lawyers Association?
 14 MR. KARAPITA:
 15 A. Just over eight years now.
 16 KENNEDY, Q.C.:
 17 Q. Okay, so eight years. Now, you indicated
 18 that you brought to the attention of your
 19 colleagues in St. John's, did anyone from,
 20 any lawyers in St. John's contact you or
 21 anyone on behalf of the Campaign to Protect
 22 Accident Victims?
 23 MR. KARAPITA:
 24 A. No, the initial contact was from me to Steve
 25 Marshall at the firm of -

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1 KENNEDY, Q.C.:

2 Q. Roebathan McKay Marshall.

3 MR. KARAPITA:

4 A. Thank you.

5 KENNEDY, Q.C.:

6 Q. Okay, so when did you contact Mr. Marshall

7 and how did you go about that?

8 MR. KARAPITA:

9 A. I contacted him by email and I believe it

10 was early last week.

11 KENNEDY, Q.C.:

12 Q. And what was your purpose in contacting Mr.

13 Marshall?

14 MR. KARAPITA:

15 A. My purpose was to highlight some of the

16 concerns that I saw with respect to the IBC

17 communications and interest and

18 encouragement to lawyers here and other

19 concerned parties to raise some of these

20 concerns with elected officials.

21 KENNEDY, Q.C.:

22 Q. Okay, so if we can now look at – if we can

23 go to your letter in terms of number one,

24 Mr. Wynperle, or Mr. Karapita, is there any

25 further comment you'd make on your brief

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1 review of Ontario's no fault auto insurance

2 system?

3 MR. WYNPERLE:

4 A. Well, I think that we – again what you

5 experience is, you know, a system where the

6 insurance companies have us on a – really on

7 a carousel of amendments; if at first you

8 don't succeed, try, try, try, try again, and

9 continue to amend the legislation. Each

10 amendment really taking away rights of

11 injured victims, and also costing all

12 parties a significant amount of money to

13 then figure out how to implement these

14 systems without, I should say, real

15 verifiable audited financial statements from

16 the insurance companies to prove the need

17 for either reduction in the policy rights of

18 individuals or to increase premiums either

19 way. That has never been provided in

20 Ontario. The insurers can get increases in

21 premiums. They do not have to provide line

22 item statements to the regulator or to the

23 public, and nor do they have to when they

24 ask for reductions in the policy.

25 KENNEDY, Q.C.:

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1 Q. If we could then move to number two, the

2 need for greater transparency and

3 accountability from the property and

4 casualty insurance sector on the performance

5 of auto insurance companies in Canada, with

6 examples from Ontario, would either of you

7 like to speak to that, please?

8 MR. WYNPERLE:

9 A. Well, I think that's what I was just talking

10 about, it's just that we believe that

11 because every motorist in Ontario, and I

12 presume here as well, is required to carry

13 auto insurance when they drive a car, and

14 that's become a fact of life that most

15 people have to drive in order to get to work

16 and get around. You know, the insurance

17 companies are in a privileged position, and

18 as such with privileges come

19 responsibilities, and we believe that one of

20 those responsibilities should be fair

21 disclosure of information so that everybody

22 can see real evidence of the need for the

23 changes before we go and make all these

24 changes.

25 MR. KARAPITA:

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1 A. A further point to add to that, insurers

2 reports financial data on a global basis

3 across the country, and they'll do that to

4 the federal regulator, the office of the

5 Superintendent of Financial Institutions.

6 They do not break down specific information

7 by line of business, auto insurance, for

8 example, in Newfoundland and Labrador. So

9 that we do not have access to detailed

10 information, apart from the claims

11 information that we might see with GISA, but

12 that's the issue, and one further point that

13 I'll just add as part of that background,

14 IBC used to release that global financial

15 data and I believe it was when I was there

16 12 or 13 years ago, they stopped releasing

17 even the publicly available data. It is

18 available, but it's kind of tricky to find.

19 You have to navigate the site at OSFI and

20 understand how to combine the numbers.

21 KENNEDY, Q.C.:

22 Q. Number three refers to a review of the

23 profitability of insurers with examples from

24 a York economics professor, Fred Lazar. Do

25 either of you want to comment on that,

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1 please?

2 MR. KARAPITA:

3 A. Yeah, I'll just comment on that briefly.

4 Following that period in 2012 or so, the

5 latest analysis by Dr. Lazar from York

6 University shows that profitability in

7 Ontario auto increased dramatically, some 60

8 percent to 1.5 billion dollars in 2016, or a

9 return on –

10 KENNEDY, Q.C.:

11 Q. Sorry, how much – what was that, sir?

12 MR. KARAPITA:

13 A. 1.5 billion dollars in Ontario auto premium

14 or auto insurance alone, and that represents

15 16 percent return on equity for the entire

16 industry in Ontario.

17 KENNEDY, Q.C.:

18 Q. What year was that, Mr. Karapita?

19 MR. KARAPITA:

20 A. 2016.

21 KENNEDY, Q.C.:

22 Q. Sorry. Continue, sir.

23 MR. KARAPITA:

24 A. What he also suggested - because Dr. Lazar

25 and his colleagues some years previously had

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1 reviewed for the Ontario government the

2 profitability benchmark that companies would

3 be allowed to shoot for as part of their

4 underwriting criteria for setting premiums

5 and rates, and he did that review, and as

6 part of our analysis, he has suggested that

7 what they ought to have done was settled on

8 a rolling ten year average to see the

9 profitability benchmark move more quickly

10 than it has over time. He suggests, based

11 on his analysis and economic considerations,

12 that again going back to that 2016 year,

13 that where the industry earned 16 percent,

14 according to his calculation he feels that

15 the benchmark should have been no more than

16 5.1 percent return on equity for the

17 industry.

18 KENNEDY, Q.C.:

19 Q. Mr. Wynperle, and Mr. Karapita, has there

20 ever been in your experience a time when the

21 insurance industry or IBC, on behalf of the

22 insurance industry, has claimed to be losing

23 money in the automobile insurance industry?

24 MR. WYNPERLE:

25 A. Quite regularly they are claiming that the

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1 product is either losing money or just not

2 sustainable as it exists in its form at that

3 time.

4 MR. KARAPITA:

5 A. It's often the challenge of getting

6 information on that because while they can

7 sometimes and frequently claim to be losing

8 money, they seldom admit to making money.

