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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(9:00 a.m.)
CHAIR:
Q. Good morning, everybody. I think we're going right to IBC to introduce your first presenter.
STAMP, Q.C.:
Q. Yes, Madam Chair. Ms. Viivi Riis is here with us. I circulated her CV yesterday, so that should be on the system. I notice my friends next to me don't have a screen yet, so I don't know – the screen is not lit up.
CHAIR:
Q. We'll call our expert.
KENNEDY, Q.C.:
Q. That's fine.
STAMP, Q.C.:
Q. It's on.
CHAIR:
Q. Thank you.
STAMP, Q.C.:
Q. Good morning, Ms. Riis.
A. Good morning.
Q. Thank you for agreeing to come to St. John's to help us with this. First of all, I'd like, if you would, to introduce yourself

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and we're going to have you walk through your CV. It's been brought up on the screen in front of you. You may have a copy of it, in any event.
MS. RIIS:
A. Okay, thank you very much. My name is Viivi Riis. I'm a physical therapist by training, and I've been most recently working as a consultant to a variety of different parties, but to begin with my working career started in the physiotherapy field treating largely musculoskeletal injuries. I worked in private practice. I worked with the Workers Compensation Board in Ontario, now known as the Workplace Safety and Insurance Board. I also worked for several years at Sunnybrook Health Sciences Centre, and I became the supervisor of the outpatient physiotherapy department. Outpatient meaning people who were able to live at home, but could come in for treatment, and I focused primarily again on musculoskeletal injury, post-traumatic injury, and also I was the attending physiotherapist on the pain clinic there. So I've always had quite

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an interest in pain management as well. I have to apologize, I notice that there's 1986 to 1991 is missing from my CV, and I think that was a formatting error on my part. So between 1986 and 1991, I worked for a company called Therapy Supplies, and I was an educational consultant, really part of the sales force, and I essentially went around to the hospitals and health organizations to train people on the use of transcutaneous electrical nerve stimulation, functional electrical stimulation, and those kinds of modalities. In 1991 through 1993, I worked as an ADP authorizer. This is a process in Ontario where we can prescribe equipment, wheelchairs, walkers, through a government program for people who needed such equipment, and the government would fund 75 percent of the equipment if prescribed by an ADP authorizer. So I had a lot of experience in dealing with the kinds of equipment that people with a variety of disabilities and impairment have. Then in 1992, I started a business called Dynamic Rehabilitation with a partner who was also a

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physical therapist. Her particular area of interest was spinal cord injury, and, of course, my expertise was in musculoskeletal injury, and we started to offer health care services to people after motor vehicle collisions who were waiting to get publicly funded therapy. So even at that time, publicly funded treatment was available to people injured in traffic collisions, but often there was a waiting list, so we were delivering private therapy services in the home. That was an interesting time because we did a lot of work with insurance companies. We got referrals from insurers as well as from plaintiff lawyers. Insurers discovered that we were pretty comfortable with the health care system, we knew how to speak with physicians, we knew how to understand the test results, so a lot of insurers and lawyers started to use our company for case management services. That meant that we acted as navigators for injured people to work through the health care systems, and I say "systems" because in Ontario the public health system was first

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

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worked because the adjusters were responsible for this large sum of money, and they had to decide what was reasonable and necessary and what wasn't. The important piece that I always tried to reinforce was that it's not the adjuster's role to make medical decisions, but certainly they needed medical information to make good adjudication decisions. So we tried to give them information that would assist them in making good claims decisions, while not attempting to control the medical process. So I did a lot of training for insurance companies through that period.

STAMP, Q.C.:

Q. Ms. Riis, would you have any indication as to sort of what percentage of the Section B adjusters with All State, for example, it was a program involving All State, what percentage you saw or trained?

MS. RIIS:

A. My estimate would be 90 percent or more. They essentially rolled this out across the country, so we did training across the country ultimately, and through that process

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– I was trying to recall when I actually met IB, but I think it was during the process of insurance company training because I ended up being hired by other insurance companies to offer training to Section B adjusters around health care issues. We also did some training on Section A, looking particularly at brain injury and spinal cord injury issues, but I believe IBC heard about this program and then IBC actually contracted with me to develop an IBC claims manual and training program for AB adjusters, and again with IBC, I traveled across Canada; Alberta, the Atlantic Provinces, Ontario, to deliver this training to adjusters. So because Ontario had gone from a primarily tort system to a hybrid no fault in tort, there was a real adjustment for the insurance industry, and so they were trying to bring the adjusters up to speed on how to make good claims decisions around complex medical issues.

STAMP, Q.C.:

Q. When you say "AB adjusters", do you mean accident benefit adjusters?

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MS. RIIS:

A. Accident benefits adjusters, yes.

STAMP, Q.C.:

Q. And do you have any recollection of the time frame that this – I guess, this first arrangement with IBC unfolded?

MS. RIIS:

A. I think it was around 2000 when I first started to do bits and pieces of work with IBC. I know there was – I think my initial engagement was around a project they were doing with McMaster University around fibromyalgia, to try to get their heads around what is fibromyalgia, how does it result after an auto collision and so on. So I did small pieces, and then that grew to the claims manual, but I'd say it was around 2000.

STAMP, Q.C.:

Q. Okay. I'm sorry, carry on.

MS. RIIS:

A. So in the process of doing all of this education for the insurance industry, I also was able to – and it took me, I'd say, a decade. I was able to understand better how

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

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

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from Toronto to Collingwood, two hours north of Toronto, so I wasn't able to continue the policy work that I was doing. So between 2006 and 2010, I also did work for an IBC arm called Health Claims for Auto Insurance. This is an online platform where health providers submit injury claim forms electronically directly to the insurance company. The insurance company adjudicates online, and the adjudication decision is transferred back to the health provider electronically. So it sort of streamlined some of the paperwork, and so I was engaged to liaise with the health industry to help them adopt and get accustomed to using this electronic platform, and this was of great interest to me because one of my passions is the need for more data in the private health system.

(9:15 a.m.)

In the public health system since 1984, the Canadian Institute of Health Information has required publicly funded institutions to submit standard data. So that's why CIHI can print all of these reports about waiting

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

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reading. Now I'd say about a third of my work is clinical practice, homecare, physiotherapy. I'd say about a third of my work is policy consultation with IBC. The work I do with IBC has covered the provinces where private insurance is in place; Alberta, Ontario, and the Atlantic Provinces, as well as Newfoundland, and then a third of my work is also working with health professional organizations, again continuing to work with them largely in the area of auto insurance and how can you find that work easier to do, because it's still – after years of being at it, it's still challenging for the health providers, as well as the insurers to manage that system. I'm not sure if I've missed anything.

STAMP, Q.C.:

Q. No, I don't think you did. That's fine.

MS. RIIS:

A. A mixed bag of tricks really.

STAMP, Q.C.:

Q. So you're still a physiotherapist today?

MS. RIIS:

A. Yes.

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STAMP, Q.C.:

Q. You still do actual physiotherapy work yourself personally?

MS. RIIS:

A. Yes, and I've had no complaints sustained against me.

STAMP, Q.C.:

Q. And you say about a third of your work currently involves IBC – is it just IBC or insurers generally?

MS. RIIS:

A. Yeah, insurers because I have been hired by individual insurance companies to develop training programs for that company alone, so IBC and insurers would be about a third of my work. Another third would be other health professional organizations, clinics and so on, and then a third would be clinical practice in homecare.

STAMP, Q.C.:

Q. Right, okay. Now then I want to come back to your engagement. The reason you're here in the first instance, of course, I think you would have been contacted by IBC in this circumstance. Can you just outline for us

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how that evolved?

MS. RIIS:

A. So again I consult with IBC on a variety of policy issues, but certainly the topic of minor injury, and I don't like that term, and I'll speak to that, but I'm going to use it because it's the term that's in use in various provinces, but whenever the issue of minor injury cap or diagnostic and treatment protocols arise, IBC tends to consult with me. So I did understand in the spring of this year that something was going on in Newfoundland. I had understood there was a closed claims study happening, but I wasn't quite clear on what was happening, and I think it was around May that IBC shared a submission that was made to the Board, so I was able to read that submission, and they asked me my thoughts on it. Then it was in, I believe, early July that they asked me to get more involved and comment on three aspects of their submission, and these are the three areas I feel quite comfortable speaking to.

Q. So tell me about that request and how did it

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come to you to do a report that you've done and so on, and on the three –

MS. RIIS:

A. So Ryan Steyn basically approached me in July. We discussed the submission that IBC was putting forward, and whether or not I would be willing to comment on the three points that they asked me to speak on, and that's the issue of how do you define minor injuries, evidence-based treatment protocols, as well as the impact of litigation on injuries.

STAMP, Q.C.:

Q. Those are the three topics that you were asked to think about?

MS. RIIS:

A. Right.

STAMP, Q.C.:

Q. Were you given any direction, Ms. Riis, as to how your report should be prepared?

MS. RIIS:

A. No. Quite honestly, I think that my work over the – since 2004 around the topic of minor injury definitions, diagnostic and treatment protocols, I think my work has

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informed IBC submission. So in some respect, I'm sort of speaking to recommendations I have made to IBC.
STAMP, Q.C.:
Q. You may come to this in your report generally, but was there involvement that you had had also, for example, in other Atlantic region areas on the definition issue of minor injury and so on?
MS. RIIS:
A. Did I have input on that?
STAMP, Q.C.:
Q. Well, I'm just wondering if it's going to come up in your next—in your report discussion or in something we –
MS. RIIS:
A. Yes.
STAMP, Q.C.:
Q. Okay.
MS. RIIS:
A. I'll be talking about the definition of minor injury. I didn't—I wasn't actively involved in developing IBC's submission to the Board. They did that on their own and gave it to me to read after it was done, and

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I had really no major suggestions to them at that time.
STAMP, Q.C.:
Q. Mr. Stein, as you say, contacted you with a request that on three specific points –
MS. RIIS:
A. Right.
STAMP, Q.C.:
Q. - could you provide some sort of a report to IBC that they would present to this Board?
MS. RIIS:
A. Right, yes.
STAMP, Q.C.:
Q. Is that correct?
MS. RIIS:
A. That's right, and then I wrote the report and submitted it to Mr. Stein.
STAMP, Q.C.:
Q. And did Mr. Stein have any input in the content of the report?
MS. RIIS:
A. No, I –
STAMP, Q.C.:
Q. Other than to name the topics?
MS. RIIS:

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A. No, I submitted the final report to him. He did not have any input on it.
STAMP, Q.C.:
Q. Okay. So, the report that we have presented here is your report?
MS. RIIS:
A. Yes.
STAMP, Q.C.:
Q. Prepared solely by you?
MS. RIIS:
A. Yes.
STAMP, Q.C.:
Q. No input from anybody else except to identify the three topics that you've been asked to speak about?
MS. RIIS:
A. Yes, yes.
STAMP, Q.C.:
Q. Okay. After you presented the report to Mr. Stein, did you have any communication with him? Was there any criticism on his part that, you know, you've gone too far or didn't go far enough? Anything of that nature that occurred?
MS. RIIS:

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A. No, you know, I did mention to him that I may have said a couple of things that were not complementary to the insurance industry in the report, so I wanted to give him a head's up.
STAMP, Q.C.:
Q. Okay. All right, well then, perhaps if we can bring up that report. You probably have a copy anyway, Ms. Riis, but we'll bring it up on the screen.
MS. RIIS:
A. Do you want to the report or the presentation?
STAMP, Q.C.:
Q. The presentation.
MS. RIIS:
A. The presentation.
STAMP, Q.C.:
Q. Yes, or the—you need both of those. How are you going to approach this?
MS. RIIS:
A. I was just going to speak to the presentation slides.
STAMP, Q.C.:
Q. Yes, okay.

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MS. RIIS:
A. Which really speaks to the report, and then I'm happy to entertain questions about either.
STAMP, Q.C.:
Q. Sure.
MS. RIIS:
A. Okay.
KENNEDY, Q.C.:
Q. I'm just wondering, Madam Chair, has that been provided? I -
STAMP, Q.C.:
Q. Well, they were sent in here to IBC—to the PUB. I don't know where—if they've been circulated.
CHAIR:
Q. The presentation –
STAMP, Q.C.:
Q. It's just that these are charts that –
KENNEDY, Q.C.:
Q. They might just be charts, but we haven't—my understanding is we were to be provided with copies of any documents to be referred to the day before the hearing.
CHAIR:

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

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counsel because we made that mistake earlier ourselves in here.
CHAIR:
Q. Yes, I understand that. I haven't seen the slides, so I'm not sure if –
STAMP, Q.C.:
Q. I don't know when they were—I think they were passed to the PUB a couple of days ago.
MS. KEAN:
Q. It was filed with the Board on September 6th.
STAMP, Q.C.:
Q. Okay. That would be Monday, you said, right? The 6th.
CHAIR:
Q. But not copied to other counsel?
STAMP, Q.C.:
Q. Apparently not.
MS. KEAN:
Q. That was Thursday and apparently not copied, no.
STAMP, Q.C.:
Q. No.
O'FLAHERTY, Q.C.:
Q. Yes, Madam Chair, I think it's simply an oversight on—in terms of the filing of the

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document. I haven't seen the documents. As you say, they haven't been distributed among counsel. Maybe what we can do is simply they can be put on the—and we can have a look at them and see what the document is. And if it's something that Mr. Kennedy is—his client feels we need to take five minutes to look at and—or ten minutes to look at, maybe we can deal with on that basis, but as the witness has commented, they appear to be descriptive rather than text in any event. So, maybe we can just see what this is we're dealing with.
KENNEDY, Q.C.:
Q. That's fine.
CHAIR:
Q. We'll proceed.
KENNEDY, Q.C.:
Q. That's fine, yes.
CHAIR:
Q. We'll proceed and see where it goes.
MS. RIIS:
A. Thank you.
STAMP, Q.C.:
Q. So, if we can have the slides. Ms. Riis, is

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that what you prefer to see first of all? We all have a copy of the report, but we can bring the slides up. You'd like the slides brought up first?

MS. RIIS:

A. Sure.

STAMP, Q.C.:

Q. Okay.

MS. RIIS:

A. Yeah.

STAMP, Q.C.:

Q. We'll do it that way.

MS. RIIS:

A. All right, so again, thank you for allowing me to present here. I'm here because I do want to speak in support of the recommendations made by IBC related to the auto insurance system in Newfoundland and Labrador, and I'm going to speak to defining minor injuries. I'm going to say at this point that I also in my report did make a recommendation that that term not be used. It's been show in research that injured people find that it trivializes the impact of the injury on them. So, I will use the

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

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

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

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but researchers also point out that a small percentage may go on to develop prolonged disability associated with chronic conditions such as chronic pain syndromes or debilitating psychological impairments which may lead to serious impairment in the person's ability to function in their daily life, and it's for this reason, and there's no way of predicting who will or won't recover, we have to address compensation for those individuals who aren't at fault and in spite of having sought evidence-based treatment, don't recover fully. So, to address this, IBC has excluded from the definition, "Those who go on to suffer serious impairment." So, the now the question is what do we mean by "serious impairment"? So, that does need to be defined and I don't believe IBC's submission has defined it, but certainly in other provinces it's been defined using the person's ability to function at their pre-accident level.

(9:30 a.m.)

MS. RIIS:

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A. This is important because it's impossible to define disability or one's ability to function without taking into account a variety of factors. And could I have the next slide? For example, amputation of someone's non-dominate baby toe may have no effect on the ability of say a lawyer to return to their occupation, but amputation of a baby toe can derail the career or a ballerina. The injury or diagnosis does not define the disability, and for this reason I put up the World Health Organization International Classification of Functioning. And this is essentially how they identify function and ability or disability. So, the World Health Organization International Classification of Functioning conceptualizes a person's level of functioning as a dynamic interaction between his or her health conditions, environmental factors and personal factors. It is a biopsychosocial model of disability based on an integration of the social and medical models of disability. And this is a really important piece and needs to be considered when

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

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

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treatment is good, more treatment must be better. And we see this approach in conversations about Canada's public health system. Many people are simply asking for more money to be put in and more money to be put in, but when you go deeper into the discussion about Canada's health system, there is recognition that we need to structure it differently, not just put more money into it. So, I've seen many injured people because of this perception that more must be better. I've seen many injured people subjected to months and years of a variety of different treatment types including physiotherapy, chiropractic, massage therapy, naturopathy, injections and so on. Often, I see that the only reason more treatment is recommended by a health professional is because the patient is not getting better. And so, it seems like trying something different might work. And I also think that as a health professional we feel compelled to do something. So, even though I know my patient is not getting better, I feel I need to keep trying. And

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so, sometimes we sort of fall a victim to this instinct to want to be helpful even though we know it's not working, but in fact, the research on type 1 injuries shows that high levels of initial health care utilization are actually associated with poorer recovery, worse recovery from neck injuries after traffic collisions. Too many health visits, too many different care providers seem to result in poorer outcomes. So, I can't say that that's an absolute fact, but the research is pointing in that direction. So, much of the research we're reading now is recommending less treatment, not more treatment. And in fact, the sort of common intervention that's recommended for all injuries is to offer reassurance and education. So, it's important to explain to injured people who have type 1 injuries that this will not disable for life, this will heal, and you need to resume your usual activities as soon as possible. If people receive this kind of guidance, they tend not to become fearful, they tend not to withdraw from activities. I don't know if any of you

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are following the "Exercise is Medicine" piece, but the Canadian health care system has a program called Exercise is Medicine, and they've basically said if you could put exercise into a pill, 100 percent of us would be taking this pill. So, movement, activity, resuming your normal activities is the most important thing for people who have type 1 injuries, but if the injured person has pain and nobody explains to them that it's okay for them to gradually increase their activities, they tend to avoid activities which makes them weaker, which makes them less tolerant to healing and recovering from the injury. The next slide, please. So, another reason to promote evidence-based care in the form of guidelines or protocols is that it's hard for health professionals to stay current with all of the literature that's published on the variety of health conditions they treat. As a physiotherapist I treat people after traffic collisions, but I also have patients with stroke, myasthenia gravis, ALS, spinal cord injury and so on. If I

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were to stay current on all of those topics and what the best treatment is for all of those conditions, I wouldn't have any time to see patients. Evidence-based guidelines help me by summarizing what we know works and what we know doesn't work. And often they're sort of a middle ground. The guidelines often will say, "We know that this works. We're not sure about this. We're 50/50 on this intervention. So, you can try it if you think it'll work," or it will say, "This intervention is not recommended because we know it doesn't work or it impedes recovery." The guidelines also offer me protection against malpractice suits, because it lays out in general terms what good treatment looks like. So, most health professionals like working with guidelines. Guidelines are not intended to be prescriptive. They are not written to say, "You must do this. You must do that." Guidelines are written to offer a summary of the research, what research supports, what it doesn't support, where treatment is considered to be equivocal, and it also

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

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abreast of all of the current literature, we continue to practice through habit. So, for example, you know, as a physiotherapist I often will put a hot pack on somebody and if I were to read up about it, I would probably find that hot packs are not shown to be particularly effective in management of neck pain. But it's something, you know, we learn to do as an undergraduate. You've done it. It feels good to the patient, so sometimes we keep doing those treatments.

I also looked up images for whiplash treatment and I got many pictures like the one you're looking at showing somebody wearing a soft collar. But in fact, it's long been demonstrated that a soft collar in fact is detrimental to recovery from mild to moderate neck pain injuries. So, again, if you were to ask the general population what's the treatment for whiplash, I'll bet you many of them would to this day say "oh yeah, a collar is what you need after a whiplash injury". But in fact, the research shows us that we should not be prescribing collars. So, that's an example of an

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evidence-based guideline would say do not offer a collar. So that would protect me from getting a malpractice complaint. It would help me to know I shouldn't be prescribing a collar. But it would also say that yoga has been shown to be effective in some studies, not effective in other studies. So, even though it's not proven to be effective, if I think it might be suitable for an individual patient, I'd be free to prescribe that.

So, in my view, treatment should not be denied a patient if it is helping the person to recover their ability to function. But injured people shouldn't be subject to prolonged treatment that's ineffective or perhaps even harmful and Newfoundland drivers should not have to pay for ineffective or harmful treatment. So, I think that's another important piece. If ineffective treatment is being offered, it's costing everybody some money and it's not helping the patient.

And again, many of my patients are so frustrated by the system because they are

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told to continue attending treatment, even though they know it's not helping. And often I'll ask them, "well, why do you keep going to treatment if it's not helping? Well, my lawyer told me I should keep going." And I said "well, does your physiotherapist or chiropractor want you to keep going? No, they discharged me but the lawyer told me to keep going, so the physiotherapist said that's fine". And of course, as a physiotherapist, if I have a private practice, I'm happy to have patients come to me.

So, I think this prolonged and ongoing treatment is a burden primarily to the injured person. So, I think if somebody is being subjected to prolonged and repetitive treatment, it's really important that it be helping them and that it be helping them to return their ability to participate in their families, their social lives and to become a contributing member of society as well. I think those larger goals are important to consider.

STAMP, Q.C.:

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

MS. RIIS:

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

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(9:45 a.m.)

