THE MEDICAL EXPERT WITNESS

A Practical Guide for Doctors

Presented by:
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"The best test of whether an expert is impartial is whether his or her opinion would not change regardless of which party retains him or her".[1]

I. Introduction

Experts provide the court with specialized knowledge to assist the judge and jury in deciding the case. In personal injury cases, lawyers rely on experts to provide opinions on scientific and technical subjects which include anything from the nature of injuries suffered to the mechanics of the collision. The most effective experts are those who remain intellectually honest and unbiased. This paper reviews the role of the expert and provides a guide to how an expert can best fulfill that role and be of assistance to the court.

II. What is an expert?

An expert is a person with specialized knowledge and experience on a certain subject. This knowledge and experience qualifies the expert in the eyes of the court to provide an unbiased and objective opinion regarding that subject.

III. Why does the legal system need experts?

Experts provide "a ready-made inference which the judge and jury, due to the technical nature of the facts, are unable to formulate".[2] In order for the court to consider an expert's opinion necessary the following criteria must be met:

> (1) the subject-matter of the expert's inquiry must be such that ordinary people are unlikely to form a correct judgment about it, if unassisted by the expert; and
>
> (2) the expert offering expert evidence must have gained his special knowledge by a course of study or previous habit which secures his habitual familiarity with the matter in hand.[3]

If the judge or jury can form their own conclusions without the help of the expert, the opinion of the expert is unnecessary.[4]

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[1] P. Mitchell & R. Mandhane, "The Uncertain Duty of the Expert Witness" (2005) 42 Alta. L. Rev. 635 at para. 7.
[2] *R. v. Abbey*, [1982] 2 S.C.R. 24 at p. 42.
[3] *Kelliher v. Smith*, [1931] S.C.R. 672 at 684.
[4] S.N Lederman, A.W. Bryant, & M.K. Fuerst, *The Law of Evidence in Canada*, 3d ed. (Toronto: LexisNexis, 2009) at 786.

IV. What should an expert do?

A. Role of the Expert

Judges have created a number of guidelines which experts should follow when forming and drafting their opinions:

- Expert evidence must be the independent product of the expert uninfluenced by the exigencies of litigation.
- Experts must provide independent assistance to the court with an objective unbiased opinion.
- An expert's opinion should not go beyond his or her expertise and should make it clear when a particular question or issue falls outside the expert's expertise.
- An expert must state the facts and assumptions on which the opinion is based.
- An expert must not omit to consider material facts and assumptions which may detract from his or her opinion.
- If an expert needs more information on which to make a proper opinion, this must be stated, and that the opinion given is a provisional one.
- An expert should never assume the role of advocate.[5]

B. The Opinion of the Expert

When retained by a party to provide an opinion, the expert must give that opinion in writing in an expert report.

i) Contents of the Expert Report

It is recommended that the expert report include the following headings:

- Statement of Qualifications
- Facts and Assumptions
- Opinion
- Appendix A: Findings on Clinical Assessment
  - Medical History
  - Examination
  - Collateral Information
- Appendix B: List of Documents Reviewed
- Appendix C: Information in Records Reviewed

Experts must be wary of only relying on the facts that support their opinion. If there are facts and information that can support an alternate opinion they should be included in the report to show that they were considered.

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[5] See *Perricone v. Baldassarra,* [1994] O.J. No. 2199 (Gen. Div.) at para. 21 where the Court cited the English case of *Ikarian Reefer*, [1993] 2 Lloyd's Rep. 68.

Opinions can often be lengthy. Jurors and Judges lose patience with long verbose reports and appreciate an executive summary of the opinion in one or two paragraphs setting out the cause of the injury, the present condition of the patient, and the prognosis for recovery.

It is not necessary to critique another expert's opinion in a report unless specifically requested in the retainer letter.

ii) Causation and Language

The "language used by experts can have a powerful impact on the quality of their evidence and on the evaluation of its reliability".[6] For example, opinions expressed using the phrase "consistent with" can raise problems in law. In cases where causation is at issue the use of "consistent with" is problematic, because it does not mean "caused". "Consistent with" provides an imprecise association that is unlikely to assist the judge or jury.[7]

The standard applied to prove causation differs in medicine and in law. Medical experts often apply a test of "medical certainty" that seems to approximate proof beyond a reasonable doubt. In civil cases the legal standard is not so stringent. The law requires only that causation be proven on a balance of probabilities.[8] The trauma must have more likely than not caused the injury. Injuries that "probably" or "likely" resulted from the trauma satisfy the standard, while injuries that "possibly" or "maybe" resulted from the trauma do not.

Experts may want to employ specialized concepts and technical jargon to express their opinion, but the opinion must be logical, make progressive sense and be comprehensible to the trier of fact.[9] If jargon is employed then definitions should be footnoted in the report along with an explanation of the medical term or procedure to assist the trier of fact.

iii) Authoritative Literature

In the report, "the expert is permitted to refer to authoritative treatises and the like, and any portion of such texts upon which the witness relies is admissible into evidence".[10] The expert may, while on the stand, refer to any authoritative textbooks or papers cited in their report and use those authorities to help explain how their opinion was formulated. When there is controversy in the literature it is important to recognize it and state what portions of the authority you are adopting.

iv) Changing an Expert Opinion

Experts must provide a supplementary report when their opinion changes in a material way.[11] The supplementary report must be identified as supplementary, signed by the