9 KENNEDY, Q.C.:

10 Q. In terms of number four, and we can get some

11 further examples from Dr. Lazar tomorrow,

12 number four, perhaps if either of you would

13 like to speak to the pertinent examples from

14 recent Ontario history where insurers have

15 promised better and more responsive

16 coverage?

17 MR. WYNPERLE:

18 A. Well, I think one of the examples I already

19 spoke about today was the minor injury

20 guideline, which is that type of, you know,

21 sort of canned treatment, if you will, that

22 starts off the process and how it's really

23 used in the province of Ontario is to try

24 and cap out injured people from taking more

25 than \$3,500.00 in treatment. So you

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1 essentially have to get – you have to get

2 beyond the minor injury guideline, and they

3 restrict you significantly in how you do

4 that, and as I said, that has come at a

5 serious cost for the defence, the

6 plaintiffs, and the system itself, the

7 government run system is at an expense, the

8 dispute resolution system. You know, it

9 costs a lot of money to do that.

10 KENNEDY, Q.C.:

11 Q. And of you mentioned earlier that at one

12 point there were medical benefits of

13 \$100,000.00, reduced to \$3,500.00?

14 MR. WYNPERLE:

15 A. Prior to September of 2010, every Ontario

16 resident injured in a motor vehicle

17 accident, or every person injured in Ontario

18 in a motor vehicle accident, would get up to

19 \$100,000.00 in medical and rehabilitation

20 benefits, so long as the treatment was

21 reasonable and necessary and related to the

22 injury. In 2010 that changed and that minor

23 injury guideline was brought in, and I would

24 estimate that probably 75 to 85 percent of

25 people injured in accidents get caught in

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1 that minor injury guideline. Now a number
 2 of them eventually get out of the minor
 3 injury guideline with the help of legal
 4 counsel, but that is a long difficult
 5 process and a costly one, unfortunately.
 6 KENNEDY, Q.C.:
 7 Q. So when did it go down to \$3,500.00?
 8 MR. WYNPERLE:
 9 A. 2010, September.
 10 KENNEDY, Q.C.:
 11 Q. And so do you know – in terms of the
 12 profitability of the insurers, you’re saying
 13 Dr. Lazar says 1.5 million in 2016.
 14 MR. WYNPERLE:
 15 A. Billion.
 16 KENNEDY, Q.C.:
 17 Q. Do you know if they made money in other
 18 years between 2010 and 2016?
 19 (1:45 p.m.)
 20 MR. WYNPERLE:
 21 A. Well, we believe that they are making money
 22 in Ontario, although that’s always in
 23 serious question, and the issue in Ontario
 24 has been to try and reduce premiums. There
 25 has been a big push on to reduce premiums

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1 because, as I said earlier, we have the
 2 unenviable position of having the most
 3 expensive premiums, and, unfortunately,
 4 despite all of these changes, that has not
 5 happened, and so the money really has to be
 6 going somewhere.
 7 KENNEDY, Q.C.:
 8 Q. When were the – this threshold, this verbal
 9 threshold, when was this system brought in
 10 in Ontario?
 11 MR. WYNPERLE:
 12 Q. It was first brought in in 1990 in a
 13 different form, but the present form of
 14 verbal threshold where you have to prove
 15 serious and permanent injuries to get any
 16 pain and suffering damages, and by the way,
 17 any future cost of care damages as well, was
 18 in its present form brought in in 1996,
 19 November, ’96.
 20 KENNEDY, Q.C.:
 21 Q. Mr. Karapita, is there anything you want to
 22 add on number four?
 23 MR. KARAPITA:
 24 A. No, sir.
 25 KENNEDY, Q.C.:

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1 Q. And number five, have you already spoke
 2 about that, Mr. Wynperle, in terms of the
 3 offloading of services from the insurance
 4 system to the public health care system?
 5 MR. WYNPERLE:
 6 A. Thank you. I believe that my comment about
 7 the Auditor General’s Report, the Auditor
 8 General has reported on this issue twice now
 9 in Ontario, not recently, but I believe the
 10 last time was 2014, and it should be a
 11 significant concern for all taxpayers that
 12 the insurance industry is under funding the
 13 health care system significantly.
 14 KENNEDY, Q.C.:
 15 Q. And number six, need for a more thorough
 16 review of insurer operations, especially
 17 with regard to insurance expenses and
 18 efficiencies, would either of you like to
 19 comment on that, please?
 20 MR. WYNPERLE:
 21 A. I don’t know that there’s any more I can add
 22 on that.
 23 MR. KARAPITA:
 24 A. I’d just add that one of the points that Dr.
 25 Lazar raised was the current expense ratio

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1 of 25 percent allowable in Ontario is
 2 something that’s probably not been looked at
 3 for a long time, and as he said, I believe,
 4 in his report, it’s quite likely that
 5 companies have worked and achieved greater
 6 efficiencies and are, in fact, hitting below
 7 that number and, therefore, deriving further
 8 profit as a result.
 9 KENNEDY, Q.C.:
 10 Q. My last question for you at this point, and
 11 again it reiterates the comment that Mr.
 12 Stamp put to Dr. Misik in terms of why are
 13 you here today, I know you’ve explained
 14 that, Mr. Karapita, in your introductory
 15 comments, but could either one of you
 16 elaborate on why the Ontario Lawyers
 17 Association, the two of you, have taken time
 18 out of your busy schedules to come to and
 19 appear before the PUB here in Newfoundland
 20 and Labrador?
 21 MR. WYNPERLE:
 22 A. Well, we believe that all Canadians who in
 23 their provinces have private insurance, auto
 24 insurance systems, are facing the same
 25 problems. The insurance companies are

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1 complaining and are concerned, and are
 2 putting political pressure on elected
 3 officials because they believe the product
 4 is not profitable, but at the same time we
 5 all face the same difficulty in that we do
 6 not have the necessary financial data,
 7 audited verifiable financial information, in
 8 order to allow us to make decisions. Not
 9 just politicians, but all stakeholders
 10 within the industry, should have that
 11 information available before any decisions
 12 are made, and we see an ongoing miscarriage
 13 in the way things are being done in our
 14 province, and we hope to help show you some
 15 of the pitfalls that we have faced in order
 16 that you not face those as well.
 17 KENNEDY, Q.C.:
 18 Q. Before I get to you, Mr. Karapita, has there
 19 ever been any – one of the suggestions made
 20 here to counsel for APTLA was that there
 21 was, I don't know if hiding of reserves, but
 22 they would overestimate reserves in one year
 23 to show a loss in another year. Have you
 24 encountered anything like that in Ontario?
 25 MR. WYNPERLE:

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1 A. We have experienced some situations, for
 2 example, with respect to bodily injury cost
 3 four or five years ago where the initial
 4 estimates in the GISA data showed a dramatic
 5 increase in both the number and the cost per
 6 insured vehicle, and the seriousness of that
 7 was borne out because that information made
 8 its way into the legislated review of the
 9 product, and, therefore, some conclusions
 10 that were reached by the regulator with
 11 respect to those costs that they were, in
 12 fact, seriously high and out of control, and
 13 those trends if they existed at all
 14 initially and showed up in that data, they
 15 were not borne out by the data in subsequent
 16 years. What was even more concerning,
 17 however, was that even though that trend
 18 towards higher costs turned out to be not
 19 correct, the information that was initially
 20 passed along was even included in much more
 21 recent reviews of the product, and I'm
 22 speaking of the review by David Marshall in
 23 Ontario just last year, where he cited the
 24 same information, the out of date now, out
 25 of date information from 2014. So we've

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1 seen the effect on the policy decisions when
 2 incorrect data isn't corrected.
 3 KENNEDY, Q.C.:
 4 Q. My last point, is there anything you want to
 5 add, Mr. Karapita, on why you're here today,
 6 that you haven't already said?
 7 MR. KARAPITA:
 8 A. No, sir.
 9 KENNEDY, Q.C.:
 10 Q. Good. So those would be my questions, Madam
 11 Chair.
 12 CHAIR:
 13 Q. Thank you, Mr. Kennedy. Mr. Gittens?
 14 GITTENS, Q.C.:
 15 Q. APTLA waives any questions. Thank you.
 16 CHAIR:
 17 Q. Thank you, Mr. Gittens. Mr. Fraize?
 18 FRAIZE, Q.C.:
 19 Q. No questions.
 20 STAMP, Q.C.:
 21 Q. I have some questions. Thank you.
 22 CHAIR:
 23 Q. Okay.
 24 STAMP, Q.C.:
 25 Q. Mr. Karapita, first of all, if I can just

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1 ask you: the position you had with IBC, was
 2 that a communications position?
 3 MR. KARAPITA:
 4 A. Not initially, no. It was a government
 5 relations or lobbying.
 6 STAMP, Q.C.:
 7 Q. What does that mean?
 8 MR. KARAPITA:
 9 A. Government relations?
 10 STAMP, Q.C.:
 11 Q. Yeah, what does it mean?
 12 MR. KARAPITA:
 13 A. That means primarily a role facilitating
 14 contact with elected officials.
 15 STAMP, Q.C.:
 16 Q. So, you're not an actuary?
 17 MR. KARAPITA:
 18 A. I'm not, sir.
 19 STAMP, Q.C.:
 20 Q. You're not an economist?
 21 MR. KARAPITA:
 22 A. No, sir.
 23 STAMP, Q.C.:
 24 Q. And when you talk about the GISA data being
 25 unreliable or incorrect, you're relying on

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1 someone else’s opinion to say that that’s
 2 the case?
 3 MR. KARAPITA:
 4 A. Not entirely, no. I’m relying on the
 5 observations that I made based on an
 6 understanding of GISA data and an
 7 understanding that I think probably compares
 8 well with several in the industry, perhaps
 9 not as advanced as an actuary, but the
 10 trends were clear. They were well
 11 established. I saw numbers that in one year
 12 were significantly higher than in subsequent
 13 years as a result of the development of
 14 data. And I think it takes that
 15 understanding of how industry data does
 16 develop over time. It’s not like a
 17 financial report where you see a number
 18 issued by XYZ company in their financial
 19 statements and it’s like that for all time.
 20 We know that insurance data does develop.
 21 And as a result of that understanding, we
 22 saw changes in bodily injury -
 23 STAMP, Q.C.:
 24 Q. Who’s “we saw”? Who’s we?
 25 MR. KARAPITA:

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1 A. Well, I think our association, but I saw it.
 2 STAMP, Q.C.:
 3 Q. You saw it. So, again, you’re not an
 4 actuary. You’re not an economist. Yet
 5 you’re seeing this actuarial unfolding --
 6 this actuarial information unfolding in
 7 front of you?
 8 MR. KARAPITA:
 9 A. Let me specify that. No, I don’t think it’s
 10 actually actuarial data. These are claims
 11 trends that are well established. The
 12 numbers are – we could have a discussion,
 13 I’ll show you the numbers on the page. It’s
 14 quite obvious.
 15 STAMP, Q.C.:
 16 Q. Okay. You’re asserting that you’ve studied
 17 these documents and you’re coming here to
 18 this Board and telling them that you’re
 19 satisfied that the GISA data shows that the
 20 – that GISA data is incorrect. That’s what
 21 you’re saying?
 22 MR. KARAPITA:
 23 A. I’m suggesting that the GISA that was
 24 represented in a report issued by David
 25 Marshall in April 2016 parroted the data

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1 that appeared four years previously and that
 2 report by David Marshall was prepared in
 3 association with our Ministry of Finance and
 4 our regulator and yes, I maintain, based on
 5 the clear numbers on the page, which I think
 6 are readily understandable by people with
 7 some understanding and some orientation to
 8 that data, as incorrect.
 9 STAMP, Q.C.:
 10 Q. You talk about this incorrect data and yet
 11 the data that GISA generates is generated
 12 strictly for the rate regulators across the
 13 country. They tell GISA what to generate.
 14 GISA generates the data. How does it
 15 possibly make sense that the rate regulators
 16 across the country and the regulators
 17 generally, the Superintendents of Insurance
 18 and so on, don’t know what they’re doing and
 19 you do know?
 20 MR. KARAPITA:
 21 A. I think that’s an unusual characterization
 22 of what I said. I think what I’m getting at
 23 is that I have faith in the GISA data. I
 24 understand how the GISA data works and it’s
 25 on the basis of the reputation of GISA that