Next slide please. So, not only is it unfair to injured persons to receive ineffective treatment, it's also unfair to policyholders across the province to have to pay for ineffective treatment. So, that's in part the goal of evidence-based care. Injured persons shouldn't have to waste their time on treatment that's unlikely to help and drivers in Newfoundland should not pay increasing premiums in order to pay for treatment that doesn't work.

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

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treatment for Type 1 injuries.

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

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

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

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

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

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so to speak.

I think also that the conflict between Section B intended for recovery and Section A to compensate for pecuniary and non-pecuniary losses is confusing to many injured people. I think many injured people don't understand the difference between Section B and Section A. They often don't understand that there are two insurance companies involved. Or if the third party was insured by the same insurance company that covers Section B, they think it's all one person or one claim against the at-fault party. I think it generates a lot of difficulty for the injured person.

Also, one of the biggest problems with this hybrid systems is that if an insurance adjuster denies a claim for treatment, the patient often feels angry and they feel "this isn't fair. I should have this treatment" and that creates a sense of injustice and the sense of injustice has been shown in health care research to contribute to prolonged disability. So, this system which is somewhat adversarial I

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think actually can inhibit recovery because it creates friction between the insurance company and the injured person. So, I think that's also one of the downsides. So, one of the other recommendations I've made is to provide some more education for the general consumer, the public, as well as for the other stakeholders in the system.

Next slide. So, these are the additional points that I wanted to mention. I wasn't asked to comment on this, but I offered the information anyway to the Board. I would hope that you could be the first province in Canada not to use the term "minor injury". Type 1 injury is one suggestion. You may find something better. But I do think the term "minor injury" trivializes the impact of this injury on some people and it creates friction again. Patients have told us that, you know, "when you tell me my injury is minor, I think you don't believe me" and it forces the injured person to sort of prove that they're hurting, to prove that they're disabled and it becomes a real struggle.

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The second piece is consumer education. I think consumers need access to easy-to-understand information about navigating the system and knowing their rights. This is hard because when we buy insurance we typically don't think we're going to need it. So, we don't read up about the system until after we've been in an accident. And so, at that point, you're dealing with your injury. You're dealing with the paperwork involved in making a claim. You're dealing with getting your car fixed. And it's not a great time to be reading about the complexities of the auto insurance system. So, there needs to be education not only to consumers, but also to health care professionals, so in general there's a heightened sense of how the system works and that with Section B, you're working with your own insurance company.

And I also think stakeholder education is critical. So, everybody involved in the system, if you're going to introduce a new system, particularly the evidence-based treatment protocols and the minor injury

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cap, education and ongoing guidance during implementation can reduce a lot of conflict and delays due to this misunderstanding of the intent of the new system.

In Alberta, when we implemented in 2004, we set up a stakeholder dialogue prior to implementation and following implementation, we had a monthly teleconference with all stakeholders, including government representatives, the health professional associations. I was there for IBC. Insurers were on the call. And we talked about what's working, what's not working. When something was not working because of lack of clarity, the government had the power to issue explanatory bulletins. So, the government would issue a bulletin underscoring the intent of certain parts of the process.

That was really helpful and the system implemented quite well and insurers and health professionals had a much stronger working relationship. Prior to that, health professionals perceived insurers as the enemy of the injured person and I think that

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really improved after we had these stakeholder dialogues ongoing for several months. And that lasted for well over a year and it really helped put the system into play.

So, those are my comments and I will be happy to entertain questions.

STAMP, Q.C.:

Q. Ms. Riis, before you turn over to questions from others, I did speak to you initially at one point about the Nova Scotia, New Brunswick experience and so on. But I guess, maybe can you answer this way: how does this protocol arrangement work? I mean, a patient is injured. How does it actually work in practice? What happens?

MS. RIIS:

A. So, the scenario would be this: The collision happens. Very often people with Type 1 injuries do not feel the need to go to emergency. They don't generally call the paramedics. They might go see their family doctor. But the first thing they'd typically do, if they've been in a collision, is call their insurance company

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and let them know they've been in a collision.

And so, in say Nova Scotia or Alberta, what would happen, the insurance company is expected – I think I even – I'm not sure, but I think they're required to give the injured person guidance to seek medical attention. So, whether that's go to Emerg, go to your family doctor, go to your – you know, if you have a physiotherapist, your physiotherapist or chiropractor. And they would also tell the injured person to tell your health care professional to call us and we'll set up an arrangement so payment can happen directly to the clinic. So, when these have been implemented, one of the benefits of it is that the patient does not have to pay for the treatment and then get reimbursed by the insurer. The insurer sets up a direct pay mechanism with the health care clinic. And I think that's a huge advantage. Takes away a great deal of bureaucracy out of the process.

Because the insurance company and the treatment provider understand what the

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treatment protocol is, everybody knows what the treatment is going to look like. So, the insurer doesn't need to get a detailed explanation of what treatment are you going to do, how many times and so on. The treatment is pre-approved. So, the clinician knows they're going to get paid for the protocol treatment and the insurer knows that they're going to pay it. And so basically treatment starts.

STAMP, Q.C.:

Q. And how is it followed?

MS. RIIS:

A. So, in the guideline, there's usually the requirement for an initial assessment. That would be included as part of the guideline. And you can include reporting periods, so progress report might be required at 12 weeks. So, at the 12-week mark -- so most of the guidelines cover a 12-week period, three months post injury because three months is generally a timeline during which most of these injuries should be resolving. And at three months, the provider either discharges the patient, if the patient has done well,

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or if the patient needs additional treatment, a progress report would be submitted with a request for additional treatment to continue. And at that point, the insurance company would adjudicate based on what they understand is going on.

The health care providers, they're not very good at times in explaining to the insurance company why more treatment would help. They simply put in a request for more treatment. So, what the insurance company sees is "okay, this person has had 12 weeks of treatment. They don't seem to be any better" and sometimes health providers don't give a progress report on function to the insurer. So, the insurer thinks "well, they're no better". So, the insurance company is stuck with the situation where the patient's not getting better and now we're being asked to pay for more treatment. How do we know this more treatment is going to help? So, there's a lot of work, I think, that could be done to help the health professionals communicate more clearly with insurers and for insurers to know what

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questions to ask to understand why will this additional treatment help.

But in any case, if somebody hasn't recovered during the protocol, then they go into the traditional system where they submit a claim for further treatment, explain to the insurance adjuster why. The insurance adjuster approves or denies that treatment.

STAMP, Q.C.:

Q. So, have you had any direct involvement with say the Nova Scotia situation or New Brunswick, for example, and to see how it's worked over there?

(10:00 a.m.)

MS. RIIS:

A. I haven't been involved recently with Nova Scotia. I was involved in the initial introduction of the diagnosis treatment protocols. I was involved in the training. To be honest, I haven't heard anything good or bad in terms of what's happening in Nova Scotia. So, I'm assuming it's coasting. I don't know.

STAMP, Q.C.:

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Q. And what about Alberta, for example?

MS. RIIS:

A. Yeah. In Alberta, I continue to be involved and I think their diagnostic treatment protocols continue to work quite well. I believe the relationships between the health industry and the insurance industry are generally very good, much better than in Ontario and other provinces.

STAMP, Q.C.:

Q. Ms. Riis, thanks very much. Others will have questions for you, of course.

MS. RIIS:

A. Sure.

KENNEDY, Q.C.:

Q. Thank you, Madam Chair. I will be asking some questions on behalf of the Campaign.

O'FLAHERTY, Q.C.:

Q. Excuse me, Mr. Kennedy. Just one moment. Madam Chair, just for the sake of order for the assistance of counsel, we do have copies of the slides. I don't – I think they track the presentation. I don't know if counsel want those now or would you like to have the slides for the purposes of your questioning?

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Because we have them printed right now.

KENNEDY, Q.C.:

Q. I think what I'd prefer to do, because I want to make sure that we use our time wisely, I'll just continue with the questioning, Mr. O'Flaherty, and there's a break. There's one particular slide I want to look at. So, we could either do it now or do it then, Madam Chair, whatever you want.

CHAIR:

Q. If you – when you request it, we can do it then.

KENNEDY, Q.C.:

Q. Thank you. Ms. Riis, my name is Jerome Kennedy. I'm appearing on behalf of the Campaign to Protect Innocent Victims – Accident Victims. Ms. Riis, I'm going to refer you to report, if we could call the report up, please, at page 13. In the second paragraph there, Ms. Riis, you say that you recommend – support the recommendations made by IBC. Do you see that?

MS. RIIS:

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A. Yes.

KENNEDY, Q.C.:

Q. Okay, now one of the recommendations made by IBC is that there be a minor injury cap of $5,000 for general damages for pain and suffering, are you aware of that?

MS. RIIS:

A. I am aware of that.

KENNEDY, Q.C.:

Q. And do you support that recommendation?

MS. RIIS:

A. I am not going to comment on the amount that's being recommended, but I do support the concept of a cap. I have no objection to that.

KENNEDY, Q.C.:

Q. And why would you support the recommendation of a cap if we're dealing with implementation of protocols for evidence based treatment, what is the relationship between the two?

MS. RIIS:

A. Having worked with people with catastrophic injury, I really feel that somebody with a spinal cord—a young man with a spinal cord

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injury for the rest of his life is going to need a lot of money, shouldn't be capped, and I think the money needs to be directed towards those severe injuries. The pecuniary losses of an individual with a Type 1 injury is not going to be capped, as I understand it. This is a cap on general damages, is that correct?

KENNEDY, Q.C.:

Q. That's correct, yes, that's the IBC proposal, yes.

MS. RIIS:

A. Yeah, so it's my understanding that if somebody with a Type 1 injury requires treatment for a prolonged period of time, that that can be covered through the settlement.

KENNEDY, Q.C.:

Q. But I don't understand, I guess what I'm missing here as a healthcare provider, and you're here talking about basically accident benefits, improving the delivery of benefits, why you would have any position on the imposition of a minor injury cap?

MS. RIIS:

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A. I said I have no objection to the imposition of a cap and that's partly because of the comments I made about the effects of litigation. I think that the pain and suffering award essentially compensations for disability and so I think people who are in the position of trying to recover, but at the same time wanting to maximize the pain and suffering award, I think that puts them in an awkward situation. So I think if the pain and suffering award is capped in cases of minor injury, or Type 1 injuries, I don't think they're going to miss out on necessary treatment, on lost income. I think it's a cap on the general damages, which is different from capping future treatment.

KENNEDY, Q.C.:

Q. So this is, you're using the words "I think", "my opinion", so it's basically your subjective opinion, is that correct?

MS. RIIS:

A. Yes.

KENNEDYD, Q.C.:

Q. Okay. Now, on Monday I think it was, this is Wednesday now, on Monday we heard from

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two victims, innocent victims of motor vehicle accidents and we heard from a panel of lawyers, have you reviewed the testimony provided by these individuals?

MS. RIIS:

A. I have copies of the testimony, but I haven't reviewed all of it, I reviewed parts of it. It was quite extensive.

KENNEDY, Q.C.:

Q. So when you say you reviewed parts of it, what have you reviewed?

MS. RIIS:

A. I reviewed, I believe it was two cases of people who had Type 1 injuries who went on to suffer prolonged disability and prolonged impact on their lives.

KENNEDY, Q.C.:

Q. So if there was a cap in place, since you've given your opinion, would they be caught by the cap, in your opinion as a healthcare -

MS. RIIS:

A. According to the definition as I read it, no.

KENNEDY, Q.C.:

Q. They wouldn't.

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MS. RIIS:

A. No.

KENNEDY, Q.C.:

Q. So the woman with the whiplash, there was three, I think, one woman had been involved in three accidents, you're saying that there would be a cumulative effect of all three accidents?

MS. RIIS:

A. I don't know the case in sufficient detail, so I don't want to comment on that.

KENNEDY, Q.C.:

Q. You just commented, Ms. Riis, you said it wouldn't be caught by the cap.

MS. RIIS:

A. I don't want to comment on it because I haven't read it in detail and I'm afraid that you are going to interpret my responses as if I've read it in detail and I just haven't.

KENNEDY, Q.C.:

Q. Well you just said that –

MS. RIIS:

A. My initial impression was that I didn't think they would be caught by the cap

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because it was my impression, having not read the entire document, that they went on to suffer significant impairment.
KENNEDY, Q.C.:
Q. So wouldn't a better answer have been "I have no comment"?
MS. RIIS:
A. Thank you.
KENNEDY, Q.C.:
Q. Would that have been your better answer?
MS. RIIS:
A. Yes, thank you.
KENNEDY, Q.C.:
Q. Yeah, it would, sure. Now, in terms of the Closed Claim Study prepared by Oliver Wyman, have you reviewed that?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. So do you know how many cases were looked at in the Closed Claims Study?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. No. So when we're talking here about

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definitions and you don't like the term "minor injury", did you review the evidence of Dr. Karl Misik who testified five or six days ago, on a Friday?
MS. RIIS:
A. Again, only in part.
KENNEDY, Q.C.:
Q. Okay, and what part did you review?
MS. RIIS:
A. The first two pages.
KENNEDY, Q.C.:
Q. The first two pages of his testimony?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Dr. Misik also didn't like the term "minor injury", but for different reasons because he basically, if I can summarize, testified that the effect upon individuals can be very different and what you describe minor for one person would not be minor for a second person, do you agree with that assessment by Dr. Misik?
MS. RIIS:
A. I wouldn't use that language, but I

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

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A. No.
KENNEDY, Q.C.:
Q. No. You also state, "I have been engaged in the introduction of minor injury definitions and/or evidence based protocols in Alberta, Nova Scotia, New Brunswick and Ontario." That's correct, is it?
MS. RIIS:
A. Correct.
KENNEDY, Q.C.:
Q. And at each of these occasions you've been hired by IBC, is that correct?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay, so we know that the Nova Scotia and New Brunswick definitions came in around—or the caps came in around 2003, 2004, so your relationship –
MS. RIIS:
A. Alberta was 2004.
KENNEDY, Q.C.:
Q. Nova Scotia and New Brunswick were on 2003, 2004, weren't they? I thought Alberta was 2007?

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MS. RIIS:
A. I don't think so, I think Nova Scotia was later than that. Amanda, do you know?
KENNEDY, Q.C.:
Q. We can deal with that, I don't think—I think it's around—in 2007 there's a constitutional challenge in Nova Scotia, is that what you're talking about?
MS. RIIS:
A. Well I was involved in Nova Scotia in 2012.
KENNEDY, Q.C.:
Q. Okay, so in any event, you've been involved in four different provinces in terms of the introduction of minor injury definitions and protocols?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. In each one of those provinces, IBC was the proponent or a proponent for the cap, a minor injury cap on general damages for pain and suffering?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:

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

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you indicate that you have authored several injury reference manuals on the topic of rehabilitation for auto insurance companies, so that would have started with Allstate, would it, and then with IBC and other individual insurance companies?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay. Then in 2004 to 2010, you were a consultant for the Insurance Bureau of Canada participating as a researcher in a survey among automobile insurers to gather data pertaining to the utilization of the minor injury guideline.
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay, so we know at least until 1994 you're working in some aspect with the insurance industry, is that the first time that you had worked with the insurance industry or for the insurance industry?
MS. RIIS:
A. Apart from treating patients that were

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injured in traffic collisions, yes.
KENNEDY, Q.C.:
Q. So then in 2008, you consulted with the IBC in reparation and presentation of paper and poster at World Congress on Neck Pain, a survey—is this all the one thing, a survey examining the effect of reforms on the Alberta benefit system?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay, so in 2008 you consulted, I'm assuming you were hired as a consultant to work with IBC?
MS. RIIS:
A. Yes, yes.
KENNEDY, Q.C.:
Q. Okay, if we then go to page 2, you see expert witness at the Nova Scotia Constitutional Challenge. Now that's why I think—I thought Nova Scotia and we had a lawyer from Nova Scotia here earlier, I thought it was 2003, 2004, around then that the cap came in, in Nova Scotia, and then there was a constitutional challenge. So

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your CV indicates that you were an expert witness at the Nova Scotia Constitutional Challenge?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. And that's 2009.
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Did you testify there?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Who did you testify for as a witness? Who called you as a witness?
MS. RIIS:
A. IBC.
KENNEDY, Q.C.:
Q. IBC. When we look at the next one, Taskforce Member, May to October, 2011, you were appointed as the IBC representative to New Brunswick Minor Personal Cap Working Group by the Minister of Justice to assist in development of recommendations regarding

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definition of minor personal injury and cap. So you were the IBC representative?
MS. RIIS:
A. Correct.
KENNEDY, Q.C.:
Q. In 2013, I think this one may be referred to in your report, I think it is referred to, actually, you call it the Optima Project Expert Panel.
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. You represent IBC on an expert panel which resulted in publication enabling recovery from common traffic injuries that focus on the injured person?
MS. RIIS:
A. Correct.
KENNEDY, Q.C.:
Q. How many people were on that panel?
MS. RIIS:
A. Oh, I'd have to count, but I'd say 20 at least.
KENNEDY, Q.C.:
Q. Okay, and were there such things as voting

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members and non-voting members?
MS. RIIS:
A. Yes, and I was a non-voting member.
KENNEDY, Q.C.:
Q. Okay, how many voting members on that panel were there?
MS. RIIS:
A. I'm going to say at least 15.
KENNEDY, Q.C.:
Q. And were there other non-voting members besides yourself?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. How many of those were there?
MS. RIIS:
A. Again, I don't know what the accurate number is?
KENNEDY, Q.C.:
Q. What was the difference between a voting member and a non-voting member to the best of your understanding?
MS. RIIS:
A. A voting member was a scientist that participated in the actual scientific

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research review process that lead to the publication. The non-voting members were there to offer guidance and to establish a framework for some of the discussions. So we had a lot of researchers from around the world who didn't understand how the auto insurance system worked and the non-voting members were there to offer sort of a framework in which to consider the research.
KENNEDY, Q.C.:
Q. If you go up a little bit further then, the National Pain Strategy, December 2017 to present, as stakeholder representing the Insurance Bureau of Canada at the McMaster Health Forum. So again, you were appointed or hired by the IBC.
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Is that health forum, is that an ongoing thing, Ms. Riis?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. And if we could go to page 1 of your CV,

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please? And we talked about 1992 to 2008, 2008 to the present, so Health Service Management, that's simply your company, I'm assuming?

MS. RIIS:

A. Yes.

KENNEDY, Q.C.:

Q. Okay. The second bullet from the bottom of that one, I guess, develop training programs for insurance companies on catastrophic claims, we've talked about that, you talked about that earlier, did you?

MS. RIIS:

A. Yes.

(10:15 a.m.)

KENNEDY, Q.C.:

Q. Consulting on auto insurance issues and reform in Alberta, Nova Scotia and New Brunswick?

MS. RIIS:

A. Yes.

KENNEDY, Q.C.:

Q. Okay, and you talked about that. And then consulting with Ontario, Alberta and Nova Scotia health professional associates and

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academic groups. Who would—give me an example, please, of a health professional association?

MS. RIIS:

A. So the Ontario Physiotherapy Association; the Registered Massage Therapist Association; I spoke with the Nova Scotia Physiotherapy Association, I did presentations for them; University of Toronto; Dalhousie, so various health professional groups would invite me in to speak on the reforms and the impact on the delivery of healthcare.

KENNEDY, Q.C.:

Q. Okay. If I could now ask you to look at page 2 again, we're still on page 2, and this is where you talk about—it's the sentence after you talk about also been engaged in the introduction of minor injury definitions and/or evidence based protocols, Alberta, Nova Scotia, New Brunswick and Ontario. And you go on to say, "This has allowed me to work closely with multiple stakeholders, the general public, governments, health professional

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associations" et cetera, but then in all of these circumstances you were hired by the IBC, is that correct?

MS. RIIS:

A. Yes, I was engaged with IBC, but I was also engaged separately by some health professional associations around the same issue, but when I was engaged by, say the Ontario Physiotherapy Association or the Alberta Physiotherapy Association, they wanted me to speak to them as a physiotherapist trainer.

KENNEDY, Q.C.:

Q. When you were involved in Alberta, Nova Scotia, New Brunswick and Ontario in terms of the introduction of minor injury definitions and/or evidence based protocols, your submissions would have supported IBC's submission, is that correct?

MS. RIIS:

A. I'd like to think that IBC supports my recommendations.

KENNEDY, Q.C.:

Q. IBC are paying you, correct? You're not paying them?

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MS. RIIS:

A. That's correct.

KENNEDY, Q.C.:

Q. Yes. Have you ever been retained, for example, to question the validity of a cap or whether or not a minor injury cap should be brought in?

MS. RIIS:

A. I've been asked to consider the pros and cons of a cap, but certainly I have not written this type of a submission opposing a cap.

KENNEDY, Q.C.:

Q. Okay. We've talked about minor injuries, so I'm not going to deal with that because you are pretty clear on that, except I'm going to come back to that report that you refer to—or maybe, let's do it now. There has been a report prepared by the Newfoundland and Labrador Chiropractic Association which has been filed with the Board, have you seen that?