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[6] G.R. Anderson, *Expert Evidence*, 2d ed. (Markham: LexisNexis, 2009) at 355.
[7] *Ibid.*
[8] In addition, causation can be legally established in one of two ways: the "but for" test and the "material contribution" test: *Frazer v. Haukioja*, [2010] O.J. No. 1334 (Ont. C.A.), at para. 41. The general, but not conclusive, test for causation is the "but for" test, which requires the plaintiff to show that the injury would not have occurred but for the negligence of the defendant: *Horsley v. MacLaren*, [1972] S.C.R. 441.
[9] J.N. Iannuzzi, *Cross-Examination: The Mosaic Art*, (Toronto: Prentice-Hall, 1982) at 216.
[10] J. Sopinka, S.N Lederman, & A.W. Bryant, *The Law of Evidence in Canada*, (Toronto: Butterworths, 1992) at 560.
[11] B.C. Reg. 168/2009, Rule 11-6(6).

expert, include the necessary certification[12] and set out the changes in the opinion and the reason for it.[13]

C. The Expert's File

Experts have an obligation to disclose their file on request. The expert's file includes all draft reports, notes and documents in the possession of the expert that they used in formulating their opinion.[14] Under the *Supreme Court Civil Rules* this disclosure must be made at least 14 days prior to trial.[15]

D. Cross-Examination of the Expert

Experts and their opinions are rarely destroyed by cross examination. Instead the cross examiner employs questions designed to establish the following:

1. The expert is limited in his or her education, qualifications, knowledge and experience;

2. The expert does not teach, conduct research, or publish and does not keep up with advances in the field through continuing education, conferences, etc.;

3. The opinion is founded on incomplete or inaccurate information provided to the expert by the lawyer or other sources;

4. The opinion is based on hypothetical assumptions that are incomplete or inadequate;

5. The expert has employed inappropriate or outdated methodology;

6. Prior statements, testimony, published papers, expert reports or seminar presentations of the expert are inconsistent with the opinion presented at trial;

7. The expert harbors an intellectual bias or hidden motivation for testifying;[16] and

8. The expert has not conducted a personal examination or assessment of the patient that may be contrary to ethical guidelines established by the expert's professional governing body.

By raising concerns about the credibility of the expert or the expert's opinion the cross examiner hopes to argue that little weight should be given to the expert's evidence. When these issues are raised on cross-examination, the best approach is to deal with them in a straightforward manner. For example, if an expert has not had the opportunity to examine the patient, this should be clearly set out in the report and the expert should state that as a result the opinion is a provisional one.

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[12] *Ibid.* Rule 11-2(2).
[13] *Ibid.* Rule 11-6(7).
[14] Privilege is waived over reports and documents in possession of the expert as a result of the decision to tender the expert's report and opinions into court: G.R. Anderson, *Expert Evidence*, 2d ed. (Markham: LexisNexis, 2009) at 281.
[15] *Ibid.* Rule 11-6(8).
[16] L.E. Schwartz, *Proof, Persuasion, and Cross-Examination: A Winning New Approach in the Courtroom*, (New Jersey: Executive Reports Corporation, 1978) at 2103.

Lawyers will tempt experts to opine outside their area of expertise during cross-examination. The expert should refuse the invitation and politely defer to another expert who is qualified to give an expert opinion on that issue.

During cross-examination, experts may be questioned on any text or publication which he or she acknowledges as authoritative or recognizes as a standard work in the field. The use of authoritative literature in cross-examination is not to prove the truth of the treatise, but as a means of testing the value of the expert's conclusion.[17] It is therefore immaterial that the expert does not agree with or acknowledge the validity of the particular published work, only that it is regarded in his field of expertise as an authoritative source. However, if the expert agrees with the reference from the authoritative source it becomes evidence in the trial.

In cross-examination, lawyers will typically provide the expert with a fresh set of facts and assumptions that support an opinion that is different to the one offered in the expert's report. The unbiased expert will provide an opinion based on only those new facts and assumptions, and will not let any other factors affect his or her opinion. The judge and jury will understand that the new opinion is based on facts and assumptions that may not be true. Let the lawyer be the advocate.

V. What should an expert NOT do?

A. Do not become an advocate

While treating patients, doctors are advocates for the best health of their patients. But in court doctors testifying as experts must provide an objective and unbiased opinion about the patient's condition. The expert who becomes an advocate in litigation risks having his or her opinion disregarded on the basis that the opinion is biased towards one party. This can affect not only the credibility but the reputation of the expert. Mr. Justice Henderson discussed the difference between advocating for your opinion versus advocating for a party:

> In attempting to put forward their views as clearly and positively as they can, the experts will, in a sense, argue with each other. Insofar as an expert is arguing for the correctness of his views and the incorrectness of opposing views within the realm of expertise, then argument is unobjectionable.
>
> What the courts have taken frequent objection to is argument by experts on matters which fall outside the scope of their expertise. These are experts who portray a lack of objectivity by showing an inappropriate eagerness to assist the party who hired them.[18]

Below are some lessons to help experts avoid being viewed as an advocate for one party. Excerpts from judgments are included to show how judges have criticized experts who have crossed the line.

LESSON 1: Admit when another diagnosis is possible

> Dr. A would not admit to the possibility of any other diagnosis ... despite being shown credible evidence contrary to his diagnosis ...

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[17] *Supra* note 10 at 660-661.

