THE GREAT DIVIDE: SOME ISSUES TO CONSIDER FROM THE PLAINTIFF'S PERSPECTIVE TO BRIDGE THE GAP BETWEEN TORT AND ACCIDENT BENEFITS

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I. INTRODUCTION

The year 2008 was truly extraordinary. We witnessed an extraordinary collapse of the global economy, extraordinary changes in the value of our dollar, an extraordinary proroguing of our federal parliament and the election of an extraordinary new leader south of the border. Although not nearly as extraordinary as the events that took place on the world stage, the year 2008 brought about some significant developments in motor vehicle accident law. These developments include:

a) a dismissal by Divisional Court Justice Jane Ferguson in September 2008 of the defence's leave to appeal application in *Arts v. State Farm Insurance Co.*[1] thereby allowing to stand the decision of Superior Court Justice Robert MacKinnon that psychological/psychiatric impairments may be assigned a percentage rating to be combined with physical impairments for the purposes of calculating catastrophic impairment under criteria 2 (1)(f) of the SABS, affirming Mr. Justice Spiegel's decision in *Desbiens v. Mordini*, [2004]O.J. No. 4735

[1] *Arts (Litigation guardian of) v. State Farm Insurance Co.* (2008), 91 O.R. (3d) 394

(S.C.J.);

b) the April 2008 Court of Appeal decision in *Monks v. ING Insurance Company of Canada* [2] permitting declaratory relief for future entitlement to goods and services outlined in a future plan of care when the insured can prove that the proposed items are reasonable and necessary, the case before the Court must be genuine and the declaration must be capable of having some practical effect in resolving issues in dispute. The *Monks* case further concludes that the material contribution test is alive and well in the statutory accident benefits context;

c) two Superior Court cases decided by Justice T.R. Lofchik in *Cromwell V. Liberty Mutual Insurance Co.*[3] and *Vanderkop v. Personal Insurance Co. of Canada*[4] essentially concluding that lump sum payments pursuant to a settlement of a long term disability claim not specifically broken down do not constitute "a payment under any income continuation plan" in accordance with section 7 of the SABS, and consequently need not be deducted from an income replacement

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[2] *Monks v. ING Insurance Company of Canada*, (2008), 235 O.A.C. 1

[3] *Cromwell v. Liberty Mutual Insurance Co.* (2008) 89 O.R. (3d) 352

[4] *Vanderkop v. Personal Insurance Co. Of Canada* [2008] O.J. no. 1937 currently under appeal

benefit that may be ongoing.

These decisions have generated a great deal of “buzz” among those who practice motor vehicle accident litigation. The potential ramifications are significant, yet there remains a great deal of uncertainty as to how or whether they will impact on future cases and the manner in which we will handle them.

In this paper, I will attempt to apply the concepts we glean from these recent decisions to a specific fact pattern, in an effort to illustrate how they impact on tort and accident benefits, and the practical problems they present to us as practitioners.

II. THE FACTS

A 47 year old construction worker is spending a pleasant September afternoon riding his motor cycle on a 2 lane highway in rural Ontario. A vehicle traveling the opposite direction attempts to pass the vehicle traveling in front of it by crossing a double solid yellow line, and tragically collides with the construction worker and his motorcycle. The collision results in the amputation of the construction worker’s right leg just above the knee. He also sustains some soft tissue injuries to his shoulders, neck and back, and develops some features of depression. The construction worker lives in a 2 storey home in rural Ontario with his wife. It is completely unsuitable for an amputee, and the cost of modifying the home is approximately $300,000.00.

III. THE ISSUES

a) To Be or Not to Be? Is it a Catastrophic Impairment?

The amputation above the knee does not automatically qualify as a “catastrophic impairment” under s. 2.(1.2) of the SABS. For accidents occurring as of October 1, 2003, the amputation has not caused the “total and permanent loss of use of both arms or both legs” as required by criterion 1.2 (b), nor has it caused the “total and permanent loss of use of one of both arms and one of both legs” as required by criterion 1.2 (c).