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1 I concluded that there were changes in the
 2 accident years 2013 and 2012, 2013 and 2014
 3 and that the revisions that showed up in the
 4 GISA data upon which, you know, I’ve made my
 5 statements that the previous data, which may
 6 have been correct at the time that it was
 7 initially compiled, could no longer be seen
 8 as correct because it was changed by GISA
 9 itself.
 10 MR. WYNPERLE:
 11 A. And just to continue that thought, the
 12 problem is people who are assessing the need
 13 for change in the government, some of them,
 14 are still using the out of date GISA data,
 15 not the updated GISA data, in order to
 16 justify decisions which are being made.
 17 That’s the comment.
 18 STAMP, Q.C.:
 19 Q. Mr. Perland – I’m sorry, Wynperle
 20 MR. WYNPERLE:
 21 A. Yeah.
 22 STAMP, Q.C.:
 23 Q. Is it Wynperle, I’m sorry?
 24 MR. WYNPERLE:
 25 A. Yeah, that’s fine.

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1 STAMP, Q.C.:

2 Q. One of the things you spoke about was this

3 downloading of insurance costs to the public

4 system.

5 MR. WYNPERLE:

6 A. Yes.

7 STAMP, Q.C.:

8 Q. Why would that happen when the Minister of

9 Finance or whichever minister is responsible

10 for it can apply a levy against the

11 insurance companies to recover the

12 downloaded costs?

13 MR. WYNPERLE:

14 A. Well, that's a great question and I suspect

15 that you would have to ask the governments

16 of the day why they would tolerate that.

17 All I can really speak to is what the

18 Auditor General of Ontario has said, which

19 is that the governments are not collecting

20 an amount of money in the levy which is

21 commensurate with the cost on the system and

22 it's shortchanging what we call OHIP, the

23 Ontario health area system, by hundreds of

24 millions of dollars a year and it's a real

25 problem that's being pointed out. But, no

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1 government has taken up the torch, so I

2 can't speak to that.

3 STAMP, Q.C.:

4 Q. And can you speak to the fact that the levy

5 is placed in Newfoundland every year? It

6 varies every year based on the calculations

7 that are done by the appropriate officials?

8 MR. WYNPERLE:

9 A. I don't want to make any comment about the

10 levy in Newfoundland. I don't know anything

11 about that. But what I do know is that –

12 again, just speaking about the Ontario

13 system, that changes to the system have

14 caused increasing downloading, not only by

15 the way on the health care system, but on

16 the social services system and that that

17 will continue to be the case. And taxpayers

18 ought to be aware of that risk and I

19 certainly commend your legislature to

20 protect taxpayers against that risk. And if

21 they're doing that then that's great.

22 STAMP, Q.C.:

23 Q. And you have no reason to believe that in

24 Newfoundland it's not being done?

25 MR. WYNPERLE:

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1 A. Absolutely not, sir. I cannot speak to the

2 Newfoundland experience. That's not my area

3 of knowledge.

4 STAMP, Q.C.:

5 Q. Now, one of the areas, Mr. Wynperle, that

6 you spoke about was this issue of getting

7 your clients, others I guess, get their

8 clients out of the – what do you -

9 MR. WYNPERLE:

10 A. Minor injury guidelines.

11 STAMP, Q.C.:

12 Q. Minor injury guideline. And I understand

13 your firm has published an article on that

14 very point.

15 MR. WYNPERLE:

16 A. Okay. It may be so. It may be so.

17 STAMP, Q.C.:

18 Q. Well, I'm looking at an article published by

19 your firm April 3rd, 2018. So, it's just –

20 it's not very old.

21 MR. WYNPERLE:

22 A. Okay.

23 STAMP, Q.C.:

24 Q. “There are three readily accessible methods

25 for removing an injured person from the

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1 MIG.”

2 MR. WYNPERLE:

3 A. Yes.

4 STAMP, Q.C.:

5 Q. Psychological or psychiatric impairment.

6 MR. WYNPERLE:

7 A. Yes, related to the accident.

8 STAMP, Q.C.:

9 Q. Chronic pain.

10 MR. WYNPERLE:

11 A. Yes.

12 STAMP, Q.C.:

13 Q. Pre-existing condition. And then you go on

14 to explain what to do about having these

15 issues canvassed and, I guess, pushed

16 forward so to try and make sure that a

17 client comes out.

18 MR. WYNPERLE:

19 A. Right. So, in Ontario, what happens is if

20 you get to the end of the minor injury

21 guideline and the health care practitioner

22 asks for a further extension of treatment,

23 the insurer can accept that or reject it and

24 if they reject it, what's going to happen is

25 they're going to send the insured person to

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1 medical assessment. Oftentimes the medical
 2 assessment says they should be maintained
 3 within the minor injury guideline. Then the
 4 insured person has to dispute that if they
 5 want further treatment paid by the insurance
 6 company. Either that or they have to go
 7 without treatment or they have to pay for it
 8 out of their own pocket because it's not
 9 covered elsewhere.

10 STAMP, Q.C.:

11 Q. Or, as you say, they are determined to be
 12 outside the guideline?
 13 (2:00 p.m.)

14 MR. WYNPERLE:

15 A. Well, right. The insurance company has that
 16 option, but oftentimes what has to happen is
 17 the insured person, through help by legal
 18 counsel, has to mount medical evidence to
 19 prove that. And unfortunately, we've had
 20 amendments to the process of how disputes
 21 work in Ontario. So that if an injured
 22 person has such a dispute with their
 23 insurance company and is found to actually
 24 be properly outside the minor injury
 25 guideline and incurred cost, not just from a

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1 lawyer but for medical people to write
 2 reports and so on and so forth, none of that
 3 is recoverable in Ontario in the accident
 4 benefits system any longer.

5 That is a further change that the
 6 insurance industry really wanted. They were
 7 very unhappy with the previous dispute
 8 resolution system and they asked for changes
 9 and they received changes which have
 10 essentially led us to a point where
 11 insurance companies, even if they were wrong
 12 in the initial decision, do not have to pay
 13 any contribution towards legal costs or
 14 disbursements, which is very problematic for
 15 injured people, a number of whom are not
 16 working.