[18] *Bolton v. Vancouver (City),* [2002] B.C.J. No. 908, 2002 BCSC 537 at para. 9 (B.C.S.C.).

Throughout the cross-examination of Dr. A, he was argumentative and refused to consider material facts which might detract from his opinion. This is not the proper role of an expert, who must provide an unbiased opinion and consider material facts which are put to him or her: Perricone v. Baldassarra (1994), 7 M.V.R. (3d) 91, [1994] O.J. No. 2199 (Gen. Div.). I am satisfied that Dr. A was an advocate for the defence and his opinion should be given very little weight.

LESSON 2: Do not provide an opinion based on incomplete information

CASE A

Counsel for the Plaintiff submits that Dr. B, though qualified as an expert to give opinion evidence, crossed the line and became an advocate in the Defendants' cause; he reached a conclusion that was patently unreasonable, given his own evidence.

Dr. B testified that the back problems that the Plaintiff suffers from today probably arise from his work injuries. Yet he readily conceded that he had no information regarding the Plaintiff's back condition just prior to the injuries at work or its condition after he returned to work ... he had no information about the nature of the work at the time of those injuries, other than the very cryptic description on the W.C.B. Report form.

In my view, counsel's criticism of Dr. B's evidence is well merited and I can give little weight to it.

CASE B

Dr. C did not attend at trial. However I had the benefit of observing a video tape where he was examined under oath. A transcript of his testimony has been entered in evidence.

I find it most unusual that Dr. C did not avail himself of clinical records and opinions concerning the condition of the plaintiff in the period between the accident and his examinations. In addition he was unaware of certain facts that would have had a bearing on the opinion he rendered. He conceded this in cross-examination when he heard for the first time that the plaintiff had carried out substantial overtime during the year following the accident and thereafter. I would have expected that an opinion on causation with respect to an injury sustained over four years earlier would have required consideration of evidence other than x-rays and the subjective complaints of the plaintiff. Surely the clinical records in the one or two years following the accident would be of assistance to Dr. C. The medical legal reports during the first two years indicated the plaintiff had suffered a mild injury. In addition there was some evidence indicating he had lumbar problems that had prevented him from working before and after the accident. Dr. C must have been aware that his opinion was being sought to support a claim in court that would assist the plaintiff in recovering damages arising out of the motor vehicle accident.

The video of the examination of Dr. C demonstrated to me that he was responding more as an advocate than a scientist. He reached unnecessarily for opportunities to support the plaintiff's cause.

CASE C

In my view the evidence of Dr. D should be given limited weight. He is no doubt a well-qualified orthopaedic surgeon. However, his opinion with respect to causation is based to a large extent on incorrect and incomplete information. His factual conclusions are, for the most part, inconsistent with the findings of fact made by the Court ...

As I see it, Dr. D acted as an advocate for the defendants, not an expert whose sole purpose is to assist the Court. He highlighted all matters that would support the defence position and either downplayed or ignored those that would support the position of Mr. P.

LESSON 3: Balance your practice

In my view, the suggestion that evidence has been tainted because of motives of economic reward applies not to the plaintiff, but rather, to the defendant's expert, Dr. E. Dr. E has been receiving a substantial amount of referral work from ICBC for many years. In 1999 he received $338,510 from ICBC, and in 2000 he received $315,734 from ICBC. These monies were received as payment for the preparation of what Dr. E classifies as independent medical reports, which he says he prepares for the Court. The fees he collects from ICBC amount to approximately three-quarters of his total annual income ...

I find that Dr. E was argumentative and condescending. His interaction with plaintiff's counsel was akin to sparring, indicating that he was more of an advocate than an independent professional. I give his evidence very little weight.

LESSON 4: Consider all material facts and if your opinion changes, be able to explain why

Dr. F in his report of April 9, 1987 now concludes that the plaintiff is totally disabled and there is no possible resolution for her problem. Dr. F has in my opinion crafted his evidence to fit the plaintiff's claim. That is the only conclusion that can be arrived at by his complete change in the diagnosis and prognosis of this plaintiff's problems. His initial opinion was that there was "no likelihood of permanent disability arising at a later date as a result of the said accident". He now says "this situation has been progressive ever since the date of the accident and there is no possibility of any resolution of her problem in the future". He completely attributes her current disability to the motor vehicle accident in 1978 and refers to her industrial accident as a "minor aggravating factor". That is inconsistent and nonsense in itself, particularly when she was off work for a longer period of time following the industrial accident than for the motor vehicle accident. Dr. F's evidence is totally unreliable, untrustworthy and unacceptable.

In a previous case, I expressed a good deal of concern with Dr. F's evidence. I attached little weight to it. I was not impressed with him as an expert witness. On appeal the Court of Appeal agreed:

> "The rather cavalier way in which Dr. F readily attributed the cause of the appellant's complaints to the automobile accident and at the time showed a complete lack of concern with regard to the appellant's pre-accident history of her back problems constituted evidence from which the trial judge could properly reach the conclusion that Dr. F's medical opinion, both as to cause and duration of the appellant's complaints, should carry little weight. Moreover, from an examination of the record, it appears that Dr. F's reluctance on cross-examination to admit the obvious significance of the pre-accident history in ascertaining the cause of the injuries, lends support to that conclusion."