Nonetheless, the impact of the amputation is staggering, and even more so for a person who makes his living as a construction worker.

Subsections 1.2 (e) (ii) through (g) of the definition preclude a catastrophic determination until a prognosis is established, either by the passage of time, or by a medical report stating that the condition will not cease to be catastrophic. On or after October 1, 2003, the determination of catastrophic impairment cannot be made before two years. Assessors familiar with the Guides are reluctant to perform assessments too early, lest it be concluded that the report is premature.

b) Medical and Rehabilitation: Burning the Limits -

The future care costs associated with an amputation are staggering and include but are not limited to occupational therapy, physiotherapy, assistive devices such as wheelchairs which will have to be replaced over time, prostheses which will also require

ongoing maintenance and replacement, modifications to vehicles, medications and other assistive devices. Psychological services may also be required. In a case like this, it is not difficult to foresee that the available non-catastrophic limits of $100,000.00 can be exhausted within the first 12-18 months after the accident.

c) Housing

As a result of the accident, the insured was unable to return to his home, and upon his release from hospital, he was required to live in a hotel room. In other similar cases, the insured has been required to live in a retirement home or other similar facility for an extended period of time pending the resolution of the housing issue.

The costs associated with these alternative living arrangements are prohibitive. The accident benefits insurer is often unclear as to its authority to cover the rental costs, especially if the insured and his/her spouse are both residing at the alternate facility. These costs are often well in excess of the non-catastrophic limit of $3,000.00 per month available for attendant care, and rent is not necessarily a “home modification” or “home device” as set out in section 15 (5) of the SABS.

The accident benefits insurer is often reluctant to pay rental costs for too long for fear of exhausting the available limits. The problem is compounded in a loss transfer situation, when the accident benefits insurer is answerable to another insurer for all the benefits paid, especially in the initial post-accident phase.

The dilemma for the insured is obvious. There is nowhere else for him to live until the housing issue is resolved. This cannot happen until one of the following occurs:

a) the tort case is resolved;

b) the tort insurer makes a substantial advance payment; or

c) a determination of catastrophic impairment is made.

Until these issues are sorted out, the insured lives in a state of constant stress, which is not what the SABS intended.

d) Attendant Care

Often, the insured person's spouse is providing most of the attendant care in the initial stages of an injury. The spouse's life has also been irretrievably altered, by requiring to move out of the family home and often, by having to take a leave of absence from work, and arrange child care, if necessary.

The accident benefits insurer may pay the spouse an attendant care benefit, but only at the non-catastrophic rate of a maximum of $3,000.00 per month. The insurer will not often cover the portion of the rental costs for the insured's spouse, and may insist that the attendant care money be applied to the rent in the alternative accommodation.

Again, the insurer is concerned about the limits. However, attendant care benefits paid at non-commercial rates, are often barely sufficient to cover the basic housing

needs of both spouses, let alone child care expenses, if required.[5]

e) Case managers

A severely injured person is overwhelmed by his sudden disability and is doing everything he/she can to cope with the new reality. Upon release from hospital, numerous treatments and therapies are required, transportation is a major issue and regrettably, plans are not always in place at the time of discharge.

Section 17 of the SABS does not permit the appointment of a case manager unless a catastrophic determination has been made or unless the optional medical, rehabilitation and attendant care benefits have been purchased by the insured.

It is submitted that case managers are critical, at least in the initial stages after the insured's release from hospital, to coordinate the insured's treatment and alleviate his/her obvious stress. These professionals have the expertise to deal with the

[5] The recent May 2008 decision of Arbitrator Judith Killoran in the case of *Cynthia Johnson and Cyril Johnson v. Allstate Insurance Company of Canda*, FSCO A07-000194 and the January 2008 Divisional Court decision in G.B. v. Pilot Insurance Company support the proposition that nanny or babysitting expenses will be covered under section 15 of the SABS while the insured is attending rehab, only if the insured was a caregiver at the time of the accident and the services were necessary to assist the insured to reintegrate into the family and/or into their societal roles.

complex requirements of an amputee, and can facilitate the necessary referrals to specialists. It is this author's view that the lack of provision for a case manager in a serious injury case, that may take an extended period of time before a catastrophic determination can be definitively made, is a critical gap in the legislation and is not in keeping with the remedial goals that the SABS were designed to address.

f) What if the insured can afford to wait until a prognosis can be established?