MS. RIIS:

A. No, I haven't.

KENNEDY, Q.C.:

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Q. Could we bring that up, please? And first I guess I should ask, since you determined that certain treatments are ineffective, do you accept that chiropractic is an effective treatment for some injuries sustained in motor vehicle accidents?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Do you accept that massage therapy is an effective treatment for injuries sustained in motor vehicle accidents?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Do you accept that physiotherapy is an appropriate treatment?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Would kinesiology or a kinesiologist be individuals or a practice which could help in the treatment of motor vehicle injuries?
MS. RIIS:
A. Yes.

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KENNEDY, Q.C.:
Q. So when you say that there are certain treatments that have been shown to be ineffective, which ones are you referring to?
MS. RIIS:
A. Soft collar, rest, avoiding usual activities.
KENNEDY, Q.C.:
Q. So you would consider those to be treatments?
MS. RIIS:
A. Yes. A treatment, a term we often use instead of treatment is "intervention", so if I sit down with my patient and speak to them about what happened to you, what's the anatomy of your injury, what is the impact of your injury, I consider that an intervention that's geared towards supporting their health.
KENNEDY, Q.C.:
Q. Okay.
MS. RIIS:
A. We can spend a lot of time talking about the literature and what works and what doesn't work. In general, passive treatments are shown to offer symptomatic relief only and tend generally not to contribute to functional recovery.

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KENNEDY, Q.C.:
Q. Okay, so let's deal with the ones that don't work. We talked about the ones you accept work, so the neck collar is one?
MS. RIIS:
A. Right.
KENNEDY, Q.C.:
Q. Rest; in other words, to rest.
MS. RIIS:
A. Basically immobility is detrimental in most cases.
KENNEDY, Q.C.:
Q. Avoiding your daily activities?
MS. RIIS:
A. Right.
KENNEDY, Q.C.:
Q. What else? Is there anything else there? Like Tylenol, you said, doesn't work for lower back pain.
MS. RIIS:
A. For low back pain.

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KENNEDY, Q.C.:
Q. Okay, anything else?
MS. RIIS:
A. I would not be able to comment right now because I would have to have it in front of me, there are so many studies that list so many different interventions that work, don't work, are equivocal, so I'm not prepared to try to make a list of them right now.
KENNEDY, Q.C.:
Q. Okay, now I'm assuming that in your work you have done for IBC and as a physiotherapist you've seen reports that have been prepared by medical doctors, by physicians?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. And oftentimes we'll see in these medical reports, "I saw the patient within days of the accident, I prescribed rest, I told the patient to rest, to avoid doing their daily activities and to take Tylenol." Common in a medical report we will see in personal injuries cases, isn't it?

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MS. RIIS:
A. That's right.
KENNEDY, Q.C.:
Q. So do you disagree with the medical profession in that respect, that they're not doing things properly?
MS. RIIS:
A. I can't comment on an individual report.
KENNEDY, Q.C.:
Q. I'm talking in general, Ms. Riis, and this is something that we can provide probably hundreds of reports where those kinds of comments are made by physicians. Do you disagree with what physicians are prescribing?
MS. RIIS:
A. I can't comment without knowing the specifics of the case.
KENNEDY, Q.C.:
Q. The neck collar which you say is an ineffective treatment, can physiotherapists prescribe a neck collar? Can they give a neck collar?
MS. RIIS:
A. Yes.

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KENNEDY, Q.C.:
Q. Okay, most often it would be the physician at first instance, is that correct? Or the emergency, the doctor in the emergency ward?
MS. RIIS:
A. I would say that most Type 1 injuries tend not to go to emergency, but if they do, then they would see a doctor. In some hospitals they have implemented physiotherapists to do the triage, so it could be a doctor or physiotherapist, depending on what programs that hospital had in place.
KENNEDY, Q.C.:
Q. So do you know what happens in Newfoundland and Labrador?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. No. So in this province if a neck collar is prescribed, it's usually done at the emergency, I would suggest to you at the emergency ward, the emergency department or in the doctor's office.
MS. RIIS:
A. Yes.

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KENNEDY, Q.C.:
Q. So do you disagree with the medical profession in terms of the prescribing of the neck collar?
MS. RIIS:
A. I can't comment on an individual case.
KENNEDY, Q.C.:
Q. But you had made general statements here that there are ineffective treatments—and I've just given you examples, you've given us examples, all of which appear to me to be areas in which the physician prescribes the kinds of things that you deem to be ineffective.
MS. RIIS:
A. I also said that evidence based guidelines are not prescriptive, they don't prohibit a health professional from prescribing a treatment that may not have support in the literature. That's why I can't comment on a specific case. I can't in general disagree.
KENNEDY, Q.C.:
Q. Okay, so now if we can go to the Chiropractic Association Report and if I could ask you to look at, the pages are not

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numbered, Ms. Riis, one, two, three, four, five—the sixth page in defining minor injury. Now, if we look at the minor injury here, you'll see that that's the term that's used in the provinces of Nova Scotia, New Brunswick, Alberta, Ontario, with some differences in terms of, I'm not sure they all have the clinically associated sequelae.
MS. RIIS:
A. Right.
KENNEDY, Q.C.:
Q. Okay. So the Chiropractic Association then goes on to talk about, they refer to this report and this is the report on which you sat on a panel as a non-voting member.
MS. RIIS:
A. Uh-hm.
KENNEDY, Q.C.:
Q. Was this a qualified panel and report, do you think?
MS. RIIS:
A. Was this a?
KENNEDY, Q.C.:
Q. The panel that looked at, that was put together to look at this, to prepare this

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report, were they qualified?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Was it a--is the report a good report in your opinion?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay, do you agree with the statement that's outlined there in the Chiropractic Report, "Having considered the narrative of persons who have experienced injuries and received care under the MIG, Minor Injury Guidelines, we have concluded that it is not appropriate to categorize either the injuries or their associated symptoms as minor injuries. In as much as they can be associated with a broad range of symptomatology and with some degree of disability for activities of daily life and work. It is our view there is no scientific rationale or merit in continuing to employ the term minor injury." Do you agree with that statement?
MS. RIIS:

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A. I do.
KENNEDY, Q.C.:
Q. Okay. Now if we go to the next page, excuse me, it starts at the bottom of the page, "Cote also acknowledges"—sorry, we have to go back to the page we were on, yeah, next page, right there, okay, up a little bit further, thank you. "Cote also acknowledges for the purpose of the development of this guideline the population of interest included injured persons with injuries commonly caused or exacerbated by a traffic collision. These are injuries that lead to a physical, mental or psychological impairment for which the scientific evidence suggests that at least 50 percent of the patients recover within six months." Do you agree with that statement?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. So that would mean that 50 percent of the patients don't recover within six months?
MS. RIIS:
A. That's what it implies, yes.

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KENNEDY, Q.C.:
Q. Do you agree with that?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay, there's a report here a little bit further down and I'll ask if you're familiar with this, it's quoted in this, "The Bone and Joint Decade Taskforce on Neck Pain and Associated Disorders suggest that most people with neck pain do not"—well, first, are you familiar with this report?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay. "Most people with neck pain do not experience a complete resolution of symptoms. Between 50 percent and 85 percent of those who experience neck pain at some initial point will report neck pain again one to five years later. These numbers appear to be similar in the general populations in workers and after motor vehicle crashes." Do you agree with that statement?

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MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Okay, so now I want to discuss very briefly the issue of the clinically associated sequelae that's part of the definition in a couple of provinces, does that relate to psychological or emotional pain or distress?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Now, would you agree with me, Ms. Riis, that the effect of motor vehicle injuries can not only be significant physical pain, but significant psychological and emotional stress?
MS. RIIS:
A. May I read an excerpt from that paper, from the Optima paper?
KENNEDY, Q.C.:
Q. Sure, if you—where are you referring to this –
MS. RIIS:
A. It's on page 4 of my report.
KENNEDY, Q.C.:

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Q. Okay.
MS. RIIS:
A. So it's the fourth paragraph in italics, starts with "Injuries resulting from traffic collisions often present as clusters of physical, mental and psychological impairments." So yes.
KENNEDY, Q.C.:
Q. Okay, because we heard from two ladies who were injured in motor vehicle accidents here on Monday and although they were very physically, the physical injuries were real, the psychological pain, the emotional stress was palpable. So is that a factor that should be considered in terms of any definition of Type 1 or minor injuries?
MS. RIIS:
A. Yes, I think that those kinds of symptoms is what needs to be considered when evaluating whether someone has suffered a serious impairment.
KENNEDY, Q.C.:
Q. Because we can see broken bones, I think one of the ladies actually used this term, you see a broken bone, you know it's going to

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get better, but the depression, and anxiety, the stress can be very real. Do you agree with that?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. And I'll just use the example of, we had two single mothers, one single mother who was very active, she ran marathons, she was in body building competitions, she went to the gym every day, she walked 10 kilometers and all of a sudden she gets rear-ended. She says, "I don't feel I can look after my children, I am depending on everyone for everything." She talked about the effect on her psychologically and emotionally. Do you feel that that psychological and emotional effect is considered enough in terms of these definitions that you are putting forward and treatment protocols?
MS. RIIS:
A. I think that would be the whole point of the treatment protocols is to ensure that the psychological sequelae that come with most traffic collisions, strain and sprain

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injuries, they need to be addressed early on. They shouldn't be allowed to blossom into full blown severe depression. If addressed early on and the guideline can include management of those symptoms early on, I think that can only help.
(10:30 a.m.)
KENNEDY, Q.C.:
Q. Okay, so are you suggesting that this psychological injury, emotion distress, call it what you like, is a minor injury?
MS. RIIS:
A. A psychological injury is a psychological injury, whether it goes on to become a serious impairment or not is a different question.
KENNEDY, Q.C.:
Q. So are you, I guess my question for you, you can, are you minimizing in any way the significance of psychological injury, emotional stress on individuals who are involved in motor vehicle accidents?
MS. RIIS:
A. No, and in fact my position is that these injuries have been undertreated

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historically. Physical treatment provides, such as physiotherapists, chiropractors, kinesiologists, massage therapists, we have tended to focus on the body part and we need to do a better job of addressing the psychological after effects of traffic injuries.
KENNEDY, Q.C.:
Q. If I can now ask you to go to, just excuse me please, at pages 6, let's start at page 6 of your report and it's the paragraph, go down a little bit, please, and this is the paragraph, "Regardless of how a person is injured or who is at fault, treatment should be consistent and based on the scientific evidence of effectiveness so the public can have confidence that treatment is likely to promote good health outcomes. To deprive quality healthcare from persons who are in some way responsible for a collision is unethical and will result in higher costs to his or her family, insurers, the healthcare system and society at large." You say you've spoken to some Section B adjusters in this province?

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MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. How many have you spoken to?
MS. RIIS:
A. Two.
KENNEDY, Q.C.:
Q. Do they give you the impression that Section B works wonderfully, that people are provided with the treatments that they are prescribed by their physicians and other health care providers?
MS. RIIS:
A. I would say that their comments suggested that in some cases, treatment tends to be prolonged and seemingly of no effect. Not all cases, but some.
KENNEDY, Q.C.:
Q. Okay, I guess my question is, lawyers don't prescribed treatment, correct?
MS. RIIS:
A. I hope not.
KENNEDY, Q.C.:
Q. No, that's correct. So, when you say that the lawyers tell the clients to continue to

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go to treatments, that's not an accurate statement in being prescribe treatments, is it?
MS. RIIS:
A. Lawyers are not qualified to prescribe treatment, but in my experience, they have given instruction to my patients to continue treatment.
KENNEDY, Q.C.:
Q. Do you know how anything happens in Newfoundland and Labrador?
MS. RIIS:
A. Colleagues of mine in Newfoundland and Labrador have indicated that that happens here as well.
KENNEDY, Q.C.:
Q. Now, let's just look at what happened with one of our accident victims who testified the other day. She testified that on numerous occasions or a number of occasions, if not numerous occasions, her lawyer had to get involved because the adjuster, her adjuster would not provide further treatment that were prescribed by the physician. Did you read that part in her testimony?

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MS. RIIS:
A. No, I didn't. So, the adjuster would not approve a claim for additional treatment prescribed by the doctor.
STAMP, Q.C.:
Q. That's not actually what was said, Madam Chair. What was said was there was a delay in getting the approval. That's a different thing.
KENNEDY, Q.C.:
Q. If you can go back to—we got the transcript and what Ms. Elliott said was that without her lawyer getting involved, she would not have received the treatments. She said there was a delay in the response from the Section B adjuster, but that she felt that without the lawyer, the treatments wouldn't have been approved.
STAMP, Q.C.:
Q. It wasn't refused, there was a delay.
CHAIR:
Q. I think the qualification as to the way she felt is fine. We can check the transcript for the accuracy.
KENNEDY, Q.C.:

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

that Section B coverage in this province, there's a maximum of $25,000.00.

MS. RIIS:

A. Yes.

KENNEDY, Q.C.:

Q. That you refer to the disability income, I think is $140.00 per week. So, the maximum is $25,000.00, but according to what you're saying, we should never get close to the maximum, should we?

MS. RIIS:

A. I can't comment on an individual case. I think it's entirely conceivable that you might get close to a maximum.

KENNEDY, Q.C.:

Q. Okay. So, let's just look at what—if we could go to page 11 of this report prepared by Oliver Wyman, under the heading "Accident Benefits", next page, or next heading please. So, we see here under Accident Benefits, "as part of the 2018 Closed Claim Study, the survey asked for information pertaining to amounts collected under Accident Benefits from the Third Party's own insurer", so that's Section B, correct?

MS. RIIS:

A. Correct.

KENNEDY, Q.C.:

Q. - "that reduced the amounts payable by the first party insurer under bodily injury coverage. The majority of claimant files did not include this information and was coded as unknown. Specifically, as we stated in our Closed Claim Summary Report dated April 19, 2018 'insurers were asked to report Medical Rehabilitation costs and Disability Income Costs pertaining to Auto No-Fault (Section B). For the majority of claimants these items were reported as unknown. For the 235 claimants that had reported Medical and Rehabilitation costs, the average Medical and Rehabilitation costs were $3,058.00. For the 234 (sic.) claimants who had reported Disability Income costs, the average paid disability income costs were $462.00". So you see those numbers there.

MS. RIIS:

A. I see those numbers.

KENNEDY, Q.C.:

Q. Do you know what it costs for either massage or physiotherapy or chiropractic in this Province per hour and per treatment?

MS. RIIS:

A. I was told that typically treatments are billed per visit and it's approximately $90.00 an hour.

KENNEDY, Q.C.:

Q. Okay. So, if the average of those 235 people was $3,058.00, does that should to you like the right amount? Do you have any way to know what the right amount is?

MS. RIIS:

A. I have no way of knowing that.

KENNEDY, Q.C.:

Q. So, if we were simply to divide 90 into $3,058.00, can you help me there?

MS. RIIS:

A. I can't help you there.

KENNEDY, Q.C.:

Q. Okay. So, 30 treatments? Does that sound like that should be a good amount of treatments to you?

MS. RIIS:

A. I have no idea what went into that three

thousand dollars. It could have been a report for $2,000.00; I have no idea what's in there, so I can't comment. I can't take this as a proxy for the number of treatments somebody had.

KENNEDY, Q.C.:

Q. Okay. Well, let's go down here now, further. "IBC who validated the data collected for the Newfoundland and Labrador 2018 Closed Claim Study is unable to verify the reported data for the Section B questions in the survey". So, it's coming from, this data is coming from IBC, but they can't validate it or whatever, but in any event, you're saying that improved treatment will—not improved treatment, let me put it this way—that there would be more money available for costs—we could go up to $50,000.00, correct?

MS. RIIS:

A. Right.

KENNEDY, Q.C.:

Q. So, what difference does it make to the injured person if they can only access three or five thousand if there's a maximum

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increased?
MS. RIIS:
A. I'm afraid I don't understand the question.
KENNEDY, Q.C.:
Q. So, we have a maximum right now of $25,000.00.
MS. RIIS:
A. Right.
KENNEDY, Q.C.:
Q. We have an average of 235 claimants with $3,000.00.
MS. RIIS:
A. Right.
KENNEDY, Q.C.:
Q. So, one of the proposals is to increase accident benefits to $50,000.00.
MS. RIIS:
A. Right.
KENNEDY, Q.C.:
Q. What difference will it make if there were not—if it's only $3,000.00 being utilized? Why would the situation improve?
MS. RIIS:
A. I can't comment on the financial analysis, I'm sorry.

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KENNEDY, Q.C.:
Q. Okay.
MS. RIIS:
A. I can say that if somebody had a spinal cord injury that $50,000.00 would be a great use.
KENNEDY, Q.C.:
Q. Now, let's go to page 9 of your report. You're talking about the impact of litigation. So, we've talked about or we've heard from the lawyers and the victims in terms of accessing, the difficulty in accessing Section B benefits. "Litigation and the prospects for large financial awards tend to reward poor health outcomes more generously the good ones". Are you saying that people are engaging in fraudulent activity?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. You go on to state that, and I think your term here today, if I can just find it, yeah, let's go to your report first and then I'll come to your statement today. Page 10 of the report please. You're talking about

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an Australian inquiry in terms of linking benefits to delayed rehabilitation related treatment. "While this is not necessarily true in all cases, I can attest to it being true in patients with whom I have worked. Some of whom received instruction from counsel not to go back to work or normal activities until they felt 100 percent better". So, that's something in your personal experience have encountered.
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Now, we heard from two accident victims here on Monday who said they had to go back to work, they had no choice. They were single mothers with children; they needed to work. So, are you suggesting that the $140.00 per week that would come from the disability income is enough to keep people going while they are off work?
MS. RIIS:
A. I'm not qualified to comment on that.
KENNEDY, Q.C.:
Q. Okay. And then you say in receiving

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instructions from counsel. Now, treatment—there's a prescription from a doctor as to, for physiotherapy or massage, for example, and/or, usually physio then massage. Is that the practice that you're aware of?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. The person goes to the physiotherapist or the massage therapist or the chiropractor, are you aware, in this province, that the Section B adjuster will then require a report from the physiotherapist or the massage therapist as to whether or not more treatments are required and if so, how many?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. So, how is the lawyer impacting that if they physiotherapist or the massage therapist who are presumably doing their job professionally and ethically are referring or are advising there should be further treatment? How is that the lawyers fault?
MS. RIIS:

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A. I didn't say that that was the lawyer's fault.
KENNEDY, Q.C.:
Q. You said that the lawyer told me to keep going, but it's not helping me. The individual said to you that the lawyer—I'm going to treatments –
MS. RIIS:
A. Yes, so in my –
KENNEDY, Q.C.:
Q. - the lawyer told me to keep going.
MS. RIIS:
A. In my experience I have discharged a patient to a home program with follow-up in a month or two months and the patient called me back and said, my lawyer wants me to keep coming on a weekly basis.
KENNEDY, Q.C.:
Q. So, how many instances of that has occurred?
MS. RIIS:
A. I would say at least 20 to 30.
KENNEDY, Q.C.:
Q. Twenty to thirty, do you know if that happens in this province?
MS. RIIS:

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A. Yes, because colleagues of mine told me that it happens.
KENNEDY, Q.C.:
Q. So, colleagues of yours being which colleagues?
MS. RIIS:
A. Physiotherapists.
KENNEDY, Q.C.:
Q. Physiotherapists, okay. So, the physiotherapists you're saying, is simply agreeing with the lawyer that treatment should continue?
MS. RIIS:
A. A lot of physiotherapists and chiropractors are intimidated when a lawyer gets involved in this kind of a case. There have been incidents where—I'll give you another example of mine. I had worked with a patient's physiatrist. We had designed a gradual return-to-work program. The physiatrist supported that program. And when I tried to implement the program, a complaint was filed against me to my college. So, there's some anxiety among health professionals getting involved with

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

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required.
MS. RIIS:
A. Right.
KENNEDY, Q.C.:
Q. You're aware that that happens, that's a standard thing?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. Are you also aware that Section B adjusters will have or require their own insured to engage in an independent medical examinations?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. And are you aware that that is something that regularly occurs?
MS. RIIS:
A. Yes.
KENNEDY, Q.C.:
Q. And are you aware of recent problems, at least in Ontario, with independent medical examiners?
MS. RIIS:

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

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

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me there?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. Have you seen letters from doctors in the province saying I advise so and so to be off work until two weeks, three weeks, come back and gives another letter?
MS. RIIS:
A. Not from this province, but from other provinces.
KENNEDY, Q.C.:
Q. Okay. And are you aware of one of the victims who testified here the other day who said, even though her doctor told her to stay off work, she had to go back. Are you aware of situations –
MS. RIIS:
A. No, -
KENNEDY, Q.C.:
Q. - like that?
MS. RIIS:
A. - oh yes, I understand there are people who will go back to work under any circumstances.

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

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this out now. So doctors prescribe treatments that don't work, lawyers involvement in the system simply obstructs the system and judges are not qualified to make decisions. Are those accurate summaries of your comments?