Dr. F's opinion has also been questioned in many other trials:

> "It is difficult to understand why Dr. F did not, until cross-examination at trial, correct the error he clearly made in assuming that the accident had caused a compression fracture of the thoracic vertebra. Dr. F perpetuated the belief the accident caused the compression fracture in the several reports right, (sic) right up to a report of July 15, 1987.
>
> In these circumstances, I find that Dr. F's opinion is unreliable and unacceptable."

In the case at bar Dr. F cannot expect the court to place any weight on evidence that virtually makes a full circle.

LESSON 5: Do not opine outside your area of expertise

Mr. Justice Vickers ... noted comments made by Mr. Justice Finch in "Expert Witnesses, Opinion Evidence and Privilege", (1989) 47 Advocate 21 at p.21:

> The problem that has developed with opinion evidence generally is that experts have been encouraged by lawyers, and permitted by judges, to go far beyond the proper scope of opinion evidence. The experts have become advocates. They assume facts favourable to the parties who retain them. They give opinions based upon other opinions, the factual premises of which are in dispute.

It is regrettable but, in light of previous judicial comment, I feel it necessary to comment regarding the propriety of counsel representing defendants in cases such as the one at bar (who are in my understanding effectively ICBC) tendering evidence such as that given by Mr. G. In the following cases Mr. G has been called as an expert witness:

... In each of those cases the Court has commented that his opinion outreached his expertise. After so many instances of negative judicial comment, over so many years, for ICBC to continue to tender Mr. G's incomplete and too far-reaching opinions is, in my view, utterly inappropriate.

LESSON 6: Do not be argumentative

> While I found Dr. H to be a very knowledgeable witness, during his testimony, particularly during cross-examination, he had difficulty maintaining the appearance of impartiality and independence, and instead appeared to adopt the role of advocate or partisan on the plaintiff's behalf. He was prepared to express opinions that went beyond the areas he was specifically asked to address, and sometimes diverged into areas in which his qualifications as an expert could not be said to extend. He was argumentative with counsel, and unduly defensive in response to a pointed, but polite cross-examination. For that reason, while I do place weight on the results of the testing administered by Dr. H, I find his opinions based on more subjective considerations to be entitled to little or no weight.

B. Do not comment on the credibility of the patient

As experts, doctors should not comment on the credibility of the patient. The Waddell Signs are a good example of where this can happen.[19] The Waddell Signs are occasionally used by expert doctors as a means to justify opining on the credibility of the patient. They should not be used for this purpose and there is medical literature to support the position that positive Waddell Signs do not signify malingering.[20] It is appropriate to comment on the results of the Waddell Signs but credibility is for the judge and jury to determine. By commenting on the credibility of the patient, the expert assumes the role of advocate which undermines his or her credibility with the trier of fact.

VI. What do experts need to know about the Supreme Court Civil Rules?

A. Duty of the Experts

The *Supreme Court Civil Rules* are the rules that govern expert reports and the role of experts at trial. The rules state:

> **Duty of expert witness**
> (1) In giving an opinion to the court, an expert appointed under this Part by one or more parties or by the court has a duty to assist the court and is not to be an advocate for any party.

The common law has always required experts to be objective and to fulfill this duty to the court. The requirement for experts to acknowledge their duty to the court in writing was adopted in response to frustration by the courts with experts who were increasingly adopting the role of advocate.[21] While it is appropriate to advocate for an opinion it is inappropriate to advocate for a party. That is the role of the lawyer not the expert.

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[19] Named after G. Waddell from his article co-authored by J.A. McCulloch, E. Kummel & R.M. Venner "Nonorganic physical signs in low back pain" (1980) 5 *Spine* 117; The Waddell Signs can be used to detect whether or not there is a non-organic cause of a patient's pain.

[20] D.Fishbain et al., "A Structured Evidence-Based Review on the Meaning of Nonorganic Physical Signs: Waddell Signs" (2003) 4 *Pain Medicine* 141; D. Fishbain, R. B. Cutler, H. L. Rosomoff, & R. Steele Rosomoff, "Is There a Relationship Between Nonorganic Physical Findings (Waddell Signs) and Secondary Gain/Malingering?" (2004) 20 *Clinical Journal of Pain* 399.

[21] *Supra* note 5, at para. 19.

Expert reports **must** contain a certification which states that the expert has a duty not to be biased. The Rule requires that the expert report include the following:

(a) The expert is aware of his or her duty in 11-6(1) referred to above;
(b) The expert has made the report in conformity with that duty, and
(c) The expert will, if called on to give oral or written testimony, give that testimony in conformity with that duty.[22]

B. Timelines

In British Columbia, the admissibility of expert evidence is governed by Rule 11-6.[23] Under Rule 11-6 the expert report must be served on all parties at least 84 days prior to the beginning of trial.[24] A responding expert report must now be served on all parties at least 42 days prior to trial.[25] The expert also has the opportunity to provide a supplemental report if new information has come to light which alters the original opinion in a material way.[26]

VII. Conclusion

Experts are essential resources to the court, providing the benefit of their knowledge and experience to the judge and jury. Expert doctors must provide opinions that are objective and intellectually honest. Experts that become advocates for a party fail in their duty to the court. They also run the risk of negative comments from a judge which can tarnish their professional reputation. Experts who are impartial and concise can be of great assistance to the court and to counsel. Cases can often resolve and issues can be narrowed because an expert has done a good job.

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[22] *Supra* note 11, Rule 11-2.
[23] *Supra* note 11, Rule 11-6
[24] *Ibid*, Rule 11-6(3).
[25] *Ibid.* Rule 11-6(4).
[26] *Ibid.* Rule 11-6(6).