Recent case law has decidedly leaned in favour of affording the insured a more than reasonable chance of being found "catastrophically impaired " under criterion 2 (1.2) (f) of the SABS ie., an impairment or combination of impairments in accordance with the American Medical Association *Guides to the Evaluation of Permanent Impairment*, 4th edition, 1993, ("the *Guides*") resulting in 55 per cent or more impairment of the whole person.

Starting with the landmark case of *Desbiens v. Mordini,*[6] decisions both in Court and at FSCO have arguably expanded the definition of catastrophic impairment to include psychological disorders and pre-existing injuries. Mr. Desbiens was a paraplegic before the subject motor vehicle accident of 1999 which resulted in a loss of the functional independence he formerly enjoyed. Mr. Desbiens was found by Mr. Justice Spiegel to have met the catastrophic definition on the grounds that his accident related

[6] *Desbiens v. Mordini,* [2004] O.J. No. 4735 (S.C.J.)

psychological impairments could be translated into a whole person impairment ("WPI") and added to his physical impairment rating score, to reach a global 55% WPI as a result of the accident.

Arbitrator Blackman in *B.P. v. Primmum Insurance Co.* (2006) O.F.S.C.D. No. 202, followed Justice Spiegel's decision in *Desbiens.* In this case, as a result of a motor vehicle accident in 2002, B.P. was required to undergo an amputation of his right leg at the knee. The *Guides* dictated that a single limb amputation provides a maximum impairment rating of 40%. In his analysis, Arbitrator Blackman went beyond the maximum impairment rating of 40% prescribed by the *Guides* and looked at the functional implications of the amputation alone. He noted loss of mobility and skin complications directly relating to the amputation itself, which allowed him to make a finding of 50% for the amputation itself, and a whole person impairment ("WPI") of 62% when this was combined with the other ratings for some mental and behavioural issues and other less serious orthopaedic injuries.

The inclusive approach of combining psychological and physical impairments when assessing catastrophic impairment was applied by Superior Court Justice Robert MacKinnon in the May 28, 2008 decision of *Arts v. State Farm Insurance Co*[7]. In September of 2008, Divisional Court Justice Jane Ferguson dismissed a leave to appeal application by the defence which sought a ruling on whether it is "permissible to

[7] *Arts (Litigation guardian of) v. State Farm Insurance Co.* (2008), 91 O.R. (3d) 394

assign percentage ratings in respect of a person's psychological or psychiatric impairments and combine then with a percentage rating in respect of the person's physical impairments, for the purpose of determining whether the person's impairments meets the definition of catastrophic impairment as defined by s. 2 (1) (f) of the SABS."

Mr. Arts' injuries included a right posterior parietal depressed skull fracture with underlying brain contusion and evidence of intracranial hemorrhage and diffuse axonal injury, fracture of the right clavicle, right posterior maxillary and lateral orbit wall of the right orbit and soft tissues to the neck, right shoulder and low back. He underwent an open craniotomy and elevation of the depressed skull fracture and debridement of the contused brain. He continued to suffer from a number of cognitive impairments, headaches, subjective vertigo, tinnitus, sleep disturbance, panic attacks and a number of psychiatric diagnoses including mood disorder due to a general medical condition with depressive features, cognitive disorder, adjustment disorder and personality change due to a general medical condition.