MS. RIIS:

A. That's not what I said, no, that's not what I said.

KENNEDY, Q.C.:

Q. I thought you said judges are not qualified or they're –

MS. RIIS:

A. I don't think judges are qualified to make medical decisions.

KENNEDY, Q.C.:

Q. Wait now, so judges are not qualified to make medical decisions. So, experts testify in front of judges. A judge has to make a determination, that's the way our system works.

MS. RIIS:

A. I think the judge is qualified to make the determination based on medical information provided by medical experts, yes.

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KENNEDY, Q.C.:

Q. Okay. So, my question to you was, when there are two—you talk about two medical/legal reports with conflicting opinions and my question to you was whether or not the judge is in a good position or qualified to make that decision. I thought you said you didn't know if they were qualified, but they had the authority to do it.

MS. RIIS:

A. That's right.

KENNEDY, Q.C.:

Q. So, are they qualified or not to make the decision?

MS. RIIS:

A. If somebody without medical training reads to medical reports and doesn't assess the patient, it is unclear to me how they can made the medical decision. Perhaps I'm perplexed, perhaps that's my answer.

KENNEDY, Q.C.:

Q. So, if we look at these evidence based protocols you're talking about and again, I want to make sure that I understand this

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correct, your testimony was you would hope that we would be the first province in Canada to avoid the use of minor. So, that pre-supposes the introduction of a minor injury cap, is that correct? Because it doesn't matter if they're general damages for—if the system stays the same, the definition of minor injury doesn't matter, does it?

MS. RIIS:

A. I don't think I understand your question.

KENNEDY, Q.C.:

Q. Okay. Your testimony was that you would hope that we would be the first province in Canada to avoid the use of minor, the term minor or minor injury.

MS. RIIS:

A. Yes.

KENNEDY, Q.C.:

Q. So, that pre-supposes that there will be a cap brought in.

MS. RIIS:

A. So, if these changes are implemented, I would hope that Newfoundland would avoid the use of the term "minor". I do not pre-

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suppose that these changes are happening. It's my understanding that's why we're at the hearing so the Board can consider whether or not to proceed. Am I correct?

KENNEDY, Q.C.:

Q. Yes, but that's not the way you phrase your answer. You said you would hope, you didn't say if this Board or if the Province brings in –

MS. RIIS:

A. I apologize for my mis-statement.

KENNEDY, Q.C.:

Q. Now, the insurance industry doesn't need a cap to argue for evidence based treatment protocol, do they? They're two separate issues.

MS. RIIS:

A. I believe you're right, yes.

KENNEDY, Q.C.:

Q. That's not in your report, is it?

MS. RIIS:

A. No.

KENNEDY, Q.C.:

Q. In terms then of the IBC proposal to make Section B mandatory and I don't think anyone

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disagrees with that and to increase benefit levels to $50,000.00 for medical rehabilitation. Are you aware of what percentage of claimants in this province get cut off after $5,000.00 of benefits?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. Are you aware of what percentage of claimants get cut off after $1,000.00, $3,000.00 or $4,000.00 of benefits?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. Do you know what percentage of claimants in Newfoundland and Labrador actually exhaust the limit of $25,000.00?
MS. RIIS:
A. No.
KENNEDY, Q.C.:
Q. So, do you know whether the move to $50,000.00 from $25,000.00 would even make a practical difference to any claimants if you had not looked at these statistics?
MS. RIIS:

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

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

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physiotherapist, but also in relation to the insurance industry. I mean, that's obvious on the face of it. But it's also that over the years you have done an extensive amount of work for independent insurance companies and then for an extensive period of time, you've been—we'll use whatever expression you want to use—carrying the water for the IBC is the one I would use, but you've been acting on their behalf. Is that a fair statement?
MS. RIIS:
A. Yes, I've consulted to them.
MR. GITTENS:
Q. Okay, you're a consultant to them, but in many of these situation that you find yourself, your –
MS. RIIS:
A. Yes.
MR. GITTENS:
Q. - assessment of what the policies you will support are pretty much congruent with theirs.
MS. RIIS:
A. Yes.

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MR. GITTENS:
Q. Okay. So, we know then and we can go through the rest of it for the more recent times from 2014 coming up now, you can give us that there. Yeah, you went back into physiotherapy in one third of your professional life.
MS. RIIS:
A. Um-hm.
MR. GITTENS:
Q. You've maintained one third of your professional life with the IBC or within the industry and I didn't get—the other third was what?
MS. RIIS:
A. The other third was working with health care companies, health professional associations, working with the health care industry.
MR. GITTENS:
Q. Okay, got ya. So, you have a cross-section of involvement, but it's not unfair to you to say that, as I've used the expression, you've carried the water for the IBC before.
MS. RIIS:
A. Yes.

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

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

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

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every single one of my patients is an individual needing individual treatment. But then you came today and what did you say? Well, you said, well no two people react the same to the same injury.

MS. RIIS:

A. Correct.

MR. GITTENS:

Q. Which is just another way of saying what he's saying.

MS. RIIS:

A. Yes.

MR. GITTENS:

Q. He was basing a lot of his comments that you saw on his research into what he says was genetics. And he was saying like, you know, each person, even the person who is very stoic gets hurts, says, no big deal, keeps on going. You can trace some of that, he's suggesting, back to the genetic makeup of that person. Whereas somebody else got the same injury, same degree of pain and they're out of it for god knows how long; they're a basket case. So, I take it when you use the word—you say you're not supporting the use

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of the word "minor", you're essentially saying much of what he is saying, is you can't take this definition and put a line through and mark off a whole bunch of people.

MS. RIIS:

A. Correct.

MR. GITTENS:

Q. Okay, but when you said minor, you then went on to say, well you know, it's probably more like a Type One—you'll accept the definition of say Type 1 type of injuries and run with that, instead of using the word minor. Am I getting that correct?

MS. RIIS:

A. I borrowed the term from the OPTIMa Collaboration Publication, Enabling Recovery from Traffic Injuries. That's what they called it. So, I don't have a better word, so I used Type 1 injuries, but I wouldn't be opposed to other terms either.

MR. GITTENS:

Q. Well, you know, as a lawyer representing plaintiffs, let's just call it, the people we're going to shaft. You see how you can

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put any words you want in it, right, the people –

MS. RIIS:

A. Exactly.

MR. GITTENS:

Q. - who we say you don't qualify for any type of settlement except what we are going to say is 5 or 7 or $10,000.00, words are words. You can define it as minor; we can define it as Type One; or we can define it as those people we are going to screw out of the current system, so that we can do better for the other people. Understand what I'm saying?

MS. RIIS:

A. I do understand.

MR. GITTENS:

Q. Okay. Now, when we use the definition of what was minor and I'll take you to page 3 of your report, the top of page 3, the "minor" definition was sprains, strains and whiplash injuries including any clinically associated sequelae whether physical or psychological in nature that does not result in serious impairment. We're all familiar

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with that definition. It takes in most of what is going on in Ontario, Nova Scotia, New Brunswick and PEI, at least. I haven't checked with the other provinces. If you go down to the second paragraph on that page, define minor injuries realistically you say, that's where you introduce the concept of Type 1. And the Type 1 injury as you define at the very bottom there, you say, Type 1 injuries are those traffic injuries which have been shown in epidem –

MS. RIIS:

A. Epidemiological.

MR. GITTENS:

Q. Thank you—studies to have a favourable natural history, recovery times ranging from days to a few months. And then you go on to say, you're not saying but you're adopting this.

MS. RIIS:

A. I'm citing from a paper.

MR. GITTENS:

Q. Right. "These injuries include musculoskeletal injuries such as neck pain and associated disorders, any of these,

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grades one through three. Grades one and two sprains and strains of the spine and limbs, traumatic radio—can you say that word for me too?

MS. RIIS:

A. Radiculopathies.

MR. GITTENS:

Q. Thank you very much—mildly traumatic brain injuries and post traumatic psychological symptoms such as anxiety and stress". So you take your Type 1 and you really stuff a bunch of stuff in there and add on a fair number of other injury types to the minor definition. Is that what is happening?

MS. RIIS:

A. That's' what this group of researchers did.

MR. GITTENS:

Q. Alright. And then you say, more often—so, we've listed all those things and if you go down to the next quote, it says "injuries resulting from traffic collisions often present as clusters of physical, mental and psychological impairments. Although the primary symptoms of NAD is neck pain. It also includes physical and psychological

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symptoms such as back pain, headaches, arm pain, temporomandibular disorders and depressive symptomology". So, to be honest, what's going on here while we've taken the very specific minor definition which only referred to the sequelae, back to that, associated sequelae and physical and psychological in nature that does not result in serious impairment, when you transform that into the Type 1 you add on all these additional injury types including disorders and depressive symptomology. So, that minor definition has, in fact, been expanded. Is that a fair statement?

MS. RIIS:

A. No. I think the term sequelae captures what was outlined in that paper.

MR. GITTENS:

Q. Okay. So, therefore, instead of using a generic term, you've simply put all these additional things into that minor injury definition.

MS. RIIS:

A. I just cited from the paper what the researchers indicated about Type 1 injuries.

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MR. GITTENS:

Q. Right.

MS. RIIS:

A. So, Type 1 injuries, it's not a simple, physical injury. There are various other things that happen simultaneously. And it's difficult to tease out to say that the sore neck is one piece and the anxiety is a separate injury. They are part and parcel of the same syndrome or pattern.

MR. GITTENS:

Q. Okay, so is it fair for me to say to this Board that when we use the expression that has been used so far, "minor injury" or whether we translate it into the new and improved Type One, there are a lot of details—the devil is in the detail, as they say –

MS. RIIS:

A. Yes.

MR. GITTENS:

Q. - all these additional things that make up what is intended to be covered by whatever cap is going to be imposed.

MS. RIIS:

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A. Yes.

MR. GITTENS:

Q. Alright. So, first we know you got an impressive background; second we know you're here for the IBC; third we know that the definition of minor includes a lot of other stuff that is being proposed that there be a cap on. Am I getting it all correct so far?

MS. RIIS:

A. I wouldn't say it's including a lot of other stuff. I think it's being clear about what we mean when we talk about neck associated disorders. Neck associated disorders is not a simple neck injury. Neck associated disorder may be neck pain as well as anxiety, as well as some pain down the arm, as well as some dizziness. So, we're trying to describe the actual injury more precisely. And I know in Alberta they have a health practitioner's guide where they specifically define what do we mean by Grades 1 and 2 sprain. So, I think that kind of detail can be very helpful implementation should the Board decide to go in this direction.

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

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

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MR. GITTENS:
Q. "Type 1 injury is that at least 50 percent of patients should be expected to recover within six months".
MS. RIIS:
A. Yes.
MR. GITTENS:
Q. Okay. Being an ornery type, I read that to say 50 percent of the patients will not be expected to recover within six months?
MS. RIIS:
Q. Yes.
MR. GITTENS:
Q. Fair statement?
MS. RIIS:
A. Yes.
MR. GITTENS:
Q. Now the cap, whatever definition is used, is intended to draw a line for all the people, and I don't know whether the line is six months, if they aren't resolved in six months or not, but at some point we know that even within six months if we were to have the cap cut off all those people who normally would be resolved within six

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

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So there's already a pretty high prevalence of next pain. So to think that recovery is equivalent to being pain free is a concept that the health care professionals are starting to recognize is possibly not achievable.

MR. GITTENS:

Q. Okay, so I gather what you're saying is everybody is hurting somewhat, so to bring everybody back to a point where they're not hurting is unrealistic?

MS. RIIS:

A. Right.

MR. GITTENS:

Q. All right, but a cap and a definition of what it applies to is going to have some component of when it is – where you cut it off, where you realistically expect these people to be no longer suffering from the injury caused by the accident. Isn't that implicit in this process?

MS. RIIS:

A. One of my comments was that should the Board implement this cap, I think that there needs to be great consideration given to the

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

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(11:45 a.m.)

MR. GITTENS:

Q. Okay. So you're telling me there are caps in several provinces across Canada. You're here as an expert in this field, and correct me if I'm wrong, but I'm hearing you telling this Board that at this point in time you are not satisfied with a definition that's really applicable?

MS. RIIS:

A. I have only seen the definition that's being put forward. It offers an exception based on serious impairment, and it would be my recommendation that should it be adopted, that serious impairment be carefully defined. It has been defined in other provinces, and I think that it has been effective in other provinces.

MR. GITTENS:

Q. Okay. So when you talk about serious impairment then, are we talking – is there a time limit, is there a six month – I'm looking at the documentation that was produced.

MS. RIIS:

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A. I would say that it not be based on a time limit because there's so much variation. I think – it's my sense that basing the definition of serious impairment on a person's ability to do activities that they did prior to the accident would be the fairest way of proceeding. So if somebody is impeded from being able to work, if they are unable to carry on with their child care activities, et cetera, then they should be able to escape the cap. I don't think it should be based on chronological symptoms or stiffness or anything like that.

MR. GITTENS:

Q. Okay. It's curious because when you made that comment, it reminds me of some of the testimony of Dr. Misik, when he kept referring to the fact that, you know, I've got clients – patients that he's dealt with seven or eight years ago, and they come back and he knows that what they're suffering from six, seven, eight years later has its genesis in the incident that he treated them for five to seven years earlier. So when you are talking about not having a time

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frame of – I was using six months because of what they had here. You are saying that there should be some mechanism that allows a person who experiences some impact or deficiency in their functioning, regardless of when that occurs, to escape the cap?

MS. RIIS:

A. Assuming that sufficient time has passed to allow for healing, and after the person has sustained whatever treatment is necessary to promote the healing. So I wouldn't want to assign that definition two days after the accident, but I think after a sufficient amount of time has passed for healing to happen, for appropriate treatment to have been received, to have ruled out the possibility of further improvement, I think at that point it is probable reasonable to assess their ability to function.

MR. GITTENS:

Q. Okay. Forgive me for not letting you get off this one easy by saying I think it should be some time frame. You're here as the expert in the physiotherapy and in the insurance industry, and you're carrying—good

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God, and I (unintelligible) a lot again—you're carrying the –

MS. RIIS:

A. Water.

MR. GITTENS:

Q. - argument for the IBC. No, no, the argument. What time frame do you have in mind should be applied to say to these people, you know, if you go beyond that, you're probably not capped?

MS. RIIS:

A. I'm not prepared to answer that question. It wasn't part of my submission. I would be able to come up with an answer if I was given a chance to do some more review about healing times and recovery times, and rehabilitation times, but I can't give you an answer right now.

MR. GITTENS:

Q. So you're telling this Board that despite your many years of involvement on all these policy groups and so on, and being intricately involved in this analysis, up to this point in time you don't have a sense of whether or not a cap, if it's going to be

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imposed, should have a time frame for people who should not be underneath it?

MS. RIIS:

A. I have a sense, but I'm not prepared to put an answer forward.

MR. GITTENS:

Q. Maybe we can meet after and you can tell it to me in sign language or something.

MS. RIIS:

A. I would be happy to do that.

MR. GITTENS:

Q. Fine. The circumstances that jump at me when I hear the definition of any of that, however, is the clients that I have who come forward later and say, you know, Ernest, everything is fine, I'm doing great, but I have the occasional flare up, you know. They seem to be able to function completely, do all their jobs they used to do before, they've plateaued or whatever the expression the doctors want to use for them, but they continue to experience the occasional – the best words I can use is the words they use, "flare ups". How does a cap deal with, or how will a cap that you're contemplating

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deal with those individuals?

MS. RIIS:

A. It's my understanding that the cap is not intended to deal with health care needs going forward. I would think that the settlement would deal with that as a pecuniary loss. For example, if I had a patient who had had ongoing symptoms related to a Type 1 type injury, and they came to me, I'd been seeing them for six months, they come back every two or three weeks and say, oh, I had a flare up last week, and I see this as a pattern, I would make a recommendation that they have access to treatment on a monthly basis for, you know, for treatments on an ongoing basis, and I would think that would be covered by the pecuniary settlement.

MR. GITTENS:

Q. Okay. That actually brings up another issue I have with what you've said, and it takes us into the third category of your evidence, your presentation, and that is when you were dealing with the role of litigation and the process. Correct me if I'm wrong, but I

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gather from what you've said, and this is my summation of it, my interpretation, that you saw the litigation process as being the mechanism by which there would be compensation primarily for pecuniary damages; loss of wages, cost of future care, things of that sort. I didn't gather from you that you appreciated that part of the litigation process is designed to compensate someone for, as best as it can, inconvenience, pain, discomfort, you know, loss of the lifestyle?

MS. RIIS:

A. I do understand that, and I apologize if I didn't make that clear. I'm not opposed to the non-pecuniary loss settlement or damages being paid out. There's something called perceived injustice. Research shows us that if injured people feel that they've been treated unfairly, that that actually contributes to prolonged symptoms, more severe symptoms, prolonged disability. So trying to achieve a sense that some justice has happened is actually good for your health. So I'm not opposed to the concept

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of pain and suffering awards, but at the same time, I know that whenever my patients have received that compensation, it doesn't make them better, and they've said to me, well, they could have given me $100,000.00 and I still would have been no better.

MR. GITTENS:

Q. Right.

MS. RIIS:

A. So it's my understanding that the non-pecuniary losses are to try to even the scales of justice a little bit, so the victim feels that some punishment or some justice has been achieved because they were injured through no fault of their own. So I don't think it's a bad thing, but again I know from my experience that it doesn't cure patients, and whether you give them $5,000.00 or $5,000,000.00, they're not going to feel any better.

MR. GITTENS:

Q. I couldn't agree with you more, but when I just asked you about what is your recommendation in relation to flare ups, for instance, you went directly to the issue of,

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well, we could offer them another three weeks or four weeks, five weeks of treatment to deal with the immediate issue that they're dealing with, and I didn't see a sense – I didn't get a sense from you of a component that has to deal with the fact that it's been 15 damn years and I'm still having this irritation every few weeks or every couple of months, you know, frustrating.

MS. RIIS:

A. Uh-hm. If somebody is having flare ups that are significantly impacting their lives, they need to go and see a doctor and have that checked out. Most flare ups, in my experience, can be dealt with through short periods of treatment, and I'm hoping that that treatment will work, it will reduce the flare up, it will get them back up on their feet and going. So to me, I see the flare up as a temporary problem. It doesn't flare and stay there. It's an up and down, and the whole point of treatment, which is a health care expense, is to reduce the symptoms during that flare up and help the

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person cope with it.

MR. GITTENS:

Q. Okay, but there's no component for the aggravation.

MS. RIIS:

A. I would think that would be in the pain and suffering award.

MR. GITTENS:

Q. Okay, and the pain and suffering award is the one that you're trying to put the cap on?

MS. RIIS:

A. Talking about cap on, yes.

MR. GITTENS:

Q. Got ya. Now the biggest issue I had with what you were saying throughout your testimony, and Mr. Kennedy picked up on it earlier, so I feel confident that I'm not the only one, is that your background in treatment of people who have been injured, and your promotion of the concept of evidence-based treatment protocols, which I said earlier on, and I stay with, just seems quite sensible and quite practical and should be helpful, I didn't know where you

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

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MS. RIIS:

A. Wherever a minor injury cap and diagnostic and treatment protocols have introduced, there's a link between the two. So people who are injured with the type of injury that's defined as a minor injury are eligible for treatment in the treatment protocols. So they're fast tracked to receive pre-approved treatment, and that's part of the condition of – if they want to escape the cap, if they turn out not to have a good recovery that's anticipated, we know that they have done everything they can to mitigate their injuries, and, therefore, if they do have a serious impairment, in my view that would be inability to function at their pre-accident activities, then they would be eligible to escape the cap. So I've always seen there to be a link between the diagnostic treatment protocols, eligibility for the treatment protocols, and then moving forward to the cap, and IBC asked me to comment on the definition from a health care perspective.

MR. GITTENS:

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Q. I've always been concerned about the psychologist or the scientist who put the fly in the bottle, and then congratulate themselves because they teach the fly how to get out of the bottle. You're creating a cap, okay, you're creating a cap, and then you're telling us it's going to be helpful for people if they're able to find a way not to be covered by the cap, because that's going to assist them in their recovery, unless I'm misinterpreting what you're saying, that appears to be what you're saying?

MS. RIIS:

A. Yeah, quite honestly, I'm sort of confused at what you just said also. Can you repeat?

MR. GITTENS:

Q. Sure.

MS. RIIS:

A. Yeah, quite honestly, I'm sort of confused at what you just said also. Can you repeat?

MR. GITTENS:

Q. Sure. It just means that we're both on the same page. Right now, there is no cap in this province.

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MS. RIIS:

A. Um-hm.

MR. GITTENS:

Q. A person gets injured, you are suggesting that we should be basing their treatment on evidence-based treatment protocols. Full marks. I'm with you on that. We can be in lockstep on that one. And when the person—because we've implemented that, we expect that their treatments will be shorter, their recovery time will be shorter, they'll get better faster. That's the basis on which you're saying that?

MS. RIIS:

A. Right, right.

(12:00 p.m.)

MR. GITTENS:

Q. Okay. And that's what we have right now. Well, apart from a better, oh no, you're right, a better evidence-based treatment protocol. I'm with you. Then you stop there, and you say, "Oh by way, while we're talking about this, you should implement a cap." And I'm saying—I'm asking you to please show the Board why one is connected

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to the other. And then, I understand you to say, "Well, you know, it's connected because a person is able to not be covered by the cap, they will get this evidence-based treatment which will get them back to good health sooner."