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SAMPLE MEDICAL LEGAL REPORT

May 9th, 2012

PRIVILEGED – PREPARED FOR COUNSEL

Ms. Wandy Lawyer
The Best Law Offices
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Box 121, 1000 Your Street
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RE: INDEPENDENT MEDICAL EXAMINATION
MS. YOUR CLIENT
DOB: September 3, 1973
MVA: January 1, 2004
File No.: 0912

I acknowledge correspondence from you dated November 3rd, 2009, asking me to conduct an independent medical examination of Ms. Your Client in regards to the above-referenced motor vehicle accident. I note that as a result of the accident she is alleging injuries to her head, temporomandibular joint (TMJ), neck, left shoulder, left arm, left wrist, right shoulder, upper back, mid back, low back, hips and knees. She is also alleging problems with pain, suffering, headaches, depression, nauseousness/vomiting, sensitivity to light, ringing in the ears, sleep problems, anxiety, memory problems, pain in both feet, loss of enjoyment of life and loss of earning capacity.

You asked me to address seven different issues, which I will do in the body of my report.

STATEMENT OF QUALIFICATIONS

I am a medical doctor licensed to practise in British Columbia since 1980. I completed medical school training at the University of Western Ontario in 1974, worked as a general practitioner for five years and completed specialty training in psychiatry in 1985 at University of British Columbia. I am a member of the Canadian Psychiatric Association. I was the Head of the Department of Psychiatry and Psychiatrist-in-Chief at Children's & Women's Health Centre of British Columbia from 1987 until 2007. I am the Psychiatric Consultant to Life Mark Brain Injury Program. I am a Clinical Professor in the Department of Psychiatry, University of British Columbia. A brief curriculum vitae is attached to this report.[1]

[1] Curriculum Vitae – Derryck H. Smith, M.D., F.R.C.P.(C)

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I have completed more than 1,000 independent medical examinations.

I am a member of the editorial board for the *Canadian Psychiatric Journal* and a member of the scientific review board for the Canadian Psychiatric Research Foundation and the Ontario Neurotrauma Foundation.

I have been certified as an expert in disability assessments by the American Board of Independent Medical Examiners.

I have been accepted as an expert in psychiatry in the Supreme Court of British Columbia on a number of occasions. As a psychiatrist, I have expertise in the interpretation of psychological and neuropsychological testing.

I deliver lectures and courses on a regular basis concerning traumatic brain injury, the psychiatric sequelae of trauma, and Attention Deficit/Hyperactivity Disorder in children, teenagers and adults.

In my practice at the Children's & Women's Health Centre of British Columbia I mainly assess and treat children, youth and their parents. I have a private practice in which I mainly assess and treat adults. I have completed more than 1,200 independent assessments for adults experiencing disabilities in the workplace and routinely assess claimants as part of the adjudication process of the Claims Review Committee for unionized employees.

I have been the guest editor and author for a two-volume series in the *British Columbia Medical Association Journal* of November and December 2006 on mild traumatic brain injury. Currently I am the President of the Medical Legal Society of British Columbia.

I am personally responsible for reviewing the records, conducting the interviews and formulating the opinions in this report. The facts and assumptions on which I base my opinions are outlined herein.

In forming my opinion I rely upon all of the assumptions and facts found during my review of the records and my examination. My comments are identified by *italicized* text.

PURPOSE OF THIS REPORT

The purpose of this report is to address the medical and, in particular, the psychiatric and psychological sequelae of the motor vehicle accident of October 17th, 2005. I will comment on issues of causation, pre-existing conditions, prognosis and treatment.

I certify that in giving my opinion to the court, my duty is to assist the court and not to be an advocate for any party as referred to in Rule 11(2)(1). I have prepared my report in accordance with this rule and, if called to give oral or written evidence, will do so in accordance with it.

FACTS AND ASSUMPTIONS

The following is a summary of the facts and assumptions. Readers are directed to review the attached Appendices A and B for a full listing of facts and assumptions. I also acknowledge that the lines between facts, assumptions and opinions are not entirely clear.

1. Ms. Your Client was born in Ottawa. She was sexually abused at age 3. She was frequently and severely neglected. She was forced to drink her own urine. She was removed by social services at age 5.

2. She was in a foster home between the ages of 5 and 11 and developed behavioural problems.

3. Between ages 11 and 16 she was involved in drug use and prostitution.

4. Ms. Your Client ran away from Ottawa and moved by herself to Vancouver at age 14. At age 15 she became pregnant and had a son, who is currently 18.

5. At age 21 she had a daughter with her husband. This relationship lasted about 10 years.

6. It was reported that she achieved her GED (general educational development) at age 20.

7. At age 21 she had a son. Her relationship with her husband lasted for about 10 years. In her late 20s the relationship broke up, and she became distressed. The Ministry of Children and Family Development placed her son with the father's mother, but her son is now back living with Ms. Your Client.

8. From the records of Dr. Abrahams she was concerned that she had shared a needle with someone with AIDS in August of 1991.

9. In February of 1993 she was depressed and was treated with the antidepressant medication Zoloft.

10. In January of 2003 this woman injured her left leg and required surgery by an orthopedic surgeon to fix this.

11. In February of 2003 she was occasionally binge drinking and using marijuana occasionally. In August of 2005 she was feeling stressed and depressed.