Justice MacKinnon followed Justice Spiegel's decision in *Desbiens*, concluding that the *Guides* are to be interpreted liberally, and that assessors must use their clinical judgment to arrive at impairment "estimates" in dealing with psycho-emotional impairments for the purpose of calculating WPI. He stated at paragraph 14 as follows:

> The legislature's definition of 'catastrophic impairment' is intended to foster fairness for victims of motor vehicle collisions by ensuring that accident victims with the most health needs have access to expanded medical and rehabilitation benefits. That definition is intended to be remedial and inclusive, not restrictive.

At paragraph 15 of the decision, Justice MacKinnon further states:

> An injured victim may fall short of being found catastrophically impaired on the basis of any one of the other seven parts to the definition of catastrophic impairment, but when all of his/her impairments are considered, he/she may well have a 55 per cent Whole Body Impairment. To deprive Ontario motor vehicle accident victims in these circumstances the right to recover needed attendant care and medical-rehabilitative benefits is both unreasonable and unjust. That cannot have been the intention of the provincial legislature.

Therefore, if the insured has the financial means to wait until his impairments can be assessed, there is a body of law upon which he can rely in order to be determined to have sustained a catastrophic impairment in accordance with criterion (f).

g) What if the insured cannot afford to wait until a prognosis can be established?

The accident benefits insurer is faced with the dilemma of having to balance the insured's obvious and immediate needs with the requirement to act prudently to preserve the available limits in the event the insured is not catastrophically impaired. The insured, however, lives in limbo for an indefinite period of time. He is anxious about housing, worried about his finances and desperately wants to regain his independence but fears that he will never be able to find alternative employment given his lack of transferable education, training or experience. At the same time, he is trying

to participate in rehabilitation to learn how to live with a shocking new disability. The stress of this situation results in severe psychological hardship to these individuals, which our system was designed to prevent.

Moreover, in our increasingly diverse society, the insured may lack proficiency in English which only compounds his bewilderment and sense of loss. The psychological consequences can be dramatic, possibly even developing into a class 4 impairment (marked impairment) or class 5 impairment (extreme impairment) due to mental or behavioural disorder under s. 2 (1.2) (g) of the SABS.

The practical realities for these accident victims is a gap in the tort and accident benefits schemes that must be addressed.

IV. POSSIBLE REMEDIES FROM THE PLAINTIFF'S PERSPECTIVE

1. The insured's/plaintiff's counsel should issue the tort claim as quickly as possible and be proactive in advancing the stages of litigation by:

    a) serving an affidavit of documents including all relevant medical records, hospital records, income and employment records and tax returns to guard against the anticipated position of the tort insurer that it lacks sufficient information upon which to assess the case;

b) arranging and conducting timely discoveries; and

c) moving before the court for a timetable, if necessary, to govern the dates by which various steps in the litigation must be completed.

2. The insured's/plaintiff's counsel must keep in mind that for accidents after October 1, 2003, Bill 198 permits a plaintiff to sue in tort for excess health care expenses regardless of whether or not he/she has sustained a catastrophic injury. The plaintiff must, instead, establish that he/she satisfies the criteria of the verbal threshold, namely that he/she suffers from a "permanent serious disfigurement or permanent serious impairment of an important physical, mental or psychological function."

Therefore as soon as possible, it is incumbent upon the insured's/plaintiff's counsel to obtain a Future Care Cost Report from a qualified expert and have the report reviewed by the insured's/plaintiff's treating physicians to ensure that the recommendations made in the report are both reasonable and necessary.

The risk to the tort insurer is enormous in that, should the case proceed to trial, the plaintiff is entitled to claim the full measure of his/her damages in accordance with the principles set out in the Court of Appeal in *Bannon v. McNeeley.* [8]

[8] *Bannon v. McNeeley* (1998), 38 O.R. (3d) 659.