17 STAMP, Q.C.:

18 Q. Let's just be clear though. Insurance
 19 companies don't write legislation, do they?

20 MR. WYNPERLE:

21 A. But the insurance – I can say with absolute
 22 certainty that the insurance industry
 23 advocated very strongly for that last change
 24 that I speak of with you and Justice
 25 Cunningham in a report certainly talked

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1 about these changes. But, the changes have
 2 been significant and to the benefit of
 3 insurance companies, absolutely to the
 4 benefit of insurance companies and not one
 5 benefit has come to insured individuals and
 6 injured individuals in the last eight years
 7 in the Province of Ontario. The system has
 8 gone out of whack because we are – like I
 9 said, before we're on this carousel of every
 10 couple of years there's a crisis and we're
 11 back to amending the legislation and then
 12 there's another crisis and we're back to it
 13 again and in the meantime, nine million
 14 motorists are not getting reduced premiums
 15 either. So, again, the money has to go
 16 somewhere.

17 STAMP, Q.C.:

18 Q. Well, one of the things that we have to
 19 concern ourselves on where the money goes is
 20 the kinds of costs that are lost costs in
 21 the system; how much it costs to pay claims;
 22 how much it costs to manage those claims.

23 MR. WYNPERLE:

24 A. Sure.

25 STAMP, Q.C.:

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1 Q. All that's part of the process we have to
 2 deal with.

3 MR. WYNPERLE:

4 A. Yes.

5 STAMP, Q.C.:

6 Q. I want to refer you to another one of your
 7 publications, your firm's publications.
 8 This is a publication that was March 14th,
 9 2018, "Don't Post and Plead", and in this
 10 publication, you talk about a Supreme Court
 11 BC case in 2015 Tombasso and Holmes, and you
 12 point out in the publication that an
 13 argument had focused on the injuries
 14 suffered by a young woman as a result of two
 15 motor vehicle accidents, injuries that
 16 included depression, had left the claimant
 17 "scared to go outside" and in a state where
 18 she had even "stopped seeing her friends".
 19 Then the defence, you say in the
 20 publication, entered her Facebook page into
 21 evidence. 184 entries to be exact. Updated
 22 photographs, other posts showed her engaged
 23 in activities that include snowboarding,
 24 hiking, water tubing, partying with her
 25 friends. It didn't look like – to say what

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1 you say in this publication, “it sure didn’t
2 look like she was suffering”. When
3 addressing the Court, Justice Jenkins noted
4 that the statements by Ms. Tombasso are
5 simply not true. As a result, the plaintiff
6 received no damages. The judge also awarded
7 special costs against the plaintiff for her
8 ongoing effort to deceive the court. But
9 this is the part I find really interesting.
10 MR. WYNPERLE:
11 A. Okay.
12 STAMP, Q.C.:
13 Q. Your publication then goes on to say “the
14 lesson for plaintiffs, family and friends,
15 is clear. During the course of personal
16 injury litigation, avoid posting pictures on
17 social media.” So, the lesson is not that
18 don’t fabricate claims. Don’t come to Court
19 and tell lies. Don’t post information on
20 social media. Because you go down a little
21 further down and you say “by making social
22 media posts, you are essentially providing
23 opposing parties with access to evidence of
24 your daily activity. It may contradict the
25 plaintiff’s own evidence.” Now that, to me,

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1 Mr. Wynperle, is a scandalous recommendation
2 for a law firm to make.
3 MR. WYNPERLE:
4 A. Yeah, I don’t think that I wrote that
5 article. I don’t know where you got that
6 from. But in any event, here’s what I would
7 say to you. Certainly if somebody is not
8 telling the truth, then they should be dealt
9 with accordingly.
10 STAMP, Q.C.:
11 Q. Sure.
12 MR. WYNPERLE:
13 A. Absolutely. I don’t have any issue with
14 that, okay. I absolutely couldn’t agree
15 with you more. If a person is not telling
16 the truth to the court or to their doctors
17 or to their insurer, they should not be
18 proper – they should not be compensated for
19 that mistruth.
20 STAMP, Q.C.:
21 Q. And we’re in full agreement on that.
22 MR. WYNPERLE:
23 A. Okay.
24 STAMP, Q.C.:
25 Q. But what I find, as I said, the troubling

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1 piece is that the lesson your firm puts out
2 to the public, to your clients I guess as
3 well, the lesson for plaintiffs it says is
4 not to tell the truth. Don’t put the
5 damaging evidence on the social media.
6 MR. WYNPERLE:
7 A. Facebook pictures can be misconstrued, just
8 as surveillance can be misconstrued.
9 STAMP, Q.C.:
10 Q. Well, Judge Jenkins didn’t get confused by
11 it.
12 MR. WYNPERLE:
13 A. Well, again, you’re talking about a British
14 Columbia case, and like I said, I didn’t
15 write that article.
16 STAMP, Q.C.:
17 Q. I’m talking about your article.
18 KENNEDY, Q.C.:
19 Q. Perhaps the witness could be shown the
20 article? We have not been provided with
21 that in advance.
22 MR. WYNPERLE:
23 A. It’s not an article authored by myself.
24 KENNEDY, Q.C.:
25 Q. If Mr. Stamp is going to make allegations

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1 like that against other lawyers, that’s
2 pretty serious stuff.
3 STAMP, Q.C.:
4 Q. Well, Mr. Wynperle’s -
5 MR. WYNPERLE:
6 A. It’s okay. It’s not authored by me.
7 STAMP, Q.C.:
8 Q. - firm posted it.
9 MR. WYNPERLE:
10 A. It’s not something authored by me in any
11 event.
12 STAMP, Q.C.:
13 Q. Wynperle Law.
14 MR. WYNPERLE:
15 A. So, initially it was said to be authored by
16 me. It’s not -
17 MR. GITTENS:
18 Q. Madam Chair, I would interrupt simply
19 because there are times when as lawyers we
20 do despicable things because we feel we’re
21 serving our client’s interest. To suggest
22 to Mr. Wynperle that he is somehow
23 responsible for an article that someone in
24 his firm has posted and to suggest that he
25 or his firm are coaching people to lie when