12. The Canada Revenue Agency recorded income in 2001 of less than $3,500. In 2002 it was slightly above $3,500, and in 2003 it was $11,750.

13. I reviewed an undated biography of this woman in which she states that she has ADHD (Attention Deficit/Hyperactivity Disorder).

14. She graduated from Capilano University with a certificate in acting. Her grade point average (GPA) was 3.23. In May of 2001 she went on to take a term at UBC (2001/2002) working towards a bachelor of fine arts and had four courses scoring a B.

15. Dr. Ron Abrahams as of August 30th, 2005 identified that this woman is suffering from severe depression, which is resistant to treatment and is likely to persist for the next nine to twelve months.

16. On October 17th, 2005, Ms. Your Client was walking across Any Street when she was struck by a truck. There is no evidence that she suffered a loss of consciousness. She was lifted off her feet but landed back on her feet. She was able to take the bus to St. Paul's Hospital, where she was examined.

17. She was assessed in the emergency room. It was noted that she had an exaggerated pain response. There were no objective findings. She was diagnosed with a contusion. She stated that her arm was numb in a glove distribution, but she would not allow any motion of the shoulder, elbow or wrist.

18. She followed up with Dr. Abrahams on October 21st, 2005. There was no loss of consciousness. She was diagnosed with a soft tissue injury and advised to treat herself with ice and physiotherapy.

19. Dr. Abrahams first prescribed narcotic analgesics on November 4th, 2005, and she has essentially been on narcotics since then in escalating doses.

20. In November she received some counselling from her doctor in regard to her son. She was complaining of neck and back pain as of November 25th, 2005.

21. Ms. Your Client was seen in the emergency room at Vancouver General Hospital (VGH) on July 3rd, 2006, with neck pain. She was treated with Tylenol 3.

22. She attended the emergency room at St. Paul's Hospital on July 24th, 2006, with a complaint of dizziness and neck pain. She was treated with Percocet and Ativan.

23. The pain specialist Dr. Condon in July of 2006 diagnosed this woman with chronic regional pain syndrome, and he recommended rehabilitation rather than surgery. She was assessed by the neurosurgeon Dr. Turnbull in September of 2006. He noted a number of non-organic findings. This woman refused to move her head more than 20 degrees. He noted that there had been an unusual episode of paralysis.

24. On September 15th, 2006, she was seen with a complaint of left arm pain and was treated with Ativan and oxycodone.

25. In November of 2006 Dr. H. Lau opined that there was no evidence of chronic regional pain syndrome. He felt that the pain was related to disc protrusion in her neck.

26. This woman was admitted to the department of psychiatry at St. Paul's Hospital between November 23rd and November 27th, 2006. She presented primarily because of pain. Pain was causing her to have flashbacks of memories of abuse. It was noted that there is a sister who suffers from depression and has made multiple suicide attempts and a brother who had also made suicide attempts. She was diagnosed with Major Depression secondary to pain. I can see no concerted effort to treat this woman for depression. She was prescribed the antidepressant medication Celexa, 10 mg, but this is a subtherapeutic dose. Unfortunately there was no discharge summary from this admission.

27. She attended the emergency room at the emergency room on December 3rd, 2006. She had some vaginal bleeding, which led to her developing dizziness and vertigo.

28. On December 6th, 2006, she arrived at the emergency room at Vancouver General Hospital complaining of having paralysis in her arms and legs since an epidural injection at St. Paul's Hospital.

29. She presented to the emergency department at Vancouver General Hospital with suicidal thoughts because of earaches and headaches. She also complained of tinnitus. From the emergency department she was admitted to the psychiatry department at Vancouver General Hospital between January 6th and 23rd, 2007. She presented with many somatic symptoms. As part of the investigation, she was assessed by the psychologist Dr. Chotem, who gave this woman two instruments to fill out on her own. On the Personality Assessment Inventory (PAI) there was evidence that this woman's symptoms were exaggerated. She was diagnosed by Dr. Chotem as having severe Major Depression and Post-Traumatic Stress Disorder (PTSD), although no attribution was given to either of these diagnoses. In the discharge summary from Dr. Miller she was diagnosed on Axis I with, 1, Post-Traumatic Stress Disorder, 2, Depressive Disorder NOS, and 3, rule out Somatoform Disorder. On Axis II she was diagnosed with narcissistic and borderline traits, and her GAF (Global Assessment of Functioning) was 25 on admission and 50 on discharge, although I note from the emergency room records the initial GAF was higher. It was noted that this woman is not able to express herself emotionally and likely produces physical symptoms in response to psychological distress. In spite of the fact that this woman was on a psychiatric ward for 17 days there does not appear to be any significant psychiatric follow up other than noting that this woman could access SAFER (Suicide Attempt Follow-up, Education and Research), which is a suicide prevention counselling service.

30. She was referred to see the pain specialist Dr. Armstrong. In February of 2007 he opined that she needed twice weekly rehabilitation exercises. He diagnosed this woman with chronic myofascial pain and pre-existing Generalized Anxiety Disorder. He opined that she was totally disabled and that she needed a rehabilitation program.

31. In February of 2007 Dr. C. Fisher noted that this woman has chronic pain behaviour.

32. Ms. Your Client was assessed by the neurologist Dr. Curt in March of 2007. He noted that there were no findings of carpal tunnel syndrome. In fact he opined that this woman suffered from a "severe psychiatric disorder" and needed treatment. He did not believe that there was any evidence of discogenic neck pain.