Moreover, the Court can order that the Plaintiff who recovers damages in the action assign to the tort defendant all rights to future statutory accident benefits in accordance with section 267.8(12) of the Insurance Act[9], which codifies the common law principles set out in *Cox v. Carter.*[10]

3. From the point of view of the insured's/plaintiff's counsel, the importance of obtaining a Future Care Cost Report is even more critical in light of the April 2008 Court of Appeal decision in *Monks v. ING Insurance Company of Canada.*[11] In this case, Ms. Monks' counsel was permitted to file portions of a future care cost report which set out certain items that the parties agreed that she would need. The trial judge concluded that Ms. Monks had sustained a catastrophic impairment (as a result of a third motor vehicle accident), and granted ongoing benefits by way of a declaration of entitlement to income replacement, medical/rehabilitation, attendant care and housekeeping benefits. Justice Cronk, writing for Justices Gillese and Watts, dismissed the insurer's appeal.

The *Monks* case opens the door for Plaintiffs to obtain a declaration of future entitlement to benefits provided that two criteria are satisfied: namely that "[T]he case before the Court must be genuine, not moot or hypothetical; and the

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[9]Insurance Act, R.S.0. 1990. C. I.8 , as amended

[10]*Cox v. Carter*, (1978), 13 O.R. (2d) 717 (H.C.)

[11]*Monks v. ING Insurance Company of Canada,* (2008), 235 O.A.C. 1

declaration must be capable of having some practical effect in resolving issues the case raises."[12] Moreover, the Court of Appeal rejected a narrow and restrictive interpretation of the word "incurred" as used in the accident benefits legislation, and held that an insured need not actually **receive** the items or services nor **finance** same for the insurer to be obligated to pay for them.

The combined risks to the insurer of declaratory relief for future entitlement, the right of the insured/plaintiff to sue for health care expenses in tort regardless of a determination of catastrophic impairment and the risk of an assignment, should provide the tort insurer with considerable incentive to settle, especially in view of the fact that the tort insurer is exposed to commercial rates for both attendant care and housekeeping and home maintenance services , which are substantially higher than those proscribed by the SABS.

4. Counsel for the insured/plaintiff must also keep in mind that the tort insurer's obligation under section 258.5(1) of the *Insurance Act*[13] is that "it shall attempt to settle the claim as expeditiously as possible." An adjunct of that statutory provision is that the tort insurer should be approached to make an advance payment under section 285.5 (2) which reads as follows:

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[12]This was the test originally set out in the case of *Monachino v. Liberty Mutual* 2000 CanLii 5686 (ON C.A.), (2000), 47 O.R. (3d) 481.

[13]Insurance Act, R.S.0. 1990. C. I.8 , as amended

> If the insurer admits liability in respect of all or part of a claim for income loss, the insurer shall make payments to the person making the claim pending the determination of the amount owing.

Despite the wording of this section, in my experience, tort insurers will often make advance payments on the understanding that the amount of the advance will be credited, usually against the general damages ultimately paid, when the tort case is resolved. Plaintiff's counsel should consider bringing a motion for either an advance payment and/or for partial summary judgment when appropriate, if liability for the collision is admitted, in an effort to secure much-needed funds for the insured/plaintiff. Again, the importance of timely discovery is essential, as the tort insurer may be more inclined to make an advance payment after the examinations for discovery have been completed.

V. THE MEDIATION: WHO SHOULD BE INVITED?

The case of the construction worker involves a loss/transfer. In these types of situations, the tort insurer will likely not agree to privately mediate the case unless the accident benefits insurer is present, together with a loss/transfer representative. In a loss/transfer situation, it makes abundant sense to have all parties present, given that the ultimate payor is the same insurance company for both the tort and accident benefits claims. In addition, this approach is sensible, as it allows for a meaningful dialogue between the loss/ transfer insurer and the accident benefits insurer that is

actually adjusting the file. It also provides the framework for a collaborative approach on the part of all interested parties, and allows all insurers to focus on the needs of the insured in a global sense.

Whether or not to invite the accident benefits insurer to mediation arranged in the context of the tort action depends on many factors which include the following:

a) whether or not the injuries are catastrophic;

b) whether the tort insurer's available policy limits are at risk;

c) whether the plaintiff is still receiving a substantial amount of treatment;

d) whether the plaintiff is credible and presents well;

e) whether there is surveillance upon which one of the insurers intends to rely;

f) whether the plaintiff has commenced an action or arbitration proceeding in the accident benefits case;

g) whether there is a pending trial date or arbitration date in either the tort or accident benefits case;

h) whether defence medicals produced in the tort case will impact upon the accident benefits case;

i) whether there are concerns about the plaintiff meeting the threshold; and

j) whether there are complex liability issues.