MS. RIIS:

A. So, it's my understanding that ultimately the issue is to try to reduce the cost of auto insurance premiums for drivers. And I think that imposition of a cap is intent to try to do that. I'm not an expert on the actuarial analysis around that and I'm not going to comment on any figures, but theoretically if--the literature suggests that about 80 percent of the injuries sustained in traffic collisions worldwide tend to be soft-tissue injuries. And many of these go on to heal without any need for treatment, any claim for benefits. Some of them go onto need some treatment, and the person recovers fully, and gets back to their life and doesn't have any events. And then, there are a few people that will go on to suffer prolonged disability. I think

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that if--the treatment protocols are intended to get the best possible treatment to these people as soon as possible. In Newfoundland I've seen that your treatment costs have gone up and I understand from IBC that the cost of settlement for non-pecuniary damages have gone up. So, that tells me that you're paying more and more for treatment, but people aren't getting better which is why you're paying more and more for pain and suffering, because more people are having more pain and more suffering in spite of the industry paying for more treatment. So, something is not working. And I think if we can put in a situation where we have some assurance that more people will recover better and faster, there is going to be less need for the pain and suffering. And as I said, in my experience, whether you give somebody X or Y dollars, it's not going to cure them. They're going to continue to have some issues if they have that kind of a settlement.

MR. GITTENS:

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Q. Okay. I hear what you're saying, and I understand you come before the Board as an expert in the treatment and that you have said that in—when it comes to the treatment, you're a proponent of this evidence-based treatment protocols. And then, I hear you to say in your last answer, at some point that's the way it stops. And then you've been told that there is this cost situation that has to be dealt with, and you've been told by the IBC that this cost situation can be dealt with by a cap, and you're all in for that? Am I getting this correct, or am misrepresenting you?

MS. RIIS:

A. I'd say that's accurate.

MR. GITTENS:

Q. Okay. So, let's nail down—I think I'm almost done. Number one, you have an extensive background assisting the IBC. Number two, you're here not really as an independent person giving independent analysis, you're here as part of the IBC's proposal that they want this Board to understand. Number three, when it comes to

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minor—the definition of a minor injury, you're more inclined to go with the type 1, but when you go with the type 1, you're recognizing that that includes a fair number of other things that need to be made—people need to be made aware of?

MS. RIIS:

A. Yes.

MR. GITTENS:

Q. Because it covers all of those things?

MS. RIIS:

A. Yes.

MR. GITTENS:

Q. Not just whatever one might think the word "minor" says?

MS. RIIS:

A. And treatment needs to be focused on that.

MR. GITTENS:

Q. And treatment. And then, you get to the treatment protocols. You're accepting that some people who will normally go through that process, 50 percent of them within six months or thereabouts, but you don't have any—no, I'm sorry, I don't say you don't have any idea. You're not willing to share

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with the Board what you think the timeframes should be as a cut-off point for those individuals. So, we're not able to that, but that's fair enough. I'm not going to force you on that. And finally, when it comes to the link between the cap and what you're knowable about, which is treatment protocols and your patients, you're acknowledging that that's just the stuff that the IBC passed onto you and you're passing onto the Board? Am I getting –

MS. RIIS:

A. I think you're characterizing my understanding of the cap as a cost-saving measure in a limited way. I have been engaged in conversations about that and I do believe that IBC generally believes it will be a cost-saving measure, but I can't give testimony in that regard. I also want to comment about my independence. I am first and foremost a licensed physical therapist.

MR. GITTENS:

Q. Got you.

MS. RIIS:

A. I am on the Board of the Canadian

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Physiotherapy Association. I've just been invited to the Board of Spinal Cord Injury Ontario which is an advocacy group promoting health care and integration issues for people with spinal cord injury. I am in great part motivated by what's best for injured people. And I think at some level all of the stakeholders are, but I think as a health care professional like Dr.—was it Misik?

MR. GITTENS:

Q. Misik.

MS. RIIS:

A. Misik. I think I'm on that team as well.

MR. GITTENS:

Q. Got you.

MS. RIIS:

A. I appreciate they're not paying me to be here, but I want to assure you that I very much am sitting on that bench as well.

MR. GITTENS:

Q. I don't challenge you in that regard at all.

MS. RIIS:

A. Okay.

MR. GITTENS:

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Q. Thank you very much. No further questions, Madam Chair.

CHAIR:

Q. Thank you, Mr. Gittens. Mr. Fraize?

FRAIZE, Q.C.:

Q. We have some questions. My colleague is going first, I'm going second.

CHAIR:

Q. Okay.

MS. FRAIZE-BURRY:

Q. I just have a few questions and then we'll move onto him. In your practice or your experience dealing with other medical professionals, have you seen patients that were capped, say either in any of the other provinces that do have a cap right now, that you would consider to have a serious impairment? So, have you experienced people falling through the cracks?

MS. RIIS:

A. Oh, so people capped when they serious impairment?

MS. FRAIZE-BURRY:

Q. Yes.

MS. RIIS:

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A. I have seen many disputes like that. I personally have not had a case like that, but I definitely have seen disputes around where an insurance company said, "We think that they fall under the cap," whereas the injured person says, "No, I don't." And I've seen these disputes go both ways, and often it's dueling medical examinations and you know, there's—in provinces there are different dispute resolution mechanisms or trial. So, I have seen situations where there are grey areas. And again, these disputes often will highlight where there's a problem with the definition. And that's why, thinking now, so if Newfoundland decides to put in place some sort of a cap, thinking carefully about the language around that is important.

MS. FRAIZE-BURRY:

Q. Just as a –

MS. RIIS:

A. People can fall through the cracks, yes.

MS. FRAIZE-BURRY:

Q. And so, it has happened?

MS. RIIS:

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

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possible around health care needs, but also being fair to the people who are paying for the system.
MS. FRAIZE-BURRY:
Q. Okay. And I heard you just mention that you have joined the Board of Spinal Cord Injury Ontario?
MS. RIIS:
A. Yes.
MS. FRAIZE-BURRY:
Q. Obviously we're Spinal Cord Injury Newfoundland and Labrador.
MS. RIIS:
A. Yes.
MS. FRAIZE-BURRY:
Q. So, I will ask if a person with a spinal cord injury was to say receive a secondary injury in an automobile accident, and that would be say a minor injury or a type one, what kind of impact would you expect that injury to have on their quality of life?
MS. RIIS:
A. Again, I can't comment on an individual situation. So, you're talking about somebody who already has a spinal cord

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

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

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in some of your previous evidence, you discuss certain treatments that primarily deal with the management of symptoms rather than dealing with -

MS. RIIS:

A. Right.

MS. FRAIZE-BURRY:

Q. - what's causing the issue. But, those treatments, if they're allowing that person to be able to live their daily life as best they can, isn't there some inherent value in that in and of itself?

MS. RIIS:

A. Yeah, and so this is – we're talking about maintenance and this has been sort of a controversial thing and various health professional associations have taken varying positions on it feeling that maintenance is something separate from treatment. I think if it's clear that say a massage therapy treatment, you know, every couple of weeks keeps that person able to work or able to play a golf game every week, I think that's fair game. But to me, that would not be affected by the cap. That would be covered

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by the pecuniary side of the settlement.

MS. FRAIZE-BURRY:

Q. All right. Do you want to -

FRAIZE, Q.C.:

Q. I have some questions. Can you hear me?

MS. RIIS:

A. Yes.

FRAIZE, Q.C.:

Q. Just a couple of things. I think you agree that insurance companies, for the most part, want to maximize their profits. Do you agree with that?

MS. RIIS:

A. No.

FRAIZE, Q.C.:

Q. They're private enterprise.

MS. RIIS:

A. I can only give you my experience, based on working with the insurance industry. Certainly they're private companies. Just as all of us with private businesses want to maximize our profits, I think insurance companies don't want to be in the red. I think that the behaviour of some insurance adjusters certainly gives that impression

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and I think that's unfortunate.

FRAIZE, Q.C.:

Q. Oh, I'm going to get to that in a couple of minutes.

MS. RIIS:

A. But I think that the industry at large recognizes that they're going to maximize their profits by getting people well.

FRAIZE, Q.C.:

Q. Do you also agree that one of the – the cap is supposed to reduce the premiums for the insured, a person that caused the accident, correct?

MS. RIIS:

A. No. The cap is supposed to reduce the premium for all drivers who buy an insurance policy.

FRAIZE, Q.C.:

Q. But, it's the insured is the person that causes the accident and they're the ones that paid the premium. So, indirectly, we're trying to reduce the premiums maybe across the board, but it's the party that's caused the injury that we're trying to reduce the premium for, correct?

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MS. RIIS:

A. Well, if you could predict who's going to cause the injury then you're going to be – you can select who you apply the reduction to or not. But, I don't know how you could do that.

FRAIZE, Q.C.:

Q. Okay. Now, and of course, the victim wants to be compensated, put back to where they were, because of the accident and so forth.

MS. RIIS:

A. Right.

FRAIZE, Q.C.:

Q. One of the problems that is going to be created with a cap is that we're going to have a definition and for lawyers that represent injured parties, the innocent parties, the first thing we're going to have to argue that this injury is not within this definition. So, not only do we have to argue the injury, the quantum of damages, now we got to get us outside of a definition suggested by the insurance company.

Now, in litigation there's a little catch 22. It's called when you go to court,

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they can put in an offer in a sealed envelope. At the end of the day, if you don't win all the costs go against you. You can bet that the amount offered by the insurance company will be the cap amount.

So, one of the dangers of this cap and the definition, depends on how it make – how big you make the definition, is you've made the situation uneven for the injured party versus the insurance company. So, going to what you were saying about the definition, the definition is critical because the wider that definition, the harder it is to get compensation for the victim. Are you with me?

MS. RIIS:

A. I'm with you, but I have a question about your first statement. You said the first thing you have to do is figure out how to get somebody out of the cap. But -

FRAIZE, Q.C.:

Q. What I mean by that is outside the definition.

MS. RIIS:

A. Right.

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FRAIZE, Q.C.:

Q. Because if you fall within the definition, a cap applies.

MS. RIIS:

A. To the general damage, the non-pecuniary losses.

FRAIZE, Q.C.:

Q. So, litigation in other provinces have shown the battle is trying to get outside of the definition. Now, with that said, I want to go back to a point my learned colleagues have raised. Part of your report talks about changing the treatment process. I'm going to use the word treatment process. Is that a fair statement, how injured parties are treated, the treatment given? Isn't that what you're saying inside your report?

MS. RIIS:

A. I'm going to say that it may not result in much change in treatment, but hopefully it will improve treatment in some circumstances. I mean, I'm assuming that most health care professionals are doing the best they can.

FRAIZE, Q.C.:

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Q. But you've indicated in your report like the protocol as you call it for Section B and Section A.

MS. RIIS:

A. Um-hm.

FRAIZE, Q.C.:

Q. Now, in this province, our accidents are going down, okay. For some reason, they're going down. We got safer drivers maybe, I don't know.

MS. RIIS:

A. Fewer moose.

FRAIZE, Q.C.:

Q. Less potholes. I'm not quite sure what the problem is. But, if we are correct that – you seem to be emphasizing in your report that if we can somehow get these – I think you used the words "treatment protocols" put in place that will get people better quicker and reduce the quantum of damage. So, theoretically, if we listen to what you've said and that works and our accidents are going down, so therefore the damage awards that insurance companies would have to pay would go down without the cap.

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MS. RIIS:

A. I can't comment on that because I haven't seen – I don't know what all of the numbers are. I know that treatment costs have been going up.

FRAIZE, Q.C.:

Q. But if accidents are going down -

MS. RIIS:

A. You would hope, but I don't know if that's true.

FRAIZE, Q.C.:

Q. Yeah, and your process is the treatment protocols are going to make people get better quicker. So, two of them together should somehow reduce the amounts that the insurance companies have to pay out theoretically.

MS. RIIS:

A. It sounds like a logical assumption, but I can't confirm it.

(12:15 p.m.)

FRAIZE, Q.C.:

Q. Okay. Now, you're a physiotherapist. I don't know if you've encountered this, but as a practising lawyer, I've encountered

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problems dealing with insurance companies when we have to get medical reports, and I suggested we get a physiotherapist's report, a massage report, a chiropractor, then the insurance company comes back or the adjuster says "no, we're not going to pay for those, but we want the doctor to give us a report telling us all about the treatments". Now, that's sort of arse backwards. I find that. Have you encountered that in your practice?

MS. RIIS:

A. Yes, and I agree with you on this.

FRAIZE, Q.C.:

Q. Right, it's arse backwards.

MS. RIIS:

A. I'm not going to say that.

FRAIZE, Q.C.:

Q. Okay. I'm just picking up where Mr. Gittens left off.

MR. GITTENS:

Q. Bad example.

FRAIZE, Q.C.:

Q. Almost there, Ernie. Almost there. Now, question for you. We have an aging population and that means we got more people

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out there driving that are seniors. Do you agree that an accident would affect a senior more than a young person?

MS. RIIS:

A. So, I go back to my World Health Organization International Classification of Functioning. That's the whole point of using that kind of a framework is because you can't judge a person's injury or severity of injury based on the diagnosis alone. There are so many factors that have to be taken into consideration and in fact, one of the other things that I got from the International Association for the Study of Pain is that psychologically informed practice which balances the individuals and societal needs is something that we have to get better at doing in the health care system. So, I think the protocols will help that happen.

FRAIZE, Q.C.:

Q. Well, the reason why I – I end up dealing with a number of seniors, mostly dealing with estate planning and some other organizations I'm involved with. And from

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what I've observed is that when seniors get into an accident, especially say around 75, when they have an accident, what is called a soft tissue, what the insurance company calls minor and I have other words for it, but that person ends up getting treatment. So, they end up having to go back and forth and so forth and they get numerous treatments because as they're older, they take longer for them to get better.

MS. RIIS:

A. Yes.

FRAIZE, Q.C.:

Q. And as one of my clients did a math exercise for me and they looked at what their pension was and how much time they spent doing the physio and massage and the chiropractor over the three years and when we did the calculations, the settlement that that person got was sort of equal to that. Because it opened my eyes to a question. When we look at a senior, because they're in later years of life, an accident has a great effect on their quality of life. A. they don't move as fast, number one, plus they

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got to take time out of their limited time to get the necessary treatments. Now do you agree that because of a senior, their quality of life is far more affected than say a 22-year-old?

MS. RIIS:

A. I wouldn't say that as a blanket statement. I do agree that in many situations a senior can be more severely affected. I just had dinner with a woman yesterday who fell off a ladder and broke her humerus in four spots. She's 82. And she had surgery six months ago; had to totally reconstruct her arm and shoulder, and she basically said "I'm back to normal now". So, I think everybody's different and that's why sometimes I'm reluctant to comment on these general statements. So, I think what you're saying may be true in many cases with seniors, but I think – I don't think we can take it as a blanket rule.

FRAIZE, Q.C.:

Q. But if we get into the situation of a senior and that – like these definitions the insurance companies want to use for the cap

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

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

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

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

MS. RIIS:

A. So, you're talking about posttraumatic stress disorder?

FRAIZE, Q.C.:

Q. Yes.

MS. RIIS:

A. So, as I understand it, if somebody is affected by a psychological impairment that affects their ability to function in life, they could escape the cap.

FRAIZE, Q.C.:

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

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

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

MS. RIIS:

A. Yes.

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FRAIZE, Q.C.:

Q. And that's where the field is going to become uneven for the victims because first you got to argue either you're outside the cap or it's a serious impairment and you're going to have the medical evidence, so you're going to have that first line. So, these treatment protocols that you're talking about are completely independent of the concept of a cap, correct?

MS. RIIS:

A. Yes.

FRAIZE, Q.C.:

Q. Okay. Have no connection? The cap is simply -

MS. RIIS:

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

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

FRAIZE, Q.C.:

Q. But your report, for the most part, has nothing to do with a cap. You're talking about treatments. You're talking about the treatment protocols.

MS. RIIS:

A. Yes.

FRAIZE, Q.C.:

Q. A person that's injured, what they should have.

MS. RIIS:

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

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without waiting for approvals. They can just start treatment. The treatment provider doesn't have to submit a report about how many visits or what kind of treatment. It speeds the process of starting treatment. The injured person, I hope, would feel like wow, this is happening fast and I'm not arguing with anybody. There's less paperwork. So, I think that's one of the real benefits of the protocol.

Secondly, the injured person, the health care provider and the insurer all know what is involved in evidence-based treatment and they feel confident that this person's getting the best treatment possible for them.

FRAIZE, Q.C.:

Q. But you can have all of that without having a cap?

MS. RIIS:

A. Yes, you could.

FRAIZE, Q.C.:

Q. Because a cap is just for reducing premiums. You made a comment of making a connection

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after a settlement of an accident that treatments stop? Okay. Because under our Section B, I think it goes to four years after the accident. So, you know, Section B has a timeline, not only a quantity.

MS. RIIS:

A. Yes.

FRAIZE, Q.C.:

Q. An amount, but also expires.

MS. RIIS:

A. Yes. Four years here.

FRAIZE, Q.C.:

Q. My point being that sometimes these accidents are settled two years or three years out and then the treatments, as supplied by Section B, are no longer available and in the settlement, they are provided funding for future treatment, okay. So, consequently, I don't even know how you would even gauge if the people still got their treatments or not because it wouldn't be done by the Section B. It would just be the person doing it themselves. Maybe they've exhausted their cover, right. And I think – all right. Those are all my

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questions. Thank you.

CHAIR:

Q. Thank you.

STAMP, Q.C.:

Q. Oh, I'm sorry, yes. I was just going to say a point, but I forgot -

CHAIR:

Q. Sure.

STAMP, Q.C.:

Q. My apologies.

CHAIR:

Q. Consumer Advocate.

MR. WADDEN:

Q. Afternoon, Ms. Riis. How are you? Thanks very much for coming. I'm Andrew Wadden. I'm counsel for the Consumer Advocate, Mr. Browne sitting to my right. We appreciate your evidence today and we were discussing over the break how it's thus far been quite helpful, so we thank you for that.

MS. RIIS:

A. Thank you.

MR. WADDEN:

Q. I just got a few sort of points of clarification and follow up. Mr. Browne may

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as well.

MS. RIIS:

A. Sure.

MR. WADDEN:

Q. One of the things you started off with today is talking about training that's needed for adjusters in terms of new accident benefits regimes and that's been done, and I think you said you've done some training in fact with All State in the US.

MS. RIIS:

A. Um-hm.

MR. WADDEN:

Q. Give me a better idea, if you would, of what that looks like. Let's just say the new – a new accident benefits regime comes in in Newfoundland. What happens? I mean, do you and others like you sort of descend on the province and sort of go to the insurance companies and -

MS. RIIS:

A. Like Batman.

MR. WADDEN:

Q. Does IBC facilitate? How does that work?

MS. RIIS:

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A. What has happened in other provinces is that the government facilitates that.
MR. WADDEN:
Q. Okay.
MS. RIIS:
A. So, the government pulls together stakeholders prior to implementation, discusses with stakeholders what the plans are for implementation. So, for example, the medical association, the chiropractic association, the physiotherapy association, they could then convey this information back to their members prior to implementation. Most of these associations also have private practice groups which are the people that most typically treat auto collisions and so, these private practice groups would get more and more involved. The insurance industry would also be considered a stakeholder and would be given preliminary information and my experience has been government pulls these stakeholders together.

I have worked with all stakeholder groups to produce training and we had

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insurance adjusters, health care providers and actually lawyers, plaintiff lawyers, in the same room. So, we all heard the same information. A lot of questions, good questions were raised which gave guidance to the government in terms of where do we need to issue interpretive bulletins to clarify the intent of the new regulation.

So, that's what we've done in the past. And as I also mentioned earlier, in Alberta, we followed up with monthly stakeholder conversations where we shared what's working, what's not working. So, insurance companies would call me and say "you know, we've got chiropractors and they're always trying to put in for 30 visits for temporomandibular joint". I'd contact the registrar of the College of Chiropractors in Alberta and say "is this reasonable practice?" The registrar would say "well, not really. I'll talk to them." Or the health – a physiotherapist would call the physiotherapy association and say "this adjuster refuses to approve any of my recommendations for this treatment" and the

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physiotherapy person would contact me and I'd talk to the insurance company and say – I try to give them information about why this is perhaps not a reasonable approach or a supportable approach.
(12:30 p.m.)

So, we did a lot of very casual back and forth without having to go through disputes and engaging lawyers in the early stage of a process. So, I personally thought that was really good and I know in conversations I've had with other stakeholder groups, they also felt that worked really well.
MR. WADDEN:
Q. Okay. Thank you. I guess sticking with the topic of accident benefits and reform, in that vein. We're trying to get a better idea of sort of consumer satisfaction where that's been done elsewhere, okay, consumer, injured person satisfaction. One of the things we heard from a panel of injured people that were here today, and we've all heard anecdotally I'm sure at times, is issues with response times. In other words,

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the injured person being able to avail of their accident benefits, okay. So, have you seen in other jurisdictions that that particular issue is rectified?
MS. RIIS:
A. I know the problem is universal. I think there's always room for the insurance industry to respond more rapidly and I've heard many complaints of injured persons and health care providers saying "the insurer won't call me. The insurer won't call me." I've heard just as many complaints from the insurance industry saying "the health provider won't call me", physicians refusing to hand over medical records until they receive huge payments for it. So, the problem comes from both sides.