33. In May of 2008 Dr. R.C. Schweigel noted that this woman reports pain in her neck and arm, but there are no physical findings. He does not believe that there is any operation that is going to relieve her symptoms.

34. Dr. Abrahams in May of 2008 noted that this woman was being treated with methadone, 12 mg a day. She was complaining of "brain tingling" and memory loss. The diagnosis was non-organic causes.

35. The neurosurgeon Dr. Richard Chan in July of 2008 recommended that this woman have a discectomy at C5/6, which he performed on August 6th, 2008. In follow-up he was concerned that this woman may have some left carpal tunnel symptoms. He did not appear to be aware that Dr. Curt had ruled this out in March of 2007. In April of 2009 Dr. Chan recommended discontinuing morphine and continuing, along with methadone, Lyrica and baclofen. This advice has not been acted on.

36. The orthopedic surgeon Dr. Masri in November of 2008 notes that as a teenager Ms. Your Client was using marijuana, cocaine, LSD and heroin. He opined that she sustained no substantial injury secondary to the pedestrian/motor vehicle accident and the disc problems are unrelated based on the fact that there was calcium in the disc, indicating a chronic process. He has summarized that there were "lots of hysterical symptoms with no organic or structural basis."

37. Based on my examination Ms. Your Client presents with ongoing but reduced pain in her left arm and shoulder. She also has pain in her neck, left temporomandibular joint and both hips. She believes she has been diagnosed with fibromyalgia. She reported having pain and emotional symptoms with vaginal bleeding. She also believes she has a lump on her spine because of the surgery that she underwent from Dr. Chan.

38. Ms. Your Client has difficulty initiating sleep. She experiences pain at night while sleeping. She feels tired throughout the day and tries to sleep in the evening two or three times a week.

39. Currently Ms. Your Client is living with her son. This boy has been ill, and from what her mother told me she was recently diagnosed at BC Children's Hospital as having non-epileptic seizures, a condition likely related to emotional distress. They live in an apartment that they are renting.

40. Ms. Your Client is looking for work as a writer, entering competitions sponsored by TeleFilm Canada. She was unsuccessful in the last competition.

41. She told me that she has been accepted into an outpatient therapy program for Post-Traumatic Stress Disorder at Vancouver General Hospital, a program that she will start in mid January of 2010.

CURRENT MEDICATIONS

Her current medications include:

1. methadone, 12 mg per day
2. morphine, 50 mg per day
3. baclofen, 10 mg twice daily
4. Topamax, one at bedtime
5. Ativan, one per day
6. Seroquel, 75 mg at bedtime

OPINION

Your Client had a horrific childhood marked by physical and sexual abuse as well as neglect. She was apprehended at age 5 and placed in a foster home but did not thrive in this environment. She began using street drugs as an 11-year-old and engaged in prostitution. At age 14 she ran away and came to Vancouver.

To her credit she obtained her grade 12 equivalency and went on to study at Capilano College and UBC in the field of writing for films.

Ms. Your Client is at considerable risk for developing a psychiatric illness given the fact that both of her parents suffer from alcoholism and her mother suffered from depression. Ms. Your Client herself has been treated for depression episodically since 1993. In an autobiography she wondered whether she had Attention Deficit/Hyperactivity Disorder, but this diagnosis has never been made. There was good evidence from the records of Dr. Abrahams that this woman was suffering from severe depression that was resistant to treatment as of August 30th, 2005.

On October 17th, 2005, she was a pedestrian crossing Any Street when she was struck by a truck. It is my opinion, based on the description of this accident, that she did not suffer a loss of consciousness or traumatic brain injury. She managed to land back on her feet and then took the bus to St. Paul's Hospital. She had an exaggerated pain response.

In the ensuing hospital records and in particular the discharge summary of Dr. Debra Miller from Vancouver General Hospital it is noted that this woman does not have much of an emotional vocabulary. I noted this during my examination as well. Individuals with this type of a psychological makeup are frequently unable to express emotional distress and do so through the production of physical symptoms or pain. It is my opinion that this explains many of this woman's unusual symptoms and elevated pain levels. This also explains the so called "non-organic" findings of Dr. Turnbull in September of 2006.

There have been various opinions as to the cause of this woman's pain, including opinion pro and con on a diagnosis of Chronic Regional Pain Syndrome (CRPS).

She was admitted to the Department of Psychiatry from the emergency room on November 23rd and November 27th, 2006. It is clear that the pain she was experiencing was triggering flashbacks to the abuse she suffered as a child. Although she was diagnosed with Major Depression, she was inadequately treated with a subtherapeutic dose of Celexa, 10 mg.

She went on to have some epidural injections to assist with back pain, but she reacted badly to these and presented in a paralyzed state at Vancouver General Hospital on December 6th, 2006, but again there was a lack of organic findings.

She was subsequently admitted to the hospital and had multiple somatic symptoms. There was evidence on the Personality Assessment Inventory that her symptoms were being exaggerated. She was diagnosed with Post-Traumatic Stress Disorder and a Depressive Disorder with a rule-out of a Somatoform Disorder.

ISSUES OF A SOMATOFORM DISORDER

The common feature of the Somatoform Disorders is the presence of physical symptoms that suggest a general medical condition but are not fully explained by the medical condition. It is my opinion that the medical records show ongoing unexplained somatic symptoms and pain that is deemed to be exaggerated in the context of the physical findings. One of the Somatoform Disorders is Pain Disorder, in which pain is the predominant focus of clinical attention but psychological factors are judged to have an important roll in its onset, severity, exacerbation and maintenance.