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1 in fact all that is being said, from what
 2 the extraction that has been put before the
 3 Board, is that cautioning individuals who
 4 are making claims that you should not post
 5 anything on social media because it gives
 6 the opposing party opportunities to
 7 challenge you is a normal part of
 8 representing a client.
 9 I can tell this body that in our firm,
 10 we make a commitment to the client at the
 11 very start: these are things you should do.
 12 These are things you shouldn't do. You
 13 should keep receipts for everything you
 14 spend. You should keep track of when you go
 15 to psychotherapy or whatever it might be.
 16 And you should not post anything on the
 17 media – on social media. Because we know
 18 that these things can be taken and used
 19 against a client.
 20 To suggest that Mr. Wynperle is in
 21 anyway supporting perjury or anything of
 22 that sort is improper and I would ask that
 23 it be stopped.
 24 STAMP, Q.C.:
 25 Q. Madam Chair, I'm referring to publications

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1 by Wynperle Law posted, as I said, on March
 2 14th and the other on April 3rd, both 2018.
 3 I'll be happy to provide Mr. Wynperle with
 4 copies.
 5 MR. WYNPERLE:
 6 A. You can. Again, they're not – they're
 7 things – if they're posted, you know,
 8 they're not authored by me and I've
 9 explained to you, as I said, people who are
 10 not telling the truth should not be
 11 compensated. That is not the role of a
 12 lawyer to suggest otherwise.
 13 STAMP, Q.C.:
 14 Q. Can I just make sure, Mr. Wynperle -
 15 O'FLAHERTY, Q.C.:
 16 Q. So, Madam Chair -
 17 STAMP, Q.C.:
 18 Q. - you are the principal -
 19 O'FLAHERTY, Q.C.:
 20 Q. Just one second, Mr. Stamp. I'd just like
 21 to point out as hearing counsel that the
 22 witness is not under cross-examination in an
 23 adversarial hearing and we're now starting
 24 to disintegrate into a stage where we're not
 25 getting a proper transcript because people

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1 are interrupting each other.
 2 MR. WYNPERLE:
 3 A. Sorry.
 4 O'FLAHERTY, Q.C.:
 5 Q. And we do want to maintain a genuine
 6 discussion of the issues, I think. It's the
 7 mandate of the Board to do that.
 8 CHAIR:
 9 Q. And thank you, Mr. O'Flaherty. I'd like to
 10 just take that just a little bit further and
 11 the issues have to stay germane to what the
 12 Board is actually being charged to do. So,
 13 I'd just caution on that piece as well.
 14 STAMP, Q.C.:
 15 Q. Thank you, Madam Chair. I just have one
 16 last question for Mr. Wynperle.
 17 CHAIR:
 18 Q. Absolutely.
 19 STAMP, Q.C.:
 20 Q. Am I correct in understanding on the bio
 21 that's attached to the letter that you are
 22 the principal of Wynperle Law?
 23 MR. WYNPERLE:
 24 A. I am.
 25 STAMP, Q.C.:

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1 Q. That's what it says. I don't know if -
 2 MR. WYNPERLE:
 3 A. I am.
 4 STAMP, Q.C.:
 5 Q. Okay. So, you are the Wynperle of Wynperle
 6 Law?
 7 MR. WYNPERLE:
 8 A. There is no other. I don't think you'd find
 9 that name too often.
 10 STAMP, Q.C.:
 11 Q. Those are all my questions. Thank you, Mr.
 12 Wynperle.
 13 MR. WYNPERLE:
 14 A. Thank you.
 15 CHAIR:
 16 Q. Thank you, Mr. Stamp. Mr. Wadden.
 17 MR. WADDEN:
 18 Q. Good morning, gentlemen. My name is Andrew
 19 Wadden. I'm counsel for the Consumer
 20 Advocate. Unfortunately he had to leave a
 21 little earlier than I because we've gone
 22 beyond our time today, but I do want to say
 23 thank you very much for taking it upon
 24 yourselves to travel here.
 25 MR. WYNPERLE:

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1 A. Thank you for your indulgence.
 2 MR. WADDEN:
 3 Q. I think it's very good of you. I only have
 4 a couple of questions and the first one is
 5 just a quick point of clarification. You
 6 referenced, Mr. Wynperle, a report from a
 7 David Marshall in Ontario. Was that some
 8 sort of review of the product in Ontario?
 9 MR. WYNPERLE:
 10 A. Yeah, so it was specifically meant to be a
 11 review of the accident benefits legislation
 12 in Ontario. It did make some comments on
 13 tort reform as well, but it was largely
 14 authored for accident benefit amendments.
 15 MR. WADDEN:
 16 Q. Okay. And that's a recent report? We can
 17 access that publicly online, I suppose?
 18 MR. WYNPERLE:
 19 A. Yes.
 20 MR. WADDEN:
 21 Q. If you don't mind, let's just get back to
 22 basics here. Because I will admit to you,
 23 quite frankly, that I'm not entirely
 24 educated in the Ontario system. I know the
 25 accident benefit system is quite a different

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1 animal than the one we have here.
 2 MR. WYNPERLE:
 3 A. Yes.
 4 MR. WADDEN:
 5 Q. So, let's - to put everything in context for
 6 the Board, the participants and any member
 7 of the public who may want to review what's
 8 gone on here during these hearings, let's
 9 just look at what happens when you have an
 10 accident in Ontario.
 11 MR. WYNPERLE:
 12 A. Yes.
 13 MR. WADDEN:
 14 Q. So, you know, someone is rear-ended.
 15 There's no question of liability.
 16 MR. WYNPERLE:
 17 A. Yes.
 18 MR. WADDEN:
 19 Q. What do they do then? I know what they do
 20 here. What happens in Ontario?
 21 MR. WYNPERLE:
 22 A. They would hopefully call their insurance
 23 company and report the accident shortly
 24 after the incident. You know, obviously
 25 they might seek medical treatment before

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1 that, but in terms of the claims process,
 2 they would report to their insurance
 3 company. They would get an application for
 4 accident benefits, and I would say that even
 5 before the accident benefits claims forms
 6 are completed, an insurance company will
 7 usually agree to allow an injured person to
 8 start the treatment under the Minor Injury
 9 Guidelines. So, that treatment, as the
 10 witness said earlier today, that Minor
 11 Injury Guideline treatment does happen
 12 quickly usually if the person seeks out, you
 13 know, a chiropractor, massage, you know
 14 physiotherapy type treatment.
 15 MR. WADDEN:
 16 Q. Okay. And the MIG, the Minor Injury
 17 Guidelines relate solely to accident
 18 benefits and availing of those benefits?
 19 Correct?
 20 MR. WYNPERLE:
 21 A. Yes. Sorry if that wasn't clear. I
 22 apologize.
 23 MR. WADDEN:
 24 Q. No, no, that's fine. Thank you.
 25 MR. WYNPERLE:

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1 A. Yes.
 2 MR. WADDEN:
 3 Q. Now, here, as I'm sure you know, aside from
 4 availing of accident benefits, Section B
 5 benefits, people also sue for pain and
 6 suffering, loss of income, et cetera.
 7 MR. WYNPERLE:
 8 A. Right.
 9 MR. WADDEN:
 10 Q. Is that option not available or is available
 11 to a much more limited extent in Ontario?
 12 Explain that.
 13 MR. WYNPERLE:
 14 A. Must more limited extent. So, it depends on
 15 your situation that you found yourself in
 16 before the accident, but again, pain and
 17 suffering damages and cost of care damages,
 18 health care cost of care are only payable if
 19 the injuries related to the accident are
 20 both serious and permanent. And so, that's
 21 the restriction, and then assuming that you
 22 meet that criteria, you can make the claims,
 23 but on pain and suffering damages, there is
 24 an additional deductible which now stands at
 25 \$38,000. It's indexed to inflation. So,

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1 any claim for pain and suffering under
 2 \$125,000 is subject to that deductible. In
 3 fairness people with, for example, a spinal
 4 cord injury would not be subject to that
 5 same deductible.
 6 MR. WADDEN:
 7 Q. Right.
 8 MR. WYNPERLE:
 9 A. So, it vanishes after \$125,000, but anyone
 10 with chronic pain essentially would be
 11 captured within that—with that 38-thousand-
 12 dollar deductible.
 13 MR. WADDEN:
 14 Q. Okay. So, is it fair to say then for the
 15 most part in Ontario, people with soft-
 16 tissue injuries end up not claiming for or
 17 do not get anything for pain and suffering?
 18 MR. WYNPERLE:
 19 A. Well, they get a limited recovery often
 20 times, and as the deductible goes up each
 21 year, more and more people are excluded. I
 22 said earlier to the Board, I really think
 23 that senior citizens have been--you know,
 24 somebody used the words “fall through the
 25 cracks” earlier today. Well, senior

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1 citizens as a group have fallen through the
 2 cracks in a big way in the Ontario system
 3 because if you do not—if you have chronic
 4 pain as a senior citizen related to an
 5 accident, and maybe your pain and suffering
 6 damages are worth \$75,000 or \$85,000 on a
 7 full value assessment, I have to tell you
 8 that \$38,000 of that is coming right off the
 9 top and going back to the at-fault insurance
 10 company because that’s the way the system is
 11 run in Ontario. And that often times, I’m
 12 telling them that their award gets cut in
 13 half for that very reason. So, it’s very
 14 difficult. And as you can imagine, the
 15 system of litigation is expensive. So, you
 16 know, if the damages aren’t of a reasonable
 17 value, they might not seek to claim anything
 18 because it might not be a risk they’re
 19 prepared to take, and you know, that’s my
 20 experience.
 21 MR. WADDEN:
 22 Q. I think you indicated the Minor Injury
 23 Guidelines came into effect September of
 24 2010?
 25 MR. WYNPERLE:

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1 A. Yes.
 2 MR. WADDEN:
 3 Q. In terms of accident benefits?
 4 MR. WYNPERLE:
 5 A. Yes.
 6 MR. WADDEN:
 7 Q. These other reforms I suppose in terms of
 8 the deductible, did those also come into
 9 effect in 2010?
 10 (2:15 p.m.)
 11 MR. WYNPERLE:
 12 A. Well, the deductible has been this every-
 13 increasing sort of snowball rolling down the
 14 hill. It started originally in 1994 at
 15 \$10,000 and then in ’96 it was changed to
 16 15, and then I’m going to say in 2003 it
 17 became 30, and now in the last two years
 18 it’s on this indexation. So, again, it’s at
 19 38 this year, and next year it will probably
 20 be 40 or something like that. You know, and
 21 so we go.
 22 MR. WADDEN:
 23 Q. Okay. So, the deductible has steadily
 24 increased over the –
 25 MR. WYNPERLE:

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1 A. Oh, it is increasing, yes.
 2 MR. WADDEN:
 3 Q. Okay. We don’t have the data in front of us
 4 to speak to this specifically, but can you
 5 tell me anecdotally in terms of auto
 6 premiums in Ontario, what’s been going on
 7 the past 10 to 15 years? Have they gone up?
 8 Have they gone down? Have they maintained?
 9 What’s the story?
 10 MR. WYNPERLE:
 11 A. Well, over 10 or 15 years there’s no doubt
 12 auto premiums have gone up significantly,
 13 but you know, since some of these reforms in
 14 two thousand and—I think starting in 2013
 15 the government went on a real campaign of
 16 trying to reduce premiums. There was a goal
 17 set of reducing premiums by 15 percent. It
 18 was a well-recognized statement of policy
 19 that the government made in Ontario. And
 20 so, a lot of cuts which have occurred
 21 recently have been towards achieving that
 22 goal for motorists in Ontario. And
 23 initially there were some decreases in
 24 premium costs, but just as examples, I mean
 25 I believe Intact last year received a five

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1 percent premium increase. I believe Sonnet
 2 Insurance which is an online insurer that is
 3 part of Economical Group got a ten percent
 4 increase. And these are significant
 5 insurers in the province of Ontario. These
 6 are not—you know, Intact is probably the
 7 biggest insurance company in the Province of
 8 Ontario. So, would say that once again
 9 despite these cuts, we're seeing this trend
 10 back to rising premiums, and you know, it's
 11 a problem. And I think already what that's
 12 caused is that, you know, many in the
 13 insurance industry are already calling, you
 14 know, upon a new government who has just
 15 taken over in the summer to make further
 16 cuts, probably to the accident benefit
 17 system in order to achieve more savings.
 18 MR. WADDEN:
 19 Q. The definition that's used in terms of how
 20 it's determined how people are able to
 21 achieve pain and suffering awards, you know,
 22 in terms of somebody not being subject to
 23 that 38-thousand-dollar deductible, has that
 24 definition changed much over the years? Has
 25 it been edited?