But from the perspective of the insurance industry, I know that's a problem. It's certainly one in the training sessions I've done, it's one of the things we emphasize is that in this system, we don't want to be adversarial. We don't want the patient to feel that they're not being

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serviced by their own insurance company. This is your policyholder. You need to be responsive to them. So, it's certainly something we've emphasized. Have we cured it in all cases? I can't comment on that.

MR. WADDEN:

Q. Okay.

MS. RIIS:

A. I wish we could cure it. But I hope that that kind of behaviour is reduced when the system becomes more cooperative.

MR. WADDEN:

Q. Okay. Can we bring up the – it's the IBC February 2018 report or submission, I should say. And Ms. Riis, while we're waiting for that, is that a report you – you wouldn't have that physically in front of you, do you?

MS. RIIS:

A. I don't have it in front of me.

MR. WADDEN:

Q. Okay.

MS. RIIS:

A. I was just thinking about one of the – may I just go ahead?

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MR. WADDEN:

Q. Go ahead. Yeah, while we're waiting you might as well go ahead.

MS. RIIS:

A. In Alberta, we studied injury claims data prior to implementation of the reforms and after implementation of the reforms and one of the things we discovered is that insurance companies were paying more per claim in the first 12 weeks post-injury. So, insurers were paying more to support treatment of injured people, but at 26 weeks, at six months after, there was a lower average cost per claim. So, this sort of supports the concept that if you treat people well and give them good treatment early on, it can reduce the overall cost of claims.

The other thing we looked at is disputes. So, we used the IME as a proxy for dispute and we had fewer episodes of disputes requiring an independent medical examination. So, this study suggests that the process of having the diagnostic

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treatment protocols in place did reduce disputes. It's not – I can't prove that it's 100 percent there and it's still continuing, but at that time, it was looking good.

MR. WADDEN:

Q. Right, okay. Thank you. We have that up now. Can we go to page nine? And I should ask you as well, Ms. Riis, did you – have you reviewed – have you seen this report?

MS. RIIS:

A. No. I saw their May submission. I don't think I've reviewed their February submission.

MR. WADDEN:

Q. Okay. So, you wouldn't have had any input into this particular report then?

MS. RIIS:

A. No.

MR. WADDEN:

Q. All right. Well, that's fine. Can we pan down just under that graph that paragraph there, starts with "Alberta"? Yeah. And they're speaking of their proposal here in terms of accident benefits and you can see

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"Alberta and Nova Scotia also have diagnostic and treatment protocols. The intent is to provide people with common injuries with immediate access to evidence-based treatment" and it goes on. And I can tell you that the – without bringing it up, that Intact, in their submission, has also suggested a similar change to the accident benefits program and have touted that it will mean easier and faster access, okay.

So that sounds great, but this idea of immediate access, and I suppose the word "immediate" has various definitions, but we're trying to get an idea of how quickly a consumer is going to be able to get at their Section B, okay. And you're telling me that there's still, in other jurisdictions, presumably Nova Scotia and Alberta where new Section B ways have been implemented, that there are still delays for the client, the consumer?

MS. RIIS:

A. I meant that sometimes when a client tries to reach an adjuster, does the adjuster return the phone call immediately.

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MR. WADDEN:
Q. Right.
MS. RIIS:
A. So, I'm talking about that.
MR. WADDEN:
Q. Yeah.
MS. RIIS:
A. But in terms of access to treatment, I would say that that's happening quickly because all that has to happen, theoretically I could go from my damaged car, walk into a physiotherapy or chiropractic clinic and say "I was just hurt in a car accident. Can you treat me?" and it starts then. The patient would have to give his insurance information to the physiotherapist. I would call the insurer and say "your policyholder is here. He's just had an accident" and the insurer will tell me "great, get started".
MR. WADDEN:
Q. So that has sped up, okay.
MS. RIIS:
A. That has sped up.
MR. WADDEN:
Q. Okay. That's helpful. And I think Mr.

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Stamp was asking you earlier sort of what it looks like on the ground when someone gets hurt, right.
MS. RIIS:
A. Yes.
MR. WADDEN:
Q. So, let's – if you don't mind, can I just go into that in a little more detail?
MS. RIIS:
A. Sure.
MR. WADDEN:
Q. I'm in an accident on a Monday. On Wednesday, I'm having some effects in my neck. I haven't gone to see my GP yet. I feel I want some physiotherapy treatment. So, how am I getting there?
MS. RIIS:
A. Have you called your insurer?
MR. WADDEN:
Q. No, but I will if you want me to.
MS. RIIS:
A. Okay. So, all you'd have to do is contact your physiotherapist, chiropractor, doctor, to say "I was in an accident. I need to be seen".

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MR. WADDEN:
Q. Right. That simple?
MS. RIIS:
A. It's that simple. And that's why the education is important. If this is implemented, the physiotherapist and chiropractor or massage therapist have to know they need to contact the insurer to tell the insurer.
MR. WADDEN:
Q. Yes, right.
MS. RIIS:
A. There's a claim coming forward, but they're here for treatment now.
MR. WADDEN:
Q. Okay. And in practice, in your view, that appears to be working in these other jurisdictions?
MS. RIIS:
A. Yes.
MR. WADDEN:
Q. Okay.
MS. RIIS:
A. I would say that works. The only time it gets complicated, sometimes patients want to

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

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some physiotherapy and I think you could benefit from massage" and I could coordinate all of that.

But there needs to be some coordination because what has happened in the past is patients are seeing multiple treatment providers, none of whom talk with each other. In the private sector, there's a lot of silos of health care. We don't have team meetings. Nobody's paying for it. So, there's a lack of coordination. But the protocols permit a structure that encourages coordination of care, which I think is good.

MR. WADDEN:

Q. Okay, so you've taken me to my next point and I want to get a better understanding of the role of this coordinating position, and it's actually referenced in the next paragraph in that report, and I guess that is in terms of the ongoing treatment for that person, right?

MS. RIIS:

A. Yes.

MR. WADDEN:

Q. So this can generally be that person's

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existing family physician or if it could be- what if they don't have a family physician?

MS. RIIS:

A. You know, ideally it's perfect if it would be the person's existing family physician or an existing chiropractor or existing physio, somebody who knows this person because that's often the question, at what level were you functioning prior to the accident? But if the person has been perfectly healthy all their life, they've never seen a doctor in their life, then they can go to a walk-in clinic, they can go to the physiotherapist down the road, the chiropractor down the road. And again, hopefully if they don't know what to do, they will contact their insurance company who can give them this kind of advice. The insurance company shouldn't be able to force them to go to any particular clinic, that's how it's worked in the other jurisdictions, so again, if a patient has a history with a certain clinic, the patient is free to continue with the clinic that's familiar to them.

MR. WADDEN:

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Q. Yes. Any issues in the other jurisdictions where this sort of methodology has been implemented whereby there's trouble accessing a coordinating physician, you know.

MS. RIIS:

A. Honestly physicians are not primarily the coordinators.

MR. WADDEN:

Q. Okay.

MS. RIIS:

A. It tends to be physiotherapists and chiropractors in the other jurisdictions.

MR. WADDEN:

Q. Oh, all right, okay.

MS. RIIS:

A. Most physicians aren't interested in doing this piece of the work, so it tends to go to physiotherapists and chiropractors, so many patients who see a physician, the physician says that's not a problem, you should see a physiotherapist or a chiropractor and that physio or chiropractor will coordinate and keep the family physician in the loop.

MR. WADDEN:

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Q. Okay, so I want to backtrack there now, you just said oftentimes it seems to be the case, in your view, that physicians aren't interested in that particular piece of work. Is it not the case that, and that paragraph in fact discussed it, where we just were, the one that starts with "The protocols", that in those jurisdictions there's a government approved fee schedule, so it is, they do get paid for it?

MS. RIIS:

A. Yes.

MR. WADDEN:

Q. But it's the case that generally it ends up not being the coordinating—a physician being the coordinating individual?

MS. RIIS:

A. That's my experience, yes.

MR. WADDEN:

Q. Okay. One of the things that was discussed is this idea that under a new accident benefits regime the auto insurer, at least in the other jurisdictions, as I understand it, becomes first payer?

MS. RIIS:

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

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and we have people, for example who have their own, we'll say Blue Cross insurance that they pay for and a change has been made, so now Blue Cross is no longer the first payer, do you know if people in those jurisdictions have experienced a reduction in premiums for those insurers who normally they would have gone to to be the first payer?
MS. RIIS:
A. I have no idea.
MR. WADDEN:
Q. Okay.
MS. RIIS:
A. It's interesting, though, in Ontario where the auto insurer is still last payer, I have seen group health insurers exclude coverage for motor vehicle accidents.
MR. WADDEN:
Q. Optionally or –
MS. RIIS:
A. No, they basically say that, so, if it's a group health carrier, they'll say that, you know, we'll cover whatever musculoskeletal injuries you have, but we don't cover

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

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

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effectively, they're going to get better, and it's accepted that 90 days or three months is typical tissue healing time. So if at 90 days this individual is not recovered or significantly improved, one needs to start asking some questions about is there something we missed? Is there an occult fracture that has been overlooked, is this person developing chronic pain syndrome? There needs to be a sober second look at what's happening here, so that's why it's sort of a chance to pause and reassess the whole situation at 90 days, which is from a medical point of view, a reasonable point for this type of an injury.

MR. WADDEN:

Q. Tell me what you've seen in other jurisdictions with respect to this 90-day time period? Are people getting, you know, practically are people getting cut off after 90 days and it becomes much more difficult for them to avail, to continue to avail of the benefits or what's happening?

MS. RIIS:

A. In my experience they're not getting cut off

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at all, again if the healthcare professional can explain why further treatment is needed, what the goals of treatment are and if the health professional can report on their success in achieving the goals, I find the insurers are happy to approve ongoing treatment. So I haven't had the experience that they get cut off. That's not to say that there aren't some insurers that may just try to cut people off at the 90 days, but certainly that hasn't been my experience in Alberta, Ontario or Nova Scotia.

MR. WADDEN:

Q. Okay, and after that 90-day period, assuming that there is some sort of report required, who is dealing with that? Is it again that coordinating individual, is the onus upon the insured to get that report and get it to the insurer or what's going on there?

MS. RIIS:

A. No, the healthcare practitioner, the coordinating healthcare practitioner has to write a report on what's happening, what's needed going forward and again, I find there's fewer disputes at this point because

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the working relationship generally is very good during the course of the protocols. And as I said, there was less reliance on IMEs when we looked at the Alberta data after implementation.

MR. WADDEN:

Q. Okay. Can we just move down, it's already there on the screen, No. 4 there and I'll just read it into the record, it says, "Also as in Alberta and Nova Scotia, physicians, physiotherapists and chiropractors should be the only health providers eligible to coordinate treatment within the protocols; however, they should be able to use some of the injured person's treatment visits for massage therapy, acupuncture, dental services, psychological services and occupational therapy." So I read that and it kind of struck me that there almost seems to be some sort of imposed segregation between the professions. So, someone such as yourself, a physiotherapist, you can be a coordinator?

MS. RIIS:

A. Right.

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MR. WADDEN:

Q. Or a physician obviously, right?

MS. RIIS:

A. Right.

MR. WADDEN:

Q. But if you're a massage therapist, you don't get to do that. What's the rationale there?

MS. RIIS:

A. I think that the original rationale is that massage therapists are not regulated health professionals in all provinces, I'm not sure if they are regulated here or not, but physicians, physiotherapists, chiropractors are regulated health professionals and again, they're sort of the obvious treatment providers for musculoskeletal injury, that's what these people do.

MR. WADDEN:

Q. Sure.

MS. RIIS:

A. The reason that they didn't include an acupuncturist, for example, again, there are a variety of people doing acupuncture and the regulation of that field is, varies from place to place. Dental services are

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probably rarely required, if somebody has a jaw strain or sprain, and likewise psychological services, most of these people start with a physical injury first and then it might progress and psychological symptoms become recognized in the first week or two of treatment. So as a starting point most of these injuries start as a physical injury, so the physical treatment provider is engaged. All of these treatment providers, physicians, physiotherapists, and chiropractors are able to assess for psychological symptoms, they cannot diagnose a psychological problem, but I am required to determine if somebody says "I can't sleep, I'm crying all the time", I need to recognize that this person needs help, so I might call their family physician and say I think there's some psychological issues that need to be addressed, or I can say to the patient are you interested in seeing a psychologist or a councillor and we can put that into play.

MR. WADDEN:

Q. Okay. Let me just ask you generally, rather

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than going through, you know, 50 different questions, in your experience in these other jurisdictions where this new accident benefits regime has been put in place, what are the main, if any, problems?

MS. RIIS:

A. I would say ambiguity around the definition and how people interpret the definition. That's where I have seen a lot of the dispute. I always say to health professionals it's not your business to decide if this falls in the cap or not, it's irrelevant. You just need to treat that patient, assess the patient, figure out what's wrong with them and treat them. But then if the insurance company starts to say they're in the cap, they're not in the cap, the ambiguity around the definition has always been a problem and that's why there have been efforts to refine and improve the definition in some areas.

MR. WADDEN:

Q. In terms of, and you're talking about the cap now, so let me just go to the cap for a second. In other jurisdictions, aside from

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the new accident benefits regime that may have been implemented, where a cap has been implemented, right, so we'll say Nova Scotia, obviously as you know there's oftentimes disputes as between the injured person or the injured person and their counsel and the insurer, right?

MS. RIIS:

A. Yes.

MR. WADDEN:

Q. Do you ever get called in on any of these disputes to give sort of any—or any of your colleagues to give a professional opinion on whether or not a person should be restricted to cap damages or if they fall outside the cap?

MS. RIIS:

A. No, to me that's a legal definition.

MR. WADDEN:

Q. Right.

MS. RIIS:

A. So as a physiotherapist I'm called to provide my opinion on what the injuries are, and so I would provide my opinion to say here's what I think the injuries are, here's

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what I think the physiotherapy prognosis is, and that's the end of my expertise. I think that's where we've had a lot of problems. When these systems are implemented, sometimes the healthcare professionals think it's their job to make that legal determination and they don't understand that it is a legal determination, not a medical one. So there's confusion about who should be making the determination, so again, I underscore the need to educate all the stakeholders about the definition being a legal definition and it's not one that health providers should be making or trying to make. Did I go off on a tangent?

MR. WADDEN:

Q. No, no, not at all, that's fine. Just one more point of clarification because when I asked you a moment ago about struggles and problems in terms of any new accident benefits regime that's been implemented, you started talking more about the cap and arguments over the definitions, that's why I followed up with a question.

MS. RIIS:

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A. Yes.
MR. WADDEN:
Q. But let me go back to that for a second because, you know, someone could avail of their accident benefits, as long as they're injured, you know, it's a no fault type of regime, but I'm just trying to get an idea with all these new protocols that are being suggested for Newfoundland and which have already been implemented elsewhere, and under which we're being told the system works better, people get more treatment, this accident benefits regime is overall better than what you have in Newfoundland right now, I get the sense from you it is better, in your view, but again, I want to get—there's got to be challenges with it, right, there's got to be the criticisms in other jurisdictions.
MS. RIIS:
A. Of course.
MR. WADDEN:
Q. So if our government, this Board decides that this new regime that's being suggested is a good idea, what can we expect to be the

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main problems to come out of it?
(1:00 p.m.)
MS. RIIS:
A. I think there's always criticisms no matter what you do, you're going to have criticisms if you stay where you are, you're going to have criticisms if you implement a new system. I would think that initially when implemented effectively so everyone understands their role in the process, I think you're going to see some benefits. I think over the long term there will be some effort to find ways of escaping the cap, because I think people who have been injured through no fault of their own feel that they want as much justice as possible, so escaping the cap makes them feel like they're going to get a larger settlement and that's going to be more fair for them. So over time sometimes we see erosion of the premium savings that come from implementation. So I'd say that's one problem and again, it often revolves around ambiguities in interpretation of the definition, and part of that problem is

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because health providers think that they're supposed to be making the determination which, in my view, they should not be. They should simply be assessing the patient, treating them. So I'd say again, I think I'm repeating myself, I guess the other problems I've seen, I mean, I'm thinking of an example in Ontario but we're not talking about the Ontario system here. If I think of anything else, I'll –
MR. WADDEN:
Q. All right, that's fine. I think Mr. Browne may have a couple of questions for you as well. Thank you very much.
BROWNE, Q.C.:
Q. Yes, I wanted to go to the Ontario system because in the Ontario system –
MS. RIIS:
A. Don't.
BROWNE, Q.C.:
Q. - you have a large deductible as one of the possibilities there and here we're all talking cap, a deductible is one of terms of reference that has to be looked at as well. Can you comment on the Ontario system

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deductible and how that works in terms of your profession?
MS. RIIS:
A. No. I'll be honest with you, I have not had much to do in any discussions around the deductible, exactly how that is applied and how it works, so I would be uncomfortable commenting on that.
BROWNE, Q.C.:
Q. In terms of your own report, you stated on page 10, if we can go to page 10 and we see on the top of the page there, "The purpose of auto insurance is to facilitate recovery of any financial loss and most importantly enable injured persons to recover and return to their pre-accident lives. It is my experience that the litigation process cannot undermine achievement of this latter goal. This has been documented in the medical literature." Can you expand upon that?
MS. RIIS:
A. So again, I've provided two examples where this Australian inquiry found that in this situation the third party insurer is

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unwilling to accept any liability, so this forces the injured person into a posture where they have to prove their disability, emphasize their disability, focus on their disability and that's from a rehabilitation perspective, that's the last thing you want somebody to do is focus on how horrible their life is, but the system sort of forces one to think about how disabled I am, you have to answer a lot of questions about what I can't do, what I wish I could do, how much pain I have and you're repeating this over and over. And, of course, there's the perception that the size of the award, the non-pecuniary damages is tied to absence of recovery, so there's a perception that there's a disincentive to recovery in some situations.

BROWNE, Q.C.:

Q. In terms of the, you're talking about a return to their pre-accident lives, a return to work, and in terms of a return to work, you go to the first, a person who is injured in an accident, goes to see their physician. The physician's first diagnosis really is

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you need a few days off work and therefore, three or four days off to see how you are doing. And there's now some concern that that immediate prescription of taking the first few days off is not perhaps the correct one. Some employers get notes that say "So and so has been in an accident", they can't work because they have a doctor's note saying they're off for three or four days. There's some jurisdictions that are considering an implementation at that particular point of the doctor's note, for the doctor to also give the employer a functional abilities, can you comment on that?

MS. RIIS:

A. Abilities, uh-hm. I think in most cases when a doctor is asked to comment on disability, it's a very difficult thing to do. Essentially when you go to see your doctor, the doctor is going to say, you think you can work? And if you say no, I can't work, the doctor is going to sign you off. A functional abilities evaluation is something that's carried out by, typically

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

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recommendations to resume normal activities as soon as possible. That seems to result in better health outcomes in the long term.

BROWNE, Q.C.:

Q. You also mention in your evidence about the Tylenol study, you know, they go to the doctor and the doctor says, well take Tylenol for a few days, but some doctors are prescribing other than Tylenol and we have a bit of a crisis in this country now because of what is out there in the system. Can you tell us your experience in reference to that? Is there an over prescription of painkillers that have addiction in their result, have you had that experience?

MS. RIIS:

A. I'm a drugless practitioner so I don't have expertise in prescription medications, et cetera. I think I would just refer you to what you can read in the media, there are a lot of initiatives by the Canadian Pain Society, there's a number of national groups that are publishing information and recommendations on prescribing patters of physicians and alternative treatments for

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pain, instead of medication. So I think there's some movement happening in that regard and I suspect that is going to continue for a number of years now.

BROWNE, Q.C.:

Q. You must have worked within your own profession with clients who are under some kind of pain prescription as well, have you come across it, anecdotally?

MS. RIIS:

A. Yes, so certainly as a physiotherapist, or chiropractors, we're supposed to ask what medication are you taking, because often a patient may be experience headaches or dizziness and that may be a side effect of medication. So, you know, if we are concerned that medication is causing side effects, we have to contact the physician, express our concern and the physician would then review the medication. So certainly I've seen those cases, I've seen cases in particular where patients had prescription medication from their physician and then they're buying over-the-counter stuff as well, and so that's of great concern, so we

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always have to refer back to the physician, let them know that there's over-the-counter, so I think the medication issue is being looked at far more closely by all healthcare professionals.

BROWNE, Q.C.:

Q. In terms of your resumé, some things caught my attention there under your professional activities it states there, the third last from, the bottom there, it says, "Expert witness at FSCO arbitration, file number between Shiva Ahmadi and Allstate.