It is my opinion that this woman does qualify for a diagnosis of Pain Disorder.

ISSUES OF DEPRESSION

It is clear that this woman suffered from episodes of Major Depression prior to the motor vehicle accident in question. She is at very significant risk for depression given the family history, including alcohol abuse, episodes of depression and her sister's suicide. It is well recognized that the genes for alcoholism are the same genes that are responsible for depression. Her family physician Dr. Abrahams noted that as of the end of August of 2005 that this woman was suffering from severe depression that was resistant to treatment and that this condition would likely persist for up to one year. It is therefore evident that at the time of the motor vehicle this woman was very significantly and severely depressed. It is clear that these symptoms of depression persisted after the motor vehicle accident but she has received, in my opinion, inadequate treatment. For example, she received treatment at St. Paul's Hospital with a subtherapeutic dose of the antidepressant Celexa. Although it is my opinion that she is still suffering from depression, she is not currently under any active treatment for depression.

POST-TRAUMATIC STRESS DISORDER

Ms. Your Client has been diagnosed by various psychiatrists as suffering from Post-Traumatic Stress Disorder as a result of this accident. I am in agreement that she meets many of the criteria for PTSD, although her symptoms are somewhat in remission. Yet again it does not appear that she has ever received effective treatment for this condition, but she told me that she has now been accepted into a PTSD program at Vancouver General Hospital, where hopefully she will receive some effective interventions.

DIAGNOSIS

Axis I

1. Pain Disorder secondary to the motor vehicle accident of October 17th, 2005, although this woman may have had predisposing issues from her past life that made her susceptible to pain.

2. Major Depression a pre-existing condition.

3. Post-Traumatic Stress Disorder: This woman was vulnerable to developing PTSD given her past history of gross abuse, neglect and assault. Having said that, it would appear that the motor vehicle accident did trigger symptoms of PTSD with intrusive memories directly related to the motor vehicle accident for which she has never received effective treatment.

Axis II Diagnosis deferred.

Axis IV Psychosocial stressors: severe. This woman is on disability or some type of social support. Her daughter is likely suffering from a somatoform-type disorder marked by seizures that are emotionally regulated. She is very concerned about whether she is ever going to be able to get back to her career, but it is not clear to me from the review of her records that she was ever terribly successful as a writer.

Axis V Global Assessment of Functioning – 55. This woman has moderate symptoms and has moderate difficulty in social and occupational functioning.

TREATMENT RECOMMENDATIONS

1. Ms. Your Client requires effective treatment for all three of her psychiatric conditions. Without such treatment it is unlikely that she is going to improve. She needs to be referred to a community-based psychiatrist who will organize and monitor her ongoing treatment, including treatment for PTSD, which is likely to start at the outpatient department. It may well be that one of the psychiatrists at Vancouver General Hospital would take her on as a long-term patient. Maintaining consistent follow-up with a single psychiatrist will be critical to her overall outcome.

2. I should note that there are a number of obstacles to obtaining ongoing effective psychiatric care. Many times psychiatrists are frustrated with individuals with Somatoform Disorders, particularly Pain Disorders.

3. This woman also requires effective treatment for Post-Traumatic Stress Disorder and treatment with psychotherapy and an antidepressant for her Major Depression, which is currently in partial remission.

4. Another resource, perhaps the best hospital-based program, would be the Pain Program at St. Paul's Hospital, which has psychologists, psychiatrists and pain experts. The wait list for this program is unfortunately very long.

5. It is also imperative that Ms. Your Client receive some type of treatment or counselling for dealing with her daughter, who appears to have a similar Somatoform Disorder to her mother. Her daughter needs to be under the care of a community-based child and adolescent psychiatrist, and Ms. Your Client should be involved in the sessions with her daughter's psychiatrist as well.

PROGNOSIS

It is my opinion that with effective ongoing psychiatric treatment aimed at managing her Pain Disorder, Major Depression and Post-Traumatic Stress Disorder, this woman can be returned to the level of functioning she had prior to the motor vehicle accident of October 17th, 2005. Having said that, she has suffered a horrendous childhood and has a large genetic loading for depressive and other types of psychiatric illnesses, and it is not clear to me that she was functioning particularly well, based on her employment earnings, and the fact that she was severely depressed as of the end of August 2005, even prior to the motor vehicle accident.

Her chosen profession of being a writer is uncertain at the best of times, and there may be some role for vocational counselling to attempt to get her into a more regularized profession that could result in more certainty in terms of job and income.

REQUEST FOR ADDITIONAL RECORDS

1. A service was billed to the psychiatrist Dr. Susan Golden in June of 2006. You should secure these records.

2. There is a psychiatric consultation from Dr. Voutsilakos from May 7th, 2009, which should be reviewed.

3. Most important is to secure the raw test data of Dr. Chotem from January of 2007. The PAI has validity variables that would suggest that this woman is exaggerating her symptoms. I would like the opportunity to review these.

I am the sole person responsible for this report. My findings and conclusions are based on information contained herein.

Yours respectfully,

Derryck H. Smith, M.D., F.R.C.P.(C)
Clinical Professor, Department of Psychiatry
University of British Columbia

APPENDICES

Appendix A – Review of Records

Appendix B – Clinical Interview

Appendix C – Additional Clinical Interview