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1 MR. WYNPERLE:
 2 A. The application of—if you're saying the
 3 threshold, what we call the threshold
 4 definition –
 5 MR. WADDEN:
 6 Q. Yes, thank you.
 7 MR. WYNPERLE:
 8 A. - which is the definition which requires the
 9 injury to be serious and permanent –
 10 MR. WADDEN:
 11 Q. Yes.
 12 MR. WYNPERLE:
 13 A. - the definition has changed over the years
 14 actually. And the government, and I'm
 15 trying to remember what year it was now,
 16 brought in a regulation. I believe it was
 17 after 2010, but I could stand to be
 18 corrected on that, brought in a regulation
 19 clarifying, if I can use that term, this
 20 issue of serious and permanent. So, it gave
 21 further definition to what is considered
 22 serious. And again, if you're—if you were
 23 working before the accident and you're not
 24 after, that would generally be considered
 25 serious, but it's much harder to, you know,

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1 crystalize that definition when it comes to
 2 senior citizens. So, again senior citizens
 3 because they weren't working before the
 4 accident, it's much harder to have a clear
 5 yes, you would qualify, or no, you wouldn't.
 6 It's much greyer, no pun intended, in the
 7 case of senior citizens as to whether they
 8 will get over that serious and permanent
 9 threshold, much more difficult to assess as
 10 lawyers, and that doubt creates problems. I
 11 think it's almost a sense of coercion I
 12 think for older people because they don't
 13 like to take risk. It's not something that
 14 they are comfortable generally doing.
 15 They're at a point in their life when
 16 they're on a fixed income and it's just—it's
 17 not something that they like doing. And so,
 18 if the lawyer is uncertain about whether
 19 they'll meet the definition, and get any
 20 pain and suffering damages, then seniors
 21 tend to be—tend to shy away from the system,
 22 and that happens a lot I think.
 23 MR. WADDEN:
 24 Q. Thank you. Madam Chair, I don't have any
 25 more questions. That's fine.

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1 KENNEDY, Q.C.:
 2 Q. Madam, there is one point I'd like to
 3 clarify, Madam Chair.
 4 CHAIR:
 5 Q. Yes, sure, absolutely.
 6 KENNEDY, Q.C.:
 7 Q. Mr. Wynperle, while Mr. Stamp was
 8 questioning you on that article, you started
 9 to interject and say it's not what it seemed
 10 or something like that, but I just want to
 11 read you the quote he put to you, and then
 12 read a little bit further down. What he put
 13 to you was the quote, "The lesson for
 14 plaintiffs, family and friends is clear.
 15 During the course of personal injury
 16 litigation, avoid posting pictures on social
 17 media." The concluding paragraph in the
 18 article states, "Smiling faces on a screen,
 19 contradicting updates, activities or
 20 locations that raise questions; if you post
 21 on social media, you run the risk of
 22 misinterpretation because these pictures may
 23 portray a desired appearance or a snapshot
 24 in time. Social media posts are a variable
 25 and allow for a wide margin for

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1 interpretation. This can be detrimental to
 2 your personal injury claim, making it more
 3 difficult or even impossible to reverse what
 4 now seems obvious to the viewer.” Could you
 5 explain to the Board, please, what you meant
 6 by those comments, what Mr. Stamp put to you
 7 and what I just read to you?
 8 MR. WYNPERLE:
 9 A. People who have psychological injuries are
 10 put under a tremendous amount of scrutiny
 11 because their injuries are very hard to see,
 12 and it’s—you know, most of my clients, I
 13 hope, try to get on with their life as best
 14 they can, which means interacting with their
 15 families for example, whether it’s at family
 16 occasions or whether it’s going, you know,
 17 visiting. In my area, Niagara Falls would
 18 be a popular tourist site close to home, and
 19 a smiling picture taken of someone who is
 20 claiming to be depressed or anxious
 21 certainly can be misinterpreted and can be
 22 misused in very unfortunate ways despite the
 23 fact that on all other information available
 24 the person is truly suffering and is truly
 25 having those functional restrictions that

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1 your earlier witness today talked about.
 2 And it’s just not right that that occur.
 3 And so, I don’t encourage social media. To
 4 be honest with you as a personal point I
 5 don’t. I don’t really engage in personal
 6 media. It’s not wise that you give people
 7 misimpressions. It happens all the time. I
 8 see it with my kids quite frankly, when they
 9 use social media. It happens all the time.
 10 People misinterpret that information, and in
 11 the context of a lawsuit, where you are
 12 under a magnifying glass, and you are, as an
 13 injured person under a magnifying glass,
 14 that is very hard to deal with. That’s it.
 15 KENNEDY, Q.C.:
 16 Q. That would be the only point I’d like to
 17 clarify.
 18 CHAIR:
 19 Q. Thank you, Mr. Kennedy. Any questions? And
 20 we have no questions from the Panel. Thank
 21 you, gentlemen. Have a safe –
 22 O’FLAHERTY, Q.C.:
 23 Q. Thank you for your time and thank you for
 24 staying extra-long and helping us out.
 25 CHAIR:

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1 Q. Safe travels home.
 2 O’FLAHERTY, Q.C.:
 3 Q. Thank you.
 4 CHAIR:
 5 Q. Thank you.
 6 KENNEDY, Q.C.:
 7 Q. Yes, I would also like to thank you, Madam
 8 Chair and members of the Board indulging us
 9 here today. So, thank you, and all the
 10 counsel, thank you.
 11 CHAIR:
 12 Q. We’re on again for 9:00 a.m. tomorrow and
 13 Dr. Lazar. We’ll see you in the morning.
 14 Thank you.
 15 Upon conclusion at 2:25 p.m.
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CERTIFICATE

I, Judy Moss, hereby certify that the foregoing is a true and correct transcript in the matter of the 2017 Automobile Insurance Review heard before the Board of Commissioners of Public Utilities, 120 Torbay Road, St. John’s, Newfoundland and Labrador and was transcribed by me to the best of my ability by means of a sound apparatus.

Dated at St. John’s, Newfoundland and Labrador this 12th day of September, 2018

Judy Moss

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