MS. RIIS:

A. That was a financial services commission of Ontario which would be the counterpart to the Board, and it was a case, that case I had mentioned earlier where I had developed a return to work plan with the woman's physiatrist and the claimant disputed that I was appropriate in recommending that return to work problem, so it was a dispute resolution mechanism.

BROWNE, Q.C.:

Q. Okay, do you see dispute resolution mechanisms as more appropriate than perhaps

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the litigation, the court litigation, do you have any comments on that from your own experience?

MS. RIIS:

A. Again, not my area of expertise. I don't think I want to comment on that without being able to give it much more thought.

BROWNE, Q.C.:

Q. Thank you very much.

MS. RIIS:

A. Thank you.

CHAIR:

Q. Thank you. Any questions, Mr. O'Flaherty?

O'FLAHERTY, Q.C.:

Q. I don't have any questions for the presenter, thank you.

STAMP, Q.C.:

Q. Madam chair, I just have one question. Ms. Riis, a couple of questions have focussed on the issue of serious impairment because that's obviously an exclusion from the definition, whatever you want to call that definition or how do you define it or what you call it, how you label it, and it talks about, these definitions appear to talk

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about impairment of a physical or cognitive function, is that the standard type of exclusion?

MS. RIIS:

A. I know that's one definition, but it really—so physical or cognitive function, physical means the functioning of your body, your anatomy; and cognitive means the functioning of your mind and your ability to think. But then the question is what constitutes a serious impairment of that and that again, my feeling is referring to the World Health Organization classification and framing that in terms of functioning would be the most reasonable way to go because I think what I heard is that many presenters have commented that the same injury in two different people manifests itself or can manifest itself in very different ways, so that's why we have to look at the end result of how are they functioning.

STAMP, Q.C.:

Q. And so the serious impairment definition is also important because that picks up on both the psychological, as well as the physical?

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MS. RIIS:
A. Yes, of course.
STAMP, Q.C.:
Q. Thank you.
CHAIR:
Q. Thank you. Thank you, Ms. Riis, that's very helpful, very interesting.
MS. RIIS:
A. Thank you.
CHAIR:
Q. I guess you can step down whenever you're ready. You don't have to sit there and listen to us.
MS. RIIS:
A. Okay.
KENNEDY, Q.C.:
Q. Members of the Board, we've got a bit of a scheduling problem here. We have two individuals from Ontario who are here and ready to give evidence, but based on what I'm seeing, even if we can present their evidence in an hour, we're going to need who knows for cross-examination, so I'd think at a minimum it would be an hour and a half. I don't know would the Board, we'd obviously

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

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will have a few questions for sure, and other counsel, I don't know.
CHAIR:
Q. So we need at least an hour.
KENNEDY, Q.C.:
Q. We need an hour and a half, I think to be fair.
CHAIR:
Q. Let's suggest we take a nature break because we're going to be here for an hour and a half in any event, if we come back.
MR. WADDEN:
Q. Madam Chair, we really want to hear from the Ontario Trial Lawyers Association, quite frankly, but we have other commitments this afternoon.
CHAIR:
Q. That's what I was going to say, you're going to have to canvass amongst each other to see if there's either party who can't stay for the afternoon, then I guess we can't –
MR. WADDEN:
Q. Maybe there's another solution, maybe we can even start earlier tomorrow, I don't know, but this afternoon is going to be a problem.

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CHAIR:
Q. Okay.
KENNEDY, Q.C.:
Q. Well maybe can we just start now and we need to present these witnesses, they're going to be also referring to some of the things that Ms. Riis talked about.
CHAIR:
Q. Well if we're going to start now and you're going to be an hour, I need a break.
KENNEDY, Q.C.:
Q. Sure, and I know staff and everyone is going to need a break, that's what I'm saying, yeah.
CHAIR:
Q. I can sit here until 5:00 but I do need a few minutes break.
STAMP, Q.C.:
Q. Madam Chair, have we determined what time the consumer advocate has to leave, is that something we can identify?
CHAIR:
Q. Yes, that would be helpful, so can I just suggest, maybe you can canvass amongst each other, that will be helpful too. I'll go do

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

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

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

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

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

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

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

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all the time, despite all of these cuts.

O'FLAHERTY, Q.C.:

Q. Madam Chair, just one moment, I'm sorry to interrupt the presentation. We have a technical issue. We need a moment just to change the card in the machine.

(OFF RECORD)

REPORTER:

Q. We are back on the record, thank you.

CHAIR:

Q. Thank you very much.

MR. WYNPERLE:

A. A few things that were raised today which I found very interesting, in Ontario one of the significant issues has been whether the auto insurance system is paying its fair share of the rehabilitation costs in the province, and what we have actually seen is our auditor general in Ontario describing a downloading from the auto insurance system onto the public system, which is, in my submission very dangerous. As a taxpayer it is very upsetting that the auto insurance system is short changing the provincial healthcare system by hundreds of millions of

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dollars over almost thirty years now. The auditor general said in 2014 that over a billion dollars was essentially missing from the Ontario healthcare coffers over the course of time as a result of the shifting of the burden, if you will, by not having people properly funded for their healthcare by their auto insurer. And it is a significant issue.

The other thing I just want to raise that I heard today in the discussions was about seniors. I think they are the most affected by the changes in legislation. They don't have claims for loss of income because they're retired, generally speaking, and pain and suffering damages mean a lot to them, and taking that away has seriously affected the rights of senior citizens; in fact, I've had that conversation with politicians who are responsible for senior citizens in Ontario. It is a very hard thing to tell someone whose life has been dramatically affected, their quality of life has been dramatically affected there is very little or nothing I can do for you because

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the cost of taking a case to trial is worth far more than your pain and suffering damages once we take off the deductible, or in a situation like there where you are taking a huge risk with a senior in a situation where the case might be capped at $7,500 or something like that. It is very hard to tell them that. It is not something they deserve after a lifetime's worth of work, so those are my comments.

KENNEDY, Q.C.:

Q. Mr. Karapita, could you please have some preliminary comments?

MR. KARAPITA:

A. Thank you. I was just going to add to the dialogue here today to give you some context for why we got involved, and I think it started when we saw the letter that the IBC had sent to MHAs last week about the review before this Board and I read it, and as I read it, it brought to mind many of the experiences that we faced in Ontario is eerily reminiscent over the last several years of what we've seen in our dealings with the Insurance Bureau of Canada, the

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property casualty insurance industry in general. And in the letter a number of points stood out to me because, as I say, they were similar to what we've seen, that auto insurance premiums are too high, our claims are too high relative to premiums, that real change is needed, that there is a well-meaning dialogue that is being sought with elective officials, but on that point there is a complaint about sources from outside the industry and a suggestion that –

STAMP, Q.C.:

Q. Excuse me, Madam Chair, if I just might inquire, do we have a copy of this letter that is being referred to?

CHAIR:

Q. The Board?

STAMP, Q.C.:

Q. Is it in the materials we have?

MR. FELTHAM:

Q. No, it's not in the Board record, I just made that inquiry myself.

STAMP, Q.C.:

Q. Okay, that's fine, go ahead, thank you.

MR. KARAPITA:

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

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

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claims costs drop. We saw the trends towards higher premiums and yet the IBC went so far as to suggest that we were provocating myths and that they were the purveyors of fact and they alone.

(1:30 p.m.)

MR. KARAPITA:

Q. What they did at the time too, they were warning of what they called a tsunami rolling through Ontario's auto insurance system because of unresolved legal disputes, which never came to pass. They wrote to our finance minister at the time urging concern about the term the "fragile savings" that were brought about through the 2010 reform. And it's pretty clear that the data since that time, the data initially, but the data since that time has confirmed and the data I'm talking about is the GISA data which is generated by the industry itself, but it proved that those savings were permanent and well entrenched. So it was in the context of that history that we faced in Ontario that we brought forward some concerns to our colleagues here in St. John's to talk about

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our own experience. It's what we saw as a pattern of the industry focussing on selected mounting claims costs, using the Ontario context, if you will, and the pattern of downplaying the insurance industry's profitability and dismissing the need, frankly, for accountability and transparency in some of that data.

KENNEDY, Q.C.:

Q. Okay, so if I could just ask you a couple of points of clarification, Mr. Karapita. First, I see from your background, which is attached to the letter that's been filed with the Board, that at one point did you work with the Insurance Bureau of Canada?

MR. KARAPITA:

A. That's correct, sir, I did.

KENNEDY, Q.C.:

Q. Where did you work with them and for how long?

MR. KARAPITA:

A. I worked for the IBC in Toronto from March 1999 until January 2008.

KENNEDY, Q.C.:

Q. And what was your role with the Insurance

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Bureau of Canada?

MR. KARAPITA:

A. Initially I was the manager of government relations in the Ontario regional office of IBC which is part of the headquarters in Toronto, and then I moved on to the public affairs and marketing department of IBC first as an external relation or media relations manager and manager of regional issues.

KENNEDY, Q.C.:

Q. How long have you been with the Ontario Trial Lawyers Association?

MR. KARAPITA:

A. Just over eight years now.

KENNEDY, Q.C.:

Q. Okay, so eight years. Now, you indicated that you brought to the attention of your colleagues in St. John's, did anyone from, any lawyers in St. John's contact you or anyone on behalf of the Campaign to Protect Accident Victims?

MR. KARAPITA:

A. No, the initial contact was from me to Steve Marshall at the firm of –

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KENNEDY, Q.C.:
Q. Roebothan McKay Marshall.
MR. KARAPITA:
A. Thank you.
KENNEDY, Q.C.:
Q. Okay, so when did you contact Mr. Marshall and how did you go about that?
MR. KARAPITA:
A. I contacted him by email and I believe it was early last week.
KENNEDY, Q.C.:
Q. And what was your purpose in contacting Mr. Marshall?
MR. KARAPITA:
A. My purpose was to highlight some of the concerns that I saw with respect to the IBC communications and interest and encouragement to lawyers here and other concerned parties to raise some of these concerns with elected officials.
KENNEDY, Q.C.:
Q. Okay, so if we can now look at – if we can go to your letter in terms of number one, Mr. Wynperle, or Mr. Karapita, is there any further comment you'd make on your brief

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review of Ontario's no fault auto insurance system?
MR. WYNPERLE:
A. Well, I think that we – again what you experience is, you know, a system where the insurance companies have us on a – really on a carousel of amendments; if at first you don't succeed, try, try, try, try again, and continue to amend the legislation. Each amendment really taking away rights of injured victims, and also costing all parties a significant amount of money to then figure out how to implement these systems without, I should say, real verifiable audited financial statements from the insurance companies to prove the need for either reduction in the policy rights of individuals or to increase premiums either way. That has never been provided in Ontario. The insurers can get increases in premiums. They do not have to provide line item statements to the regulator or to the public, and nor do they have to when they ask for reductions in the policy.
KENNEDY, Q.C.:

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Q. If we could then move to number two, the need for greater transparency and accountability from the property and casualty insurance sector on the performance of auto insurance companies in Canada, with examples from Ontario, would either of you like to speak to that, please?
MR. WYNPERLE:
A. Well, I think that's what I was just talking about, it's just that we believe that because every motorist in Ontario, and I presume here as well, is required to carry auto insurance when they drive a car, and that's become a fact of life that most people have to drive in order to get to work and get around. You know, the insurance companies are in a privileged position, and as such with privileges come responsibilities, and we believe that one of those responsibilities should be fair disclosure of information so that everybody can see real evidence of the need for the changes before we go and make all these changes.
MR. KARAPITA:

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A. A further point to add to that, insurers reports financial data on a global basis across the country, and they'll do that to the federal regulator, the office of the Superintendent of Financial Institutions. They do not break down specific information by line of business, auto insurance, for example, in Newfoundland and Labrador. So that we do not have access to detailed information, apart from the claims information that we might see with GISA, but that's the issue, and one further point that I'll just add as part of that background, IBC used to release that global financial data and I believe it was when I was there 12 or 13 years ago, they stopped releasing even the publicly available data. It is available, but it's kind of tricky to find. You have to navigate the site at OSFI and understand how to combine the numbers.
KENNEDY, Q.C.:
Q. Number three refers to a review of the profitability of insurers with examples from a York economics professor, Fred Lazar. Do either of you want to comment on that,

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please?
MR. KARAPITA:
A. Yeah, I'll just comment on that briefly. Following that period in 2012 or so, the latest analysis by Dr. Lazar from York University shows that profitability in Ontario auto increased dramatically, some 60 percent to 1.5 billion dollars in 2016, or a return on –
KENNEDY, Q.C.:
Q. Sorry, how much – what was that, sir?
MR. KARAPITA:
A. 1.5 billion dollars in Ontario auto premium or auto insurance alone, and that represents 16 percent return on equity for the entire industry in Ontario.
KENNEDY, Q.C.:
Q. What year was that, Mr. Karapita?
MR. KARAPITA:
A. 2016.
KENNEDY, Q.C.:
Q. Sorry. Continue, sir.
MR. KARAPITA:
A. What he also suggested - because Dr. Lazar and his colleagues some years previously had

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reviewed for the Ontario government the profitability benchmark that companies would be allowed to shoot for as part of their underwriting criteria for setting premiums and rates, and he did that review, and as part of our analysis, he has suggested that what they ought to have done was settled on a rolling ten year average to see the profitability benchmark move more quickly than it has over time. He suggests, based on his analysis and economic considerations, that again going back to that 2016 year, that where the industry earned 16 percent, according to his calculation he feels that the benchmark should have been no more than 5.1 percent return on equity for the industry.
KENNEDY, Q.C.:
Q. Mr. Wynperle, and Mr. Karapita, has there ever been in your experience a time when the insurance industry or IBC, on behalf of the insurance industry, has claimed to be losing money in the automobile insurance industry?
MR. WYNPERLE:
A. Quite regularly they are claiming that the

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product is either losing money or just not sustainable as it exists in its form at that time.
MR. KARAPITA:
A. It's often the challenge of getting information on that because while they can sometimes and frequently claim to be losing money, they seldom admit to making money.
KENNEDY, Q.C.:
Q. In terms of number four, and we can get some further examples from Dr. Lazar tomorrow, number four, perhaps if either of you would like to speak to the pertinent examples from recent Ontario history where insurers have promised better and more responsive coverage?
MR. WYNPERLE:
A. Well, I think one of the examples I already spoke about today was the minor injury guideline, which is that type of, you know, sort of canned treatment, if you will, that starts off the process and how it's really used in the province of Ontario is to try and cap out injured people from taking more than $3,500.00 in treatment. So you

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essentially have to get – you have to get beyond the minor injury guideline, and they restrict you significantly in how you do that, and as I said, that has come at a serious cost for the defence, the plaintiffs, and the system itself, the government run system is at an expense, the dispute resolution system. You know, it costs a lot of money to do that.
KENNEDY, Q.C.:
Q. And of you mentioned earlier that at one point there were medical benefits of $100,000.00, reduced to $3,500.00?
MR. WYNPERLE:
A. Prior to September of 2010, every Ontario resident injured in a motor vehicle accident, or every person injured in Ontario in a motor vehicle accident, would get up to $100,000.00 in medical and rehabilitation benefits, so long as the treatment was reasonable and necessary and related to the injury. In 2010 that changed and that minor injury guideline was brought in, and I would estimate that probably 75 to 85 percent of people injured in accidents get caught in

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that minor injury guideline. Now a number of them eventually get out of the minor injury guideline with the help of legal counsel, but that is a long difficult process and a costly one, unfortunately.

KENNEDY, Q.C.:

Q. So when did it go down to $3,500.00?

MR. WYNPERLE:

A. 2010, September.

KENNEDY, Q.C.:

Q. And so do you know – in terms of the profitability of the insurers, you're saying Dr. Lazar says 1.5 million in 2016.

MR. WYNPERLE:

A. Billion.

KENNEDY, Q.C.:

Q. Do you know if they made money in other years between 2010 and 2016?

(1:45 p.m.)

MR. WYNPERLE:

A. Well, we believe that they are making money in Ontario, although that's always in serious question, and the issue in Ontario has been to try and reduce premiums. There has been a big push on to reduce premiums

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because, as I said earlier, we have the unenviable position of having the most expensive premiums, and, unfortunately, despite all of these changes, that has not happened, and so the money really has to be going somewhere.

KENNEDY, Q.C.:

Q. When were the – this threshold, this verbal threshold, when was this system brought in in Ontario?

MR. WYNPERLE:

Q. It was first brought in in 1990 in a different form, but the present form of verbal threshold where you have to prove serious and permanent injuries to get any pain and suffering damages, and by the way, any future cost of care damages as well, was in its present form brought in in 1996, November, '96.

KENNEDY, Q.C.:

Q. Mr. Karapita, is there anything you want to add on number four?

MR. KARAPITA:

A. No, sir.

KENNEDY, Q.C.:

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Q. And number five, have you already spoke about that, Mr. Wynperle, in terms of the offloading of services from the insurance system to the public health care system?

MR. WYNPERLE:

A. Thank you. I believe that my comment about the Auditor General's Report, the Auditor General has reported on this issue twice now in Ontario, not recently, but I believe the last time was 2014, and it should be a significant concern for all taxpayers that the insurance industry is under funding the health care system significantly.

KENNEDY, Q.C.:

Q. And number six, need for a more thorough review of insurer operations, especially with regard to insurance expenses and efficiencies, would either of you like to comment on that, please?

MR. WYNPERLE:

A. I don't know that there's any more I can add on that.

MR. KARAPITA:

A. I'd just add that one of the points that Dr. Lazar raised was the current expense ratio

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of 25 percent allowable in Ontario is something that's probably not been looked at for a long time, and as he said, I believe, in his report, it's quite likely that companies have worked and achieved greater efficiencies and are, in fact, hitting below that number and, therefore, deriving further profit as a result.

KENNEDY, Q.C.:

Q. My last question for you at this point, and again it reiterates the comment that Mr. Stamp put to Dr. Misik in terms of why are you here today, I know you've explained that, Mr. Karapita, in your introductory comments, but could either one of you elaborate on why the Ontario Lawyers Association, the two of you, have taken time out of your busy schedules to come to and appear before the PUB here in Newfoundland and Labrador?

MR. WYNPERLE:

A. Well, we believe that all Canadians who in their provinces have private insurance, auto insurance systems, are facing the same problems. The insurance companies are

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complaining and are concerned, and are putting political pressure on elected officials because they believe the product is not profitable, but at the same time we all face the same difficulty in that we do not have the necessary financial data, audited verifiable financial information, in order to allow us to make decisions. Not just politicians, but all stakeholders within the industry, should have that information available before any decisions are made, and we see an ongoing miscarriage in the way things are being done in our province, and we hope to help show you some of the pitfalls that we have faced in order that you not face those as well.

KENNEDY, Q.C.:

Q. Before I get to you, Mr. Karapita, has there ever been any – one of the suggestions made here to counsel for APTLA was that there was, I don't know if hiding of reserves, but they would overestimate reserves in one year to show a loss in another year. Have you encountered anything like that in Ontario?

MR. WYNPERLE:

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

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seen the effect on the policy decisions when incorrect data isn't corrected.

KENNEDY, Q.C.:

Q. My last point, is there anything you want to add, Mr. Karapita, on why you're here today, that you haven't already said?

MR. KARAPITA:

A. No, sir.

KENNEDY, Q.C.:

Q. Good. So those would be my questions, Madam Chair.

CHAIR:

Q. Thank you, Mr. Kennedy. Mr. Gittens?

GITTENS, Q.C.:

Q. APTLA waives any questions. Thank you.

CHAIR:

Q. Thank you, Mr. Gittens. Mr. Fraize?

FRAIZE, Q.C.:

Q. No questions.

STAMP, Q.C.:

Q. I have some questions. Thank you.

CHAIR:

Q. Okay.

STAMP, Q.C.:

Q. Mr. Karapita, first of all, if I can just

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ask you: the position you had with IBC, was that a communications position?