The above is clearly a non-exhaustive list, as there are many additional factors that determine whether it is best to have both insurers at the negotiating table. In most cases, I prefer to settle with the tort insurer and leave the accident benefits claim open for a period of time thereafter. This approach provides the injured victim with certainty of result and closure of one major aspect of the case, with all her rights preserved vis-a-vis the accident benefits insurer.

The question of who should be invited to a private mediation is much more complicated if a claim for long term disability benefits is being made by the insured while the tort and accident benefits cases remain ongoing.

Two 2008 Superior Court cases decided by Justice T.R. Lofchik, *Cromwell v. Liberty Mutual Insurance Co.*[14] and *Vanderkop v. Personal Insurance Co. of Canada,*[15] have held that lump sum payments pursuant to a settlement of a long term disability claim not specifically broken down do not constitute "a payment under any income continuation plan" in accordance with section 7 of the SABS and consequently need not be deducted from ongoing income replacement benefits.

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[14] *Cromwell v. Liberty Mutual Insurance Co.* (2008) 89 O.R. (3d) 352

[15] *Vanderkop v. Personal Insurance Co. Of Canada* [2008] O.J. no. 1937 currently under appeal

The *Cromwell* case involved a motion for an Order for partial summary Judgment compelling the accident benefits insurer, Liberty Mutual, to pay income replacement benefits which the Plaintiff alleged were wrongfully withheld. The Plaintiff was also entitled to long term disability benefits from Sun Life, and was required to commence an action against Sun Life when those benefits were denied. The Sun Life case was settled for a lump sum; with a portion representing past benefits and deemed taxable, and a larger non-taxable portion representing future benefits in the amount of $160,000.00.

Justice Lofchik considered the various sections of the SABS and in particular, section 7(1), which permits the accident benefits insurer to deduct collateral benefits from income replacement benefits. Justice Lofchik relied on the FSCO decision of *Lee v. Certas Direct Insurance Co*[16] in stating at paragraph 20 that "only collateral benefits paid pursuant to an indemnity policy are deductible from income replacement benefits." The payments from Sun Life representing past benefits were held to be deductible; however, Justice Lofchik stated at paragraph 40 that the future benefits were not to be deductible "as Sun Life was "not obliged, under the terms of its policy to pay a lump sum with respect to future payments."

In *Vanderkop,* Justice Lofchik concluded that a lump sum settlement with a long term

[16] *Lee v. Certas Direct Insurance Co* [2006], O.F.S.C.D. No. 98

disability carrier was not to be treated as "net weekly payments for loss of income that are not being received by the person as a result of the accident" in accordance with section 7(1) of the SABS, but rather a lump sum payment arrived at after a lawsuit was commenced and negotiated as a compromise. The accident benefits insurer, the Personal, was not entitled to a deduction for the lump sum payment by the long term disability insurer, Manulife, in the circumstances.

Also, the accident benefits insurer made no income replacement benefit payments in the 12 month period prior to its claim for repayment, therefore no amount was repayable. The *Vanderkop* decision has been appealed to the Ontario Court of Appeal.

These cases are problematic from the insurer's perspective, as they indeed seem to have changed the landscape of the deductibility rules, and open the door for the potential for "double dipping."

Suffice it to say that if my client had a concurrent long term disability benefits claim, I would not consider inviting the long term disability carrier to a global mediation, as it would be more advantageous to attempt to negotiate a lump sum settlement of his entitlement to long term disability benefits separately, in keeping with *Cromwell* and *Vanderkop.*

VI. THE FIVE YEAR REVIEW

To my knowledge, the Five Year Review on Auto Insurance has yet to be released. Many interested parties have provided their feedback to the Minister of Finance. The Ontario Trial Lawyers Association, the Ontario Bar Association and the Advocates' Society have made several recommendations, including:

Accident Benefits

a) a simpler and more efficient procedure for claiming, disputing, and receiving statutory accident benefits;

b) reducing transaction costs, including assessment costs and administration costs, in accident benefits cases;

c) adopting the concept of proportionality so that the cost of determining entitlement to benefits is in proportion to the importance and value of the benefit at stake;

d) a return to the system of accident benefits delivery available under the OMPP (Bill 68) No-Fault Benefits Schedule in force for accidents after June 21, 1990 up to December 31, 2003, subject to some amendments, including increasing the maximum amount of the income replacement benefit to $500 per week (recommended by the Advocates' Society).

There is some disagreement among the various proposals as to whether to abolish the catastrophic impairment designation.

Tort

a) repealing sections 4.1 and 4.2 of Ontario Regulation 461/96 defining the verbal

threshold;

b) repealing the $30,000 deductible applicable to non-pecuniary damages, or reducing the deductible to the pre-October 1, 2003 amount of $15,000;

c) repealing the $15,000 deductible for Family Law Act claims, or reducing the amount of the deductible to $5,000.00;

d) eliminating the deductible for fatal accident claims entirely;

e) repealing sections 267.5(3) (the verbal threshold - protection from health care expenses) and 267.5 (5) (the verbal threshold-protection from non-pecuniary loss).

It remains to be seen what the future will hold, but it is becoming increasingly apparent that the system within which we are currently operating is inefficient, expensive and difficult for members of the public to understand.

Moreover, it is redundant, in my respectful opinion, to have a verbal and monetary threshold for tort claims, as concluded by the Honourable Coulter Osborne, former Associate Chief Justice of Ontario in his Civil Justice Reform Project dated November 2007. Under the current regime, the outcome of claims where the threshold is in issue remains uncertain until the conclusion of trial, requiring the parties to expend substantial sums of money on legal fees, expert reports and expert evidence without knowing the outcome a threshold motion at the end of trial.

The recent Bill 198 threshold decision of Madam Justice J. A. Milanetti in the case of *Darlene Sherman v. John Guckelsberger, John Clough and Son Ltd. and Wawanesa Insurance Company*, (heard June 12, 16, 17, 18, and 19, 2008, Reasons for Judgment released on December 29, 2008), is a perfect example of the foregoing. Justice Milanetti concluded after five days of trial that 32 year old Darlene Sherman, who was suffering from chronic pain and who had gone back to some form of work, albeit with difficulty, failed to adduce sufficient evidence of the ”function” impairment to satisfy s. 4.2 (1) 2 of the threshold. She states that she considered the decision of Justice Morrisette in *Nissan v. McNamee,* [17] and noted at paragraph 102 of her Reasons for Judgment that Justice Morrisette concludes that, “in her view, the Bill 198 legislative changes do little to change the Bill 59 legislation that predated it. Respectfully, I have a different view of the changes and their ramifications.”

At paragraph 149 of her reasons, Justice Milanetti states that “[E]ven before the amendments, the Court of Appeal in *Meyer v. Bright*[18] said that, “When the legislation qualified permanent impairment” by the word serious, it obviously intended that injured persons must endure some permanent impairment without being able to sue.”

Does this seem fair?

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[17] *Nissan v. McNamee* (2008) W.L. 1955825 (Ont. S.C.J.)

[18] *Meyer v. Bright*, [1993], 15 O.R. (3d) 129 (C.A.)

Although Justice Milanetti states at paragraph 150 of her Reasons that “each case depends on its own facts and that what is a serious injury to one individual is not necessarily to another, “ this case is illustrative that the waters are becoming murkier under Bill 198.

It is hoped that in the very near future, our elected officials will be able to come up for air from the extraordinary events of 2008, and will begin to address these very serious deficiencies in our motor vehicle accident legislation.

February 16, 2009