MR. KARAPITA:

A. Not initially, no. It was a government relations or lobbying.

STAMP, Q.C.:

Q. What does that mean?

MR. KARAPITA:

A. Government relations?

STAMP, Q.C.:

Q. Yeah, what does it mean?

MR. KARAPITA:

A. That means primarily a role facilitating contact with elected officials.

STAMP, Q.C.:

Q. So, you're not an actuary?

MR. KARAPITA:

A. I'm not, sir.

STAMP, Q.C.:

Q. You're not an economist?

MR. KARAPITA:

A. No, sir.

STAMP, Q.C.:

Q. And when you talk about the GISA data being unreliable or incorrect, you're relying on

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someone else's opinion to say that that's the case?
MR. KARAPITA:
A. Not entirely, no. I'm relying on the observations that I made based on an understanding of GISA data and an understanding that I think probably compares well with several in the industry, perhaps not as advanced as an actuary, but the trends were clear. They were well established. I saw numbers that in one year were significantly higher than in subsequent years as a result of the development of data. And I think it takes that understanding of how industry data does develop over time. It's not like a financial report where you see a number issued by XYZ company in their financial statements and it's like that for all time. We know that insurance data does develop. And as a result of that understanding, we saw changes in bodily injury -
STAMP, Q.C.:
Q. Who's "we saw"? Who's we?
MR. KARAPITA:

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A. Well, I think our association, but I saw it.
STAMP, Q.C.:
Q. You saw it. So, again, you're not an actuary. You're not an economist. Yet you're seeing this actuarial unfolding -- this actuarial information unfolding in front of you?
MR. KARAPITA:
A. Let me specify that. No, I don't think it's actually actuarial data. These are claims trends that are well established. The numbers are – we could have a discussion, I'll show you the numbers on the page. It's quite obvious.
STAMP, Q.C.:
Q. Okay. You're asserting that you've studied these documents and you're coming here to this Board and telling them that you're satisfied that the GISA data shows that the – that GISA data is incorrect. That's what you're saying?
MR. KARAPITA:
A. I'm suggesting that the GISA that was represented in a report issued by David Marshall in April 2016 parroted the data

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that appeared four years previously and that report by David Marshall was prepared in association with our Ministry of Finance and our regulator and yes, I maintain, based on the clear numbers on the page, which I think are readily understandable by people with some understanding and some orientation to that data, as incorrect.
STAMP, Q.C.:
Q. You talk about this incorrect data and yet the data that GISA generates is generated strictly for the rate regulators across the country. They tell GISA what to generate. GISA generates the data. How does it possibly make sense that the rate regulators across the country and the regulators generally, the Superintendents of Insurance and so on, don't know what they're doing and you do know?
MR. KARAPITA:
A. I think that's an unusual characterization of what I said. I think what I'm getting at is that I have faith in the GISA data. I understand how the GISA data works and it's on the basis of the reputation of GISA that

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I concluded that there were changes in the accident years 2013 and 2012, 2013 and 2014 and that the revisions that showed up in the GISA data upon which, you know, I've made my statements that the previous data, which may have been correct at the time that it was initially compiled, could no longer be seen as correct because it was changed by GISA itself.
MR. WYNPERLE:
A. And just to continue that thought, the problem is people who are assessing the need for change in the government, some of them, are still using the out of date GISA data, not the updated GISA data, in order to justify decisions which are being made. That's the comment.
STAMP, Q.C.:
Q. Mr. Perland – I'm sorry, Wynperle
MR. WYNPERLE:
A. Yeah.
STAMP, Q.C.:
Q. Is it Wynperle, I'm sorry?
MR. WYNPERLE:
A. Yeah, that's fine.

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STAMP, Q.C.:
Q. One of the things you spoke about was this downloading of insurance costs to the public system.
MR. WYNPERLE:
A. Yes.
STAMP, Q.C.:
Q. Why would that happen when the Minister of Finance or whichever minister is responsible for it can apply a levy against the insurance companies to recover the downloaded costs?
MR. WYNPERLE:
A. Well, that's a great question and I suspect that you would have to ask the governments of the day why they would tolerate that. All I can really speak to is what the Auditor General of Ontario has said, which is that the governments are not collecting an amount of money in the levy which is commensurate with the cost on the system and it's shortchanging what we call OHIP, the Ontario health area system, by hundreds of millions of dollars a year and it's a real problem that's being pointed out. But, no

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government has taken up the torch, so I can't speak to that.
STAMP, Q.C.:
Q. And can you speak to the fact that the levy is placed in Newfoundland every year? It varies every year based on the calculations that are done by the appropriate officials?
MR. WYNPERLE:
A. I don't want to make any comment about the levy in Newfoundland. I don't know anything about that. But what I do know is that – again, just speaking about the Ontario system, that changes to the system have caused increasing downloading, not only by the way on the health care system, but on the social services system and that that will continue to be the case. And taxpayers ought to be aware of that risk and I certainly commend your legislature to protect taxpayers against that risk. And if they're doing that then that's great.
STAMP, Q.C.:
Q. And you have no reason to believe that in Newfoundland it's not being done?
MR. WYNPERLE:

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A. Absolutely not, sir. I cannot speak to the Newfoundland experience. That's not my area of knowledge.
STAMP, Q.C.:
Q. Now, one of the areas, Mr. Wynperle, that you spoke about was this issue of getting your clients, others I guess, get their clients out of the – what do you -
MR. WYNPERLE:
A. Minor injury guidelines.
STAMP, Q.C.:
Q. Minor injury guideline. And I understand your firm has published an article on that very point.
MR. WYNPERLE:
A. Okay. It may be so. It may be so.
STAMP, Q.C.:
Q. Well, I'm looking at an article published by your firm April 3rd, 2018. So, it's just – it's not very old.
MR. WYNPERLE:
A. Okay.
STAMP, Q.C.:
Q. "There are three readily accessible methods for removing an injured person from the

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MIG."
MR. WYNPERLE:
A. Yes.
STAMP, Q.C.:
Q. Psychological or psychiatric impairment.
MR. WYNPERLE:
A. Yes, related to the accident.
STAMP, Q.C.:
Q. Chronic pain.
MR. WYNPERLE:
A. Yes.
STAMP, Q.C.:
Q. Pre-existing condition. And then you go on to explain what to do about having these issues canvassed and, I guess, pushed forward so to try and make sure that a client comes out.
MR. WYNPERLE:
A. Right. So, in Ontario, what happens is if you get to the end of the minor injury guideline and the health care practitioner asks for a further extension of treatment, the insurer can accept that or reject it and if they reject it, what's going to happen is they're going to send the insured person to

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

STAMP, Q.C.:

Q. Or, as you say, they are determined to be outside the guideline?

(2:00 p.m.)

MR. WYNPERLE:

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

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

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

STAMP, Q.C.:

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

MR. WYNPERLE:

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

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

STAMP, Q.C.:

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

MR. WYNPERLE:

A. Sure.

STAMP, Q.C.:

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

MR. WYNPERLE:

A. Yes.

STAMP, Q.C.:

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

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you say in this publication, "it sure didn't look like she was suffering". When addressing the Court, Justice Jenkins noted that the statements by Ms. Tombasso are simply not true. As a result, the plaintiff received no damages. The judge also awarded special costs against the plaintiff for her ongoing effort to deceive the court. But this is the part I find really interesting.

MR. WYNPERLE:

A. Okay.

STAMP, Q.C.:

Q. Your publication then goes on to say "the lesson for plaintiffs, family and friends, is clear. During the course of personal injury litigation, avoid posting pictures on social media." So, the lesson is not that don't fabricate claims. Don't come to Court and tell lies. Don't post information on social media. Because you go down a little further down and you say "by making social media posts, you are essentially providing opposing parties with access to evidence of your daily activity. It may contradict the plaintiff's own evidence." Now that, to me,

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Mr. Wynperle, is a scandalous recommendation for a law firm to make.

MR. WYNPERLE:

A. Yeah, I don't think that I wrote that article. I don't know where you got that from. But in any event, here's what I would say to you. Certainly if somebody is not telling the truth, then they should be dealt with accordingly.

STAMP, Q.C.:

Q. Sure.

MR. WYNPERLE:

A. Absolutely. I don't have any issue with that, okay. I absolutely couldn't agree with you more. If a person is not telling the truth to the court or to their doctors or to their insurer, they should not be proper – they should not be compensated for that mistruth.

STAMP, Q.C.:

Q. And we're in full agreement on that.

MR. WYNPERLE:

A. Okay.

STAMP, Q.C.:

Q. But what I find, as I said, the troubling

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piece is that the lesson your firm puts out to the public, to your clients I guess as well, the lesson for plaintiffs it says is not to tell the truth. Don't put the damaging evidence on the social media.

MR. WYNPERLE:

A. Facebook pictures can be misconstrued, just as surveillance can be misconstrued.

STAMP, Q.C.:

Q. Well, Judge Jenkins didn't get confused by it.

MR. WYNPERLE:

A. Well, again, you're talking about a British Columbia case, and like I said, I didn't write that article.

STAMP, Q.C.:

Q. I'm talking about your article.

KENNEDY, Q.C.:

Q. Perhaps the witness could be shown the article? We have not been provided with that in advance.

MR. WYNPERLE:

A. It's not an article authored by myself.

KENNEDY, Q.C.:

Q. If Mr. Stamp is going to make allegations

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like that against other lawyers, that's pretty serious stuff.

STAMP, Q.C.:

Q. Well, Mr. Wynperle's -

MR. WYNPERLE:

A. It's okay. It's not authored by me.

STAMP, Q.C.:

Q. - firm posted it.

MR. WYNPERLE:

A. It's not something authored by me in any event.

STAMP, Q.C.:

Q. Wynperle Law.

MR. WYNPERLE:

A. So, initially it was said to be authored by me. It's not -

MR. GITTENS:

Q. Madam Chair, I would interrupt simply because there are times when as lawyers we do despicable things because we feel we're serving our client's interest. To suggest to Mr. Wynperle that he is somehow responsible for an article that someone in his firm has posted and to suggest that he or his firm are coaching people to lie when

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in fact all that is being said, from what the extraction that has been put before the Board, is that cautioning individuals who are making claims that you should not post anything on social media because it gives the opposing party opportunities to challenge you is a normal part of representing a client.

I can tell this body that in our firm, we make a commitment to the client at the very start: these are things you should do. These are things you shouldn't do. You should keep receipts for everything you spend. You should keep track of when you go to psychotherapy or whatever it might be. And you should not post anything on the media – on social media. Because we know that these things can be taken and used against a client.

To suggest that Mr. Wynperle is in anyway supporting perjury or anything of that sort is improper and I would ask that it be stopped.

STAMP, Q.C.:

Q. Madam Chair, I'm referring to publications

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by Wynperle Law posted, as I said, on March 14th and the other on April 3rd, both 2018. I'll be happy to provide Mr. Wynperle with copies.

MR. WYNPERLE:

A. You can. Again, they're not – they're things – if they're posted, you know, they're not authored by me and I've explained to you, as I said, people who are not telling the truth should not be compensated. That is not the role of a lawyer to suggest otherwise.

STAMP, Q.C.:

Q. Can I just make sure, Mr. Wynperle -

O'FLAHERTY, Q.C.:

Q. So, Madam Chair -

STAMP, Q.C.:

Q. - you are the principal -

O'FLAHERTY, Q.C.:

Q. Just one second, Mr. Stamp. I'd just like to point out as hearing counsel that the witness is not under cross-examination in an adversarial hearing and we're now starting to disintegrate into a stage where we're not getting a proper transcript because people

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are interrupting each other.

MR. WYNPERLE:

A. Sorry.

O'FLAHERTY, Q.C.:

Q. And we do want to maintain a genuine discussion of the issues, I think. It's the mandate of the Board to do that.

CHAIR:

Q. And thank you, Mr. O'Flaherty. I'd like to just take that just a little bit further and the issues have to stay germane to what the Board is actually being charged to do. So, I'd just caution on that piece as well.

STAMP, Q.C.:

Q. Thank you, Madam Chair. I just have one last question for Mr. Wynperle.

CHAIR:

Q. Absolutely.

STAMP, Q.C.:

Q. Am I correct in understanding on the bio that's attached to the letter that you are the principal of Wynperle Law?

MR. WYNPERLE:

A. I am.

STAMP, Q.C.:

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Q. That's what it says. I don't know if -

MR. WYNPERLE:

A. I am.

STAMP, Q.C.:

Q. Okay. So, you are the Wynperle of Wynperle Law?

MR. WYNPERLE:

A. There is no other. I don't think you'd find that name too often.

STAMP, Q.C.:

Q. Those are all my questions. Thank you, Mr. Wynperle.

MR. WYNPERLE:

A. Thank you.

CHAIR:

Q. Thank you, Mr. Stamp. Mr. Wadden.

MR. WADDEN:

Q. Good morning, gentlemen. My name is Andrew Wadden. I'm counsel for the Consumer Advocate. Unfortunately he had to leave a little earlier than I because we've gone beyond our time today, but I do want to say thank you very much for taking it upon yourselves to travel here.

MR. WYNPERLE:

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

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animal than the one we have here.
MR. WYNPERLE:
A. Yes.
MR. WADDEN:
Q. So, let's – to put everything in context for the Board, the participants and any member of the public who may want to review what's gone on here during these hearings, let's just look at what happens when you have an accident in Ontario.
MR. WYNPERLE:
A. Yes.
MR. WADDEN:
Q. So, you know, someone is rear-ended. There's no question of liability.
MR. WYNPERLE:
A. Yes.
MR. WADDEN:
Q. What do they do then? I know what they do here. What happens in Ontario?
MR. WYNPERLE:
A. They would hopefully call their insurance company and report the accident shortly after the incident. You know, obviously they might seek medical treatment before

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that, but in terms of the claims process, they would report to their insurance company. They would get an application for accident benefits, and I would say that even before the accident benefits claims forms are completed, an insurance company will usually agree to allow an injured person to start the treatment under the Minor Injury Guidelines. So, that treatment, as the witness said earlier today, that Minor Injury Guideline treatment does happen quickly usually if the person seeks out, you know, a chiropractor, massage, you know physiotherapy type treatment.
MR. WADDEN:
Q. Okay. And the MIG, the Minor Injury Guidelines relate solely to accident benefits and availing of those benefits? Correct?
MR. WYNPERLE:
A. Yes. Sorry if that wasn't clear. I apologize.
MR. WADDEN:
Q. No, no, that's fine. Thank you.
MR. WYNPERLE:

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

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any claim for pain and suffering under $125,000 is subject to that deductible. In fairness people with, for example, a spinal cord injury would not be subject to that same deductible.

MR. WADDEN:

Q. Right.

MR. WYNPERLE:

A. So, it vanishes after $125,000, but anyone with chronic pain essentially would be captured within that—with that 38-thousand-dollar deductible.

MR. WADDEN:

Q. Okay. So, is it fair to say then for the most part in Ontario, people with soft-tissue injuries end up not claiming for or do not get anything for pain and suffering?

MR. WYNPERLE:

A. Well, they get a limited recovery often times, and as the deductible goes up each year, more and more people are excluded. I said earlier to the Board, I really think that senior citizens have been--you know, somebody used the words "fall through the cracks" earlier today. Well, senior

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citizens as a group have fallen through the cracks in a big way in the Ontario system because if you do not—if you have chronic pain as a senior citizen related to an accident, and maybe your pain and suffering damages are worth $75,000 or $85,000 on a full value assessment, I have to tell you that $38,000 of that is coming right off the top and going back to the at-fault insurance company because that's the way the system is run in Ontario. And that often times, I'm telling them that their award gets cut in half for that very reason. So, it's very difficult. And as you can imagine, the system of litigation is expensive. So, you know, if the damages aren't of a reasonable value, they might not seek to claim anything because it might not be a risk they're prepared to take, and you know, that's my experience.

MR. WADDEN:

Q. I think you indicated the Minor Injury Guidelines came into effect September of 2010?

MR. WYNPERLE:

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A. Yes.

MR. WADDEN:

Q. In terms of accident benefits?

MR. WYNPERLE:

A. Yes.

MR. WADDEN:

Q. These other reforms I suppose in terms of the deductible, did those also come into effect in 2010?

(2:15 p.m.)

MR. WYNPERLE:

A. Well, the deductible has been this every-increasing sort of snowball rolling down the hill. It started originally in 1994 at $10,000 and then in '96 it was changed to 15, and then I'm going to say in 2003 it became 30, and now in the last two years it's on this indexation. So, again, it's at 38 this year, and next year it will probably be 40 or something like that. You know, and so we go.

MR. WADDEN:

Q. Okay. So, the deductible has steadily increased over the –

MR. WYNPERLE:

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A. Oh, it is increasing, yes.

MR. WADDEN:

Q. Okay. We don't have the data in front of us to speak to this specifically, but can you tell me anecdotally in terms of auto premiums in Ontario, what's been going on the past 10 to 15 years? Have they gone up? Have they gone down? Have they maintained? What's the story?

MR. WYNPERLE:

A. Well, over 10 or 15 years there's no doubt auto premiums have gone up significantly, but you know, since some of these reforms in two thousand and—I think starting in 2013 the government went on a real campaign of trying to reduce premiums. There was a goal set of reducing premiums by 15 percent. It was a well-recognized statement of policy that the government made in Ontario. And so, a lot of cuts which have occurred recently have been towards achieving that goal for motorists in Ontario. And initially there were some decreases in premium costs, but just as examples, I mean I believe Intact last year received a five

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percent premium increase. I believe Sonnet Insurance which is an online insurer that is part of Economical Group got a ten percent increase. And these are significant insurers in the province of Ontario. These are not—you know, Intact is probably the biggest insurance company in the Province of Ontario. So, would say that once again despite these cuts, we're seeing this trend back to rising premiums, and you know, it's a problem. And I think already what that's caused is that, you know, many in the insurance industry are already calling, you know, upon a new government who has just taken over in the summer to make further cuts, probably to the accident benefit system in order to achieve more savings.

MR. WADDEN:

Q. The definition that's used in terms of how it's determined how people are able to achieve pain and suffering awards, you know, in terms of somebody not being subject to that 38-thousand-dollar deductible, has that definition changed much over the years? Has it been edited?

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MR. WYNPERLE:

A. The application of—if you're saying the threshold, what we call the threshold definition –

MR. WADDEN:

Q. Yes, thank you.

MR. WYNPERLE:

A. - which is the definition which requires the injury to be serious and permanent –

MR. WADDEN:

Q. Yes.

MR. WYNPERLE:

A. - the definition has changed over the years actually. And the government, and I'm trying to remember what year it was now, brought in a regulation. I believe it was after 2010, but I could stand to be corrected on that, brought in a regulation clarifying, if I can use that term, this issue of serious and permanent. So, it gave further definition to what is considered serious. And again, if you're—if you were working before the accident and you're not after, that would generally be considered serious, but it's much harder to, you know,

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crystalize that definition when it comes to senior citizens. So, again senior citizens because they weren't working before the accident, it's much harder to have a clear yes, you would qualify, or no, you wouldn't. It's much greyer, no pun intended, in the case of senior citizens as to whether they will get over that serious and permanent threshold, much more difficult to assess as lawyers, and that doubt creates problems. I think it's almost a sense of coercion I think for older people because they don't like to take risk. It's not something that they are comfortable generally doing. They're at a point in their life when they're on a fixed income and it's just—it's not something that they like doing. And so, if the lawyer is uncertain about whether they'll meet the definition, and get any pain and suffering damages, then seniors tend to be—tend to shy away from the system, and that happens a lot I think.

MR. WADDEN:

Q. Thank you. Madam Chair, I don't have any more questions. That's fine.

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KENNEDY, Q.C.:

Q. Madam, there is one point I'd like to clarify, Madam Chair.

CHAIR:

Q. Yes, sure, absolutely.

KENNEDY, Q.C.:

Q. Mr. Wynperle, while Mr. Stamp was questioning you on that article, you started to interject and say it's not what it seemed or something like that, but I just want to read you the quote he put to you, and then read a little bit further down. What he put to you was the quote, "The lesson for plaintiffs, family and friends is clear. During the course of personal injury litigation, avoid posting pictures on social media." The concluding paragraph in the article states, "Smiling faces on a screen, contradicting updates, activities or locations that raise questions; if you post on social media, you run the risk of misinterpretation because these pictures may portray a desired appearance or a snapshot in time. Social media posts are a variable and allow for a wide margin for

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interpretation. This can be detrimental to your personal injury claim, making it more difficult or even impossible to reverse what now seems obvious to the viewer." Could you explain to the Board, please, what you meant by those comments, what Mr. Stamp put to you and what I just read to you?

MR. WYNPERLE:

A. People who have psychological injuries are put under a tremendous amount of scrutiny because their injuries are very hard to see, and it's—you know, most of my clients, I hope, try to get on with their life as best they can, which means interacting with their families for example, whether it's at family occasions or whether it's going, you know, visiting. In my area, Niagara Falls would be a popular tourist site close to home, and a smiling picture taken of someone who is claiming to be depressed or anxious certainly can be misinterpreted and can be misused in very unfortunate ways despite the fact that on all other information available the person is truly suffering and is truly having those functional restrictions that

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your earlier witness today talked about. And it's just not right that that occur. And so, I don't encourage social media. To be honest with you as a personal point I don't. I don't really engage in personal media. It's not wise that you give people misimpressions. It happens all the time. I see it with my kids quite frankly, when they use social media. It happens all the time. People misinterpret that information, and in the context of a lawsuit, where you are under a magnifying glass, and you are, as an injured person under a magnifying glass, that is very hard to deal with. That's it.

KENNEDY, Q.C.:

Q. That would be the only point I'd like to clarify.

CHAIR:

Q. Thank you, Mr. Kennedy. Any questions? And we have no questions from the Panel. Thank you, gentlemen. Have a safe –

O'FLAHERTY, Q.C.:

Q. Thank you for your time and thank you for staying extra-long and helping us out.

CHAIR:

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Q. Safe travels home.

O'FLAHERTY, Q.C.:

Q. Thank you.

CHAIR:

Q. Thank you.

KENNEDY, Q.C.:

Q. Yes, I would also like to thank you, Madam Chair and members of the Board indulging us here today. So, thank you, and all the counsel, thank you.

CHAIR:

Q. We're on again for 9:00 a.m. tomorrow and Dr. Lazar. We'll see you in the morning. Thank you.

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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